2010 Report on Children and Youth

Served by the
District of Columbia
Department of Mental Health

June 2010

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%.

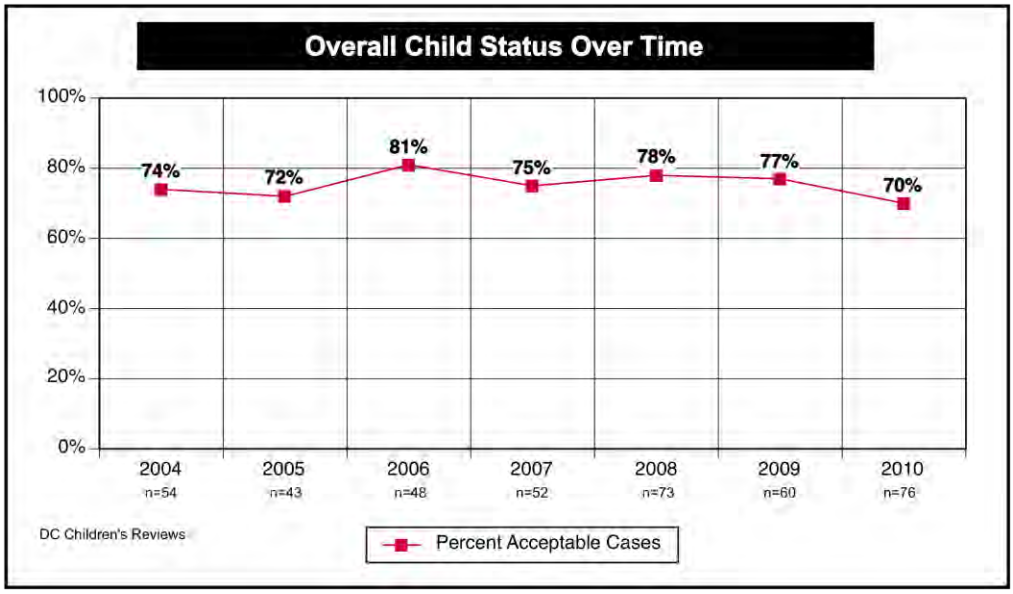
The sample for the 2006 Dixon Court Monitoring Children's Review consisted of 54 children served. The results for the 2006 children's review were completed in April 2006. The findings were overall acceptable child status ratings for 81% of the children and overall acceptable system performance of 54%.

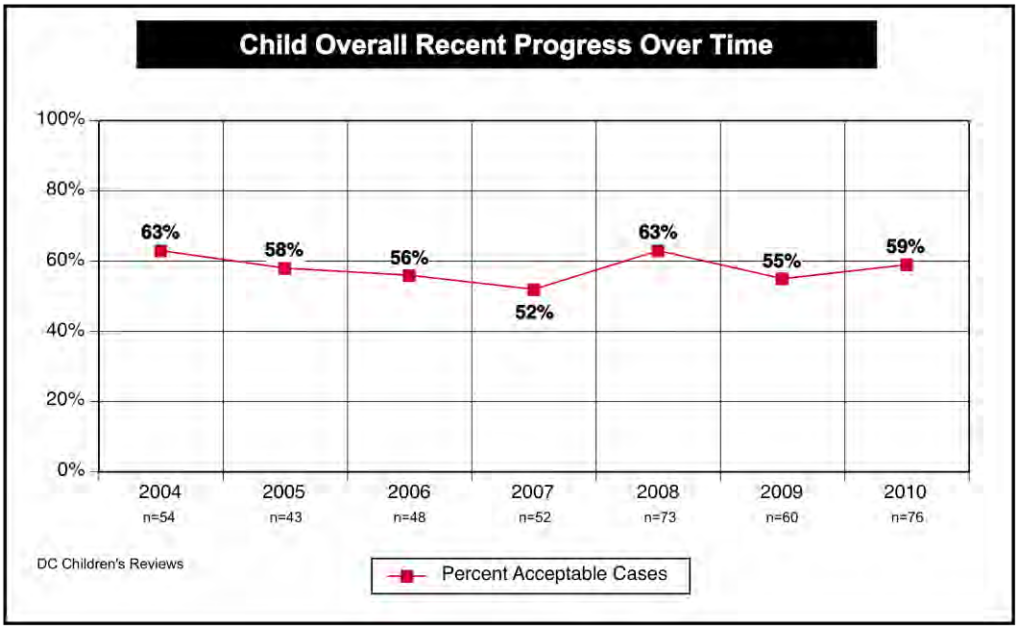
Fifty-two youth were reviewed in March 2007, with the overall child status rating acceptable for 75% of the youth. The system performance was found acceptable, overall, for 48% of the youth reviewed.

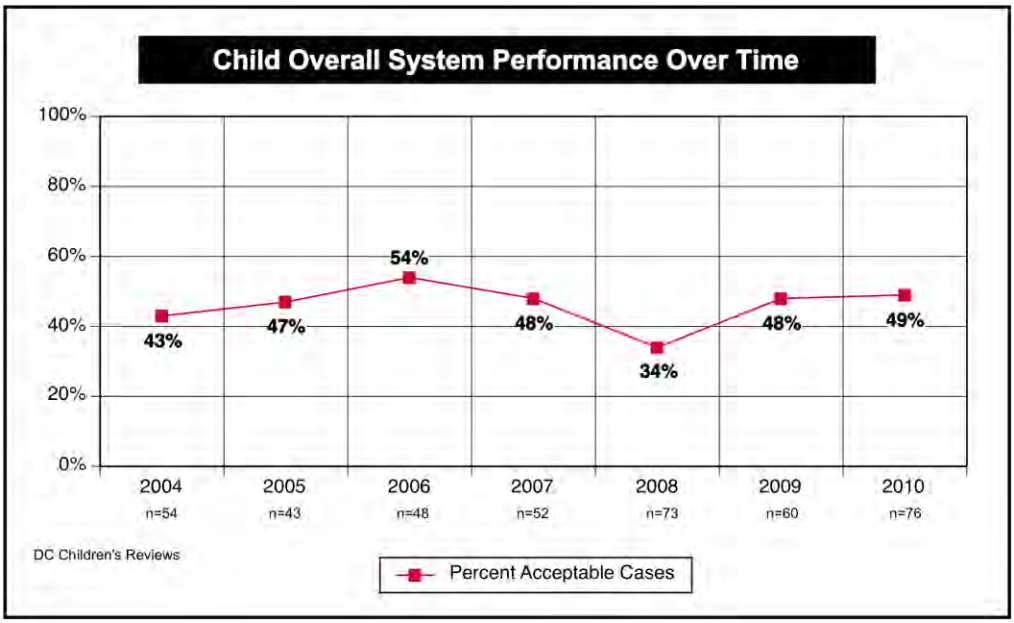
In March 2008, personnel affiliated with Human Systems and Outcomes, Inc. (HSO), conducted 53 reviews and 20 reviews were completed by staff of the Department of Mental Health (DMH) for a total of 73 youth in the sample. The overall child status rating was acceptable for 79% of the youth. The system performance was found acceptable, overall, for 34% of the youth reviewed.

The 2009 review focused on 60 children and youth; reviewers affiliated with HSO conducted 42 reviews and staff from DMH completed 18 reviews. The overall child status rating was acceptable for 77% of the youth. The system performance was found acceptable overall for 48% of the youth reviewed.

The following graphs display the Child Status, Child Progress, and System Performance ratings over seven years—2004 through 2010.







2010 Dixon Court Monitoring Children's Review

The design of the 2010 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 2010 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. The timeliness of payments 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 providers still report that team meetings and time spent on setting up and coordinating team meetings are not adequately reimbursable.

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 placement in 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.

The most notable activity during 2009 was the transition of most adults and children receiving services at the DCCSA to other core services agencies (CSAs) and the structuring of DCCSA to a smaller, more targeted organization now referred to as the Mental Health Services Division (MHSD). The Court Monitor, together with DMH leadership and HSO, agreed not to include DCCSA in the children's sample due to the timing of the transition and restructuring. Thus, the target sample size was reduced from 86 to 60.

The 2009 review also welcomed the addition of a Consumer Services Review unit at DMH. This unit consists of one half-time and two full-time positions to assist with logistics and review activities during the Dixon reviews and to conduct Community Services Reviews (CSRs) throughout the remainder of the year. This unit was developed with the intention of continuing measurement and practice development, inherent in the CSR process, for DMH provider agencies. One of the first reviews conducted by the Consumer Services Review unit included consumers who had previously been receiving services at the DCCSA who had transitioned to a new provider.

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 three-week period of time. Reviewers trained to standard by HSO trainers completed the child reviews. HSO-affiliated personnel conducted 52 reviews and staff of DMH completed 24 reviews. CFSA staff also co-reviewed cases in which youth and families were involved with both DMH and CFSA; however, concurrent data were not collected.

Changes to the Review Process

There were no fundamental changes to the review process during the 2010 review. Families were again offered a $25 gift card from Target at the conclusion of their interviews with reviewers in order to show appreciation for their time and participation in the review.

CSAs responded positively to the feedback process that was executed during the 2008 and 2009 reviews. 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 an opportunity for dialogue with service providers and practitioners about the individual practice issues pertaining specifically to the youth being reviewed. Feedback includes the sharing of information, suggestions for next steps, and problem solving around barriers and challenges. Feedback sessions do not serve as employee job performance evaluations or as supervision. Follow-up from DMH occurs in rare instances that require a mandatory report due to safety or threat of harm or as 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. Feedback sessions occurred at a much higher rate in the 2010 reviews than during 2008 and 2009, with 80% of the cases reviewed having feedback given to one or more service providers.

The Sample for Children and Youth

The targeted number of children and youth to review was determined to be 86. A stratified random sample of 94 youth (86 youth plus a 10% oversampling) and replacement names were drawn from the DMH eCURA data system for youth receiving services between April 1 and November 15, 2009. The stratified random sample of 94 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 designated timeframe).

Forty-two youth were replaced in the original sample to make up the final number of 80 scheduled reviews. Reviews were completed for 76 youth, with four reviews not yielding usable quantitative data for a total review sample of n=76. 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 2471 children, an increase of 163 youth from 2009.

Core Service Agencies

According to the information supplied to HSO by the DMH eCURA system, there were a total of 2471 children who received a billed-for service between April 1 and November 15, 2009, from 22 different provider agencies. These provider agencies differ substantially in the total number of children they serve. 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 CSA 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. As noted below, one agency did not appear in eCURA during the sampling timeframe; however, this agency was represented in the review sample. Additionally, the DCCSA appeared in the sampling timeframe and further transitioned into the MHSD. In the review sample, there was one youth still affiliated or listed as DCCSA and two as MHSD.

Display 1
Number of Children Receiving a Billed Service Between April 1 and November 15, 2009, According to the eCURA Data System

Core Service Agency	# In Population	# In Sample	# Reviewed
1. First Home Care Corporation	586	21	21
2. Community Connections, Inc.	354	12	10
3. Scruples Corporation	280	10	8
4. Launch, LLC	224	8	5
5. Universal Health Care Management	188	7	6
6. Life Stride, Inc.	108	4	4
7. Hillcrest Children's Center	103	4	5
8. DCCSA/Mental Health Services Division	88	4	3
9. Progressive Life	85	3	3
10. Family Matters	67	2	1
11. Family Preservation	62	2	2
12. Fihankra Place, Inc.	55	2	1
13. PSI	50	2	2
14. MD/DC Family Resource Center	49	2	0
15. RCI Counseling Center	14	0	0
16. Mary's Center	13	2	2
17. Youth Villages	13	0	0
18. Latin American Youth Center	12	1	1
19. Anchor Mental Health	2	0	0
20. Neighbors Consejo	1	0	0
21. Volunteers of America	1	0	0
22. GUH Mobile	1	0	0
23. Affordable Behavioral Consultants	0	0	2
24. Unassigned Youth	38	0	0
25. Disenrolled	77	0	0
Totals	2471	86*	76

•Does not include the oversample of eight youth.

Age and Gender of Youth

When selecting the sample for the 2010 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 2010

Age of Youth	# In Population	% Of Population	# In Sample	% In Sample	# In Review	% In Review
Birth to 4 years	13	<1%	1	<1%	1	1%
5-9 years	630	26%	22	26%	22	29%
10-13	799	32%	28	33%	22	29%
14 +	1029	42%	35	41%	31	41%
Totals	2471	100%	86	100%	76	100%

Gender	# In Population	% Of Population	# In Sample	% In Sample	# In Review	% In Review
Female	970	39%	34	40%	29	38%
Male	1492	60%	52	60%	47	62%
Unidentified	9	<1%	0	0%	0	0%
Totals	2471	100%	86	100%	76	100%

Child's Level of Need

The child's level of need was separated into three categories—low, medium, and high. The survey completed by the provider agencies was used to collect specific information, such as the current array of services a youth was receiving. Other level of care indicators, such as the current 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)

Forty-two (55%) of the 75 children and youth age five and older were receiving services in the medium level of need range.

Children and Families Included in the Review

Although the targeted number of 86 children reviewed was not met this year, the review findings 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 District's mental health system. The sampling process 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 2010 review, 42 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	# of Youth Replaced
Discharged from services/inactive	35
Not receiving services in D.C.	1
Refused to participate	6
Total Replacements	42

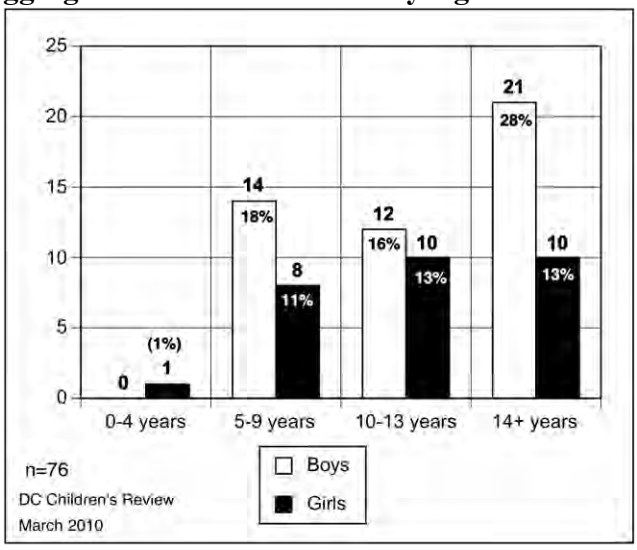
Description of the Children and Youth in the Sample

A total of 76 child and family reviews were completed during March 2010. Presented in this section are displays that detail the characteristics of the children and youth in the eighth-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 review sample of 76 children and youth distributed by both age and gender. As shown in this display, boys made up 62% of the youth reviewed and girls made up 38% of the youth reviewed. It is not uncommon for more boys to be receiving services within the active population. Children under age ten comprised 30% of those reviewed (23 youth). Twenty-two children (29%) were in the 10-13-year-old age group. Thirty-one teenagers age 14 and older (41%) were included in the review. Eighty-nine percent of the youth reviewed were of African-American ethnicity and 5% were of Latino-American descent.

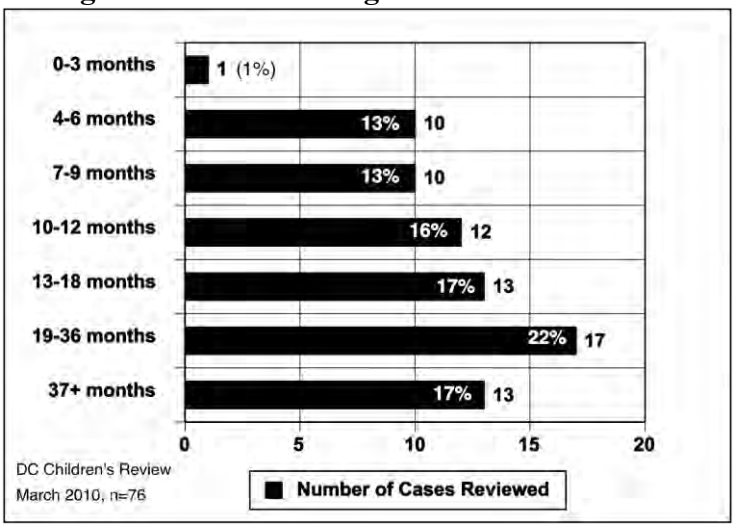
Display 4
Aggregate of Reviewed Cases by Age and Gender



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, 39% or 30 of the youth had been receiving services for 19 months or longer, and 43% (33 youth) had been receiving services for 12 months or less. Fewer sample members had received services for more than 19 months in the 2010 review than in the 2009 sample (55% in 2009; 39% in 2010). A notable difference when compared with the 2009 data is in regard to the number of youth receiving services for one year or less. In the 2009 review, 38% had been in services for fewer than 12 months, while in 2010, this portion increased to 43%.

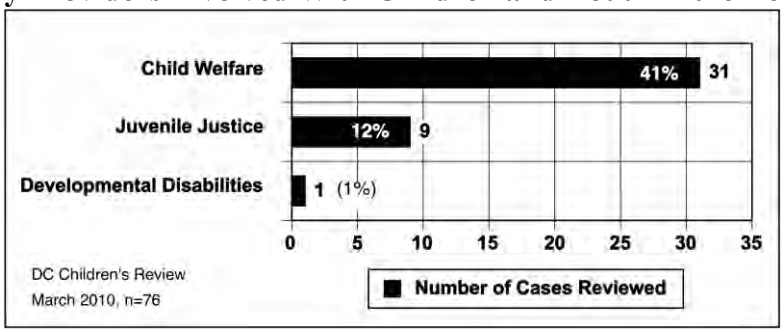
Display 5
Length of Time Receiving Mental Health Services



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 41 youth served by one or more of these agencies, 31 were involved with CFSA representing 41% 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, 62% in 2008, and 42% in 2009. This year, nine youth (12%) in the review sample were involved with the Department of Youth Rehabilitation Services (DYRS). In the past four reviews (2009, 2008, 2007, 2006), there were one, two, five, and four, respectively, youth involved with DYRS. There was one child involved with developmental disability services this year; there were two in 2009 and none in 2008.

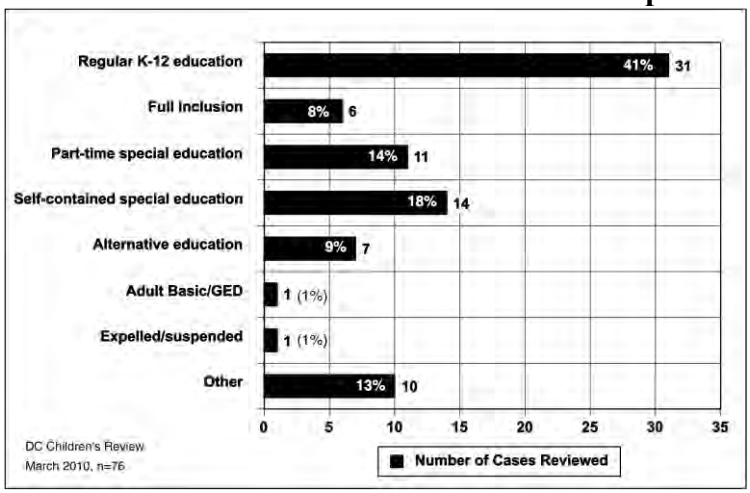
Display 6
Other Agency Providers Involved With Children and Youth in the Review Sample



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. The categories are not mutually exclusive; more than one educational placement may be reported for a single child. Thirty-one youth (41%) were in regular K-12 educational settings. Thirty-one youth (41%) were receiving some type of special educational service, either full inclusion (8%; six youth), part-time special education services (14%; 11 youth), or in a self-contained special education setting (18%; 14 youth). One youth was expelled or suspended, and one was enrolled in an adult education/GED program. Ten of the youth reviewed were in other educational settings, which included preschool (two youth), a therapeutic school (one youth), a Level V school (two youth), hospital (one youth), and homebound services (one youth). One youth had been "disenrolled" and was transitioning, another was in in-school suspension until the next placement could be determined, and one youth had a 504 accommodation plan in regular education.

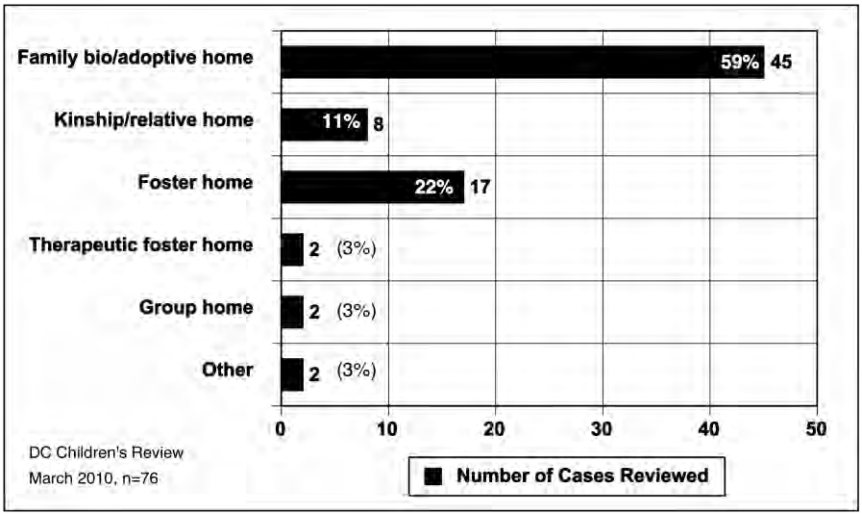
Display 7
Types of Educational Services/Placements or Educational Status for Children and Youth in the Review Sample



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 review sample members according to their residences at the time of the review. Fifty-nine percent or 45 youth in the review sample were living with their birth or adoptive family; an additional eight youth (11%) were living with relatives. The remaining youth were living outside of the family/kinship home. Twenty-two percent or 17 youth were living in a foster home and 3% (two youth) were living in a therapeutically supported setting. Two youth (3%) lived in a group home. The "Other" categories of living situations included one youth in a mental health hospital setting and one youth living in a pre-adoptive foster home.

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). Thirty-three percent or 25 youth in the 2010 review sample had at least one placement change in their lifetime. Thirty-five youth (46%) had from one to five different placements. In 2009, 25% (15 youth) had at least one placement change with nearly one-half (29 of 60 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 Review	% of Review
No placement changes	37	49%
1-2 placement changes	25	33%
3-5 placement changes	10	13%
6-9 placement changes	2	3%
10 or more placement changes	2	3%
Totals	76	100%

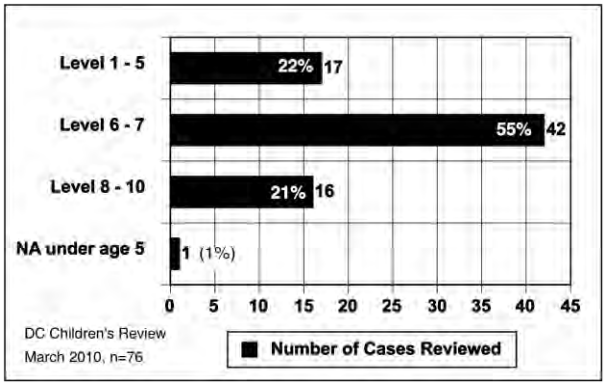
Functional Status

Display 10 provides the distribution of the review sample across functioning levels for the 75 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.

Seventeen youth in the review sample had level of functioning scores in the lowest range (22% of the review sample). This range captures youth requiring many supports and, oftentimes, involving multiple agencies. Children in the 2010 review sample are evenly distributed across the high and low 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; there was one child in the 2010 review younger than age five. The youngest children in the review had the lowest rate of low functioning while youth with the highest level of need (those with low to moderate level of functioning) were more likely to be ten years or older.

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

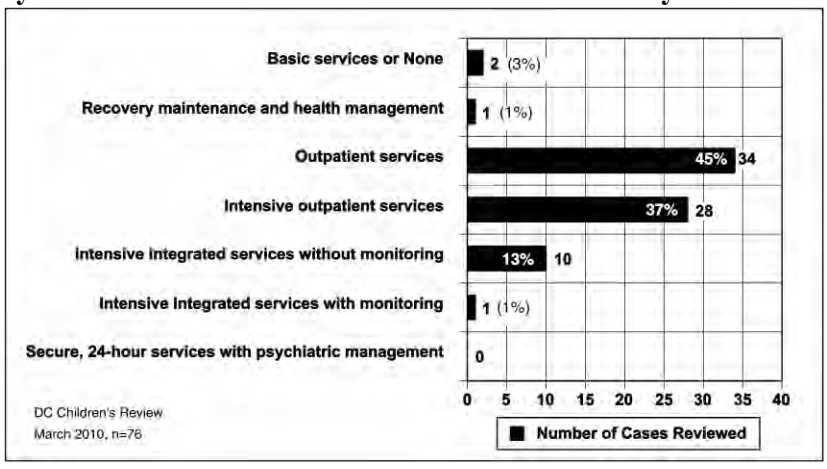
Age Ranges	Low Level of Functioning	Moderate Level of Functioning	High Level of Functioning	Totals in the Review
5-9 Years Old	1 (1%)	16 (21%)	5 (7%)	22
10-13 Years Old	5 (7%)	11 (15%)	6 (8%)	22
14 Years or Older	11 (15%)	15 (20%)	5 (7%)	31
Totals	17 (23%)	42 (56%)	16 (21%)	75

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 all 76 of the youth reviewed. When 2010 CALOCUS ratings are compared to those of the 2009 review, the rate of use of outpatient services has been reduced to 45% in 2010 (34 youth) compared to 69% (41 youth) in 2009. The 2010 data are consistent with the 2008 rate of 44% and 38% in 2007 for outpatient services. In the 2010 review, only two youth (3%) were receiving basic services compared to 2% in 2009, 14% in 2008, and 17% in 2007.

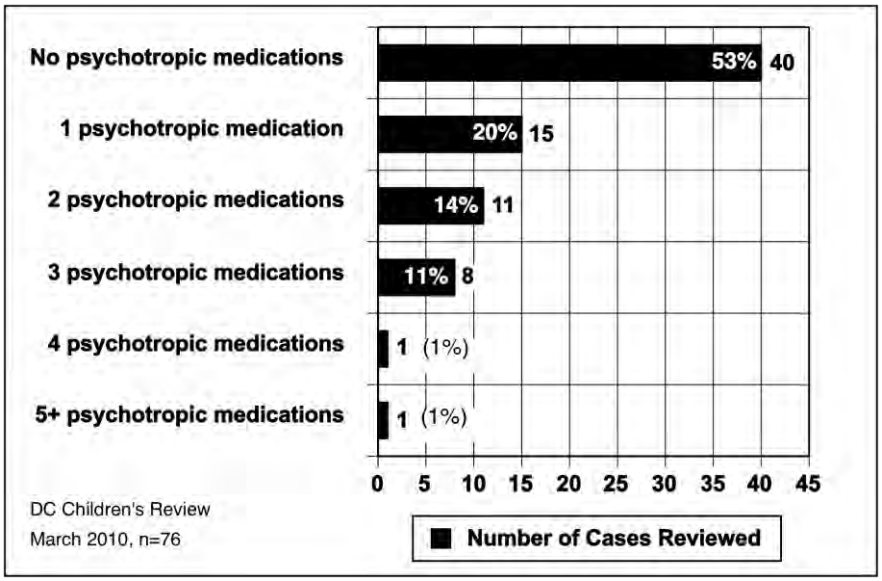
Display 12
CALOCUS for Range of Services Received
by Children and Youth in the Review Assessed by Reviewers



Medications

The number of psychotropic medications prescribed for children and youth in the review sample were counted and reported by reviewers. Thirty-six youth were prescribed psychotropic medications (**Display 13).** Twenty percent (15 youth) were prescribed one medication in 2010, while the rates of prescribing one medication in 2009, 2008, and 2007 were 20%, 23%, and 29%, respectively. The rate of prescribing two psychotropic medications in 2010 is 14% (11 youth) down from 27% (16 youth) in 2009. In 2009, four youth were prescribed three or four psychotropic medications, while in 2010, ten youth were prescribed three or more with one youth prescribed five psychotropic medications at the time of the review.

Display 13
Number of Psychotropic Medications Prescribed for Children and Youth at the Time of the Review



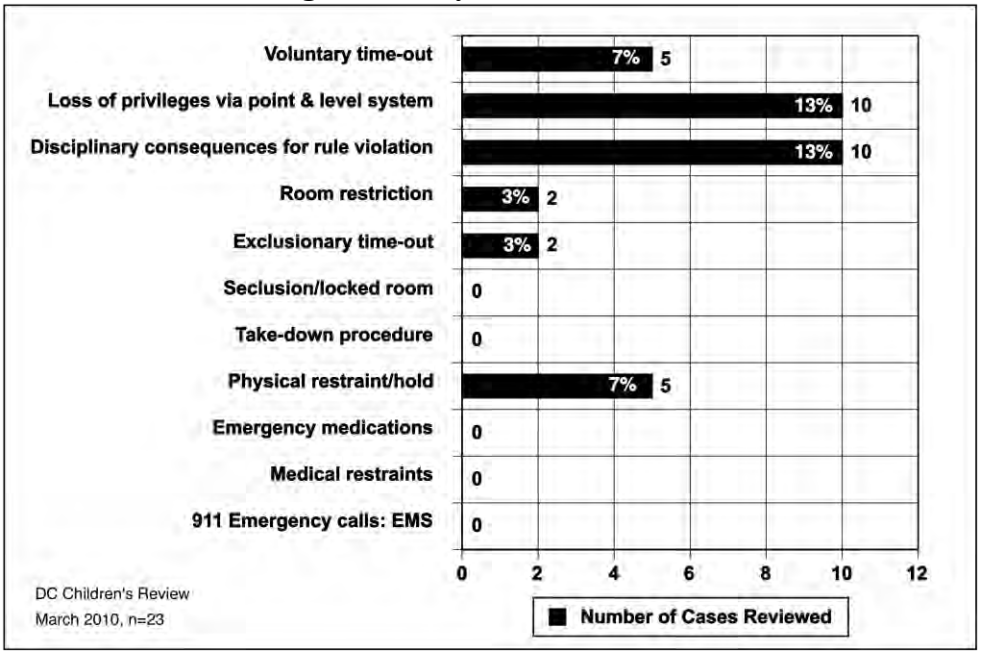
Special Procedures

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 2010 review are attributed to a

relatively small number of children. This year, slightly less than one-third of the youth reviewed (n=23) were found to have experienced a special procedure in the 30 days prior to the review. In 2009, the use of special procedures applied to 18 youth or 30% 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 the current review and in last year's review, no youth had a 911 call. For 2008, 5% of the 20 youth having a special procedure had a 911 call during the 30-day timeframe. In 2007, 29% of the youth reviewed (n=14) had at least one 911 emergency call in the 30 days preceding the review. There was no increase in the rate of youth having a disciplinary consequence in the month prior to the review in 2010 (23 of the 76 youth or 30%) compared to 2009 (18 of the 60 youth or 30%).

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 76 children and youth in March 2010, 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

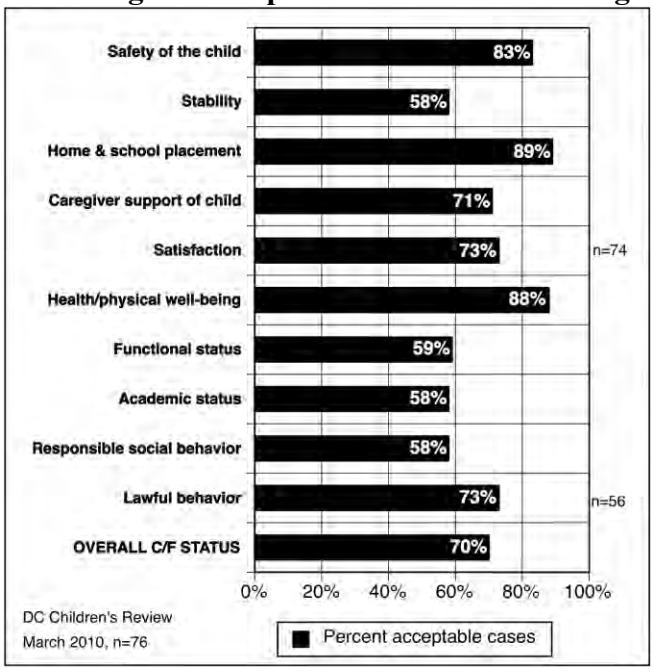
Review activities in each case included a review of plans and records as well as interviews with the child, caregiver, and others involved in providing services and supports. A total of 446

persons were interviewed for the 76 children and youth reviewed this year. The number of interviews ranged from a low of two persons in one case to a high of nine persons in another case. The average number of interviews was 5.9. (mean: 5.9; median: 5.5; mode: 6)

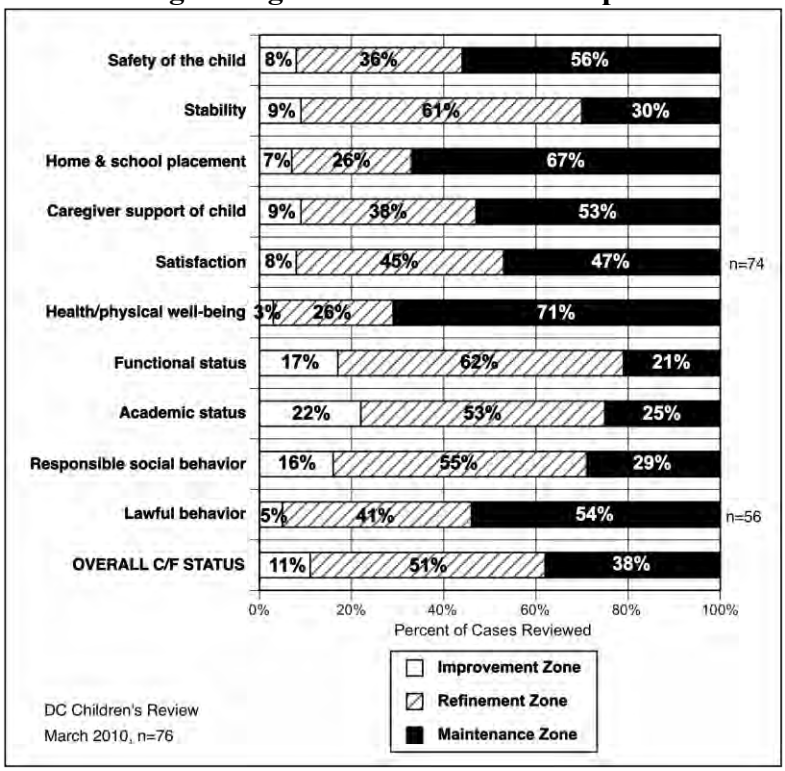
Child Status Results

Ten indicators related to the current status of the child or youth were contained in the CSR Protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. The next two displays present findings for each of the ten indicators. **Display 15** uses a "percent acceptable" format to report the proportion of the sample members for whom the item was determined applicable and acceptable. **Display 16** uses the "action zone" framework that divides the 6-point rating scale into three segments corresponding to the maintenance, refinement, and improvement zones. Findings on both displays are presented concurrently below. While these two different displays are useful in presenting findings to different audiences, it should be remembered that both displays are derived from the same database of findings.

Display 15
Percentage of Acceptable Child Status Ratings



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 76 youth participating in the review, 70% were found to have acceptable overall status. This is a decrease of 7% from 2009. The overall child status scores were distributed across the zones as follows: 11% needed immediate attention and were in the improvement zone, 51% were in the refinement zone, and 38% were in the maintenance zone. When compared to overall ratings of child status for prior years, the data for 2010 show a 6% increase in the percentage of youth in the improvement zone over 2009 when there were 5% found in this zone. A lower percentage of youth was found in the maintenance zone this year (38%) when compared to 2009 and 2008 (43% in 2009 and 48% in 2008). **Display 17** shows the overall child status results for the reviews since 2004. Overall child status ratings have been stable and in the same percentage range for the past seven years, with the highest

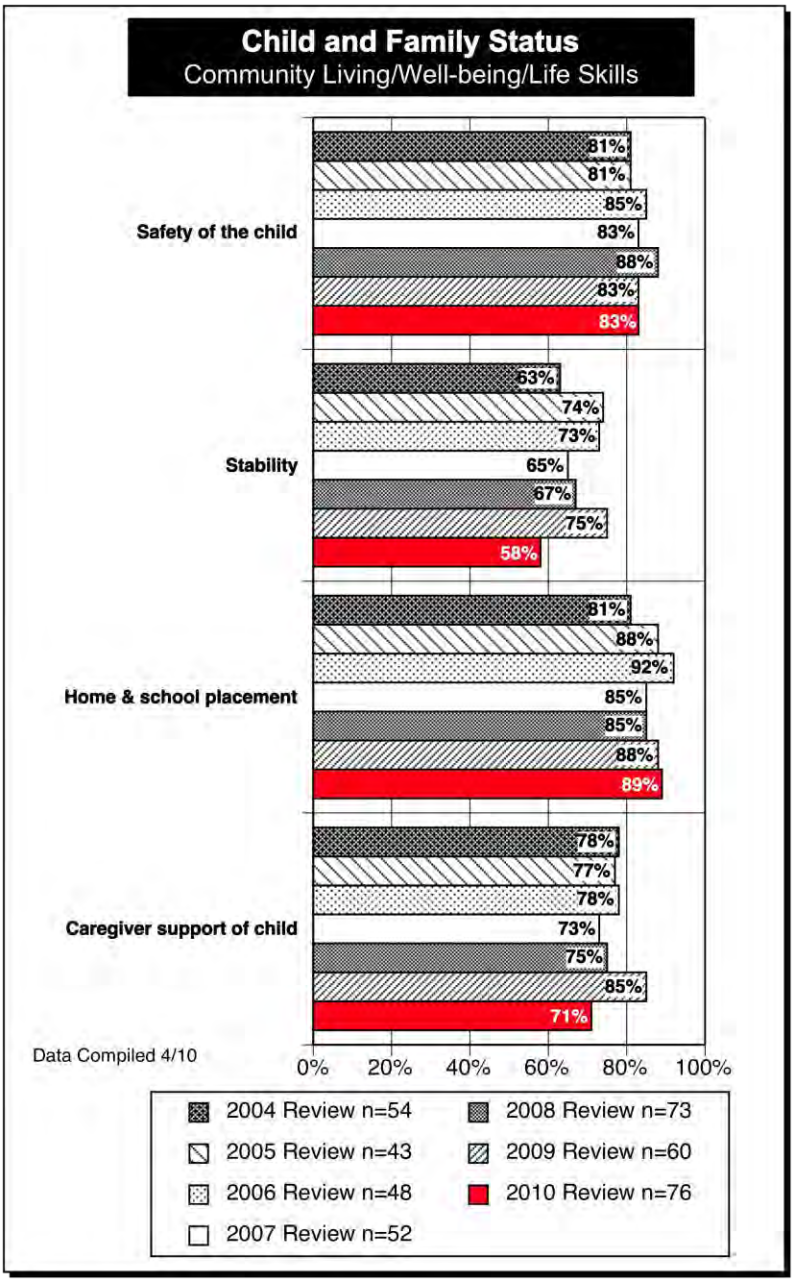
results achieved during the 2006 review in which 81% of the youth reviewed were rated acceptable for overall status.

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 (88% acceptable). Eighty-nine percent 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 review who are living in permanent family and adoptive and kinship homes (59% family/adoptive and 11% in kinship care).

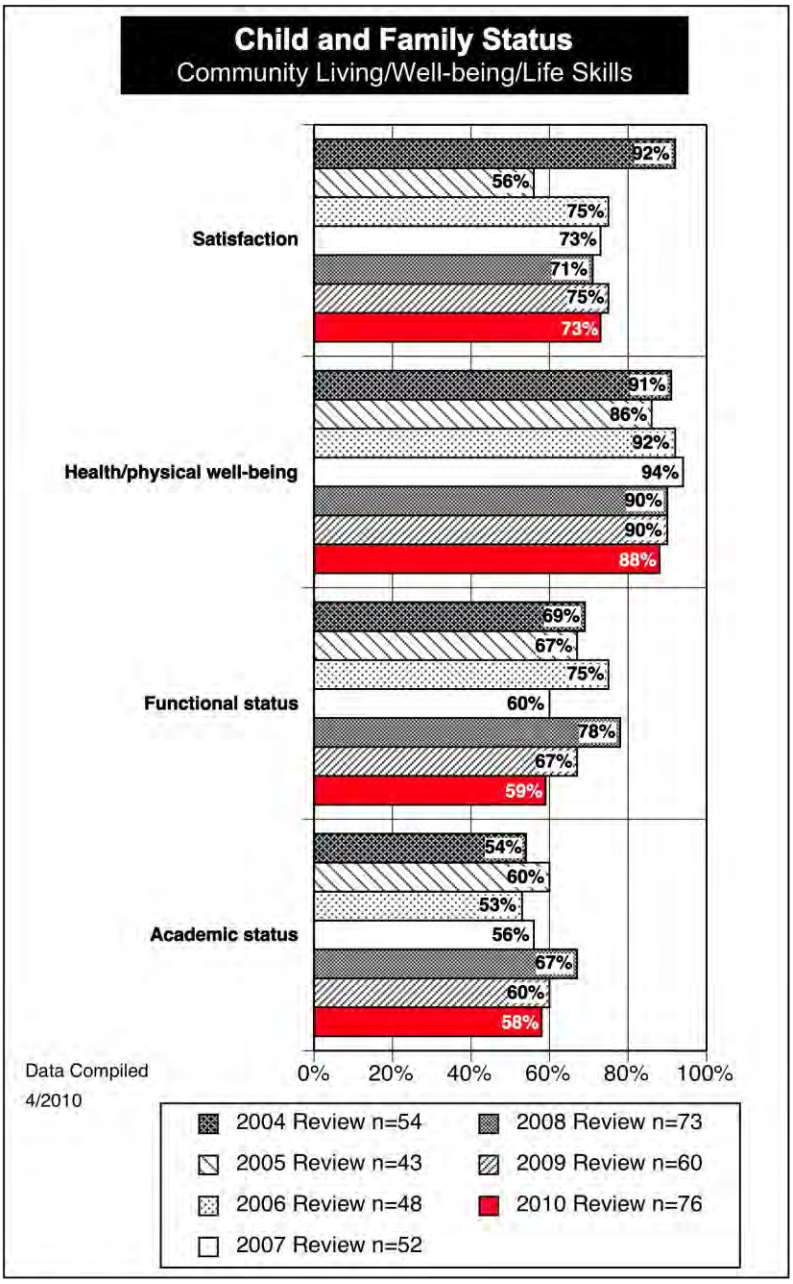
The three lowest scoring indicators were identified in academic, functional, and responsible behavior status. Fifty-eight percent of the youth reviewed were found to have acceptable academic status, with 22% requiring immediate attention in the improvement zone, 53% in the refinement zone, and 25% in the maintenance zone. The functional status indicator was rated 59% acceptable, with 17% in the improvement zone, 62% in the refinement zone, and 21% in the maintenance zone. The responsible social behavior status indicator was rated 58% acceptable, with 16% in the improvement zone, 55% in the refinement zone, and 29% 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 a 17% decline over 2009 (75% acceptable in 2009; 58% acceptable in 2010). Caregiver support of the child reflected a 14% decline over 2009 (85% acceptable in 2009; 71% acceptable in 2010), and lawful behavior declined by 13% over 2009 (86% acceptable in 2009 with n=37 of 60 youth; 73% acceptable in 2010 with n=56 of 76 youth).

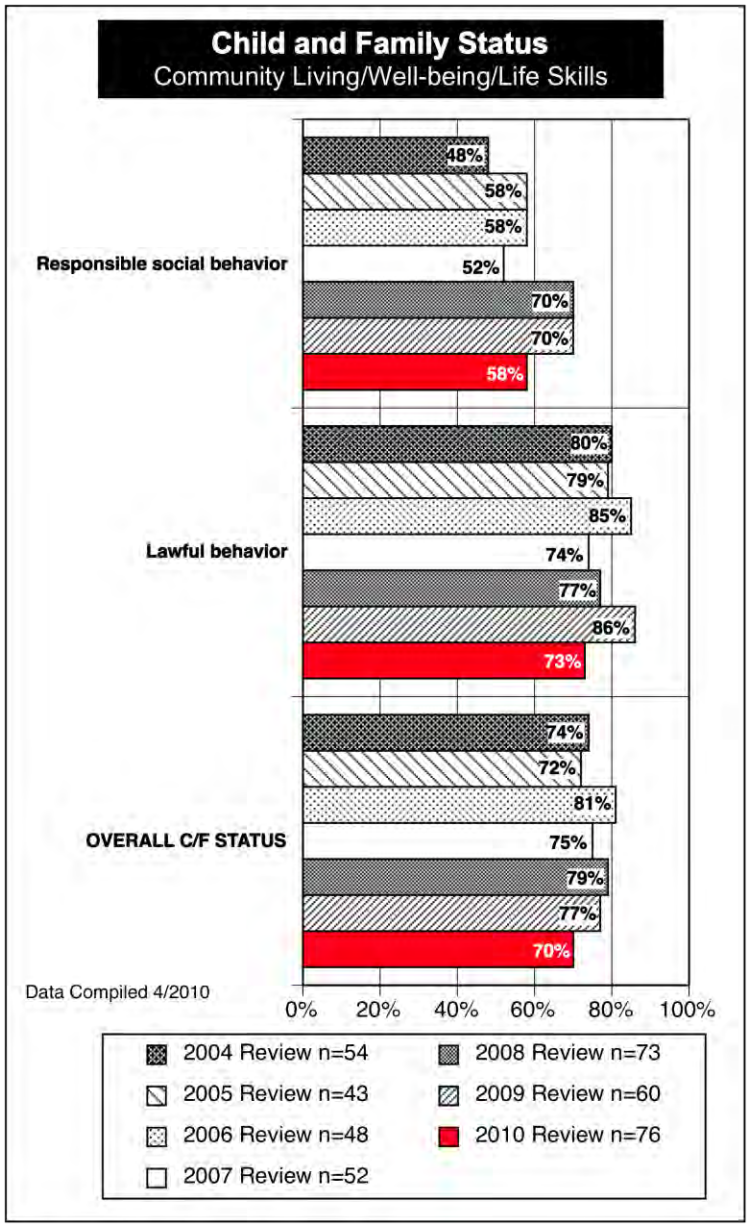
Display 17
Overall Child Status Results for Seven Reviews



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



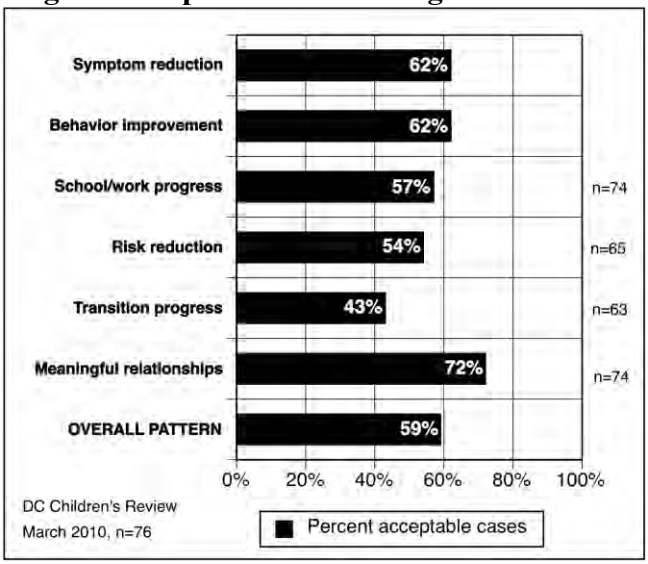
Display 17 (continued)
Overall Child Status Results for Seven Reviews



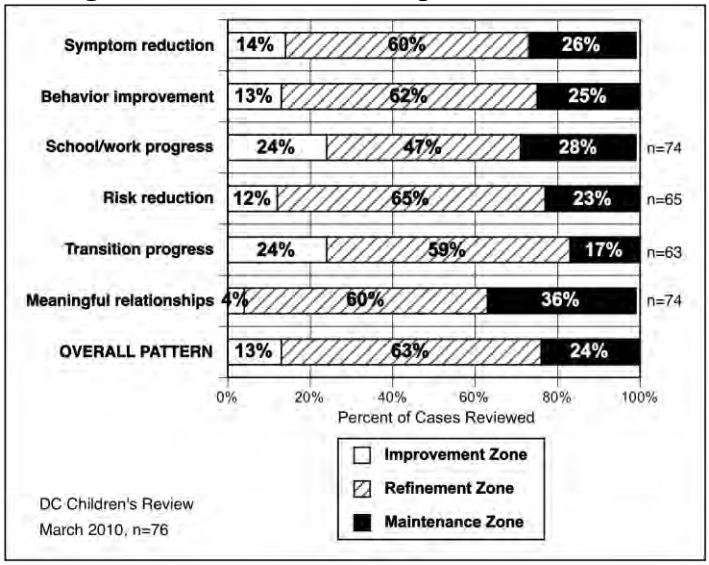
Recent Progress Patterns Showing Change Over Time

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

Display 18
Percentage of Acceptable Recent Progress Pattern Ratings



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 59% of the 76 youth reviewed. This is a 4% increase from last year (55% acceptable overall progress pattern in 2009). Overall progress pattern ratings were distributed among the three-tiered zones as follows: 13% were found to need improvement, 63% were in the refinement zone, and 24% were in the maintenance zone.

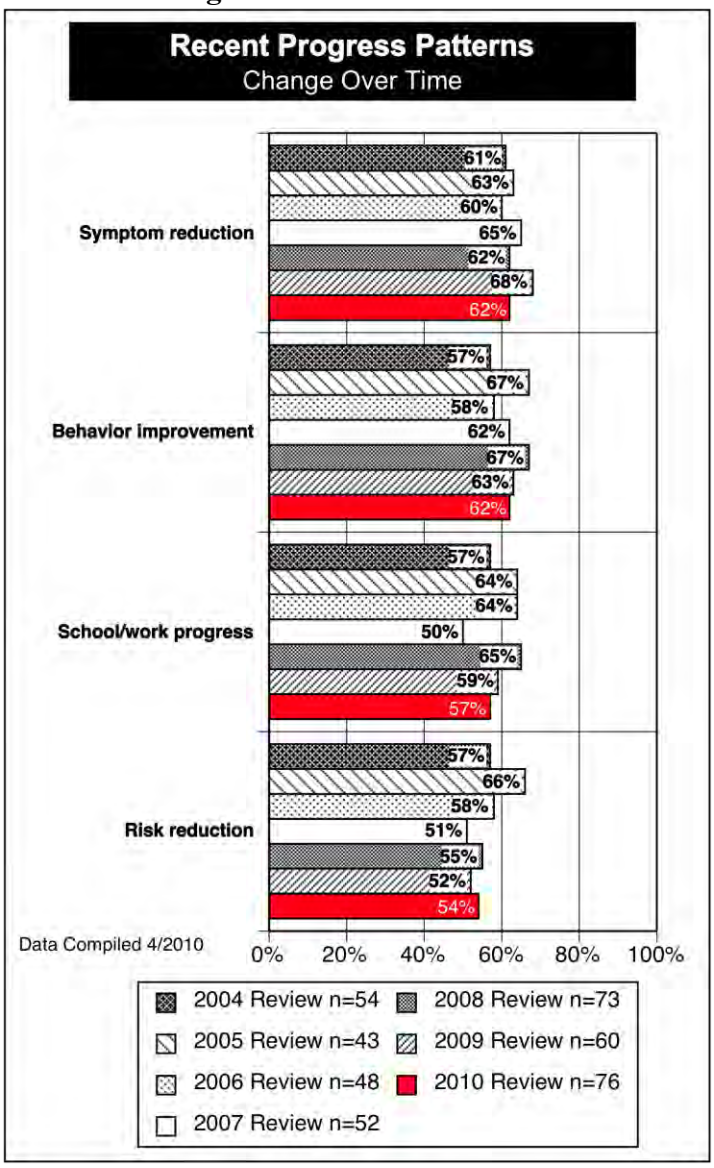
Progress toward meaningful relationships was the indicator with the highest rating with 72% of youth reviewed having acceptable progress in this area. Symptom reduction, the extent to which psychiatric symptoms are being reduced for the child or youth, showed a 6% decline over 2009.

Transitions were identified as applicable for 63 of the 76 children and youth in the 2010 review sample. If the child had not experienced any transitions within the previous six 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 27 (43%) of the 63 youth for whom this indicator was applicable. This is a decrease of 3% from 2009. As will be discussed later, practice and team functions, such as planning, long-term guiding view, tracking and

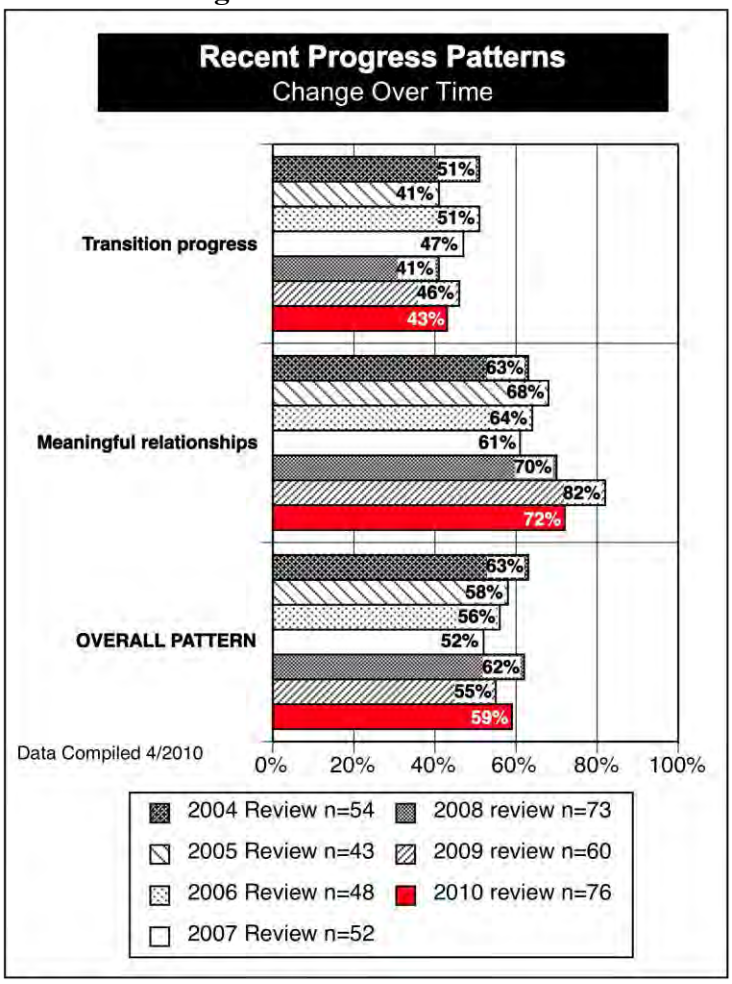
adjustments, and child and family issues, such as stability and permanency, impact the likelihood of youth having successful transitions.

Display 20 shows the data for 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 Seven Reviews



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



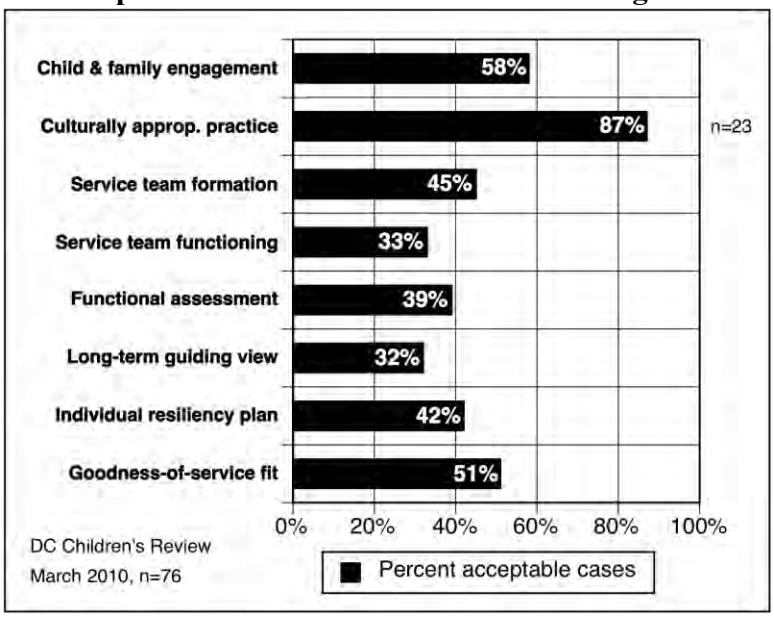
Child-Specific Performance of Practice Functions

The CSR Protocol contains 16 indicators of practice performance that are applied to the service situations observed for members of the review sample. See **Appendix A** for further information about the questions probed through these indicators. For organizational purposes, the 16 indicators are divided into two sets 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.

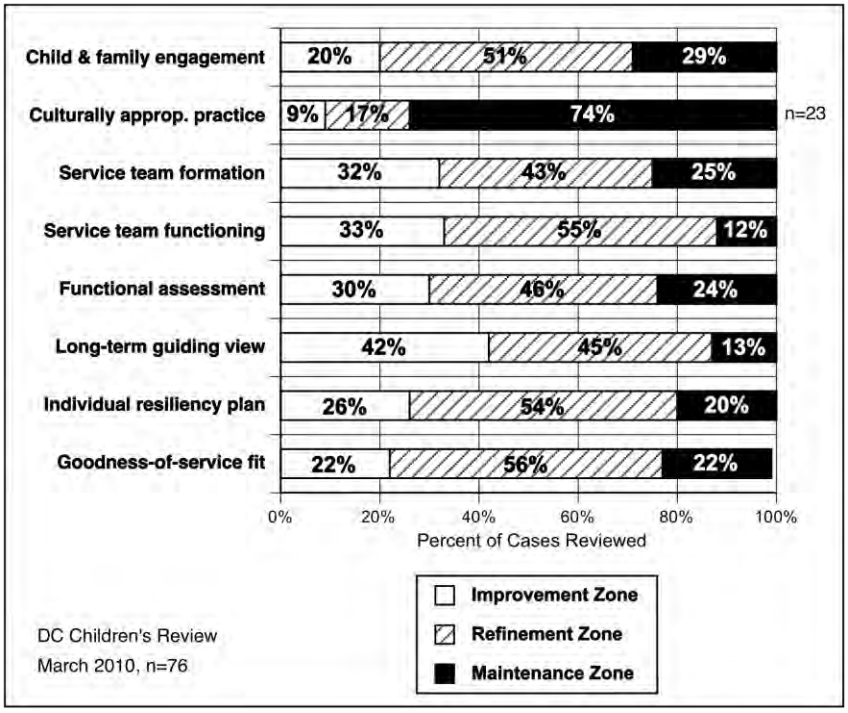
Practice Performance: Planning Treatment

Findings for the first set of indicators are presented in **Displays 21 and 22** and summarized below. **Display 33**, starting on page 57, 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 members 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. Twenty-nine percent were fully engaged and required maintenance efforts only, 20% needed improvement, and 51% 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 2010 CSR results showed that in 87% or 20 of 23 case situations, service providers made appropriate cultural accommodations to children and their families. This was a 17% increase from 2009.

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 means that the persons who need to be communicating about a child's participation and effectiveness of interventions, changing circumstances, and results achieved on an ongoing basis are not communicating effectively. It 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 34 (45%) of the 76 youth reviewed in the 2010 CSR. This is an increase of 5% from last year. When these data are disaggregated and viewed in terms of ratings on the 1 to 6 scale, 43% of the cases were rated in the refinement zone for team formation and 32% were rated in the improvement zone for team formation.

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 33% of the youth reviewed this year; however, for 88% of the review sample, refinement or 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 39% of the youth reviewed, a 1% decline from the 2009 review. Viewed another way, 76% of the review sample population was rated as needing either refinement or improvement in the assessment and understanding indicator. One area that was particularly noteworthy this year is a lack of in-depth diagnostic assessment as part of the clinical intake process giving direction to treatment planning.

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 32% of the children and youth reviewed had a long-term view that could be articulated by service providers compared to 18% in 2009. For 87% of the review 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. This year, performance on this indicator improved by 10% to 42% acceptable. However, for 80% of the cases sampled this year, refinement or improvement was indicated. Three issues were characteristic of challenges to the treatment planning process.

These included a lack of engagement and participation of older youth in the design and development of their IRPs, lack of timely adjustment to IRPs when circumstances for the child or youth changed, and coordination of services and strategies within but not across agency interveners.

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 2010, similar to the findings in 2008 and 2009, the combination and sequencing of supports and services was found to be acceptable for one-half of the children and families served, i.e., a rating of 4, 5, or 6; however, this year, for 56% of the sampled cases, refinement was warranted, i.e., a rating of 3 or 4.

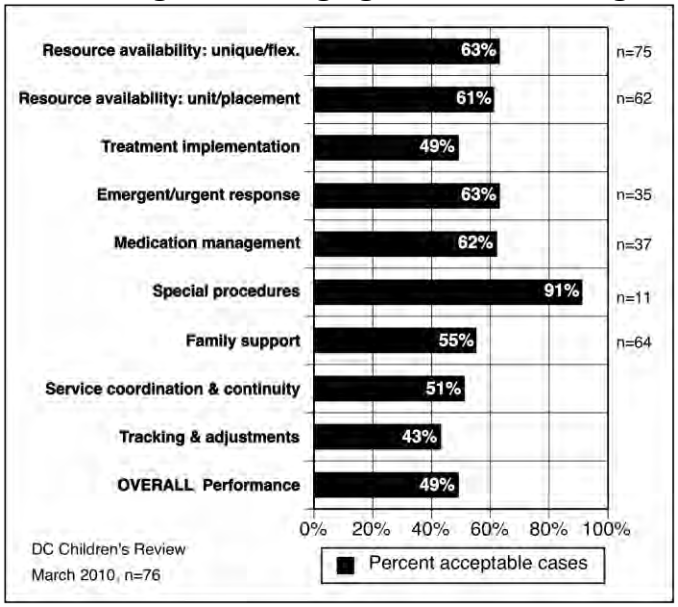
Findings across the key indicators for planning treatment indicate strengths to build upon in child and family engagement and cultural sensitivity. The weaker area of understanding the family situation and underlying issues through formal and informal assessments and information gathering directly affects 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 2010 review, consideration and articulation of a long-term view for a child and family improved significantly over 2009. Although there were incremental improvements in 2010, there continue to be issues with the consistent forming of complete teams and with the understanding of what "teaming" entails. Again in 2010, reviewers found that most providers and core service agencies are staffing cases and meeting with their internal agency team 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 or the engagement and participation of the older youth.

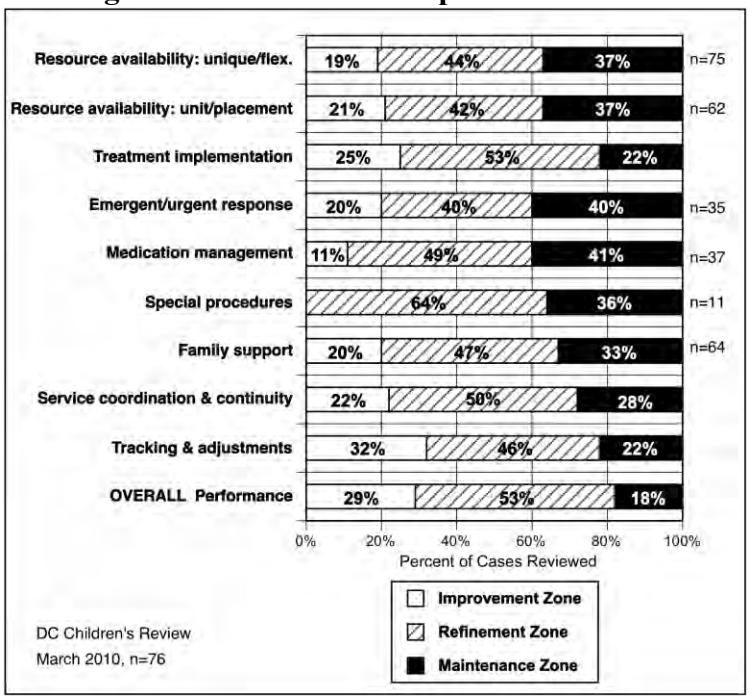
Practice Performance: Providing and Managing Treatment

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 57.

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, accessibility, 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 again in the 2010 review. Sixty-three percent of the youth reviewed had acceptable availability of flexible resources, such as wrap services or community support; however, 63% were rated as needing refinement or improvement (n=75). Sixty-one percent had adequate access to unit or placement-based services, such as therapy, with 63% needing refinement or improvement (n=62). These data were comparable to 2009 in both sub-indicators (64% flexible resources and 62% unit-based in 2009).

These results suggest that the availability of resources in the District is not a primary barrier to treatment implementation. An exception to this observation is that timely access to individual therapists appeared to be a barrier for several children/youth. Agencies pointed to the managed care organization's (MCO's) paneling process for therapists as the primary cause for this delay.

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 2010 was at a rate of 49% acceptable, an improvement over 2009 when the rate was 45%. However, in 2010, 78% 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 63% acceptable this year, up from 27% in 2009. Of the 35 children or youth for whom this indicator was applicable, 21 or 60% 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 cognitive behavior therapy, 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. Thirty-seven youth were rated on this medication management indicator, although **Display 13** indicates that only 36 youth were prescribed one or more medications at the time of the review. One youth (RS) was not prescribed medications at the time of the review; however, the reviewer rated this indicator for this youth because information gathered indicated the need for an evaluation to determine the need for medication. Sixty-two percent of the youth had an acceptable rating on this indicator. For 15 of these children (41%), the rating was good or optimal; for the remaining 22 (60%), 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 2010, the use of special procedures was applicable for 11 children or youth and found to be acceptable in 91% of these cases. For 64% or seven children, the use of these procedures could be refined.

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 depend 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 found to be acceptable in the 2010 review in 55% of the applicable cases reviewed, a decline of 14% from 2009. This item applied to 64 children or youth in the review sample and was rated as good or optimal for 21 (33%) 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 51% of the children and youth reviewed this year, a 6% increase from 45% acceptable in 2009; however, this indicator was in need of refinement or improvement for 72% of the review sample. Working with schools appeared to be an area of significant challenge for many teams.

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

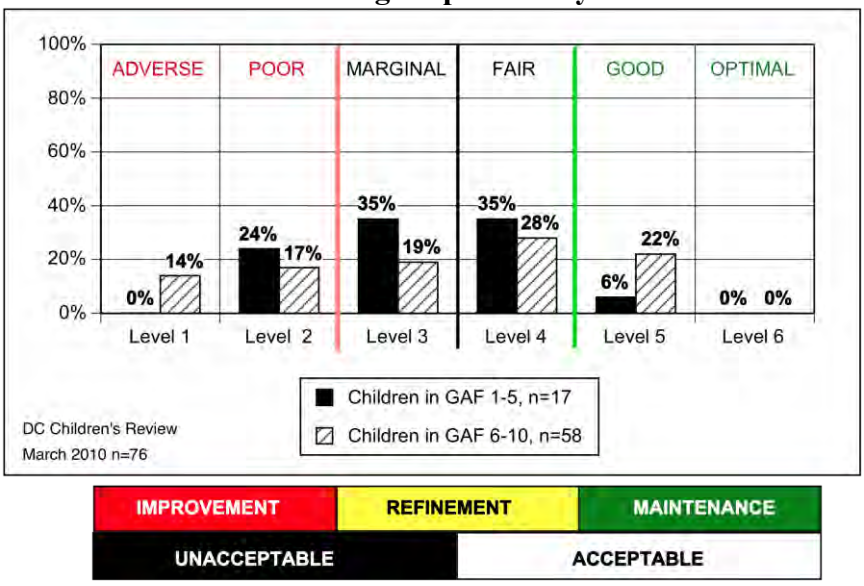
working with each other. Forty-three percent of the children and youth reviewed showed evidence of an acceptable process for tracking and modifying services to meet the changing needs of the child or youth and family, a 7% loss over 2009. This indicator was rated as good or optimal for 22% or 17 of the 76 children or youth with refinement or improvement indicated for 78% of the youth reviewed.

Overall Practice Performance. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall practice performance rating." Applying this rubric resulted in the determination that overall practice performance was rated as adequate (rating levels 4, 5, and 6) in 49% of the children and youth included in the review, a 1% increase from the 2009 results (48% overall in 2009). In 2010, 29% of the children or youth reviewed were found to need improvements, 53% were in the refinement zone, and 18% were in the maintenance zone. This distribution, when compared with 2009, shows a 3% increase in youth in the maintenance zone (15% in 2009), a 1% increase in the refinement zone (52% in 2009), and a 4% decrease in youth requiring immediate improvement (33% in 2009). A reasonable overall judgment is that although 2010 showed slight 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.

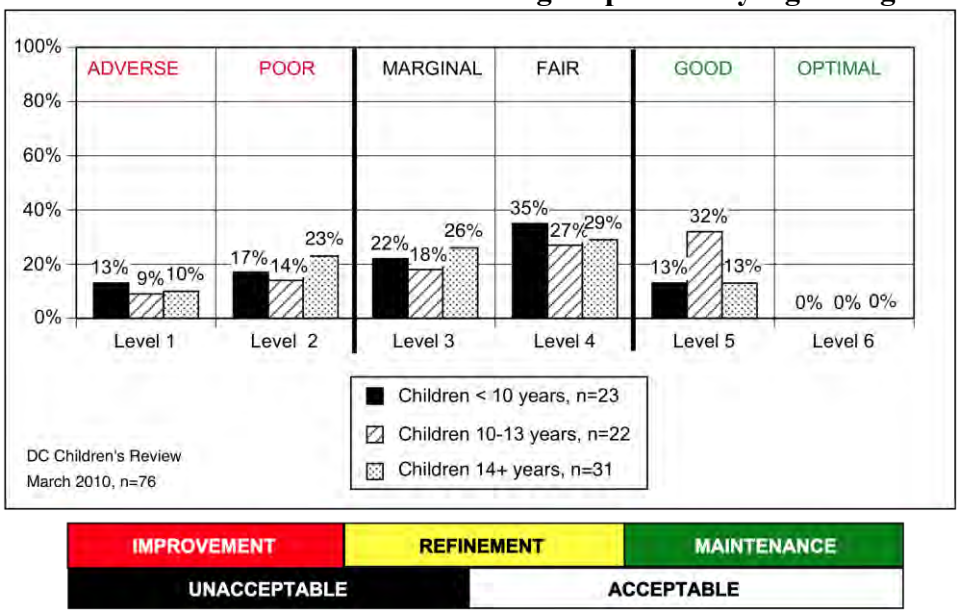
In **Appendix C** of this report are agency-by-agency results for the children and families reviewed. **This agency-by-agency comparison should be interpreted with caution, since sample sizes for some of the provider agencies are extremely small**. **Generalizations regarding specific agency practice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

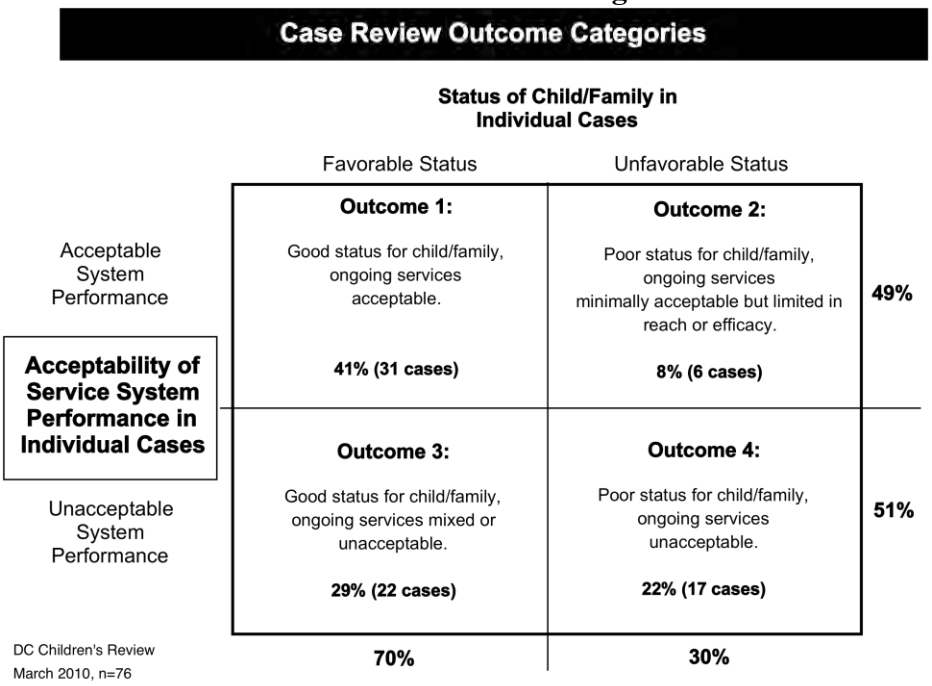


Case Review Outcome Categories

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.

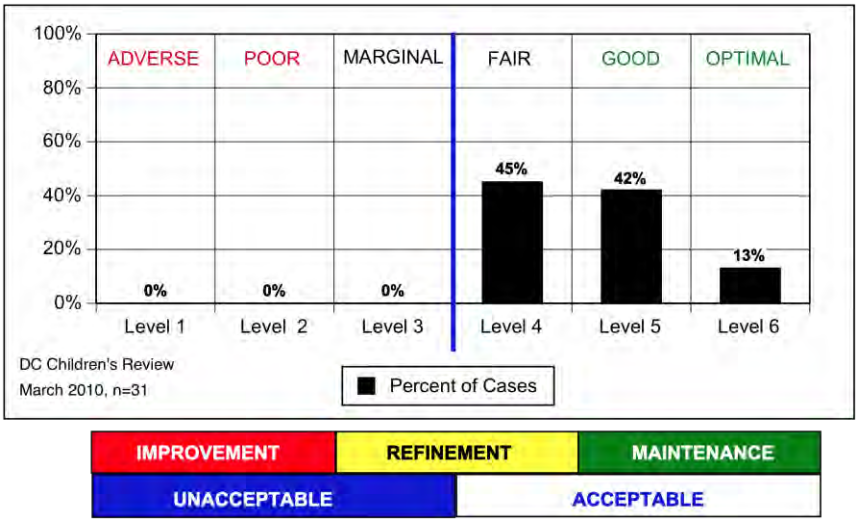
As **Display 27** indicates, 31 (41%) of the 76 cases fell into outcome category 1. Outcome 1 is the desired situation for all children and families receiving services. There were six youth (8%) in outcome category 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent system performance of the service system, the overall status of the child or youth is still unacceptable. Twenty-nine percent or 22 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, 17 youth or 22% of the review sample, fell into outcome category 4, compared to 12 youth or 20% in 2009. 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

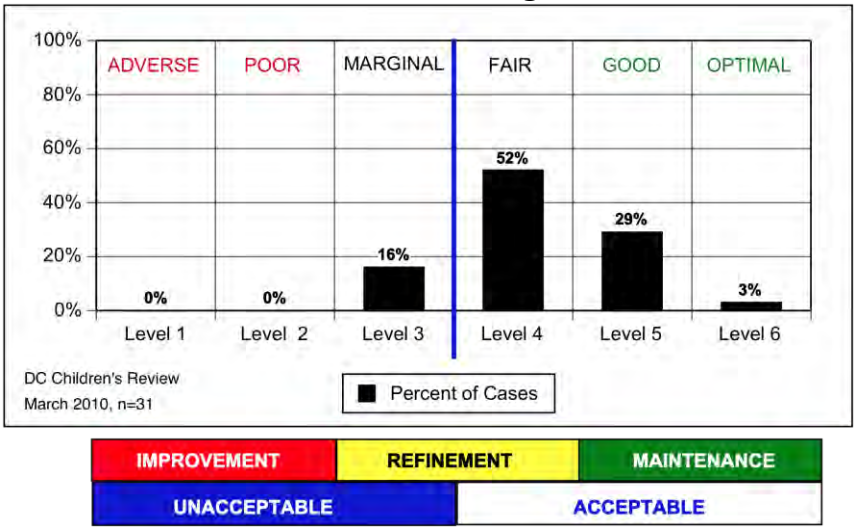


Displays 28 to 31 show the distribution of scoring on the six-point scale for the children who fall in each of the outcomes shown in Display 27. For example, for outcome 1, the charts in Displays 28a, 28b, and 28c show the distribution of child status ratings, the distribution of progress indicators, and the distribution of system performance ratings. Display 28a shows that 55% of the 31 children in outcome 1 had overall status indicators rated at 5 or 6, and all 31 were rated as having acceptable status. Display 28b shows that 32% 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 31 cases. Forty-two percent were rated as having good practice performance, and all 31 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.

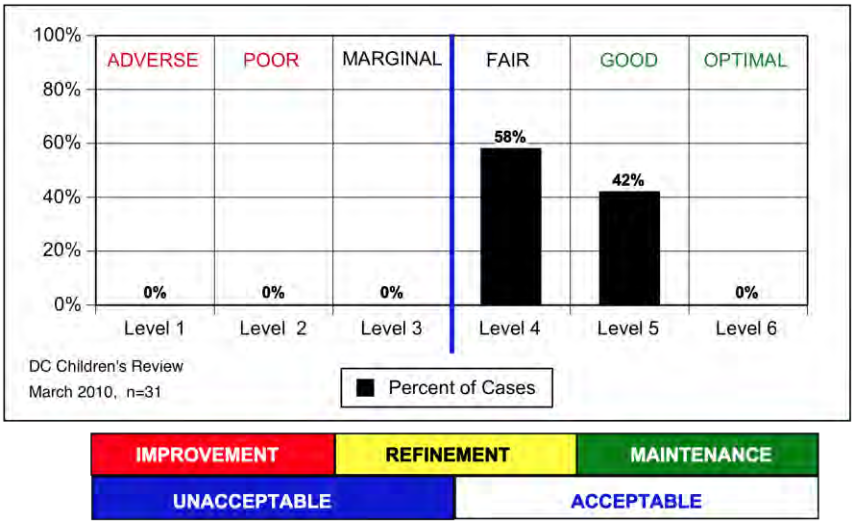
Display 28a
Outcome 1
Overall Child/Youth Status



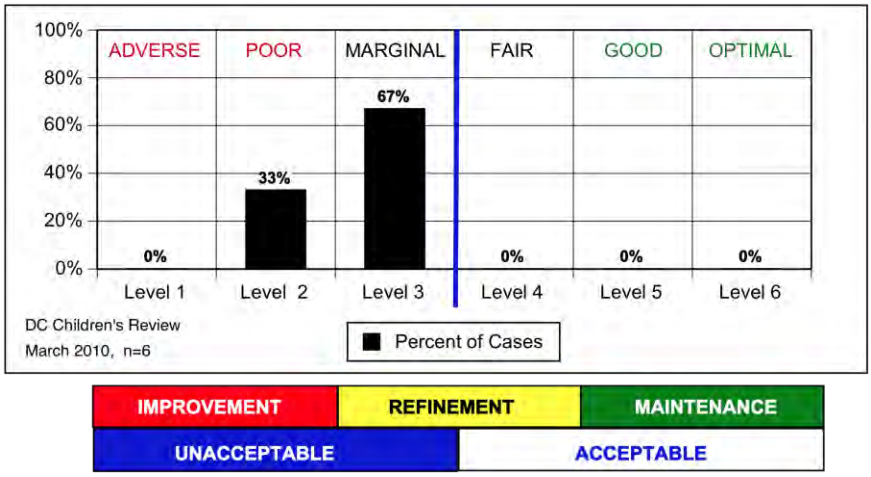
Display 28b
Outcome 1
Overall Recent Progress



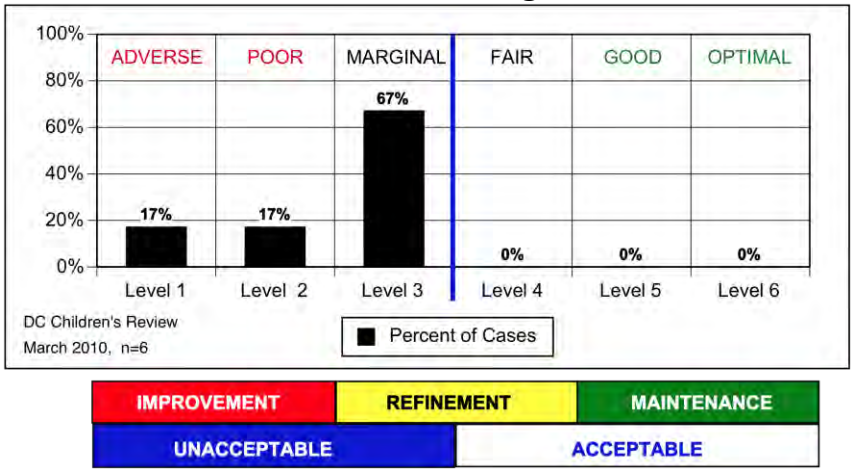
Display 28c
Outcome 1
Overall Practice Performance



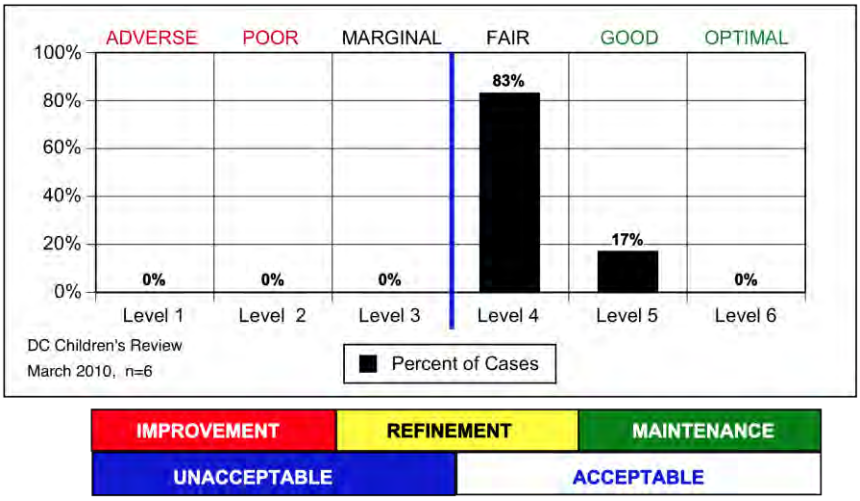
Display 29a
Outcome 2
Overall Child/Youth Status



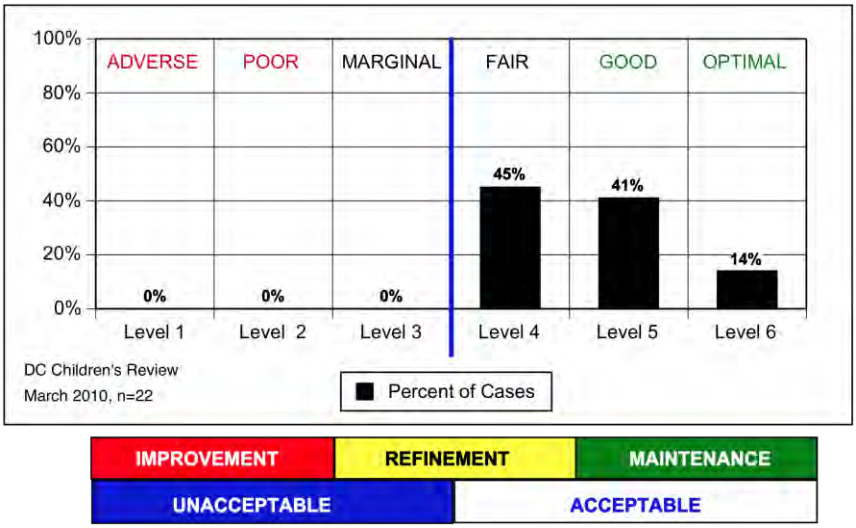
Display 29b
Outcome 2
Overall Recent Progress



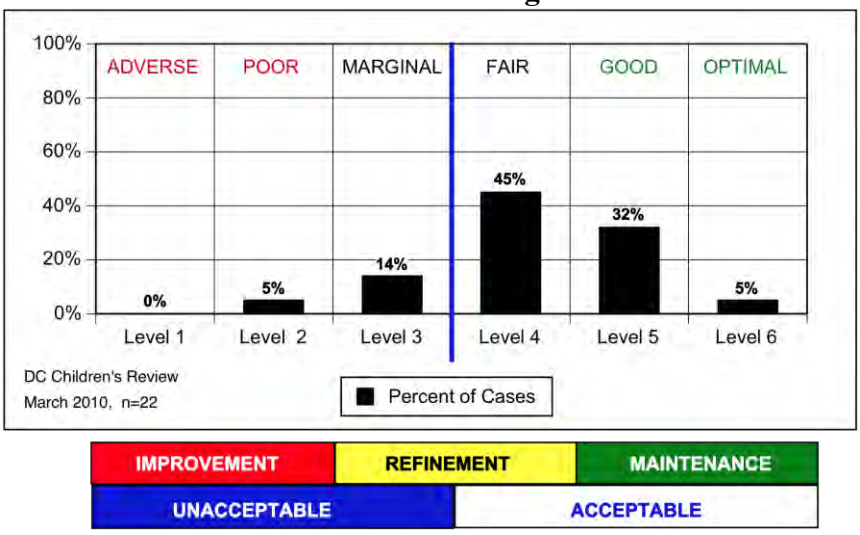
Display 29c
Outcome 2
Overall Practice Performance



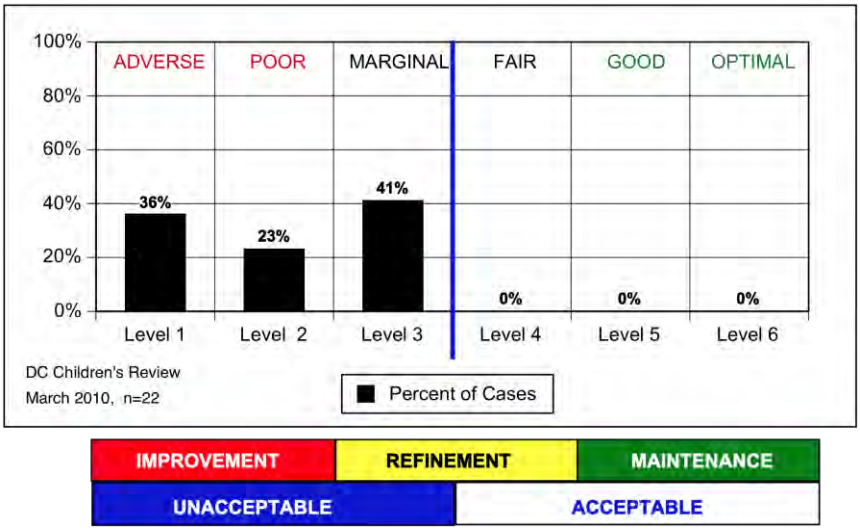
Display 30a
Outcome 3
Overall Child/Youth Status



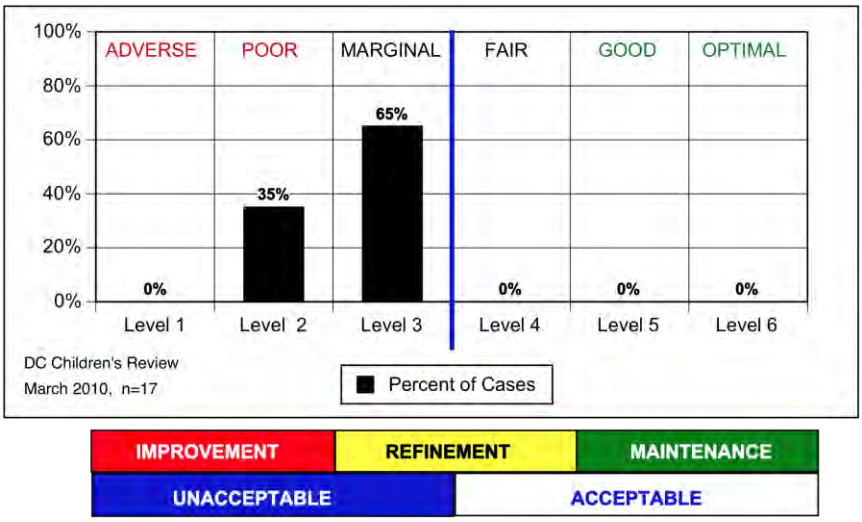
Display 30b
Outcome 3
Overall Recent Progress



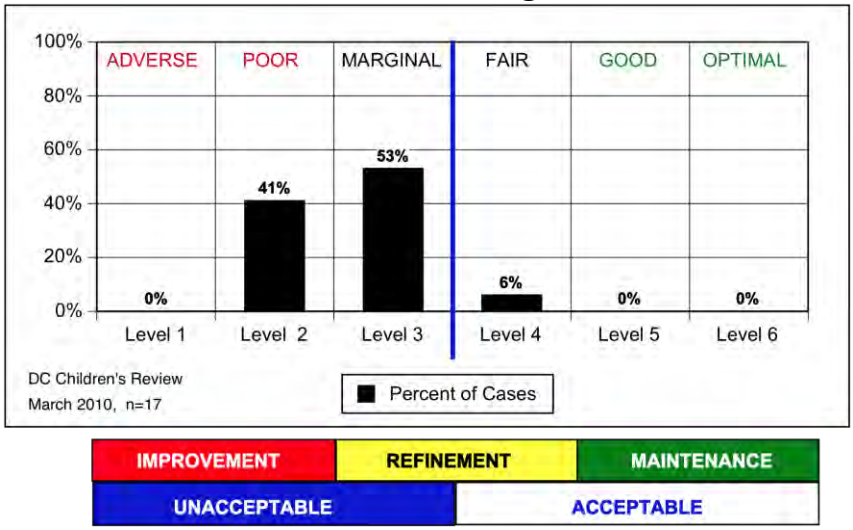
Display 30c
Outcome 3
Overall Practice Performance



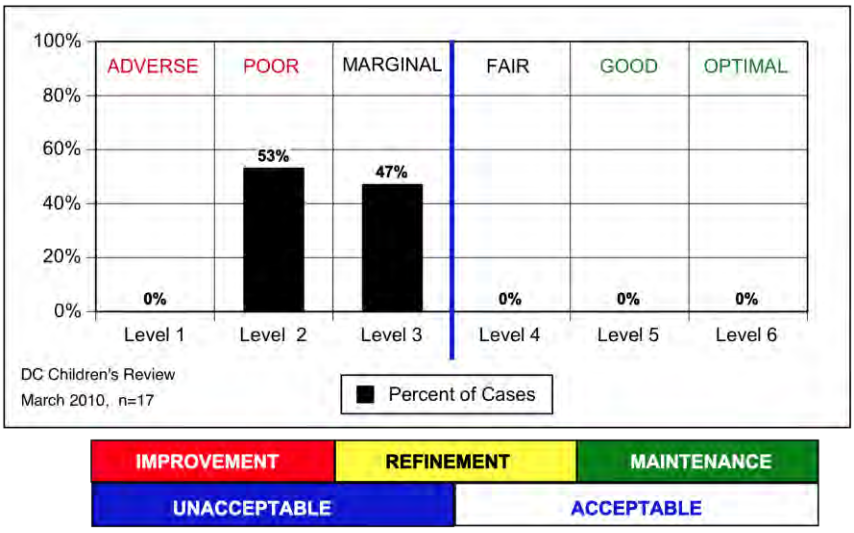
Display 31a
Outcome 4
Overall Child/Youth Status



Display 31b
Outcome 4
Overall Recent Progress



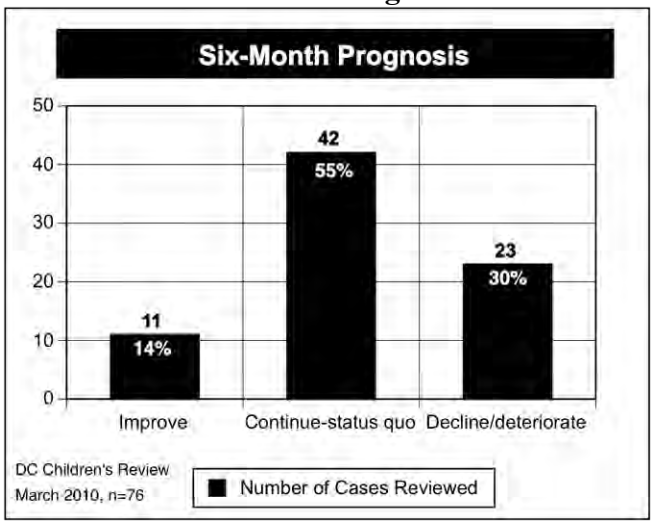
Display 31c
Outcome 4
Overall Practice Performance



Six-Month Prognosis

Reviewers provide a six-month prognosis for each member of the sample based on an overall impression of the current status and trajectory of the child or youth, how the system is performing for that individual child or youth, and any known upcoming transitions or changes. **Display 32** presents the six-month prognosis offered by reviewers for all children and youth in the review. As the display indicates, 11 youth (14%) were expected to improve, 42 (55%) were expected to remain about the same, and 23 (30%) 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 2009 review—53% and 32%, respectively. There is a 1% decrease in the youth expected to improve over the next six months (15% in 2009).

Display 32
Six-Month Prognosis

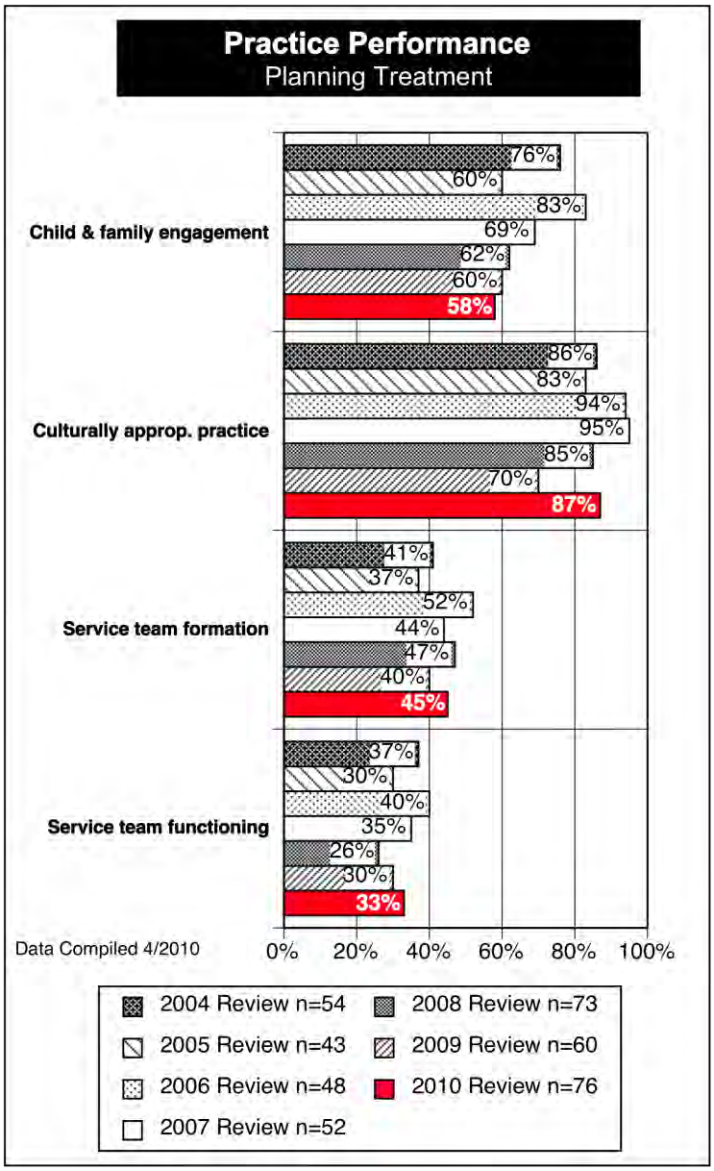


Overall, the results of the 2010 CSR data show that at a minimum, the consistency and quality of practice has improved somewhat over the past year, returning to the level reported in 2007 and 2009. The percentage of children who are provided services with the quality, coordination, consistency, and diligence necessary to achieve progress and improvements in children has improved by 15% 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

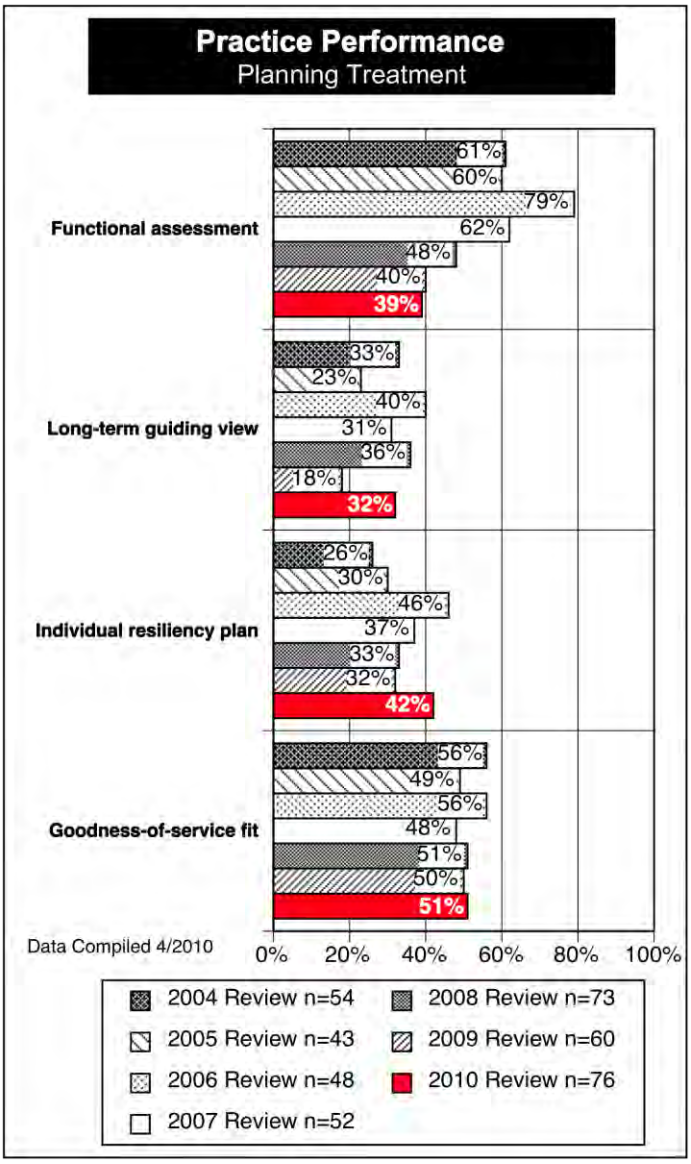
not being consistently met for approximately one-half of children and youth in the District of Columbia.

Display 33 shows the results for practice performance for seven of the eight 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.

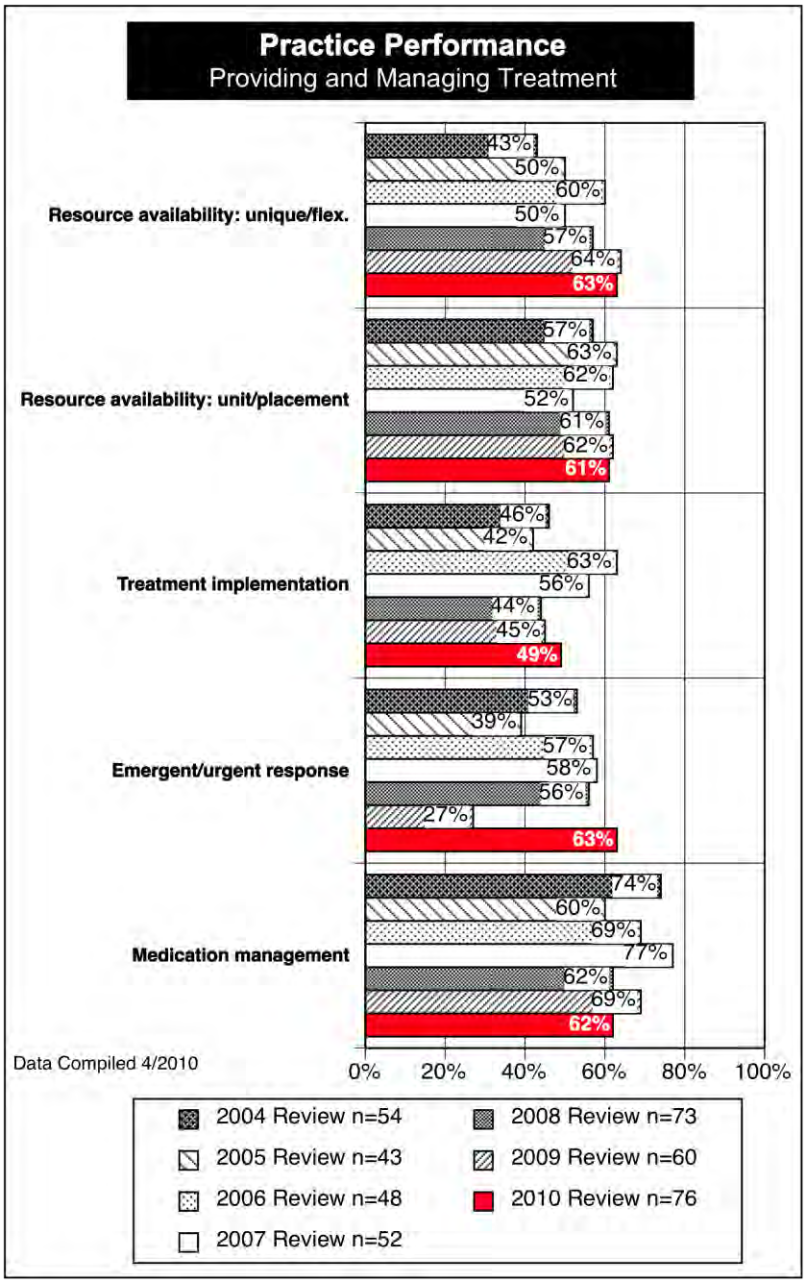
Display 33
Overall Child Practice Performance Results for Seven Reviews



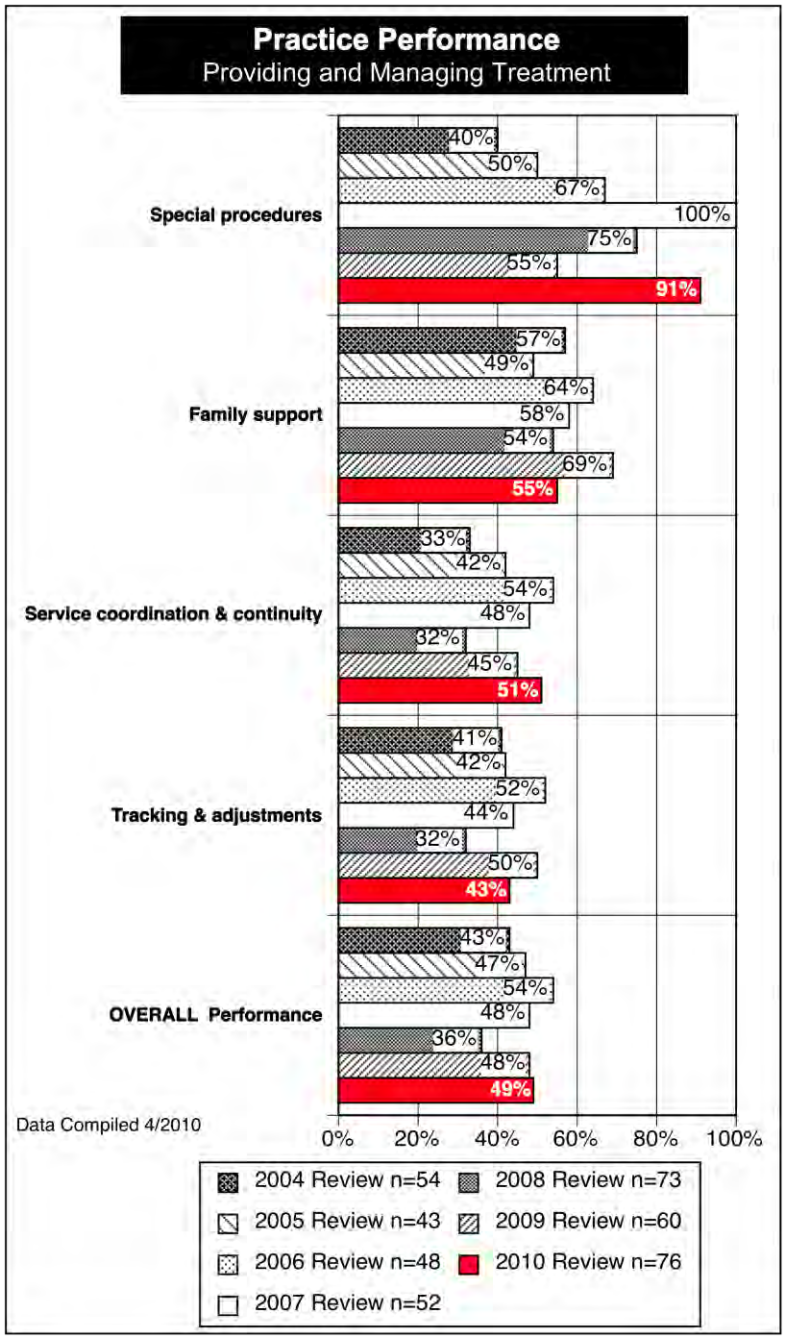
Display 33 (continued)
Overall Child Practice Performance Results for Seven Reviews



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



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



These findings are further reflected in the thematic issues identified in the case write-ups and debriefing of the service strengths, barriers, and patterns found for the 76 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 2010 review of services for children and youth. Ratings of 60% or more in the acceptable range included culturally appropriate practice, resource availability, urgent response, medication management, and special procedures. Ratings of 40% or less in the acceptable range included adequacy of team functioning, functional assessment, and long-term guiding view. 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 49% 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. (When the initials for a child/youth are duplicative, the birth year is provided for clarity.)

Role and Function of the CSW

The CSW position is evolving and plans are underway to identify the core competencies of this position, training, and a certificate that will attest to the position's status and importance. The CSW is an important link to families and its function greatly enhances the ongoing engagement

and assessment processes. Persons in these positions have identified the need for substantive training to help them better understand the role and scope of their positions. However, they do not want to be penalized for falling short of productivity goals while attending training. Other factors that were noted to negatively impact the effectiveness of this position included the geographic distribution of caseloads, paperwork requirements, making time for teaming, the need for stronger skill sets to deal with crises, and helping families understand the CSW's role and limitations. Case summaries that offer very positive descriptions of the use of the CSW position include: AB-1996, AH, MB-1999, PM, and LC. Case summaries that provide an illustration of issues related to the CSW position included: DG, RS, DM, DP, DL, AW, TS, MM, TH, LD, RB-2005, MP, and TH-2002.

Accessing Individual Therapists

Many of the individual therapists working with CSAs are contracted, and the time required by the MCO paneling process often results in delays in matching a therapist to a child, youth, or family. Families that come to the mental health system have often experienced severe trauma and violence, and 72% of the families served are also involved in child welfare, an additional indicator of trauma. Although there has been a change in the reimbursement rate, many of the therapists trained in trauma-informed therapy a few years ago left the area when the anticipated reimbursement rate did not materialize when expected through a change in the Medicaid state plan. Case summaries that provide an illustration of issues related to accessing individual therapists included: DV, MD, AB-1996, DL, PS, AM, and KW.

Team Formation and Functioning

Staff members within a CSA, e.g., the CSW and therapist, are often in regular communication with each other concerning a family, but communication and planning across agencies for a single family is an area of concern. Although staff members are aware of the expectation that treatment plans and interventions will be derived through a team process that involves the family, youth, and other persons that significantly impact the child or youth, the range of variability across CSAs is significant. Case summaries that provide illustrations of good team formation and functioning include: DB, ID, QC, DM, and AB-1994. Other case summaries that provide an illustration of issues related to team formation and functioning include: DG, RF, DM,

DJ, DP, AB-1996, DL, BS, DC, MB, CJ, AW, PS, TS, RF, KW, MM-1994, TW, DM-2002, MM-2004, RB-2005, TW-1993, NM, AC, SA, RB-1995, MP, AB-2006, TH-2002, JB, and DC-1996.

Treatment Planning

Treatment plans should be dynamic documents that describe the path that interveners will follow during a specified timeframe. Plans should show integration of strategies and services across providers with the goal of helping the child or youth function adequately at home, at school, and in the community, based upon a well-articulated long-term guiding view. The services, supports, and interventions that are authorized by the treatment plan should be known and understood by the family. When circumstances warrant, treatment plans should be changed and/or updated. Case summaries that provide an illustration of issues related to treatment planning include: RV, AG, DP, AB-1996, BS, DC, CJ, NW, TS, RF, TH, SJ, NM, SA, RB-1995, TJ, and DA.

Diagnostic Assessment

The clinical intake process is the opportunity for the mental health agency to create an in-depth understanding of the family context and focus child or youth, including school performance, health status, and emotional functioning. This diagnostic assessment process will create interveners' first impressions of the presenting problems and underlying issues. The process must lead to creation of a diagnosis that has functionality and gives direction to treatment planning. A three-hour comprehensive assessment can be billed, and additional hours can be pre-authorized by DMH, if clinically appropriate. Case summaries that provide an illustration of issues related to diagnostic assessment include: RS, CW, AB-1996, MB-1998, DS, TH, TM-1997, DH, RB-1995, JD, and AB-2006.

Working With Schools

Because one-third of a child or youth's typical day involves what goes on in school, the treatment team, and more specifically, interveners in positions like the CSW position, need to stay abreast of what is happening at school with a child or youth. Open lines of ongoing communication with the school help in planning and coordinating effective interventions. Whenever possible, school personnel need to be part of the treatment planning process. Case

summaries that provide an illustration of issues related to working with schools include: RV, DG, ID, DP, BS, AP-1992, DC, PS, MM-2004, LB, LD, MM-1996, and TH-2002.

Youth Voice

Around the age of 12 years, youth should begin to play an active role in the decisions made about treatment planning, services, and service providers. Engagement of the youth is critical to the success of many interventions. Together with their parents or other caregivers, youth should begin to assume some responsibility for their treatment by participating in team planning meetings and expressing their preferences for schedules, activities, and locations where services will be provided. Case summaries that provide an illustration of issues related to youth voice include: SN, DJ, DP, DL, TS, TW-1993, KS, DA, TJ, and AP-1993.

Stakeholder and Focus Group Observations

In addition to the child and family reviews, which included interviews with 446 persons, stakeholder interviews and focus groups were conducted with 66 persons who are involved with children's services in the District. 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, CFSA, D.C. Public Schools, and Magistrate Judge Goldfrank.

- Some CSAs are investing time and training for frontline staff in understanding and executing an articulated practice model. Staff reports increased focused attention on identifying family strengths and working with the family to set goals. The issue of teaming activities (contacts with collaterals) not being billable continues to be reported as a barrier to teaming. They also report that getting other agencies' frontline staff who should be on a particular child's team to respond to calls and participate in meetings is difficult.
- Areas of service access that continue to be challenging include after-school programming, housing for youth ages 18-21 years, access to psychiatrists (for both parents and staff), and waiting lists for individual therapists.

- Coordinating services with schools and maintaining ongoing lines of communication are often challenging. Schools are more responsive when the child/youth is presenting problems during the school day. CSWs and CBI workers are often the link between the school and the child's home. Communication and coordination of services with Level 5 schools appears to be particularly challenging.
- It is generally agreed that the mobile crisis unit is working well. Schools are benefitting from this service and some improved teaming with schools has been noted as a result.
- DMH is acknowledged as doing an excellent job in problem-solving issues related to credentialing a psychiatrist.
- The paneling process for individual therapists has been a barrier to some children/youth receiving timely services.
- More children are entering foster placements in Maryland creating challenges for service providers based in the District who must travel to the foster home, or for the foster parents who must transport the child to the District for service appointments.
- CFSA is working with DMH and has articulated a practice model that includes the following: no decisions made without a team, the CFSA social worker is the team convener, and individual performance is measured using the CSR methodology. CFSA reports the lowest number of children in residential treatment centers and an increase in the stability of children in foster placements with 80% or more having fewer than two placement changes.
- DMH is working with DYRS and CFSA to use the System of Care planning process to coordinate services and convene team meetings to divert children from residential treatment. The Director of Child and Youth Services reported that in one 90-day period, the diversion rate increased from 49% to 88%.
- Regular meetings are occurring between the DMH Director of Child and Youth Services, her staff, and the courts to problem-solve issues. The Assessment Center has significantly improved the timeliness of assessments generated for court-involved youth to 15 days or less.
- The CSW position has been widely adopted, and the role and expectations for the position vary across agencies. Of the 36 CSWs attending two focus group sessions, 11 had one year or more of experience. That means in this sample of workers, 70% had less than one year of experience. Common observations concerning the position included: paperwork is redundant and most of it is done at home after work hours; if 27 hours of billable work is not recorded,

vacation time is deducted from the employee; driving time to family homes is extensive; and some CSWs are unclear about their roles.

- CBI is a time-limited service (six months) that is too short for some children and youth. A step-down period should be allowable to transition the child/youth and family to a less intensive level of service. There is significant variability in the training and expertise of persons in this position across CSAs.
- Coordination of entry and discharge from the Psychiatric Institute of Washington is of concern with regard to medication continuity and follow-up.
- Stakeholders across the District are extremely positive about the leadership provided by the DMH Director of Child and Youth Services and find her responsive and engaged in effective problem solving.

The issues cited above are specific aspects of service delivery that need to be reviewed and refinements made to the processes that are identified as barriers. However, at this stage in the development of the children's mental health services in the District, it is apparent that there is wide variability of performance across providers. If DMH is to provide high quality consistent services across the district, then they are going to have to address the variability of performance at the provider level.

A positive example of providing providers with feedback following the 2009 review is that Community Connections made significant changes to supervision and training to focus more directly on the core practice functioning and dramatically improved their system performance results. **Appendix D** contains the aggregated performance of the top three providers on child status, child progress, and system performance compared with the ratings aggregated across the rest of the providers. The data are clear that there are significant differences in practice performance across providers.

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:

- Leadership in DMH that is committed to engaging collateral and other child service agencies, such as child welfare, in identifying and solving problems that affect the timely delivery of quality mental health services to children and youth and their families in the District.
- Leadership in CFSA that is similarly committed to creating stability for children and youth in foster care who need mental health services.
- CSAs that are seeing the CSR process as a learning and organizational development opportunity that benefits not only the children and youth and their families served by the agency, but also the professionals who strive to provide quality services.
- Dedicated and committed CSWs and therapists who make every effort to improve the functioning and well-being of the children and families they serve. These staff members frequently overcome significant challenges to make a difference in children's lives. More effort needs to be made to ensure that the processes and requirements of the system facilitate and not impede the efforts of these staff members to provide high quality services responsive to the needs of their clients.

Recommendations

- In the short term, data from the CSRs that have occurred since 2004 should be aggregated by provider and given to each mental health provider that currently contracts with DMH for children's services. DMH staff and the provider agency should develop intervention strategies that focus on improving performance in engagement, assessment and understanding, long-term guiding view, teaming, treatment implementation, and service coordination.
- Also in the short term, DMH staff should review the steps Community Connections has taken during the past 12 months that have led to substantial improvement in their overall performance rating for 2010, which was 70% acceptable for ten cases (25% acceptable for 12

cases in 2009). There may be lessons to be learned from their focus on articulating and promoting the practice model within the agency, training both frontline and supervisory staff in the practice model, and supporting supervisors in making clinical supervision effectively relate to the practice model.

- Pursue the creation of core competencies, training, and a certification process for the CSW position to give this position status and consistency across the District.
- Review the clinical intake and ongoing assessment process to ensure that it is robust and serves to create the essential information for arriving at a diagnosis and an in-depth understanding of a child and family's circumstances that has functionality and gives direction to treatment planning.
- Provide frontline workers with access to the community resource directory online at http://www.211metrodc.org/. The National Capital Regional 2-1-1 Database has information about human services programs that provide assistance in finding child care, jobs, health care, and emergency services in the District, Maryland, and Northern Virginia.

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.

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

Managing Treatment & Support

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

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

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

Appendix B

CSR Interpretative Guide for Child Status

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Improvement Zone: 1-2

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

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

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

Unacceptable Range: 1-3

CSR Interpretative Guide for Practice Performance

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

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= 2 DC Child Review March 2010

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

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

CSR/Child Status and Performance Profile

Affordable Behavioral Consultants | n= 2 | DC Child Review March 2010

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

CSR/Child Status and Performance Profile

Community Connections n= 10 DC Child Review March 2010

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	10	60%	10%	40%	50%
Stability	10	60%	0%	70%	30%
Home & school placement	10	90%	0%	50%	50%
Caregiver support of child	10	60%	30%	10%	60%
Satisfaction	10	70%	0%	50%	50%
Health/Phy well-being	10	80%	0%	30%	70%
Functional status	10	50%	40%	60%	0%
Academic status	10	50%	30%	40%	30%
Responsible social behavior	10	40%	10%	80%	10%
Lawful behavior	8	63%	0%	63%	38%
Overall C & F Status	10	60%	10%	60%	30%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	10	50%	20%	70%	10%
Behavior improvement	10	30%	20%	80%	0%
School/work progress	9	56%	33%	44%	22%
Risk reduction	9	67%	11%	78%	11%
Transition progress	8	38%	13%	75%	13%
Meaningful relationships	10	80%	0%	80%	20%
Overall Progress	10	50%	20%	70%	10%

CSR/Child Status and Performance Profile

Community Connections n= 10 DC Child Review March 2010

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	10	80%	0%	60%	40%
Culturally appropriate practice	3	100%	0%	0%	100%
Service team formation	10	80%	0%	50%	50%
Service team functioning	10	50%	0%	80%	20%
Functional assessment	10	50%	0%	70%	30%
Long-term guiding view	10	50%	20%	70%	10%
IRP	10	70%	10%	70%	20%
Goodness-of-service fit	10	60%	10%	70%	20%
Resource avail.: unique/flex.	10	70%	10%	50%	40%
Resource availability: unit/place.	8	50%	0%	50%	50%
Treatment implementation	10	60%	10%	70%	20%
Emergent/urgent response	6	67%	0%	67%	33%
Medication management	7	71%	0%	57%	43%
Special procedures	1	100%	0%	100%	0%
Familty support	9	78%	11%	33%	56%
Service coord. & continuity	10	70%	0%	50%	50%
Tracking & adjustment	10	70%	0%	60%	40%
Overall Practice Performance	10	70%	10%	70%	20%

CSR/Child Status and Performance Profile

Family Matters n= 1 DC Child Review March 2010

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

CSR/Child Status and Performance Profile

Family Matters n= 1 DC Child Review March 2010

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%	0%	100%	0%
Functional assessment	1	0%	100%	0%	0%
Long-term guiding view	1	0%	0%	100%	0%
IRP	1	0%	0%	100%	0%
Goodness-of-service fit	1	0%	0%	100%	0%
Resource avail.: unique/flex.	1	100%	0%	100%	0%
Resource availability: unit/place.	1	100%	0%	0%	100%
Treatment implementation	1	0%	100%	0%	0%
Emergent/urgent response					
Medication management					
Special procedures					
Familty support	1	0%	100%	0%	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

Family Preservation n= 2 DC Child Review March 2010

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

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

CSR/Child Status and Performance Profile

Family Preservation n= 2 DC Child Review March 2010

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

CSR/Child Status and Performance Profile

Fihankra Place n= 1 DC Child Review March 2010

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	1	100%	0%	0%	100%
Stability	1	0%	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	100%	0%	100%	0%
Academic status	1	100%	0%	0%	100%
Responsible social behavior	1	100%	0%	0%	100%
Lawful behavior					
Overall C & F Status	1	100%	0%	100%	0%

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

CSR/Child Status and Performance Profile

Fihankra Place n= 1 DC Child Review March 2010

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	0%	0%	100%	0%
Long-term guiding view	1	0%	100%	0%	0%
IRP	1	0%	0%	100%	0%
Goodness-of-service fit	1	0%	100%	0%	0%
Resource avail.: unique/flex.	1	0%	0%	100%	0%
Resource availability: unit/place.					
Treatment implementation	1	0%	0%	100%	0%
Emergent/urgent response					
Medication management					
Special procedures					
Familty support	1	0%	100%	0%	0%
Service coord. & continuity	1	0%	0%	100%	0%
Tracking & adjustment	1	0%	0%	100%	0%
Overall Practice Performance	1	0%	100%	0%	0%

CSR/Child Status and Performance Profile

First Home Care n= 21 DC Child Review March 2010

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	21	81%	10%	48%	43%
Stability	21	57%	10%	76%	14%
Home & school placement	21	86%	10%	24%	67%
Caregiver support of child	21	81%	5%	38%	57%
Satisfaction	21	81%	5%	52%	43%
Health/Phy well-being	21	95%	0%	24%	76%
Functional status	21	48%	14%	67%	19%
Academic status	21	62%	29%	52%	19%
Responsible social behavior	21	48%	19%	62%	19%
Lawful behavior	13	77%	0%	38%	62%
Overall C & F Status	21	67%	5%	57%	38%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	21	57%	14%	62%	24%
Behavior improvement	21	57%	19%	62%	19%
School/work progress	21	48%	29%	43%	29%
Risk reduction	19	42%	5%	68%	26%
Transition progress	16	50%	25%	50%	25%
Meaningful relationships	21	76%	5%	57%	38%
Overall Progress	21	57%	14%	62%	24%

CSR/Child Status and Performance Profile

First Home Care n= 21 DC Child Review March 2010

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	21	71%	19%	48%	33%
Culturally appropriate practice	4	100%	0%	0%	100%
Service team formation	21	57%	24%	52%	24%
Service team functioning	21	48%	19%	67%	14%
Functional assessment	21	48%	19%	62%	19%
Long-term guiding view	21	29%	33%	57%	10%
IRP	21	52%	29%	52%	19%
Goodness-of-service fit	21	76%	19%	48%	33%
Resource avail.: unique/flex.	21	76%	14%	33%	52%
Resource availability: unit/place.	18	72%	28%	22%	50%
Treatment implementation	21	62%	19%	48%	33%
Emergent/urgent response	10	80%	20%	50%	30%
Medication management	8	100%	0%	38%	63%
Special procedures	5	100%	0%	80%	20%
Familty support	21	81%	10%	38%	52%
Service coord. & continuity	21	67%	14%	43%	43%
Tracking & adjustment	21	57%	19%	52%	29%
Overall Practice Performance	21	71%	24%	52%	24%

CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 5 DC Child Review March 2010

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	5	80%	20%	20%	60%
Stability	5	40%	40%	40%	20%
Home & school placement	5	80%	20%	40%	40%
Caregiver support of child	5	60%	0%	60%	40%
Satisfaction	5	40%	0%	60%	40%
Health/Phy well-being	5	80%	20%	20%	60%
Functional status	5	40%	20%	40%	40%
Academic status	5	40%	40%	40%	20%
Responsible social behavior	5	40%	40%	40%	20%
Lawful behavior	5	60%	0%	60%	40%
Overall C & F Status	5	40%	40%	40%	20%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	5	40%	20%	80%	0%
Behavior improvement	5	40%	40%	40%	20%
School/work progress	5	40%	40%	40%	20%
Risk reduction	4	25%	0%	75%	25%
Transition progress	5	20%	40%	40%	20%
Meaningful relationships	5	60%	20%	60%	20%
Overall Progress	5	40%	20%	60%	20%

CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 5 DC Child Review March 2010

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	5	40%	0%	80%	20%
Culturally appropriate practice	2	50%	0%	100%	0%
Service team formation	5	20%	20%	80%	0%
Service team functioning	5	20%	40%	40%	20%
Functional assessment	5	20%	60%	40%	0%
Long-term guiding view	5	20%	60%	40%	0%
IRP	5	20%	0%	80%	20%
Goodness-of-service fit	5	20%	0%	80%	20%
Resource avail.: unique/flex.	5	20%	0%	100%	0%
Resource availability: unit/place.	4	25%	0%	75%	25%
Treatment implementation	5	40%	20%	60%	20%
Emergent/urgent response	3	33%	0%	67%	33%
Medication management	3	33%	0%	100%	0%
Special procedures	1	100%	0%	0%	100%
Familty support	4	50%	0%	75%	25%
Service coord. & continuity	5	40%	0%	80%	20%
Tracking & adjustment	5	20%	20%	60%	20%
Overall Practice Performance	5	20%	0%	80%	20%

CSR/Child Status and Performance Profile

Launch LLC n= 5 DC Child Review March 2010

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	5	100%	0%	40%	60%
Stability	5	80%	0%	60%	40%
Home & school placement	5	100%	0%	20%	80%
Caregiver support of child	5	80%	20%	0%	80%
Satisfaction	5	60%	20%	20%	60%
Health/Phy well-being	5	100%	0%	0%	100%
Functional status	5	60%	20%	40%	40%
Academic status	5	60%	20%	40%	40%
Responsible social behavior	5	80%	20%	20%	60%
Lawful behavior	4	75%	0%	50%	50%
Overall C & F Status	5	80%	0%	40%	60%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	5	60%	0%	60%	40%
Behavior improvement	5	60%	0%	40%	60%
School/work progress	5	80%	20%	20%	60%
Risk reduction	4	75%	25%	25%	50%
Transition progress	4	50%	25%	50%	25%
Meaningful relationships	4	75%	0%	50%	50%
Overall Progress	5	60%	20%	20%	60%

CSR/Child Status and Performance Profile

Launch LLC n= 5 DC Child Review March 2010

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	5	60%	20%	40%	40%
Culturally appropriate practice	2	100%	0%	0%	100%
Service team formation	5	40%	60%	0%	40%
Service team functioning	5	40%	60%	0%	40%
Functional assessment	5	60%	20%	20%	60%
Long-term guiding view	5	60%	40%	20%	40%
IRP	5	60%	20%	20%	60%
Goodness-of-service fit	5	40%	20%	40%	40%
Resource avail.: unique/flex.	5	60%	20%	40%	40%
Resource availability: unit/place.	4	75%	0%	50%	50%
Treatment implementation	5	40%	20%	40%	40%
Emergent/urgent response	2	100%	0%	0%	100%
Medication management	1	0%	0%	100%	0%
Special procedures					
Familty support	5	40%	40%	20%	40%
Service coord. & continuity	5	40%	40%	40%	20%
Tracking & adjustment	5	60%	40%	20%	40%
Overall Practice Performance	5	60%	40%	20%	40%

CSR/Child Status and Performance Profile

Latin American Youth Services n= 1 DC Child Review March 2010

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	0%	0%	100%	0%
Satisfaction	1	100%	0%	0%	100%
Health/Phy well-being	1	100%	0%	0%	100%
Functional status	1	100%	0%	100%	0%
Academic status	1	100%	0%	100%	0%
Responsible social behavior	1	100%	0%	100%	0%
Lawful behavior	1	100%	0%	0%	100%
Overall C & F Status	1	100%	0%	100%	0%

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	0%	0%	100%	0%
Risk reduction	1	100%	0%	100%	0%
Transition progress	1	100%	0%	100%	0%
Meaningful relationships	1	100%	0%	100%	0%
Overall Progress	1	100%	0%	100%	0%

CSR/Child Status and Performance Profile

Latin American Youth Services n= 1 DC Child Review March 2010

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	1	100%	0%	100%	0%
Culturally appropriate practice	1	100%	0%	0%	100%
Service team formation	1	100%	0%	100%	0%
Service team functioning	1	100%	0%	100%	0%
Functional assessment	1	100%	0%	0%	100%
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.	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	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

Life Stride n= 4 DC Child Review March 2010

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

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

CSR/Child Status and Performance Profile

Life Stride n= 4 DC Child Review March 2010

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

CSR/Child Status and Performance Profile

Mary's Center n= 2 DC Child Review March 2010

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

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

CSR/Child Status and Performance Profile

Mary's Center n= 2 DC Child Review March 2010

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

CSR/Child Status and Performance Profile

Multicultural Human Services n= 3 DC Child Review March 2010

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

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

CSR/Child Status and Performance Profile

Multicultural Human Services **n= 3** **DC Child Review March 2010**

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

CSR/Child Status and Performance Profile

Progressive Life n= 3 DC Child Review March 2010

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

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	3	67%	33%	33%	33%
Behavior improvement	3	67%	0%	67%	33%
School/work progress	3	67%	0%	67%	33%
Risk reduction	1	100%	0%	100%	0%
Transition progress	2	0%	100%	0%	0%
Meaningful relationships	3	100%	0%	33%	67%
Overall Progress	3	67%	0%	67%	33%

CSR/Child Status and Performance Profile

Progressive Life n= 3 DC Child Review March 2010

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

CSR/Child Status and Performance Profile

PSI Services n= 2 DC Child Review March 2010

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

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

CSR/Child Status and Performance Profile

PSI Services n= 2 DC Child Review March 2010

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	2	0%	100%	0%	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%	50%	50%	0%
Resource availability: unit/place.	1	0%	100%	0%	0%
Treatment implementation	2	0%	100%	0%	0%
Emergent/urgent response	1	0%	100%	0%	0%
Medication management	1	0%	100%	0%	0%
Special procedures					
Familty support	2	0%	100%	0%	0%
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

Scruples Corporation n= 8 DC Child Review March 2010

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	8	75%	0%	63%	38%
Stability	8	63%	13%	38%	50%
Home & school placement	8	75%	13%	25%	63%
Caregiver support of child	8	63%	25%	38%	38%
Satisfaction	7	71%	14%	57%	29%
Health/Phy well-being	8	75%	0%	75%	25%
Functional status	8	63%	0%	88%	13%
Academic status	8	50%	13%	63%	25%
Responsible social behavior	8	63%	13%	63%	25%
Lawful behavior	7	71%	14%	29%	57%
Overall C & F Status	8	75%	13%	63%	25%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	8	75%	13%	75%	13%
Behavior improvement	8	88%	0%	88%	13%
School/work progress	8	50%	25%	50%	25%
Risk reduction	7	29%	29%	71%	0%
Transition progress	7	57%	14%	71%	14%
Meaningful relationships	7	57%	0%	71%	29%
Overall Progress	8	50%	0%	88%	13%

CSR/Child Status and Performance Profile

Scruples Corporation n= 8 DC Child Review March 2010

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

CSR/Child Status and Performance Profile

Universal Health Care n= 6 DC Child Review March 2010

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	6	100%	0%	33%	67%
Stability	6	50%	17%	50%	33%
Home & school placement	6	83%	17%	17%	67%
Caregiver support of child	6	67%	0%	50%	50%
Satisfaction	6	67%	33%	17%	50%
Health/Phy well-being	6	100%	0%	0%	100%
Functional status	6	100%	0%	67%	33%
Academic status	6	83%	17%	33%	50%
Responsible social behavior	6	83%	17%	50%	33%
Lawful behavior	5	80%	0%	40%	60%
Overall C & F Status	6	83%	17%	33%	50%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	6	67%	0%	67%	33%
Behavior improvement	6	83%	17%	50%	33%
School/work progress	5	100%	0%	40%	60%
Risk reduction	4	50%	25%	75%	0%
Transition progress	5	40%	20%	60%	20%
Meaningful relationships	6	67%	0%	50%	50%
Overall Progress	6	83%	17%	67%	17%

CSR/Child Status and Performance Profile

Universal Health Care n= 6 DC Child Review March 2010

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	6	33%	33%	33%	33%
Culturally appropriate practice	2	50%	50%	50%	0%
Service team formation	6	33%	50%	33%	17%
Service team functioning	6	17%	50%	50%	0%
Functional assessment	6	50%	33%	33%	33%
Long-term guiding view	6	17%	67%	17%	17%
IRP	6	17%	50%	50%	0%
Goodness-of-service fit	6	50%	50%	50%	0%
Resource avail.: unique/flex.	5	60%	40%	20%	40%
Resource availability: unit/place.	5	60%	40%	20%	40%
Treatment implementation	6	50%	50%	33%	17%
Emergent/urgent response	3	67%	33%	0%	67%
Medication management	2	50%	0%	100%	0%
Special procedures	1	100%	0%	0%	100%
Familty support	2	0%	0%	100%	0%
Service coord. & continuity	6	50%	50%	33%	17%
Tracking & adjustment	6	33%	67%	33%	0%
Overall Practice Performance	6	50%	50%	33%	17%

Appendix D

Aggregated Performance of the Top Three Providers on Child Status, Child Progress, and System Performance Compared with the Aggregated Ratings Across the Rest of the Providers

Top Three Providers (with 4 or more cases) = 35 cases or 46% of the total cases reviewed

The Rest of the Providers = 41 cases or 54% of the total cases

Overall Status and Practice
Top Three Providers (with 4 or more cases)

6/4/2010

CSR/Child Status and Performance Profile - Provider Frequency

# of kids **10** DC Child Review March 2010

Providers	Status	Practice	Number	Percent
Community Connections	**60%**	**70%**	10	100%
			10	100%

6/4/2010

CSR/Child Status and Performance Profile - Provider Frequency

# of kids **21** DC Child Review March 2010

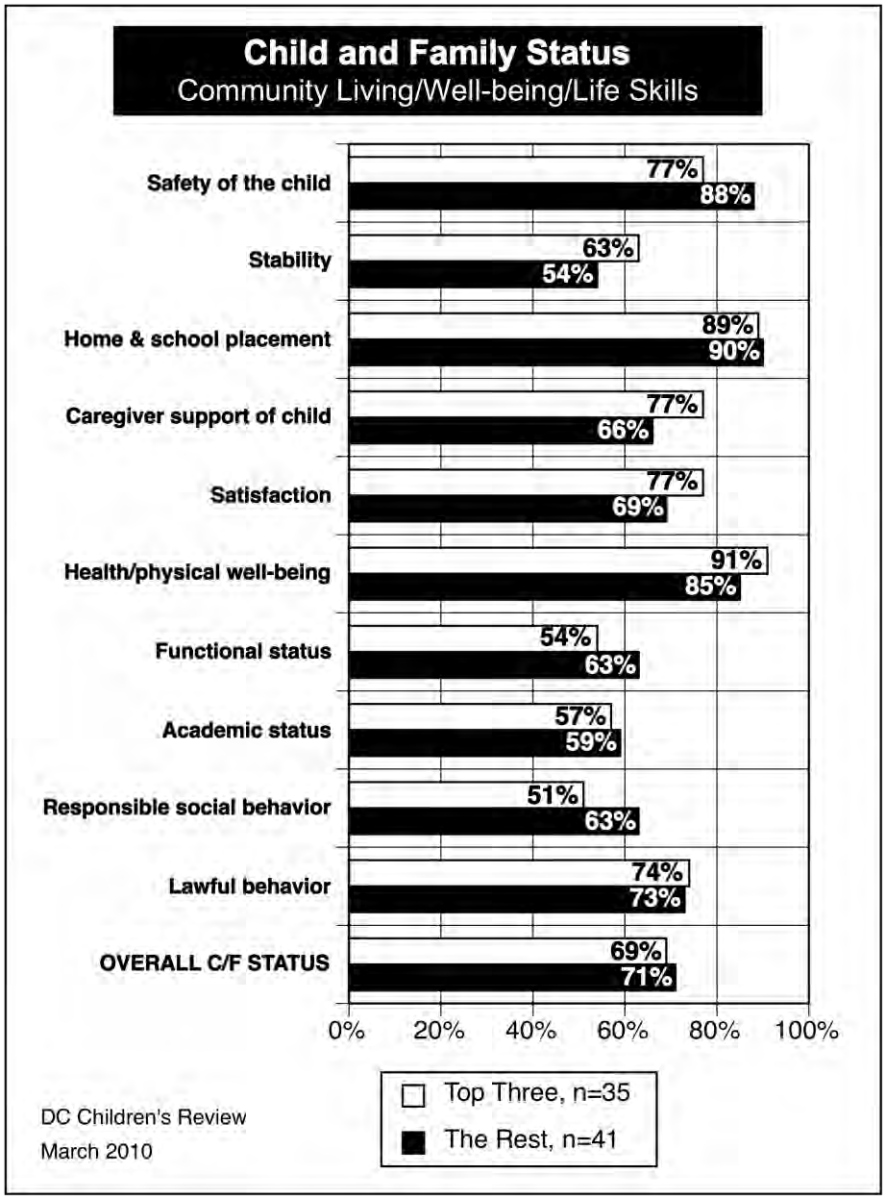
Providers	Status	Practice	Number	Percent
First Home Care	**67%**	**71%**	21	100%
			21	100%

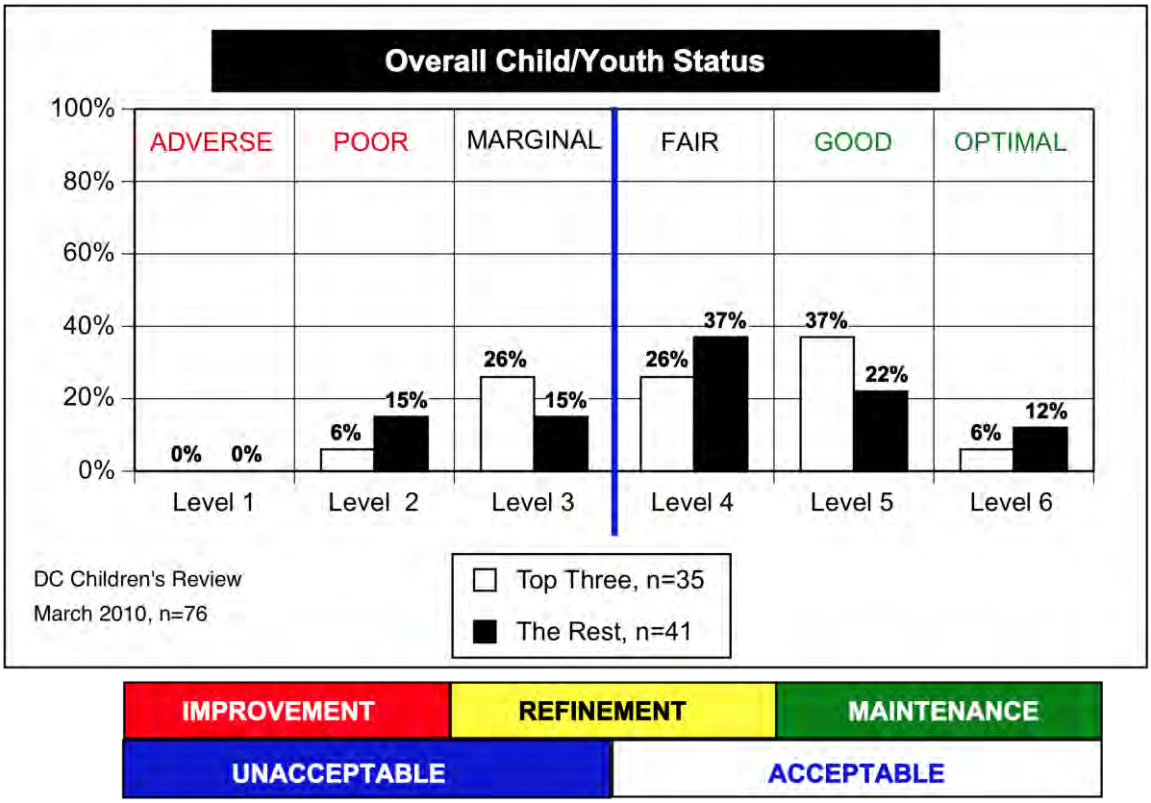
6/4/2010

CSR/Child Status and Performance Profile - Provider Frequency

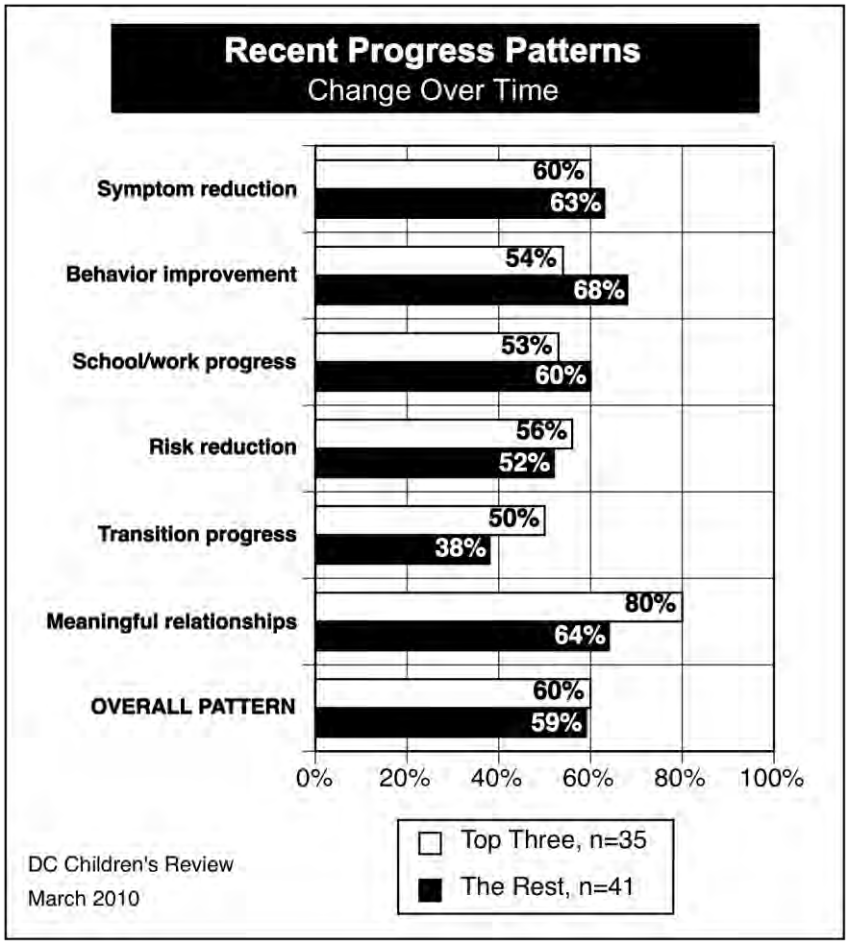
# of kids **4** DC Child Review March 2010

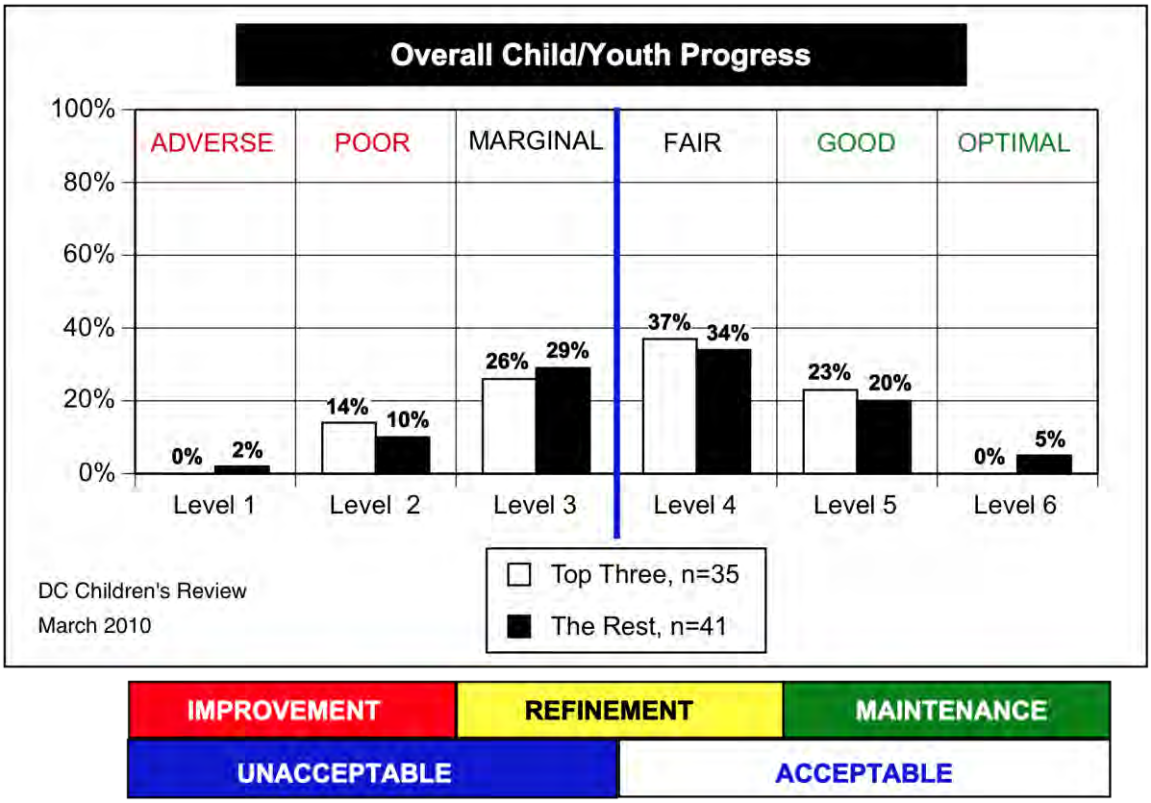
Providers	Status	Practice	Number	Percent
Life Stride	**100%**	**75%**	4	100%
			4	100%


Child and Family Status
Community Living/Well-being/Life Skills
Safety of the child
77%
88%
Stability
63%
54%
Home & school placement
89%
90%
Caregiver support of child
77%
66%
Satisfaction
77%
69%
Health/physical well-being
91%
85%
Functional status
54%
63%
Academic status
57%
59%
Responsible social behavior
51%
63%
Lawful behavior
74%
73%
OVERALL C/F STATUS
69%
71%
0%
20%
40%
60%
80%
100%
Top Three, n=35
The Rest, n=41
DC Children's Review
March 2010

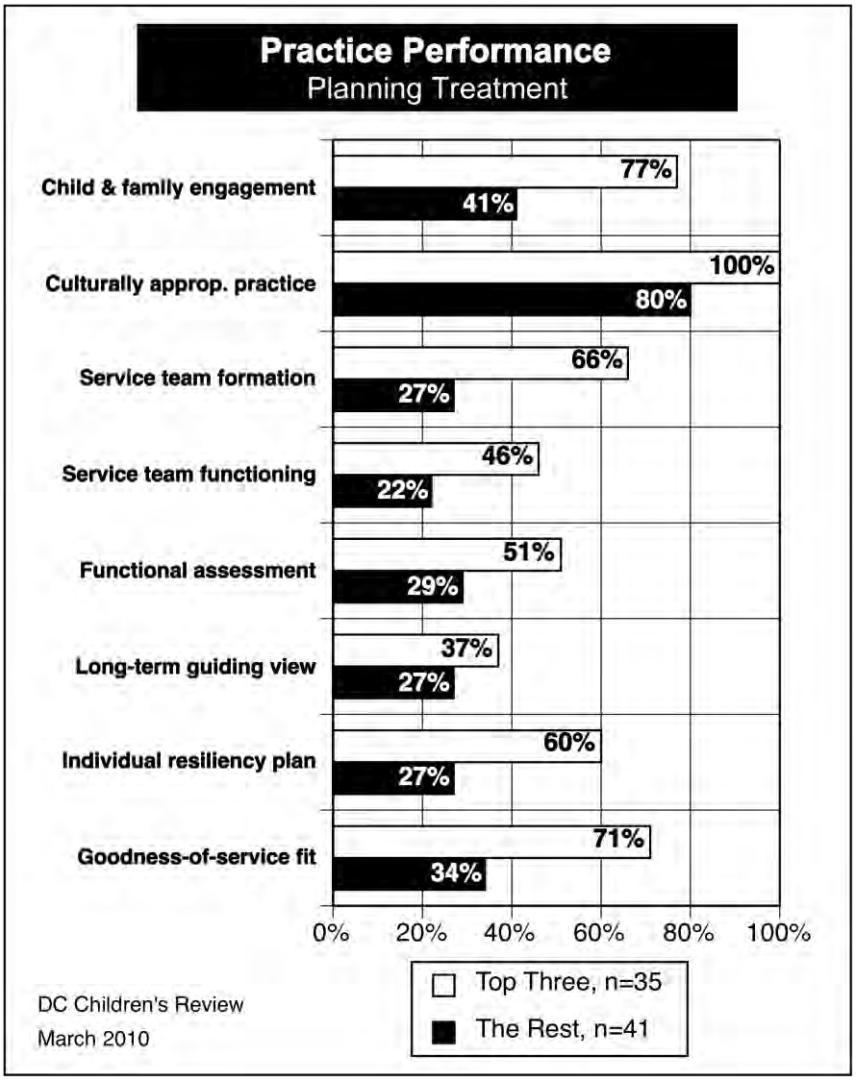

Overall Child/Youth Status
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
0%
0%
6%
15%
26%
15%
26%
37%
37%
22%
6%
12%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
DC Children's Review
March 2010, n=76
Top Three, n=35
The Rest, n=41

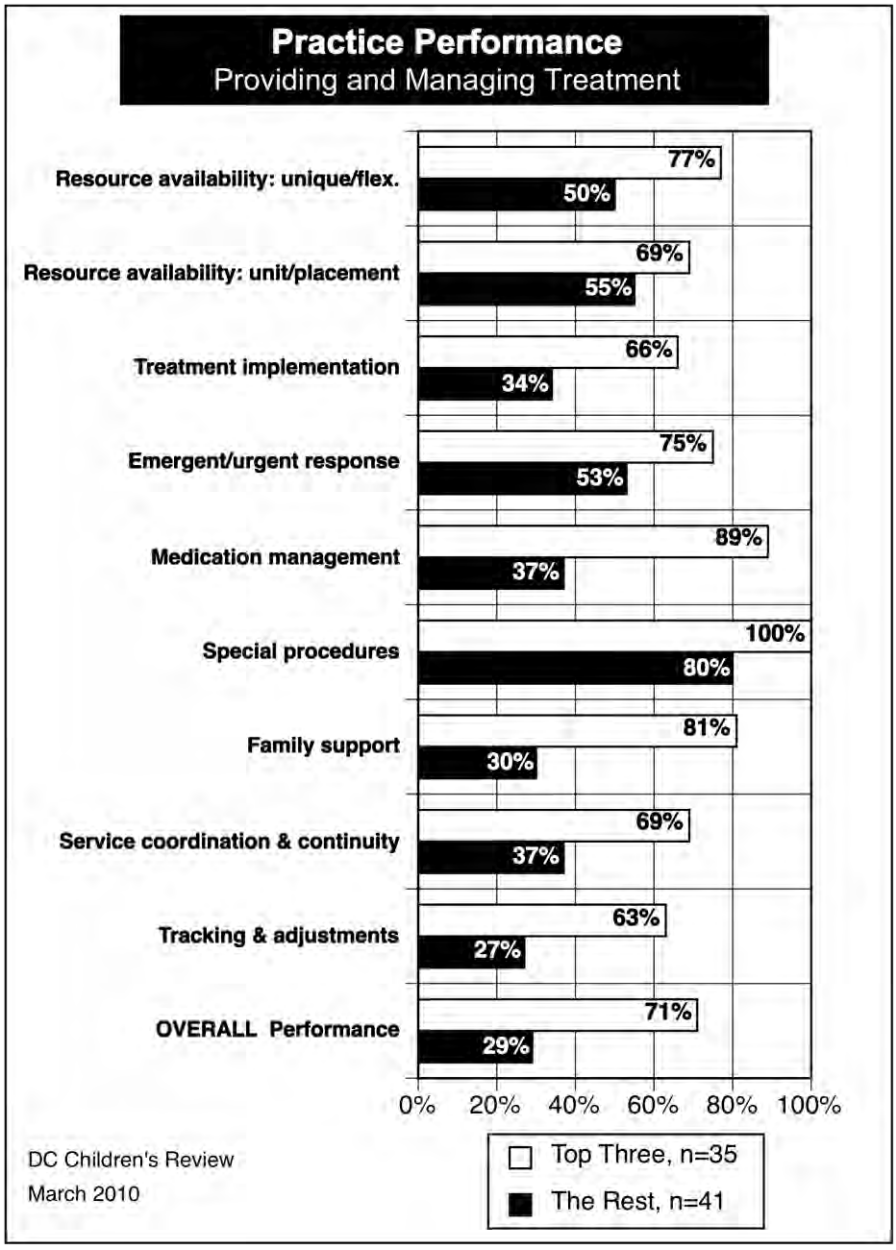
IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE

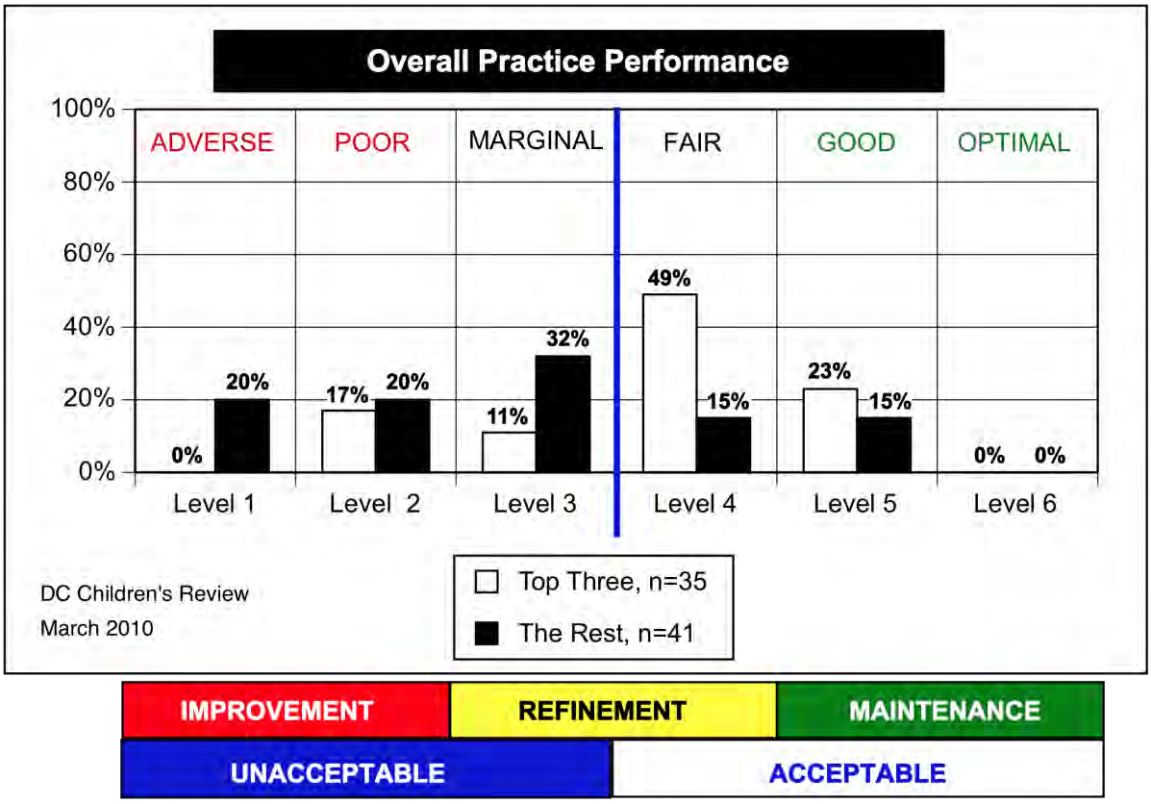

Recent Progress Patterns
Change Over Time
Symptom reduction
60%
63%
Behavior improvement
54%
68%
School/work progress
53%
60%
Risk reduction
56%
52%
Transition progress
50%
38%
Meaningful relationships
80%
64%
OVERALL PATTERN
60%
59%
0%
20%
40%
60%
80%
100%
Top Three, n=35
The Rest, n=41
DC Children's Review
March 2010


Overall Child/Youth Progress
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
0%
2%
14%
10%
26%
29%
37%
34%
23%
20%
0%
5%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
Top Three, n=35
The Rest, n=41
DC Children's Review
March 2010

IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE


Practice Performance
Planning Treatment
Child & family engagement
77%
41%
Culturally approp. practice
100%
80%
Service team formation
66%
27%
Service team functioning
46%
22%
Functional assessment
51%
29%
Long-term guiding view
37%
27%
Individual resiliency plan
60%
27%
Goodness-of-service fit
71%
34%
0%
20%
40%
60%
80%
100%
Top Three, n=35
The Rest, n=41
DC Children's Review
March 2010


Practice Performance
Providing and Managing Treatment
Resource availability: unique/flex.
77%
50%
Resource availability: unit/placement
69%
55%
Treatment implementation
66%
34%
Emergent/urgent response
75%
53%
Medication management
89%
37%
Special procedures
100%
80%
Family support
81%
30%
Service coordination & continuity
69%
37%
Tracking & adjustments
63%
27%
OVERALL Performance
71%
29%
0% 20% 40% 60% 80% 100%
DC Children's Review
March 2010
Top Three, n=35
The Rest, n=41


Overall Practice Performance
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
0%
20%
17%
20%
11%
32%
49%
15%
23%
15%
0%
0%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
DC Children's Review
March 2010
Top Three, n=35
The Rest, n=41

IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE

Case Review Outcome Categories

Status of Child/Family in Individual Cases

Acceptability of Service System Performance in Individual Cases	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/family, ongoing services acceptable. **57% (20 cases) Top Three** **27% (11 cases) The Rest**	**Outcome 2:** Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **14% (5 cases) Top Three** **2% (1 case) The Rest**	**71%** **29%**
Unacceptable System Performance	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **11% (4 cases) Top Three** **44% (18 cases) The Rest**	**Outcome 4:** Poor status for child/family, ongoing services unacceptable. **17% (6 cases) Top Threet** **27% (11 cases) The Rest**	**28%** **71%**
	68% **71%**	**31%** **29%**	

DC Children's Review
March 2010