2008 Report on Children and Youth

Served by the District of Columbia Department of Mental Health

May 2008

Presented to the Dixon Court Monitor

by

Human Systems and Outcomes, Inc.

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Background and History

The Final Court-Ordered Plan for Dixon, et al v. Fenty, et al [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 home and school activities, 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 with an 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.

The results for the 2005 Dixon Court Monitoring Children's Review of 43 children served were completed in April 2005. The findings were overall acceptable child status ratings for 72% of the children and overall acceptable system performance of 47%.

The sample for the 2006 Dixon Court Monitoring Children's Review consisted of 54 children served. The results for the 2006 children's review were completed in April 2006. The findings were overall acceptable child status ratings for 81% of the children and overall acceptable system performance of 54%.

Fifty-two youth were reviewed in March 2007, with the overall child status rating acceptable for 75% of the youth. The system performance was found acceptable, overall, for 48% of the youth reviewed.

2008 Dixon Court Monitoring Children's Review

The design of the 2008 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 in numerous states across the country. HSO was contracted by the Dixon Court Monitor and worked as staff to the monitor in conducting the reviews. Logistical preparation and organization of the on-site case review activities was 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 child reviews.

Context for the 2008 Review

A major system change process is and has been occurring in the District of Columbia for children's mental health services. The goal of the change process is to develop a system that will collaborate with children and families and the other child-serving agencies to deliver individually determined, appropriately matched, well-coordinated services to each child and family consistent with an Individualized Resiliency Plan (IRP). The expectation is that there will be a consistent level of performance across core service agencies, providers, and community partners. The expectation is that they all deliver quality services according to the practice principles of the Dixon exit criteria and a System of Care model.

A new director of the D.C. Department of Mental Health (DMH) was appointed in March 2006. During 2006, the priority issues for DMH focused on ensuring timely payments of providers and developing increased responsiveness to children involved in other child-serving agencies and the family court. This issue was largely resolved during 2006 and 2007.

Following the 2007 review, DMH focused on supporting the formation and process of teaming, both within agencies and across community partners. There is an ongoing need to support collaborative teaming, as a process, across those who service children and families. The formation and functioning of an effective team is a core aspect of System of Care principles. In order to support the formation of multi-agency teams and the use of teaming as a continuous process, DMH initiated a billing code to be used by providers. This billing code was implemented to offset the cost of non-reimbursable time of key team members in order to facilitate ongoing multi-agency collaboration as a part of treatment implementation. However, the data indicate that this billing code has not been used extensively.

Overview of the Child Review Process

The monitor's review of services for children, youth, and families is conducted by way of a qualitative review process. This process also yields quantitative data on identified indicators of

child status and system functioning. The review process is a case-based inquiry of services received by individual children, youth, and families. This process is based heavily on the face-to-face interviewing of all services providers and persons involved with a youth. Those interviewed include the child, parents or guardian, and key team members, such as a case manager, community support worker, therapist, psychiatrist, wrap-worker, teachers, juvenile justice, advocates, Individualized Education Plan (IEP) coordinator, group home staff, and foster parents. Other adults who are prevalent or who provide support to the youth or family are also interviewed. These adults can include other family members, community members, coaches, pastor and church members, and babysitters or respite/caregivers.

Reviews were completed over a two-week period of time. The child reviews were completed by reviewers trained to standard by HSO trainers. Fifty-three reviews were conducted by HSO affiliated personnel and 20 reviews were completed by staff of DMH.

Changes to the Review Process

There were a few alterations to the review process in 2008, as agreed to by the District and the Court Monitor. In addition to the increase in the sample size as noted earlier, two other changes were made: assignment of a case judge, and the process of providing individual case feedback directly to agency staff. In addition, CFSA proposed to co-review cases in which youth and families were involved with DMH and CFSA.

The case judge met with all DMH reviewers following their reviews to provide individual mentoring and support and to assure that reviewers had the information and facts to support their ratings. Reviewers provided a case description and discussed each rating with the case judge. This session was completed for all DMH reviewers and many of the HSO reviewers. Case judging was in addition to the group debriefing sessions with the team leader. Case judging this year was conducted by Dr. Ray Foster of HSO.

As is the case so far in every year of review, the 2008 Community Services Review (CSR) contained a large number of youth who are involved with the child welfare system. Sixty-two

percent (62%) of the cases reviewed in 2008 were involved with child welfare. Representatives from DMH and HSO met with staff from the Child and Family Services Administration (CFSA). The result was the decision to pair CFSA reviewers on reviews where the youth and family were currently involved with child welfare. These co-reviewed youth provided data on both the CFSA and the DMH protocols. CFSA was able to use the data as part of their ongoing monthly quality assurance practice. A total of 17 youth and families were co-reviewed. CFSA was able to collect viable data for all 17 youth.

The issue of providing direct feedback to service providers has been discussed at length. For the past two years, core service agencies (CSAs) have requested that feedback and recommendations be given for the cases reviewed. Providing feedback on individual cases takes scheduling and logistical preparation, specific training of reviewers, and preparation of staff and CSAs to receive the input. Feedback sessions are a dialogue about the individual practice issues pertaining specifically to the youth being reviewed. Feedback includes suggestions for next steps and problem solving around barriers and challenges. Feedback sessions do not serve as employee job performance evaluations. Follow-up from DMH occurs in rare instances that require a mandatory report due to safety or threat of harm or is requested by the team leader. Feedback is generally provided to staff and team members working directly with the youth and families, and includes supervisors as deemed appropriate by the CSA. For the 2008 review, the Court Monitor decided to give feedback sessions a trial run. Feedback was attempted for all cases reviewed, with 29 cases receiving direct, case-specific feedback. In instances where feedback was not given, scheduling issues prevailed.

The Sample for Children and Youth

A larger number of youth were selected this year to strengthen the statistical significance of the data. The target number to review was determined to be 86. A stratified random sample of 90 youth, plus replacement names, was drawn from the DMH eCURA data system for youth receiving services between April 1 and October 31, 2007. The random sample of 90 was used to account for sampling attrition that occurs during scheduling and the review weeks (i.e., one of the youth reviewed was hospitalized the day prior to the CSR and the guardian declined

participation on the review day). Twenty-seven youth were replaced in the original sample to make up the final sample of 86. Schedules were completed for 77 reviews, and ultimately, reviews were completed on 73 youth. Three of the youth who dropped out during the review weeks did so due to decompensation; two of these three were hospitalized during this time. The other youth had a mother with mental illness who was symptomatic at the time and rescinded participation. The fourth youth had a parent who did not respond to multiple phone contacts and missed two scheduled appointments. School staff for this youth also did not respond to multiple attempts to make appointments to interview them and the youth. Seventy-seven of the 86 schedules were completed successfully. The remaining nine youth either refused to participate or consent from the legal guardian was not able to be secured (i.e., parent not able to be located and youth was in a foster home and parental right still intact; some families were in the process of Termination of Parental Rights and CFSA was not able to sign the consent). Youth selected for the review received at least one form of billable mental health service from a provider agency during the noted timeframe. The total population served during this time period was reported to be 1475 children, a decrease of 395 youth from the previous year.

Core Service Agencies

According to the information supplied to HSO by the DMH eCURA system, there were a total of 1475 children who received a billed-for service between April 1 and October 31, 2007, from 15 different provider agencies. These provider agencies differ substantially in the total number of children they serve. Approximately 62% of all youth receiving services are receiving them from three agencies, with no other individual agency serving more than 8% of the sample. The number of children selected for review from each agency was proportionate to the percentage of youth in the total sample served by the agency. Fifteen core service agencies were identified as providing a billable service during the identified timeframe with 11 CSAs represented in the review sample. An additional CSA was reviewed due to a youth changing providers between the end of the billing period (October 31, 2007) and the beginning of the review (March 3, 2008). This addition brings the total number of CSAs to 16, 11 of which had youth who were reviewed.

The number of children reviewed from each agency is slightly different from the number originally selected. This is due to sampling and review attrition factors, such as refusal to participate, placement or relocation out of the District of Columbia and immediate area, transition from one CSA to another, and a youth discharged from services and not receiving services from another CSA. As noted above, an additional agency was reviewed due to attrition factors. The table below illustrates the sampling breakdown by agency.

Display 1
Number of Children Receiving a Billed Service
Between April 1 and October 31, 2007,
According to the eCURA Data System

Core Service Agency	# in Population	% of Population	# in Sample	# Reviewed	% of Review Sample
First Home Care	375	25%	22	24	33%
DCCSA	308	21%	19	13	18%
Community Connections	232	16%	15	14	19%
Scruples	123	8%	7	6	8%
Kidd International	98	7%	6	4	6%
MDDC	93	6%	5	3	4%
Affordable Behavioral Consultants	78	5%	5	1	1%
Universal Healthcare	68	5%	4	3	4%
Center for Therapeutic Concepts	46	3%	2	2	3%
Youth Villages	18	1.2%	1	0	0%
Family Preservation	17	1.2%	1	0	0%
Latin American Youth	9	.6%	2	2	3%
Fihankra	5	.4%	1	0	0%
Mary's Center	4	.4%	0	0	0%
Washington Hospital Center	0	0%	0	1	1%
CPEP	1	0%	0	0	0%
Totals	1475	99.8%	90	73	100%

Age of Youth

When selecting the sample for the 2008 review, there was no predetermined percentage or number of youth by age. A brief survey form was sent out for providers to complete for each of the initially randomly selected children. This instrument was used to gain some background information and updated contact information so that the sample could be stratified across the following points: (1) provider agency, (2) age of child, and (3) child's gender. **Display 2** shows the distribution of the eCURA population, random sample, and review sample, by age group.

Display 2
Age of Youth in the Population, Random Sample, and Review Sample in 2008

Age of Youth	# in Population	% of Population	# Sample	# in Review	% of Review Sample
Birth to 4 years	12	1%	1	1	1%
5 to 9 years	344	23%	26	19	26%
10 to 13 years	491	33%	26	22	30%
14 and older	628	43%	37	31	43%
Totals	1475	100%	90	73	100%

Child's Level of Need

The child's level of need was separated into three categories—low, medium, and high. The survey completed by the provider agencies was used to collect specific information, such as the current array of services a youth was receiving. Other level of care indicators, such as the current Global Assessment of Functioning Scale (GAF) score and the Child and Adolescent Level of Care System (CALOCUS) score, were also gathered as possible. 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 random sample were currently in a residential, or more restrictive, placement or had recently experienced a residential, or more restrictive, placement. None of the youth in the 2008 review were in residential or more restrictive settings. Attempts were made to ensure that the distribution of children's level of need included in the random sample were reflective of the actual distribution of children's level of need noted through the background survey results.

Children and Families Included in the Review

Although the originally specified target of reviewing 86 children was not met (73 children were reviewed), 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 District's mental health system. The

primary reasons for not meeting the target of 86 children, despite selecting 90 youth and replacing 27 youth, were 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, difficulty accessing parents and youth during the review, parents rescinding consent, change in placement or living situation, and inability of reviewers to collect enough information to complete the review. An additional factor impacting the need to replace youth initially selected is the sampling timeframe used to select children and families for the review. Some of the initial youth were no longer receiving services at any CSA during the time of the review. **Display 3** shows the general reasons for replacement and the number of youth replaced.

Display 3
Reason for Youth Replacement in Review Sample

Reason for Replacement	Number of Youth Replaced
Discharged from services	21
Unable to contact	2
Not receiving services in D.C.	1
Removed from services	1
Refused to participate	1
Not receiving services within time period	1
Total	27

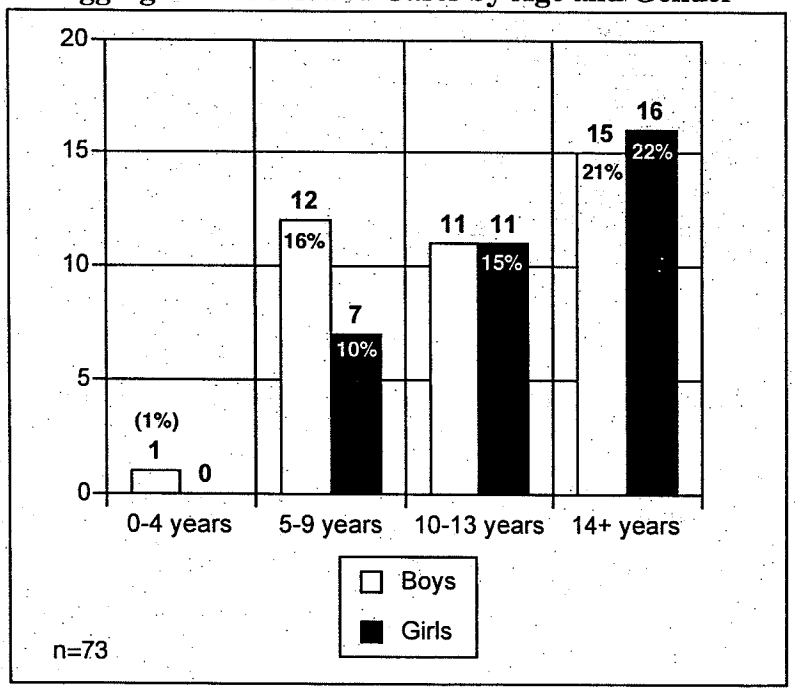
Description of the Children and Youth in the Sample

A total of 73 child and family reviews were completed during March 2008. Presented in this section are displays that detail the characteristics of the children and youth in the sixth-year sample.

Age, Gender, and Ethnicity of Youth

The review sample was composed of boys and girls drawn across the age spectrum served by DMH. The following display (**Display 4**) presents the aggregate sample of 73 children and youth distributed by both age and gender. As shown in this display, boys make up 53% of the review sample and girls make up 47% of the review sample. It is not uncommon for more boys to be receiving services within the active population. Children under age ten comprised 27% of the sample (20 youth). Twenty-two children, or nearly a third of the review sample (30%) fell in the 10-13 year old age group. Thirty-one teenagers age 14 and older (43%) were included in the review. Ninety-three percent (93%) of the youth reviewed were of African American ethnicity and 7% were of Latino-American descent.

Display 4
Aggregate of Reviewed Cases by Age and Gender

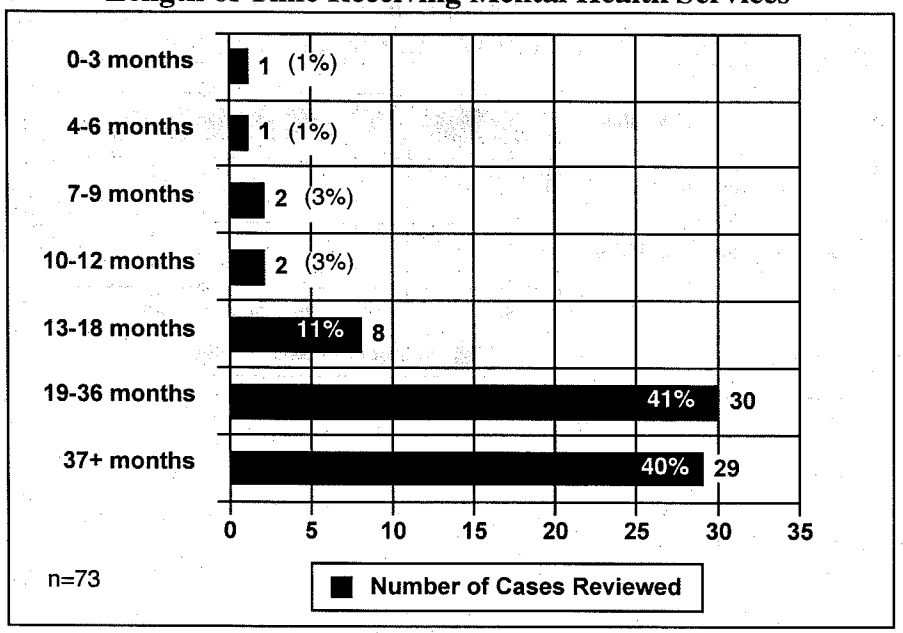


Source: DC Children's Review
March 2008

Length of Mental Health Services

Display 5 presents the amount of time the children's cases had been open during their current, or most recent, admission for services. As described below, the majority of the youth had been receiving services for longer than 19 months (81%; 59 youth) and 8% had been receiving services for less than one year. There are 53% more youth reviewed who were receiving services for more than 19 months than in the 2007 review. The most notable difference when compared with the 2007 data is in regards to the number of youth receiving services for more than three years. In the 2007 review, 17% of the sample fell into this timeframe; a difference of 23%.

Display 5
Length of Time Receiving Mental Health Services

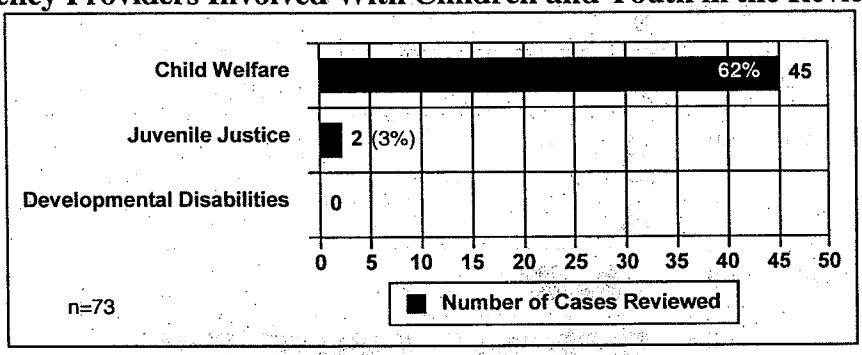


Source: DC Children's Review March 2008

Services by Other Agencies (not including education)

Some children and youth in the review sample were also receiving services from other major child-serving agencies. **Display 6** presents the number of youth identified as being served by other key agencies: child welfare, juvenile justice, and developmental disabilities. More than half of youth (62%) were involved with CFSA. For comparative purposes, 47% in the 2004 review sample, 23% in 2005, 29% in 2006, and 48% in 2007 were involved with CFSA. This year, only two youth (3%) of the review sample were involved with the Department of Youth Rehabilitation Services (DYRS). In the past two reviews (2007 and 2006), there were five and four children respectively, or close to 10% of the youth reviewed.

Display 6
Other Agency Providers Involved With Children and Youth in the Review Sample



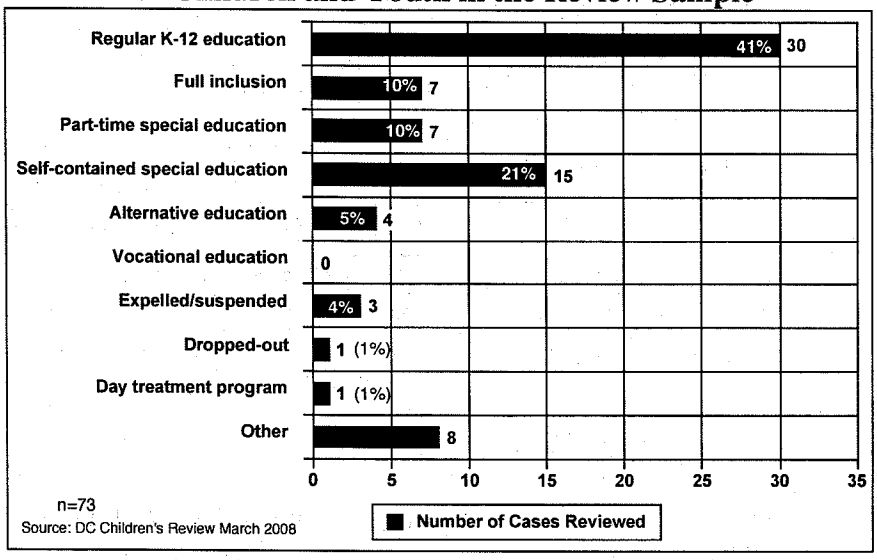
Source: DC Children's Review March 2008

Educational Program Placement

Reviewers look to see that the educational setting of a youth meets instructional and behavioral needs and provides an environment that is conducive for learning. Reviewers learn about social interactions and peer relationships, a student's ability to manage stress and frustration, and transition processes, in addition to information regarding learning style, processing, and academic achievement. The graph displayed below illustrates the educational status/placement for the children and youth in the review sample. Forty-one youth, or 30%, were in regular K-12 educational settings. Twenty-nine youth (35%) were receiving some type of special educational service, either full inclusion (10%; seven youth), part-time special education services (10%; seven youth), or in a self-contained special education setting (21%; 15 youth). Three children

were expelled or suspended, one dropped out, one was in a day treatment setting, and four were in an alternative education program. Eight of the youth reviewed were in other educational settings, which include special school for behavior disorders, regular education with a 504 plan, referral to special education, private special education school, college, or youth who are currently not enrolled and are planning to re-enroll.

Display 7
Types of Educational Services/Placements or Educational Status for Children and Youth in the Review Sample



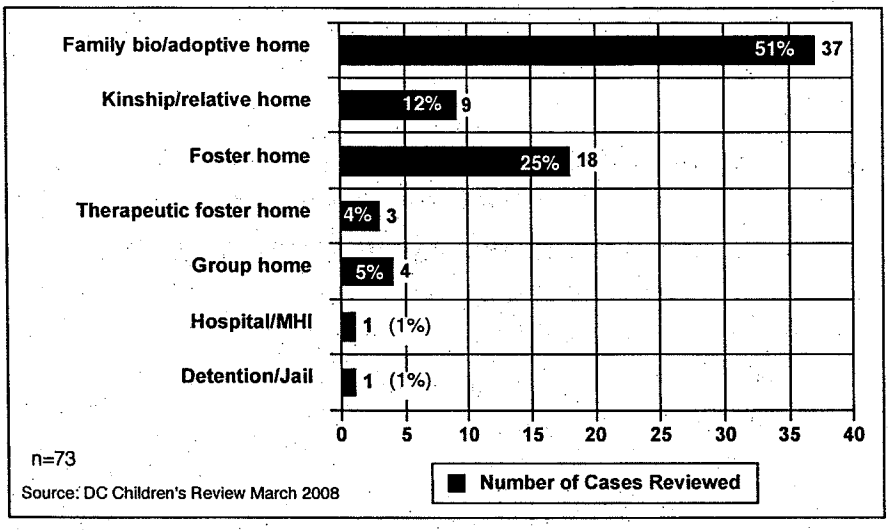
Living Setting

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. Fifty-percent of youth in the review sample were living with their birth or adoptive family; an additional nine youth (12%) were living with relatives. The remaining youth were living outside of the family/kinship home. Twenty-nine percent, or 21 youth, were living in a foster home and 4% (three youth) were living in a therapeutically-supported setting.

The most notable difference in place of residence for youth this year versus in the 2006 review is the number of youth living in traditional foster homes. In 2007, 12% of the review sample were in non-therapeutic foster homes while twice the percentage (25%) were in the same living

situation in 2008. Additionally, 27% were living in kinship or relative homes in 2007, while 12% were living with relatives in 2008.

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



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 review of records and/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). Sixty-three percent (63%) of the youth in the 2008 review had a placement change in their lifetime. The majority of youth (56%) had from one to five placements.

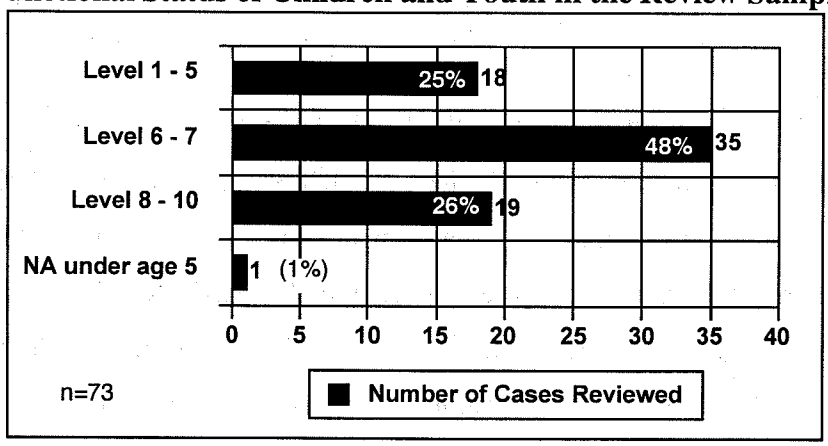
Display 9
Total Number of Placement Changes for Children and Youth in the Review Sample

Placement Changes	Frequency in Sample	Percentage of Sample
No placement changes	26 children in final sample	36%
1-2 placement changes	25 children in final sample	34%
3-5 placement changes	16 children in final sample	22%
6-9 placement changes	3 children in final sample	4%
10 or more placement changes	2 children in final sample	3%

Functional Status

Display 10 provides the distribution of the review sample across functioning levels for the 72 children and youth age five and older. These are general level of functioning ranges assigned by the reviewer at the time of the review. Reviewers use information gathered from case records, past assessments and evaluations, interviews, and specific criteria in the Dixon monitoring protocol to determine youth level of functioning. The scale is based on and similar to the Child Global Assessment of Functioning Scale. 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 8-10 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 10
Functional Status of Children and Youth in the Review Sample



Source: DC Children's Review March 2008

Eighteen youth in the review sample had level of functioning scores in the lowest range (25% of the review sample). This range captures youth requiring many supports and, oftentimes, involving multiple agencies. Children in the 2008 review appear to be functioning slightly better

than those in the 2007 review, as noted by the 13% increase in the number of youth in the Level 8-10 range (13% of youth in the 2007 review were in this level; 26% for 2008). The majority of the children (48%) reviewed continue to be in the mid-range, although this is lower than in 2007.

The following table separates level of functioning ratings by age range (level of functioning is collected for youth over age five). When separating level of functioning by age range, there were no differences in the likelihood of level of functioning. All of the youth reviewed were more likely to be at the moderate level of functioning. Youth with the highest level of need in this year's review were more likely to be 14 years or older.

Display 11
Level of Functioning Ratings for Children and Youth in the Review Sample

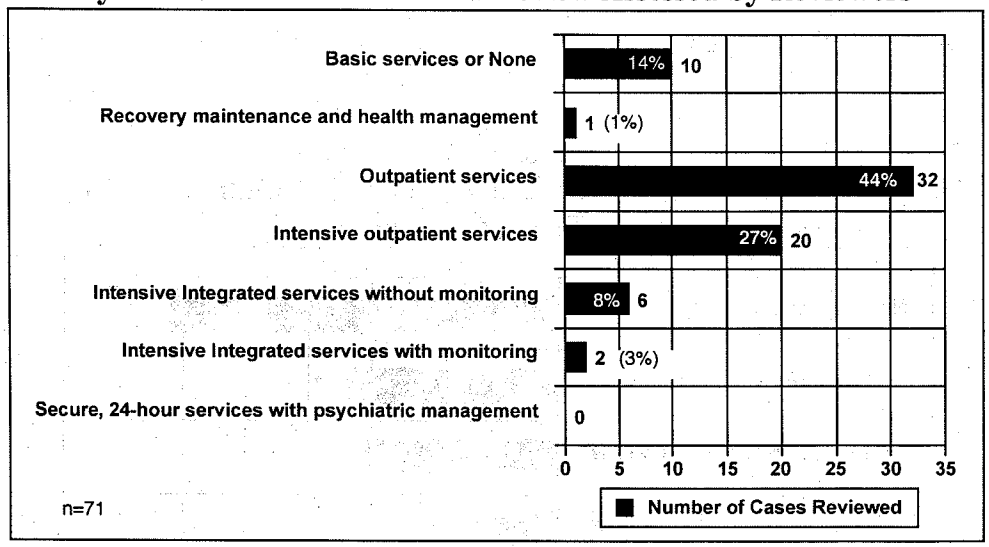
Age Ranges	Low Level of Functioning	Moderate Level of Functioning	High Level of Functioning	Totals
0-9 Years Old	5 of 19 (26%)	9 of 19 (47%)	5 of 19 (26%)	Nineteen 0-9 year olds in final sample
10-13 Years Old	4 of 22 (18%)	11 of 22 (50%)	7 of 22 (32%)	Twenty-two 10-13 year olds in final sample
14 Years or Older	9 of 31 (29%)	15 of 31 (48%)	7 of 31 (23%)	Thirty-one 14 or older in final sample
Totals	18 total children in low range	35 total children in moderate range	19 total children in high range	73 youth reviewed

Level of Care

The 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 understanding 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 12 represents the distribution of children according to their level of care. The CALOCUS rating was reported for 71 of the youth reviewed this year. CALOCUS ratings were similar to the ratings in 2007, with slightly more youth receiving outpatient services (44% in 2008 versus 38% in 2007) and slightly less youth receiving basic/none services than last year (14% in 2008; 17%in 2007).

Display 12
CALOCUS for Range of Services Received by Children and Youth in the Review Assessed by Reviewers

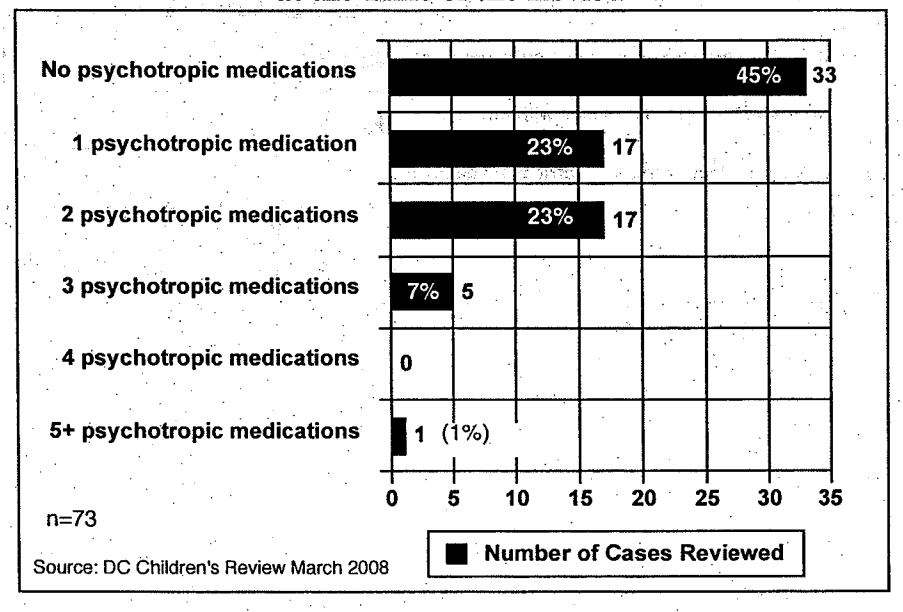


Source: DC Children's Review March 2008

Medications

The number of psychotropic medications taken by children and youth in the review sample were counted and reported by reviewers. **Display 13** presents the number of medications prescribed by youth in the review sample. The number of psychotropic medications prescribed to youth is similar to last year. The only category difference of 5% points or more is in the number of youth prescribed one psychotropic medication. Twenty-nine percent were prescribed one medication in 2007, while 23% were prescribed one medication in 2008. There is only a one or two percentage point variation in the other categories.

Display 13
Number of Psychotropic Medications Taken by Children and Youth at the Time of the Review



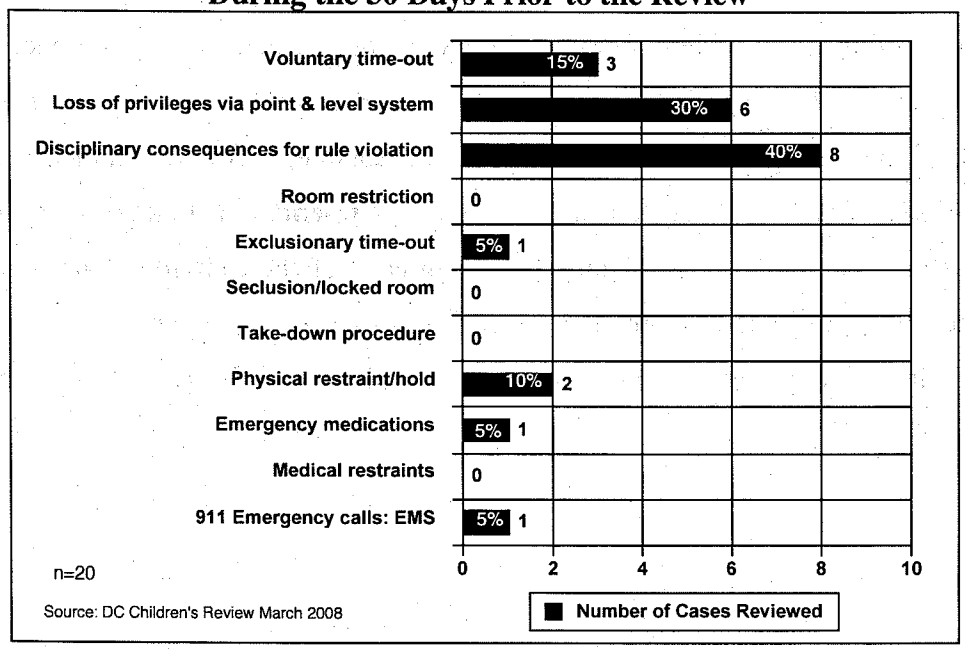
Special Procedures

Special procedures are used in certain situations to prevent harm but are not a form of therapy or treatment. **Display 14** displays the number of youth reviewed who experienced at least one of ten types of special procedures used within the 30-day period preceding the review. It should be noted that a majority of these special procedures recorded for the 2008 review can be attributed to a relatively small number of children. This year, a quarter of the youth reviewed (n=20) were

found to have experienced a special procedure in the 30 days prior to the review. Oftentimes, youth experiencing this type of intervention have more than one special procedure used in order to prevent harm.

There is a noticeable difference in the percentage of youth requiring a 911 emergency call involving police. In 2007, 29% of the youth reviewed (n=14) had at least one 911 emergency call in the 30 days preceding the review. For 2008, 5% of the 20 youth having a special procedure had a 911 call during the 30-day timeframe. There was also a 30% decrease in the number of youth having a disciplinary consequence in the month prior to the review.

Display 14
Special Procedures Experienced by Children and Youth in the Review Sample During the 30 Days Prior to the Review



Child Review Findings

Child reviews were conducted for 73 children and youth in March 2008, using the *Community Services Review Protocol*, a case-based review tool developed for this purpose. This tool was based on a resiliency-based service delivery model within 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 are 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 contains 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 child's situation, 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 is applied to this 6-point rating scale; 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.

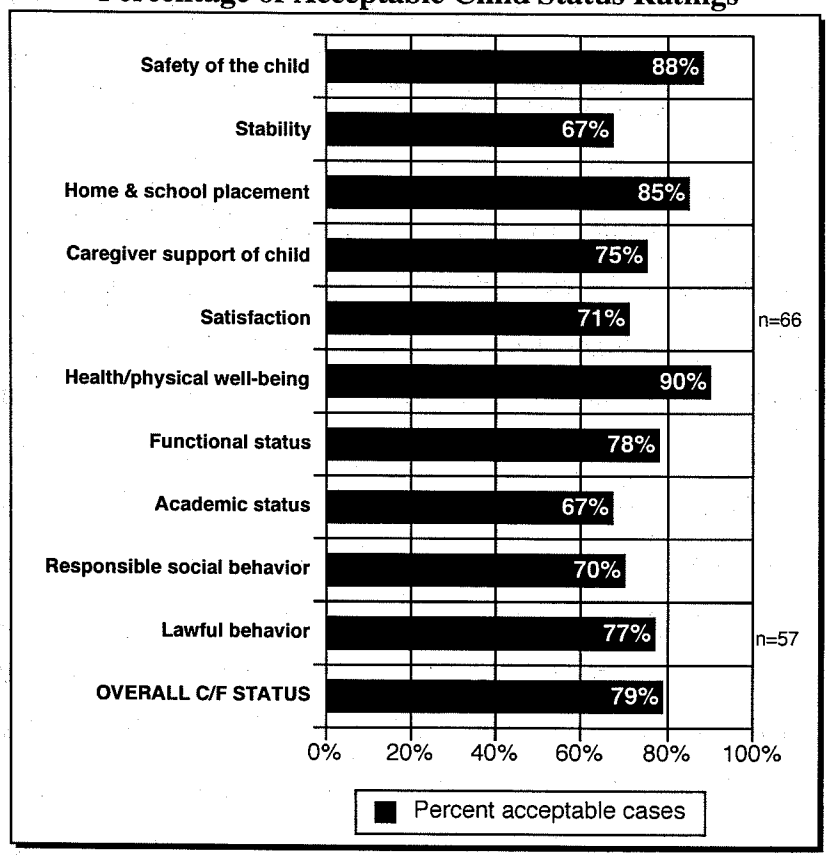
Interviews

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 413 persons were interviewed for the 73 children and youth reviewed this year. The number of interviews ranged from a low of two persons in one case to a high of ten persons in another case. The average number of interviews was 5.7 (mean=5.7, median=6, mode=6)

Child Status Results

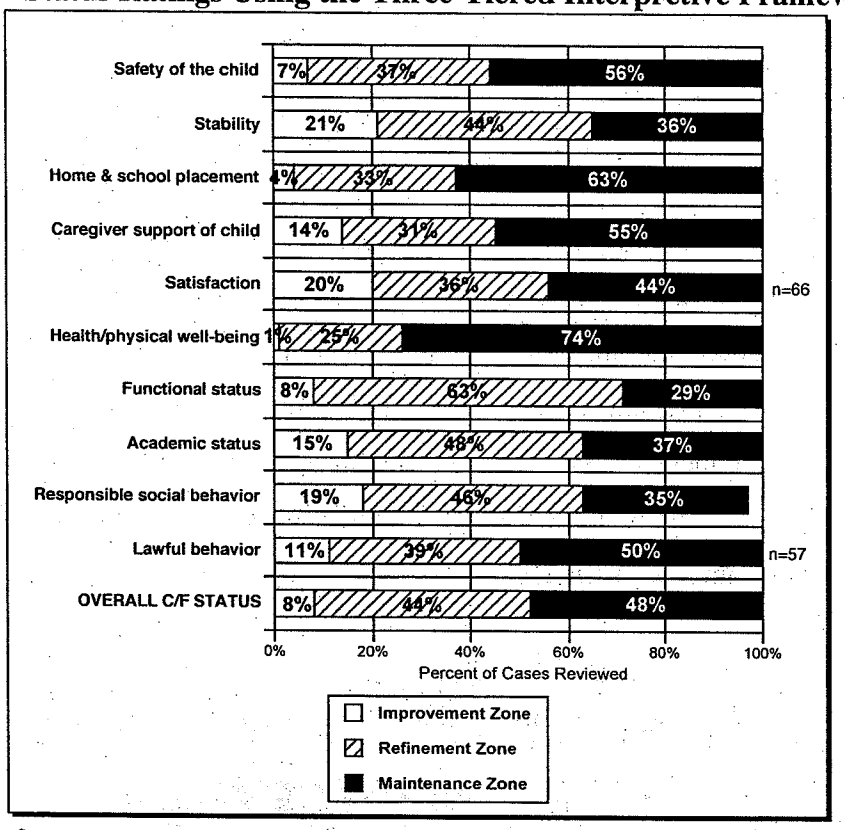
Ten indicators related to the current status of the child or youth were contained in the CSR Protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. The next two displays present findings for each of the ten indicators. **Display 15** uses a "percent acceptable" format to report the proportion of the sample members for whom the item was determined applicable and acceptable. **Display 16** 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 15
Percentage of Acceptable Child Status Ratings



Source: DC Children's Review March 2008, n=73

Display 16
Child Status Ratings Using the Three-Tiered Interpretive Framework



Source: DC Children's Review March 2008, n=73

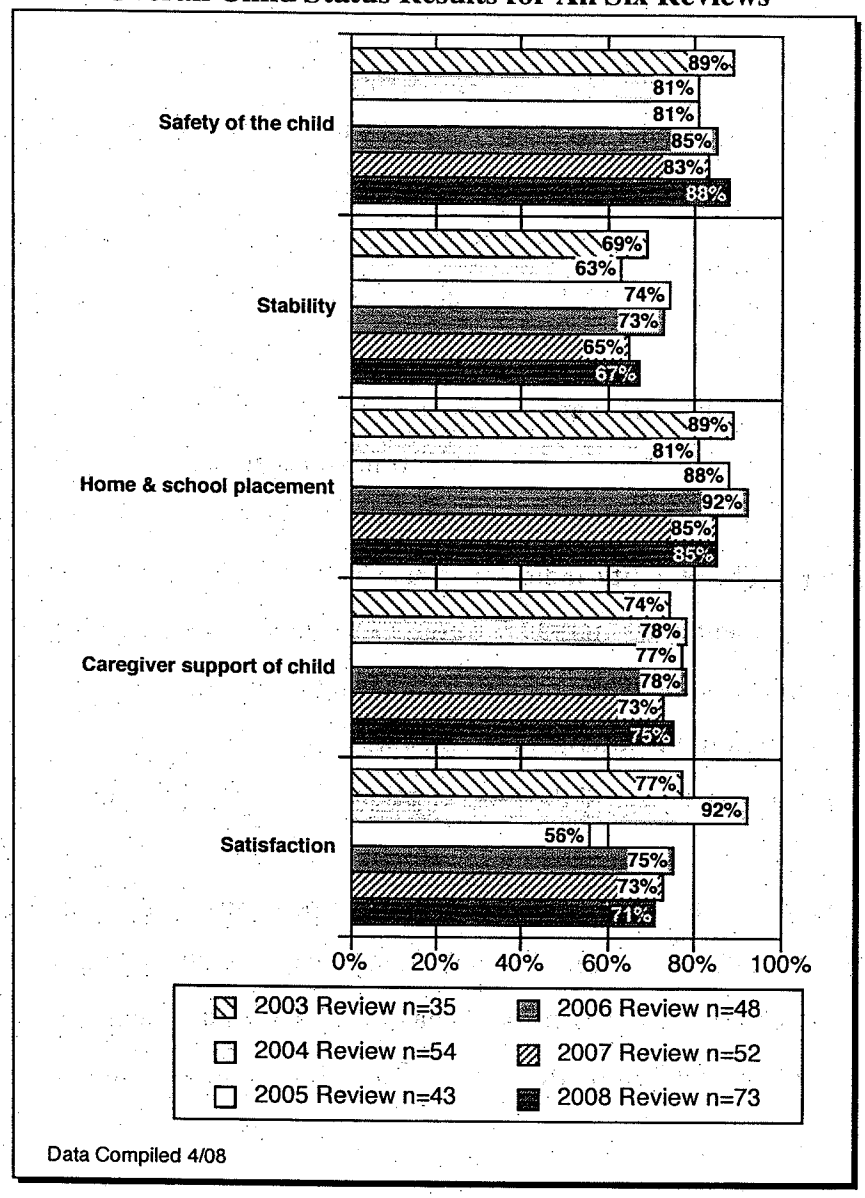
Overall Child Status. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall child status rating." Indicators are weighted accordingly, with the safety indicator being a "trump" indicator (if safety is rated a 3 or lower, in the unacceptable zone, the overall child status rating becomes the same rating as the safety rating). Of the 73 youth participating in the review, 79% were found to have acceptable overall status. This is an increase of 4% from 2007. The overall child status scores were distributed across the zones as follows: 8% needed immediate attention and were in the improvement zone; 44% were in the refinement zone, and nearly half (48%) were in the maintenance zone. Although the overall ratings are comparable to 2007, more youth were found in the maintenance zone this year (an increase of 10%). **Display 17** shows the overall child status results for all six reviews. Overall child status ratings have been stable and in the same percentage range for all six years, with the highest results achieved during the 2006 review in which 81% of the youth reviewed were rated acceptable for overall status.

There are several indicators of child well-being that rated strongly this year. Youth were found to be safe, with 88% of the youth reviewed found acceptable in this area. Youth are also, for the most part, healthy and have regular access to medical care (90% acceptable). Eighty-five percent (85%) of the youth reviewed were found to be placed in appropriate home and school settings. This may be due to the high number of youth in the sample who are living in permanent family and adoptive and kinship homes (50% family/adoptive and 27% in kinship care).

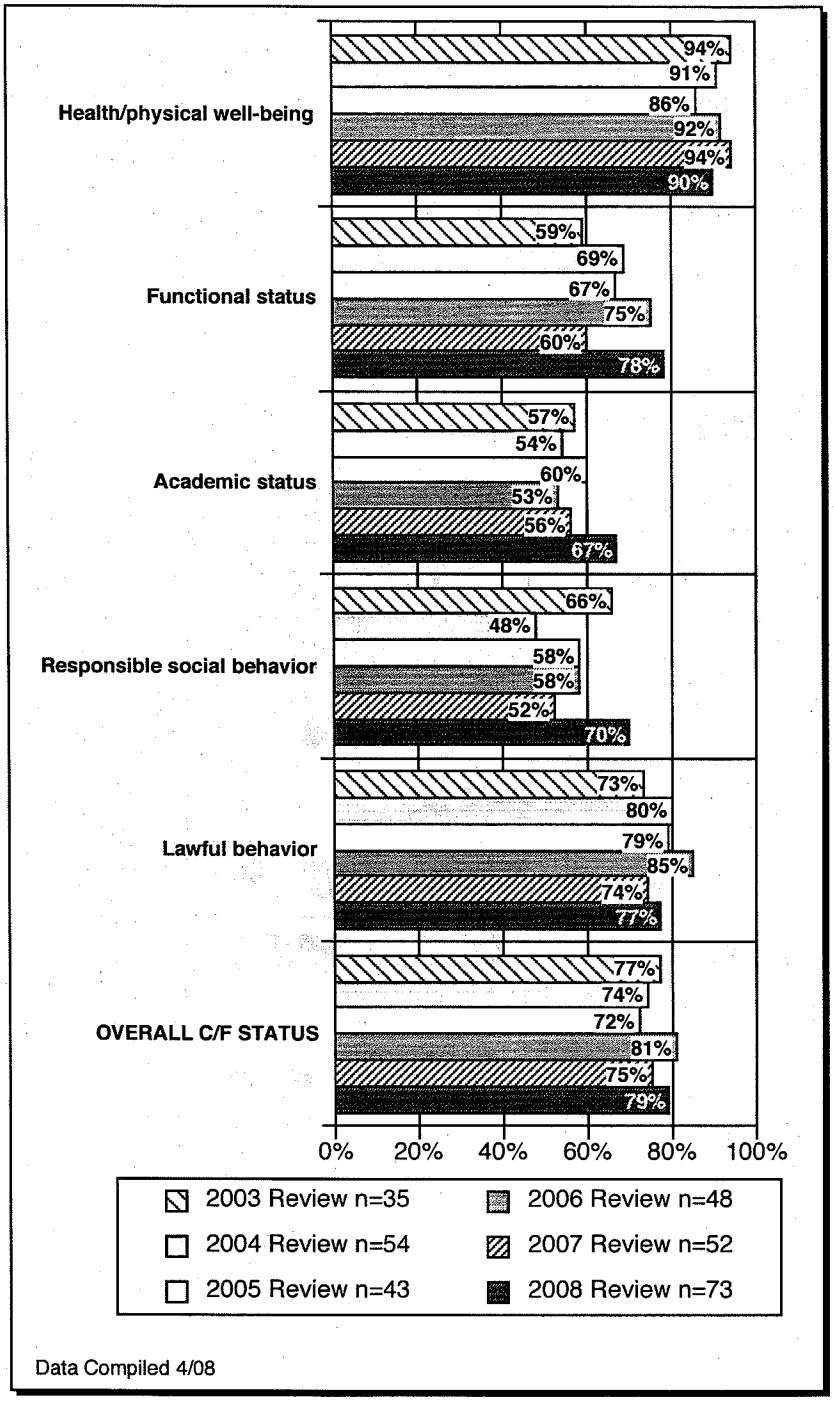
The two lowest scoring indicators were identified in academic status and stability. Sixty-seven percent (67%) of the youth reviewed were found to have acceptable academic status, with 23% requiring immediate attention in the improvement zone, 54% in the refinement zone, and 23% in the maintenance zone. The stability indicator is also rated 67%, with 17% in the improvement zone, 46% in the refinement zone, and 37% in the maintenance zone. Stability is determined by looking at several factors, such as the number of changes in living situation and caregivers, the permanency of the current living arrangement, the likelihood of disruption in the next three to six months (planned and unplanned), and the identification of factors impacting stability.

There were two indicators showing a marked increase in percentage of acceptable youth, despite still falling below the 85% acceptable threshold. There was an 18% increase in the number of youth found acceptable for both responsible behaviors (70%) and functional status (78%). This shows a marked improvement in important areas of social development and daily well-being.

Display 17
Overall Child Status Results for All Six Reviews



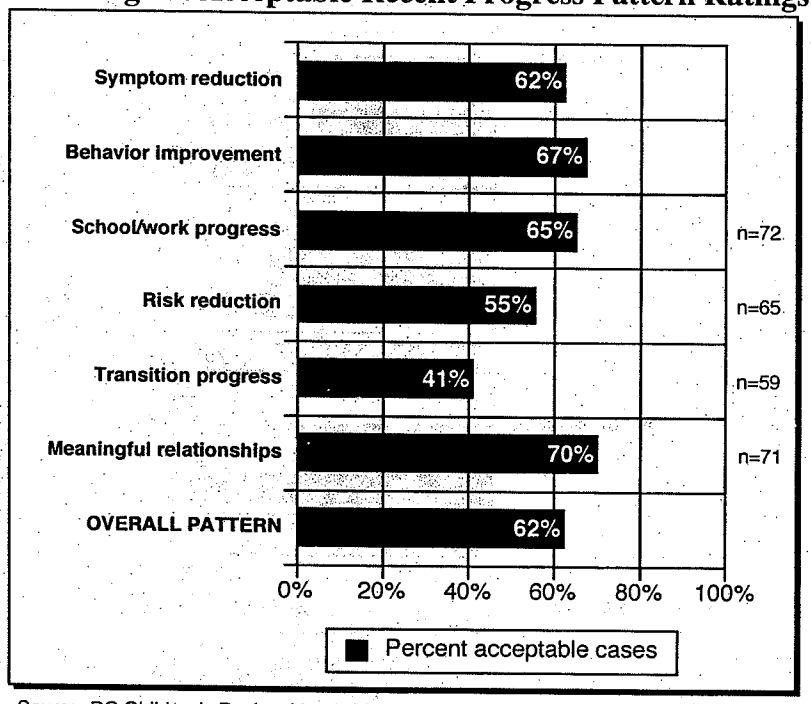
Display 17 (continued)
Overall Child Status Results for All Six Reviews



Recent Progress Patterns Showing Change Over Time

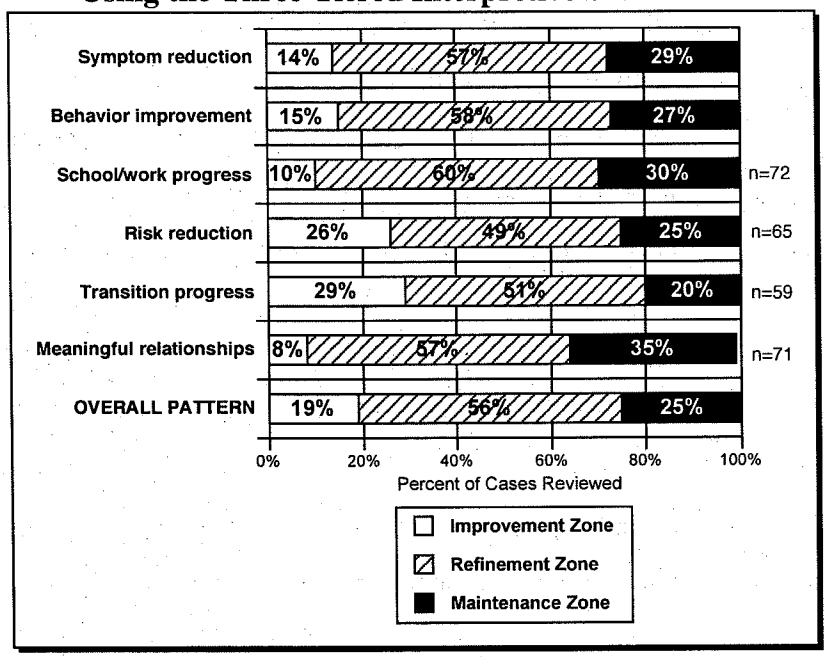
The CSR Protocol provided six indicators that enabled reviewers to examine recent progress on specific areas of treatment focus that was noted for the sample members during the review. The timeframe for noting recent progress was within the last six months or since admission to mental health services (if less than six months). Descriptions of these six indicators can be found in **Appendix A**. **Displays 18 and 19** present the findings for the progress indicators for the review sample.

Display 18
Percentage of Acceptable Recent Progress Pattern Ratings



Source: DC Children's Review March 2008, n=73

Display 19
Recent Progress Pattern Ratings
Using the Three-Tiered Interpretive Framework



Source: DC Children's Review March 2008, n=73

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 pattern was acceptable for 62% of the 73 youth reviewed. This is a 10% increase from last year (52% acceptable overall progress pattern), although it is a consistent finding when compared with reviews conducted over the past six years. Overall progress pattern ratings were distributed among the three-tiered zones as follows: 19% were found to need improvement, 56% were in the refinement zone, and 25% were in the maintenance zone.

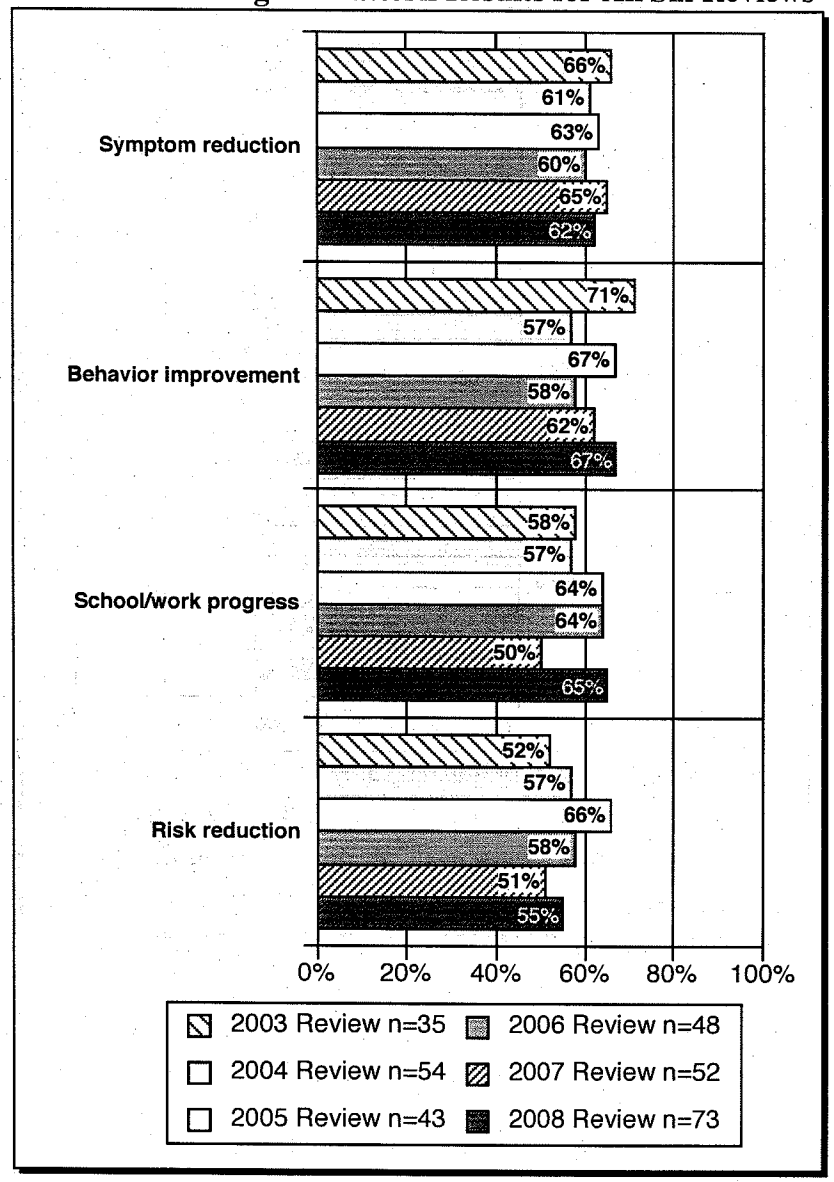
Progress towards meaningful relationships was the progress indicator with the highest rating with 70% of youth reviewed having acceptable progress in this area. This indicates that 70% of progress towards risk reduction was found acceptable for just over half of the youth reviewed (55%), up by 4% from last year. This indicator measures the progress the youth, family, and other team members have made towards identifying and reducing known risks for the youth/family.

Transitions were identified for 59 children and youth in the 2008 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 as not applicable. Progress toward smooth and successful transitions was acceptable for 41% of the 73 youth reviewed. This is a slight decrease of 6% from 2007. As will be discussed later, practice and team functions, such as planning, long-term guiding view, tracking and adjustments, and child and family issues, such as stability and permanency, impact the likelihood of youth having successful transitions.

One indicator showed a noticeable increase in acceptability. School progress increased by 15%, from 50% acceptable to 65% of youth in the review having acceptable progress in school.

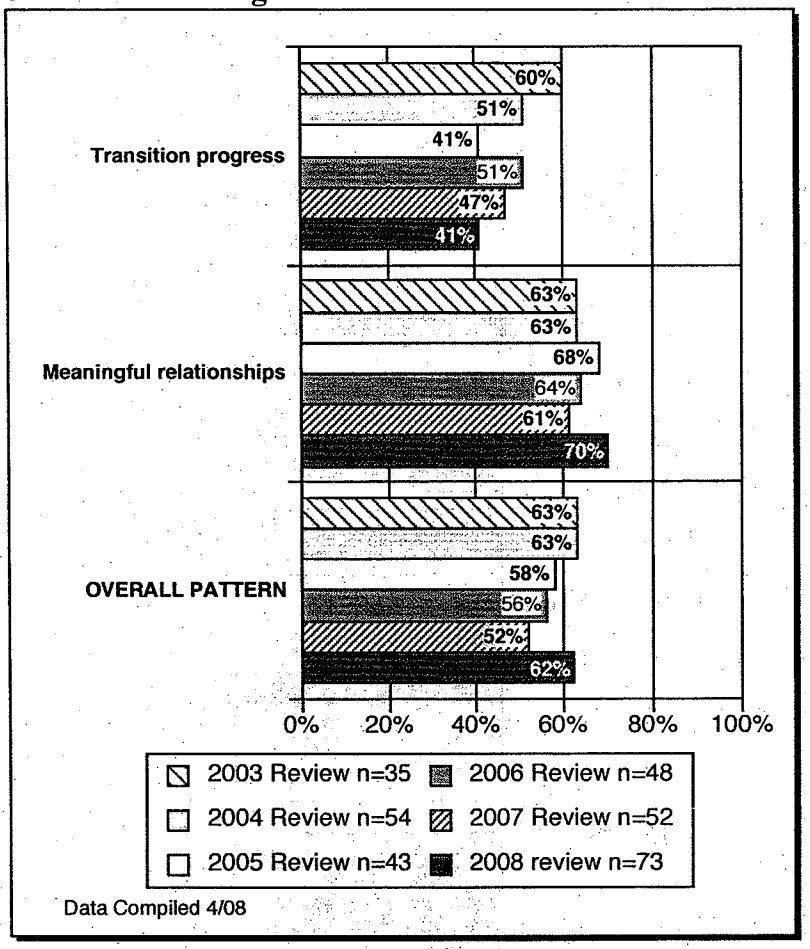
Display 20 shows the data for all six reviews on progress indicators. Overall, the results are comparable, with a slight downward trend in the overall progress patterns of youth.

Display 20
Overall Child Progress Pattern Results for All Six Reviews



Data Compiled 4/08

Display 20 (continued)
Overall Child Progress Pattern Results for All Six Reviews

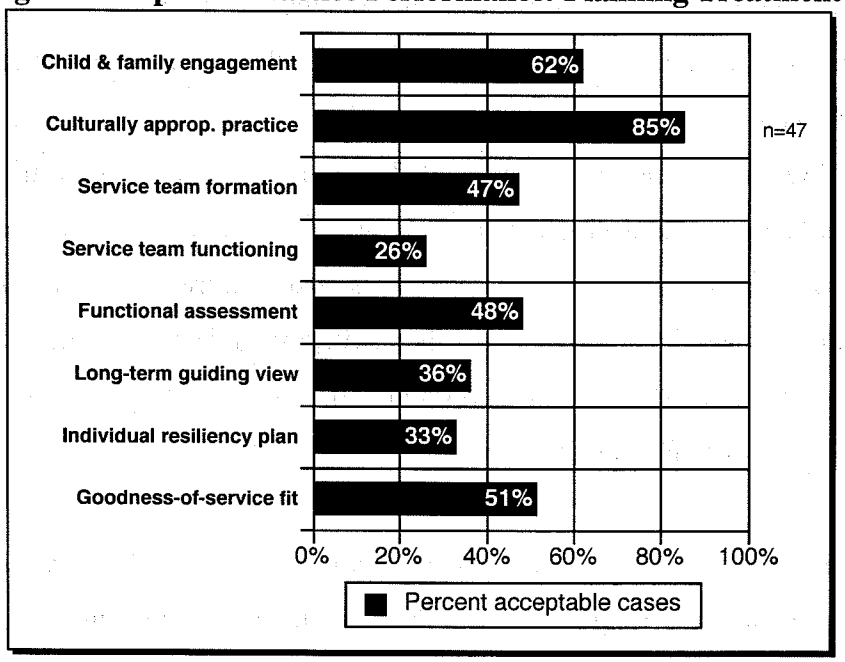


Child-Specific Performance of Practice Functions

The CSR Protocol contains 16 indicators of practice performance that are 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 are divided into two sets, which are provided in the following series of displays. The first set, focusing on planning treatment, contains 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 contains 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.

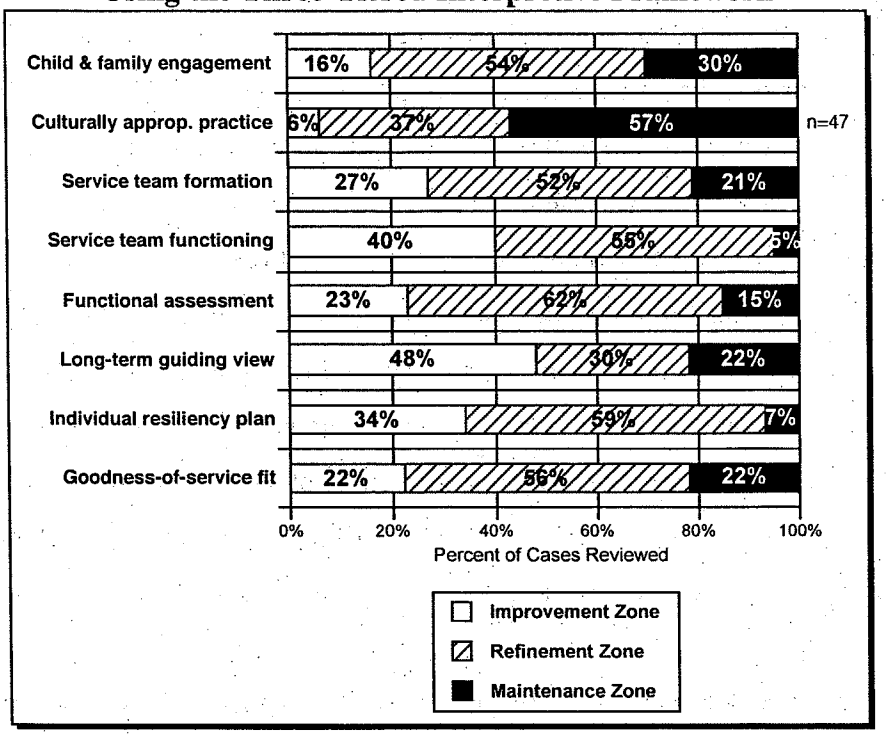
Findings for the first set of indicators are presented in **Displays 21 and 22** and summarized below.

Display 21
Percentage of Acceptable Practice Performance: Planning Treatment Ratings



Source: DC Children's Review March 2008, n=73

Display 22
Practice Performance: Planning Treatment Ratings
Using the Three-Tiered Interpretive Framework



Source: DC Children's Review March 2008, n=73

Child and Family Engagement. Engagement of a youth and family in planning and service implementation is one of the foundations of strong practice in the context of a System of Care model. Reviewers assess the efforts of team members and the effectiveness of strategies used to engage children and families in all aspects of treatment. Reviewers look to see if accommodations are made in order for parents and community partners to participate, if staff are assessable, non-judgmental, and creative in their approach, if parents and youth are actively participating in decisions regarding treatment goals and preference of providers, and if the process is youth/family centered. Engagement is a skill, rather than a talent, and team members need to be supported and mentored in developing this skill, especially in situations where a parent or child may be difficult to engage.

There was a slight decline of 7% in the acceptable ratings for child and family engagement this year. Sixteen percent needed improvement, 54% were in the refinement zone, and 30% were fully engaged and required maintenance efforts only.

Service Team Formation and Functioning. The formation and functioning of the IRP team, in coordination with all other planning processes the child is involved with, such as the IEP or family team plan, is an essential component in facilitating progress toward goals. Without all necessary personnel, such as teachers, psychiatrists, service providers, probation officers, child welfare workers, community partners, and parents, family members, and youth, working together to reach the same collectively agreed-on goals, consistent progress for the child and family is very difficult to achieve. The lack of a functional team also negatively impacts other essential practice functions, such as assessment/understanding and planning. The acceptable formation of teams, meaning that all necessary personnel were involved with the youth and family participating on the team, was found in 47% of the youth reviewed in the 2008 CSR. This is a slight increase of 3% from last year.

Strong team processes include a flow of communication and information between members in a timely manner, working together to plan and provide interventions, and using a youth/family-centered approach to practice. Teaming is a process, rather than simply an event comprised of a meeting of professionals deciding the provisions of service and inevitable fate of families. Service team functioning was found acceptable for 26% of the youth reviewed this year. This is a 9% decrease from 2007. This area is also identified as a trend, or opportunity for improvement, that is impacting practice.

Functional Assessment and Understanding. The functional assessment indicator assesses the team's level of understanding of the child and family's needs, goals, strengths, preferences, and underlying factors impacting behaviors and well-being. Assessment and understanding is not limited to the presence of assessments, evaluations, or diagnostic tools. Teams were found to have acceptable understanding for 48% of the youth reviewed, a 14% decline from the 2007 review. Because many of these children are involved with multiple agencies, it is critical that all the information known about the child and their family is shared so that the child and family/substitute caregivers and all members of the team can have a common understanding of the situation. This information must be used by the team to design and arrange the delivery of the mandated individually tailored services required for the child and family to make progress and

by the system of care practice model. After reviewing thousands of children and families across the country, a strong functioning team and good assessment of the situation is the key indicator of a satisfactory child outcome and progress and a good rating of system performance. The essence is that all the persons working with the child and family communicate with each other.

Planning. Individualized Resiliency Plans are developed for youth receiving mental health services and supports. Plans should extend beyond the function of capturing funds and reimbursement; they should be driving interventions and strategies towards tangible, achievable long-term goals. Planning processes are not limited to the achievement of goals and objectives; it includes adequately planning to prevent and intervene during crises, strategic and step-wise planning for successful transitions, plans for building sustainable natural and community supports, contingency planning, and effective behavior plans. Planning has been a challenge in the past few years with acceptable ratings on a downward trend. In 2006, 46% of the youth reviewed that year had acceptable plans, 37% in 2007, and 33% in 2008. Reviewers reported that plans lacked individuality, direction, and collaboration. IRPs were, oftentimes, completed or updated quarterly by a case manager who was not directly working with the family or team. Plans also seemed to be a formality, or an agency process, rather than an active document that was giving direction to and driving practice.

Findings across key planning and treatment indicators indicate a need for focused efforts. A team that contains all pertinent and important persons, who work in a cohesive and collective manner, and who continuously share information and work together, sets the foundation for strong practice and positive outcomes. There continue to be issues with the consistent forming of complete teams and with the understanding of what "teaming" entails. Reviewers found that most providers and core service agencies are staffing cases and meeting with the agency team members only. Respondents seem to lack full understanding of "teaming" outside of the immediate agency or institution (i.e., education, child welfare, justice, mental health) and that a child and family team is not a "team" without the presence and active participation of the family.

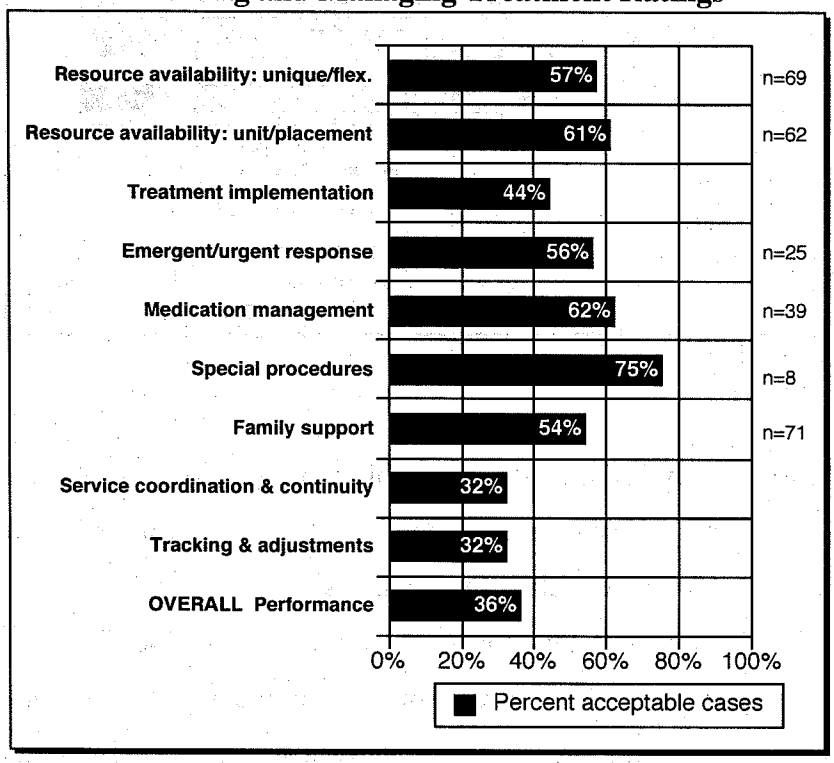
Engagement of families, team functioning, and understanding of youth and families are foundation points of other elements of practice in a System of Care model. One element of

strong planning is an IRP that starts with the inclusion of all necessary persons and is based on an in-depth, common understanding of the child and his/her family.

Practice Performance: Providing and Managing Treatment

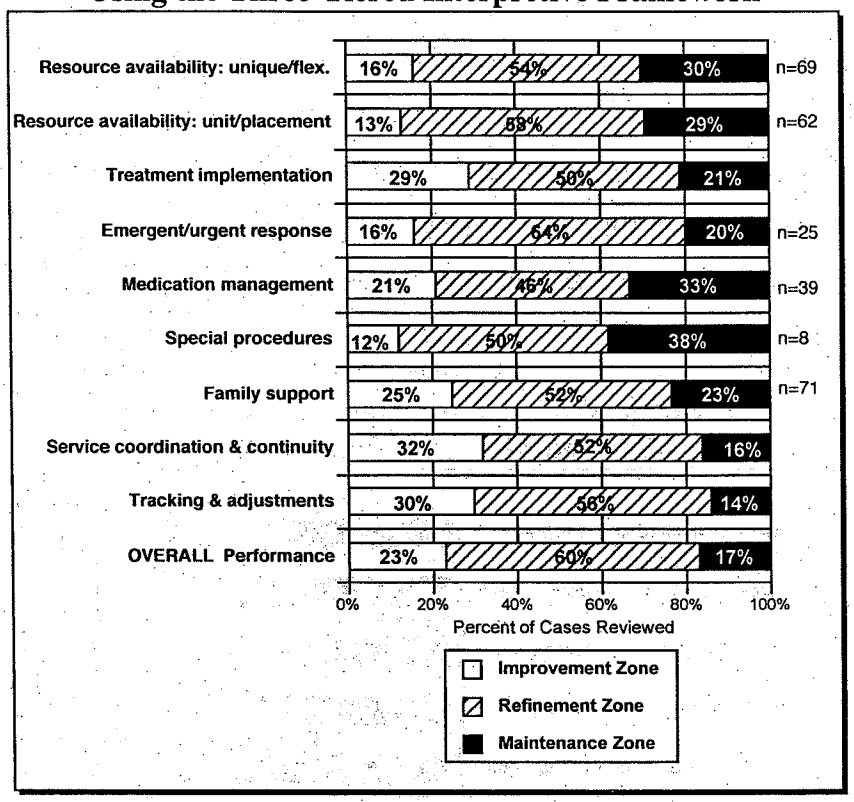
The second set of performance indicators covers important functions related to the provision and management of treatment and support services to children and families. Findings for these indicators are presented in **Displays 23 and 24** and summarized concurrently below.

Display 23
Percentage of Acceptable Practice Performance:
Providing and Managing Treatment Ratings



Source: DC Children's Review March 2008, n=73

Display 24
Practice Performance: Providing and Managing Treatment Ratings Using the Three-Tiered Interpretive Framework



Source: DC Children's Review March 2008, n=73

Resource Availability. The availability and accessibility of resources is measured for flexible and unit-based resources. This indicator is designed to assess the array of informal and formal supports and services necessary to fulfill requirements of a child's IRP. Resources need to be flexible, creative, easily accessed by providers, youth, and families, and should respond to individual needs. Resource availability, accessibly, and implementation should not be hindered by funding restrictions and team members should work together to eliminate territorial issues between agencies, providers, and protective authority.

This area is one of the stronger areas in the 2008 review and is captured in two sub-indicator ratings: resources-unique/flexible and resources-unit/placement based. Fifty-seven percent (57%) of the youth reviewed had availability of flexible resources, such as wrap services or community support. Sixty-one percent (61%) had adequate access to unit or placement-based services, such

as therapy. There is a slight increase in both sub-indicators from the 2007 data (50% flexible resources; 52% unit-based).

There were reports concerning situations regarding the accessibility of both flexible and placement or slot-based resources from the community and within agencies. Reviewers noted that families, community partners, and services providers reported challenges in accessing services. Primarily, there were concerns regarding the timely accesses to therapy and assessments and the limited availability of specialized services, such as trauma-informed assessment and care and positive behavioral supports, wraparound services, and multi-systemic therapy (MST). In some instances, respondents reported waiting 30 to 60 days or longer for therapy services to begin.

Respondents also described situations where the accessibility of resources within CSAs was challenging; for example, a community support worker (CSW) being able to communicate with the psychiatrist within the same agency, situations in which multiple family members were receiving services from different workers at the same CSA, and workers feeling they were not able or obligated to speak to other workers about a family. These situations were linked to time and billing restrictions and high turnover of staff. These and other identified trends will be discussed further in later sections.

Service Coordination and Continuity. The coordination of services is a fundamental part of practice in a System of Care model. This person is the "driver" of services and supports and is the "glue" that holds the team together. This indicator assesses the presence of a single point of coordination and communication that is accountable for the implementation and outcome of treatment interventions, supports, services, and continuity of care. Reviewers assess the presence of support services specified in the IRP that are well coordinated across providers, community partners, transitions, and levels of care for the child and family.

Acceptable service coordination was found in 32% of the youth reviewed this year, a 16% decrease from 48% acceptable in 2007. This is one of the two weakest areas in this sub-set of practice performance indicators. Reviewers noted that respondents seemed to be unclear or

unsure regarding who on the team was the coordinator or point person for the youth and family. Many cases had a CSW who provided supportive counseling, mentoring, linkage to community resources, etc. In general, the CSW was not actively coordinating services or building teams and facilitating the teaming process. Many youth had therapists who, in some cases, stepped forward to coordinate care out of necessity. Reviewers described many situations in which a case manager was present and functioned to develop and update treatment plans, oftentimes, without the involvement of other team members, including CSWs within the same CSA. Clearly, there was confusion regarding roles and responsibilities and team members appeared to be working separately from each other.

Tracking and Adjustment. The tracking, adjustment, and modification of services and supports are essential to achieving and sustaining positive gains. This process requires that a team be formed, have an adequate understanding of the youth and family, and be communicating and working with each other. This indicator is the other lowest rating in this sub-set. Thirty-two percent (32%) of the youth reviewed had teams with an acceptable process of tracking and modifying services to meet the changing needs of youth and families. This is 12% points lower than in 2007, which showed 44% with adequate tracking and adjustment.

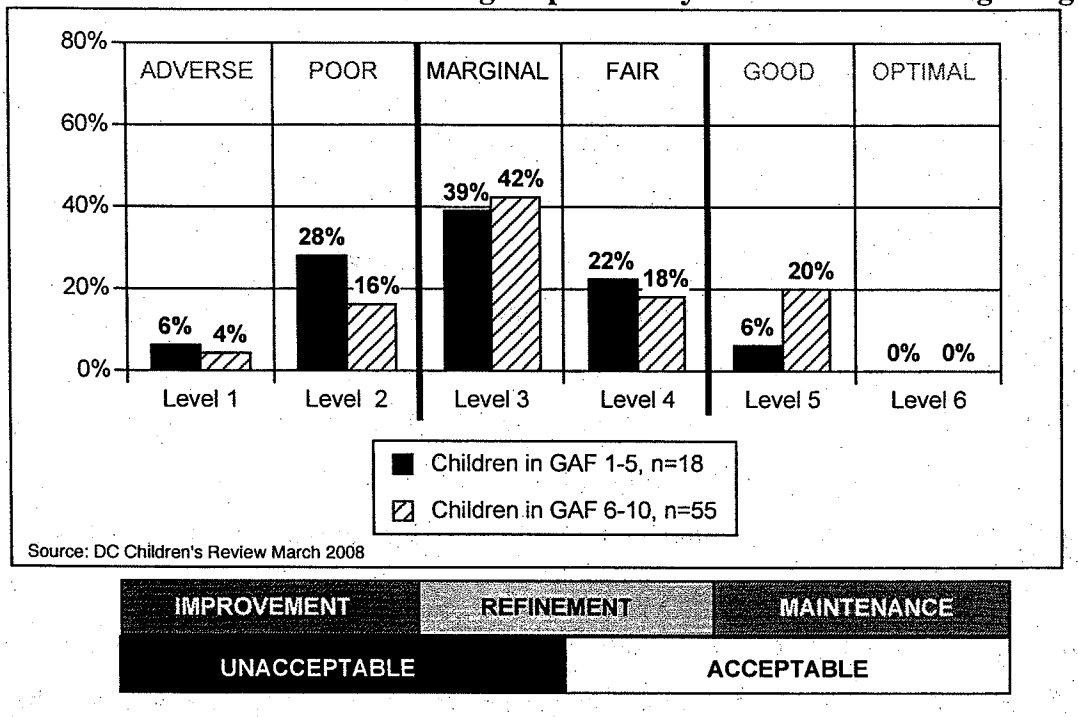
Overall Practice Performance. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall practice performance rating." Applying this rubric resulted in the determination that overall practice performance was rated as adequate (rating levels 4, 5, and 6) in 36% of the children and youth included in the review, a 12% decrease from the 2007 results (48% overall in 2007). Twenty-three percent of the youth reviewed were found to need improvements in the near-term, 60% were in the refinement zone, and 17% in the maintenance zone. This distribution, when compared with 2007, shows a 10% decrease in youth in the maintenance zone (27% in 2007), a 14% increase in the refinement zone (46% in 2007), and a slight decrease in the youth requiring immediate improvement (27% in 2007). It should be noted here that this decrease in percentage acceptable may be more reflective of the case-judging process tightening the interrater reliability of ratings than an actual decline in practice. A reasonable overall judgment is that at a minimum, there has not been progress made in implementing the system of care practice

model relative to prior years. The reasons for this lack of progress will be discussed further in later sections of this report.

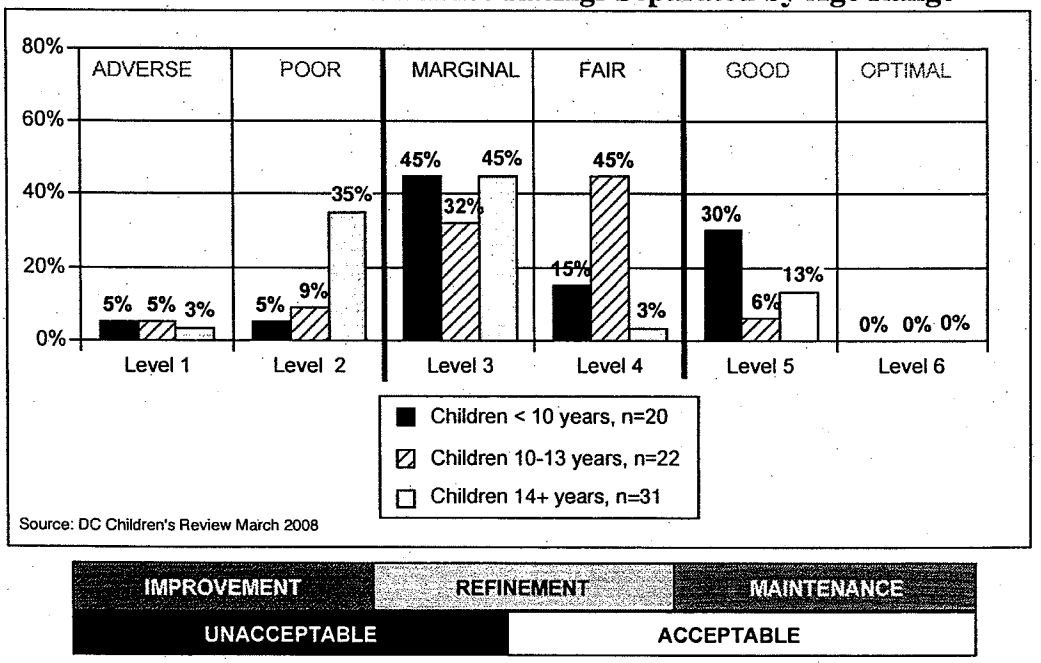
In **Appendix C** of this report are agency-by-agency results for the children and families reviewed. **This agency-by-agency comparison should be interpreted with caution, since sample sizes for some of the provider agencies are extremely small. Generalizations regarding specific agency practice should 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 and youth are illustrative of system performance for each of those randomly selected children from subsequent participating agencies and in the context of the larger mental health system. 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 sixth-year review results. **Display 25** provides the overall practice performance ratings separated by the child's general level of functioning. **Display 26** provides the overall practice performance ratings separated by age range.

Display 25
Overall Practice Performance Ratings Separated by Level of Functioning Range



Display 26
Overall Practice Performance Ratings Separated by Age Range

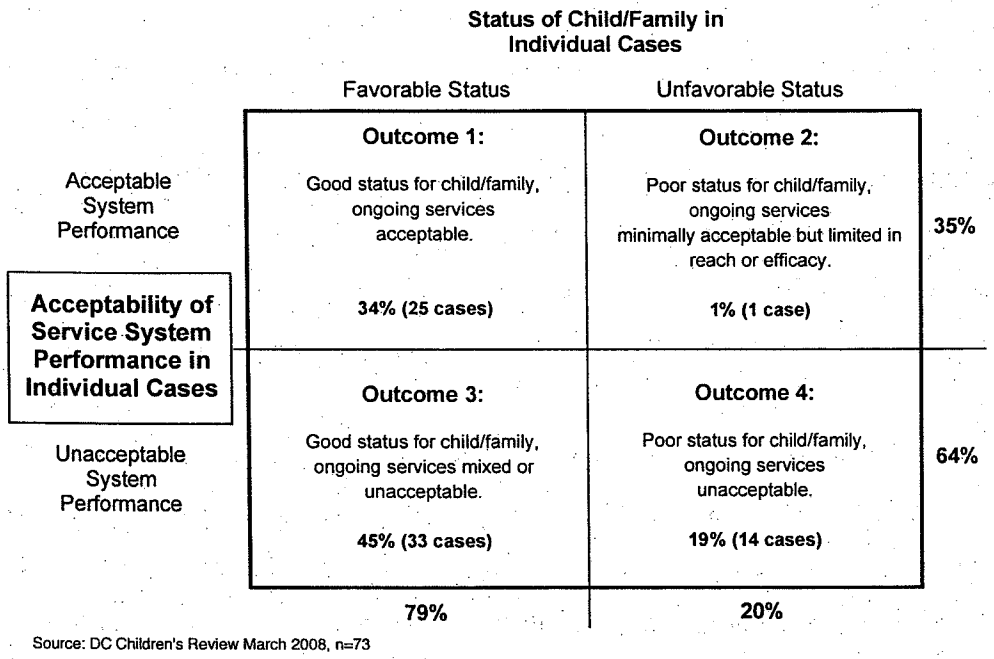


Case Review Outcome Categories

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 27** indicates, 25 of the 73 cases, or 34%, fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services. There was one youth (1%) in outcome category 2. This category represents children whose needs are so great or 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. Forty-five percent (45%), or 33 children and youth, were in outcome category 3. Outcome 3 contains those sample members whose status was favorable at least at the time of the review but who were receiving less than acceptable service system performance. Some children are resilient and may have excellent naturally occurring supports provided by family, friends, school personnel, or some other key person in their life whose efforts (frequently above and beyond the norm) are significantly contributing to the child's favorable status at the present time. However, current service system performance is limited, inconsistent, or inadequate at this time. For these children, if the team would form and function properly, the child could likely progress into the outcome 1 category. This year, 19 youth, or 14% of the review sample, fell into outcome category 4, the same percentage of youth as in the 2007 review. Outcome 4 is the most unfavorable combination as the child's status is unfavorable and system performance is inadequate.

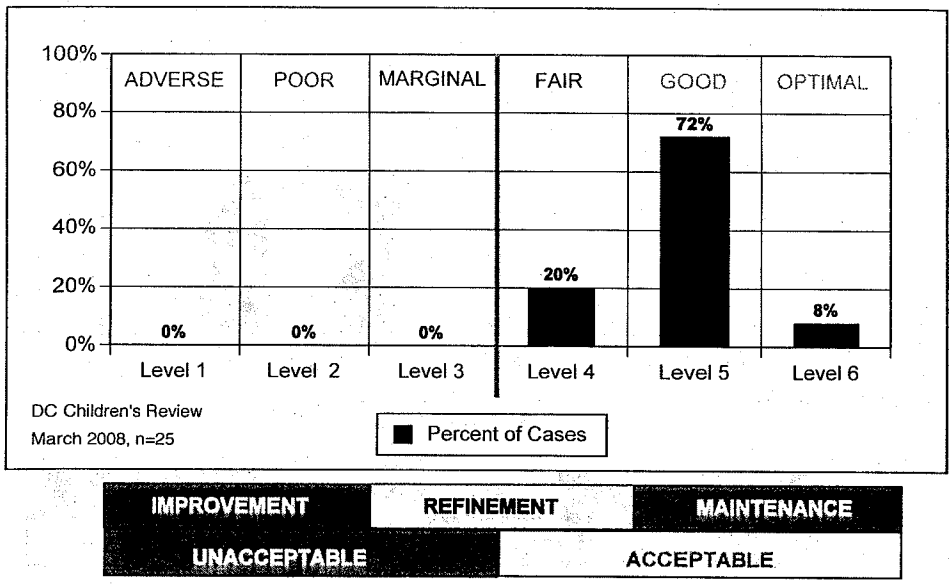
Display 27
Case Review Outcome Categories



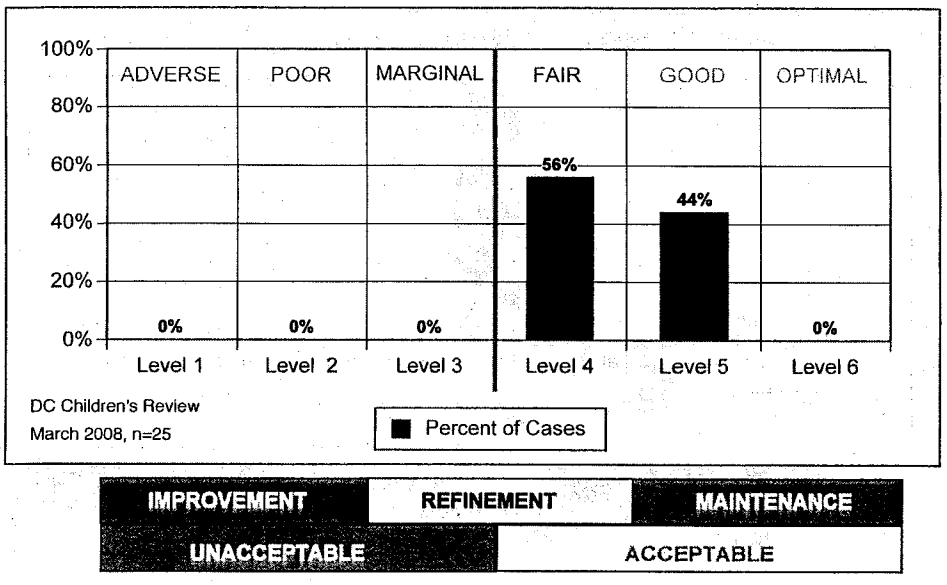
Source: DC Children's Review March 2008, n=73

Displays 28 to 31 show the distribution of scoring on the six-point scale for the children who fall in each of the outcomes shown in Display 27. For example, for outcome 1, the charts in Displays 28a, 28b, and 28c show the distribution of child status ratings, the distribution of progress indicators, and the distribution of system performance ratings. Display 28a shows that 80% of the children's overall status indicators were rated at 5 or 6. Display 28b shows that 44% of the children in outcome 1 were rated as making progress at 5 or very good progress, and all were rated as making acceptable progress. Display 28c shows the rating distribution of the system performance indicators for these 25 cases. Forty-eight percent were rated as good performance and 52% were rated as adequate performance. Review of the remaining charts for the other outcome categories shows the high degree of consistency and trend that correlates very closely across all three domains that are rated. This analysis disaggregates the total overall child status into the respective outcomes and shows that the trends and ratings are consistent with the overall system performance ratings. It also shows that children in outcome 3 could be moved into outcome 1 if the system performed with a little more consistent diligence. For outcome 3, 80% of the unacceptable ratings were at the 3 rating. This shows that with more coordination, communication, and teamwork, these children would very likely move into the 4 or better system performance rating, placing them in outcome 1.

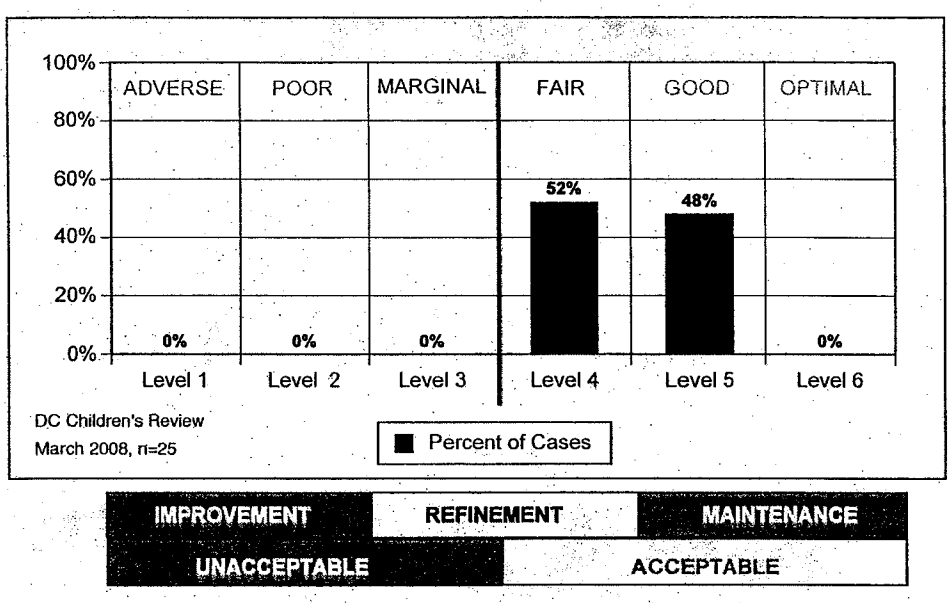
Display 28a
Outcome 1
Overall Child/Youth Status



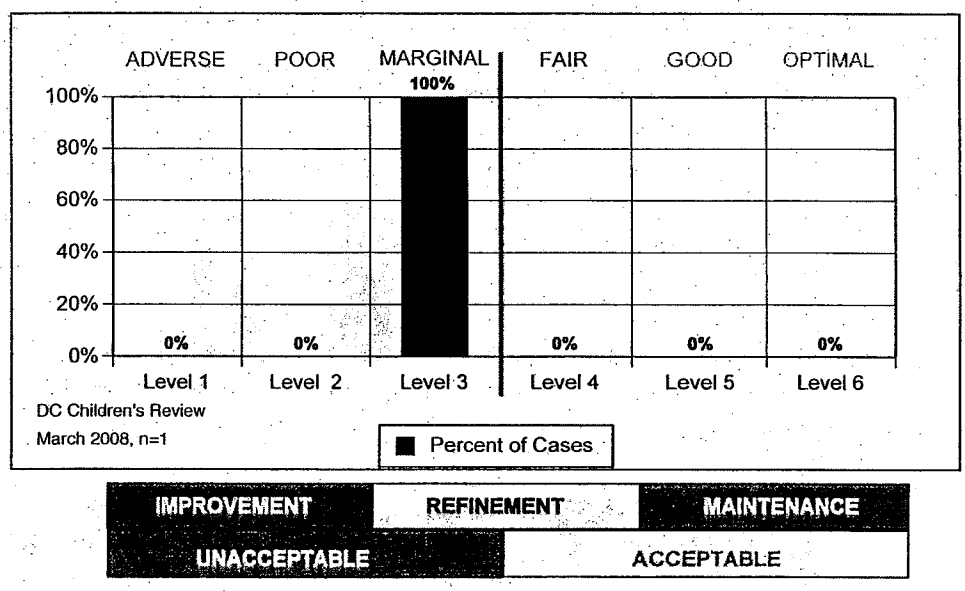
Display 28b
Outcome 1
Overall Recent Progress



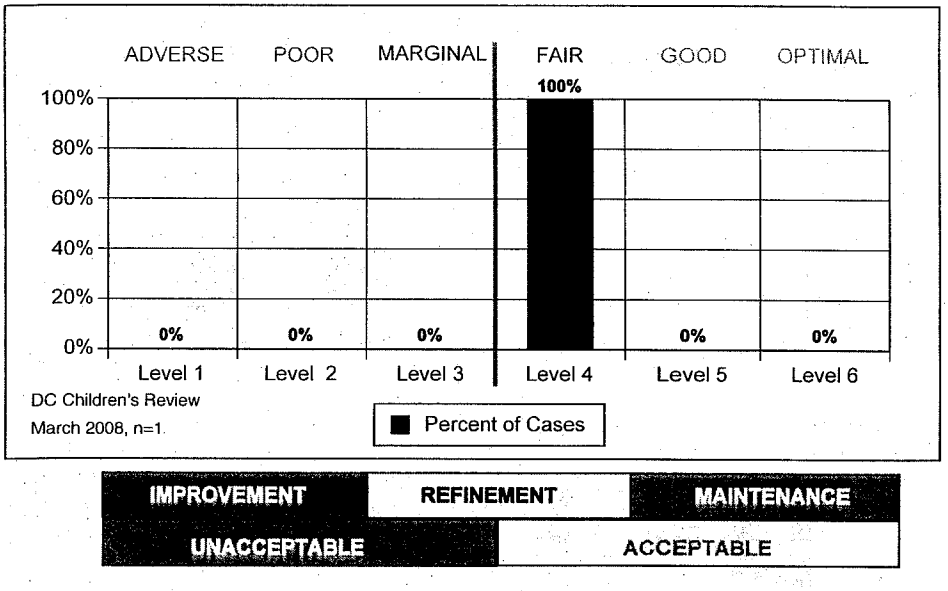
Display 28c
Outcome 1
Overall Practice Performance



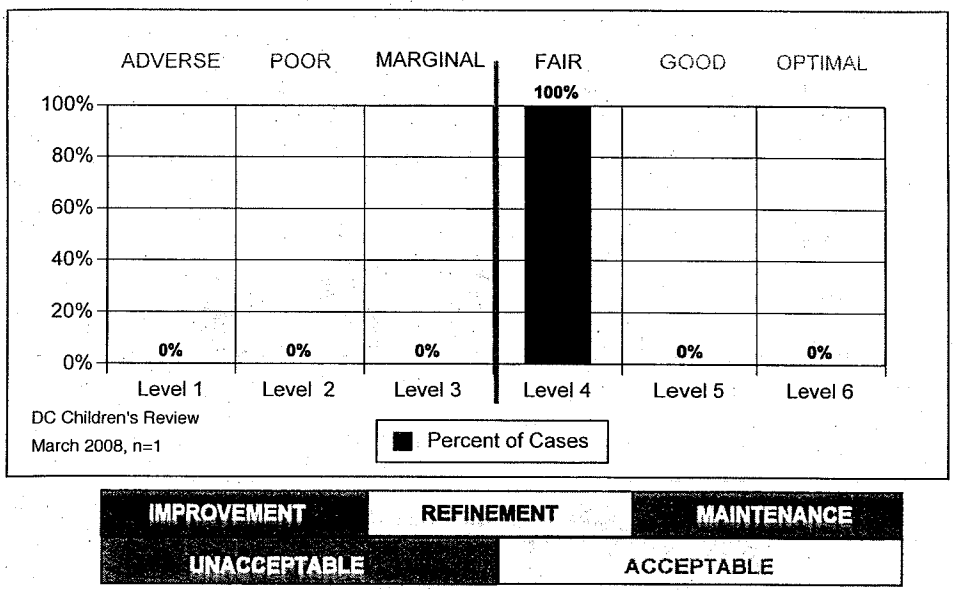
Display 29a
Outcome 2
Overall Child/Youth Status



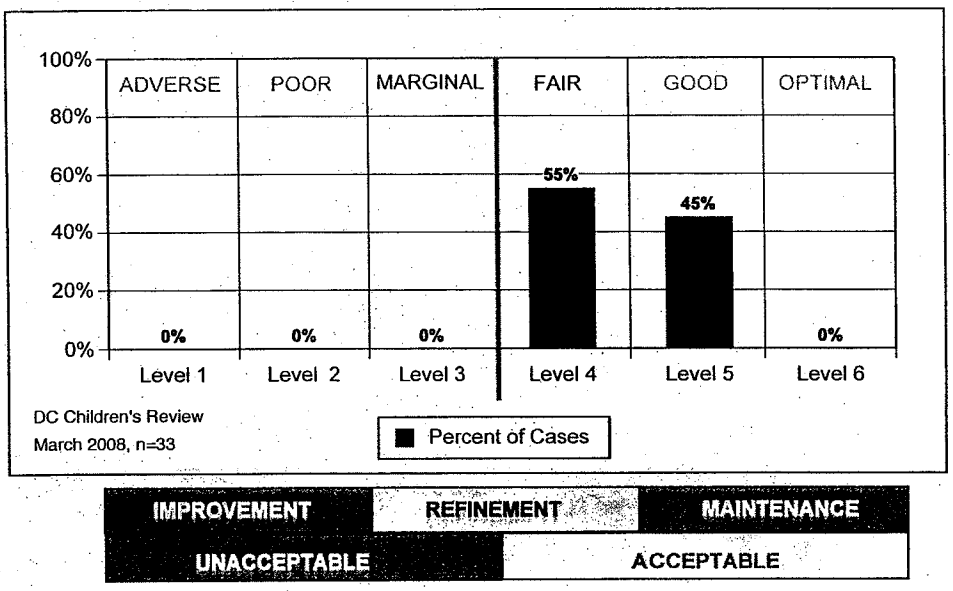
Display 29b
Outcome 2
Overall Recent Progress



Display 29c
Outcome 2
Overall Practice Performance



Display 30a
Outcome 3
Overall Child/Youth Status



Display 30b
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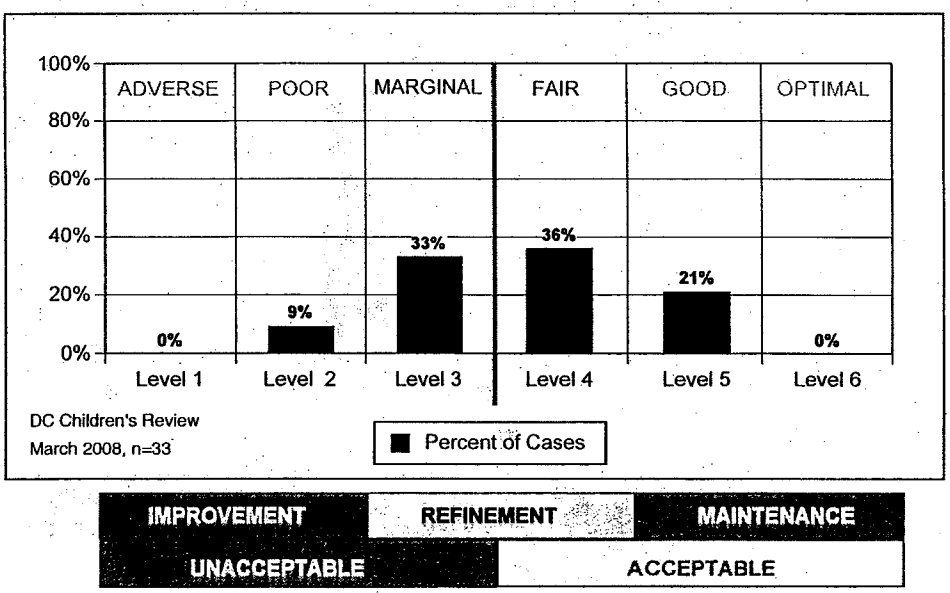
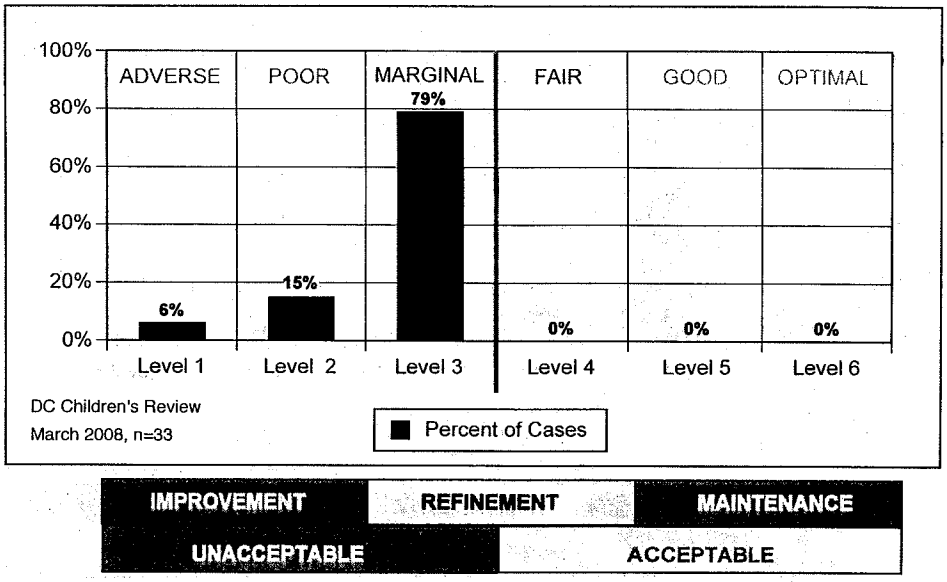
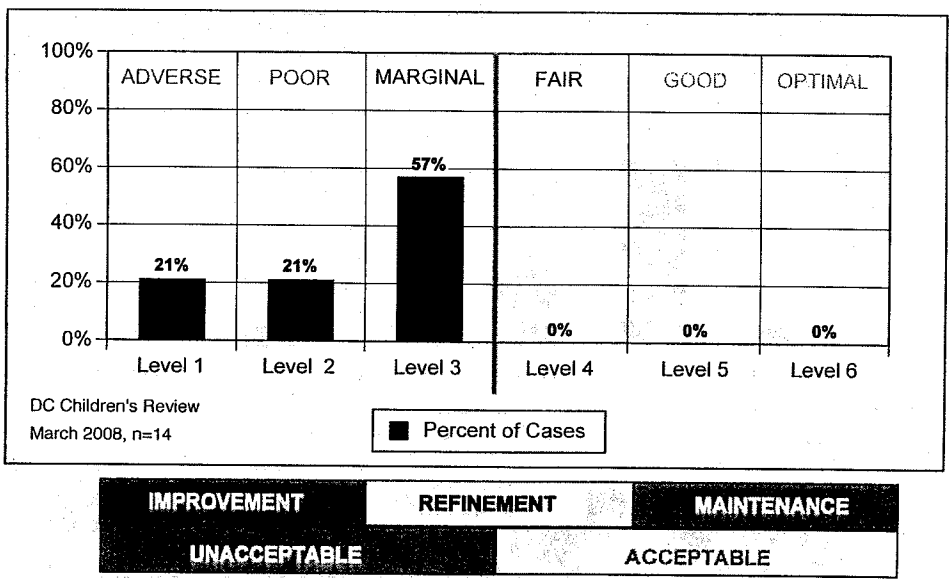
Overall Recent Progress



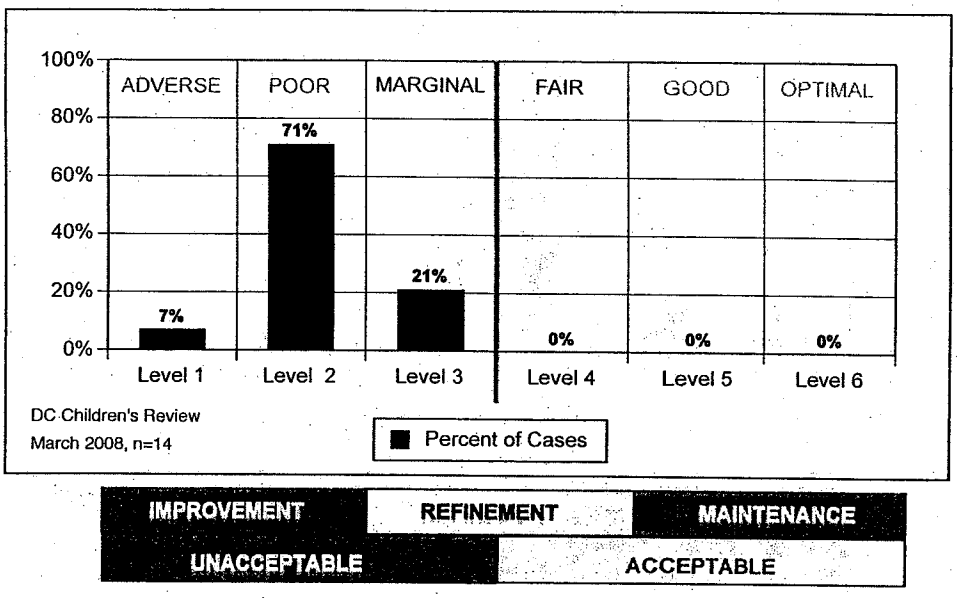
Display 30c
Outcome 3
Overall Practice Performance



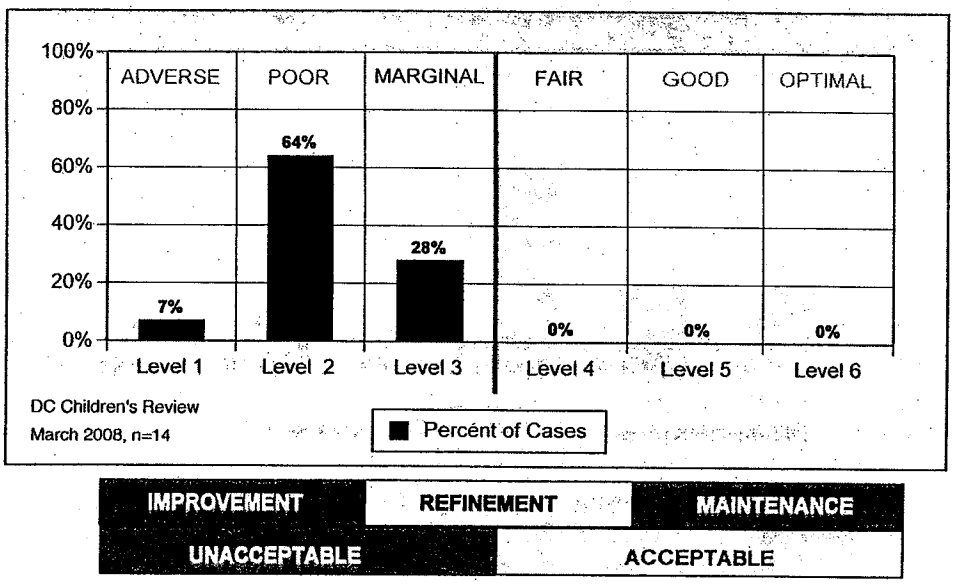
Display 31a
Outcome 4
Overall Child/Youth Status



Display 31b
Outcome 4
Overall Recent Progress



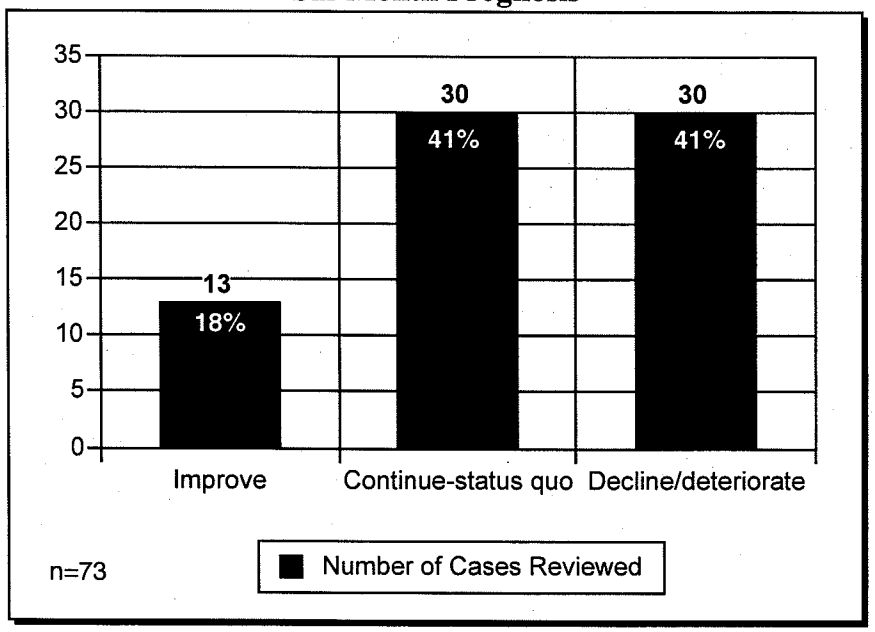
Display 31c
Outcome 4
Overall Practice Performance



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 and youth in the review. As the display indicates, 13 youth (18%) were expected to improve, 30 (41%) were expected to remain about the same, and 30 (41%) were expected to decline or experience deterioration of circumstances over the next six months. The prognosis of status-quo and decline were similar to youth in the 2007 review—38% and 35% respectively. There is a 9% decrease in the youth expected to improve over the next six months (27% in 2007).

Display 28
Six-Month Prognosis



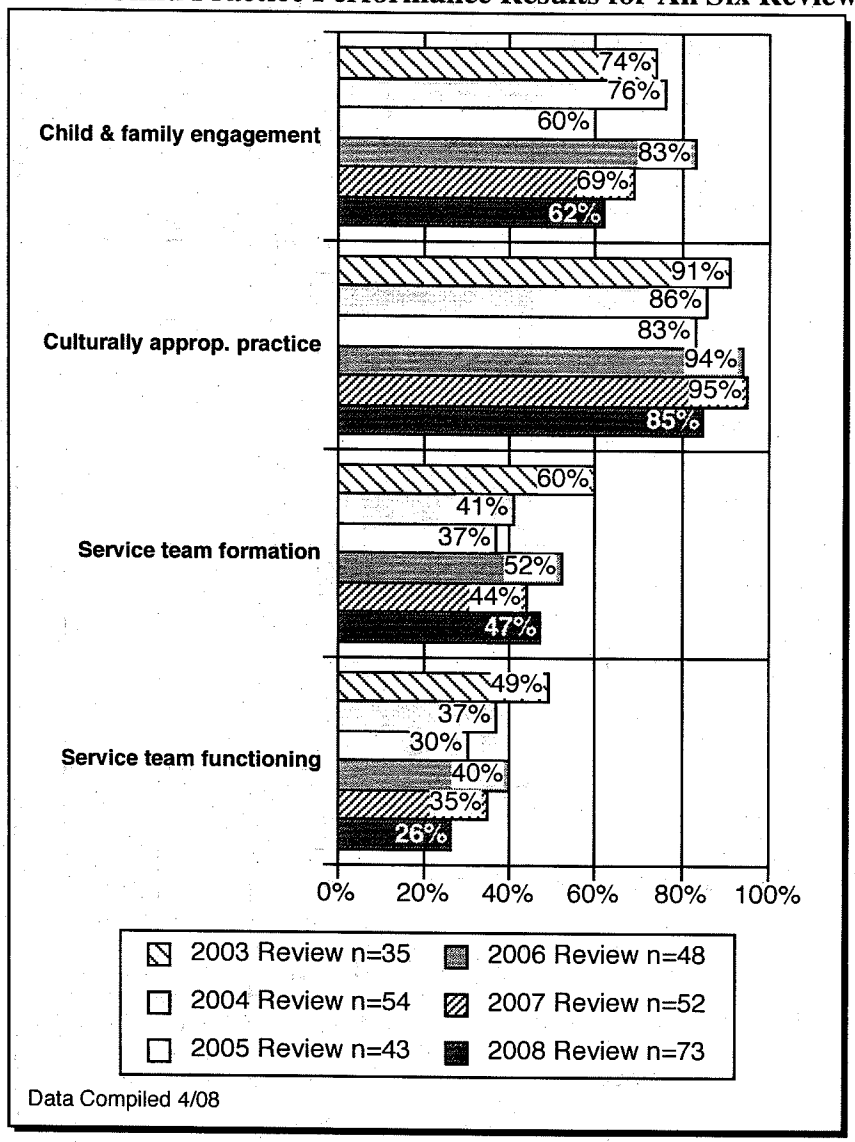
Source: DC Children's Review March 2008

Overall, the results of the 2008 CSR data show that at a minimum, the consistency and quality of practice has not improved significantly over the past year. The percentage of children who are provided services with the quality, coordination, consistency, and diligence necessary to achieve progress and improvements in children has not increased. The expectations to provide services in

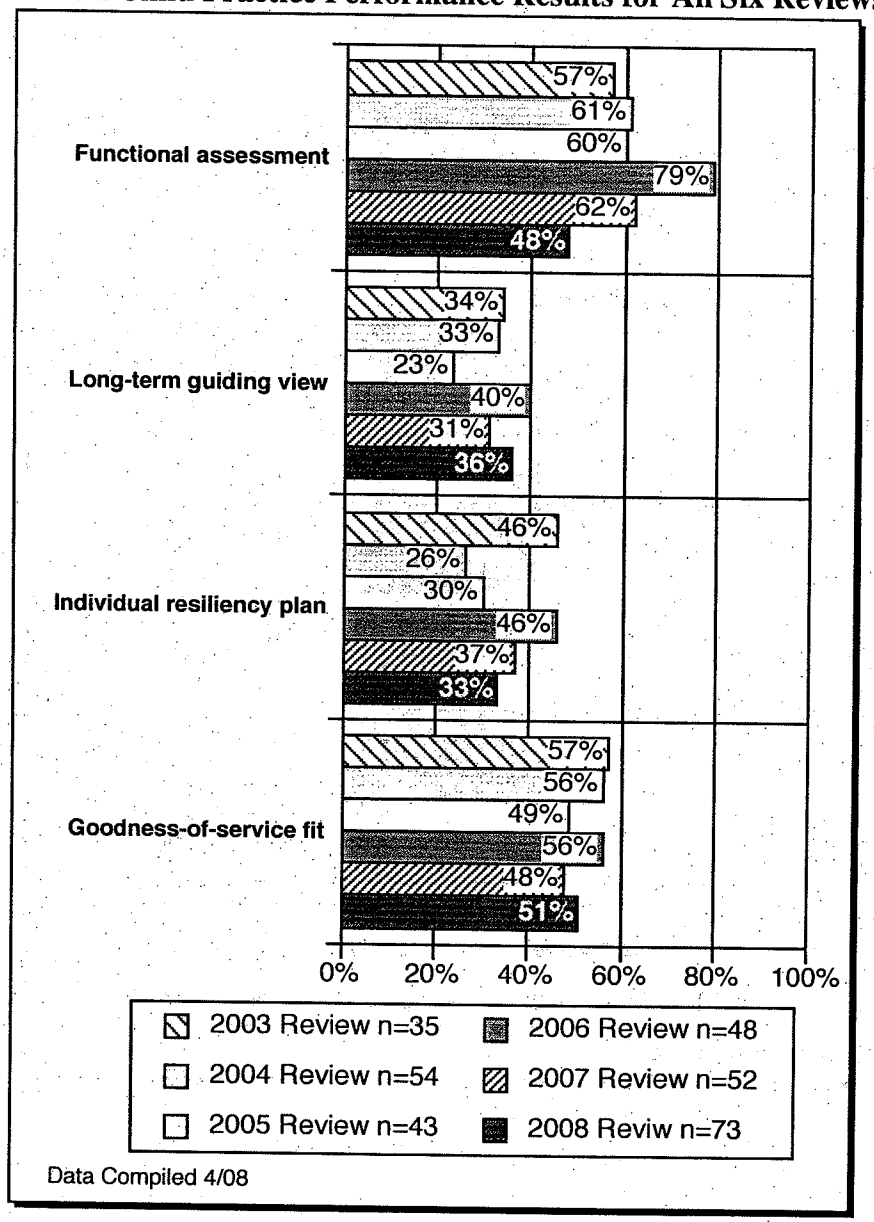
accordance with the principles of care agreed to in the Dixon consent decree and exit criteria are not being consistently met for approximately one-half to two-thirds of children and youth in the District of Columbia.

Display 29 shows the results for practice performance for the six years in which CSRs have been conducted. The data trends are clearly not showing that significant improvement is occurring in the consistent implementation of quality services. Challenges continue to be found in service team functioning, understanding of underlying issues (assessment), individual plan development, coordination of services, accessibility of services, and tracking and adjustment of treatment effectiveness. The overall quality and consistency of actual practice with children and families across the system has shown very little improvement in the past six years, at least as reflected in these measurements.

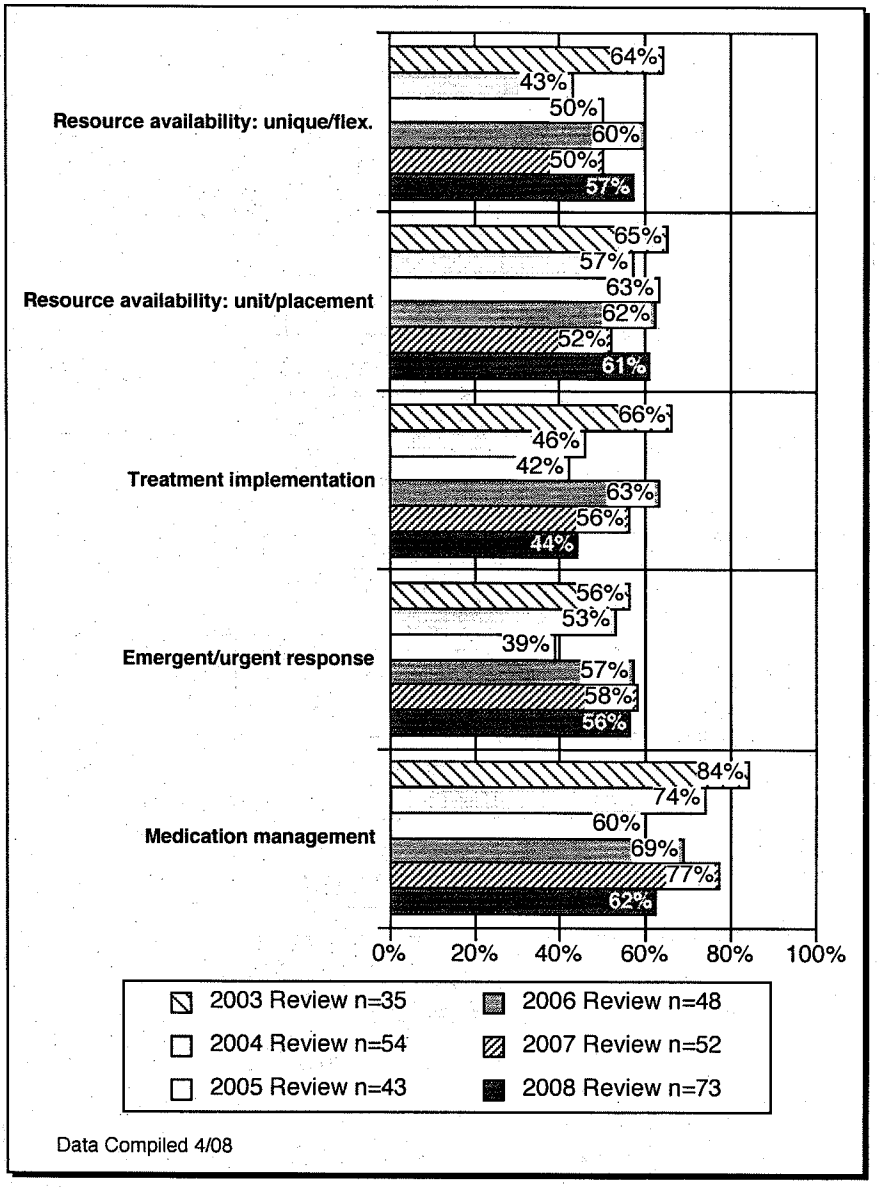
Display 29
Overall Child Practice Performance Results for All Six Reviews



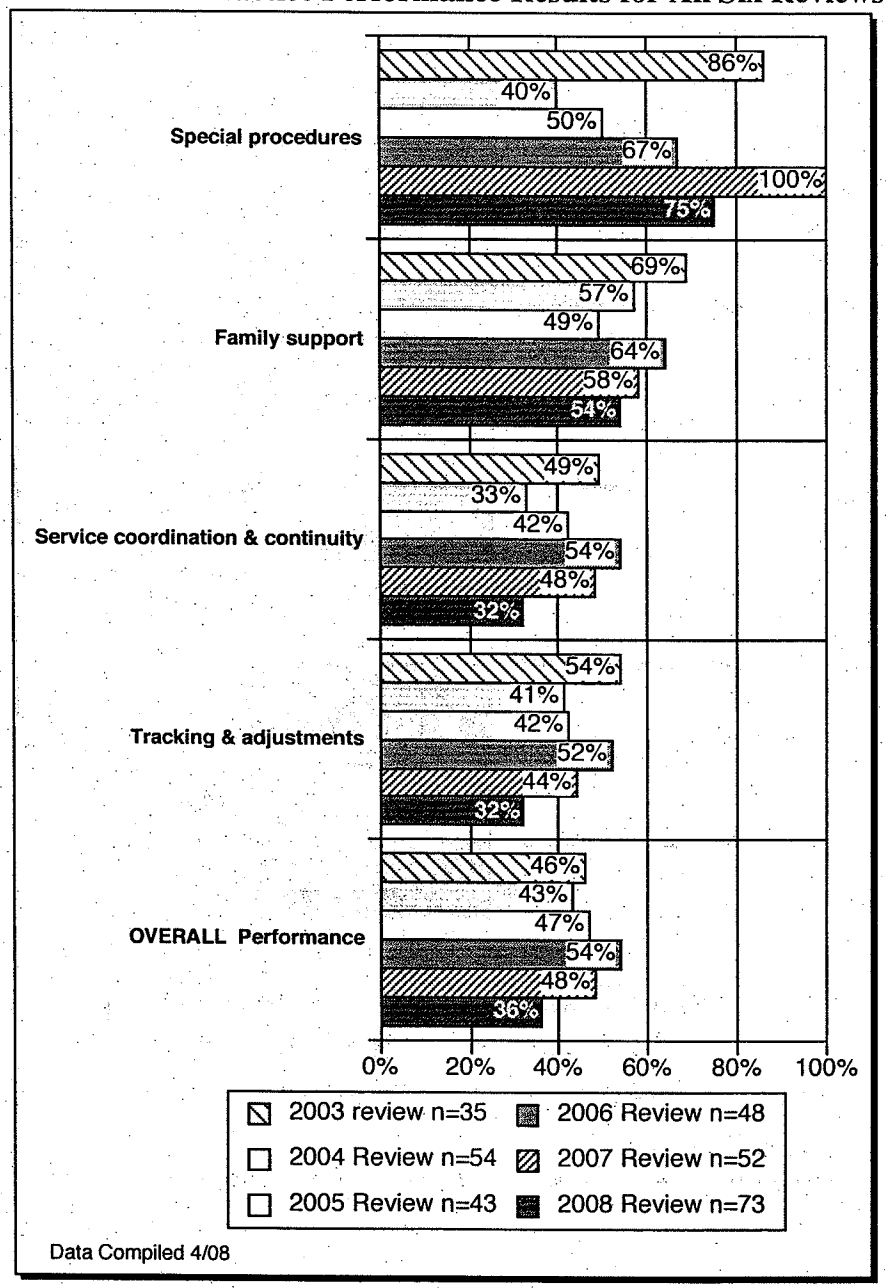
Display 29 (continued)
Overall Child Practice Performance Results for All Six Reviews



Display 29 (continued)
Overall Child Practice Performance Results for All Six Reviews



Display 29 (continued)
Overall Child Practice Performance Results for All Six Reviews



These findings are further reflected in the thematic issues identified in the case write-ups and debriefing of the service strengths, barriers, and patterns found for the 73 children and families who were reviewed. Further support for these themes was also found in the input received from the stakeholder focus groups. Input from the debriefing and stakeholder interviews, as well as themes, trends, and challenges and opportunities of change, is summarized below.

Qualitative Summary of Child Review Findings: Themes and Patterns Noted in the Individual 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. The following is a list and general discussion of systemic themes and patterns gathered from the 2008 review of services for children and youth. Again this year, the lowest ratings were in the adequacy of team formation and functioning, individual resiliency planning, service coordination, and tracking and adjustment—core areas of practice that have been identified as needing focused attention during the past several reviews. There were examples of high quality practice; however, this seems to be the exception, rather than the norm. The overall practice pattern shows that System of Care core practice functions are not being delivered with quality and consistency for two-thirds of the children and youth served. The themes and patterns identified by the reviewers illustrate these opportunities for improvement.

The following issues were identified through a trend analysis of the case write-ups and issues raised during debriefings.

- Poorly formulated plans that lack individualization. Transition planning and awareness is occurring infrequently. This may be due to staff turnover and poor case transfer processes.

- Inadequate treatment team formation and functioning. Teams that are formed are not necessarily working together or communicating with each other.

- Lack of long-term planning and perspective with youth and families. This is exacerbated by high turnover in staff and lack of team coordination and communication.

- Closing cases for lack of attendance to appointments. There is strong tension in the system regarding parental participation and follow through. There is a tendency in the system to blame the families for lack of follow through. An alternative explanation is that access to system services is not accessible at times and places that facilitate family participation, nor are services responsive in time. Delays of a month or more before services can be accessed

are common. Parents and relative caregivers have many issues to contend with, including multiple family members with high needs, emotional and substance abuse issues in the adults in the family, transportation, child care, and conflict with work issues. In addition, fear and stigma associated with mental health service. Family engagement to resolve these issues takes time and diligence on the part of care coordinators and therapists to develop an honest assessment of the situation and develop a trust relationship and meaningful and responsive solutions. Developing a trust relationship with the caregiver is one of the most critical factors in achieving progress.

- Limited, shallow, and inadequate understanding of youth and families: what needs to be addressed, what are the underlying issues, what works, or even that a comprehensive approach is appropriate.

- Lack of updated psychological evaluations and assessments.

- Poor communication between team members and within CSAs.

- Lack of fully developed plans.

- Lack of a joint vision on the functional goals for the child and how they are going to be achieved.

- Quality and type of treatment and knowledge to address treatment. No differentiated treatment.

- Lack of a deep and accurate understanding regarding what is driving behaviors of youth and parents.

- Some examples of concerns with the number of psychotropic medications (although the aggregate data do not reflect this as a problem.

- Lack of use of evidence-based treatments, including the need for more capacity for wraparound and MST level of services.

- Disconnect with school personnel and CFSA caseworkers.

- Frontline stress, heavy turnover, difficult working conditions, unfulfilling focus on billable hours.

- Kids placed outside of the District for living arrangements, including foster care and school.

- Aversive interventions, restraints in the school setting.

- Lack of inclusion of youth in the treatment planning process.

- Affordable, appropriate housing and other living arrangements within the District is a challenge.

- Confusion regarding role definition: who is responsible for the plan, coordination, and services to the family. Staff working in silos within agencies and when other agencies are involved.

In addition to the child and family reviews, including interviews with 413 persons, stakeholder interviews and focus groups were conducted with 203 persons who are involved with children services in the District. **Appendix D** includes the stakeholders that were scheduled for interviews. The following themes emerged from the stakeholder interviews. Overall, 16 focus groups were conducted over a two-week period of time and included Core Service Agency staff and management, DYRS, CFSA, D.C. Public Schools, and two judges.

The strengths of the system were identified as Mr. Baron's leadership and dedicated commitment to solving problems. Most respondents perceived that progress was being made in some areas but that there were key issues that needed to be resolved for progress to reach to the practice level.

The stakeholders were excited about the new programs that were in progress, including the wraparound Case Management Entity, crises mobile response and beds, CFSA choice provider, and school mental health expansion. In addition, all stakeholders reported much better coordination and communication across child-serving agencies at the upper level of management. This is evidenced by more joint efforts at both the service delivery and evaluation of services level.

The stakeholders also identified areas that they thought the system was in critical need of addressing.

A major issue is the fragmentation created by the MCO (Managed Care Organization) DMH bifurcation of funding and service delivery requirements. Providers report difficulties in working within the confusion of different allowable services; they must spend time sorting who can get what services. Some reported efforts to control access by the MCO between case managers and the psychiatrist, even within a CSA. Providers reported that they actually are losing money on the medication management cost center and it takes all of the reimbursable rate just to pay for the psychiatrist's time. All parties interviewed recommended that the financial side of the system be integrated and simplified. The Family Court reported serious concerns with the bifurcated system and reported difficulty in getting information and coordination for kids in the MCO services. The Family Court reported there were great inefficiencies and redundancy in effort because of the lack of coordination, sharing of information, and duplication of assessments.

The DMH children services' management reported progress with the development of new services and training but also identified the MCO bifurcation as a major barrier to quality services. They also recognized the critical need for a new director of children services and were actively recruiting for a replacement. It was noted that they had diverted 87 children from residential treatment center (RTC) placement in the past year.

Service gaps were identified for children with sexual behavior and victim issues and dual diagnoses of mental health and developmental disabilities, specifically children with pervasive developmental disorder and autism. They also report delays in access to therapists on average of

a month or more and the need for more wraparound services and MST. They also reported that more training was needed for staff that participate in and deliver community-based intervention (CBI) services in homes.

Frontline staff continue to report that they are required to focus more on billable hours than on doing what is necessary to make progress with a child and family. Caseloads are high and turnover is high, making continuity and skill development a very difficult issue for everyone. There continue to be many communication difficulties in coordinating with other frontline service providers, such as working with some schools and coordinating with probation officers and child welfare caseworkers.

CSFA middle management and frontline staff reported continued difficulties in timely access and actual delivery of services. For example, a child that was already in the system took over six weeks to get MST from Youth Villages. We walked through the steps to get approval or access, and noted the number of steps and at how many different points delays could occur. This is true even with DMH staff working at the CFSA offices. The challenge of finding an appropriate placement and level of services for children who have a history of multiple foster home placements was identified as one of the most difficult issues from the CFSA perspective. Judges are ordering children to stay in acute psychiatric placements until appropriate less restrictive placements and services are found. It was also noted that as a result of the recent cases that had not been well handled by CFSA and other child-serving agencies, many more kids were coming into foster care and were being placed in Maryland foster homes because of the lack of foster care placements within the District. These staff also reported that the quality and consistency of intensive in-home services needed to be improved. They also noted that one of the major difficulties with team meetings, SOC and otherwise, is that they are scheduled without working with participants to find a time that is workable. Unless it is a highly visible case, attendance is not what it should be. Thematically, CFSA reports that they frequently cannot get the right services for their kids when they need the services and with the quality that is necessary to be effective. As was true last year, there were specific concerns about the difficulties parents who are involved in ongoing protective services have in getting through the access hotline and into services.

Many frontline care coordinators reported that they did not feel they were adequately prepared for the job and that they did not feel supported in doing the job. They report that when they can actually pull together a team and everybody works together and communicates regularly with the child and caregiver, it really works and is very satisfying. However, there are too many barriers and factors that keep good teaming from happening on a regular basis. Many specific issues were identified regarding communication, paperwork requirements, composition of caseloads, and the travel required to plan and provide services for kids in Maryland or RTCs in far-off states. Much problem solving at a practical level is needed to refine the system so that it can be workable and satisfying on a regular basis.

As can be seen, there were many issues raised across stakeholder groups. There was actually a large amount of agreement across all of the focus groups about the challenges to the system, the areas where progress had been made and the need to make some major changes if high quality consistent practice is to be achieved for most of the children and families served. The following conclusions and recommendations are made based on a synthesis of all the input we received from the 73 child and family in-depth reviews, the CSR interviews, and the stakeholder interviews.

Conclusions and Recommendations

The strengths in the current system is the DMH leadership team, the continued commitment of the leadership in the provider agencies, and the commitment of many dedicated and caring care coordinators, therapists, teachers, and caseworkers across the child-serving agencies. The leadership of the child-serving agencies are working together and creating more integrated approaches to services delivery and evaluation of the quality of services. There is expansion and refinement of important and effective services and more expansion is planned. This is the sixth year of CSR reviews and there have been many positive changes across the child-serving agencies during this time. The development of the system is at a critical point and bold initiatives need to be taken to drive the changes forward to improve the consistency and quality of services for children and families who must be served by the children's system of care. The D.C. code

and the lawsuit exit requirements are clear about the quality of practice that must be provided to each child and family who need to access and receive services from the system. The goal is to keep children in school learning and living in the community with their family.

The challenges are that the processes to access and deliver services must be simplified, integrated, and refined. It is widely acknowledged that when the practice model is implemented appropriately, it is effective with the children, outcomes are better, and the work is satisfying and rewarding.

Specific refinements include removing the bifurcation created by the MCO process, shifting the balance of focus from the business practices to the priority of effective practices for clients, and creating a situation where frontline staff can find job satisfaction in providing effective high quality services for their clients. It must be communicated across the child-serving agencies that effective teaming and communication are the priority and that staff are expected to do what it takes to facilitate the success of their clients. There must be accountability that endorses and reinforces this priority across child-serving agencies and is consistently communicated by upper and middle management.

The interviews this year indicated that upper management and leadership across child-serving agencies are communicating to expand and integrate efforts. They are optimistic about the progress that is being made to create a system that can serve children more effectively. Increasing the support and collaboration with schools and expansion of school-based services are critical next steps. These efforts need to be continued and the MCO issue should be addressed immediately.

On the other hand, the frontline workforce is signaling through high turnover and their input that they are losing hope that they will be supported and allowed to provide the kind and quality of services they want to and believe they can provide. Therefore, it is recommended that staff from all levels of the system and all agencies be involved in a problem-solving process that builds off of what happens when we are successful in providing effective services to clients. What are the conditions of successful teaming, communication, and outcome achievement for children and

families? What are the five or six key issues/processes that can be changed to increase the likelihood that this will happen to more children on a consistent basis? The process itself will begin the process of sending the priority message and will engage a broad base of people in finding a solution. Taking steps to implement any of the key issues that are identified through the process will have a positive effect on the system in multiple dimensions.

Specifically, the following areas of recommendation should be considered carefully and appropriate action taken.

- Leadership at DMH and the CSAs must emphasize that practice in accordance with the agreed-on practice model is the most important task that must be accomplished and that all policy and funding decisions must be made to promote and support consistent practice by the frontline staff.

- Financial system changes need to be made to simplify the funding system, particularly for frontline staff. Incentives and penalties for achieving or failing to achieve consistent practice in accordance with the individualized needs and required practice functions must be implemented.

- Consideration should be given to increasing the use of CSR reviews by both DMH and providers as a practice development and feedback tool on a small sample of children on a regular and ongoing basis. All supervisors should be developed and trained so they can critique practice within the CSR framework.

- The amount and time available to access training for therapists and care coordinators must be addressed to ensure they can adequately acquire the necessary understanding and skills necessary to practice in accordance with the practice model.

- There should be practice coaches created within each CSA and they should be chosen because of their knowledge and commitment to being internal champions for improved practice.

- More latitude for action and discretion in accessing and delivering necessary services must be given to the frontline staff. The knowledge and skills regarding how to deliver effective and appropriate CBI services must be increased. Cost controls and pre-approvals should be focused on high cost services!

- A highly inclusive process should be used to work with supervisors, therapists, and care coordinators to identify the five most meaningful changes that would allow them to practice with greater consistency and quality!

- Implement the results of the identification of barriers process NOW!

- Examine successful outcomes for children and families and what worked and how to create more consistent practice in accordance with these findings.

- Focus on using strengths more often to achieve outcomes.

- Focus practice development activities on providers with the most kids.

We would like to thank the DMH staff for their full cooperation and support in conducting and completing this review and the spirit in which the review has been conducted. We would also like to thank the Court Monitor and Consumer Action Network for their support and commitment organizing and completing the reviews.

Appendix A

Community Services Review For a Child and Family

Questions to be Answered

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

Produced for Use by the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

March 2004

Questions Concerning the Status of the Child and Family

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

Community Living

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

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

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

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

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

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

Health & Well-being

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

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

Development of Life Skills

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

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

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

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

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

Questions Concerning Progress

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

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

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

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

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

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

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

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

Questions Concerning Performance of Key Service Delivery Systems

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

Planning Treatment & Support

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

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

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

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

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

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

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

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

Providing Treatment & Support

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

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

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

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

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

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

Managing Treatment & Support

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

Improvement Zone: 1-2

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

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

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

Unacceptable Range: 1-3

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. 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 and youth are illustrative of system performance for each of those randomly selected children from subsequent participating agencies.

*Note: Blanks on the following pages denote items that are not applicable.

CSR/Child Status and Performance Profile

Affordable Behavioral Consultants n= 1 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	1	100%	0%	0%	100%
Stability	1	100%	0%	0%	100%
Home & school placement	1	100%	0%	0%	100%
Caregiver support of child	1	100%	0%	0%	100%
Satisfaction	1	100%	0%	0%	100%
Health/Phy well-being	1	100%	0%	0%	100%
Functional status	1	100%	0%	100%	0%
Academic status	1	100%	0%	100%	0%
Responsible social behavior	1	100%	0%	100%	0%
Lawful behavior	1	100%	0%	0%	100%
Overall C & F Status	1	100%	0%	0%	100%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	1	100%	0%	100%	0%
Behavior improvement	1	100%	0%	100%	0%
School/work progress	1	100%	0%	100%	0%
Risk reduction					
Transition progress	1	100%	0%	100%	0%
Meaningful relationships	1	100%	0%	100%	0%
Overall Progress	1	100%	0%	100%	0%

CSR/Child Status and Performance Profile

Affordable Behavioral Consultants n= 1 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	1	100%	0%	0%	100%
Culturally appropriate practice	1	100%	0%	0%	100%
Service team formation	1	100%	0%	0%	100%
Service team functioning	1	100%	0%	100%	0%
Functional assessment	1	100%	0%	100%	0%
Long-term guiding view	1	100%	0%	100%	0%
IRP	1	100%	0%	100%	0%
Goodness-of-service fit	1	100%	0%	0%	100%
Resource avail.: unique/flex.	1	100%	0%	0%	100%
Resource availability: unit/place.	1	100%	0%	0%	100%
Treatment implementation	1	100%	0%	0%	100%
Emergent/urgent response					
Medication management					
Special procedures					
Family support	1	100%	0%	0%	100%
Service coord. & continuity	1	100%	0%	0%	100%
Tracking & adjustment	1	100%	0%	0%	100%
Overall Practice Performance	1	100%	0%	0%	100%

CSR/Child Status and Performance Profile

Center for Therapeutic Concepts n= 2 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	2	100%	0%	0%	100%
Stability	2	100%	0%	50%	50%
Home & school placement	2	100%	0%	50%	50%
Caregiver support of child	2	100%	0%	0%	100%
Satisfaction	2	100%	0%	0%	100%
Health/Phy well-being	2	100%	0%	50%	50%
Functional status	2	50%	0%	100%	0%
Academic status	2	50%	0%	50%	50%
Responsible social behavior	2	50%	0%	100%	0%
Lawful behavior	1	100%	0%	100%	0%
Overall C & F Status	2	100%	0%	50%	50%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	2	100%	0%	100%	0%
Behavior improvement	2	100%	0%	100%	0%
School/work progress	2	100%	0%	50%	50%
Risk reduction	2	100%	0%	0%	100%
Transition progress	2	50%	0%	50%	50%
Meaningful relationships	2	100%	0%	50%	50%
Overall Progress	2	100%	0%	50%	50%

CSR/Child Status and Performance Profile

Center for Therapeutic Concepts n= 2 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	2	100%	0%	0%	100%
Culturally appropriate practice	1	100%	0%	100%	0%
Service team formation	2	50%	0%	50%	50%
Service team functioning	2	50%	0%	100%	0%
Functional assessment	2	50%	0%	50%	50%
Long-term guiding view	2	50%	50%	0%	50%
IRP	2	50%	0%	50%	50%
Goodness-of-service fit	2	50%	0%	100%	0%
Resource avail.: unique/flex.	2	100%	0%	50%	50%
Resource availability: unit/place.	2	100%	0%	50%	50%
Treatment implementation	2	50%	0%	100%	0%
Emergent/urgent response	1	100%	0%	100%	0%
Medication management	2	50%	0%	50%	50%
Special procedures					
Family support	2	50%	0%	50%	50%
Service coord. & continuity	2	50%	0%	50%	50%
Tracking & adjustment	2	100%	0%	50%	50%
Overall Practice Performance	2	50%	0%	50%	50%

CSR/Child Status and Performance Profile

Community Connections n= 14 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	14	86%	7%	50%	43%
Stability	14	57%	29%	50%	21%
Home & school placement	14	79%	7%	29%	64%
Caregiver support of child	14	64%	36%	43%	21%
Satisfaction	10	70%	10%	70%	20%
Health/Phy well-being	14	93%	0%	36%	64%
Functional status	14	86%	7%	43%	50%
Academic status	14	64%	29%	29%	43%
Responsible social behavior	14	79%	14%	29%	57%
Lawful behavior	8	75%	0%	50%	50%
Overall C & F Status	14	71%	14%	36%	50%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	14	71%	21%	29%	50%
Behavior improvement	14	71%	21%	36%	43%
School/work progress	14	64%	21%	29%	50%
Risk reduction	14	50%	29%	43%	29%
Transition progress	11	45%	9%	64%	27%
Meaningful relationships	13	77%	8%	46%	46%
Overall Progress	14	57%	21%	43%	36%

CSR/Child Status and Performance Profile

Community Connections n= 14 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	14	43%	21%	64%	14%
Culturally appropriate practice	8	100%	0%	38%	63%
Service team formation	14	29%	50%	43%	7%
Service team functioning	14	7%	50%	43%	7%
Functional assessment	14	36%	21%	71%	7%
Long-term guiding view	14	14%	64%	29%	7%
IRP	14	14%	50%	43%	7%
Goodness-of-service fit	14	29%	36%	57%	7%
Resource avail.: unique/flex.	13	31%	15%	69%	15%
Resource availability: unit/place.	10	40%	10%	70%	20%
Treatment implementation	14	36%	36%	50%	14%
Emergent/urgent response	4	25%	0%	75%	25%
Medication management	6	33%	33%	50%	17%
Special procedures	2	50%	50%	50%	0%
Family support	14	36%	36%	57%	7%
Service coord. & continuity	14	14%	43%	50%	7%
Tracking & adjustment	14	21%	57%	36%	7%
Overall Practice Performance	14	14%	36%	57%	7%

CSR/Child Status and Performance Profile

DC/MD Family Resources n= 3 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	3	100%	0%	33%	67%
Stability	3	67%	0%	33%	67%
Home & school placement	3	100%	0%	33%	67%
Caregiver support of child	3	100%	0%	0%	100%
Satisfaction	3	67%	33%	33%	33%
Health/Phy well-being	3	100%	0%	0%	100%
Functional status	3	67%	33%	67%	0%
Academic status	3	67%	33%	33%	33%
Responsible social behavior	3	0%	67%	33%	0%
Lawful behavior	3	0%	67%	33%	0%
Overall C & F Status	3	67%	0%	100%	0%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	3	0%	0%	100%	0%
Behavior improvement	3	33%	33%	67%	0%
School/work progress	3	33%	33%	67%	0%
Risk reduction	3	33%	67%	33%	0%
Transition progress	3	0%	67%	33%	0%
Meaningful relationships	3	0%	0%	100%	0%
Overall Progress	3	0%	67%	33%	0%

CSR/Child Status and Performance Profile

DC/MD Family Resources n= 3 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	3	33%	67%	33%	0%
Culturally appropriate practice	2	50%	50%	50%	0%
Service team formation	3	33%	67%	33%	0%
Service team functioning	3	33%	67%	33%	0%
Functional assessment	3	33%	33%	67%	0%
Long-term guiding view	3	0%	67%	33%	0%
IRP	3	0%	67%	33%	0%
Goodness-of-service fit	3	0%	67%	33%	0%
Resource avail.: unique/flex.	3	0%	67%	33%	0%
Resource availability: unit/place.	3	0%	67%	33%	0%
Treatment implementation	3	0%	67%	33%	0%
Emergent/urgent response	2	50%	50%	50%	0%
Medication management	2	100%	0%	0%	100%
Special procedures					
Family support	3	33%	67%	0%	33%
Service coord. & continuity	3	0%	67%	33%	0%
Tracking & adjustment	3	0%	67%	33%	0%
Overall Practice Performance	3	0%	67%	33%	0%

CSR/Child Status and Performance Profile

DCCSA n= 17 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	17	100%	0%	41%	59%
Stability	17	76%	12%	53%	35%
Home & school placement	17	94%	0%	24%	76%
Caregiver support of child	17	88%	0%	35%	65%
Satisfaction	16	81%	13%	31%	56%
Health/Phy well-being	17	88%	0%	24%	76%
Functional status	17	76%	0%	76%	24%
Academic status	17	53%	18%	59%	24%
Responsible social behavior	17	59%	12%	76%	12%
Lawful behavior	15	80%	0%	47%	53%
Overall C & F Status	17	88%	0%	47%	53%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	17	53%	6%	82%	12%
Behavior improvement	17	65%	6%	82%	12%
School/work progress	17	53%	6%	76%	18%
Risk reduction	14	50%	14%	71%	14%
Transition progress	13	54%	31%	54%	15%
Meaningful relationships	17	82%	0%	71%	29%
Overall Progress	17	65%	6%	88%	6%

CSR/Child Status and Performance Profile

DCCSA n= 17 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	17	53%	18%	47%	35%
Culturally appropriate practice	11	73%	9%	36%	55%
Service team formation	17	41%	18%	71%	12%
Service team functioning	17	24%	24%	71%	6%
Functional assessment	17	65%	6%	76%	18%
Long-term guiding view	17	29%	53%	35%	12%
IRP	17	29%	29%	65%	6%
Goodness-of-service fit	17	53%	12%	65%	24%
Resource avail.: unique/flex.	16	50%	19%	63%	19%
Resource availability: unit/place.	12	50%	17%	67%	17%
Treatment implementation	17	41%	18%	59%	24%
Emergent/urgent response	5	80%	0%	60%	40%
Medication management	15	73%	20%	40%	40%
Special procedures	4	100%	0%	25%	75%
Family support	15	80%	20%	60%	20%
Service coord. & continuity	17	35%	12%	76%	12%
Tracking & adjustment	17	35%	12%	71%	18%
Overall Practice Performance	17	35%	12%	82%	6%

CSR/Child Status and Performance Profile

First Home Care n= 20 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	20	75%	15%	35%	50%
Stability	20	60%	30%	30%	40%
Home & school placement	20	85%	5%	40%	55%
Caregiver support of child	19	74%	16%	16%	68%
Satisfaction	19	58%	32%	32%	37%
Health/Phy well-being	20	90%	0%	25%	75%
Functional status	20	65%	15%	65%	20%
Academic status	20	75%	10%	50%	40%
Responsible social behavior	20	70%	30%	30%	40%
Lawful behavior	18	78%	22%	33%	44%
Overall C & F Status	20	70%	15%	45%	40%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	20	55%	25%	45%	30%
Behavior improvement	20	55%	25%	50%	25%
School/work progress	19	68%	11%	58%	32%
Risk reduction	18	56%	33%	39%	28%
Transition progress	17	29%	41%	35%	24%
Meaningful relationships	19	58%	21%	53%	26%
Overall Progress	20	55%	30%	45%	25%

CSR/Child Status and Performance Profile

First Home Care n= 20 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	20	60%	15%	60%	25%
Culturally appropriate practice	14	86%	7%	36%	57%
Service team formation	20	60%	25%	40%	35%
Service team functioning	20	20%	55%	40%	5%
Functional assessment	20	45%	40%	50%	10%
Long-term guiding view	20	40%	45%	20%	35%
IRP	20	40%	25%	75%	0%
Goodness-of-service fit	20	60%	15%	55%	30%
Resource avail.: unique/flex.	19	74%	5%	53%	42%
Resource availability: unit/place.	19	79%	5%	58%	37%
Treatment implementation	20	45%	30%	50%	20%
Emergent/urgent response	9	56%	33%	56%	11%
Medication management	10	50%	30%	50%	20%
Special procedures					
Family support	20	50%	25%	40%	35%
Service coord. & continuity	20	25%	55%	35%	10%
Tracking & adjustment	20	20%	30%	65%	5%
Overall Practice Performance	20	35%	25%	55%	20%

CSR/Child Status and Performance Profile

Kidds International n= 4 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	4	100%	0%	25%	75%
Stability	4	50%	25%	50%	25%
Home & school placement	4	75%	0%	50%	50%
Caregiver support of child	4	75%	0%	50%	50%
Satisfaction	4	100%	0%	25%	75%
Health/Phy well-being	4	100%	0%	25%	75%
Functional status	4	100%	0%	75%	25%
Academic status	4	75%	0%	100%	0%
Responsible social behavior	4	100%	0%	50%	50%
Lawful behavior	2	100%	0%	0%	100%
Overall C & F Status	4	100%	0%	50%	50%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	4	75%	0%	50%	50%
Behavior improvement	4	75%	0%	50%	50%
School/work progress	4	75%	0%	100%	0%
Risk reduction	4	50%	50%	25%	25%
Transition progress	2	50%	50%	50%	0%
Meaningful relationships	4	100%	0%	25%	75%
Overall Progress	4	75%	0%	50%	50%

CSR/Child Status and Performance Profile

Kidds International n= 4 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	4	100%	0%	25%	75%
Culturally appropriate practice	1	100%	0%	100%	0%
Service team formation	4	25%	0%	75%	25%
Service team functioning	4	50%	0%	100%	0%
Functional assessment	4	50%	0%	75%	25%
Long-term guiding view	4	50%	25%	25%	50%
IRP	4	25%	50%	50%	0%
Goodness-of-service fit	4	100%	0%	75%	25%
Resource avail.: unique/flex.	3	100%	0%	0%	100%
Resource availability: unit/place.	4	100%	0%	25%	75%
Treatment implementation	4	100%	0%	50%	50%
Emergent/urgent response	1	0%	0%	100%	0%
Medication management					
Special procedures					
Family support	4	75%	0%	75%	25%
Service coord. & continuity	4	75%	0%	50%	50%
Tracking & adjustment	4	25%	0%	100%	0%
Overall Practice Performance	4	75%	0%	75%	25%

CSR/Child Status and Performance Profile

Latin American Youth Services n= 2 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	2	100%	0%	0%	100%
Stability	2	100%	0%	50%	50%
Home & school placement	2	100%	0%	0%	100%
Caregiver support of child	2	100%	0%	0%	100%
Satisfaction	2	100%	0%	0%	100%
Health/Phy well-being	2	100%	0%	0%	100%
Functional status	2	100%	0%	50%	50%
Academic status	2	100%	0%	0%	100%
Responsible social behavior	2	100%	0%	0%	100%
Lawful behavior	2	100%	0%	0%	100%
Overall C & F Status	2	100%	0%	0%	100%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	2	100%	0%	50%	50%
Behavior improvement	2	100%	0%	50%	50%
School/work progress	2	100%	0%	50%	50%
Risk reduction	1	100%	0%	100%	0%
Transition progress	2	100%	0%	50%	50%
Meaningful relationships	2	50%	0%	50%	50%
Overall Progress	2	100%	0%	50%	50%

CSR/Child Status and Performance Profile

Latin American Youth Services n= 2 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	2	100%	0%	0%	100%
Culturally appropriate practice	2	100%	0%	0%	100%
Service team formation	2	100%	0%	0%	100%
Service team functioning	2	100%	0%	50%	50%
Functional assessment	2	100%	0%	50%	50%
Long-term guiding view	2	100%	0%	50%	50%
IRP	2	100%	0%	100%	0%
Goodness-of-service fit	2	100%	0%	0%	100%
Resource avail.: unique/flex.	2	100%	0%	0%	100%
Resource availability: unit/place.	2	100%	0%	0%	100%
Treatment implementation	2	100%	0%	0%	100%
Emergent/urgent response					
Medication management					
Special procedures					
Family support	2	100%	0%	50%	50%
Service coord. & continuity	2	100%	0%	50%	50%
Tracking & adjustment	2	100%	0%	0%	100%
Overall Practice Performance	2	100%	0%	0%	100%

CSR/Child Status and Performance Profile

Scruples Corporation n= 6 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	6	67%	17%	50%	33%
Stability	6	50%	33%	50%	17%
Home & school placement	6	50%	17%	33%	50%
Caregiver support of child	6	33%	33%	50%	17%
Satisfaction	5	40%	40%	40%	20%
Health/Phy well-being	6	67%	17%	33%	50%
Functional status	6	83%	17%	50%	33%
Academic status	6	50%	17%	33%	50%
Responsible social behavior	6	67%	17%	67%	17%
Lawful behavior	6	83%	0%	50%	50%
Overall C & F Status	6	67%	17%	33%	50%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	6	50%	17%	83%	0%
Behavior improvement	6	67%	17%	67%	17%
School/work progress	6	50%	0%	67%	33%
Risk reduction	6	50%	17%	83%	0%
Transition progress	5	20%	40%	60%	0%
Meaningful relationships	6	50%	17%	83%	0%
Overall Progress	6	50%	33%	67%	0%

CSR/Child Status and Performance Profile

Scruples Corporation n= 6 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	6	83%	0%	83%	17%
Culturally appropriate practice	4	75%	0%	50%	50%
Service team formation	6	67%	33%	67%	0%
Service team functioning	6	17%	50%	50%	0%
Functional assessment	6	17%	33%	67%	0%
Long-term guiding view	6	33%	50%	50%	0%
IRP	6	17%	50%	33%	17%
Goodness-of-service fit	6	33%	33%	50%	17%
Resource avail.: unique/flex.	6	33%	33%	67%	0%
Resource availability: unit/place.	6	33%	17%	83%	0%
Treatment implementation	6	17%	50%	50%	0%
Emergent/urgent response	2	50%	0%	100%	0%
Medication management	3	67%	0%	67%	33%
Special procedures	1	0%	0%	100%	0%
Family support	6	17%	33%	67%	0%
Service coord. & continuity	6	17%	17%	83%	0%
Tracking & adjustment	6	33%	50%	50%	0%
Overall Practice Performance	6	17%	33%	67%	0%

CSR/Child Status and Performance Profile

Universal Health Care n= 3 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	3	100%	0%	33%	67%
Stability	3	100%	0%	33%	67%
Home & school placement	3	100%	0%	67%	33%
Caregiver support of child	3	67%	0%	67%	33%
Satisfaction	3	67%	33%	33%	33%
Health/Phy well-being	3	100%	0%	0%	100%
Functional status	3	100%	0%	67%	33%
Academic status	3	100%	0%	67%	33%
Responsible social behavior	3	100%	0%	67%	33%
Lawful behavior	1	100%	0%	0%	100%
Overall C & F Status	3	100%	0%	67%	33%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	3	100%	0%	33%	67%
Behavior improvement	3	100%	0%	33%	67%
School/work progress	3	100%	0%	67%	33%
Risk reduction	2	100%	0%	50%	50%
Transition progress	2	0%	0%	100%	0%
Meaningful relationships	3	100%	0%	0%	100%
Overall Progress	3	100%	0%	33%	67%

CSR/Child Status and Performance Profile

Universal Health Care n= 3 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	3	67%	33%	67%	0%
Culturally appropriate practice	2	100%	0%	0%	100%
Service team formation	3	33%	33%	67%	0%
Service team functioning	3	67%	33%	67%	0%
Functional assessment	3	33%	67%	0%	33%
Long-term guiding view	3	67%	33%	33%	33%
IRP	3	67%	33%	67%	0%
Goodness-of-service fit	3	67%	33%	67%	0%
Resource avail.: unique/flex.	3	67%	33%	33%	33%
Resource availability: unit/place.	2	50%	50%	50%	0%
Treatment implementation	3	67%	33%	67%	0%
Emergent/urgent response					
Medication management	1	100%	0%	100%	0%
Special procedures					
Family support	3	33%	33%	67%	0%
Service coord. & continuity	3	33%	33%	33%	33%
Tracking & adjustment	3	33%	33%	33%	33%
Overall Practice Performance	3	67%	33%	33%	33%

CSR/Child Status and Performance Profile

Washington Hospital Center n= 1 DC Child Review 2008

Child & Family Status	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	1	100%	0%	0%	100%
Stability	1	100%	0%	100%	0%
Home & school placement	1	100%	0%	0%	100%
Caregiver support of child	1	100%	0%	0%	100%
Satisfaction	1	100%	0%	100%	0%
Health/Phy well-being	1	100%	0%	0%	100%
Functional status	1	100%	0%	0%	100%
Academic status	1	100%	0%	0%	100%
Responsible social behavior	1	100%	0%	0%	100%
Lawful behavior					
Overall C & F Status	1	100%	0%	0%	100%

Recent Progress	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	1	100%	0%	0%	100%
Behavior improvement	1	100%	0%	0%	100%
School/work progress	1	100%	0%	0%	100%
Risk reduction	1	100%	0%	0%	100%
Transition progress	1	100%	0%	0%	100%
Meaningful relationships	1	100%	0%	0%	100%
Overall Progress	1	100%	0%	0%	100%

CSR/Child Status and Performance Profile

Washington Hospital Center n= 1 DC Child Review 2008

Current Practice Performance	Cases applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	1	100%	0%	100%	0%
Culturally appropriate practice	1	100%	0%	0%	100%
Service team formation	1	0%	0%	100%	0%
Service team functioning	1	0%	100%	0%	0%
Functional assessment	1	100%	0%	0%	100%
Long-term guiding view	1	100%	0%	0%	100%
IRP	1	100%	0%	0%	100%
Goodness-of-service fit	1	0%	100%	0%	0%
Resource avail.: unique/flex.	1	100%	0%	100%	0%
Resource availability: unit/place.	1	100%	0%	100%	0%
Treatment implementation	1	0%	100%	0%	0%
Emergent/urgent response	1	100%	0%	0%	100%
Medication management					
Special procedures	1	100%	0%	100%	0%
Family support	1	100%	0%	100%	0%
Service coord. & continuity	1	100%	0%	0%	100%
Tracking & adjustment	1	100%	0%	100%	0%
Overall Practice Performance	1	100%	0%	100%	0%

Appendix D

Stakeholder Interviews
For the Dixon Child Review

1. First Home Care
2. D.C. Core Services Agency (two groups—one with line staff and one with supervisors)
3. Community Connections (two groups—one with line staff and one with supervisors)
4. Steve Baron, Director, DMH
5. Judge Josey-Herring
6. Judge Goldfrank
7. Senior staff at DMH
8. School-based mental health workers
9. Department of Youth Rehabilitation Services
10. DC Public Schools/Office of the State Superintendent of Education
11. A CEO/CFO group
12. CFSA (three groups—two with clinical staff and one with clinical management)