# 2009 Report on Children and Youth

# Served by the
# District of Columbia
# Department of Mental Health

**May 2009**

**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 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.

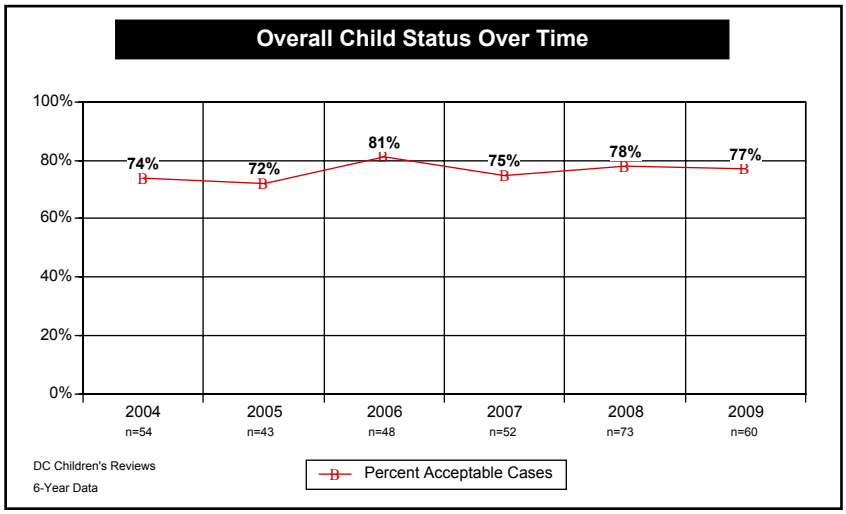
The results for the 2005 Dixon Court Monitoring Children's Review of 43 children served were completed in April 2005. The findings were overall acceptable child status ratings for 72% of the children and overall acceptable system performance of 47%.

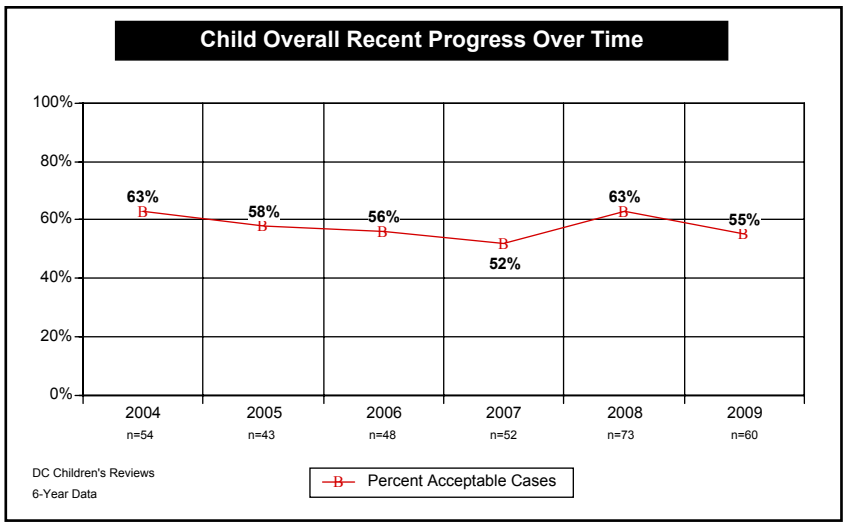
The sample for the 2006 Dixon Court Monitoring Children's Review consisted of 54 children served. The results for the 2006 children's review were completed in April 2006. The findings were overall acceptable child status ratings for 81% of the children and overall acceptable system performance of 54%.

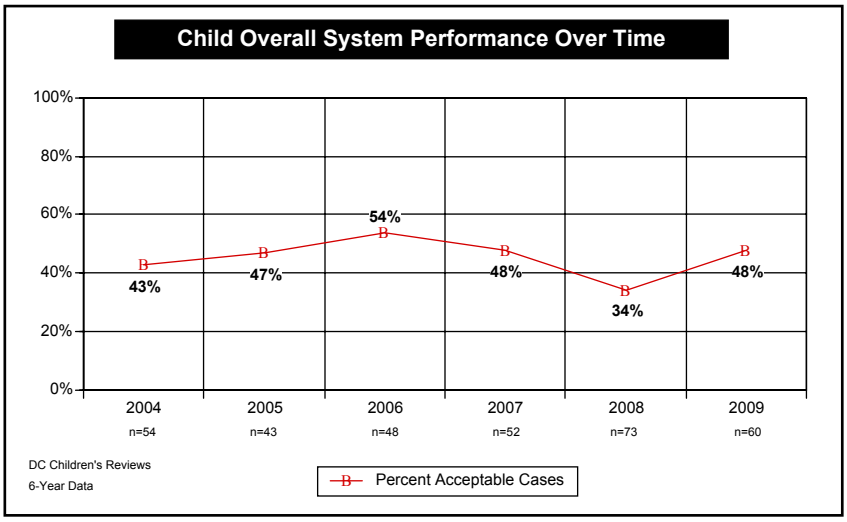
Fifty-two youth were reviewed in March 2007, with the overall child status rating acceptable for 75% of the youth. The system performance was found acceptable, overall, for 48% of the youth reviewed.

In March 2008, personnel affiliated with Human Systems and Outcomes, Inc. (HSO), conducted 53 reviews and 20 reviews were completed by staff of the Department of Mental Health (DMH) for a total of 73 youth in the sample. The overall child status rating was acceptable for 79% of the youth. The system performance was found acceptable, overall, for 36% of the youth reviewed.

The following graphs display the Child Status, Child Progress, and System Performance ratings over six years—2004-2009.


Overall Child Status Over Time
100%
80%
60%
40%
20%
0%
74%
72%
81%
75%
78%
77%
2004
n=54
2005
n=43
2006
n=48
2007
n=52
2008
n=73
2009
n=60
DC Children's Reviews
6-Year Data
Percent Acceptable Cases


Child Overall Recent Progress Over Time
100%
80%
60%
40%
20%
0%
63%
58%
56%
52%
63%
55%
2004
n=54
2005
n=43
2006
n=48
2007
n=52
2008
n=73
2009
n=60
DC Children's Reviews
6-Year Data
Percent Acceptable Cases


Child Overall System Performance Over Time
100%
80%
60%
40%
20%
0%
43%
47%
54%
48%
34%
48%
2004
n=54
2005
n=43
2006
n=48
2007
n=52
2008
n=73
2009
n=60
DC Children's Reviews
6-Year Data
Percent Acceptable Cases

## 2009 Dixon Court Monitoring Children's Review

The design of the 2009 sampling process, training of reviewers, supervision of data collection, and analysis of data were conducted by Human Systems and Outcomes, Inc., 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 2009 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, and well-coordinated services to each child and family consistent with an Individualized Resiliency Plan (IRP) (commonly referred to within the District of Columbia as an Individualized Plan of Care or IPC). 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 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.

After the 2008 review, DMH continued to focus on the process of teaming and collaboration and the contracting of Choice Provider agencies to provide mental health services to children involved with the Child and Family Services Agency (CFSA). In June 2008, DMH contracted with a vendor to provide team-based care coordination (High Fidelity Wraparound) services to a total of 124 children and youth at risk of or returning from Psychiatric Residential Treatment Facilities (PRTFs). In September 2008, the new Director of the Child and Youth Services Division joined DMH. In October 2008, new mobile crisis outreach services, including crisis stabilization beds, were also started for children and families in need of immediate crisis response, including assessment, intervention, and placement. Effective November 1, 2008, DMH increased the reimbursement rates for medication/somatic treatment, counseling, and community-based intervention (CBI). In addition, a differential has been established for medication/somatic treatment and counseling services provided to children and youth, in recognition of the need to expand the pool of qualified child-serving mental health providers.

Overview of the Child Review Process

The monitor's review of services for children, youth, and families is conducted through 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 (CSW), 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. Reviewers trained to standard by HSO trainers completed the child reviews. HSO-affiliated personnel conducted 42 reviews and staff of DMH completed 18 reviews. As in 2008, a case judging process was used and agency staff were provided with individual case feedback. CFSA staff also co-reviewed cases in which youth and families were involved with both DMH and CFSA.

Changes to the Review Process

Because the District's Community Service Agency was in the midst of restructuring at the time of the 2009 Community Services Review (CSR), the Court Monitor, together with DMH leadership and HSO, agreed to reduce the sample size and use the review process as a practice development opportunity. (The sample size in 2008 was 73; in 2009, the sample size was 60.) To encourage participation, families were offered a $25 gift card from Target at the conclusion of their interviews with reviewers.

As is the case so far in every year of review, the 2009 CSR sample contained a large number of youth who are involved with the child welfare system. Forty-two percent (42% or 25 youth) of the cases reviewed in 2009 were involved with child welfare. As in 2008, following consultation among representatives from DMH, HSO, and CFSA, the decision was made to pair CFSA reviewers with HSO 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 DMH protocols. CFSA was able to use the data as part of their ongoing monthly quality assurance practice. A total of 14 youth and families were co-reviewed. CFSA was able to collect viable data for all of the youth.

Core service agencies (CSAs) have requested that feedback and recommendations be given for the cases reviewed. As in 2008, feedback on individual cases was scheduled and logistical

preparation, specific training of reviewers, and preparation of staff and CSAs to receive the input were accomplished prior to the review weeks. 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. Given the constraints of time for staff, team members, and reviewers, approximately 20% of the sample cases received case-specific feedback. In instances where feedback was not given, scheduling issues prevailed.

## The Sample for Children and Youth

The targeted number of children and youth to review was initially determined to be 86; however, the Court Monitor opted for a final sample of 60 due to the closing of the DCCSA. A stratified random sample of 66 youth (60 youth plus a 10% oversampling) and replacement names was drawn from the DMH eCURA data system for youth receiving services between April 1 and September 30, 2008. The stratified random sample of 66 was used to account for sampling attrition that occurs during scheduling and the review weeks (e.g., one of the youth reviewed had not been receiving services during the timeframe).

Thirty-three youth were replaced in the original sample to make up the final sample of 63. Reviews were completed for 63 youth with three reviews not yielding usable quantitative data for a total review sample of n=60. 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 2,308 children, an increase of 832 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 2,308 children who received a billed-for service between April 1 and September 30, 2008, from 23 different provider agencies. These provider agencies differ substantially in the total number of children they serve. The Court Monitor concurred with the DMH request that the majority of the sample be selected from the Choice Provider Network. As such, 60% or 36 youth were chosen from the Choice Provider Network. The sample was selected differently this year for the review of children's services and was based on this formula. The number of children reviewed from each agency varied slightly from the number originally selected 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. Some agencies were not represented in the sample (or the review) as they were either not a Choice Provider or showed a low number of children in the population (low percentage of the population). The following table illustrates the breakdown of the population, sample, and youth reviewed by agency.

**Display 1**
**Number of Children Receiving a Billed Service**
**Between April 1 and September 30, 2008,**
**According to the eCURA Data System**

| Core Service Agency | # In Population | # In Sample | # Reviewed |
|---|---|---|---|
| 1. First Home Care Corporation | 475 | 10 | 12 |
| 2. Community Connections, Inc. | 272 | 10 | 12 |
| 3. Scruples Corporation | 200 | 3 | 2 |
| 4. Integrated Behavioral Health Services | 5 | 0 | 0 |
| 5. MD/DC Family Resource | 53 | 3 | 2 |
| 6. Affordable Behavioral Consultants | 89 | 3 | 3 |
| 7. Universal Healthcare Management | 181 | 8 | 7 |
| 8. Center for Therapeutic Concepts | 74 | 3 | 1 |
| 9. Youth Villages | 42 | 1 | 0 |
| 10. Family Preservation | 104 | 3 | 3 |
| 11. Latin American Youth Center | 40 | 1 | 1 |
| 12. Fihankra Place, Inc. | 23 | 1 | 1 |
| 13. Mary's Center | 5 | 1 | 1 |
| 14. PSI | 55 | 0 | 0 |
| 15. Progressive Life | 0 | 4 | 3 |
| 16. Family Matters | 5 | 4 | 4 |
| 17. Hillcrest Children's Center | 16 | 1 | 1 |
| 18. RCI Counseling Center | 14 | 1 | 1 |
| 19. DCCSA | 484 | 0 | 0 |
| 20. Launch, LLC (formerly Kidd International) | 167 | 3 | 6 |
| 21. Washington Hospital Center | 1 | 0 | 0 |
| 22. Life Stride, Inc. | 3 | 0 | 0 |
| TOTALS | 2308 | 60 | 60 |

## Age and Gender of Youth

When selecting the sample for the 2009 review, the total sample was stratified by age and gender. **Display 2** shows the distribution of the eCURA population, random sample, and review sample by age and gender. Some youth had no information in the age or gender field in eCURA.

**Display 2**
**Age and Gender of Youth in the Population, Random Sample, and Review Sample in 2009**

| Age of Youth | # In Population | % Of Population | # In Sample | % In Sample | # In Review |
|---|---|---|---|---|---|
| Birth to 9 years | 585 | 25% | 16 | 26% | 16 |
| 10 to 13 years | 731 | 32% | 15 | 25% | 15 |
| 14 and older | 962 | 41% | 29 | 48% | 29 |
| No stated age | 30 | 1% | 0 | 0% | 0 |
| TOTALS | 2308 | 100% | 60 | 100% | 60 |

| Gender | # In Population | % Of Population | # In Sample | % In Sample | # In Review |
|---|---|---|---|---|---|
| Female | 881 | 38% | 26 | 43% | 26 |
| Male | 1300 | 56% | 34 | 57% | 34 |
| Unidentified | 127 | 5% | 0 | 0% | 0 |
| TOTALS | 2308 | 100% | 60 | 100% | 60 |

## 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 Child Global Assessment of Functioning Scale (CGAF) score and the Child and Adolescent Level of Care System (CALOCUS) score, were also gathered when possible. The breakdown for level of need is as follows:

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

Twenty-two (37%) of the 60 children and youth were receiving services in the medium level of need range. 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

The targeted number of 60 children reviewed was met this year and has yielded results that are believed to be reflective of District-wide trends in the children's mental health system. The qualitative and quantitative data collected are sufficiently representative to make system-wide generalizations regarding the quality and consistency of practice across the D.C. mental health system. The sampling processed has evolved in the past few years from selecting a triple sample and then stratifying the sample based on agency, age, and gender, and then replacing from the triple sample, to selecting a stratified single sample and then replacing each youth based on agency, age, and gender. For the 2009 review, 33 youth replacements were made for a variety of reasons, most either had been discharged and were no longer receiving services or refused to participate. The sampling timeframe used to select children and families for the review can impact the number of replacements made to the original sample. 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 | 26 |
| Not receiving services in D.C. | 1 |
| Refused to participate | 6 |
| TOTAL REPLACEMENTS | 33 |

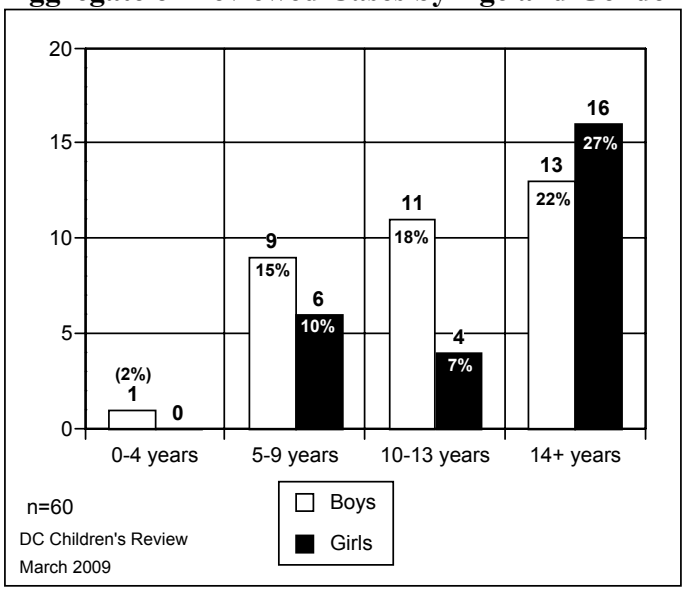
## Description of the Children and Youth in the Sample

A total of 60 child and family reviews were completed during March 2009. Presented in this section are displays that detail the characteristics of the children and youth in the seventh-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 60 children and youth distributed by both age and gender. As shown in this display, boys make up 57% of the review sample and girls make up 44% 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 (16 youth). Fifteen children (25%) fell in the 10-13-year-old age group. Twenty-nine teenagers age 14 and older (49%) were included in the review. Ninety-seven percent (97%) of the youth reviewed were of African-American ethnicity and 3% were of Latino-American descent.

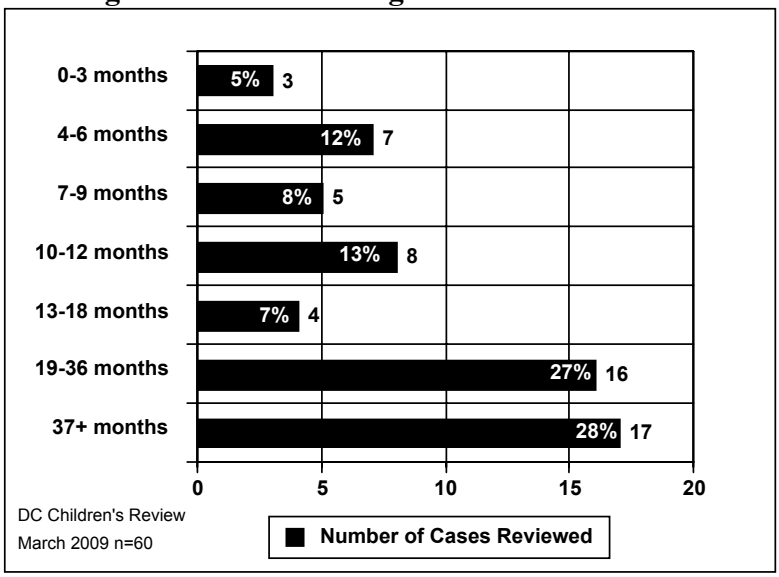
**Display 4**
**Aggregate of Reviewed Cases by Age and Gender**



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 (55%; 33 youth) and 38% (23 youth) had been receiving services for less than one year. Fewer sample members had received services for more than 19 months in the 2009 review than in the 2008 sample (81% in 2008; 55% in 2009). A notable difference when compared with the 2008 data is in regard to the number of youth receiving services for one year or less. In the 2008 review, 8% (six youth) of the sample fell into this timeframe; while in 2009, 38% had been in services for fewer than 12 months.

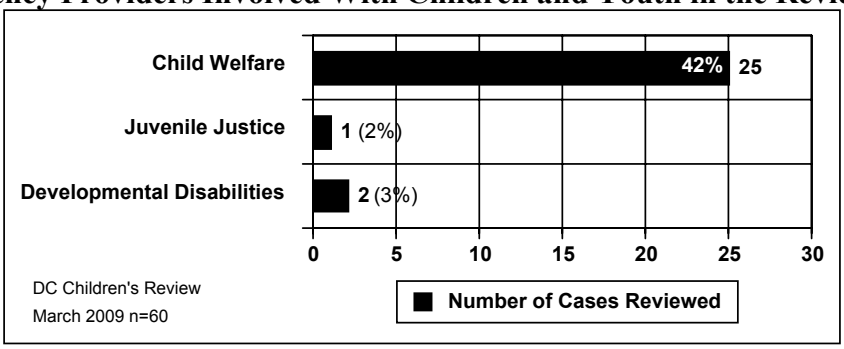
**Display 5**
**Length of Time Receiving Mental Health Services**



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. Of the 28 youth served by one or more of these agencies, 25 were involved with CFSA representing 42% of the total sample. For comparative purposes, 47% of the review sample were involved with CFSA in the 2004 CSR, 23% in 2005, 29% in 2006, 48% in 2007, and 62% in 2008 were involved with CFSA. This year, only one youth (2%) in the review sample was involved with the Department of Youth Rehabilitation Services (DYRS). In the past three reviews (2008, 2007, 2006), there were two, five, and four, respectively, sampled youth involved with DYRS. There were two children involved with developmental disability services this year and none in 2008.

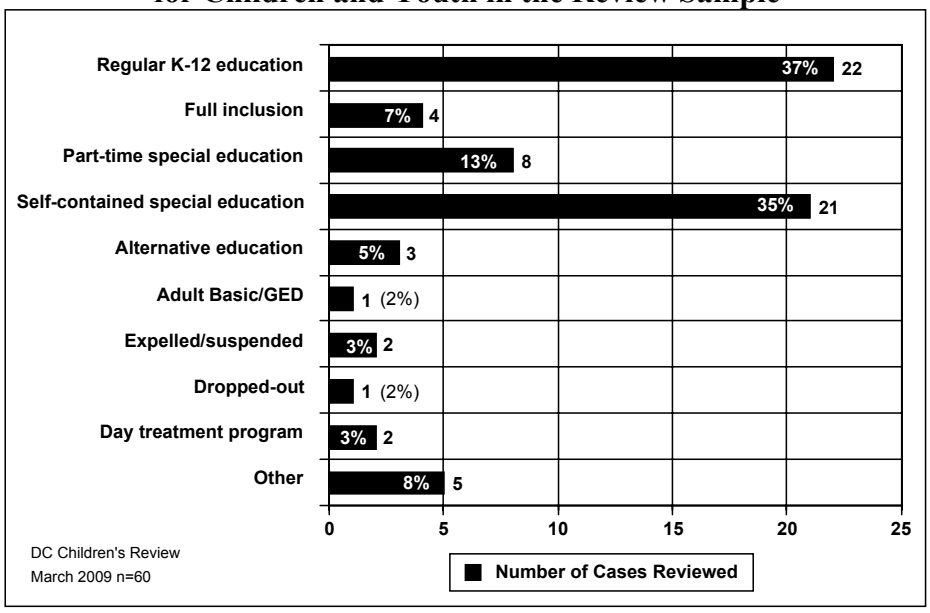
**Display 6**
**Other Agency Providers Involved With Children and Youth in the Review Sample**



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. Twenty-two youth (37%) were in regular K-12 educational settings. Thirty-three youth (55%) were receiving some type of special educational service, either full inclusion (7%; four youth), part-time special education services (13%; eight youth), or in a self-contained special education setting (35%; 21 youth). Two children were expelled or suspended, one dropped out, two were in a day treatment setting, and three were in an alternative education program. Six of the youth reviewed were in other educational settings, which included private schools (four youth) and preschool (two youth).

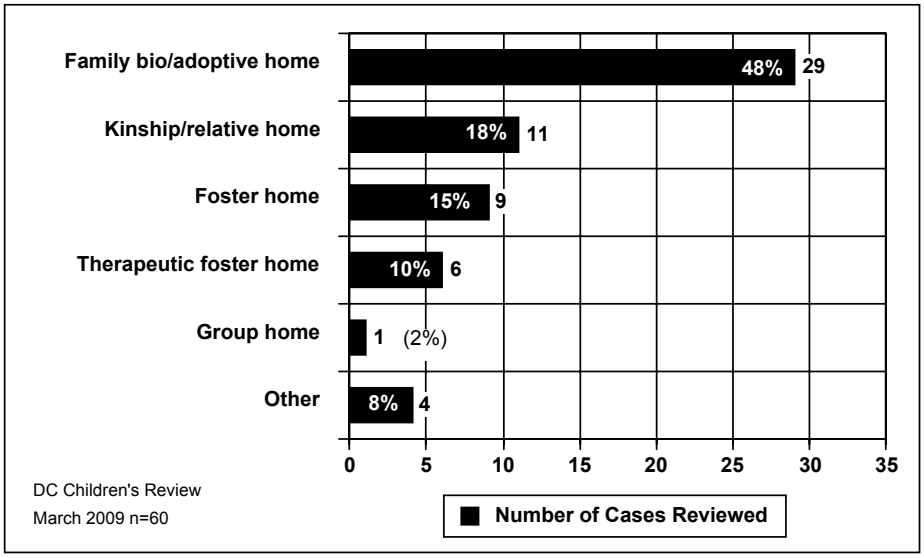
**Display 7**
**Types of Educational Services/Placements or Educational Status for Children and Youth in the Review Sample**



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. Forty-eight percent (48%) or 29 youth in the review sample were living with their birth or adoptive family; an additional 11 youth (18%) were living with relatives. The remaining youth were living outside of the family/kinship home. Fifteen percent (15%) or nine youth were living in a foster home and 10% (six youth) were living in a therapeutically supported setting. The "Other" categories of living situations included one youth in shelter care, one living with the godmother who was also the guardian, one youth in a pre-adoptive home, and one in a public charter boarding school.

**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). Fifty-eight percent (58%) or 35 youth in the 2009 sample had at least one placement change in their lifetime. Twenty-nine youth (48%) had from one to five different placements. In 2008, 63% (46 youth) had at least one placement change with the majority (41 of 72 youth) experiencing from one to five placements in their lifetime.

**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 | 25 children in final sample | 42% |
| 1-2 placement changes | 15 children in final sample | 25% |
| 3-5 placement changes | 14 children in final sample | 23% |
| 6-9 placement changes | 4 children in final sample | 7% |
| 10 or more placement changes | 2 children in final sample | 3% |

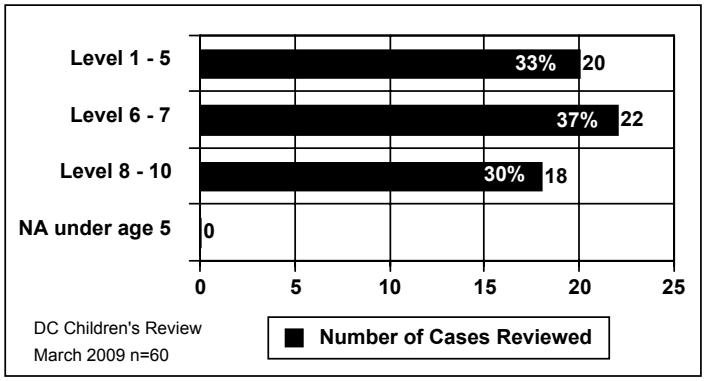
Functional Status

**Display 10** provides the distribution of the review sample across functioning levels for the 60 children and youth age five and older. (Level of functioning data are gathered for children 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 CGAF. 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 would often be receiving intensive outpatient or other in-home

supports in most settings. A child or youth receiving scores of 8-10 would have no more than a slight impairment of functioning but could be functioning well in normal daily settings, with only a minimal amount of supports.

Twenty youth in the review sample had level of functioning scores in the lowest range (33% of the review sample). This range captures youth requiring many supports and, oftentimes, involving multiple agencies. Children in the 2009 review sample are fairly evenly distributed across the functional status ratings with the mid-level (Level 6-7) representing the majority of the youth in the sample.

**Display 10**
**Functional Status of Children and Youth in the Review Sample**




**Display 11** separates level of functioning ratings by age range. Level of functioning is typically collected for youth age five and older; however, the four-year-old child in the current year sample was almost five years old and level of functioning was included for that child. The youngest children in the sample had the lowest rate of low functioning while youth with the highest level of need were more likely to be 14 years or older.

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

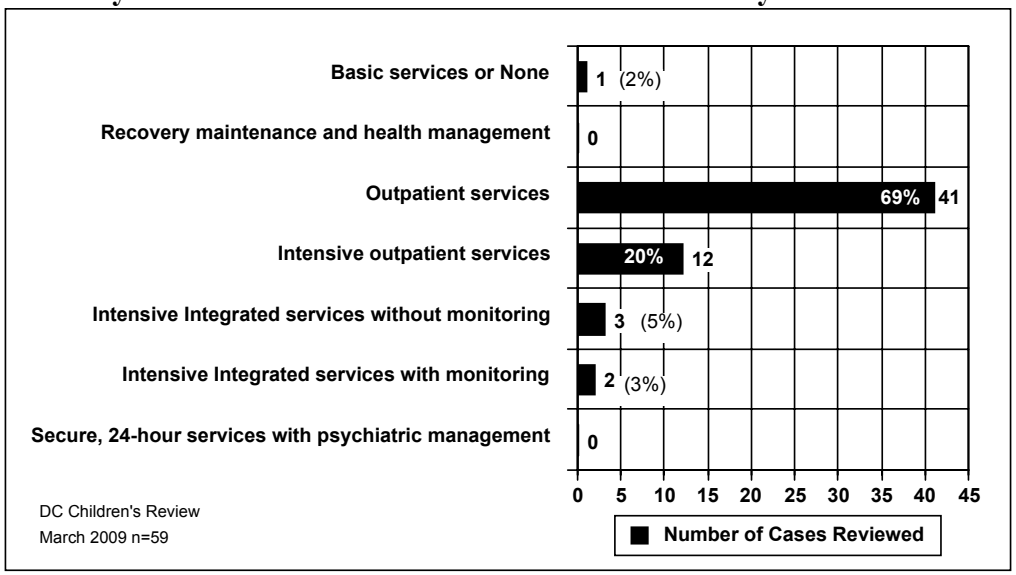
| Age Ranges | Low Level of Functioning | Moderate Level of Functioning | High Level of Functioning | Totals in the Sample |
|---|---|---|---|---|
| 0-9 Years Old | 3 (19%) | 5 (31%) | 8 (50%) | 16 |
| 10-13 Years Old | 4 (27%) | 8 (53%) | 3 (20%) | 15 |
| 14 Years or Older | 13 (45%) | 9 (31%) | 7 (24%) | 29 |
| Totals | 20 (33%) | 22 (37%) | 18 (30%) | 60 |

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 59 of the 60 youth reviewed. When 2009 CALOCUS ratings are compared to those of the 2007 and 2008 samples, more youth are currently receiving outpatient services—41 youth or 69% in 2009—compared to 44% in 2008 and 38% in 2007. In the 2009 sample, only one youth (2% of the sample) was receiving basic services compared to 14% in 2008 and 17% in 2007.

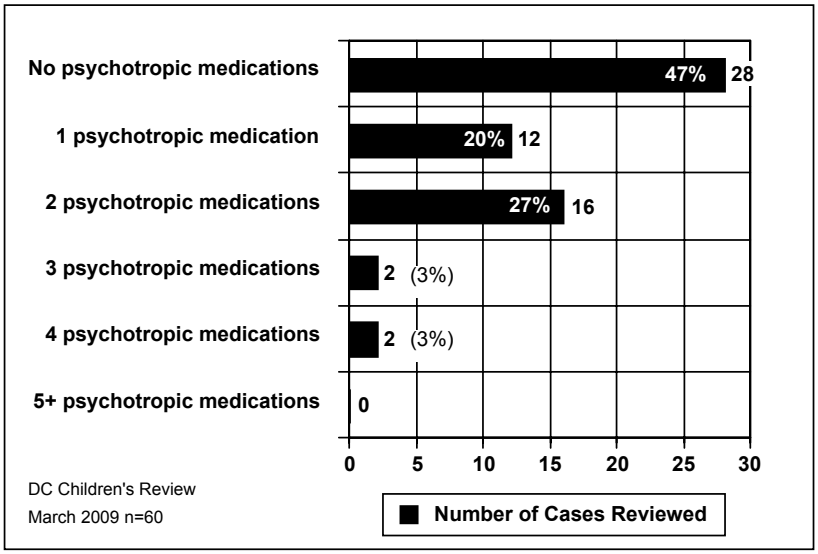
**Display 12**
**CALOCUS for Range of Services Received**
**by Children and Youth in the Review Assessed by Reviewers**



## 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 for youth in the review sample. Twenty percent (12% or 12 youth) were prescribed one medication in 2009, while 29% were prescribed one medication in 2007, and 23% were prescribed one medication in 2008. There is only a two or three percentage point variation in the other categories; however, no youth received five or more psychotropic medications in the 2009 sample.

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



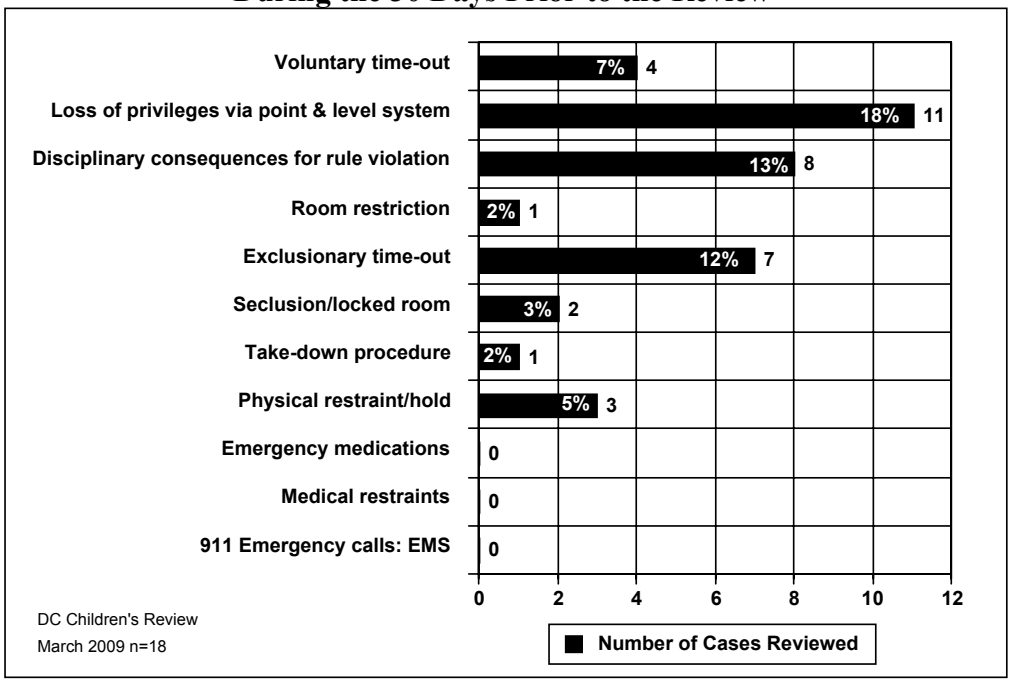

## Special Procedures

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 2009 review are attributed to a relatively small number of children. This year, slightly less than one-third of the youth reviewed (n=18) were found to have experienced a special procedure in the 30 days prior to the review. In 2008, the use of special procedures applied to 20 youth or 15% of the sample. 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, while in the current review, no youth had a 911 call. There was a 3% increase in the rate of youth having a disciplinary consequence in the month prior to the review in 2009 (18 of the 60 youth or 30%) compared to 2008 (20 of the 73 youth or 27%).

**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 60 children and youth in March 2009, 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 to 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 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 "green, yellow, or red 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 found in **Appendix B**. It should be noted that the protocol provides item-appropriate details for rating each of the individual status, progress, and performance indicators. Both the three-tiered action zone and the acceptable vs. unacceptable interpretive frameworks will be used for the following presentations of aggregate data.

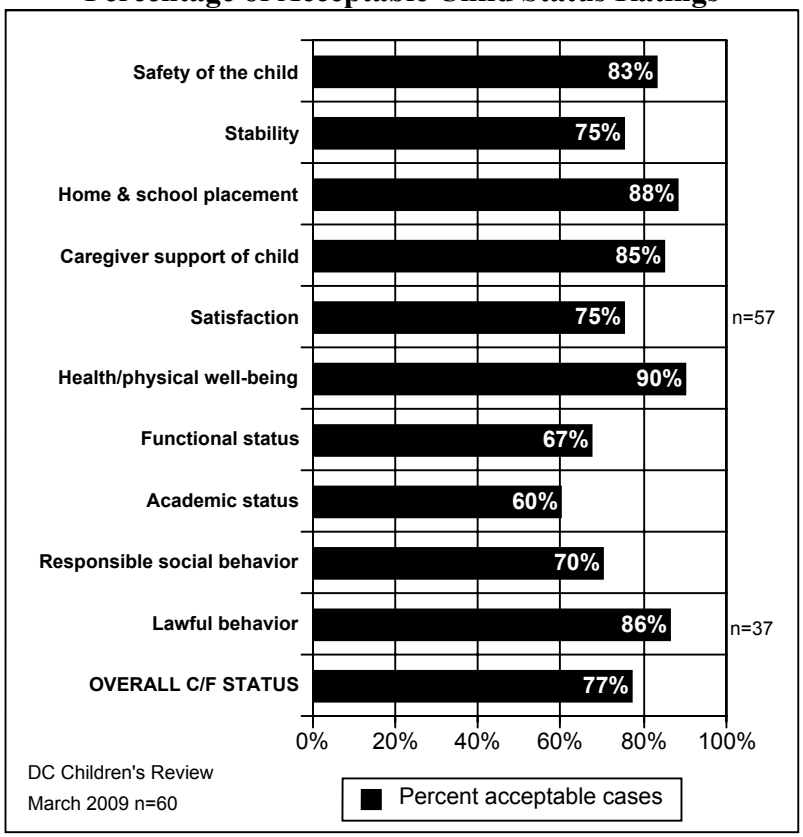
Interviews

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 377 persons were interviewed for the 60 children and youth reviewed this year. The number of interviews ranged from a low of three persons in one case to a high of 11 persons in another case. The average number of interviews was 6.3 (mean=6.3, median=7, mode=5 and 6)

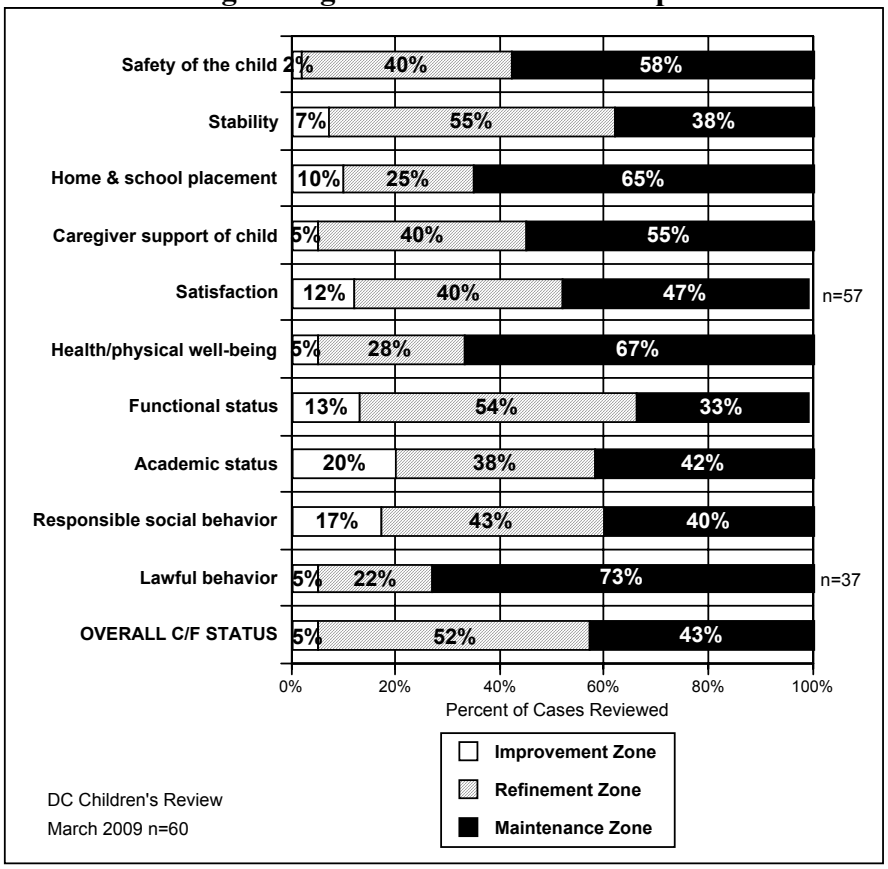
Child Status Results

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**



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




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 60 youth participating in the review, 77% were found to have acceptable overall status. This is a decrease of 2% from 2008. The overall child status scores were distributed across the zones as follows: 5% needed immediate attention and were in the improvement zone, 52% were in the refinement zone, and nearly 44% were in the maintenance zone. Although the overall ratings are comparable to 2008 and 2007, a lower percentage of youth were found in the maintenance zone this year when compared to 2008 (43% in 2009 and 48% in 2008). **Display 17** shows the overall child status results for all seven reviews. Overall child status ratings have been stable and in the same percentage range for all

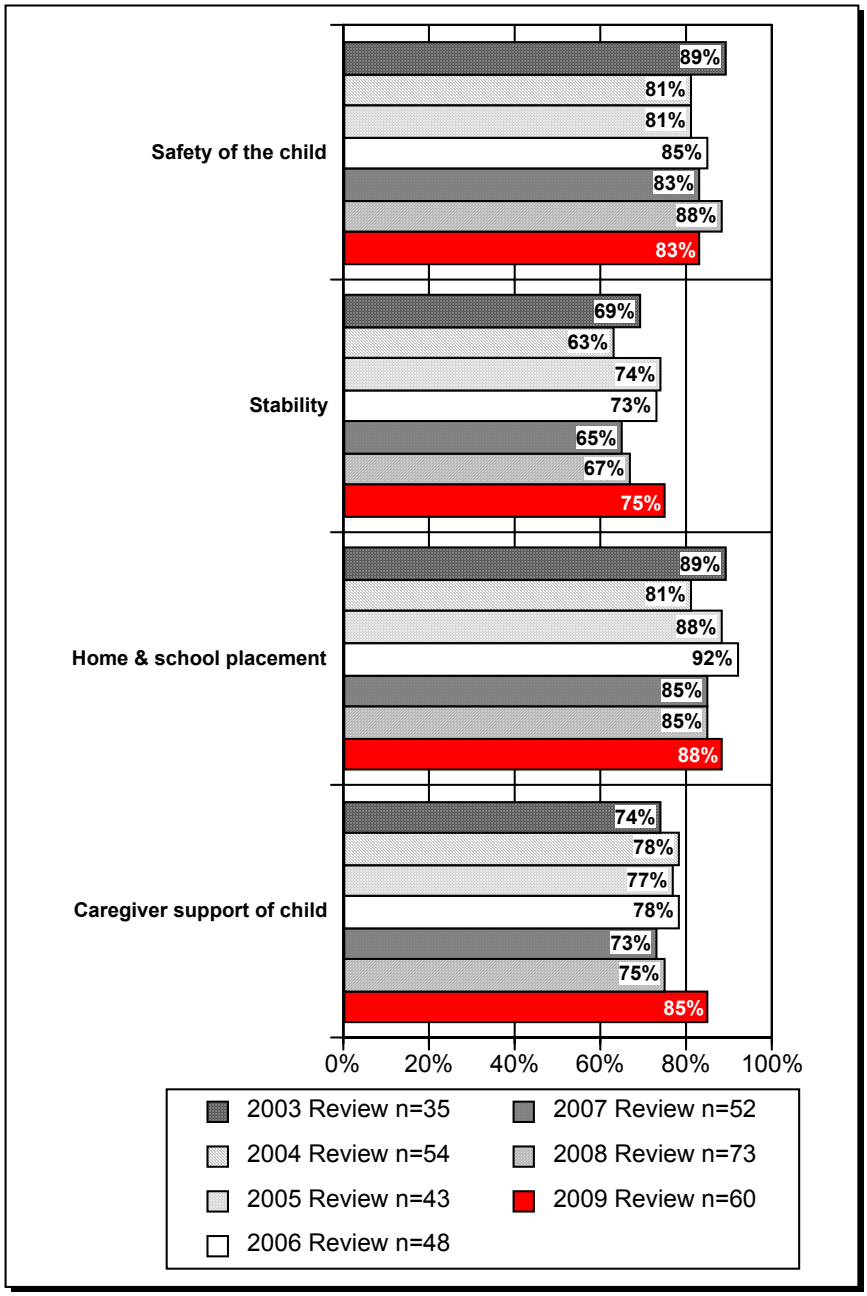
seven years, with the highest results achieved during the 2006 review in which 81% of the youth reviewed were rated acceptable for overall status.

There are several indicators of child well-being that rated strongly this year. Youth were found to be safe, with 83% 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-eight percent (88%) 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 (48% family/adoptive and 18% in kinship care).

The two lowest scoring indicators were identified in academic and functional status. Sixty percent (60%) of the youth reviewed were found to have acceptable academic status, with 20% requiring immediate attention in the improvement zone, 38% in the refinement zone, and 42% in the maintenance zone. The functional status indicator was rated 67% acceptable, with 13% in the improvement zone, 53% in the refinement zone, and 34% in the maintenance zone.

Stability, a measure of 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, showed an 8% improvement over 2008. Caregiver support of the child reflected a 10% improvement rate over 2008 and lawful behavior improved nine percentage points over 2008.

**Display 17**
**Overall Child Status Results for All Seven Reviews**

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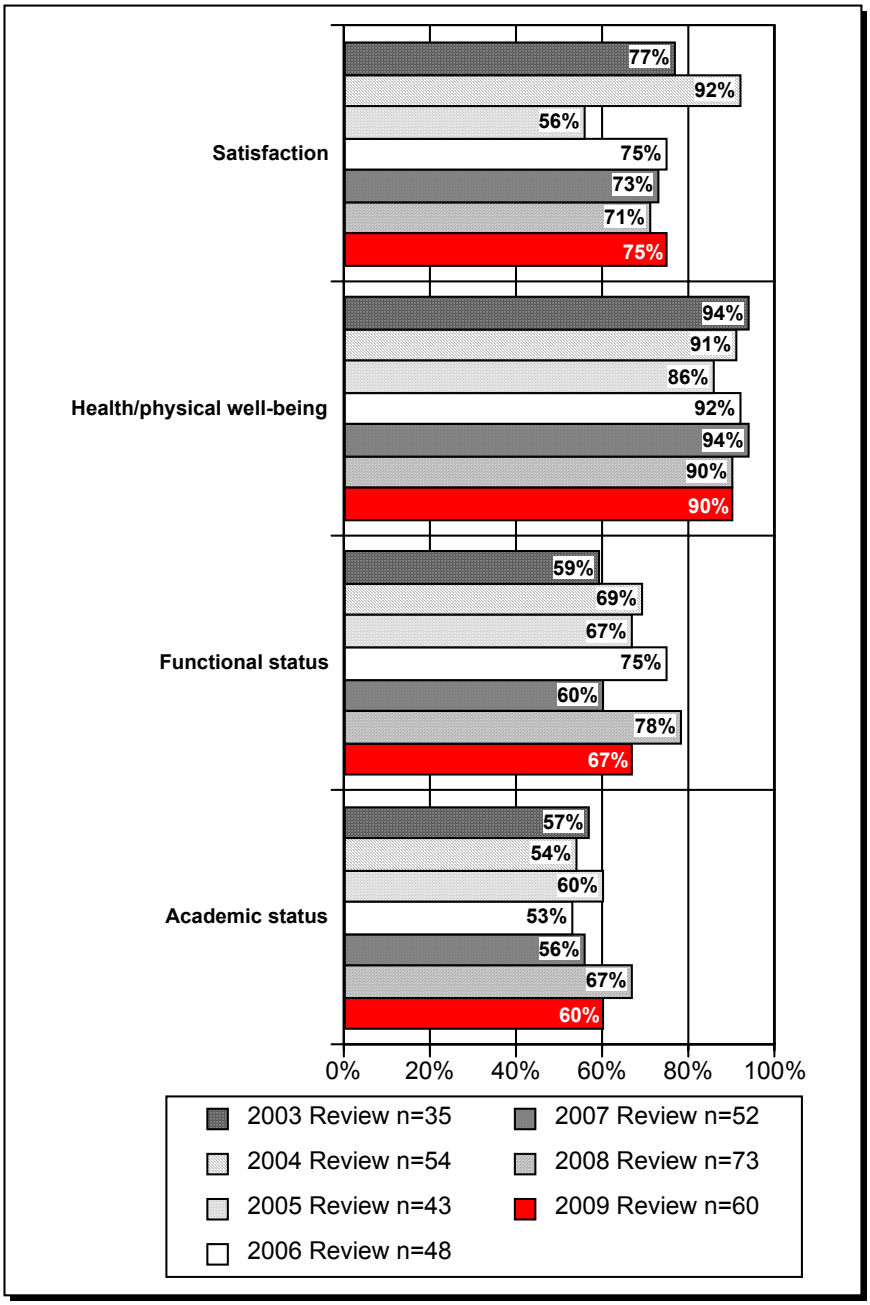
**Display 17 (continued)**
**Overall Child Status Results for All Seven Reviews**

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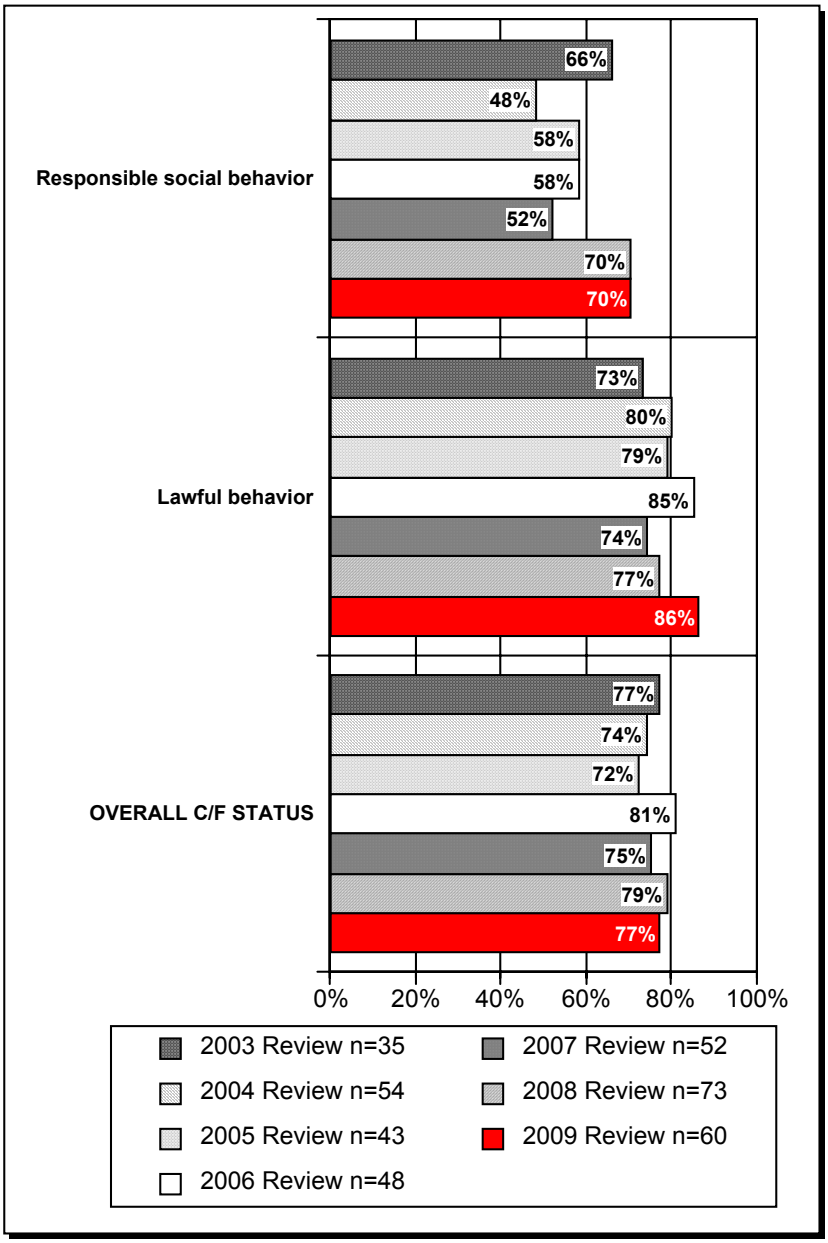
**Display 17 (continued)**
**Overall Child Status Results for All Seven Reviews**

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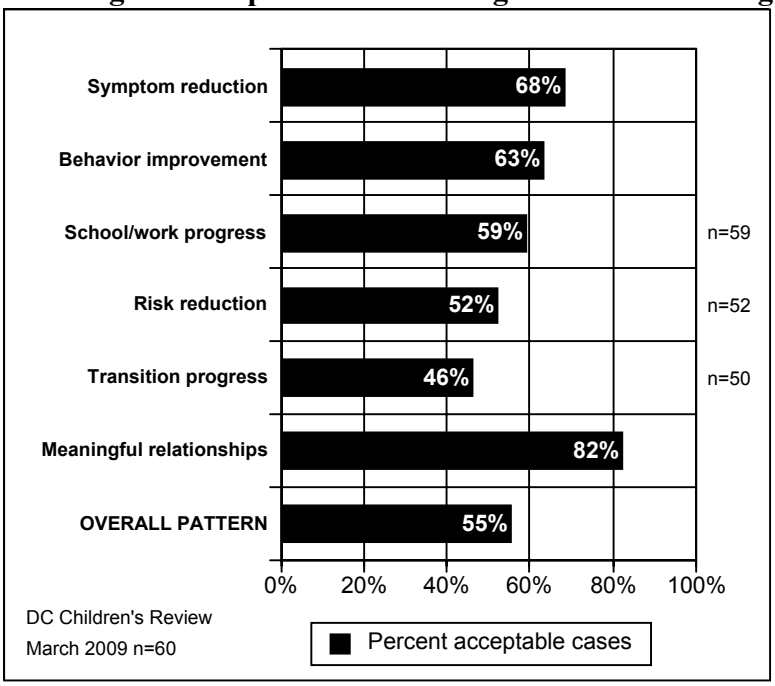
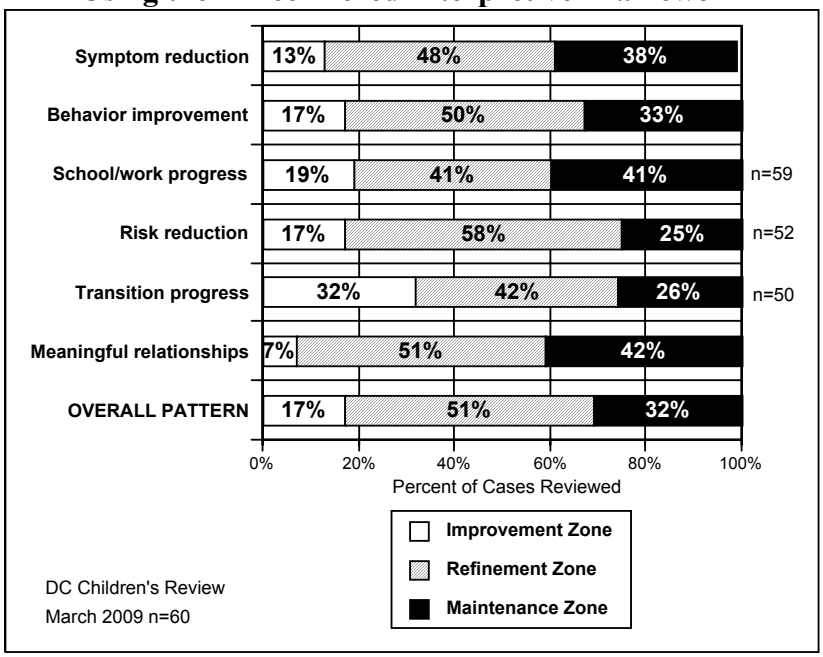
Recent Progress Patterns Showing Change Over Time

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**



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




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 55% of the 60 youth reviewed. This is a 7% decrease from last year (62% acceptable overall progress pattern in 2008), although it is a consistent finding when compared with reviews conducted over the past seven years. Overall progress pattern ratings were distributed among the three-tiered zones as follows: 17% were found to need improvement, 51% were in the refinement zone, and 32% were in the maintenance zone.

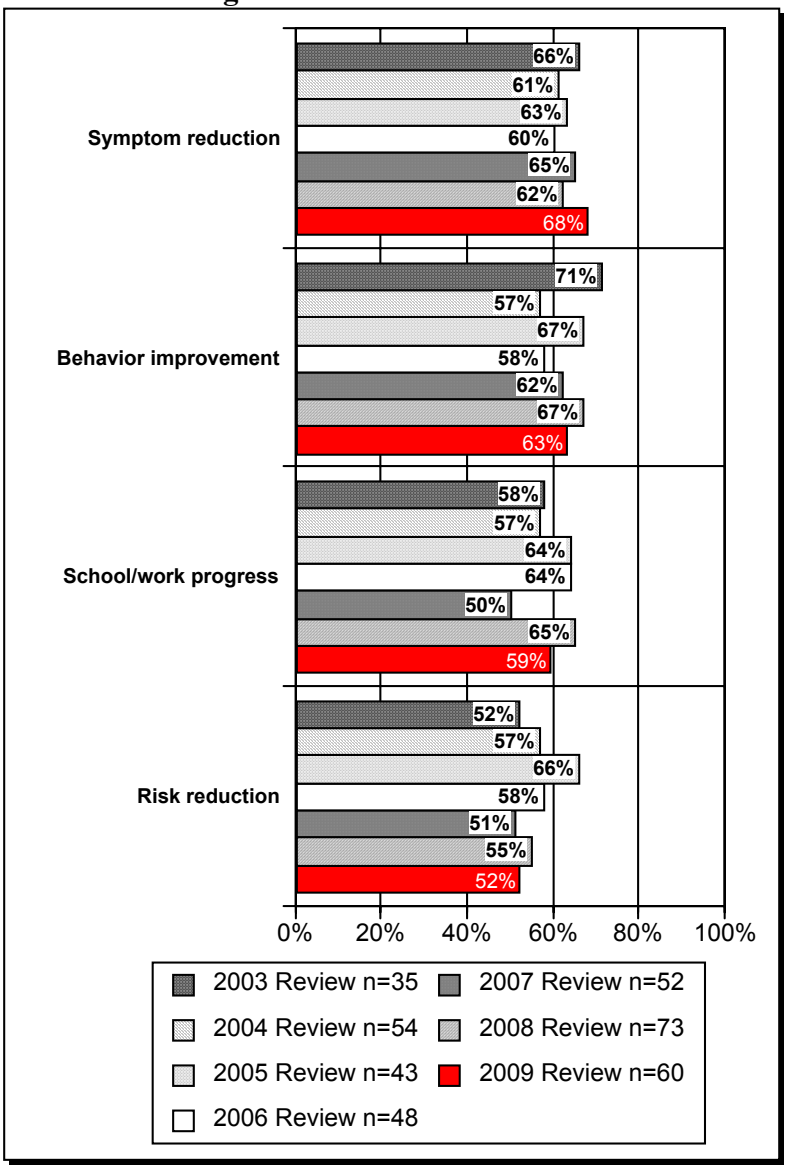
Progress toward meaningful relationships was the indicator with the highest rating with 82% of youth reviewed having acceptable progress in this area. This is a record for the seven-year review history. Symptom reduction, the extent to which psychiatric symptoms are being reduced for the child or youth, showed a 6% improvement over 2008.

Transitions were identified as applicable for 50 of the 60 children and youth in the 2009 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 23 (46%) of the 50 youth for whom this indicator was applicable. This is an increase of 5% from 2008. 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.

**Display 20** shows the data for all seven 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 Seven Reviews**

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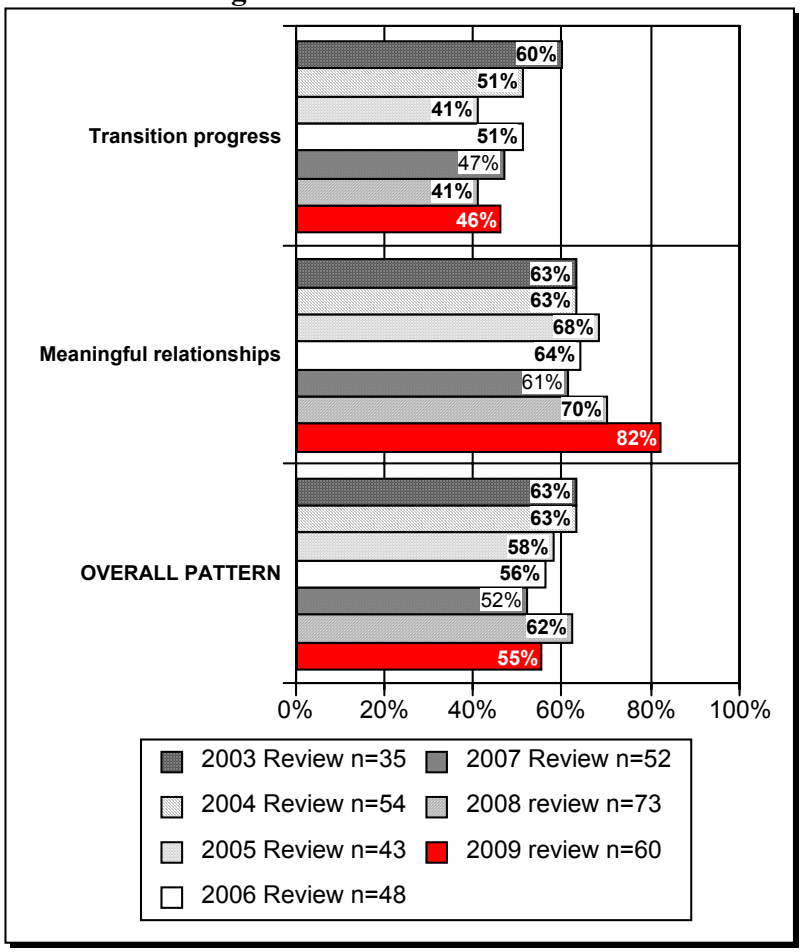
**Display 20 (continued)**
**Overall Child Progress Pattern Results for All Seven Reviews**




Data Compiled 4/09

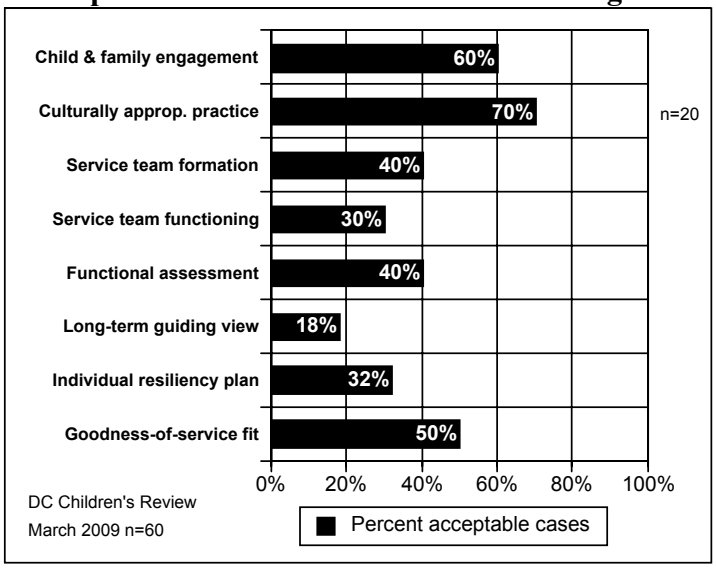
Child-Specific Performance of Practice Functions

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 that 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 with appropriate cultural sensitivity, understanding or assessing the current situation, organizing a functional team, setting directions or establishing a long-term view, organizing appropriate resiliency 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.

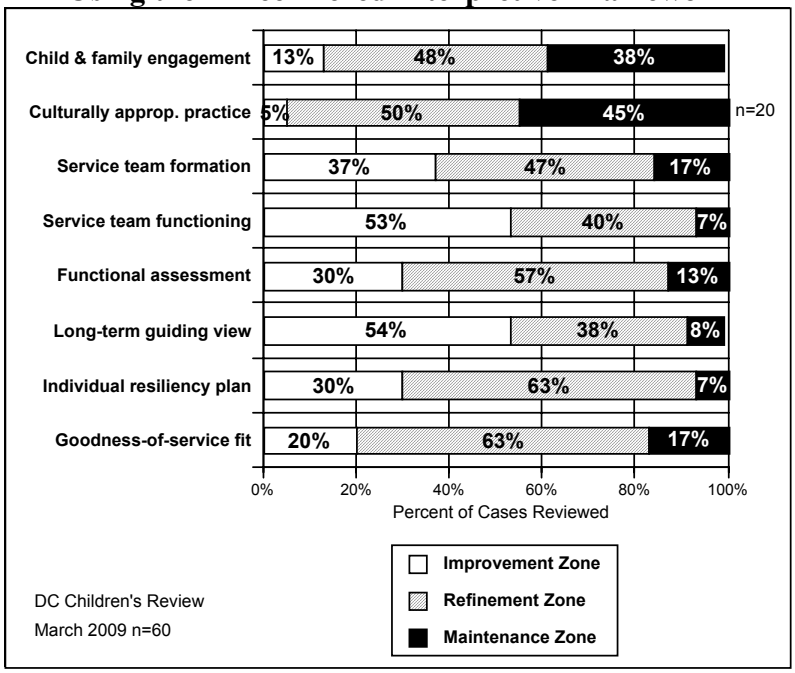
*Practice Performance: Planning Treatment*

Findings for the first set of indicators are presented in **Displays 21 and 22** and summarized below. **Display 33**, starting on page 54, provides the seven-year history of practice performance ratings.

**Display 21**
**Percentage of Acceptable Practice Performance: Planning Treatment Ratings**




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




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 accessible, 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.

Child and family engagement was a strength to build upon this year; however, there was a decline of 2% in the acceptable ratings for this indicator from 2008. Thirty-eight percent (38%) were fully engaged and required maintenance efforts only, 13% needed improvement, and 48% were in the refinement zone.

Culturally Appropriate Practice. Cultural accommodations enable service providers to serve individuals of diverse cultural backgrounds effectively. Properly applied in practice, cultural accommodations reduce the likelihood that language, culture, custom, or belief will prevent or reduce the effectiveness of treatment efforts. Reviewers look for significant cultural issues that must be understood and accommodated in order for desired treatment results to be achieved. If cultural issues are not a potential barrier in practice or if the consumer does not identify with a particular cultural/ethnic/religious group, this indicator is marked not applicable by reviewers. The 2009 CSR results showed that in 70% of case situations, service providers made appropriate cultural accommodations to children and their families. This was a 15% decline from 2008.

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-upon 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 involved with the youth and family participate on

the team, was found in 24 (40%) of the 60 youth reviewed in the 2009 CSR. This is a decrease of 7% from last year. When these data are disaggregated and viewed in terms of ratings on the 1 to 6 scale, 47% of the cases were rated in the refinement zone for team formation and 53% were rated in the improvement zone for team functioning.

Strong team processes include a flow of communication and information among 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 family and professionals to design the provision of services. Service team functioning was found acceptable for 30% of the youth reviewed this year; however, for 53% of the sample, improvement was warranted in team functioning.

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 are not limited to the presence of assessments, evaluations, or diagnostic tools. Teams were found to have acceptable understanding for 40% of the youth reviewed, an 8% decline from the 2008 review. Viewed another way, 87% of the sample population were rated as needing either refinement or improvement in the assessment and understanding indicator.

Because many of these children are involved with multiple agencies, it is critical that all the information known about the child and 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. Based on the review of thousands of children and families across the country, a strong functioning team and good assessment of the situation are the key indicators 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.

Long-Term Guiding View. A long-term view sets the purpose and path of intervention and

support for an individual child or youth. It brings coherence to a service plan. A long-term view anticipates and defines what the child must have, know, and be able to do in order to be successful following his/her next major developmental or placement transition. A long-term view "fits" the child/family situation and establishes a strategic course to be followed in a service process that will lead to achievement of strategic goals. The long-term view should answer the questions of where is the case headed and why. Reviewers found that only 18% of the children and youth reviewed had a long-term view that could be articulated by service providers compared to 36% in 2008. For 92% of the sample cases, the long-term guiding view needed to be refined or improved. For these service providers and the children they served, an end-point for services, a change in the service array suggested by the current situation, or the need to prepare an older youth for independent living were items that had not been considered by the team.

Planning. IRPs 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 toward tangible, achievable long-term goals. Planning processes are not limited to the achievement of goals and objectives; 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 are essential. Planning has been a challenge in the past few years with acceptable ratings on a downward trend. In 2007, 37% of the sample, 33% in 2008, and 32% in 2009 were rated as acceptable in this indicator. For 93% of the cases sampled this year, refinement or improvement were indicated. Often plans lacked individuality, direction, and did not reflect collaboration. IRPs were, oftentimes, completed or updated quarterly by a case manager or therapist independent of input from 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.

Goodness-of-Service Fit. All planned elements of therapy, special education, assistance, and support for the child and family should fit together into a sensible combination and sequence that is individualized to match the family's and child's situation. Understanding the situation is directly related to goodness of fit and the family's opportunity and ability to participate in and benefit from services. Goodness of fit requires that programs, services, and supports are

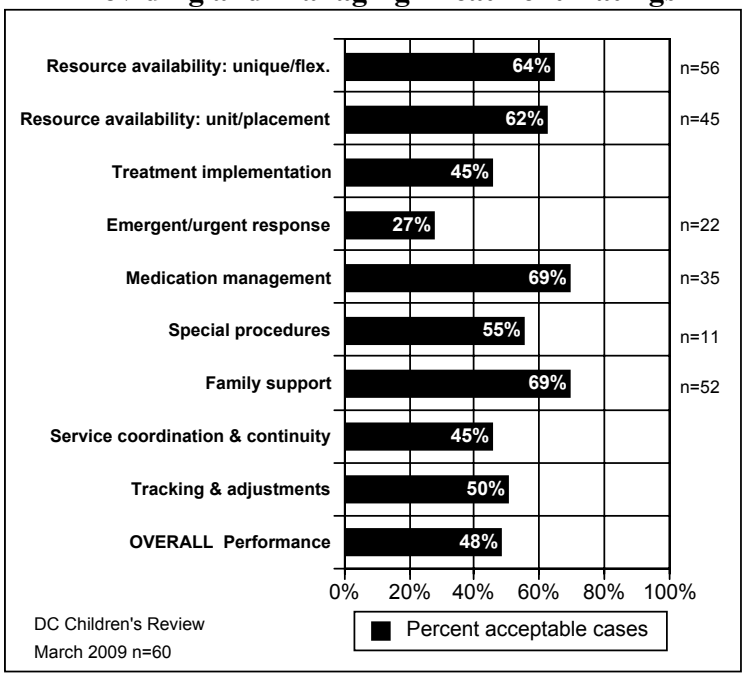
integrated and coordinated across providers and funders. Achieving a good fit optimizes the path and flow of services for maximum results. In 2009, similar to the findings in 2008, the combination and sequencing of supports and services was found to be acceptable for one-half of the children and families served; however, for 83% of the sampled cases, refinement or improvement were warranted.

Findings across the key indicators for planning treatment indicate strengths to build upon in child and family engagement and cultural sensitivity. The weaker area of understanding the family situation and underlying issues through formal and informal assessments and information gathering directly affects the fidelity of the IRP, the goodness of fit of services, and the appropriateness of any long-term view. Service team formation and functioning, built on open lines of communication among team members as well as an understanding of the degree to which teaming is required in each case, completes the foundation of treatment planning. In the 2009 review, consideration and articulation of a long-term view for a child and family was lacking in all but a handful of cases (18% acceptable). 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 their internal agency team's members only. Respondents seem to lack full understanding of "teaming" outside of the immediate agency or institution (i.e., education, child welfare, juvenile justice, mental health) and that a child and family team is not a "team" without the presence and active participation of the family.

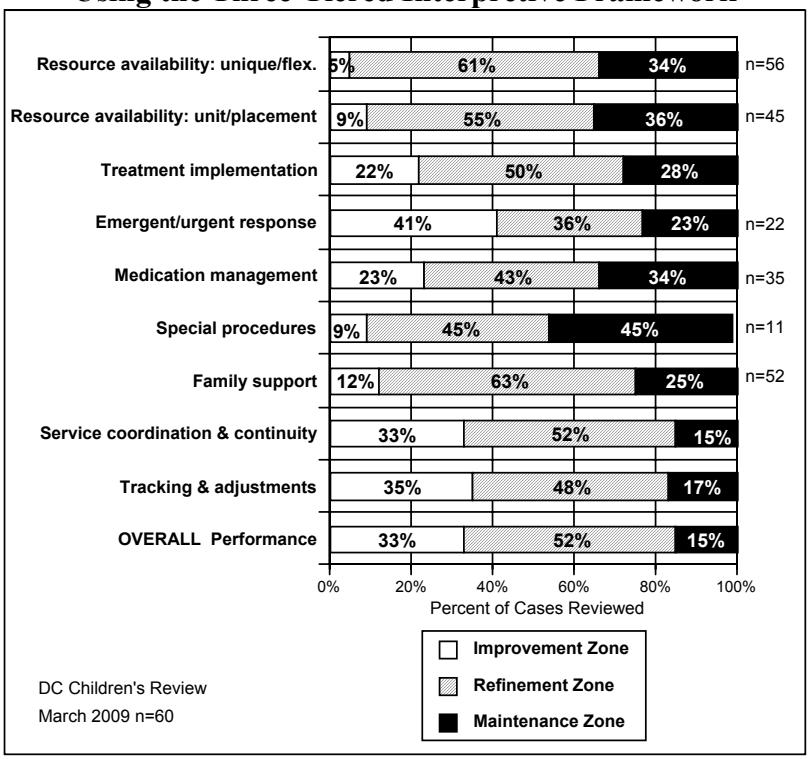
*Practice Performance: Providing and Managing Treatment*

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 below. The seven-year history of the ratings for these indicators can be found in **Display 33,** starting on page 56.

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




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



Resource Availability. 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. Resource availability is captured in two sub-indicator ratings: resources-unique/flexible and resources-unit/placement based.

Resource availability in both sub-indicators is one of the stronger areas in the 2009 review. Sixty-four percent (64%) of the youth reviewed had acceptable availability of flexible resources, such as wrap services or community support; however, 66% were rated as needing refinement or improvement (n=56). Sixty-two percent (62%) had adequate access to unit or placement-based services, such as therapy, with 64% needing refinement or improvement (n=45). There was a slight increase in both sub-indicators from the 2008 data (57% flexible resources; 61% unit-based in 2008).

These results suggest that the availability of resources in the District is not a primary barrier to treatment implementation. However, reviewers noted that some families experienced a 30-day delay between intake and the first appointment with a psychiatrist. Therapists trained in trauma-based therapy are in short supply, but high demand. There was an example of special education eligibility being established at the beginning of a school year with placement in a special class not occurring until March and of evaluation and IEP documents not being transferred to a child's new school.

Treatment Implementation. Acceptable treatment implementation includes timely, dependable, and consistent actions by the team and family; supports and services at the needed intensity to address priority needs; frontline workers (e.g., therapists, CSWs, case managers) who receive the support and supervision necessary to fulfill their responsibilities; problem solving to adapt to changing conditions; and tracking of what works to refine implementation. Treatment implementation in 2009 was at a rate of 45% acceptable, similar to 2008 when the rate was 44%. However, in 2009, 72% of the sample cases could use refinement or improvement.

Emergency/Urgent Response. A child or youth who presents dangerous psychiatric symptoms, severe maladaptive behaviors (e.g., running away, fire starting), or acute episodes of chronic health problems (e.g., seizures, HIV, asthma) may require immediate and intensive services to meet the child's urgent need and to prevent harm from occurring to the child or others in the child's environment. A safety or "crisis plan" should be designed specifically for one child, created in advance of an episode, and activated and implemented immediately. Reviewers look to see whether children, caregivers, and service providers are aware of the plan and its contents, and if they have timely access to support services necessary to stabilize or resolve urgent problems. The urgent response indicator was rated as 27% acceptable this year, down from 56% in 2008. Of the 22 children or youth for whom this indicator was applicable, 17 or 77% indicated refinement or improvement of the plan and its implementation was necessary.

Medication Management. Use of psychotropic medications is one of many treatment modalities that may be used in treating a child with mental health problems. The effects and side effects of medication use should be assessed, tracked, and used to inform decision making. Any adverse side effects should be addressed and treated. Use of medications should be coordinated with other aspects of treatment and intervention, including community-based treatment (CBT), behavior management, and school performance. Reviewers look to see that medications are taken as prescribed; prescriptions are current; medications are monitored regularly by a health care professional, usually a psychiatrist; and there is a correlation between each medication and a DSM-IV-R Axis I diagnosis. This indicator was a strength in this year's review. For 69% of the children and youth (n=35) prescribed one or more psychotropic medications, the performance rating was acceptable. For 12 of these children, the rating was good or optimal; for the remaining 23, refinement or improvement was indicated.

Special Procedures. Special procedures are emergency measures taken when a child is a danger to him/herself or others when alternative interventions are impractical or insufficient. Use of these emergency measures must be implemented in the least restrictive manner possible and ended as quickly as possible. During implementation, the child's status and the effects of the procedure must be continually assessed, monitored, and evaluated. Reviewers look to see how

often special procedures are used and under what circumstances, the training of the staff implementing the special procedures, and whether the child's environment is generally positive and therapeutic offering alternative ways of communication or getting needs met. In 2009, the use of special procedures was applicable for 11 children or youth and found to be acceptable in 55% of these cases. For 54% or six children, the use of these procedures could be refined or improved.

Family Support. Children with challenging emotional and behavioral needs place much greater demands on the skills of a caregiver and resources of the home than do other children. Parents and other caregivers may require added training, assistance, periodic relief, and supports in the home to provide for the needs of the child. The long-term stability of the home and the capacity of the caregivers to maintain the home safely with the child or youth present depends on the adequacy of the support available to the caregiver. These supports should enable the caregiver to participate in the child or youth's team and the decision making that occurs there. Family or caregiver support was a strength in the 2009 review with 69% of the cases reviewed rated as acceptable, an increase of 15% over 2008. This item applied to 52 children or youth in the sample and was rated as good or optimal for 13 (25%) of them.

Service Coordination and Continuity. The coordination of services is a fundamental part of practice in a System of Care model. 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. This person is the "driver" of services and supports and is the "glue" that holds the team together. Reviewers look for evidence of communication, coordination integration, and accountability in the implementation of the IRP and other plans, e.g., an IEP. Acceptable service coordination was found in 45% of the children and youth reviewed this year, a 13% increase from 32% acceptable in 2008; however, this indicator was in need of improvement for 85% of the sample. As was reported last year, reviewers noted that respondents seemed to be unclear or unsure regarding who on the team was the coordinator or point person for the child or youth and family. This ambiguity often translated into lack of action, confusion, and decline in functioning for the child or family.

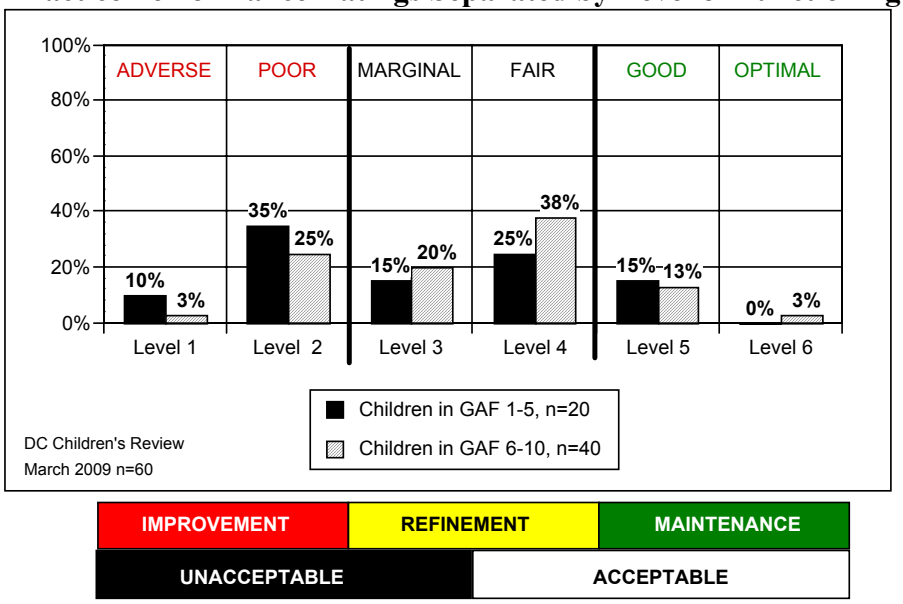
Tracking and Adjustment. The tracking, adjustment, and modification of services and supports are essential to achieving and sustaining positive gains. This process requires that a team be formed, have an adequate understanding of the youth and family, and be communicating and working with each other. Fifty percent (50%) of the children and youth reviewed showed evidence of an acceptable process for tracking and modifying services to meet the changing needs of the child or youth and family, an 18% gain over 2008; however, this indicator was rated as good or optimal for only 17% or ten of the 60 children or youth.

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 48% of the children and youth included in the review, a 12% increase from the 2008 results (36% overall in 2008). Thirty-three percent (33%) of the children or youth reviewed were found to need improvements, 52% were in the refinement zone, and 15% in the maintenance zone. This distribution, when compared with 2008, shows a 2% decrease in youth in the maintenance zone (17% in 2008), an 8% decrease in the refinement zone (60% in 2008), and a 10% increase in youth requiring immediate improvement (23% in 2008). A reasonable overall judgment is that although 2009 showed overall improvement in practice performance, 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.

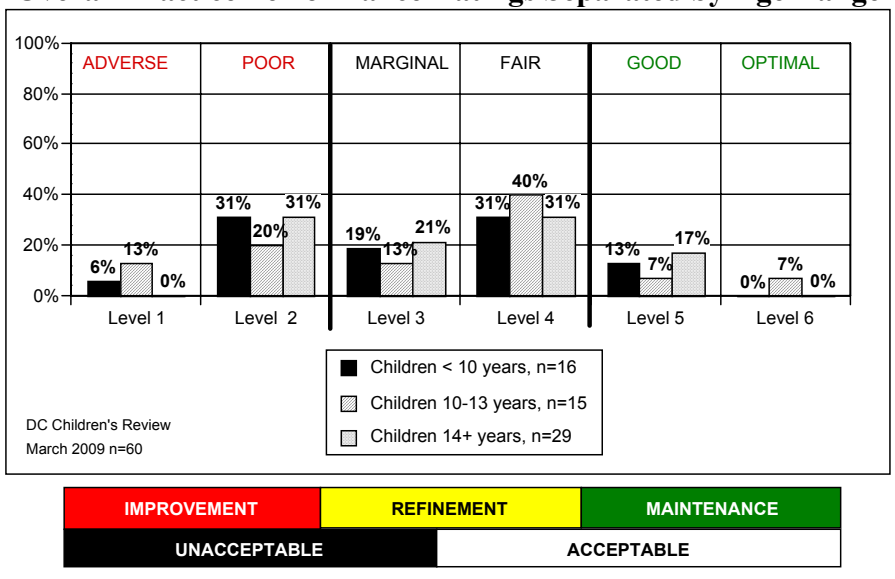
In **Appendix C** of this report are agency-by-agency results for the children and families reviewed. **This agency-by-agency comparison should be interpreted with caution, since sample sizes for some of the provider agencies are extremely small**. **Generalizations regarding specific agency practice 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 seventh-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**

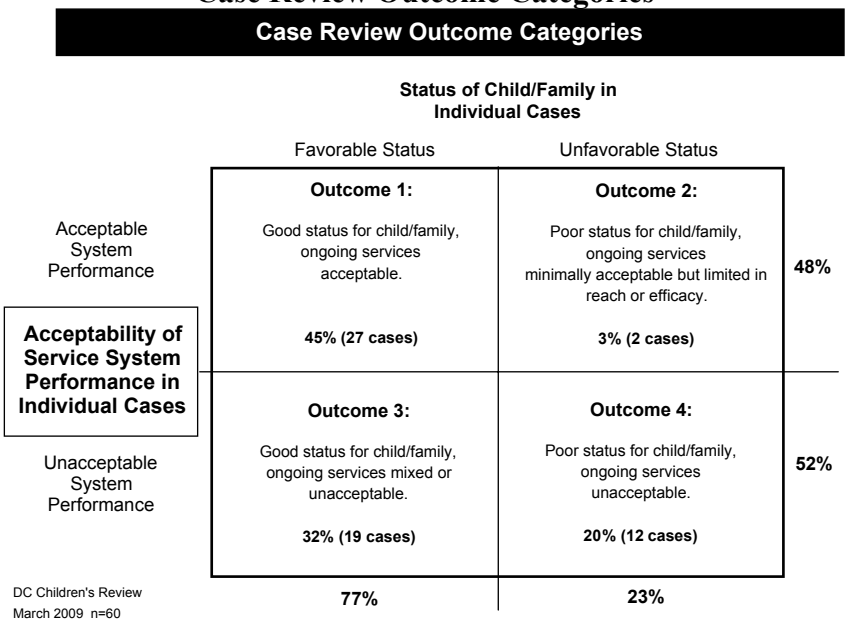


Case Review Outcome Categories

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, 27 (45%) of the 60 cases fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services. There were two youth (3%) 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. Thirty-two percent (32%) or 19 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, 12 youth or 20% of the review sample, fell into outcome category 4, compared to 14 youth or 19% in 2008. Outcome 4 is the most unfavorable combination as the child's status is unfavorable and system performance is inadequate.

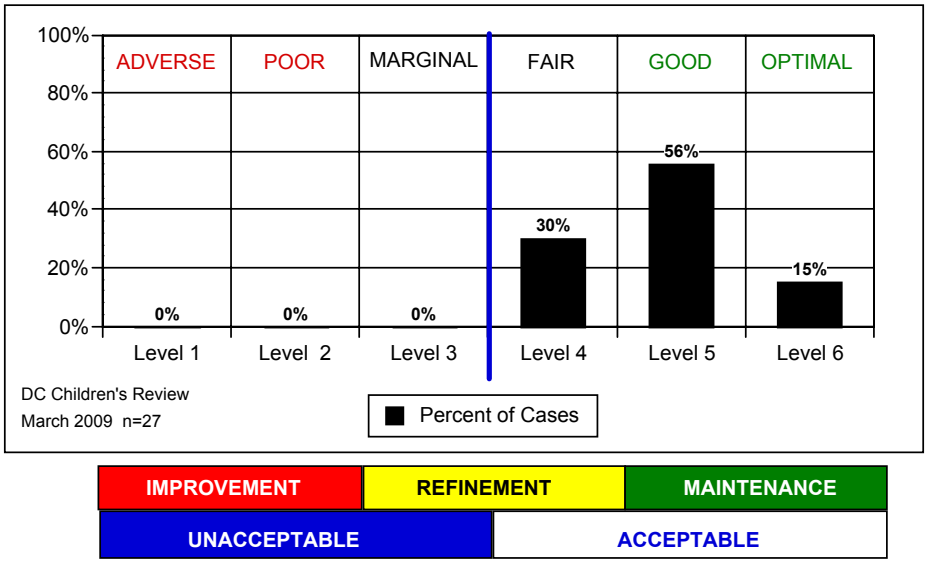
**Display 27**
**Case Review Outcome Categories**



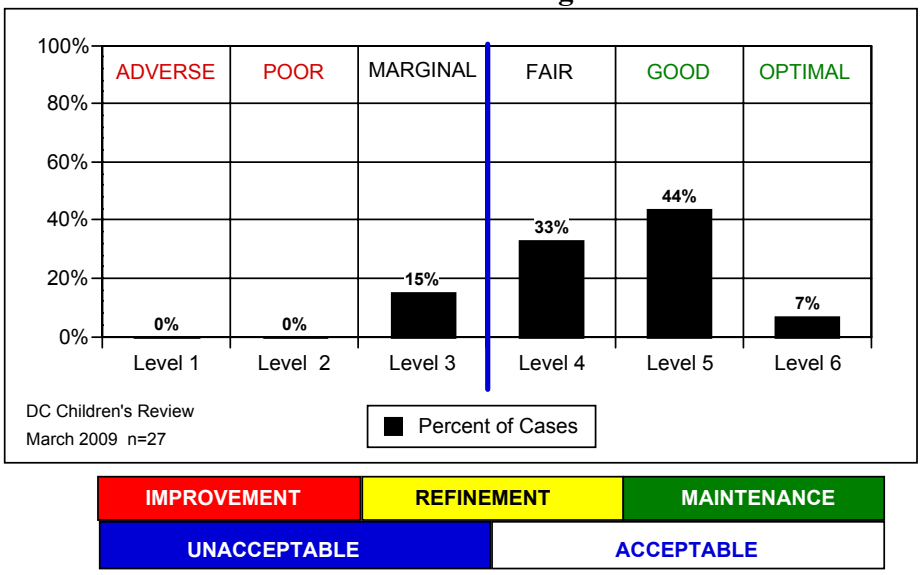

**Displays 28 to 31** show the distribution of scoring on the six-point scale for the children who fall in each of the outcomes shown in Display 27. For example, for outcome 1, the charts in Displays 28a, 28b, and 28c show the distribution of child status ratings, the distribution of progress indicators, and the distribution of system performance ratings. Display 28a shows that 71% of the 27 children in outcome 1 had overall status indicators rated at 5 or 6, and all 27 were rated as having acceptable status. Display 28b shows that 51% of the children in outcome 1 were rated as making progress at 5 or 6, and 84% were rated as making acceptable progress. Display 28c shows the rating distribution of the system performance indicators for these 27 cases. Thirty percent (30%) were rated as having good to optimal practice performance, and all 27 were rated as having acceptable levels of practice performance. Review of the remaining charts for the other outcome categories shows the high degree of consistency and trend that correlate very closely across all three domains that are rated. This analysis disaggregates the total overall child status into the respective outcomes (2-4), and shows that the trends and ratings are consistent with the overall system performance ratings. It also shows that to move children in outcome 3 into outcome 1, the system would need to perform with much more diligence.

**Display 28a**

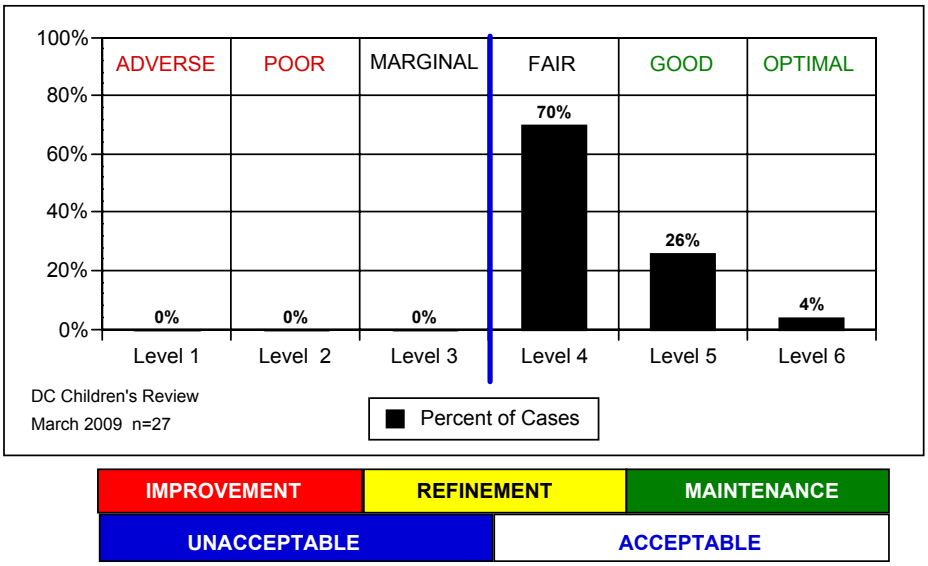
## Outcome 1
## Overall Child/Youth Status



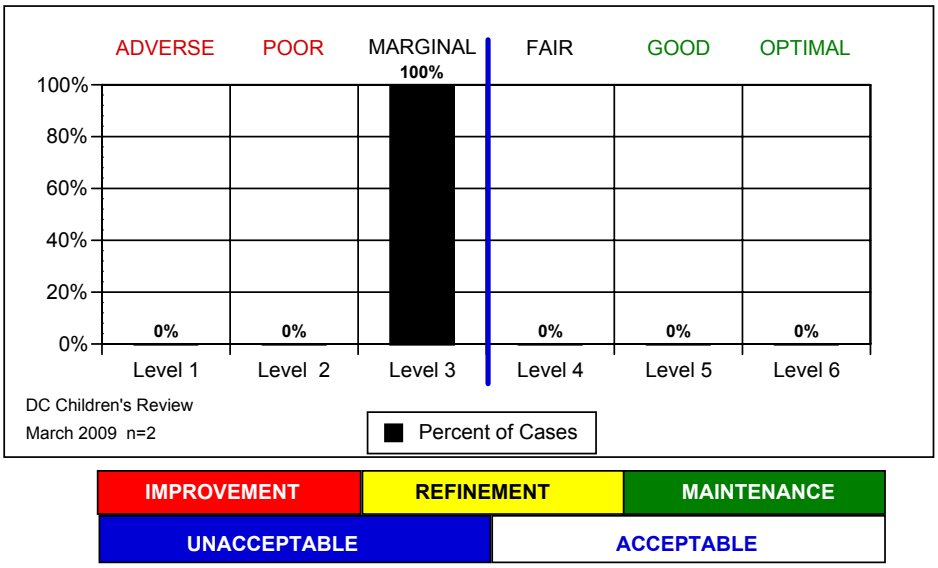

## Display 28b
## Outcome 1
## Overall Recent Progress



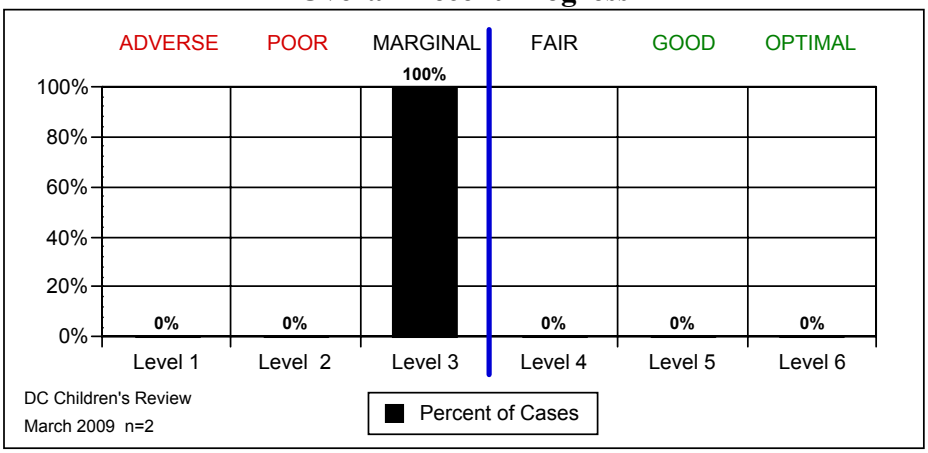
## Display 28c
## Outcome 1
## Overall Practice Performance

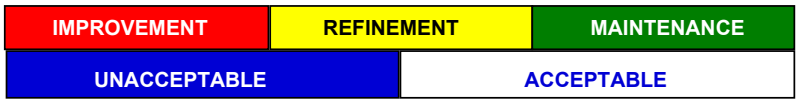



## Display 29a
## Outcome 2
## Overall Child/Youth Status

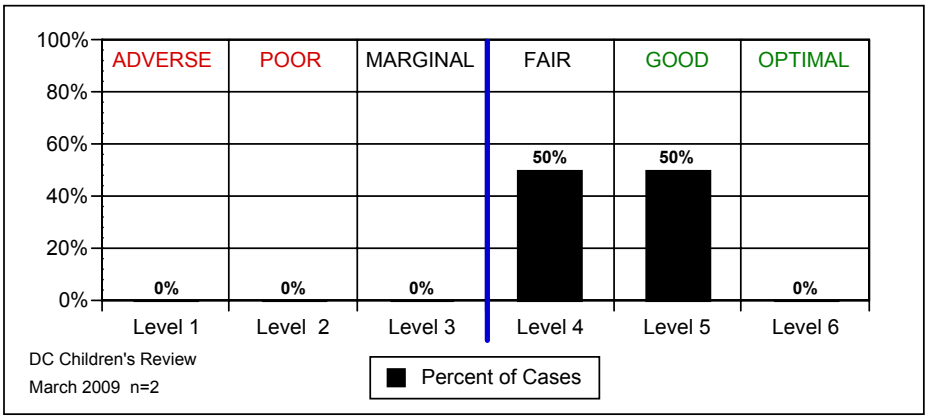


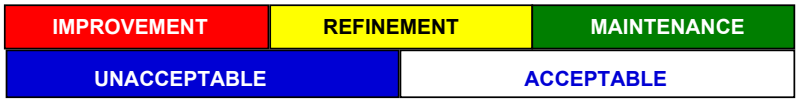
## Display 29b
## Outcome 2
## Overall Recent Progress



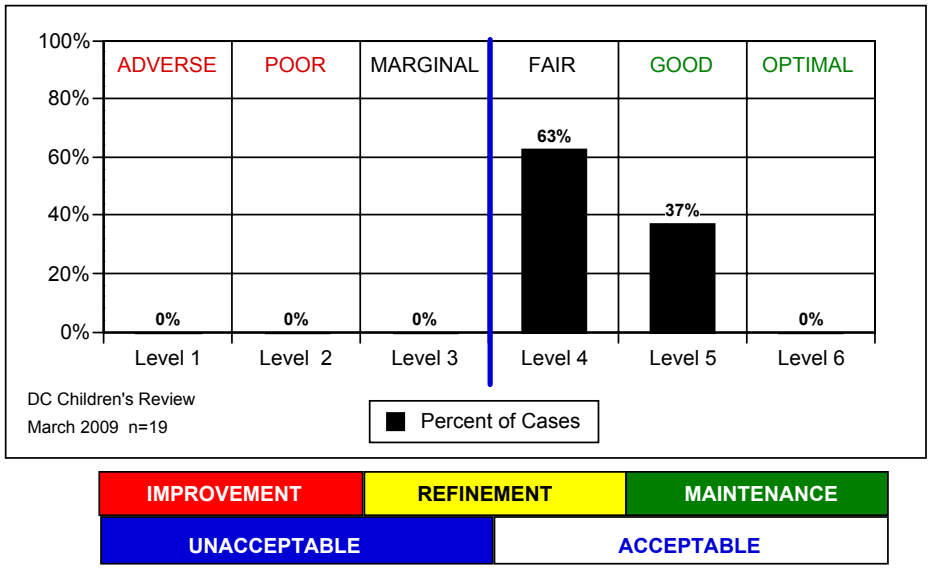




## Display 29c
## Outcome 2
## Overall Practice Performance



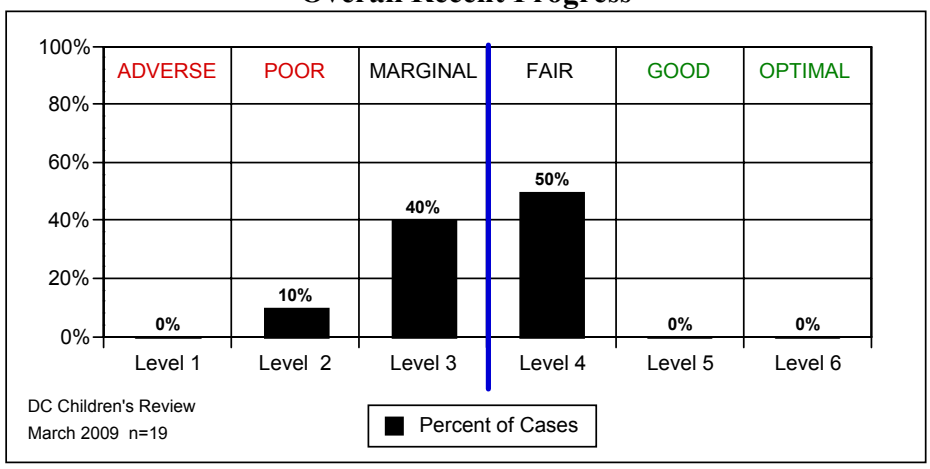



## Display 30a
## Outcome 3
## Overall Child/Youth Status



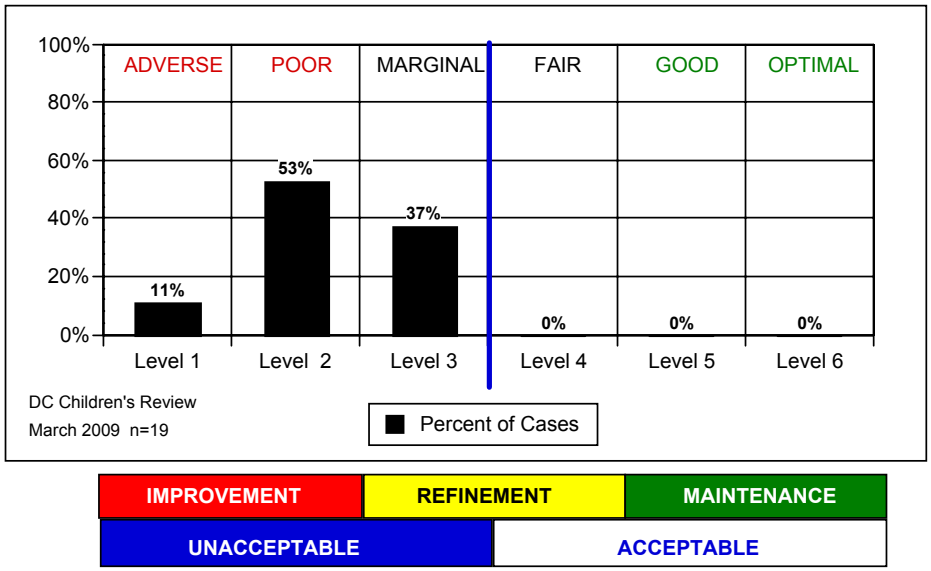

| IMPROVEMENT | REFINEMENT | MAINTENANCE |
|---|---|---|
| UNACCEPTABLE | ACCEPTABLE | |

## Display 30b
## Outcome 3
## Overall Recent Progress

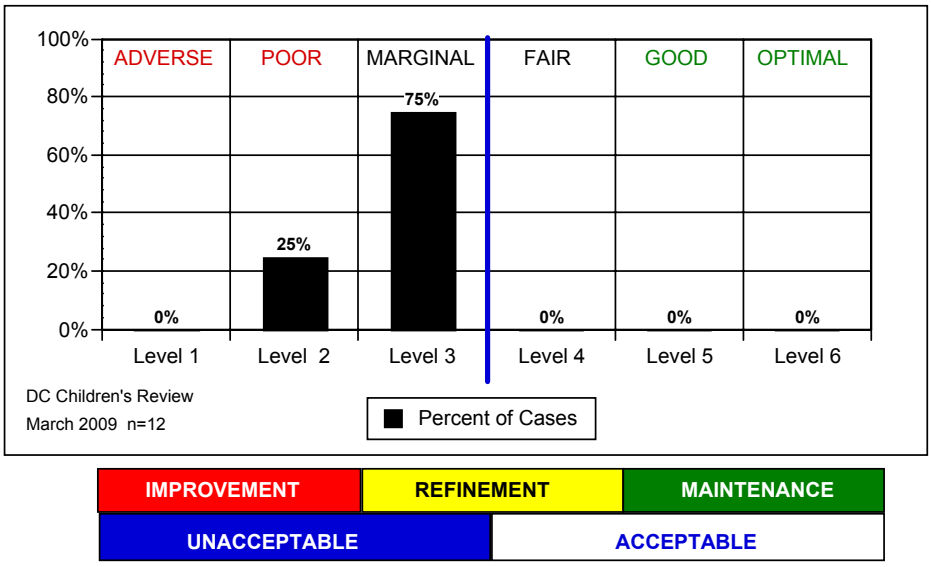



| IMPROVEMENT | REFINEMENT | MAINTENANCE |
|---|---|---|
| UNACCEPTABLE | ACCEPTABLE | |

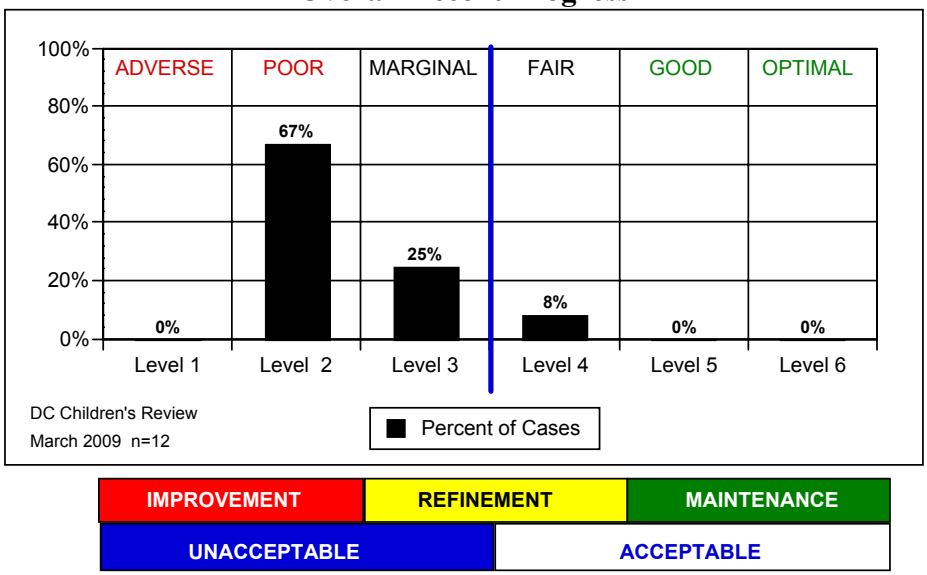
## Display 30c
## Outcome 3
## Overall Practice Performance



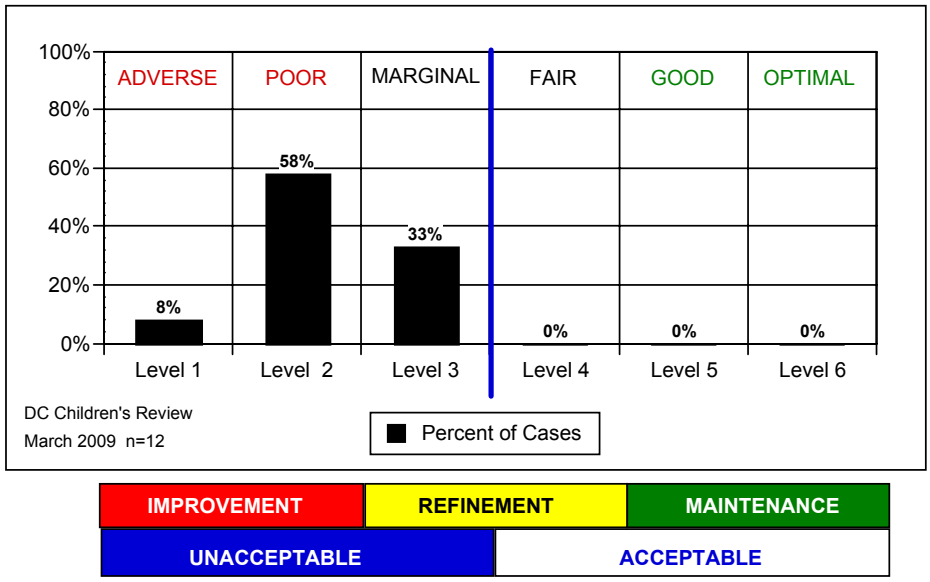

## Display 31a
## Outcome 4
## Overall Child/Youth Status



## Display 31b
## Outcome 4
## Overall Recent Progress



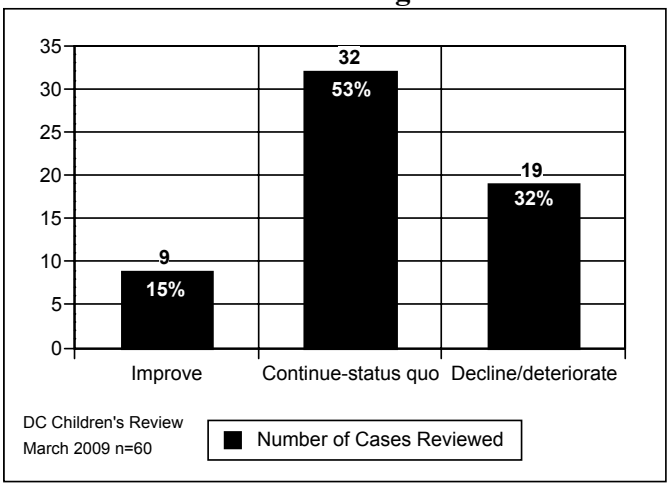

## Display 31c
## Outcome 4
## Overall Practice Performance



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. **Display 32** presents the six-month prognosis offered by reviewers for all children and youth in the review. As the display indicates, nine youth (15%) were expected to improve, 32 (53%) were expected to remain about the same, and 19 (32%) 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 2008 review—41% and 41%, respectively. There is a 3% decrease in the youth expected to improve over the next six months (18% in 2008).

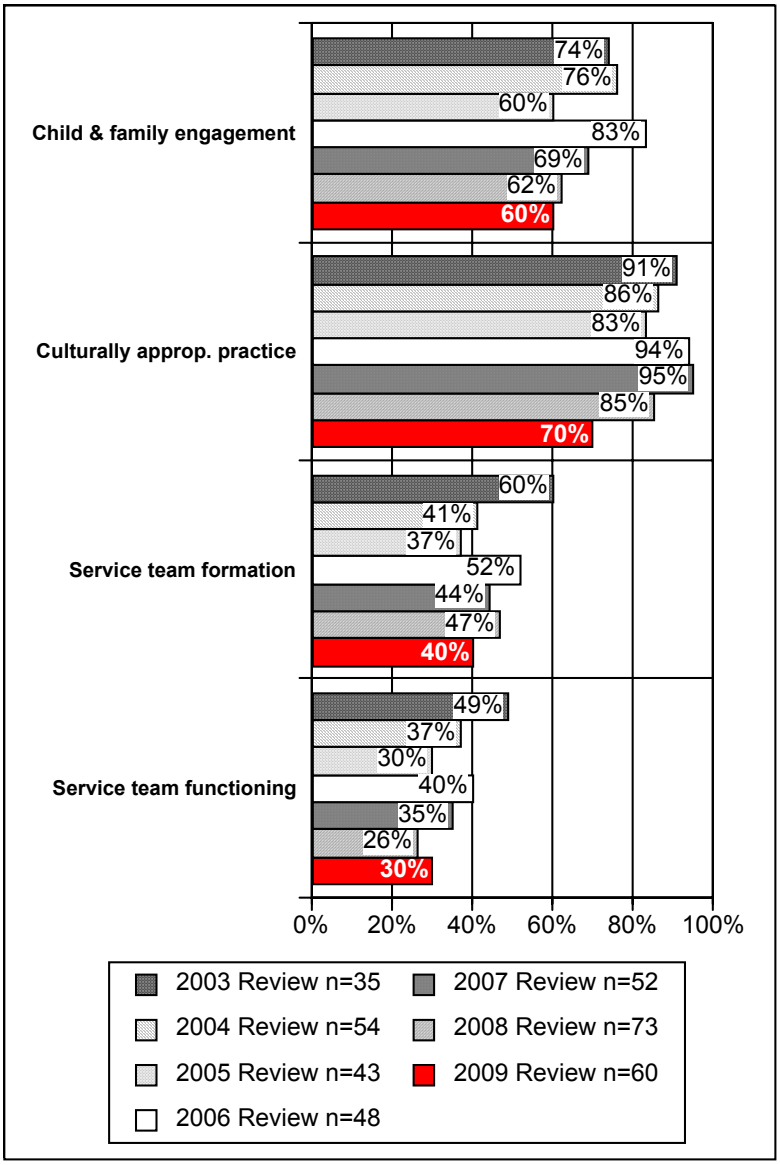
**Display 32**
**Six-Month Prognosis**




Overall, the results of the 2009 CSR data show that at a minimum, the consistency and quality of practice has improved somewhat over the past year, returning to the level reported in 2007. The percentage of children who are provided services with the quality, coordination, consistency, and diligence necessary to achieve progress and improvements in children has increased since the 2008 review; however, 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 of children and youth in the District of Columbia.

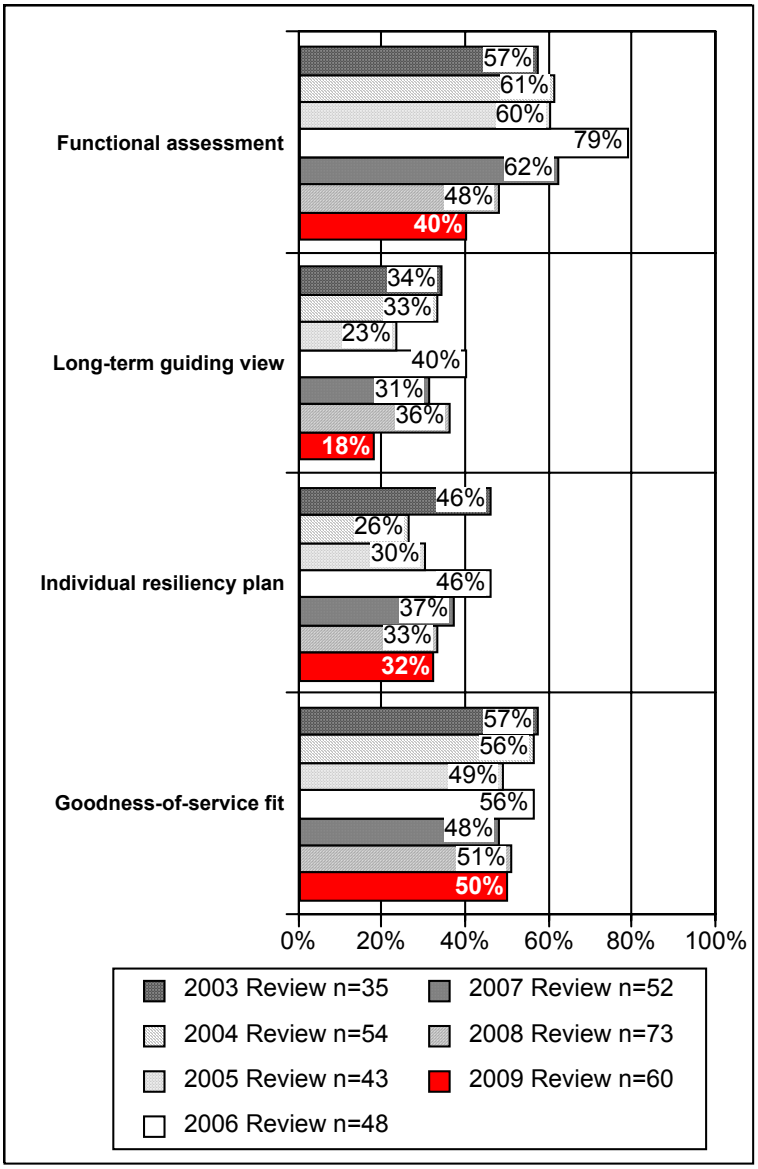
**Display 33** shows the results for practice performance for the seven years in which CSRs have been conducted. The data trends are clearly not showing that significant improvement is occurring in the consistent implementation of quality services. Challenges continue to be found in service team formation and functioning, understanding of underlying issues (assessment), identifying a long-term guiding view, individual plan development, coordination 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 seven years, at least as reflected in these measurements.

**Display 33**
**Overall Child Practice Performance Results for All Seven Reviews**



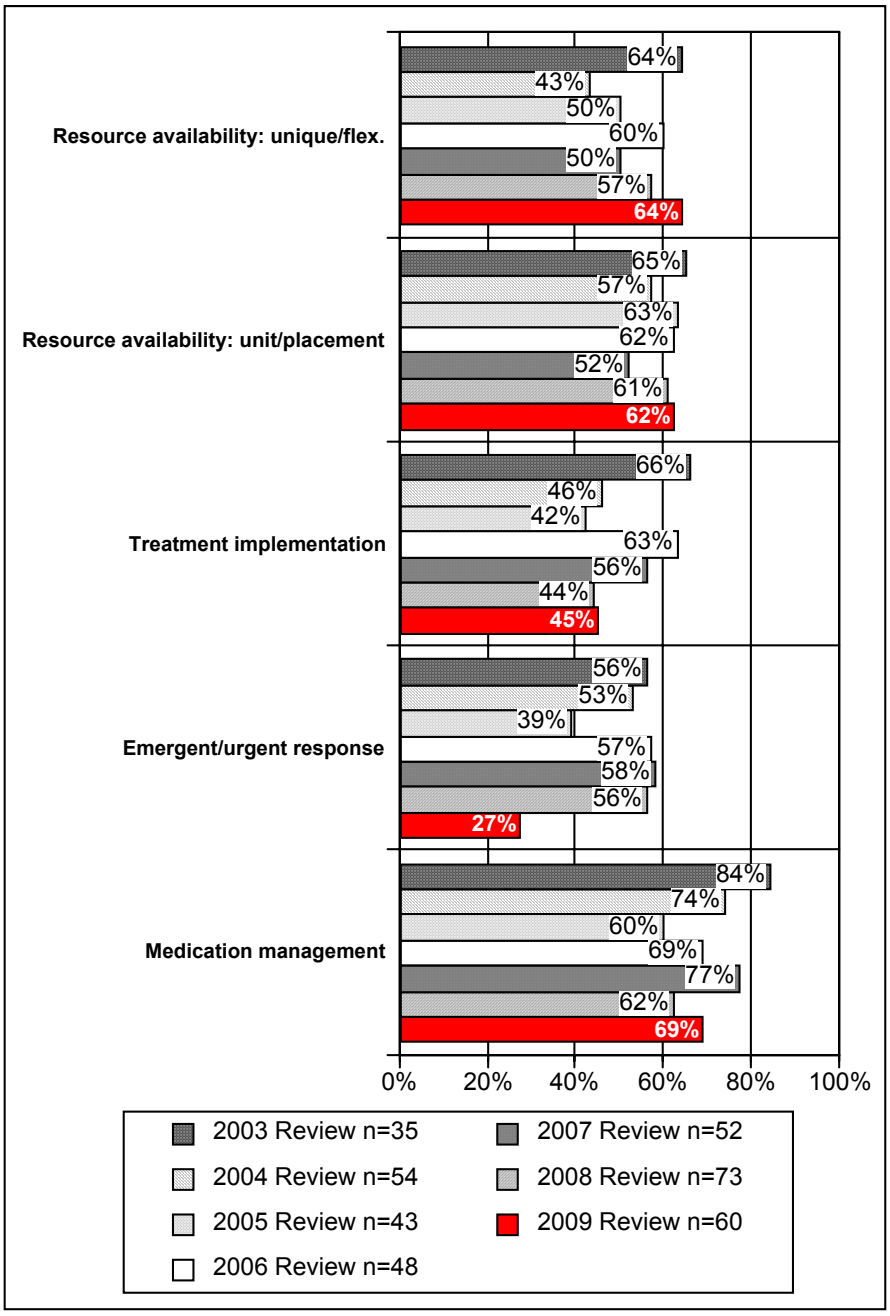

Data Compiled 4/09

**Display 33 (continued)**
**Overall Child Practice Performance Results for All Seven Reviews**



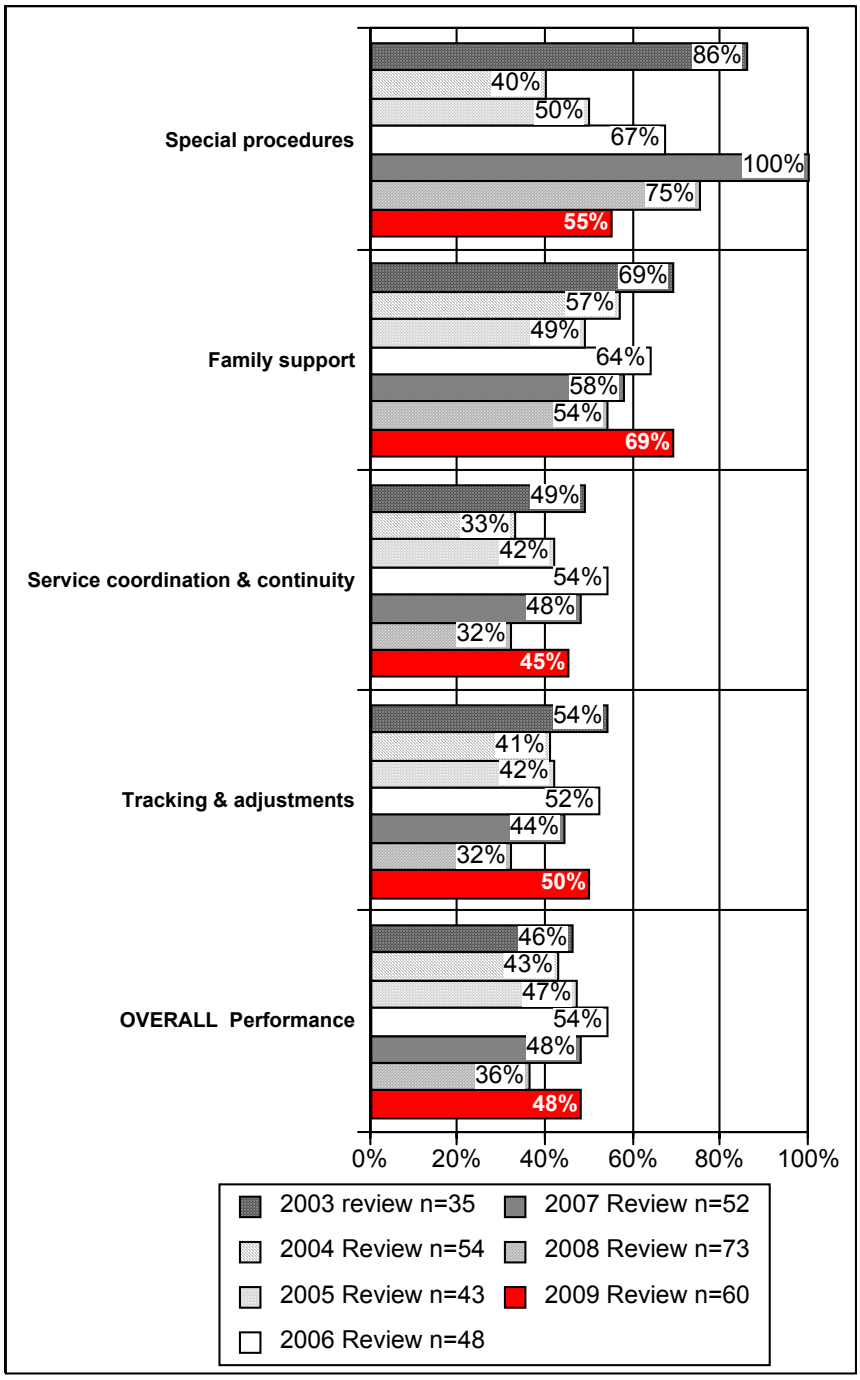

Data Compiled 4/09

**Display 33 (continued)**
**Overall Child Practice Performance Results for All Seven Reviews**




Data Compiled 4/09

**Display 33 (continued)**
**Overall Child Practice Performance Results for All Seven Reviews**




Data Compiled 4/09

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 60 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 2009 review of services for children and youth. Ratings of 60% or more in the acceptable range included engagement, culturally appropriate practice, resource availability, medication management, and family support. Ratings of 40% or fewer in the acceptable range included adequacy of team formation and functioning, functional assessment, long-term guiding view, individual resiliency planning, treatment implementation, emergency response, and service coordination. The latter are core areas of practice that have been identified as needing focused attention during the past several reviews. With an overall practice performance rating of 48% acceptable, it appears that System of Care core practice functions are not being delivered with quality and consistency for nearly one-half of the children and youth served. The themes and patterns identified by the reviewers illustrate these opportunities for improvement.

### Trends Seen Through Case Summaries

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

#### Education

- Performance and success in school are often key to a child or youth's overall status and progress. Youth who are near graduation but are failing academic subjects, as well as youth who are several years older than their grade-level peers and behind in earning credits toward

graduation, are at risk for dropping out of school. When patterns of academic failure develop, they should trigger team action. This requires communication among team members that should include the school, student, family, and core service provider staff. Someone on the team needs to have a working knowledge of the District's education system to help the team be proactive in tracking and intervening. See case summaries for TW, MP, DH, and TB.

- At least 55% of the children and youth in this sample received some form of special education services. Often, these students are highly mobile in regard to school assignments resulting from changes in living arrangements. For these children and youth, team members need to be vigilant to ensure that education placements are appropriate to the child's education needs, including the restrictiveness of the educational placement. Referrals for eligibility for special education services need to be tracked to ensure that evaluation information and IEPs occur within required timeframes, and they are transferred from school to school to ensure continuity. See case summaries for CP, DH, and SA.

- Many children in the sample had education advocates that helped and supported parents in their efforts to get the best possible education placement for their child. See case summary for DH.

Medical Issues

- More than one-half of the children and youth in this sample were prescribed at least one psychotropic medication. Ensuring that medications are taken as prescribed and that the prescriber, usually a psychiatrist, and the clinical therapist get feedback concerning the effectiveness of the medication on the child's behavior are essential components of treatment implementation and tracking and adjustment. Information from both home and school are important, requiring that a communication link exist across these environments and back to the psychiatrist and therapist. See case summaries for DT and AC.

- Some children have known medical conditions or may develop medication conditions that require tracking by a physician. When this is the case, the team should ensure that appropriate medical intervention is obtained. See case summaries for CP and DT.

Trauma-informed Assessment and Intervention

- Many of the children in the sample had histories of abuse and neglect, witnessing domestic violence and multiple residential placements during their developmental years. Growing up in chaotic and abusive environments has both immediate and long-term effects on a child or youth. Often serious acting-out behaviors are expressions of the anger, mistrust, and confusion these children have experienced. Effective interventions for these children should begin with clear identification of the issues underlying a child's behavior. Behavior for these children cannot be addressed in isolation. See case summaries for DY, MP, and MM.

Team Formation and Functioning

- For some children in the sample, team formation and functioning were examples of good practice. The appropriate people were involved and communicated regularly with each other. Often a parent plays a pivotal role in managing the service providers and ensuring that services are coordinated. See case summaries for SR, DH, EP, and DB.

- When teaming is lacking, communication (participation) is often the problem. At times, the lack of communication is across agencies, but just as frequently, the silence can occur between service providers in the same agency. If service providers work independently and fail to communicate and collaborate with each other, resources can be misused and, at times, interventions can work at cross purposes. There were concerns expressed during the stakeholder interviews that DYRS staff infrequently participate in teaming. See case summaries for NM and CS.

Planning for Transitions and Long-Term View

- As children and youth move toward eminent changes in living situations, school assignments, or changes in CSWs or therapists, the need for deliberate planning for those transitions becomes essential. When such changes are anticipated, the child and family can prepare and service providers can help them be prepared for the shift. When advance preparation does not occur, setbacks in progress may. See case summaries for KW and SR.

- Every goal in a treatment plan needs a path to get there. Goals may be short term, as in reducing or eliminating the need for medication, or long term, such as preparing for independent living. As youth enter their teens, treatment planning requires a long-term view so that courses in school, the diploma track selected, and vocational training resources can be put in place. See case summaries for AC and DA.

Stakeholder and Focus Group Observations

In addition to the child and family reviews, which included interviews with 377 persons, stakeholder interviews and focus groups were conducted with 102 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, 12 focus groups were conducted over a two-week period of time and included Core Service Agency staff and management, DMH senior staff, DYRS, CFSA, D.C. Public Schools, and three judges—Judge Parker, Judge Bush, and Judge Goldfrank.

- Stakeholders have difficulty understanding the funding streams that support children's services and which services children might be eligible for. Families, including foster families, can also have difficulty in this regard, thus, affecting the effectiveness of their advocacy on behalf of the children in their care.

- Some stakeholders expressed frustration that providers offer a "one size fits all" product. If a different service array is needed, the child and family have to develop a new relationship with a new provider, often resulting in disruption and discontinuity of services. Trauma-

informed therapy was a resource identified as needed but not available in sufficient quality or quantity to meet the demand. Several case summaries offered examples of the need. Frontline staff commented in focus groups that in order to participate in trauma-informed therapy or CBT training, they had to use personal leave time so that their billable hours would not be affected.

- Teaming is challenging. Collecting relevant information about a child and family within the required timeframes, identifying and getting the "right" people together, working through transportation barriers and travel distances (some children are in foster care in Maryland), followed by accessing the needed and agreed-upon services without delays are some of the challenges. Each agency works within its own priorities and these are not always complementary.

- Part of the teaming challenge is determining which agency will take the lead in each case. Ambiguity about leadership and accountability within a team can lead to false starts, miscommunications, unilateral decisions, and confusion for the child and family.

- Psychiatric inpatient beds in the District are time-limited, but lacking an appropriate community placement, children and youth may exceed the 42-day limit for hospitalizations. Transition from inpatient hospitals or residential treatment facilities to the community requires planning and coordination with the family, mental health service provider, and school. The standard for discharge planning and re-entry varies among agencies. A method for projecting the number of clients returning to the community within designated timeframes would be helpful information for providers.

- Some stakeholders expressed concern for the wait time in obtaining an appointment and office visit to see a physician or psychiatrist. Others offered examples of excessive delays for assessments; this is of particular concern for very young children. On the other hand, stakeholders were complimentary of efforts to identify evaluations completed by other agencies resulting in a reduction in redundant evaluations and duplication of effort.

- Young adults in need of the Independent Living Program's resources are often faced with a waiting list for these services.

- Provider agencies observed that they have geared up and improved their capacity to handle an increased client load, but referrals for services have not been forthcoming. New staff are hired, but the new clients are not coming in the door at some agencies.

- Interviews and focus group discussions indicated a concern that some therapeutic foster home parents might not have the training and skill level needed to manage the children and youth placed in their care.

- Children and youth placed in foster homes in Maryland can create challenges for both the caseworker or CSW and the foster parent. For any service provider using an in-home model, travel distances from the office to a child's foster home or between foster homes can be substantial. These foster parents must travel similar distances to take their children to services in the District.

## Conclusions and Recommendations

The review process identified many and varied strengths in the District's system for children's mental health services. These included the following:

- The DMH leadership team is committed to their mission and each member brings expertise in developing the System of Care model.

- Creation of the mobile crisis team is viewed as a positive investment of resources, as is the expansion of the wraparound program to serving 100 children. In spite of having no new resources, school-based mental health services have expanded to include 58 schools, eight of which are middle schools, and some schools include preschool students. A pilot preschool program will involve a childcare center and add the expertise of an early childhood consultant. Judges expressed support for these types of early intervention and prevention

efforts, and they acknowledged the positive contribution of monthly meetings with DMH. DMH staff's presence in court was also acknowledged as positive. Partnerships between special education program and school-based mental health staff are yielding positive results for children and youth with challenging behaviors.

- CFSA staff participated in case reviews that involved their clients this year, as in 2008. These staff were engaged in the review process, made contributions to the interviews, and attended the team debriefing sessions held in the evenings. Both CFSA and DMH have CSR units with dedicated staff. The co-location of a DMH team (consisting of a clinical psychologist, licensed social worker, and certified mental health specialist) at CFSA, which was instituted in 2007, is a collaborative model that could be expanded upon.

- The CSW position appears to be experiencing a reduced rate of turnover in some agencies. These positions are the "glue" that holds some cases together. This is largely a result of the CSWs engaging with families; knowing when to seek help; and the flexible nature of their positions, e.g., meeting their clients at home or at school, in the evenings, and on weekends. School staff reported that they rely on the CSW and/or the family to keep the lines of communication open and the flow of information timely. This adds emphasis to the important role of the CSW for school-age children and youth, as well as their need for training in these areas.

- Case managers reported, and the data confirmed, that caseloads were, in most instances, lower than in prior years. Some examples were identified of supervisors providing clinical supervision regularly and on an as-needed basis. However, supervision needs continued refinement and emphasis. Screening of applicants has been designed to identify those candidates with the greatest potential for commitment. Foster parents commented that they felt more included in the teaming process, able to access agency personnel when needed, and their voices were being heard so they could influence the tailoring of services.

- An 18-month Trauma Learning Collaborative, which is a training and coaching initiative focusing on trauma was introduced in March 2009. The course includes classroom

instruction as well as telephonic and online learning activities. This will help address the growing need for trauma-informed therapy for the District's neglected and abused children.

- Although many system challenges remain and the children and youth served are themselves challenging, 77% of the children and youth reviewed had acceptable overall status and more than one-half (55%) of them were making acceptable progress.

- DMH staff are monitoring the placement of all children and youth in psychiatric residential treatment facilities, regardless of which agency placed the child or youth.

Challenges for DMH continue to be providing leadership in the adoption of the System of Care model across service providers, with teaming, engagement of families, and assessment and understanding at the foundation. Court judges commented that DMH was helping to improve communication, sharing of information, and timely access to services across the child-serving agencies in the District. With the increase in domestic violence, criminal activity, housing issues, civil commitments, and the complexity of neglect cases in the District, mental health agencies must be able to respond to the increasing demand for services while preserving continuity of care for children to the extent possible. Often, agencies are constrained by funding limitations and Medicaid procedures frequently impede fast action for the strategic use of funds.

Designating a lead person for each team is critical for clarity and accountability. The designation of a lead or point person should be reflective of the child or youth's situation, for example, CFSA would likely be the team leader for a child in foster care while the school or a mental health case manager might be the appropriate leader for a child living at home.

Staff reported that the amount of tracking and other "paperwork" is increasing, but the emphasis on billable hours has not changed. There is a sense that data are collected for the sake of the activity, not its utility, and workers reported they rarely receive any feedback or reports that help them in their jobs as a result of the data they submit. There was also a sense that requests for data come randomly and are not coordinated from a single point or clearinghouse.

Budgeting, billings, and cash flow continue to be challenges for provider agencies. Although calls are made to remind clients of appointments, CSWs follow up with those who miss their appointments, and some therapists provide therapy in the home, no-show rates continue to be high, making billing unpredictable.

Some agencies continue to serve clients with developmental disabilities who are not responding to treatment plan interventions. For these children and youth, service providers with knowledge and experience in working with persons with developmental disabilities would be more effective than the use of mental health resources and traditional mental health strategies. For other clients who have benefitted from services, a clear reason for a mental health intervention may not be evident at present. Provider agencies should be encouraged to review the status of cases to identify those that can be appropriately dismissed from services if they have met their treatment goals and have demonstrated an appropriate level of stability over an appropriate period of time.

Recommendations

There are two core issues that are the foundation of high quality consistent System of Care practice that continue to be major challenges. To overcome these challenges, timely communication between the therapist, psychiatrist, child support worker, school personnel, child welfare worker, and juvenile probation officer involved with a family must occur.

The first issue is that adequate and complete understanding of each child and family's individual context, including clarification of diagnoses, functional issues within the family, and support needs of caregivers must be achieved. Developing this full understanding (assessment) and the development of a coherent and coordinated plan to address all necessary areas of need are ongoing challenges in District practice. Full understanding includes recognizing and addressing barriers to transportation to appointments; appropriate interventions for co-occurring conditions, such as developmental disabilities, including autism, parental psychological, physical, and functional limitations and challenges; and issues of permanency. It also includes understanding the child status relative to learning and performing in school; areas of strengths, passions, and

internal and external assets; as well as how to engage the child in satisfying and productive activities.

The second major issue is the ability to create functional teams that work in partnership with the family to address the child's and family's needs in a coordinated manner. Staff report that when good teaming occurs, the process works. When this happens, the child and family typically make progress, and it is a rewarding and satisfying experience for the staff who work on the team. HSO's Quality Services Review data collected across the country support these conclusions. Good teamwork, communication, and coordination get substantially better results. In order to create more consistent and effective teams around each child and family served, it is critical that each agency place high priority on team participation and follow-through. It is also essential that an interagency work group problem-solves barriers to teaming until the data show that teaming, appropriate to the needs of each child and family, is occurring.

While there are still a number of other issues that need to be addressed, if these two foundational issues are not addressed and significant improvement in quality and consistency made, practice will continue to be inconsistent, poorly coordinated, and less beneficial for the children and families that are served.

We would like to thank the DMH staff for their full cooperation and support in conducting and completing this review, which focused on training, practice development, and feedback. We would also like to thank the Court Monitor and Consumer Action Network for their support and commitment in organizing and managing the logistics for the process.

# 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= 3 DC Child Review March 2009

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

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

## CSR/Child Status and Performance Profile

Affordable Behavioral Consultants | n= 3 | DC Child Review March 2009

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

## CSR/Child Status and Performance Profile

Center for Therapeutic Concepts n= 1 DC Child Review March 2009

| 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% | 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 | 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% | 0% | 100% |
| Behavior improvement | 1 | 100% | 0% | 0% | 100% |
| School/work progress | 1 | 100% | 0% | 0% | 100% |
| Risk reduction | | | | | |
| 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

Center for Therapeutic Concepts n= 1 DC Child Review March 2009

| Current Practice Performance | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Child & family engagement | 1 | 100% | 0% | 100% | 0% |
| Culturally appropriate practice | | | | | |
| Service team formation | 1 | 0% | 100% | 0% | 0% |
| Service team functioning | 1 | 0% | 100% | 0% | 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% | 100% | 0% |
| Resource avail.: unique/flex. | 1 | 100% | 0% | 0% | 100% |
| Resource availability: unit/place. | | | | | |
| Treatment implementation | 1 | 100% | 0% | 0% | 100% |
| Emergent/urgent response | | | | | |
| Medication management | | | | | |
| Special procedures | | | | | |
| Familty support | | | | | |
| Service coord. & continuity | 1 | 100% | 0% | 0% | 100% |
| Tracking & adjustment | 1 | 100% | 0% | 0% | 100% |
| Overall Practice Performance | 1 | 100% | 0% | 100% | 0% |

## CSR/Child Status and Performance Profile

Community Connections n= 12 DC Child Review March 2009

| Child & Family Status | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 12 | 83% | 0% | 33% | 67% |
| Stability | 12 | 75% | 0% | 67% | 33% |
| Home & school placement | 12 | 83% | 17% | 17% | 67% |
| Caregiver support of child | 12 | 83% | 0% | 50% | 50% |
| Satisfaction | 12 | 67% | 17% | 42% | 42% |
| Health/Phy well-being | 12 | 100% | 0% | 42% | 58% |
| Functional status | 12 | 58% | 8% | 58% | 33% |
| Academic status | 12 | 25% | 33% | 50% | 17% |
| Responsible social behavior | 12 | 58% | 17% | 42% | 42% |
| Lawful behavior | 8 | 88% | 0% | 25% | 75% |
| Overall C & F Status | 12 | 83% | 8% | 75% | 17% |

| Recent Progress | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Symptom reduction | 12 | 67% | 8% | 67% | 25% |
| Behavior improvement | 12 | 50% | 25% | 42% | 33% |
| School/work progress | 12 | 33% | 33% | 42% | 25% |
| Risk reduction | 11 | 36% | 27% | 36% | 36% |
| Transition progress | 11 | 18% | 45% | 45% | 9% |
| Meaningful relationships | 12 | 83% | 17% | 50% | 33% |
| Overall Progress | 12 | 25% | 25% | 58% | 17% |

## CSR/Child Status and Performance Profile

Community Connections n= 12 DC Child Review March 2009

| Current Practice Performance | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Child & family engagement | 12 | 67% | 8% | 33% | 58% |
| Culturally appropriate practice | 4 | 100% | 0% | 50% | 50% |
| Service team formation | 12 | 33% | 42% | 58% | 0% |
| Service team functioning | 12 | 17% | 75% | 25% | 0% |
| Functional assessment | 12 | 42% | 33% | 50% | 17% |
| Long-term guiding view | 12 | 0% | 75% | 25% | 0% |
| IRP | 12 | 25% | 58% | 42% | 0% |
| Goodness-of-service fit | 12 | 42% | 17% | 83% | 0% |
| Resource avail.: unique/flex. | 11 | 55% | 9% | 64% | 27% |
| Resource availability: unit/place. | 11 | 64% | 9% | 73% | 18% |
| Treatment implementation | 12 | 25% | 8% | 67% | 25% |
| Emergent/urgent response | 3 | 0% | 67% | 33% | 0% |
| Medication management | 8 | 75% | 13% | 63% | 25% |
| Special procedures | 1 | 0% | 0% | 100% | 0% |
| Family support | 12 | 67% | 8% | 83% | 8% |
| Service coord. & continuity | 12 | 33% | 42% | 50% | 8% |
| Tracking & adjustment | 12 | 33% | 42% | 50% | 8% |
| Overall Practice Performance | 12 | 25% | 33% | 67% | 0% |

## CSR/Child Status and Performance Profile

DC/MD Family Resources n= 2 DC Child Review March 2009

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

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

## CSR/Child Status and Performance Profile

DC/MD Family Resources n= 2 DC Child Review March 2009

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

## CSR/Child Status and Performance Profile

Family & Child Services n= 4 DC Child Review March 2009

| Child & Family Status | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 4 | 100% | 0% | 50% | 50% |
| Stability | 4 | 50% | 0% | 75% | 25% |
| Home & school placement | 4 | 100% | 0% | 25% | 75% |
| Caregiver support of child | 4 | 100% | 0% | 75% | 25% |
| Satisfaction | 3 | 100% | 0% | 33% | 67% |
| Health/Phy well-being | 4 | 100% | 0% | 50% | 50% |
| Functional status | 4 | 50% | 25% | 50% | 25% |
| Academic status | 4 | 75% | 0% | 50% | 50% |
| Responsible social behavior | 4 | 75% | 0% | 50% | 50% |
| Lawful behavior | 2 | 100% | 0% | 50% | 50% |
| Overall C & F Status | 4 | 100% | 0% | 50% | 50% |

| Recent Progress | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Symptom reduction | 4 | 50% | 0% | 75% | 25% |
| Behavior improvement | 4 | 75% | 0% | 50% | 50% |
| School/work progress | 4 | 75% | 0% | 50% | 50% |
| Risk reduction | 4 | 75% | 0% | 75% | 25% |
| Transition progress | 3 | 33% | 0% | 67% | 33% |
| Meaningful relationships | 4 | 75% | 0% | 75% | 25% |
| Overall Progress | 4 | 50% | 0% | 50% | 50% |

## CSR/Child Status and Performance Profile

Family & Child Services n= 4 DC Child Review March 2009

| Current Practice Performance | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Child & family engagement | 4 | 75% | 0% | 100% | 0% |
| Culturally appropriate practice | | | | | |
| Service team formation | 4 | 50% | 0% | 50% | 50% |
| Service team functioning | 4 | 50% | 50% | 25% | 25% |
| Functional assessment | 4 | 75% | 25% | 75% | 0% |
| Long-term guiding view | 4 | 50% | 25% | 50% | 25% |
| IRP | 4 | 50% | 25% | 25% | 50% |
| Goodness-of-service fit | 4 | 75% | 25% | 50% | 25% |
| Resource avail.: unique/flex. | 3 | 67% | 0% | 100% | 0% |
| Resource availability: unit/place. | 3 | 100% | 0% | 33% | 67% |
| Treatment implementation | 4 | 75% | 25% | 50% | 25% |
| Emergent/urgent response | 2 | 50% | 0% | 50% | 50% |
| Medication management | 4 | 100% | 0% | 75% | 25% |
| Special procedures | 1 | 0% | 0% | 100% | 0% |
| Family support | 4 | 75% | 25% | 50% | 25% |
| Service coord. & continuity | 4 | 75% | 25% | 25% | 50% |
| Tracking & adjustment | 4 | 75% | 25% | 25% | 50% |
| Overall Practice Performance | 4 | 75% | 25% | 25% | 50% |

## CSR/Child Status and Performance Profile

Family Preservation n= 3 DC Child Review March 2009

| Child & Family Status | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 3 | 100% | 0% | 67% | 33% |
| Stability | 3 | 67% | 0% | 100% | 0% |
| Home & school placement | 3 | 100% | 0% | 33% | 67% |
| Caregiver support of child | 3 | 100% | 0% | 33% | 67% |
| Satisfaction | 3 | 33% | 33% | 33% | 33% |
| Health/Phy well-being | 3 | 100% | 0% | 33% | 67% |
| Functional status | 3 | 100% | 0% | 33% | 67% |
| Academic status | 3 | 100% | 0% | 0% | 100% |
| Responsible social behavior | 3 | 100% | 0% | 67% | 33% |
| Lawful behavior | 2 | 50% | 0% | 50% | 50% |
| Overall C & F Status | 3 | 100% | 0% | 67% | 33% |

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

## CSR/Child Status and Performance Profile

Family Preservation n= 3 DC Child Review March 2009

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

## CSR/Child Status and Performance Profile

Fihankra Place n= 1 DC Child Review March 2009

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

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

## CSR/Child Status and Performance Profile

Fihankra Place n= 1 DC Child Review March 2009

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

## CSR/Child Status and Performance Profile

First Home Care n= 12 DC Child Review March 2009

| Child & Family Status | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 12 | 92% | 0% | 25% | 75% |
| Stability | 12 | 92% | 8% | 50% | 42% |
| Home & school placement | 12 | 83% | 17% | 17% | 67% |
| Caregiver support of child | 12 | 75% | 8% | 25% | 67% |
| Satisfaction | 12 | 83% | 8% | 58% | 33% |
| Health/Phy well-being | 12 | 83% | 17% | 8% | 75% |
| Functional status | 12 | 83% | 8% | 58% | 33% |
| Academic status | 12 | 58% | 25% | 25% | 50% |
| Responsible social behavior | 12 | 75% | 25% | 42% | 33% |
| Lawful behavior | 7 | 86% | 14% | 0% | 86% |
| Overall C & F Status | 12 | 75% | 8% | 50% | 42% |

| Recent Progress | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Symptom reduction | 12 | 67% | 17% | 42% | 42% |
| Behavior improvement | 12 | 67% | 17% | 42% | 42% |
| School/work progress | 12 | 58% | 17% | 42% | 42% |
| Risk reduction | 11 | 55% | 18% | 64% | 18% |
| Transition progress | 10 | 30% | 40% | 40% | 20% |
| Meaningful relationships | 12 | 75% | 0% | 58% | 42% |
| Overall Progress | 12 | 67% | 17% | 58% | 25% |

## CSR/Child Status and Performance Profile

First Home Care n= 12 DC Child Review March 2009

| Current Practice Performance | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Child & family engagement | 12 | 58% | 8% | 50% | 42% |
| Culturally appropriate practice | 5 | 60% | 20% | 40% | 40% |
| Service team formation | 12 | 58% | 25% | 50% | 25% |
| Service team functioning | 12 | 42% | 33% | 58% | 8% |
| Functional assessment | 12 | 42% | 17% | 58% | 25% |
| Long-term guiding view | 12 | 17% | 42% | 42% | 17% |
| IRP | 12 | 42% | 25% | 75% | 0% |
| Goodness-of-service fit | 12 | 42% | 8% | 75% | 17% |
| Resource avail.: unique/flex. | 12 | 75% | 0% | 58% | 42% |
| Resource availability: unit/place. | 9 | 78% | 0% | 44% | 56% |
| Treatment implementation | 12 | 50% | 17% | 50% | 33% |
| Emergent/urgent response | 4 | 25% | 50% | 50% | 0% |
| Medication management | 6 | 67% | 33% | 33% | 33% |
| Special procedures | 4 | 50% | 0% | 50% | 50% |
| Family support | 10 | 70% | 0% | 70% | 30% |
| Service coord. & continuity | 12 | 33% | 17% | 58% | 25% |
| Tracking & adjustment | 12 | 58% | 25% | 58% | 17% |
| Overall Practice Performance | 12 | 50% | 33% | 42% | 25% |

## CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 1 DC Child Review March 2009

| Child & Family Status | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 1 | 100% | 0% | 100% | 0% |
| 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% | 0% | 100% |
| Health/Phy well-being | 1 | 100% | 0% | 0% | 100% |
| Functional status | 1 | 0% | 0% | 100% | 0% |
| Academic status | 1 | 0% | 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 | 1 | 100% | 0% | 100% | 0% |
| Transition progress | 1 | 100% | 0% | 0% | 100% |
| Meaningful relationships | 1 | 100% | 0% | 0% | 100% |
| Overall Progress | 1 | 100% | 0% | 100% | 0% |

## CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 1 DC Child Review March 2009

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

## CSR/Child Status and Performance Profile

Latin American Youth Services n= 1 DC Child Review March 2009

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

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

## CSR/Child Status and Performance Profile

Latin American Youth Services n= 1 DC Child Review March 2009

| Current Practice Performance | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Child & family engagement | 1 | 100% | 0% | 100% | 0% |
| Culturally appropriate practice | | | | | |
| Service team formation | 1 | 0% | 0% | 100% | 0% |
| Service team functioning | 1 | 100% | 0% | 100% | 0% |
| Functional assessment | 1 | 0% | 0% | 100% | 0% |
| Long-term guiding view | 1 | 0% | 100% | 0% | 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% | 100% | 0% |
| Emergent/urgent response | | | | | |
| Medication management | 1 | 100% | 0% | 0% | 100% |
| Special procedures | | | | | |
| Family support | 1 | 0% | 0% | 100% | 0% |
| Service coord. & continuity | 1 | 100% | 0% | 100% | 0% |
| Tracking & adjustment | 1 | 100% | 0% | 100% | 0% |
| Overall Practice Performance | 1 | 100% | 0% | 100% | 0% |

## CSR/Child Status and Performance Profile

Launch LLC n= 6 DC Child Review March 2009

| Child & Family Status | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 6 | 100% | 0% | 0% | 100% |
| Stability | 6 | 83% | 0% | 50% | 50% |
| Home & school placement | 6 | 100% | 0% | 0% | 100% |
| Caregiver support of child | 6 | 83% | 0% | 33% | 67% |
| Satisfaction | 6 | 100% | 0% | 17% | 83% |
| Health/Phy well-being | 6 | 100% | 0% | 17% | 83% |
| Functional status | 6 | 100% | 0% | 33% | 67% |
| Academic status | 6 | 100% | 0% | 50% | 50% |
| Responsible social behavior | 6 | 100% | 0% | 17% | 83% |
| Lawful behavior | 3 | 100% | 0% | 0% | 100% |
| Overall C & F Status | 6 | 100% | 0% | 0% | 100% |

| Recent Progress | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Symptom reduction | 6 | 100% | 0% | 17% | 83% |
| Behavior improvement | 6 | 100% | 0% | 33% | 67% |
| School/work progress | 6 | 100% | 0% | 17% | 83% |
| Risk reduction | 3 | 100% | 0% | 67% | 33% |
| Transition progress | 5 | 100% | 0% | 40% | 60% |
| Meaningful relationships | 6 | 100% | 0% | 17% | 83% |
| Overall Progress | 6 | 100% | 0% | 17% | 83% |

## CSR/Child Status and Performance Profile

Launch LLC n= 6 DC Child Review March 2009

| Current Practice Performance | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Child & family engagement | 6 | 67% | 17% | 17% | 67% |
| Culturally appropriate practice | 3 | 67% | 0% | 33% | 67% |
| Service team formation | 6 | 67% | 17% | 50% | 33% |
| Service team functioning | 6 | 33% | 50% | 33% | 17% |
| Functional assessment | 6 | 50% | 17% | 50% | 33% |
| Long-term guiding view | 6 | 50% | 33% | 33% | 33% |
| IRP | 6 | 50% | 0% | 83% | 17% |
| Goodness-of-service fit | 6 | 83% | 17% | 33% | 50% |
| Resource avail.: unique/flex. | 6 | 100% | 0% | 33% | 67% |
| Resource availability: unit/place. | 3 | 67% | 33% | 0% | 67% |
| Treatment implementation | 6 | 67% | 17% | 33% | 50% |
| Emergent/urgent response | 1 | 100% | 0% | 0% | 100% |
| Medication management | 2 | 100% | 0% | 50% | 50% |
| Special procedures | 1 | 100% | 0% | 0% | 100% |
| Family support | 5 | 80% | 0% | 40% | 60% |
| Service coord. & continuity | 6 | 67% | 17% | 50% | 33% |
| Tracking & adjustment | 6 | 67% | 17% | 50% | 33% |
| Overall Practice Performance | 6 | 67% | 17% | 50% | 33% |

## CSR/Child Status and Performance Profile

Mary's Center n= 1 DC Child Review March 2009

| 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% | 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% | 100% | 0% |
| School/work progress | 1 | 100% | 0% | 0% | 100% |
| Risk reduction | 1 | 100% | 0% | 0% | 100% |
| Transition progress | | | | | |
| Meaningful relationships | 1 | 100% | 0% | 100% | 0% |
| Overall Progress | 1 | 100% | 0% | 0% | 100% |

## CSR/Child Status and Performance Profile

Mary's Center n= 1 DC Child Review March 2009

| 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% | 100% | 0% |
| Service team functioning | 1 | 100% | 0% | 100% | 0% |
| Functional assessment | 1 | 100% | 0% | 100% | 0% |
| Long-term guiding view | 1 | 0% | 0% | 100% | 0% |
| IRP | 1 | 0% | 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. | | | | | |
| Treatment implementation | 1 | 100% | 0% | 100% | 0% |
| Emergent/urgent response | | | | | |
| Medication management | 1 | 100% | 0% | 0% | 100% |
| Special procedures | | | | | |
| Family support | 1 | 100% | 0% | 100% | 0% |
| Service coord. & continuity | 1 | 100% | 0% | 100% | 0% |
| Tracking & adjustment | 1 | 100% | 0% | 0% | 100% |
| Overall Practice Performance | 1 | 100% | 0% | 100% | 0% |

## CSR/Child Status and Performance Profile

Progressive Life n= 3 DC Child Review March 2009

| Child & Family Status | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 3 | 67% | 0% | 67% | 33% |
| Stability | 3 | 0% | 33% | 67% | 0% |
| Home & school placement | 3 | 0% | 67% | 33% | 0% |
| Caregiver support of child | 3 | 67% | 33% | 67% | 0% |
| Satisfaction | 2 | 50% | 0% | 50% | 50% |
| Health/Phy well-being | 3 | 67% | 33% | 33% | 33% |
| Functional status | 3 | 0% | 33% | 67% | 0% |
| Academic status | 3 | 0% | 33% | 67% | 0% |
| Responsible social behavior | 3 | 0% | 67% | 33% | 0% |
| Lawful behavior | 2 | 50% | 0% | 100% | 0% |
| Overall C & F Status | 3 | 0% | 0% | 100% | 0% |

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

## CSR/Child Status and Performance Profile

Progressive Life n= 3 DC Child Review March 2009

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

## CSR/Child Status and Performance Profile

RCI - Counseling | n= 1 | DC Child Review March 2009

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

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

## CSR/Child Status and Performance Profile

RCI - Counseling n= 1 DC Child Review March 2009

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

## CSR/Child Status and Performance Profile

**Scruples Corporation** n= 2 DC Child Review March 2009

| Child & Family Status | Cases applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 2 | 100% | 0% | 50% | 50% |
| Stability | 2 | 100% | 0% | 0% | 100% |
| Home & school placement | 2 | 100% | 0% | 0% | 100% |
| Caregiver support of child | 2 | 100% | 0% | 50% | 50% |
| Satisfaction | 2 | 50% | 0% | 50% | 50% |
| Health/Phy well-being | 2 | 100% | 0% | 50% | 50% |
| Functional status | 2 | 100% | 0% | 50% | 50% |
| Academic status | 2 | 100% | 0% | 0% | 100% |
| Responsible social behavior | 2 | 100% | 0% | 100% | 0% |
| Lawful behavior | 1 | 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% | 100% | 0% |
| School/work progress | 2 | 100% | 0% | 0% | 100% |
| Risk reduction | 2 | 50% | 0% | 50% | 50% |
| Transition progress | 2 | 100% | 0% | 50% | 50% |
| Meaningful relationships | 2 | 100% | 0% | 50% | 50% |
| Overall Progress | 2 | 100% | 0% | 50% | 50% |

## CSR/Child Status and Performance Profile

Scruples Corporation n= 2 DC Child Review March 2009

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

## CSR/Child Status and Performance Profile

Universal Health Care n= 7 DC Child Review March 2009

| Child & Family Status | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Safety of the child | 7 | 71% | 0% | 57% | 43% |
| Stability | 7 | 71% | 14% | 29% | 57% |
| Home & school placement | 7 | 100% | 0% | 43% | 57% |
| Caregiver support of child | 7 | 86% | 14% | 14% | 71% |
| Satisfaction | 6 | 83% | 0% | 67% | 33% |
| Health/Phy well-being | 7 | 86% | 0% | 29% | 71% |
| Functional status | 7 | 57% | 29% | 43% | 29% |
| Academic status | 7 | 71% | 14% | 29% | 57% |
| Responsible social behavior | 7 | 71% | 14% | 43% | 43% |
| Lawful behavior | 4 | 100% | 0% | 25% | 75% |
| Overall C & F Status | 7 | 71% | 0% | 57% | 43% |

| Recent Progress | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Symptom reduction | 7 | 71% | 14% | 43% | 43% |
| Behavior improvement | 7 | 57% | 0% | 71% | 29% |
| School/work progress | 6 | 50% | 0% | 67% | 33% |
| Risk reduction | 6 | 50% | 17% | 67% | 17% |
| Transition progress | 6 | 50% | 17% | 50% | 33% |
| Meaningful relationships | 7 | 86% | 0% | 43% | 57% |
| Overall Progress | 7 | 57% | 14% | 57% | 29% |

## CSR/Child Status and Performance Profile

Universal Health Care n= 7 DC Child Review March 2009

| Current Practice Performance | Cases Applicable | Percent Acceptable | Improvement | Refinement | Maintenance |
|---|---|---|---|---|---|
| Child & family engagement | 7 | 71% | 0% | 57% | 43% |
| Culturally appropriate practice | 2 | 50% | 0% | 100% | 0% |
| Service team formation | 7 | 43% | 43% | 43% | 14% |
| Service team functioning | 7 | 29% | 29% | 57% | 14% |
| Functional assessment | 7 | 43% | 14% | 86% | 0% |
| Long-term guiding view | 7 | 29% | 43% | 57% | 0% |
| IRP | 7 | 43% | 0% | 100% | 0% |
| Goodness-of-service fit | 7 | 43% | 0% | 86% | 14% |
| Resource avail.: unique/flex. | 7 | 71% | 0% | 57% | 43% |
| Resource availability: unit/place. | 4 | 50% | 0% | 50% | 50% |
| Treatment implementation | 7 | 57% | 14% | 57% | 29% |
| Emergent/urgent response | 4 | 25% | 25% | 50% | 25% |
| Medication management | 4 | 50% | 25% | 25% | 50% |
| Special procedures | 3 | 100% | 0% | 33% | 67% |
| Family support | 7 | 71% | 29% | 43% | 29% |
| Service coord. & continuity | 7 | 43% | 43% | 57% | 0% |
| Tracking & adjustment | 7 | 57% | 43% | 43% | 14% |
| Overall Practice Performance | 7 | 57% | 29% | 57% | 14% |

# Appendix D

**Stakeholder Interviews**
**For the Dixon Child Review**

1. First Home Care (leadership and supervisors)
2. Universal Health Care (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. Barbara Bazron, Deputy Director, DMH
6. Provider CFO/CEO meeting
7. Marie Morilus-Black, DMH
8. Judge Parker
9. Judge Bush
10. Judge Goldfrank
11. Senior staff at DMH
12. Wrap implementation group, DMH
13. Department of Youth Rehabilitation Services
14. DC Public Schools/Office of the State Superintendent of Education
15. CFSA (three groups—two with clinical staff and one with Director)
16. School-based mental health workers
17. Children's roundtable