2005 Report on Children and Youth

Served by the District of Columbia Department of Mental Health

June 2005

Presented to the Dixon Court Monitor

by

Human Systems and Outcomes, Inc.

Table of Contents

2005 Report on Children and Youth

Served by the District of Columbia Department of Mental Health

June 2005

Background and History

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 2003 review had 77% of the children having overall child status ratings in the acceptable range. Likewise, overall system performance was acceptable for 46% of the children in the 2003 review.

The 2004 Dixon Court Monitoring Children's Review had a larger sample (n=54). Review activities for the 2004 children's review were completed in March 2004. The results for the 2004 children's review had 74% of the children in the review having overall acceptable child status ratings and 43% of the children having overall acceptable system performance ratings.

2005 Dixon Court Monitoring Children's Review

The design of the 2005 sampling process, training of reviewers, supervision of data collection, and analysis of data were conducted by Human Systems and Outcomes, Inc. (HSO), an organization with extensive experience in 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. Logistical preparation and set up of the on-site case review activities were completed by Consumer Action Network (CAN). HSO expresses their deep thanks to CAN for completing the arduous task of setting up a large number of individual case reviews.

In reading this report, the reader must recognize that a large systemic change process is occurring in the District of Columbia for children's mental health services that is going to take multiple years to bring individualized, highly coordinated services to each child and family served to a consistent and fully functional level of performance across all provider agencies. Considering the large number of core service provider agencies offering children's mental health services, there is going to be some variability in the consistency of providing services commensurate with the expectations of the practice principles of Dixon. Similarly, such variability will also exist within the large number of staff working with children having mental health needs across the district. Although the 2005 findings are consistent with the review findings from the previous two on-site reviews, information learned throughout set-up activities, stakeholder interviews, and interviews of staff during the individual case reviews indicate that understanding, knowledge, awareness, and implementation of the Dixon-specified practice principles and model of practice have continued to grow across the district. Considerable progress continues to be made, and although this growth may not be entirely reflective in the data from the individual case review findings,

the system has reached the point in which more focus and effort are being put into providing services at the high level of practice specified by the Dixon Consent Decree.

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 (DMH) ECURA data system. In order to be eligible for inclusion in the review, the child must have received at least one form of a billable mental health service from a provider agency since June 1, 2004. This strategy was taken due to the experiences in previous reviews in which a proportion of children had no contact with, or were unknown to, providers (e.g., the child and family had been referred to the provider from the Access Help-Line, but there was no contact between the provider and the child and family, or the child and family refused services after referral), despite being listed in the ECURA data system. This strategy successfully reduced the number of no contact, or unknown, children and families (e.g., in 2004, there were 2,675 children listed on the ECURA system, but it was a proportion of these children that had not had contact with a core service agency and, thus, had not received services).

A stratified sample of 54 children was obtained from the larger sample of 162. The sample size was determined using a binomial distribution sampling table that would yield an estimated range of the underlying distribution of acceptable or non-acceptable performance at a 95% confidence level. This strategy for determining sample sizes has been determined to be an effective means of establishing an overall service-level baseline in other states that use similar case review methodologies as a measure for monitoring Consent decree compliance.

A brief survey instrument was sent out for providers to complete for each of the initially randomly selected children in order to gain some background information about the children so that the sample could be stratified across the following points: (1) provider agency, (2) age of child, and (3) child's level of need.

Provider Agency

According to the information supplied to HSO by the D.C. Department of Mental Health, there were a total of 2,013 children who had received a billed-for service since June 2004 from 15 different provider agencies. These data were taken from the ECURA system. These provider agencies differ substantially in the total number of children they serve. Approximately 97% of all children/youth receiving services are receiving them from the seven largest providers within the district. As such, the sample of children included in the review was proportionally selected based on size of agency from these largest core service agency providers for children and youth. Listed, these agencies are: (1) Community Connections, Inc.; (2) The District of Columbia Core Service Agency (DCCSA); (3) The Center for Mental Health, Inc.; (4) Fihankra Place; (5) First Home Care; (6) Universal Health Care; and (7) Scruples Corporation. Display 1 provides a breakdown of the number of children receiving services across these seven agencies, separated by age ranges. **However, in order to ensure that all children currently receiving services had the opportunity for inclusion in the review, one additional child was selected for the review from the remaining 3% of children receiving services from the smallest provider agencies for children and youth.**

Display 1
Number of Children Who Had Received a Billed Service Since June 2004, According to ECURA

Provider Agency	Ages 0-9	Ages 10-13	Ages 14+	Total
Center for Mental Health, Inc.	236	165	55	456
DCCSA	135	170	118	423
First Home Care	68	104	193	365
Fihankra Place	59	76	84	219
Scruples Corp.	53	68	68	189
Community Connections	48	59	57	164
Universal Health Care	31	60	38	129
Other Provider Agencies				68
Totals	630	702	613	**∑=2,013**

Note - There are 68 (~3%) children being provided services in the remaining provider agencies. Thus, one "at large" child was sampled from the remaining smaller provider agencies to allow for an equal chance of being selected for inclusion in the review.

Age of Child

The number of children receiving services at each site varies by the ages of the children. Three predetermined age ranges (0-9, 10-13, 14+) were specified as points to stratify the sample. The largest age range of children who had received a service since June 2004 was the 10-13 age range. It should also be noted that within the 0-9 age range, the majority of the children are ages five and older. There were 17 children selected for review from the 0-9 range, 20 children selected from the 10-13 range, and 17 children selected from the 14 or older range.

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 mix of services that they were receiving. Other level of care indicators, such as the current Global Assessment of Functioning Scale score and the CALOCUS score were also obtained. The breakdown for level of need is as follows:

Low Need:	Basic outpatient services (GAF 70 or higher)
Medium Need:	Intensive outpatient or wraparound services (GAF 50-69)
High Need:	Residential or partial hospitalization placement (GAF less then 50)

The majority of children were receiving services in the medium level of need range. Very few children in the original sample of 162 were either currently in a residential, or more restrictive, placement or had recently experienced a residential, or more restrictive, placement. Attempts were made during the set-up activities to ensure that the distribution of children's level of need included in the final sampling frame was reflective of the actual distribution of children's level of need noted through the background survey results.

Sampling Frame

Display 2 provides the final sampling frame for the 2005 children's review. This table indicates the number of children randomly selected from each agency separated by age range 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 2
Final Sampling Frame by Agency and Age Range (parentheses note triple sample)

Provider Agency	Ages 0-9	Ages 10-13	Ages 14+	Total
Center for Mental Health, Inc.	6 (18)	5 (15)	1 (3)	12 (36)
DCCSA	4 (12)	5 (15)	3 (9)	12 (36)
First Home Care	2 (6)	3 (9)	5 (15)	10 (30)
Fihankra Place	1 (3)	2 (6)	3 (9)	6 (18)
Scruples Corp.	2 (6)	2 (6)	2 (6)	6 (18)
Community Connections	1 (3)	2 (6)	1 (3)	4 (12)
Universal Health Care	1 (3)	1 (3)	1 (3)	3 (9)
Hillcrest	-	-	1 (3)	1 (3)
Totals	17	20	17	54 (162)

Children and Families Included in the Review

Display 3 provides the distribution of child reviews completed during the year-two review. As this table indicates, a total of 43 children were reviewed. Although the originally specified target of reviewing 54 children was not met, the review results are reflective of district-wide trends in the children's mental health system and the data are believed to be robust in their ability to make system-wide generalizations regarding the quality and consistency of practice across the D.C. mental health system. The primary reasons for not meeting the target of 54 children being included in the review was due to parents or legal guardians choosing not to allow the children to participate in the review (participation in the D.C. monitoring review is voluntary), difficulty locating the parents/legal guardians in order to gain consent to participate in the review, and the short timeframe (one month) given for the set-up activities. The short timeframe for set up is considered necessary in order for the review to be an accurate appraisal of the actual status of the child and the performance of the service system, since there exists the possibility of changes in the array of services and performance of the system as a result of being selected.

Display 3
Breakdown of Final Sample of Children Included in the Review
Separated by Provider Agency and Age Range

Provider Agency	Ages 0-9	Ages 10-13	Ages 14+	Total
Center for Mental Health, Inc.	4	6		10
DCCSA	3	3	3	9
First Home Care	1	4	4	9
Fihankra Place			2	2
Scruples Corp.	2	2	2	6
Community Connections	1	2		3
Universal Health Care	1	1	1	3
Hillcrest	-	-	1	1
Totals	12	18	13	43

Description of the Children and Youth in the Sample

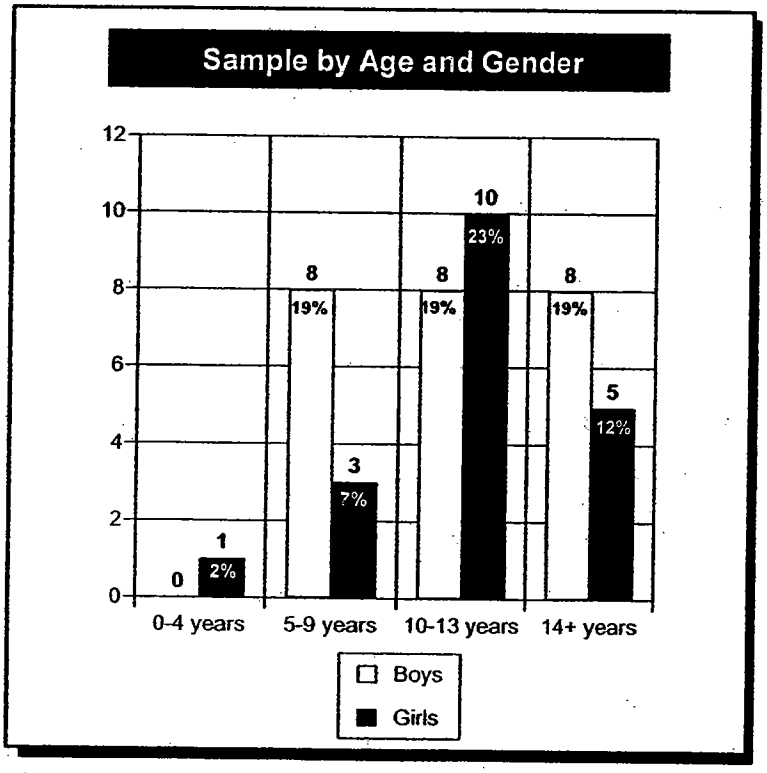
A total of 43 case reviews were completed during March 2005. These case reviews were completed over a two-week timeframe with the case reviews completed by reviewers trained to standard by HSO. Reviewers included both staff of DMH as well as external reviewers brought to D.C. to participate in the review activities. 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 3** (previous display) provides a breakdown of the final sample by core service agency, separated by age range, for the children and youth included in the review. The following display **(Display 4)** presents the aggregate sample of 43 children and youth distributed by both age and gender. As shown in this display, boys comprised 57% of the sample while girls comprised 44%. It is not uncommon for more boys to be receiving services from a System of Care within the active population. Children under age ten comprised 28% of the sample, and this is slightly less than the percentage of children age ten or younger receiving services (32%). Eighteen children (42%) 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 (36%). Thirteen teenagers (30%) were included in the review. This is comparable to the

total proportion of teenagers enrolled for services (31%). The age ranges of children included in the review are sufficiently comparable to the actual mix of age ranges of children who had received a service since June 2004, and the minor variations can be attributed to the final sample not meeting the target of 54 participants.

Display 4
Aggregate Sample Separated by Age and Gender

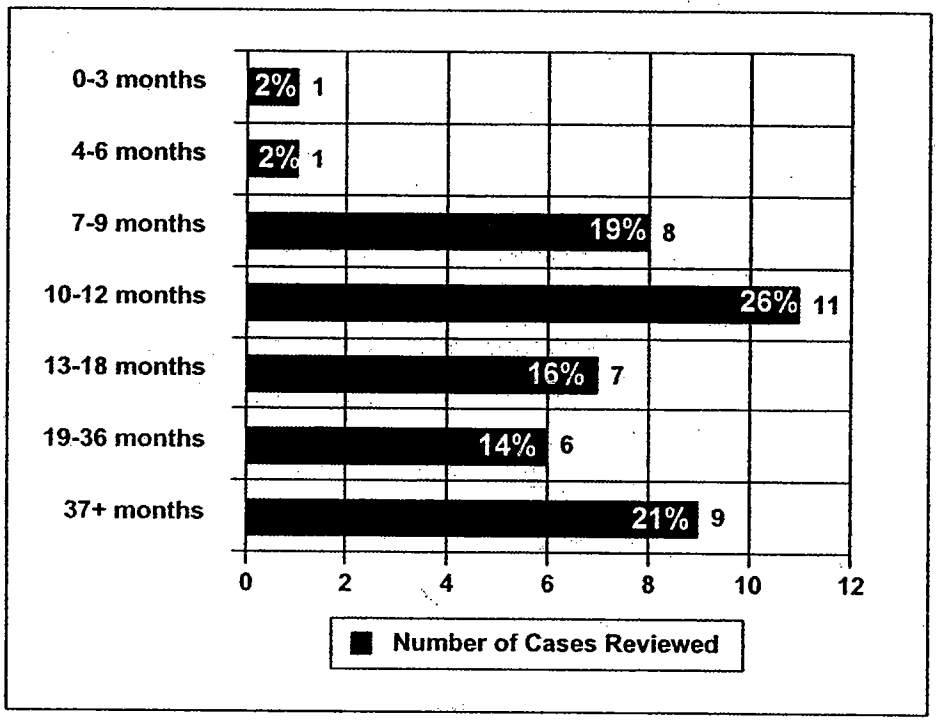


Source: DC Children's Review updated 5.4.05

Length of Mental Health Services

Display 5 presents the amount of time their cases had been open during their current, or most recent, admission for services. As can be seen in this display, 21 (49%) of the children's cases have been open for 12 months or less, 13 (30%) were open for 13 to 36 months, and nine (21%) were open for more than three years.

Display 5
Length of Time Receiving Mental Health Services

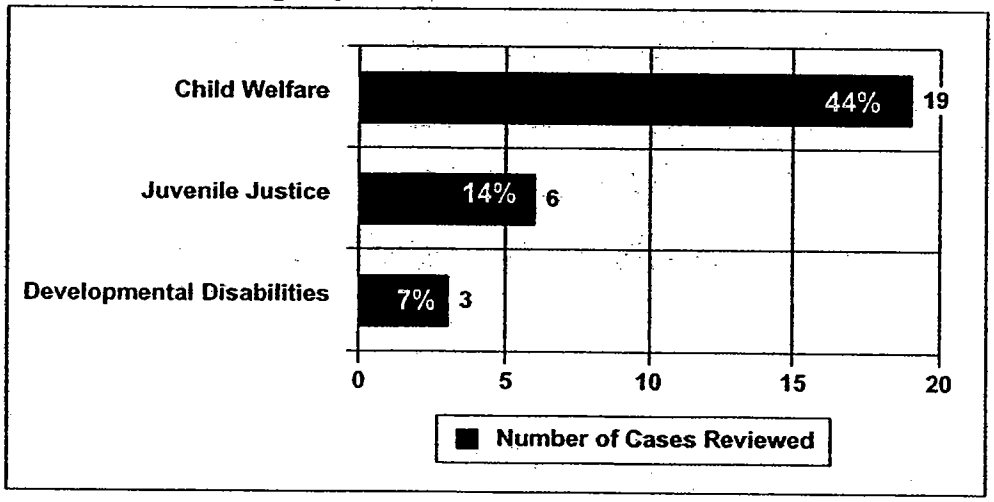


Source: DC Children's Review updated 5.4.05

Services by Other Agencies (not including education)

Some children and youth in the review sample were also receiving services from other major agencies. **Display 6** presents the number who were identified as being served by other key agencies: child welfare, juvenile justice, and developmental disabilities. As the display indicates, 19 children and youth (44%) in the review sample were involved with the child welfare system. For comparative purposes, 47% of the 2004 review sample and 23% of the 2003 review sample were receiving services from the child welfare system. There were six children (14%) who were involved with the juvenile justice system. In comparison to 2004 results, there were two children (4%) involved with the juvenile justice system. There were three children (7%) receiving services from developmental disabilities, which is comparable to 2004 results.

Display 6
Other Agency Providers Involved With Children

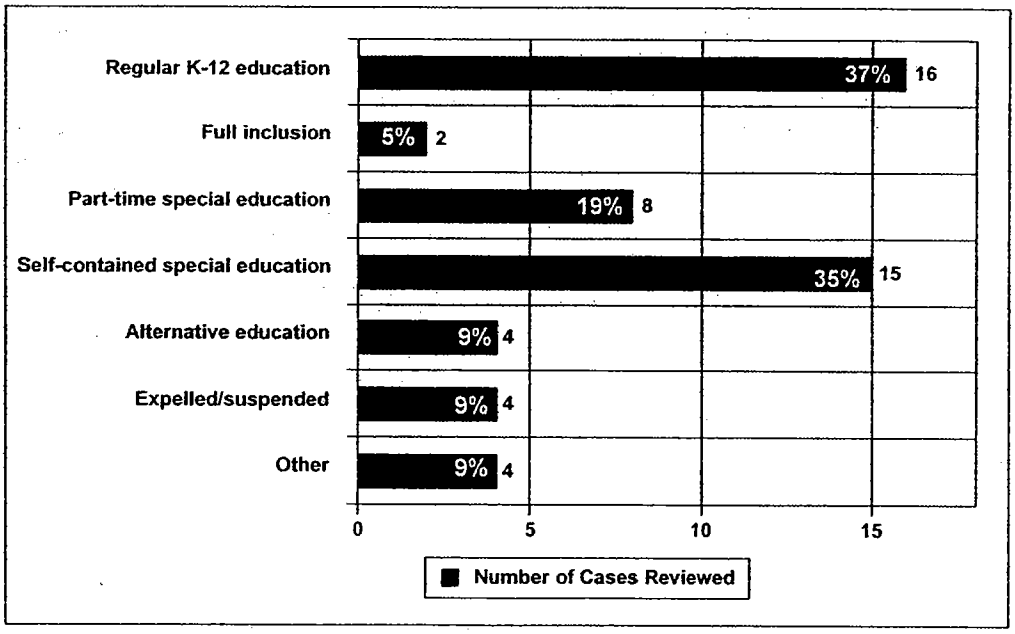


Source: DC Children's Review updated 5.4.05

Educational Program Placement

Getting an education and preparing for employment are major societal expectations for children and youth. **Display 7** describes the educational status/placement for the children and youth in the review sample. Sixteen (37%) were found to be participants in a regular K-12 educational program. Twenty-five (59%) were receiving special educational services, with 15 of those children receiving educational services in a fully self-contained program, eight in a part-time contained program, and two fully mainstreamed. Four children were either expelled or suspended at the time of the review. These children are not included in the breakdown of those in regular or special education settings. Two children or youth were in vocational programs, four in alternative education settings, one in an early intervention program (four or less years of age), and one child or youth in a boot camp academy, in which they were working on completion of their GED.

Display 7
Types of Educational Services/Placements or Educational Status For Children

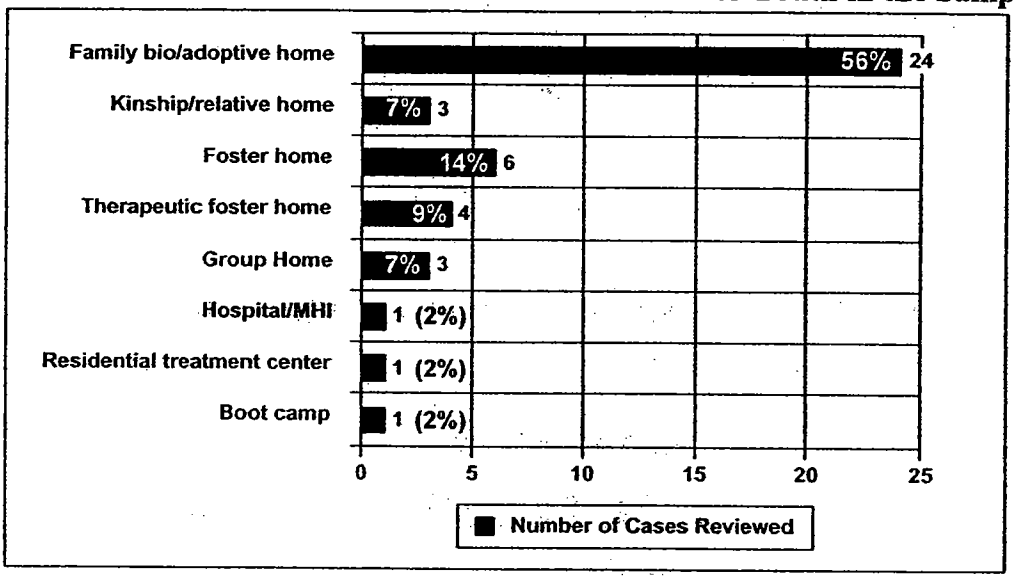


Source: DC Children's Review updated 5.4.05

Living Setting

Children and youth in the review sample were found to be living in a number of different home settings. **Display 8** shows the distribution of sample members according to their residences at the time of the review. Twenty-four (56%) of the sample members were living in their family homes while three (7%) were living with relatives. Ten children or youth (23%) were living in either foster homes or therapeutic foster homes, and six children (13%) were residing in congregate settings. Of those six children, three were living in group homes, one in a psychiatric hospitalization placement, one in a residential treatment center, and one in a boot camp setting.

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



Source: DC Children's Review updated 5.4.05

Placement Changes

The following table lists the total number of placement changes the child has experienced based on information learned during the review. The placement change history was assessed through either review of the record, or through interview findings, and is across the life of the child. Placement changes are defined as a change in the primary caregiver for the child as a result of agency intervention (including child welfare involvement). Nineteen children (44%) had experienced no disruption in placement, whereas 16 (37%) had experienced one or two changes;

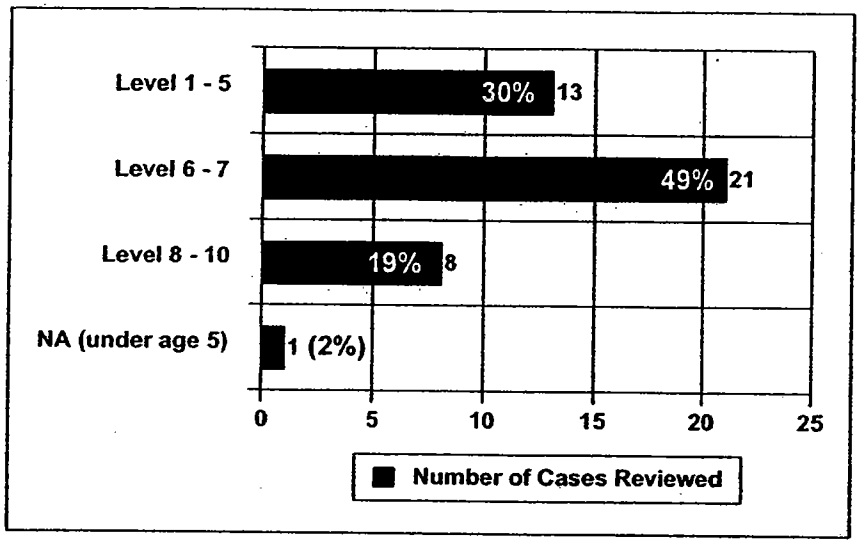
six (14%) had experienced 3-5 changes in placement, and two (5%) had experienced 6-9 changes in placement.

Placement Changes	Frequency in sample	Percentage of sample
No placement changes	19 children in final sample	44%
1-2 placement changes	16 children in final sample	37%
3-5 placement changes	6 children in final sample	14%
6-9 placement changes	2 children in final sample	5%

Functional Status

Display 9 provides the distribution of the review sample across functioning levels for the 43 children and youth age five and older. These are general level of functioning ranges, assigned by the reviewer at the time of the review according to criteria specified in the Dixon monitoring protocol. The scale is constructed somewhat like the Global Assessment of Functioning Scale. Ratings at the time of the review are assessed by the reviewer based on their impression of information learned throughout the review activities. On this scale, a child or youth in the low 1-5 range would be experiencing substantial problems in daily functioning in normal settings, and usually requiring a high level of support through intensive in-home or "wraparound" services. Often, children receiving scores from 1-5 on the functional status scale may be receiving services in a temporary treatment or alternative setting (or recently received services in one of these settings). A child receiving scores of 6-7 would have some difficulties or symptoms in several areas and are often receiving intensive outpatient or other in-home supports in most settings. A child or youth receiving scores of 7-10 had no more than a slight impairment of functioning but could be functioning well in normal daily settings, with only a minimal amount of supports.

Display 9
Functional Status of Children or Youth



Source: DC Children's Review updated 5.4.05

Thirteen (30%) in the review sample had level of functioning scores in the lowest range. The majority, or 21, (49%) of the children reviewed had scores in the mid-range. There were eight children (19%) in the highest level of functioning range. There was one not applicable, due to the child being less than five years of age.

The following table separates level of functioning ratings assigned by the reviewers sorted by the three previously set age ranges. When separating level of functioning by age range, 5-9 year olds and 10-13 year olds were most likely to be in the moderate level of functioning range, whereas, youth 14 or older were most likely to be in the lowest level of functioning range.

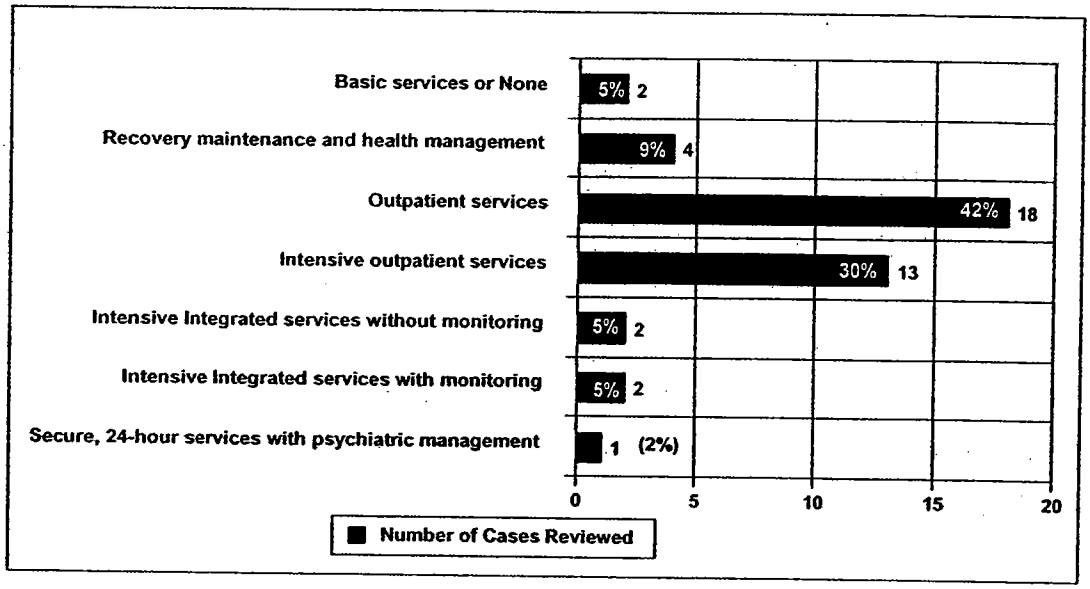
Age Ranges	Low Level of Functioning	Moderate Level of Functioning	High Level of Functioning	Totals
5-9	1 of 11 (9%)	7 of 11 (63%)	3 of 11 (27%)	Eleven 5-9 year olds in final sample
10-13	5 of 18 (28%)	11 of 18 (61%)	2 of 18 (11%)	Eighteen 10-13 year olds in final sample
14 or older	7 of 13 (54%)	3 of 13 (23%)	3 of 13 (23%)	Thirteen 14 or older in final sample
Totals	13 total children in low range	21 total children in moderate range	8 total children in high range	

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. Reviewers provided a CALOCUS rating based on their impression of the mix of services children were receiving at the time of the review using the decision matrix in the CALOCUS instrument. Reviewers were not intending to use the CALOCUS rating to specify whether a child should be receiving a different level of care other than what services were currently in place. The intent of using the CALOCUS was measuring what array of service levels children were receiving at the point in time that they were reviewed.

Display 10 presents the distribution of children according to their level of care. Two children (5%) were receiving basic/preventive services and four children (9%) were receiving recovery maintenance and health management services. Eighteen (42%) were receiving outpatient services and 13 (30%) were receiving intensive outpatient services. Two children (5%) were receiving intensive, integrated services without psychiatric monitoring while two (5%) children were receiving intensive, non-secure 24-hour integrated services with psychiatric monitoring. One child (2%) included in the review was receiving secure, 24-hour intensive services with psychiatric monitoring (pertaining to the one child in a psychiatric hospitalization placement at the time of the review).

Display 10
CALOCUS for Range of Services Received by Children or Youth in the Review Assessed by Reviewers

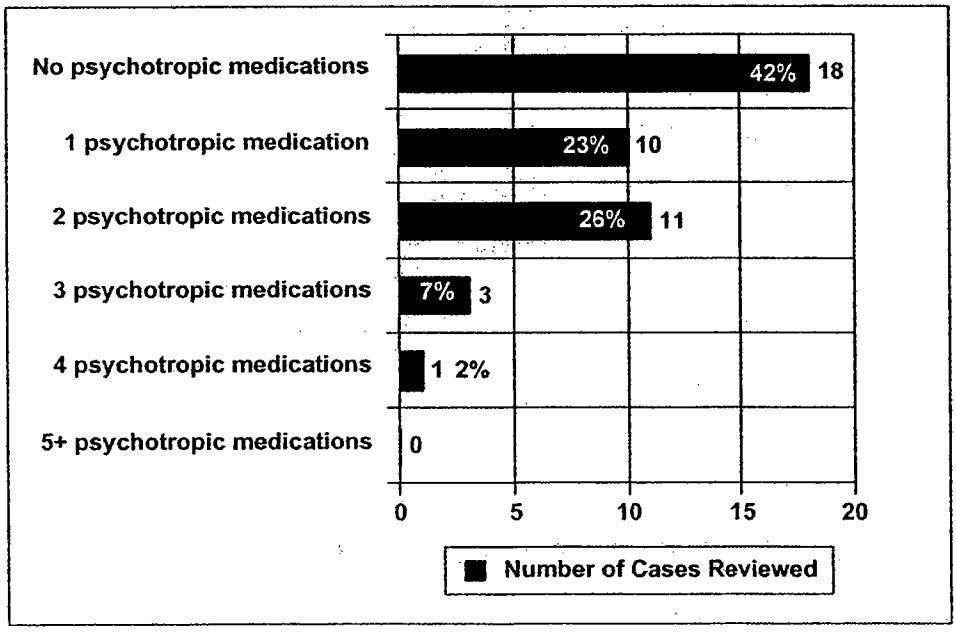


Source: DC Children's Review updated 5.4.05

Medications

The number of psychotropic medications taken by children and youth in the review sample were counted and reported by reviewers. **Display 11** presents the frequency count on medications taken by sample members. Eighteen (42%) children and youth in the sample were not prescribed psychotropic medications at the time of the review, which is comparable to the 43% not receiving psychotropic medications in the 2004 review. Ten children (23%) were taking only one medication, 11 (26%) children were taking two medications, three children (7%) were taking three medications, and one child (2%) was taking four medications. No child or youth was taking more than four medications, with a substantial majority of the children or youth either not taking any psychotropic medications, or taking one or two medications.

Display 11
Number of Psychotropic Medications Taken by Children or Youth at the Time of the Review

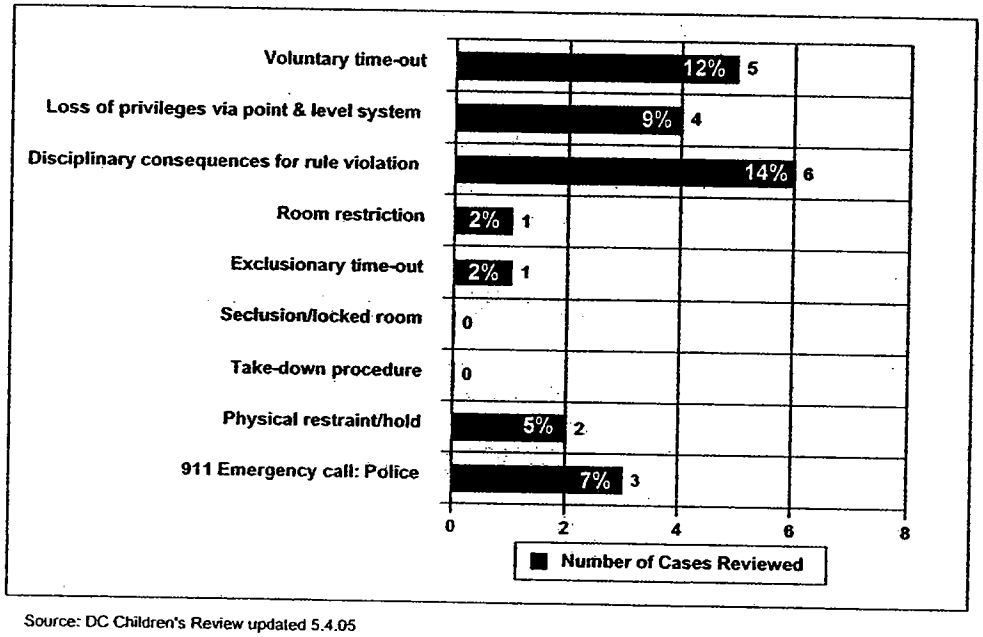


Source: DC Children's Review updated 5.4.05

Special Procedures

Special procedures are used in extreme situations to prevent harm, but are not a form of therapy or treatment. **Display 12** shows the number of sample members who had one of seven types of special procedures used within the 30-day period preceding the review. It should be noted that a 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 12
Special Procedures Experienced by Children or Youth in the Sample During the 30 Days Prior to the Review



Source: DC Children's Review updated 5.4.05

Quantitative Case Review Findings

Overview of the Case Review Process

Case reviews were conducted for 43 children and youth during the week of March 14-18, 2005, 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.

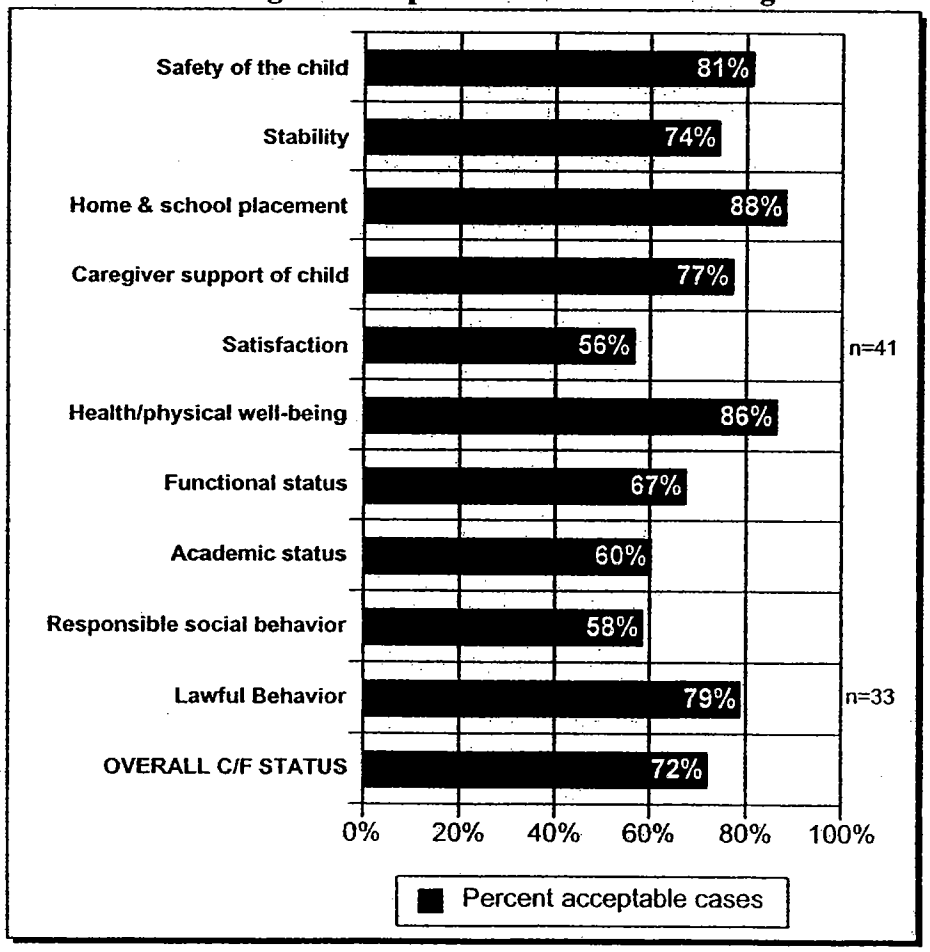
Interviews

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 233 persons were interviewed for these 43 children and youth. The number of interviews ranged from a low of two persons in one case to a high of 16 persons in another case. The average number of interviews was five (mean=5.5; median=5; and mode=5).

Child Status Results

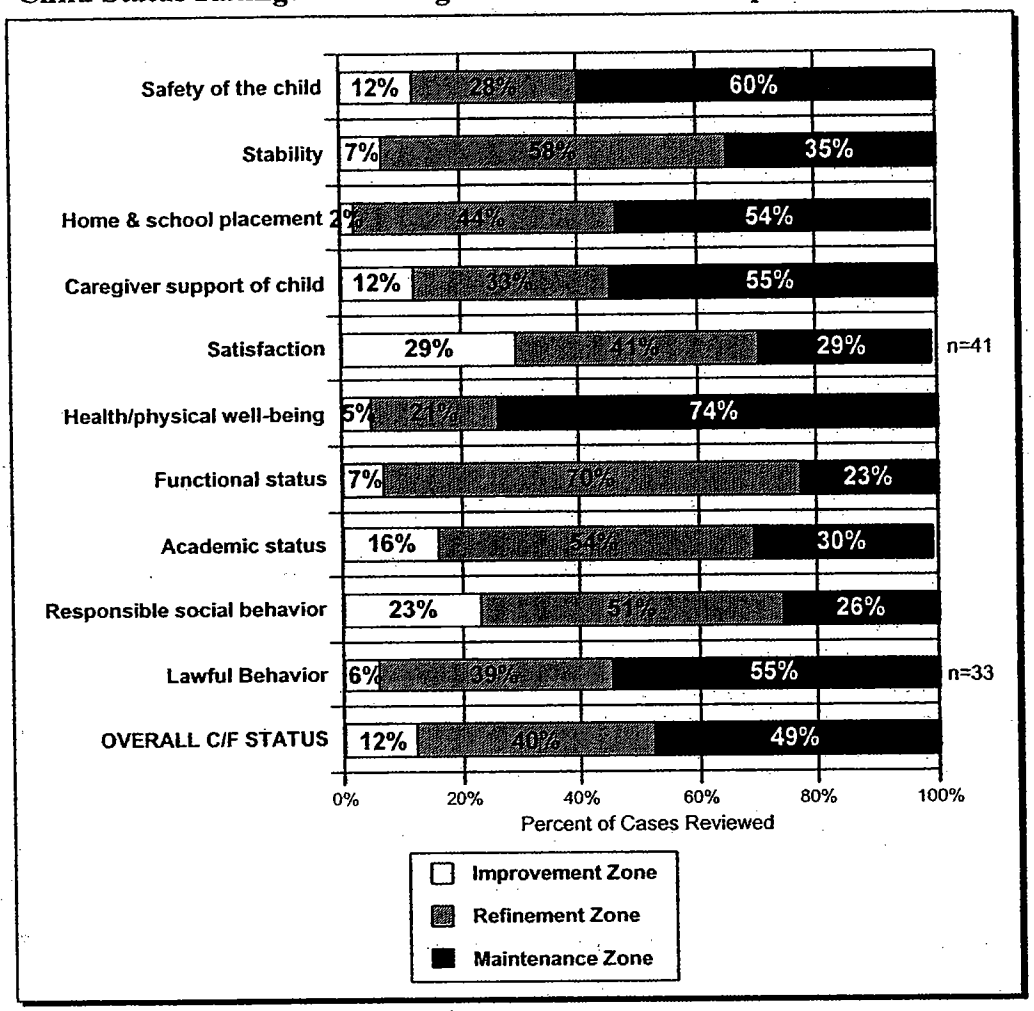
Ten indicators related to the current status of the child or youth were contained in the CSR Protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. The next two displays present findings for each of the ten indicators. **Display 13** uses a "percent acceptable" format to report the proportion of the sample members for whom the item was determined applicable and acceptable. **Display 14** 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 13
Percentage of Acceptable Child Status Ratings



Source: DC Children's Review updated 5.4.05

Display 14
Child Status Ratings According to Three-Tiered Interpretive Framework



Source: DC Children's Review updated 5.4.05

Safety. Sample members were generally safe from imminent risk of physical harm in their daily environment. Eighty-one percent (81%) were rated as having overall acceptable physical safety at the time of the review and 60% of the children have their safety status in the maintenance zone. These findings are comparable to the 2004 review results, in which 81% of the children had acceptable safety ratings and 63% had safety ratings in the maintenance or green zone.

Eight children were considered to have an unacceptable safety status at the time of the review, and of those eight children, five had safety ratings in the area needing immediate improvement.

Stability. There was improvement in the findings for stability for the children and youth included in the sample during the 2005 review, when compared to last year's review results. Seventy-four percent (74%) of the children had overall acceptable stability ratings, and 35% were in the maintenance or green zone during this year's review. In comparison, in last year's review, 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. When rating for child and youth stability, reviewers assessed both home and school settings. Approximately half (58%) of the children included in the 2005 review had stability ratings in the refinement zone, indicating that each of these children had experienced an unplanned move in either a classroom or home setting during the previous calendar year. Seven percent (7%) had overall stability needing immediate improvement, indicating that one or more placement changes had occurred in the recent past and that at the time of the review, additional disruptions were imminent.

Placement Appropriateness. A substantial majority (88%) of children or youth in the sample had home and school placement ratings in the acceptable range, with 54% in the maintenance or green zone. These findings are comparable to the 2004 review results, in which 81% were rated acceptable or better and 55% of those were considered to be in the maintenance zone. During the 2005 review, 7% had current placements considered to need immediate improvement. During the 2005 review, 27 children (63%) were residing in either their own homes or with family members, and an additional ten children (24%) were residing in either foster homes or therapeutic foster homes. There were six children (13%) or youth in the review in non-family-like, congregate settings, with three in a group home, one in a boot camp, one in a residential treatment program, and one in a psychiatric hospitalization placement.

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 77% of the cases reviewed, and of those children, 55% were considered to be in the maintenance zone. Twelve percent (12%) of the children or youth 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 33% of the children in the review had support provided by their caregivers needing some refinement. In comparison to the 2004 review, findings were generally consistent, in that, 77% had acceptable levels of support, with 50% of children in the maintenance zone, 43% in the refinement zone, and 7% in the improvement zone.

Satisfaction. Satisfaction levels were rated acceptable in 56% of the children or youth reviewed, with 29% in the maintenance or green zone, 41% in the refinement or yellow zone, and 29% in the improvement or red zone. This is a decrease from 2004 review results, in which 92% of the children or youth had acceptable ratings, with 60% of children and families' indicated current levels of satisfaction in the maintenance or green zone, 6% in the refinement or yellow zone, and 2% in the improvement or red zone.

Health/Physical Well-Being. Children or youth included in the review were consistently having their physical needs met and were considered to be healthy. Physical health was acceptable for 86% of children or youth in the sample, with 74% in the maintenance or green zone, 21% in the refinement or yellow zone, and 5% in the improvement or red zone. The ratings are comparable to 2004 review results for physical health, in which 91% of sample members were acceptable in this area, with 79% of the children and youth rated in the maintenance zone, 19% in the refinement zone, and 2% in the improvement zone.

Functional Status. Functional status, or emotional/behavioral well-being, was acceptable for 67% of the children reviewed, with 23% in the maintenance or green zone, 70% in the refinement or yellow zone, and 7% in the improvement or red zone. These ratings are comparable to 2004 review results, in which 69% had acceptable functional status, with 15% in the maintenance zone, 76% in the refinement zone, and 9% in the needing immediate improvement zone.

Academic Status. Academic status was acceptable for 60% of the children or youth included in the review, with 30% in the maintenance or green zone, 54% in the refinement or yellow zone, and 16% in the needing improvement or red zone. There was some improvement for academic status when compared to the 2004 results, in which 54% had acceptable academic status ratings,

with 22% in the maintenance zone, 59% having academic status needing some refinement, and 19% having academic status needing immediate improvement.

Responsible Social Behavior. Responsible social behavior was acceptable for 58% of the children or youth in the review, with 26% in the maintenance or green zone, 51% in the refinement or yellow zone, and 23% in the needing immediate improvement or red zone. There was some improvement in responsible social behavior ratings when compared to 2004 review results, in which 48% were acceptable.

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 and avoid reoffending, 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=33) due to children five years of age or less being excluded from this indicator. Of those children and youth included in the review, 79% had acceptable lawful behavior ratings, with 55% in the maintenance zone, 39% in the refinement zone, and 6% needing immediate improvement. These ratings are comparable with 2004 review results, in which 80% had acceptable lawful behavior, with 56% in the maintenance zone.

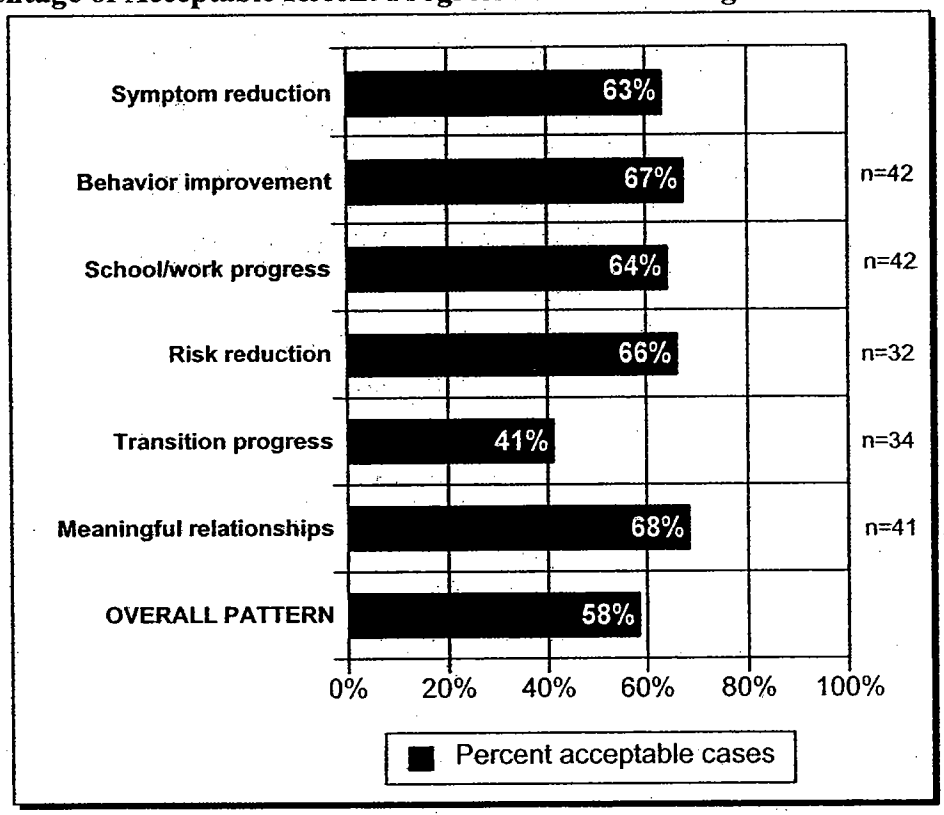
Overall Child Status. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall child status rating." Applying this rubric resulted in the determination of 72% having acceptable overall child status, with 49% in the maintenance zone, 40% in the refinement zone, and 12% needing immediate improvement. These ratings are comparable to 2004 review results, in which 74% of the children and youth reviewed had acceptable ratings for overall child status, with 44% in the maintenance zone, 48% in the refinement zone, and 7% in the improvement zone.

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

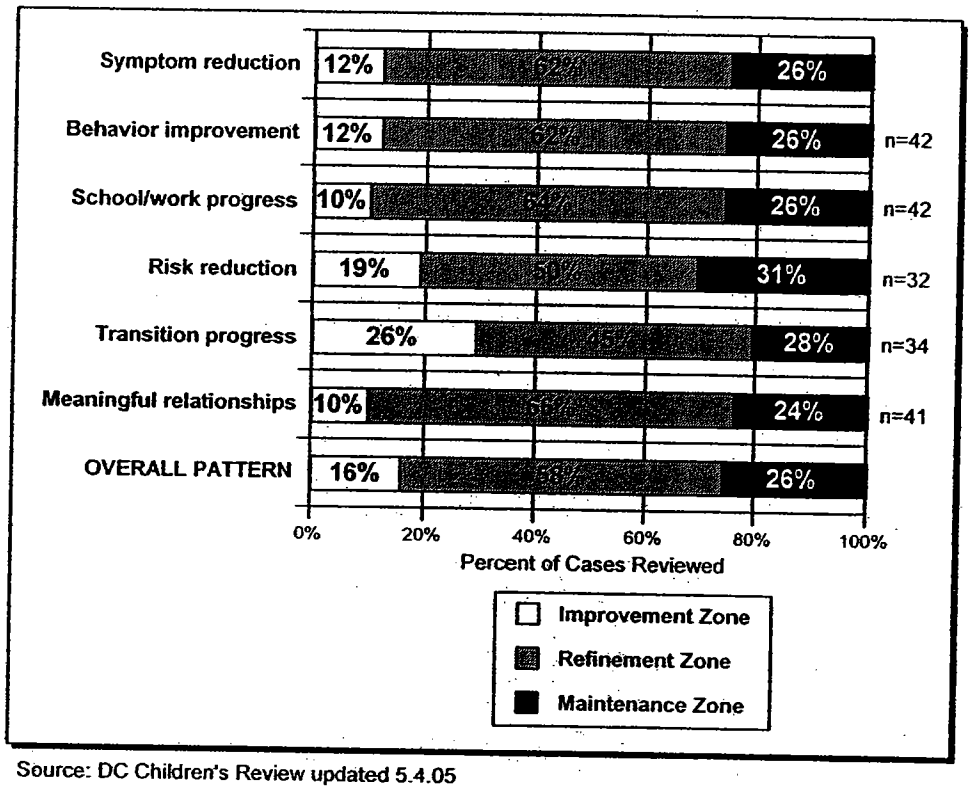
timeframe for noting recent progress was within the last six months or since admission to mental health services (if less than six months). Descriptions of these six indicators can be found in **Appendix A. Displays 15 and 16** present the findings for the progress indicators for the review sample.

Display 15
Percentage of Acceptable Recent Progress Patterns: Change Over Time Ratings



Source: DC Children's Review updated 5.4.05

Display 16
Recent Progress Patterns: Change Over Time Ratings According to Three-Tiered Interpretive Framework



Source: DC Children's Review updated 5.4.05

Symptom Reduction. Recent progress in symptom reduction was found to be at least minimally adequate for 63% of the children or youth reviewed, with 26% in the maintenance zone, 62% in the refinement zone, and 12% needing immediate improvement. These results are comparable to 2004 review results, in which 61% of the children and youth had acceptable ratings for symptom reduction, with 24% in the maintenance zone, 61% in the refinement zone, and 15% needing immediate improvement.

Behavior Improvement. As symptoms diminish, daily functioning should improve. Specific behaviors associated with daily functioning are often targeted for improvement in the treatment process. Behavior improvement was acceptable for 67% (n=42) of the children or youth included in the review, with 26% in the maintenance zone, 62% in the refinement zone, and 12% in the needing immediate improvement zone. There were some increases in the ratings for behavioral improvement when compared to 2004 review results, in which 57% children or youth had

acceptable ratings, with 26% of the sample considered to be in the maintenance zone, 54% in the refinement zone, and 20% in the needing immediate improvement zone.

School/Work Progress. Children and youth are expected to be making progress along planned academic, vocational, or employment pathways. Such progress is critical to their success in life. School and work progress was acceptable for 64% of the children or youth included in the review, with 26% in the maintenance zone, 64% in the refinement zone, and 10% needing immediate improvement. There was some improvement for school and work progress ratings when compared to 2004 review results, in which 57% of children or youth had acceptable school/work progress ratings, with 20% in the maintenance zone, 69% in the refinement zone, and 11% in the needing immediate improvement zone.

Ten of the children in the review were noted as having specific learning disabilities (SLD), and four children were noted as having mental retardation (with two of the children having MR nested in the group of ten children having SLD). Reviewers were able to obtain current reading levels for 34 of the 43 of the children in the sample. Of those 34, ten were reading more than one year below grade level, with all but one of those ten children receiving some form of special education services. There were also five additional children who were reading below grade level, with these children in non-graded educational curriculum tracks due to severe developmental limitations or mental retardation (four children noted as MR). Fifteen were reading at grade level or were age appropriate (e.g., child in early intervention program at four or less years and not reading). There were also four children who were reading above grade level, with all but one in a full-time regular education setting. If a child were reading below grade level, they were most likely reading two or more full academic years behind their assigned grade, also having a behavioral disorder and specific learning disability.

Progress in Risk Reduction. Thirty-two of the 43 (74%) children or youth included in the review had identified risks, thus, making this indicator applicable. Generally, children omitted from this indicator were of younger ages. For those children to which this rating applied, risk reduction was determined to be acceptable for 66% of the children or youth reviewed, with 31% in the maintenance zone, 50% in the refinement zone, and 19% needing immediate improvement.

When compared to the results for the 2004 review, 57% of the applicable children or youth had acceptable progress in risk reduction, with 18% in the maintenance zone, 72% in the refinement zone, and 10% in the improvement zone.

Progress toward Transition Goals. Transitions were identified for 34 of the 43 (79%) children or youth in the final 2005 review sample. If the child had not experienced any transitions within the previous three months, or there were no known transitions in the near future, then this indicator was marked "not applicable." Progress toward smooth and successful transitions was acceptable for 41% of the children or youth included in the review, with 28% in the maintenance zone, 45% in the refinement zone, and 26% in the improvement zone. When compared to 2004 review results, there was some improvement, in which 51% had acceptable ratings, with 10% in the maintenance zone, 70% in the refinement zone, and 20% needing immediate improvement.

Progress in Meaningful Relationships. Progress in meaningful relationships was acceptable for 68% (n=41) of the children and youth reviewed, with 24% in the maintenance zone, 66% in the refinement zone, and 10% needing immediate improvement. When compared to 2004 review results, there was slight improvement in the percentage of acceptable children or youth with 63% children or youth acceptable. However, changes in the distribution of ratings across the three action zones were mixed, in which 31% were in the maintenance zone, 60% were in the refinement zone, and 9% were in the needing immediate improvement zone.

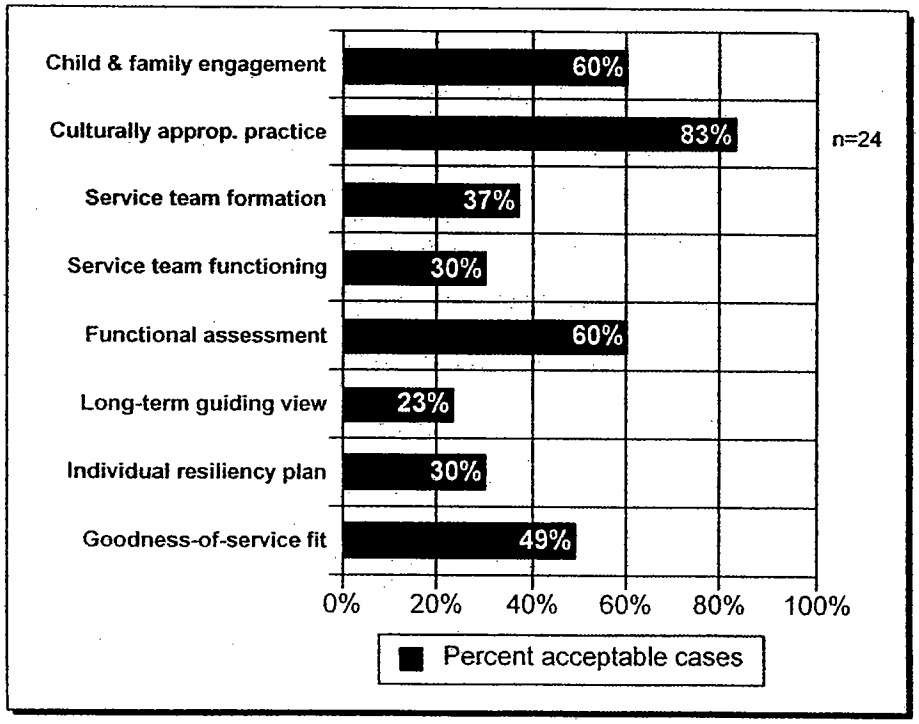
Overall Progress Pattern. Reviewers determined an overall progress pattern for each sample member based on an assessment of the general patterns of progress across each of the applicable indicators. Based on this process, the overall progress patterns for sample members was acceptable for 58% of the children or youth, with 26% in the maintenance zone, 58% in the refinement zone, and 16% needing immediate improvement. There was some decrease in the percentage when comparing this year's review findings with 2004 review results, in which 63% of children or youth had overall acceptable progress patterns during last year's review. Similarly, during last year's review, 20% of the children or youth were in the maintenance zone, 69% were in the refinement zone, and 11% were in the improvement zone.

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.

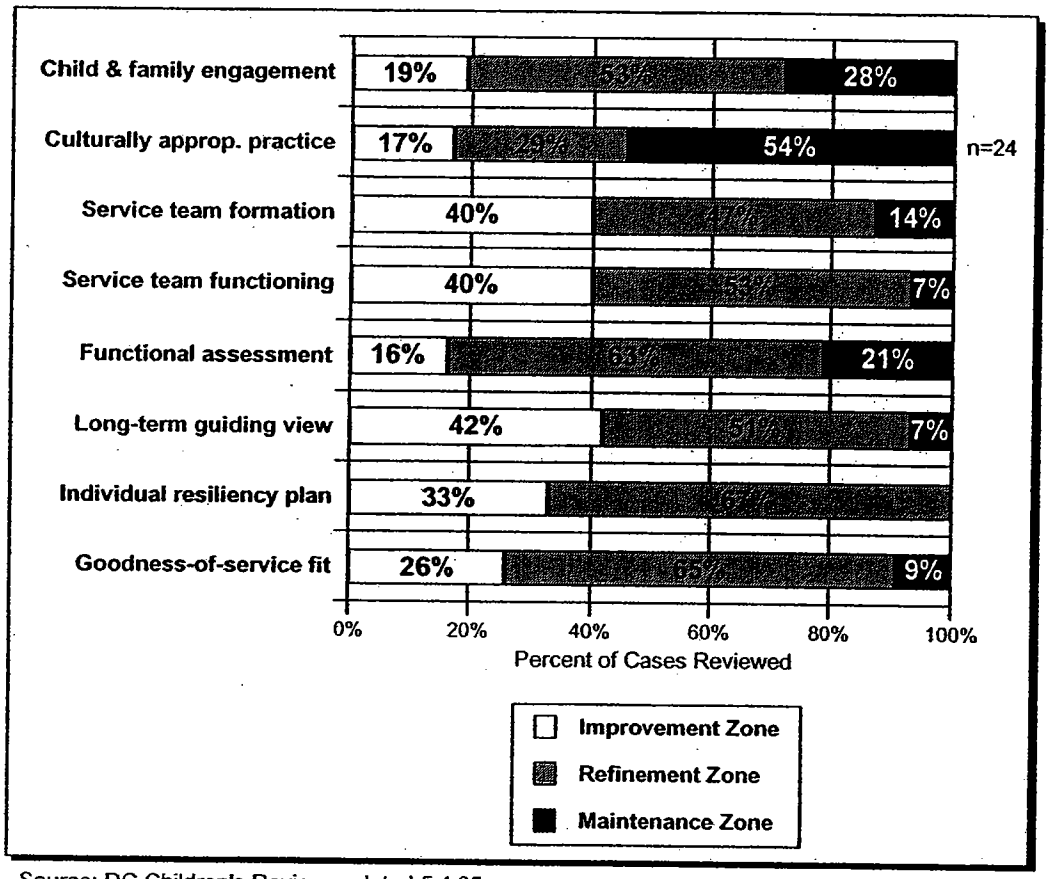
Findings for the first set of indicators are presented in **Displays 17 and 18** and summarized below.

Display 17
Practice Performance: Planning Treatment Findings for the Children or Youth Included in the 2005 Review



Source: DC Children's Review updated 5.4.05

Display 18
Practice Performance: Planning Treatment Findings Using the Three-Tiered Interpretive Framework for the Children or Youth Included in the 2005 Review



Source: DC Children's Review updated 5.4.05

Child and Family Engagement. Child and family engagement was acceptable for 60% of the children, youth, and families reviewed, with 28% in the maintenance zone, 53% in the refinement zone, and 19% needing immediate improvement. There was a slight decrease in the percentage of acceptable children or youth for engagement, when compared to 2004 results, in which 76% of the 54 sample was acceptable, with 33% in the maintenance zone, 50% in the refinement zone, and 17% needing immediate improvement.

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 24 of the 43 children and youth in the final sample. Culturally appropriate practice was acceptable for 83% of the children and youth in the review, with 54% in the maintenance zone, 29% in the refinement zone, and 17% needing immediate improvement.

Service Team Formation. 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, however, there is no fixed formula for members of a child or youth's individual service team.

Service team formation was acceptable for 37% of the children and youth included in the review, with 14% in the maintenance zone, 47% in the refinement zone, and 40% needing improvement. This is comparable to 2004 review results, in which 41% of the children and youth had acceptable service team formation ratings, with 17% in the maintenance zone, 46% in the refinement zone, and 37% needing improvement.

Service Team Functioning. Service team functioning was acceptable for 30% of the children or youth in the review, with 7% in the maintenance zone, 53% in the refinement zone, and 40% needing improvement. Results for service team functioning were comparable to 2004 results, in which 37% of the children or youth in the review had acceptable service team functioning, with 11% in the maintenance zone, 52% in the refinement zone, and 37% needing improvement.

Functional Assessment. Functional assessment was acceptable for 60% of the children and youth included in the review, with 21% in the maintenance zone, 63% in the refinement zone, and 16% needing improvement. Findings for functional assessment for this year's review were comparable with functional assessment ratings from the 2004 review, in which 61% of the children and youth had acceptable functional assessments, with 28% in the maintenance zone, 63% in the refinement zone, and 9% needing improvement.

Long-Term Guiding View (LTV). The long-term guiding view was acceptable for 23% of the children and youth reviewed, with 7% in the maintenance zone, 51% in the refinement zone, and 42% needing improvement. When compared to 2004 review results, the findings had slightly less children or youth in the acceptable range, although the distribution of findings across the three action zones were generally consistent. Last year's review had 33% of the children and youth in the acceptable range, with 7% in the maintenance zone, 48% in the refinement zone, and 44% needing improvement.

Individualized Resiliency Plan (IRP). Individual resiliency plans were acceptable for 30% of the children and youth reviewed, with no children (0%) in the maintenance zone, 67% in the refinement zone, and 33% needing improvement. These findings are comparable to the 2004 review results, in which 26% of the children or youth reviewed had acceptable IRPs. There was some reduction in the percentage of IRPs needing immediate improvement, when compared to last year's results, with 4% in the maintenance zone, 55% in the refinement zone, and 41% needing improvement.

Goodness-of-Service Fit. Goodness-of-service fit was acceptable for 49% of the children or youth included in the review, with 9% in the maintenance zone, 65% in the refinement zone, and 26% needing improvement. When compared to 2004 review results, there was a slight decrease in the percentages of acceptable children and youth, with 56% of children or youth in last year's review having acceptable goodness-of-service fit ratings. Likewise, in last year's review, 17% of the children or youth were in the maintenance zone, 68% in the refinement zone, and 15% needing improvement.

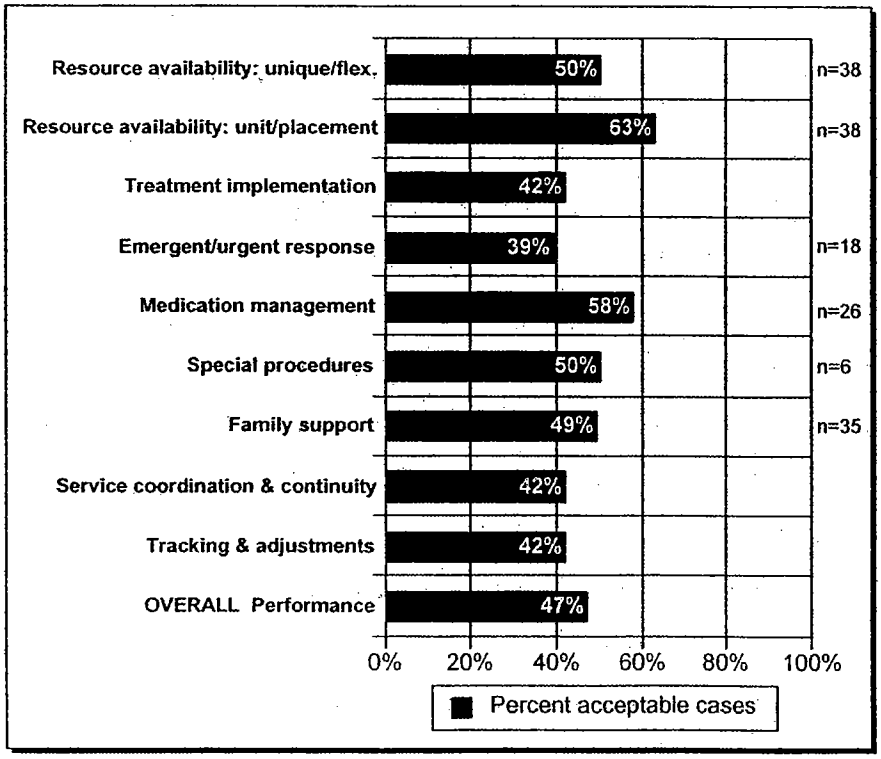
Findings across the *practice performance: planning treatment indicators* indicate that there is variability in the system's ability to provide the high level of services specified in the Dixon exit criteria consistently for children and families receiving mental health services. In the findings and data produced through the child and youth review activities, there were some exemplary stories of effective practice/system performance that were observed, highlighting the system's ability to individualize services in a manner commensurate with the standards of practice specified through the Dixon Consent Decree. Similarly, when reviewing the data for the *practice*

performance: planning treatment indicators, opportunities exist to refine the services being provided for children, youth, and families so that services adhere more closely to the model of practice contemplated in the practice principles of Dixon, and, subsequently, are measured in the CSR Protocol used to monitor the quality and consistency of practice and compliance with one of the Dixon exit criteria. By focusing on the refinement of services provided and practice with children and families, there exists the greatest opportunity to improve practice and, subsequently, the outcomes in the Community Services Review, in order for services to more closely align with the expectations of practice resulting from the Dixon lawsuit.

Practice Performance: Providing and Managing Treatment

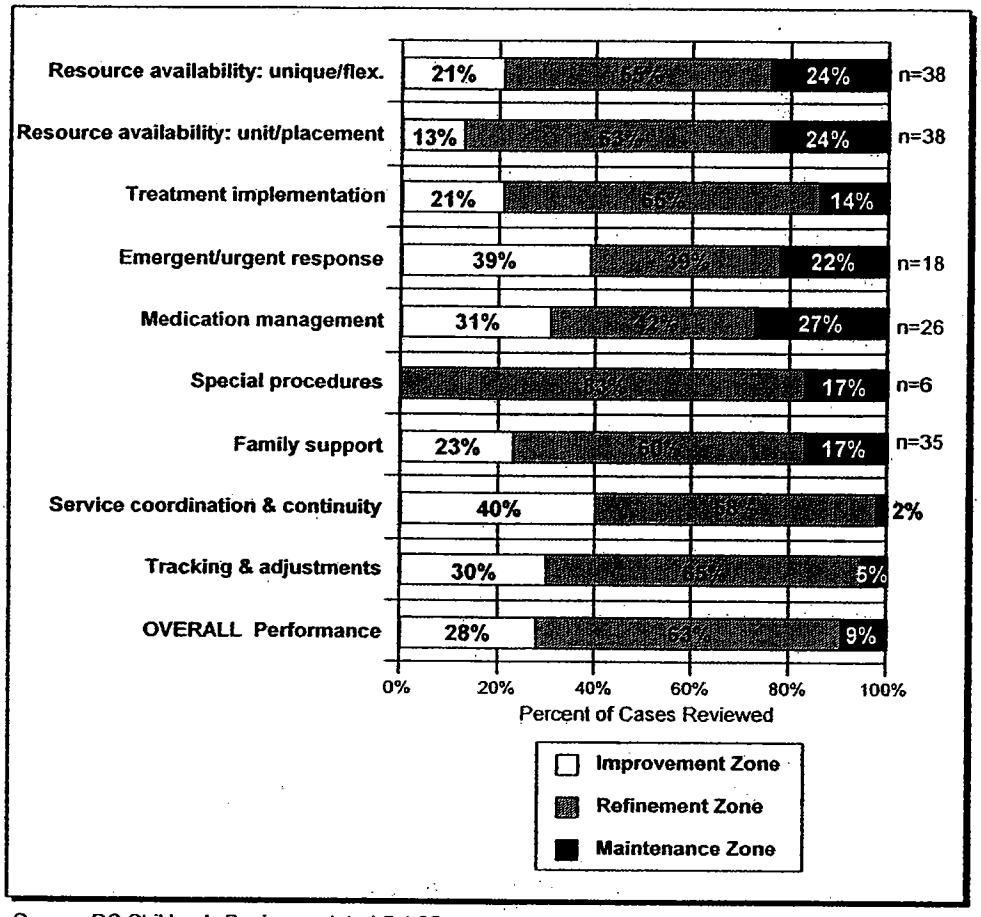
The second set of performance indicators covers important functions related to the provision and management of treatment and support services to children and families. Findings for these indicators are presented in **Displays 19 and 20** and summarized concurrently below.

Display 19
Practice Performance: Providing and Managing Treatment Findings for the Children and Youth Included in the 2005 Review



Source: DC Children's Review updated 5.4.05

Display 20
Practice Performance: Providing and Managing Treatment Findings Using the Three-Tiered Interpretive Framework for the Children and Youth Included in the 2005 Review



Source: DC Children's Review updated 5.4.05

Resource Availability: Unique Arrangements and Flexible Resources. This indicator focuses on the flexible supports and unique service arrangements (sometimes referred to as "wraparound services") that may be necessary to meet the needs of the child without the child having to change homes or schools to get needed services. Resource availability: unique and flexible resources was applicable if the child or youth was either receiving unique or flexible services or, if such services were needed, the child or youth was not receiving them. Resource availability: unique arrangements and flexible resources was acceptable for 50% of the children or youth to whom this indicator applied, with 24% in the maintenance zone, 55% in the refinement zone, and 21% in the improvement zone. When compared to the 2004 review results, there was some improvement, as 43% of the children and youth in last year's review had acceptable ratings for

this indicator, with 17% in the maintenance zone, 55% in the refinement zone, and 28% in the improvement zone.

Resource Availability: Unit-Based and Placement-Based Resources. This indicator focuses on the resources that are delivered through more traditional mental health services, such as those that are "on hand" or program-based resource options that are dispensed as "service units." These resources also include the typical "placement slots" for a child to receive services through a center-based service program, necessary for increasing the variety and/or intensity of services provided to a child, youth, or family. This indicator was applicable to 38 children or youth, in that, these children were either receiving such services, or such services were needed, but the child, youth, or family was not receiving them. Unit-based and placement-based resource availability was acceptable for 63% of the children or youth, with 24% in the maintenance zone, 63% in the refinement zone, and 13% in the improvement zone. Results for this year's review are comparable to results for the 2004 review for resource availability: unit-based or placement-based services, in which 57% of the children and youth reviewed last year had acceptable ratings for this indicator. Likewise, during last year's review, availability of such resources was considered to be in the maintenance zone for 17% of the children or youth, in the refinement zone for 71% of the children or youth, and in the improvement zone for 12% of the children or youth.

Treatment Implementation. Treatment implementation was acceptable for 42% of the children or youth included in the review, with 14% in the maintenance zone, 65% in the refinement zone, and 21% needing improvement. Findings for this year's review are comparable to results for 2004, in which 46% of the children and youth reviewed had acceptable ratings for this indicator and 17% of the children or youth were in the maintenance zone, 68% in the refinement zone, and 15% needing improvement.

Emergent/Urgent Response. The emergent or urgent response indicator was applicable if services to stabilize or resolve emergent or episodic problems of an urgent nature were needed and/or accessed within the previous 90 days. As such, this rating applied to 18 children or youth in the sample. Emergency and urgent service provision was acceptable for 39% of the children or youth

to which this indicator applied, with 22% in the maintenance zone, 39% in the refinement zone, and 39% in the improvement zone. There was some reduction in the percentage of children or youth having acceptable emergent/urgent response ratings when compared to results from the 2004 review. In last year's review, 53% of the children and youth had acceptable ratings for this indicator, with 20% of those children or youth in the maintenance zone, 67% in the refinement zone, and 13% needing improvement.

Medication Management. Twenty-six of the 43 children or youth in the sample were taking psychotropic medications; as such, this indicator applies to these sample members. Medication management was acceptable for 58% of the children and youth reviewed, with 27% in the maintenance zone, 42% in the refinement zone, and 31% in the needing improvement zone. There was a small reduction in the percentage of children or youth having acceptable medication management when compared to the 2004 results of 74% acceptable children or youth. Similarly, last year's review results had 61% of the children or youth in the maintenance zone, 29% in the refinement zone, and 10% needing improvement.

Special Procedures. The special procedures indicator was applicable if emergency seclusion or restraint was used for the child or youth within 90 days prior to the review. As such, this indicator applied to six children or youth included in the review. Of those children or youth to which this indicator applied, half had acceptable special procedure ratings, with one child in the maintenance zone and all other children or youth in this year's review needing some refinement in the use of special procedures. Of those children who required special procedures, the most common procedure included disciplinary consequences for program/placement rule violation, loss of privileges on a point or level system, or use of time-out. Two children required physical restraint as the special procedure used, and the police were notified for two children as well. It is important to note that many of these special procedures referred to here were used for the same child. Ratings for the use of special procedures were comparable to the findings from the 2004 review, in which the indicator was applicable to five children and was acceptable for two of the five children or youth.

Family Support. The family support indicator applied if caregivers were provided practice assistance, training, and supports necessary to perform essential parenting and caregiving functions for the child or youth, including supports or strategies for meeting the emotional or behavioral needs of the child or youth. This indicator was deemed applicable when either family supports were being provided or family supports were needed, and applied to 35 of the 43 children and youth in the review sample. Family support was acceptable for 49% of the children and youth to whom this indicator applied, with 17% in the maintenance zone, 60% in the refinement zone, and 23% needing improvement. There was a slight decrease in the percentage of acceptable family support ratings for children or youth when compared to the 2004 review results, in which 57% of last year's applicable sample were acceptable. Similarly, in last year's review, family support was considered in the maintenance zone for 24% of the children or youth, in the refinement zone for 60% of the children or youth, and in the improvement zone for 16% of the children or youth.

Service Coordination and Continuity. Service coordination was acceptable for 42% of the children or youth included in the review, with one child (2%) in the maintenance zone, 58% in the refinement zone, and 40% needing improvement. There was some improvement in the percentage of children or families having acceptable service coordination when compared to 2004 review results, in which 33% of the children and youth reviewed last year had acceptable service coordination ratings. However, there was a decrease in the percentage of children or youth in the maintenance zone, since 17% were in the green zone last year, 48% were in the refinement zone, and 35% were needing improvement.

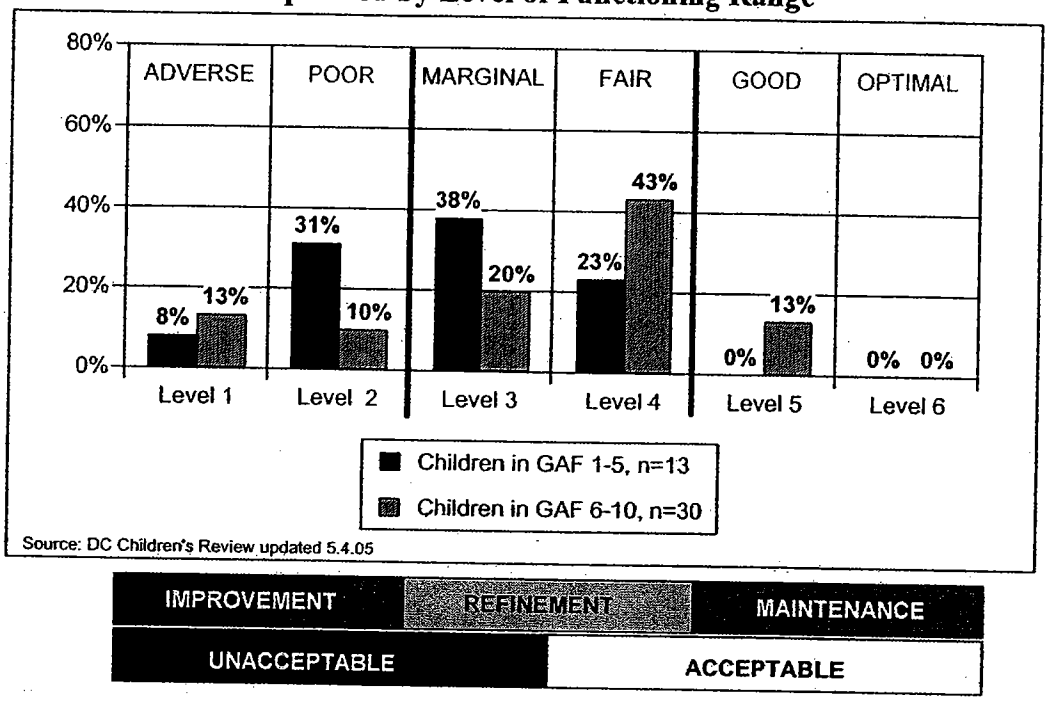
Tracking and Adjustments. Tracking and adjustments was acceptable for 42% of the children and youth included in this year's review, with 5% in the maintenance zone, 65% in the refinement zone, and 30% needing improvement. The percentage of children or youth having acceptable tracking and adjustment ratings is comparable to last year's review, in which 41% of the sample were rated acceptable for this indicator. There were some changes in the distribution of children and families across the three-tiered action zones when compared to last year's results of 19% in the maintenance zone, 50% in the refinement zone, and 31% needing improvement.

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 47% of the children or youth included in the review, with 9% in the maintenance zone, 63% in the refinement zone, and 28% needing improvement. This is some improvement when compared to last year's overall acceptable practice performance results of 43% of the children or youth reviewed. Likewise, in last year's review, 13% of the children and youth reviewed were rated in the maintenance zone, 61% in the refinement zone, and 26% in the improvement zone.

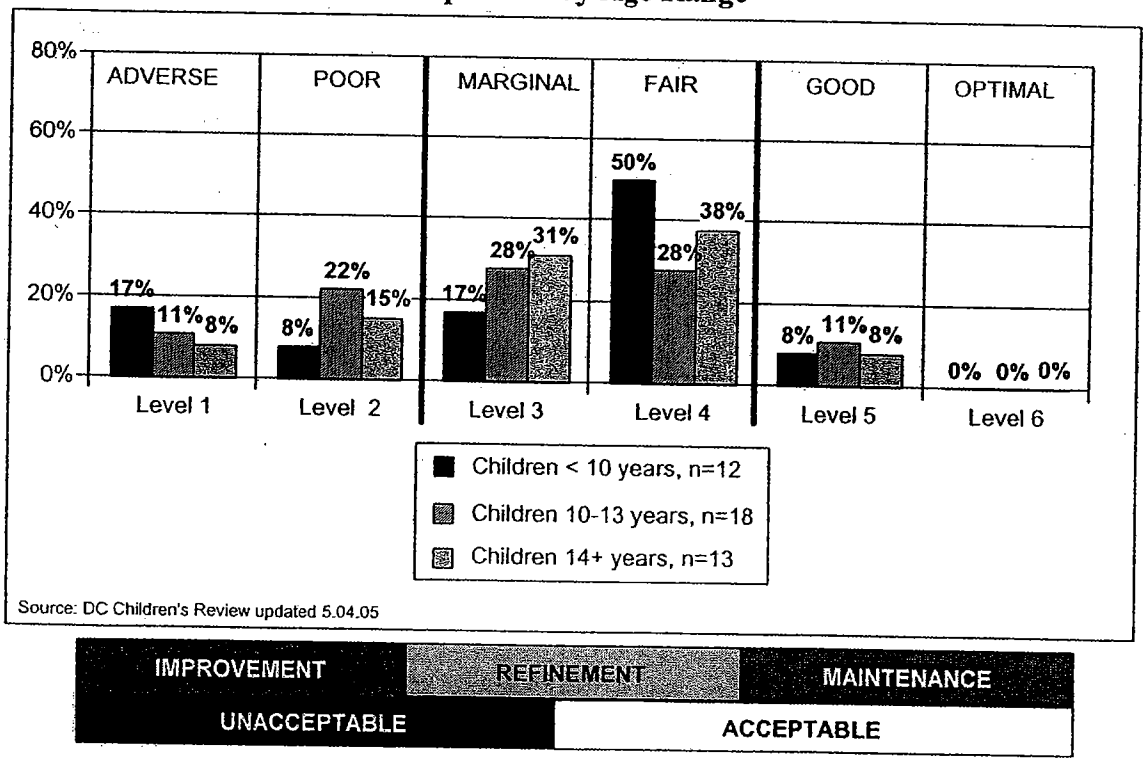
In **Appendix C** of this report are agency-by-agency results for the children and families reviewed. **This agency-by-agency comparison should be interpreted with caution, since sample sizes for some of the provider agencies are extremely small** (e.g., Hillcrest Children's Services had one child included in the final sample and Community Connections had three children included in the final sample). **Generalizations regarding specific agency practice should not be made based on the individual case review results due to the small sample sizes for the agency-specific findings**, rather the small samples of children or youth are illustrative of system performance for each of those randomly selected children from subsequent participating agencies. However, the combined or aggregate findings from the review can be considered indicative of trends and patterns for children, youth, and families receiving services across the district.

The following two displays provide additional methods of interpreting the second-year review results. **Display 21** provides the overall practice and performance rating separated by the child's general level of functioning. **Display 22** provides the overall practice and performance ratings separated by age range.

Display 21
Overall Practice and Performance Ratings for Children and Youth in the 2005 Review Separated by Level of Functioning Range



Display 22
Overall Practice and Performance Ratings for Children and Youth in the 2005 Review Separated by Age Range

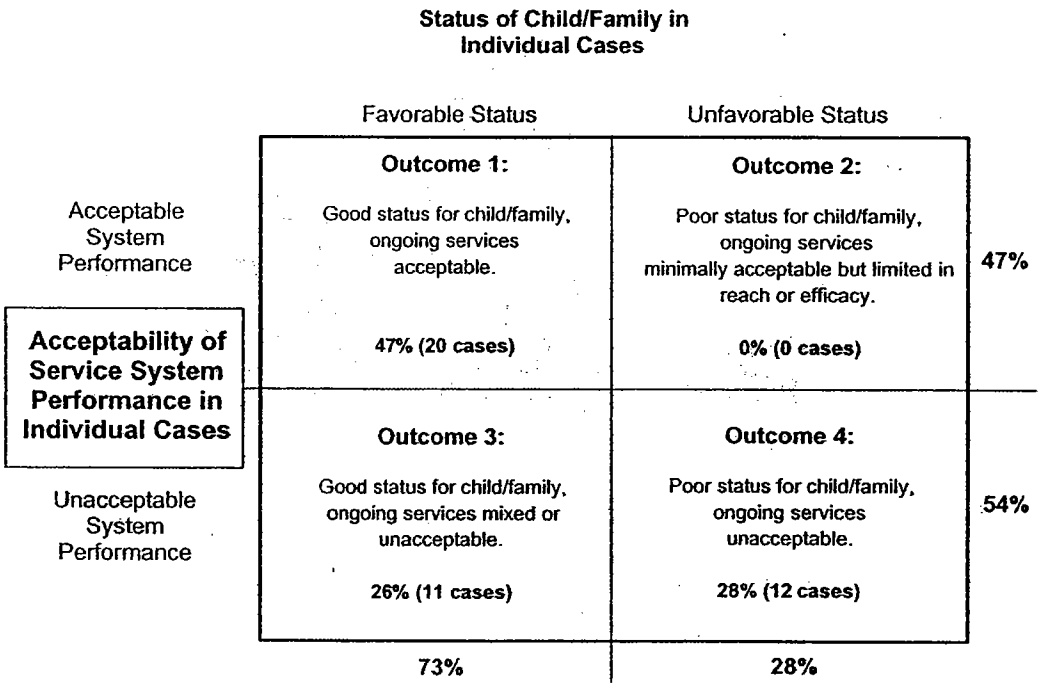


Case Review Outcome Categories

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 "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 23** indicates, 20 of the 43 cases (47%) fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services. There were no 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. Eleven (26%) 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 (28%) 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.

Display 23
Case Review Outcome Categories for Children or Youth in the 2005 Review

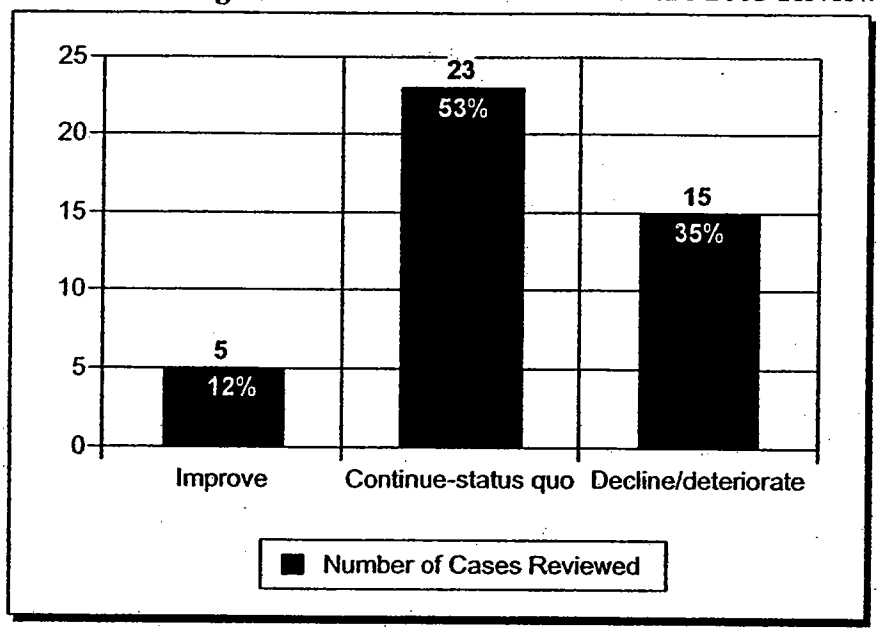


Source: DC Children's Review update 5.4.05

Six-Month Prognosis

Reviewers provide a six-month prognosis for each member of the sample based on an overall impression of the current status and trajectory of the child or youth, how the system is performing for that individual child or youth, and any known upcoming transitions or changes. The following display presents the six-month prognosis offered by reviewers for all children or youth in the review. As the display indicates, five children or youth (12%) were expected to improve, 23 (53%) were expected to remain about the same, and 15 (35%) were expected to decline or experience deterioration of circumstances over the next six months.

Display 24
Six-Month Prognosis for Children or Youth in the 2005 Review



Source: DC Children's Review updated 5.4.05

Qualitative Summary of Case Review Findings: Themes and Patterns Noted in the Individual Case Reviews

Individual child reviews completed during the CSR were debriefed with other team members in order to more readily recognize themes and patterns emerging out of the sample. Following are a list and general discussion of systemic themes and patterns noted from the cases.

- Individual stories of children and families included in the case reviews indicated that a large number of these children had experienced significant trauma, such as the unexpected death of a family member (e.g., murder of a loved one) or violence within the home. In some instances, the child or youth had been a witness to these traumatic events. The implications for practice are continued assessment and planning for grief and loss issues, as well as the possible need for more specialized trauma-informed assessment and interventions. It is promising that Duke University is currently working with the district mental health system by training clinicians in cognitive behavioral therapy for youth who have experienced trauma.

- An ongoing challenge for clinicians is the assessment of, and sufficient planning for, upcoming transitions in the life of children and youth. Points of transition in the lives of the children and families increase the possibility of a breakdown in services, if they have not been sufficiently addressed prior to the period of change. Transitions noted in the case reviews include: frequent moves/changes in residence due to the high cost of living; children in the child welfare system changing placements; parents, caregivers, or siblings becoming involved in the criminal justice system and becoming incarcerated (or returning home from a period of incarceration); and death or loss of a loved one. This is also reflected in the child and youth findings for long-term view, which had the smallest percentage of acceptable ratings of any of the system performance indicators.

- A number of children or youth in the review were living with a larger number of extended family members. In many instances, this was due to financial hardships. The needs of other family members within the home (e.g., mental health needs/substance abuse needs) were not always fully assessed, or family members may not have been receiving services that were needed.

- A number of children (59% of the sample) included in the review were receiving special education services with much variability in the quality of educational services that these children were receiving. In some instances, educational advocacy was needed, which could include participating in the child's individual educational planning team meeting. Although there were only four children identified in the review as having mental retardation, there were a larger number of children whose overall functioning was considered to be in the borderline range. Opportunities to increase the teamwork and coordination of services between education and mental health providers were noted in the case review findings. It is encouraging that in several case reviews, there were examples of community support workers going into their child or youth's school and meeting with educational providers for those children or youth and participating in the children's Individualized Education Plan (IEP) meetings as some strategies to better integrate/coordinate services for the child.

- A number of children (44% of the sample) were involved with the Child and Family Services Administration (CFSA, the district child welfare agency). For these children, there was a question whether teamwork and coordination of services across the mental health providers and CFSA, when involved, was consistently effective. In some instances, there appeared to be questions regarding who was the single point of case coordination among the child and family's service teams, if functional individualized service teams were operating with the children or youth.

- Team members during the debriefing were encouraged by the small number of children or youth in the review who were actively using substances. However, there was a larger number of parents or family members having a history of substance abuse. One systemic challenge identified during focus group interviews is the access to child/youth-oriented substance abuse programs other than those that provide residential treatment services.

- An encouraging case review result was the continued increase in the use of community support as an intervention model, as some providers have gone through the transitional process of moving away from being a traditional outpatient clinic for service delivery and are now providing community support services and services in the home. Similarly, there were stories shared that highlighted effective case management services provided by the child or youth's community support worker. Clearly, the emphasis of "getting into the child or youth's home has been heard," and new opportunities exist to assess across the child or youth's bio-psycho-social domains to improve the effectiveness of provided case management (which can include linking the family to specialized assessment or treatment, when needed).

- It is an encouraging result that children or youth in the review were receiving, had received, or had been offered some kind of service. Similarly, there were examples shared of providers attempting to engage families initially resistant after being referred to the provider from the Access Help-Line.

- Some of the smaller provider agencies are still experiencing turnover of staff, impacting the ability to provide effective and quality services in a timely manner.

- The greatest opportunity for improving the outcomes of the Community Services Review will be continued emphasis on forming appropriate individualized service teams, to include formal or informal providers other than staff within the mental health agency, and then ensuring that implementation and coordination of services within this team is done in a timely and sufficient manner. The emphasis of adequate "teaming" can be achieved through ongoing training and effective supervision (to include mentoring, modeling, and coaching of quality practice according to the practice model contemplated in the exit criteria of Dixon) of frontline staff.

- Core service agencies shared frustration with both the individual reviewers as well as in the focus group formats regarding the current billing structure for some kinds of services, such as community based interventions (CBIs) and the timely payment for services provided.

- It was noted in both the pertinent child and youth reviews and during the set-up activities that staff and management from the DCCSA have undertaken much preparation for this year's Community Services Review. In general, DCCSA staff were open and engaged in discussing their barriers to practice. There has been considerable growth in the knowledge, awareness, and understanding of practice issues relating to providing services according to the practice principles and performance expectations and required by affective implementation of a community-based System of Care and as specified in the Dixon exit criteria.

DCCSA has also undertaken a number of strategies since the 2004 Community Services Review, focusing on the agency's continuous quality improvement model (CQI), fiscal viability, and clinical viability. An action plan was jointly crafted by labor and management to develop strategies and measures to initiate and assess programs' progress toward compliance. Some of the strategies included: (1) development of a joint communiqué, or statement of intent, for leadership noting the need to successfully complete the effort of fully and consistently complying with the expectations of Dixon; (2) review of measured outcomes

for Dixon and identifying what critical success factors are implemented/needed in order to meet outcomes; (3) development of specific trainings, clinical supervision models, construction of new audit/supervision case review tools, modification of the clinical records handbook, and establishment of internal leadership/timetables to support these initiatives.

- Although there was continued growth in core service agencies' awareness and understanding of the expectations regarding the provision of services and the model of practice, there is still significant variability among these providers, particularly at the level of frontline staff, regarding the practice principles and performance expectations of appropriate and effective service delivery.

Stakeholder Interview Comments

The Dixon court monitoring review team facilitated a series of stakeholder interviews and focus groups. A series of focus groups were held at the larger core service agency providers participating in the Community Services Review, in which representatives of the management team, program leaders or supervisors, and frontline staff were interviewed. The executive management team for the Department of Mental Health were also interviewed. Lastly, focus groups were held with parents or family members of children or youth receiving mental health services, and an additional focus group was held with consumer advocates.

- Stakeholders in parent, advocate, and core service agency focus groups noted that there continues to be progress made by the system in improving services for children, youth, and families, but that consistently providing services commensurate with the model of practice articulated by the practice principles of Dixon exit criteria remains a challenge.

- Stakeholders were optimistic about the growth being made, but also identified some factors that may be limiting systemic development and attention to the refinement of frontline practice and performance. In particular, a general theme noted across core service agencies is a sense of frustration around funding and payment issues. It was difficult to discern what specific factors are most causal for the provider frustrations. Some of the issues, concerns, or

questions shared were about timely payment/reimbursement for services provided for children and families. Others included that regardless of whether an agency's caseload increases during a quarter, task orders specifying limits on total services that can be billed and paid for on a quarterly basis have been implemented. Some providers also referenced problems with Medicaid reimbursement rates for some services and related billing policies and the issues of a number of new core service agencies being certified to provide mental health services but a limited amount of money being available to provide these services, thus, causing a sense of competition among core service agencies for available dollars.

- DMH has implemented a number of checks and balances in the payment system in order to ensure appropriate payment to providers for rendered services. These checks and balances may have caused some delay in payment. DMH has implemented, and continues to implement, a number of strategies to increase the timely reimbursement for services and to create a system that efficiently supports services for children, families, and adult consumers that enables providers to deliver high quality, necessary, and appropriate services.

- Core service agencies also shared that it is difficult to make home-based services work under the current fiscal model. An example shared by stakeholders included the question of how to bill for the time spent when attempting to engage the family in the home when the family cannot be located (no shows or the family relocating) or how to account for the large amount of travel times that may be necessary for completing home visits.

- Providers noted having limited availability to flexible funding to be used to individualize services for children or youth.

- When specialized services may be needed for children and families, providers noted that private clinicians may not accept Medicaid due to the set fees for such services.

- Stakeholders noted that community-based interventions for youth or families are primarily provided through either community support case management or CBI teams, with the intent of CBIs being used mostly for children or youth with higher needs or more complexities.

However, in some instances, children, youth, and families may need a level of care or service intensity greater than what the community support model typically provides, but their need has not elevated to the level requiring the more intensive services provided through CBIs or more restrictive placement settings.

Some additional suggestions made during stakeholder interviews included:

- Increase the availability of school-based mental health services, which are a highlight program within the community.

- Develop specific strategies for increasing the coordination between the Child and Family Services Administration and the court system when child welfare is involved with the child and family. Focus group participants also noted that in some instances, the family court may be ordering specific services and providers, which has the unintended effect of limiting the individualization of services for children and families through the service teaming process.

- Continue emphasizing the importance of providing services for children in their community and developing/implementing ongoing strategies to coordinate services with the child or youth's school.

- There has been emphasis on developing access to local acute care services for children or youth and concurrently reducing the number of children placed out of state for residential treatment or psychiatric hospitalization.

- The Department of Mental Health management team has continued to emphasize development of the necessary infrastructural supports needed to support a system-change effort. The management team reported that the basic infrastructure originally needed is in place, with many of the initiatives undertaken completed ahead of schedule.

- Multi-systemic therapy (MST) is being used within the district as a step-down service (3-6 months' duration) for children needing intensive in-home services as an alternative to receiving such intensity of services in a residential setting.

Recommendations and Conclusion

Recommendations

DMH and the core service agencies have worked hard and should be recognized for the progress that has been made to make the system work more efficiently and effectively in meeting the needs of the children, youth, and families. The basic foundational supports necessary for implementing system reformation efforts are in place. This includes the understanding, articulation, and commitment to implementing a system reflective of the Dixon exit criteria by DMH and the core service agencies. However, there still are limits in the depth of understanding regarding the practice principles articulated by the exit criteria and the model of practice measured by the CSR. There is still significant competition of provider focus between fiscal and payment issues and practice/performance refinement and developing more effective measures of outcomes achieved. There are still not sufficient quality assurance mechanisms in place that are practice informed and supportive of the effective delivery of services, but they are beginning to be developed and implemented. It is important that increased emphasis and priority be given to quality improvement measurement and systematic measurement of outcomes and results achieved.

- It is recommended that further review of the fiscal model be completed to ensure that the model and policies are supportive of providing services that are congruent with the intended model of practice. Some possible barriers in the fiscal area noted during the review included task orders that limit the amount of services a core service agency can provide and be reimbursed for by quarter and whether additional services can be reimbursed when the caseloads of the providers significantly increase during these time periods; questions regarding increasing the efficiency of the reimbursement process to support a system that provides high quality, appropriate, and necessary services; the issue of new core service

agencies being recently certified and the resulting competition of agencies for a limited amount of system funding; and questions about allowable and billable community support services under the Medicaid billing policies.

- It is also recommended that strategies be explored to allow for and support more flexibility in the crafting of services, particularly in-home services or other individualized and flexible approaches for working with families, that allow for varying levels of need of children, youth, or families and that services can be individualized to allow for more than what the basic community support model can provide.

- It is encouraging that the development of the mental health system has progressed to the point where specific targeted strategies to refine the services being provided are needed. Examples of effective practice that adhere to the practice principles inherent in the Dixon Consent Decree court-ordered plan and exit criteria, as well as what is measured by the CSR were noted in the sample. These practice development strategies could include ongoing training, mentoring, modeling, and coaching of practice occurring regularly through supervision to support the development of key practice skills of frontline practitioners.

- Practice-specific skills to be focused on for the development of frontline staff having the greatest impact on the ability to provide services according to the model of practice would be the continued development of the individualized service teaming process for working with children, youth, families, and other service practitioners, including those outside the mental health system working with the youth and family such as school or child welfare, for the planning, implementation, and delivery of services.

- The strategies implemented to support the development of frontline practice should be ongoing in order to address frontline variability and turnover and should also be implemented in a manner so that the practice model becomes internalized in organizational culture of all of the core service agencies. Likewise, ongoing strategies should be jointly collaborated between DMH and the core service agencies in order to ensure that the expectations of practice are clearly articulated from senior leadership to frontline staff.

- DMH and core service agencies may also want to consider implementing specific strategies to provide ongoing training of core service agency program managers/frontline supervisors about the Community Services Review.

Conclusion

The continued growth and development of the service system is encouraging and can be credited to the commitment to implement a system-wide model of practice that is in accordance with the principles and performance expectations specified in the Dixon Consent Decree and exit criteria. The basic foundational and infrastructural supports are in place, although some review and refinement of the fiscal model may be needed.

The system has developed to the point where practice-specific strategies can be implemented in an ongoing manner to support the effective and consistent delivery of services. It is hoped that the system will see improved results for children and families in the Community Service Reviews as the system continues to progress in implementing the practice principles articulated in the Dixon court-ordered plan and exit criteria, as measured by the CSR.

HSO would like to thank the court monitor, Denny Jones, for the opportunity to facilitate and provide support to the Community Services Review process. Similarly, HSO would like to thank DMH, Consumer Action Network, all participating core service agencies' staff, and the children, youth, and families who participated in this year's review for their roles in completing this comprehensive review of 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 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?

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 to perform essential parenting or caregiving functions reliably for this child? • Is the array of in-home supports provided adequate in variety, intensity, dependability, and cultural compatibility to provide for caregiver choices and to enable caregivers to meet the challenging needs of the child while maintaining the stability of the home?

Managing Treatment & Support

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

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

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

Appendix B

CSR Interpretative Guide for Child Status

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Improvement Zone: 1-2

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

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

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

Unacceptable Range: 1-3

CSR Interpretative Guide for Practice Performance

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

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.

Appendix C

Appendix C

This agency-by-agency comparison should be interpreted with caution, since sample sizes for some of the provider agencies are extremely small (e.g., Hillcrest Children's Services had one child included in the final sample and Community Connections had three children included in the final sample). **Generalizations regarding specific agency practice should not be made based on the individual case review results due to the small sample sizes for the agency-specific findings**, rather the small samples of children or youth are illustrative of system performance for each of those randomly selected children from subsequent participating agencies.

Center for Mental Health, n=10

Current Child and Family Status

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Safety	70%		10%	40%	50%
Stability	80%		10%	80%	10%
Home/school placement	80%		10%	50%	40%
Caregiver support of the child	60%		20%	20%	60%
Satisfaction, n=9	22%		78%	11%	11%
Health/physical well-being	80%		10%	20%	70%
Functional status	60%		20%	60%	20%
Academic status	60%		20%	60%	20%
Responsible behavior	70%		30%	40%	30%
Lawful behavior, n=8	88%		0%	25%	75%
Overall Child Status	60%		10%	50%	40%

Recent Progress

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Symptom reduction	50%		30%	50%	20%
Behavior improvement	60%		20%	60%	20%
School/work progress, n=9	56%		11%	67%	22%
Risk reduction, n=7	57%		43%	14%	43%
Transition progress, n=8	13%		63%	38%	0%
Meaningful relationships, n=9	67%		11%	78%	11%
Overall Progress	50%		30%	60%	10%

Center for Mental Health, n=10

Current Practice Performance

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Child & family engagement	20%		50%	40%	10%
Cultural accommodations, n=5	60%		40%	60%	0%
Service team formation	10%		60%	40%	0%
Service team functioning	20%		60%	40%	0%
Functional assessment	40%		30%	40%	30%
Long-term guiding view	0%		70%	30%	0%
Individualized resiliency plan	10%		50%	50%	0%
Goodness-of-service fit	20%		70%	30%	0%
Resource availability: unique/flexible	20%		40%	50%	10%
Resource availability: unit/placement, n=9	22%		22%	67%	11%
Treatment implementation	10%		70%	30%	0%
Emergent/urgent response, n=3	0%		100%	0%	0%
Medication management, n=4	25%		75%	25%	0%
Special procedures, n=1	0%		0%	100%	0%
Family support, n=8	13%		50%	37%	13%
Service coordination & continuity	10%		80%	20%	0%
Tracking & adjustments	10%		80%	20%	0%
Overall Practice Performance	20%		70%	30%	0%

Community Connections, n=3

Current Child and Family Status

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Safety	100%		0%	0%	100%
Stability	100%		0%	33%	67%
Home/school placement	100%		0%	33%	67%
Caregiver support of the child	100%		0%	33%	67%
Satisfaction	67%		0%	67%	33%
Health/physical well-being	67%		0%	33%	67%
Functional status	100%		0%	100%	0%
Academic status	67%		0%	33%	67%
Responsible behavior	33%		0%	67%	33%
Lawful behavior, n=2	100%		0%	0%	100%
Overall Child Status	100%		0%	33%	67%

Recent Progress

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Symptom reduction	100%		0%	67%	33%
Behavior improvement	67%		0%	67%	33%
School/work progress	67%		0%	33%	67%
Risk reduction, n=2	50%		0%	50%	50%
Transition progress	67%		0%	33%	67%
Meaningful relationships	100%		0%	67%	33%
Overall Progress	67%		0%	67%	33%

Community Connections, n=3

Current Practice Performance

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Child & family engagement	67%		0%	33%	67%
Cultural accommodations, n=1	100%		0%	0%	100%
Service team formation	67%		33%	0%	67%
Service team functioning	67%		0%	67%	33%
Functional assessment	100%		0%	67%	33%
Long-term guiding view	67%		0%	67%	33%
Individualized resiliency plan	100%		0%	100%	0%
Goodness-of-service fit	100%		0%	67%	33%
Resource availability: unique/flexible, n=2	50%		0%	50%	50%
Resource availability: unit/placement	67%		0%	67%	33%
Treatment implementation	67%		0%	67%	33%
Emergent/urgent response, n=2	50%		0%	50%	50%
Medication management, n=2	50%		0%	50%	50%
Special procedures, n=1	100%		0%	100%	0%
Family support, n=2	50%		0%	100%	0%
Service coordination & continuity	67%		33%	33%	33%
Tracking & adjustments	67%		33%	67%	0%
Overall Practice Performance	100%		0%	33%	67%

DCCSA, n=9

Current Child and Family Status

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Safety	100%		0%	33%	67%
Stability	67%		11%	44%	44%
Home/school placement	89%		0%	44%	56%
Caregiver support of the child	78%		0%	22%	78%
Satisfaction, n=8	75%		0%	62%	38%
Health/physical well-being	89%		11%	11%	78%
Functional status	67%		0%	44%	56%
Academic status	67%		0%	67%	33%
Responsible behavior	44%		0%	67%	33%
Lawful behavior, n=7	71%		0%	71%	29%
Overall Child Status	78%		0%	56%	44%

Recent Progress

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Symptom reduction	67%		0%	67%	33%
Behavior improvement	67%		0%	67%	33%
School/work progress	67%		0%	78%	22%
Risk reduction, n=8	88%		0%	88%	12%
Transition progress, n=8	63%		0%	50%	50%
Meaningful relationships	67%		11%	56%	33%
Overall Progress	67%		0%	67%	33%

DCCSA, n=9

Current Practice Performance

	Percentage Acceptable		Percentage in 3-Tiered Format		
Indicator	**Acceptable**		**Improvement**	**Refinement**	**Maintenance**
Child & family engagement	89%		0%	56%	44%
Cultural accommodations, n=4	100%		0%	25%	75%
Service team formation	78%		11%	56%	33%
Service team functioning	33%		11%	89%	0%
Functional assessment	78%		0%	44%	56%
Long-term guiding view	33%		33%	67%	0%
Individualized resiliency plan	33%		11%	89%	0%
Goodness-of-service fit	78%		0%	89%	11%
Resource availability: unique/flexible	78%		11%	44%	44%
Resource availability: unit/placement	100%		0%	56%	44%
Treatment implementation	56%		0%	67%	33%
Emergent/urgent response, n=4	50%		0%	75%	25%
Medication management, n=6	67%		0%	83%	17%
Special procedures, n=2	0%		0%	100%	0%
Family support	33%		22%	56%	22%
Service coordination & continuity	78%		11%	89%	0%
Tracking & adjustments	44%		0%	89%	11%
Overall Practice Performance	67%		0%	89%	11%

Fihankra Place, n=2

Current Child and Family Status

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Safety	100%		0%	0%	100%
Stability	50%		0%	50%	50%
Home/school placement	50%		0%	50%	50%
Caregiver support of the child	50%		50%	50%	0%
Satisfaction	50%		50%	50%	0%
Health/physical well-being	50%		0%	50%	50%
Functional status	50%		0%	50%	50%
Academic status	50%		50%	0%	50%
Responsible behavior	50%		50%	0%	50%
Lawful behavior	100%		0%	50%	50%
Overall Child Status	50%		0%	50%	50%

Recent Progress

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Symptom reduction	50%		0%	50%	50%
Behavior improvement, n=1	0%		100%	0%	0%
School/work progress	50%		50%	0%	50%
Risk reduction, n=1	100%		0%	0%	100%
Transition progress	50%		50%	0%	50%
Meaningful relationships	50%		0%	50%	50%
Overall Progress	50%		50%	0%	50%

Fihankra Place, n=2

Current Practice Performance

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Child & family engagement	50%		0%	100%	0%
Cultural accommodations, n=1	100%		0%	0%	100%
Service team formation	0%		50%	50%	0%
Service team functioning	50%		50%	50%	0%
Functional assessment	50%		0%	100%	0%
Long-term guiding view	50%		50%	0%	50%
Individualized resiliency plan	0%		0%	100%	0%
Goodness-of-service fit	50%		50%	50%	0%
Resource availability: unique/flexible, n=1	100%		0%	100%	0%
Resource availability: unit/placement, n=1	100%		0%	100%	0%
Treatment implementation	50%		0%	100%	0%
Emergent/urgent response, n=0	NA		NA	NA	NA
Medication management, n=1	100%		0%	100%	0%
Special procedures, n=0	NA		NA	NA	NA
Family support, n=1	100%		0%	100%	0%
Service coordination & continuity	50%		50%	50%	0%
Tracking & adjustments	100%		0%	100%	0%
Overall Practice Performance	50%		0%	100%	0%

First Home Care, n=9

Current Child and Family Status

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format: Improvement	Refinement	Maintenance
Safety	67%		22%	33%	44%
Stability	67%		11%	67%	22%
Home/school placement	89%		0%	56%	44%
Caregiver support of the child	78%		22%	33%	44%
Satisfaction	67%		11%	56%	33%
Health/physical well-being	100%		0%	11%	89%
Functional status	67%		11%	89%	0%
Academic status	33%		44%	22%	33%
Responsible behavior	67%		33%	67%	0%
Lawful behavior, n=8	63%		25%	25%	50%
Overall Child Status	67%		22%	33%	44%

Recent Progress

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format: Improvement	Refinement	Maintenance
Symptom reduction	67%		22%	56%	22%
Behavior improvement	67%		22%	67%	11%
School/work progress	33%		22%	44%	33%
Risk reduction, n=8	63%		25%	50%	25%
Transition progress, n=7	43%		43%	57%	0%
Meaningful relationships	56%		11%	56%	33%
Overall Progress	56%		33%	33%	33%

First Home Care, n=9

Current Practice Performance

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Child & family engagement	56%		22%	56%	22%
Cultural accommodations, n=7	71%		29%	14%	57%
Service team formation	22%		67%	22%	11%
Service team functioning	11%		67%	22%	11%
Functional assessment	67%		11%	89%	0%
Long-term guiding view	22%		44%	44%	11%
Individualized resiliency plan	33%		33%	67%	0%
Goodness-of-service fit	44%		22%	56%	22%
Resource availability: unique/flexible	67%		11%	56%	33%
Resource availability: unit/placement, n=7	86%		14%	57%	29%
Treatment implementation	67%		22%	56%	22%
Emergent/urgent response, n=5	60%		40%	40%	20%
Medication management, n=5	80%		20%	20%	60%
Special procedures, n=0	NA		NA	NA	NA
Family support	67%		22%	44%	33%
Service coordination & continuity	33%		44%	56%	0%
Tracking & adjustments	44%		33%	67%	0%
Overall Practice Performance	56%		33%	56%	11%

Hillcrest Children's Center, n=1

Current Child and Family Status

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Safety	100%		0%	0%	100%
Stability	100%		0%	100%	0%
Home/school placement	100%		0%	0%	100%
Caregiver support of the child	100%		0%	0%	100%
Satisfaction	100%		0%	0%	100%
Health/physical well-being	100%		0%	100%	0%
Functional status	100%		0%	0%	100%
Academic status	0%		0%	100%	0%
Responsible behavior	100%		0%	0%	100%
Lawful behavior, n=0	NA		NA	NA	NA
Overall Child Status	100%		0%	0%	100%

Recent Progress

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Symptom reduction	100%		0%	0%	100%
Behavior improvement	100%		0%	0%	100%
School/work progress	100%		0%	100%	0%
Risk reduction	100%		0%	0%	100%
Transition progress	100%		0%	100%	0%
Meaningful relationships	100%		0%	0%	100%
Overall Progress	100%		0%	100%	0%

Hillcrest Children's Center, n=1

Current Practice Performance

	Percentage Acceptable		Percentage in 3-Tiered Format		
Indicator	Acceptable		Improvement	Refinement	Maintenance
Child & family engagement	100%		0%	0%	100%
Cultural accommodations	100%		0%	0%	100%
Service team formation	100%		0%	100%	0%
Service team functioning	100%		0%	100%	0%
Functional assessment	0%		100%	0%	0%
Long-term guiding view	100%		0%	100%	0%
Individualized resiliency plan	100%		0%	100%	0%
Goodness-of-service fit	0%		0%	100%	0%
Resource availability: unique/flexible	0%		100%	0%	0%
Resource availability: unit/placement	0%		100%	0%	0%
Treatment implementation	0%		0%	100%	0%
Emergent/urgent response, n=0	NA		NA	NA	NA
Medication management, n=0	NA		NA	NA	NA
Special procedures, n=0	NA		NA	NA	NA
Family support, n=0	NA		NA	NA	NA
Service coordination & continuity	0%		0%	100%	0%
Tracking & adjustments	100%		0%	100%	0%
Overall Practice Performance	0%		0%	100%	0%

Scruples Corporation, n=6

Current Child and Family Status

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format: Improvement	Refinement	Maintenance
Safety	83%		17%	17%	67%
Stability	83%		0%	50%	50%
Home/school placement	100%		0%	33%	67%
Caregiver support of the child	100%		0%	33%	67%
Satisfaction	50%		50%	17%	33%
Health/physical well-being	100%		0%	17%	83%
Functional status	67%		0%	100%	0%
Academic status	83%		0%	67%	33%
Responsible behavior	50%		33%	50%	17%
Lawful behavior, n=4	100%		0%	25%	75%
Overall Child Status	83%		17%	33%	50%

Recent Progress

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format: Improvement	Refinement	Maintenance
Symptom reduction	50%		0%	100%	0%
Behavior improvement	83%		0%	67%	33%
School/work progress	100%		0%	83%	17%
Risk reduction, n=3	33%		33%	33%	33%
Transition progress, n=3	0%		33%	67%	0%
Meaningful relationships, n=5	80%		20%	80%	0%
Overall Progress	50%		0%	83%	17%

Scruples Corporation, n=6

Current Practice Performance

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Child & family engagement	83%		17%	67%	17%
Cultural accommodations, n=2	100%		0%	50%	50%
Service team formation	33%		17%	83%	0%
Service team functioning	33%		33%	50%	17%
Functional assessment	50%		33%	67%	0%
Long-term guiding view	17%		17%	83%	0%
Individualized resiliency plan	33%		67%	33%	0%
Goodness-of-service fit	33%		17%	83%	0%
Resource availability: unique/flexible, n=3	67%		33%	67%	0%
Resource availability: unit/placement, n=5	60%		0%	80%	20%
Treatment implementation	33%		0%	100%	0%
Emergent/urgent response, n=2	50%		50%	0%	50%
Medication management, n=5	40%		60%	20%	20%
Special procedures, n=1	100%		0%	100%	0%
Family support, n=3	67%		0%	100%	0%
Service coordination & continuity	33%		17%	83%	0%
Tracking & adjustments	50%		0%	83%	17%
Overall Practice Performance	33%		17%	83%	0%

Universal Health Care, n=3

Current Child and Family Status

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Safety	67%		33%	33%	33%
Stability	67%		0%	33%	67%
Home/school placement	100%		0%	33%	67%
Caregiver support of the child	67%		0%	100%	0%
Satisfaction	67%		0%	67%	33%
Health/physical well-being	67%		0%	33%	67%
Functional status	67%		0%	67%	33%
Academic status	100%		0%	100%	0%
Responsible behavior	67%		33%	33%	33%
Lawful behavior, n=2	50%		0%	100%	0%
Overall Child Status	67%		33%	0%	67%

Recent Progress

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Symptom reduction	67%		0%	67%	33%
Behavior improvement	67%		0%	67%	33%
School/work progress	100%		0%	100%	0%
Risk reduction, n=2	50%		0%	100%	0%
Transition progress, n=2	50%		0%	100%	0%
Meaningful relationships	67%		0%	100%	0%
Overall Progress	67%		0%	67%	33%

Universal Health Care, n=3

Current Practice Performance

Indicator	Percentage Acceptable		Percentage in 3-Tiered Format		
	Acceptable		Improvement	Refinement	Maintenance
Child & family engagement	67%		0%	67%	33%
Cultural accommodations	100%		0%	33%	67%
Service team formation	33%		33%	67%	0%
Service team functioning	33%		33%	67%	0%
Functional assessment	67%		0%	100%	0%
Long-term guiding view	0%		67%	33%	0%
Individualized resiliency plan	0%		33%	67%	0%
Goodness-of-service fit	67%		0%	100%	0%
Resource availability: unique/flexible	0%		0%	100%	0%
Resource availability: unit/placement	33%		33%	67%	0%
Treatment implementation	33%		0%	100%	0%
Emergent/urgent response, n=2	0%		50%	50%	0%
Medication management	67%		33%	33%	33%
Special procedures, n=1	100%		0%	0%	100%
Family support	100%		0%	100%	0%
Service coordination & continuity	67%		33%	67%	0%
Tracking & adjustments	33%		33%	67%	0%
Overall Practice Performance	33%		33%	67%	0%