2011 Report on Children and Youth

Served by the
District of Columbia
Department of Mental Health

June 2011

Presented to the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

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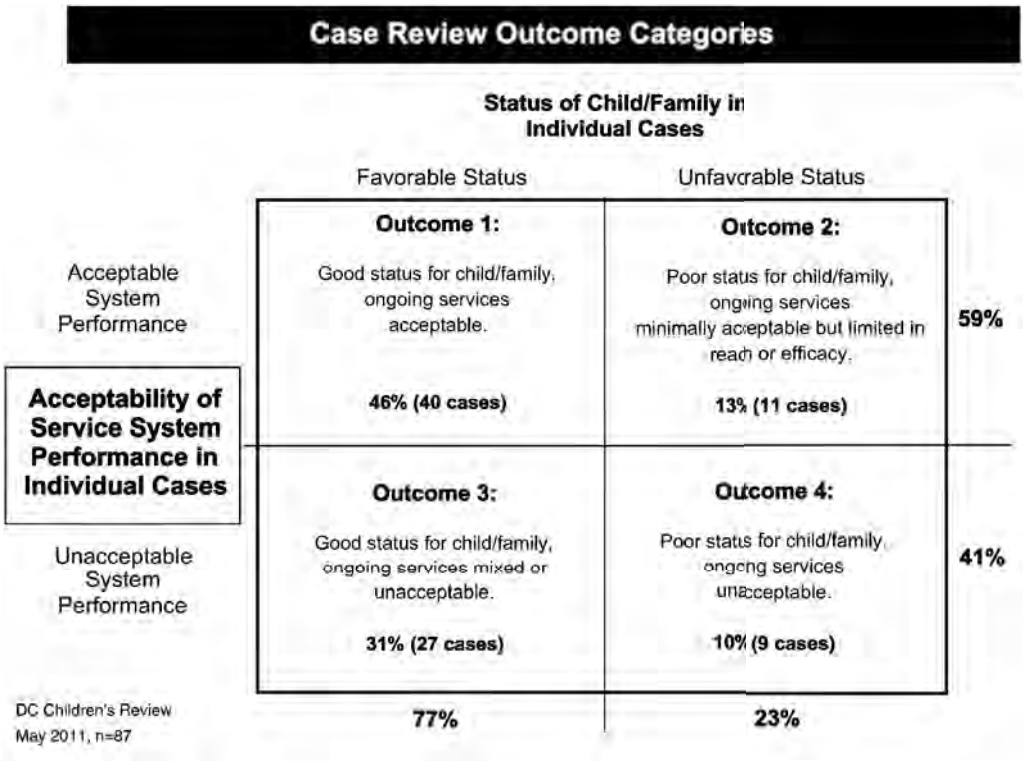
Executive Summary

The Human Systems and Outcomes, Inc. (HSO) review of services for a randomly selected sample of youth receiving services in the District of Columbia public mental health system was conducted using a qualitative review process. This process yields quantitative and qualitative data on identified indicators of child status and system functioning. This process is based heavily on the face-to-face interviewing of all service providers and persons involved with a youth receiving services. Those interviewed include the youth, parents/caregiver, and family members, as well as team members, such as a community support worker (CSW), therapist, psychiatrist, teachers and school personnel, probation officers, group home workers, behavioral specialists, etc. There were 474 people interviewed as part of the Community Services Review (CSR) this year, with an average of five interviews occurring per youth reviewed. Reviews were completed over a three-week period of time between May 9 and May 27, 2011, and included 87 youth receiving mental health services. After reviewing records and conducting interviews, reviewers then rated child status, progress, and the quality and consistency of system practice using a protocol with specific indicators in accordance with a 6-point rating scale. Simultaneous to the reviews, focus group and stakeholder interviews were conducted with persons involved with, providing, or impacted by services such as agency or core service agency (CSA) staff and community partners.

The overall results of this review were sorted into one of four categories based on the overall score for Child Status and Practice Performance. The youth can be classified and assigned to one of four categories that summarize the review outcomes. For the 2011 review, 46% or 40 of the 87 youth reviewed had an acceptable child status rating and an acceptable practice performance rating, therefore, placing them in outcome category 1. Outcome 1 is the desired situation for all

children and families receiving services. There were 11 youth (13%) in outcome category 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent practice performance of the service system, the overall status of the child or youth is still unacceptable. Thirty-one percent or 27 children and youth were in outcome category 3. Outcome 3 contains those review sample members whose status was favorable at least at the time of the review but who were receiving less than acceptable practice 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 practice performance is limited, inconsistent, or inadequate at this time. Nine youth, or 10% of the review sample, were in outcome category 4. Outcome 4 is the least favorable combination as the child's status is unfavorable and practice performance is inadequate. There were 12% fewer youth in outcome 4 category than in the 2010 review.



Overall Summary of Findings

Overall, the findings from the 2011 review of 87 youth showed that 77% of the youth had favorable status and 68% were making adequate progress. Fifty-nine percent (59%) were receiving at least minimally adequate services. It is likely that approximately six out of every ten youth are receiving appropriate, quality services at any given time. While this is an improvement over past results, there continues to be variability in the consistency and quality of services provided across CSAs.

It should be noted that these findings are limited in that the review sample reflects youth and families who are currently receiving services and who are willing to consent to participation in the review.

The following is a list and general discussion of systemic themes and patterns gathered from the 2011 review of services for children and youth.

- A large majority of the youth reviewed this year were found to be safe from harm (by self or others) and abuse/neglect (82%), were in an appropriate home and school placement (91%), and were experiencing good health (97%).
- There is an increase in acceptable overall ratings for Child Status-7% increase, Child Progress-9% increase, and Practice Performance-10% increase, when compared to the 2010 review of children's services.
- Prognosis for youth reviewed in 2011 also improved with a decrease in the percentage of youth projected to decline (18% in 2011; 30% in 2010) and an increase in youth projected to improve (26% in 2011; 14% in 2010).
- Ms. Black and her team have made notable progress in addressing systemic issues, such as integrating, coordinating, and centralizing Psychiatric Residential Treatment Facility (PRTF) placements, refining mobile crises response with exemplary efforts by ChAMPS, starting the juvenile behavioral diversion program, and continuing to promote a focus on practice among the clinical leadership of the CSAs.
- Other notable programs include school-based services and the early childhood programs of Healthy Futures and the primary age project.

- It was also noted that the Psychiatric Practice group has been a significantly positive addition to the timeliness and responsiveness of psychiatric services for children and youth.

The most evident themes this year, as in the past few reviews, is the variability across CSAs in providing consistent, high quality services. There also continues to be major variability at the child practice level in communication across agencies. Most commonly, it is reported that it depends on who the individual caseworker, CSW, or juvenile probation officer is that is assigned to a child as to whether the services are well planned and coordinated in a manner necessary to meet a child and family's needs.

Turnover at the CSA provider level as well as in the Department of Mental Health (DMH) children's program staff continues to represent major challenges to achieving the highest quality and consistency of programs for children.

The DMH management team has worked diligently to move the system towards the delivery of services in a manner that is consistent and of high quality. Some of the larger provider agencies have also committed to making internal changes in order to supervise and support higher quality and consistency of practice for each child and family served. However, individual agency performance was an even more prevalent factor in 2011 than in past reviews.

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Background and History

The Final Court-Ordered Plan for Dixon, et al v. Gray, et al [March 28, 2001] required that performance measures be developed and used within a methodology for measuring practice 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 practice 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 practice 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 practice performance of 47%.

The sample for the 2006 Dixon Court Monitoring Children's Review consisted of 48 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 practice performance of 54%.

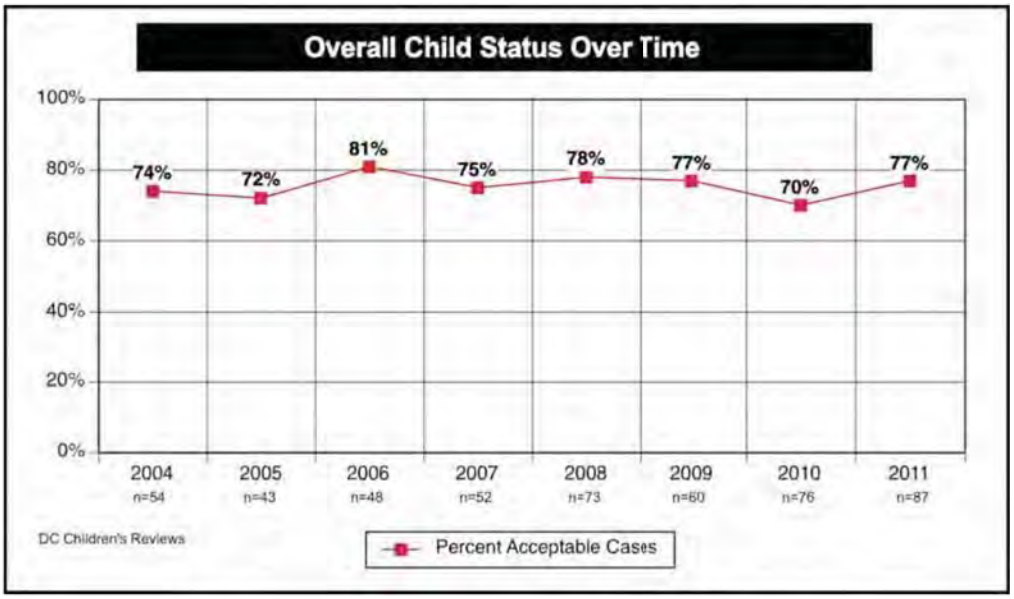
Fifty-two youth were reviewed in March 2007, with the overall child status rating acceptable for 75% of the youth. The practice performance was found acceptable, overall, for 48% of the youth reviewed.

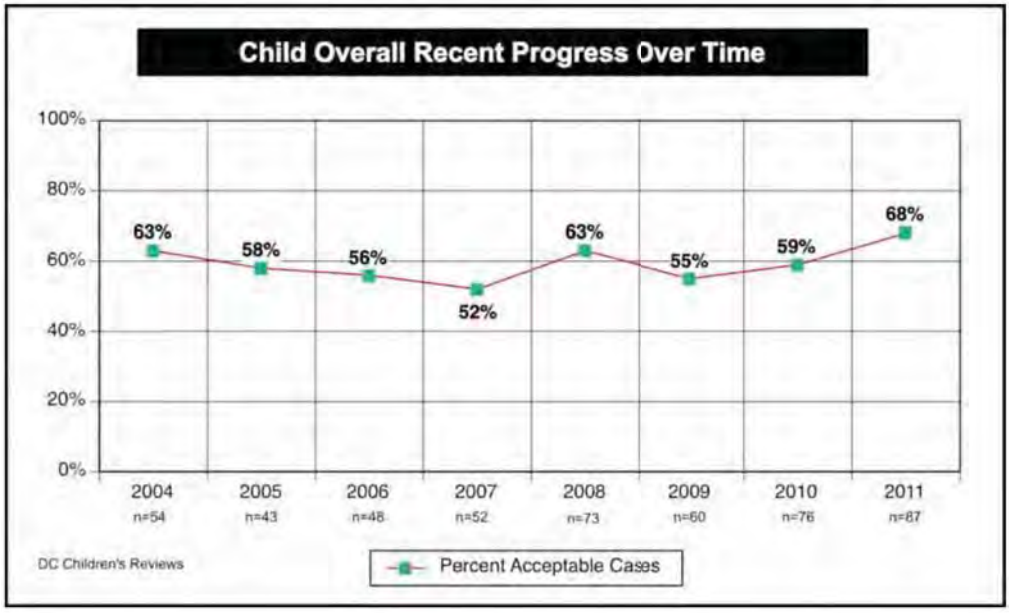
In March 2008, personnel affiliated with Human Systems and Outcomes, Inc. (HSO), conducted 53 reviews and 20 reviews were completed by staff of the Department of Mental Health (DMH) for a total of 73 youth in the sample. The overall child status rating was acceptable for 78% of the youth. The practice performance was found acceptable, overall, for 34% of the youth reviewed.

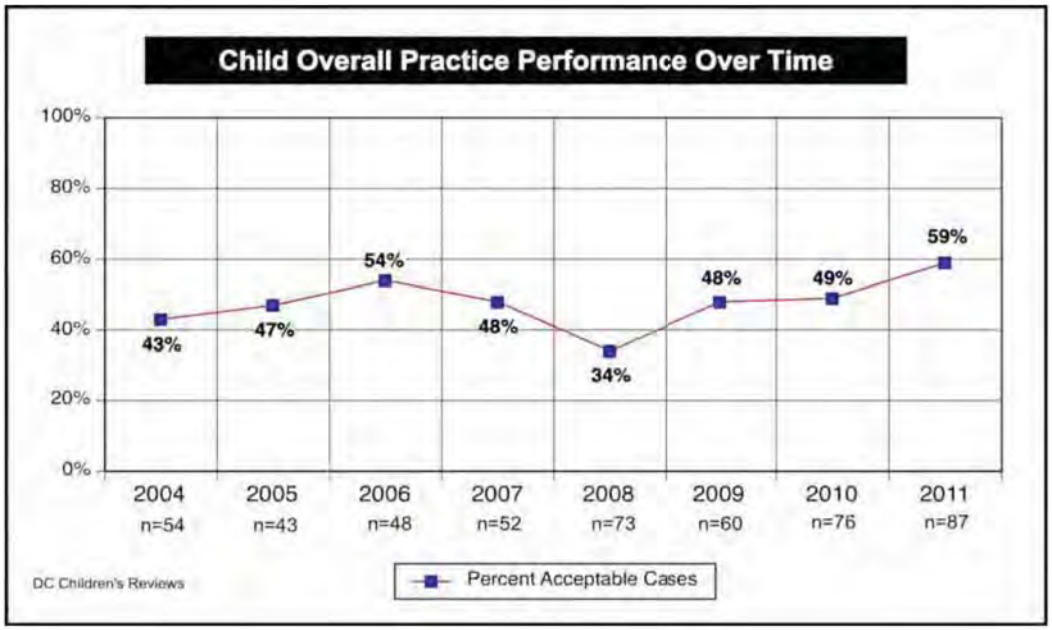
The 2009 review focused on 60 children and youth; reviewers affiliated with HSO conducted 42 reviews and staff from DMH completed 18 reviews. The overall child status rating was acceptable for 77% of the youth. The practice performance was found acceptable overall for 48% of the youth reviewed.

Seventy-six children and youth were reviewed in 2010, of which 70% had an overall acceptable status rating and 49% had an overall acceptable practice performance rating.

The following graphs display the Child Status, Child Progress, and Practice Performance ratings over eight years—2004 through 2011.







2011 Dixon Court Monitoring Children's Review

The design of the 2011 sampling process, selection of the sample, training of reviewers, supervision of data collection, and analysis of data were conducted by HSO, an organization with extensive experience in qualitative child service review processes used in monitoring services in class action litigation 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 the Far Southeast Family Strengthening Collaborative (FSFSC). HSO expresses their deep thanks to the FSFSC for completing the arduous task of setting up a large number of individual child reviews.

Context for the 2011 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 (CSAs), 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 the System of Care principles and is essential to building the relationships necessary to provide effective services. 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. There are also mixed messages delivered to frontline service providers as to whether teaming is mandatory or an option.

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 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 Community 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 Community Services Review unit included consumers who had previously been receiving services at the DCCSA who had transitioned to a new provider.

During both 2010 and 2011, major progress was achieved at Community Connections, the second largest provider of children's mental health services. Technical assistance through the Court Monitor's office was provided in 2010 to specifically identify targeted actions and strategies to improve practice. The Community Services Review unit at DMH provides feedback and assistance to agencies upon request and to select CSAs identified during the CSRs as needing additional support in practice areas. Progress was sustained during 2011, with Community Connections' scores contributing significantly to the improved overall practice performance score.

Overview of the Child Review Process

The Dixon Court 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 service 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.

Eighty-seven 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 60 reviews and DMH staff completed 27 reviews. The 87 reviews included a shadow reviewer who participated in the review process either for training purposes or as an observer. Shadows this year included the Director and Deputy Director of DMH, personnel from the Deputy Mayor's Office, and the Director of Children and Youth Services.

Changes to the Review Process

There were no fundamental changes to the review process during the 2011 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.

Positive response to the feedback process has been consistently received. 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 directives from DMH or the Dixon Court Monitor regarding how teams should proceed. 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. For the 2011 reviews, 69 reviews (79%) included feedback to the CSA team.

The Sample for Children and Youth

The targeted number of children and youth to review was determined to be 84. A stratified random sample of 94 youth (84 youth plus a 10% oversampling) and replacement names were drawn from the DMH eCURA data system for youth receiving services between October 1, 2010 to January 31, 2011. The stratified random sample of 94 was used to account for sampling attrition that occurs during scheduling and the review weeks (e.g., if a youth reviewed had not been receiving services during the designated timeframe).

Forty-one youth were replaced in the original sample to make up the final number of 94 scheduled reviews. Reviews were completed for 87 of the 94 scheduled reviews, with seven reviews not yielding usable quantitative data. 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 2159 children, a decrease of 312 youth from 2010.

Core Service Agencies

According to the information supplied to HSO by the DMH eCURA system, there were a total of 2159 children who received a billed-for service between October 1, 2010 to January 31, 2011, from 19 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, or youth discontinued services and were not receiving services from another CSA. Some agencies were not represented in the review sample as they showed a low number of children in the population (low percentage of the population). The following table illustrates the breakdown of the population, random sample, and youth reviewed by agency.

Display 1
Number of Children Receiving a Billed Service
Between October 1, 2010 to January 31, 2011
According to the eCURA Data System

Core Service Agency	# In Population	# In Sample	# Reviewed
1. First Home Care Corporation	760	26	28
2. Community Connections, Inc.	305	12	12
3. Universal Health Care Management	196	7	8
4. Family Matters	133	6	5
5. Launch, LLC	131	6	5
6. Hillcrest Children's Center	116	5	6
7. Scruples Corporation	92	4	5
8. MD/DC Family Resource Center	87	4	4
9. Progressive Life Stride, Inc./ Affordable Behavioral Consultants	76	2	2
10. Fihankra Place, Inc.	72	3	3
11. DCCSA/Mental Health Services Division	72	2	1
12. PSI	57	2	2
13. Family Preservation	25	1	2
14. Mary's Center	18	1	1
15. Latin American Youth Center	10	1	1
16. Youth Villages	5	2	2
17. Other (includes three agencies)	4	0	0
Totals	2159	84*	87

*Does not include the oversample of ten youth.

Age and Gender of Youth

When selecting the sample for the 2011 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 2011

Age of Youth	# In Population	% Of Population	# In Sample	% In Sample	# In Review	% In Review
Birth to 4 years	2	<1%	0	0%	0	0%
5-9 years	451	21%	18	21%	27	31%
10-13	798	37%	32	38%	30	34%
14+	908	42%	34	40%	30	34%
Totals	2159	100%	84	100%	87	100%

Note: Total percentages may not equal 100% due to rounding. This applies to all displays.

Gender	# In Population	% Of Population	# In Sample	% In Sample	# In Review	% In Review
Female	834	39%	33	39%	57	66%
Male	1325	61%	51	61%	30	34%
Totals	2159	100%	84	100%	87	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)

Fifty-two (60%) of the 87 children and youth age five and older were receiving services in the medium level of need range.

Children and Families Included in the Review

The target number of 84 reviews was met this year as data were gathered for 87 youth; therefore, 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 double sample and then replacing each youth based on agency, age, and gender. For the 2011 review, 41 youth replacements were made for a variety of reasons, most either had been discharged (16 youth) and were no longer receiving services or refused to participate (20 youth). The sampling timeframe used to select children and families for the review can impact the number of replacements made to the original sample. One of the initial youth was no longer receiving services at any CSA during the time of the review, and in four instances, there was difficulty locating the person authorized to consent to participation and exchange information. Two of these four categories were those that had special circumstances with CFSA. **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
Refused to participate	20
Discharged from services/inactive	16
Difficulty locating authorized signature	4
Not receiving services at time of review	1
Total Replacements	41

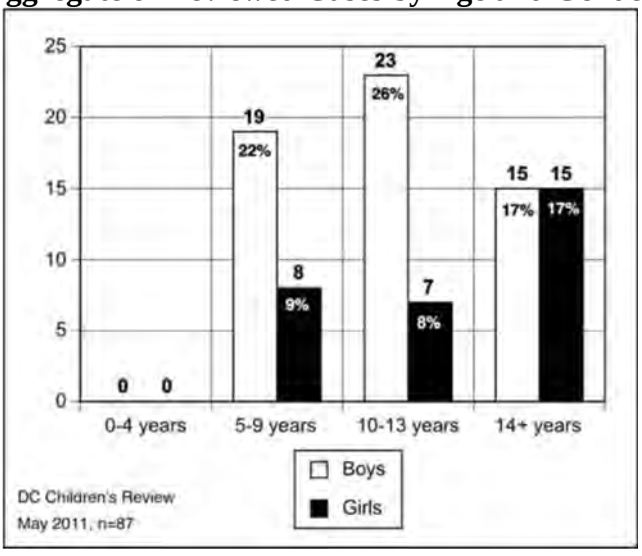
Description of the Children and Youth in the Review Sample

A total of 87 child and family reviews were completed during May 2011. Presented in this section are displays that detail the characteristics of the children and youth in the review sample this year.

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 87 children and youth distributed by both age and gender. As shown in this display, boys made up 66% of the youth reviewed and girls made up 34% of the youth reviewed. It is not uncommon for more boys to be receiving services within the active population. Children under age ten comprised 31% of those reviewed (27 youth). Thirty children (34%) were in the 10-13-year-old age group, as well as in the 14+-year-old age group. Ninety-three percent of the youth reviewed were of African-American ethnicity, 3% were of Latino-American descent, and 1% each were Caucasian, American Indian, and Biracial.

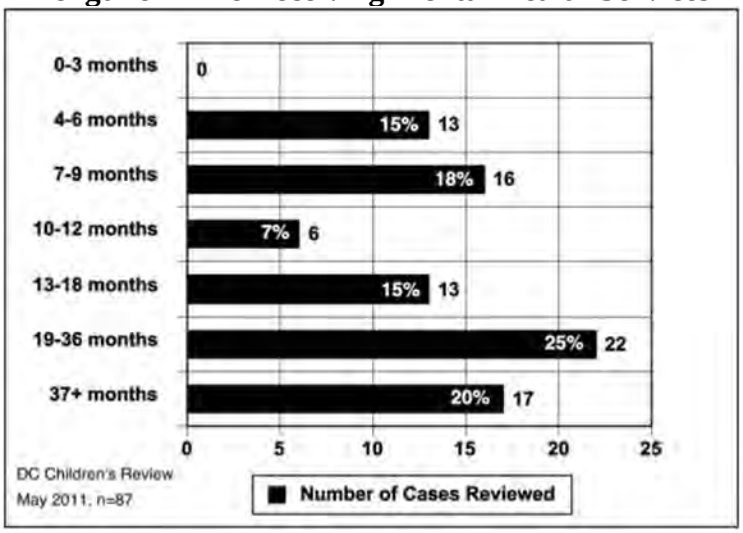
Display 4
Aggregate of Reviewed Cases by Age and Gender



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, 45% or 39 of the youth had been receiving services for 19 months or longer and 40% (35 youth) had been receiving services for 12 months or less. A higher percentage of youth reviewed received services for more than 19 months in the 2011 review than in the 2010 review, a 6% increase from 39% in 2010.

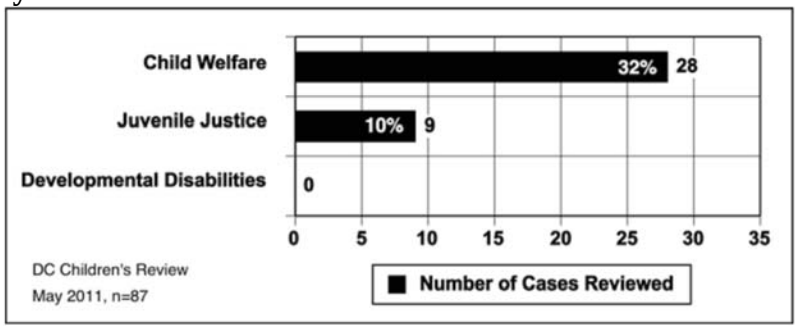
Display 5
Length of Time Receiving Mental Health Services



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 37 youth served by one or more of these agencies, 28 were involved with CFSA representing 32% of the youth reviewed. During past reviews, the range of CFSA youth reviewed varied from 23% in 2005 to 62% in 2008. This year, nine youth (10%) in the review were involved with the Department of Youth Rehabilitation Services (DYRS). In the past four reviews (2010, 2009, 2008, 2007), there were nine, one, two, and five, respectively, youth involved with DYRS. In 2011, there were no youth reviewed that were involved with developmental disabilities.

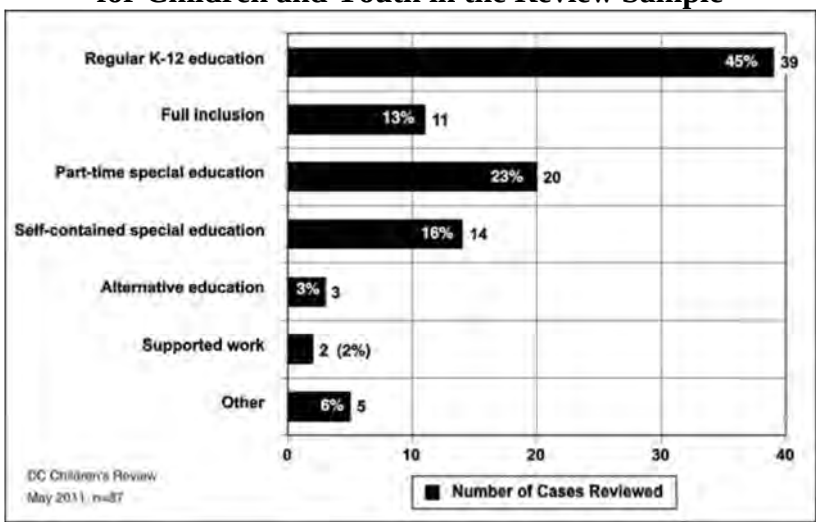
Display 6
Other Agency Providers Involved With Children and Youth in the Review Sample



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, academic levels, 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-nine youth (45%) were in regular K-12 educational settings. Forty-five youth (52%) were receiving some type of special educational service, either full inclusion (11 youth; 13%), part-time special education services (20 youth; 23%), or in a self-contained special education setting (14 youth; 16%). Three youth (3%) were in an alternative education setting, two were in supported work programs, and five were in "other" settings (therapeutic aftercare, MST, home schooling, full sped/non-public day program, and charter school).

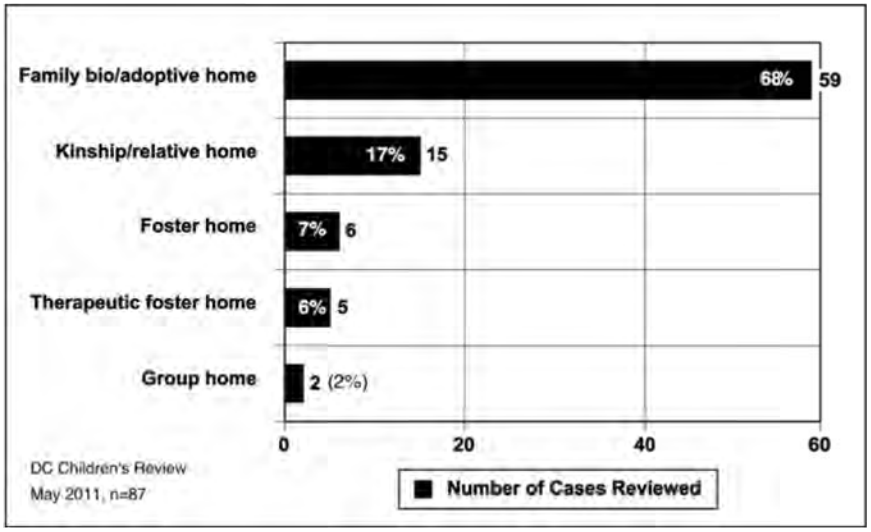
Display 7
Types of Educational Services/Placements or Educational Status for Children and Youth in the Review Sample



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 youth, or 68% of the review sample, were living with their birth or adoptive family, and an additional 15 youth (17%) were living with relatives or in kinship homes. The remaining youth were living outside of the family/kinship home. Six youth (7%) were living in a foster home, and five youth (6%) were living in a therapeutically supported setting. Two youth (2%) lived in a group 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). Fifty-four youth (62%) in the 2011 review had no placement changes in their lifetime. Twenty youth (23%) had one placement. Ten youth (11%) had 3-5 different placements and three youth (3%) had 6-9 placements. There is a notable difference in the number of youth having no placement changes when compared to the 2010 review where 37 youth (49%) had not had a placement change 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	54	62%
1-2 placement changes	20	23%
3-5 placement changes	10	11%
6-9 placement changes	3	3%
10 or more placement changes	0	0%
Totals	87	99%

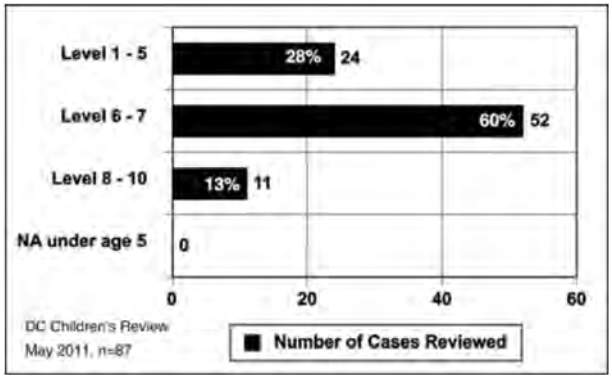
Functional Status

Display 10 provides the distribution of the review sample across functioning levels for the 87 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 review. Reviewers use information gathered from case records, past assessments and evaluations, interviews, and specific criteria in the Dixon monitoring protocol to determine youth level of functioning. The scale is based on and similar to the CGAF. On this scale, a child or youth in the low 1-5 range would be experiencing substantial problems in daily functioning in normal settings, and usually requiring a high level of support through intensive in-home or “wraparound” services. Often, children receiving scores from 1-5 on the functional status scale may be receiving services in a temporary treatment or alternative setting (or recently received services in one of these settings). A child receiving scores of 6-7 would have some difficulties or symptoms in several

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

Twenty-four youth (28%) in the review had level of functioning scores in the lowest range. This range captures youth requiring many supports and, oftentimes, involving multiple agencies. The majority of the youth in the 2011 review were in the mid-level range, with 52 youth (60%) in this range. The remaining youth had a slight impairment in functioning and required minimal support (11 youth or 13%).

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 and there were no youth in the review this year under the age of five. The majority of the youth, for all age groups, were in the 6-7 level range—having some difficulties and likely receiving intensive outpatient or similar supports.

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

Age Ranges	Low Level of Functioning (1-5)	Moderate Level of Functioning (6-7)	High Level of Functioning (8-10)	Totals in the Review
5-9 Years Old	11 (13%)	15 (17%)	1 (1%)	27
10-13 Years Old	8 (9%)	20 (23%)	2 (2%)	30
14 Years or Older	5 (6%)	17 (20%)	8 (9%)	30
Totals	24 (28%)	52 (60%)	11 (12%)	87

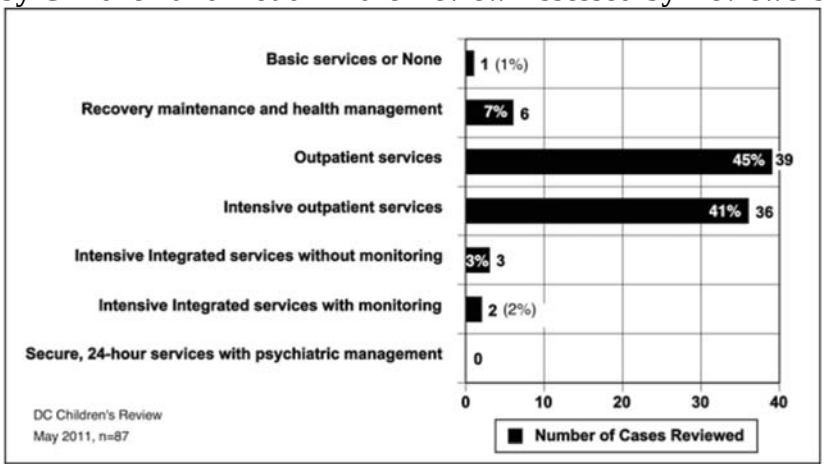
Level of Care

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 87 of the youth reviewed. Reviewers rely first on CALOCUS scores that are present in case records, and then use their best judgment to estimate service level based on current information when actual CALOCUS scores are not present. CALOCUS for 2011 youth reviewed showed 45% of the youth receiving outpatient-level services and 41% receiving intensive outpatient services.

When 2011 CALOCUS ratings are compared to those of the 2010 review, the percentage of use of outpatient services is the same at 45% of the youth reviewed. There was a lower percentage of youth in this year's review receiving intensive integrated services without monitoring: three youth (3%) versus ten youth (13%) in 2010.

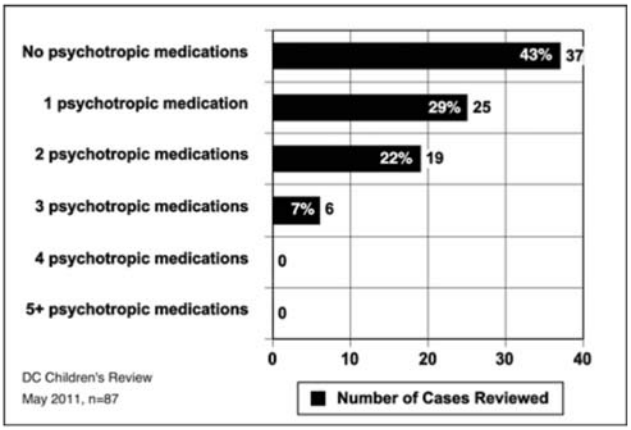
Display 12
CALOCUS for Range of Services Received
by Children and Youth in the Review Assessed by Reviewers



Medications

The number of psychotropic medications prescribed for children and youth in the review were counted and reported by reviewers. Fifty youth were prescribed psychotropic medications (**Display 13)** in 2011. Twenty-nine percent (25 youth) were prescribed one medication. The number of youth prescribed two psychotropic medications in the 2011 CSR was 22% (19 youth), an increase from 2010 where 14% or 11 youth were prescribed two medications. The remaining six youth were prescribed three medications, with no youth having more than three psychotropic medications.

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

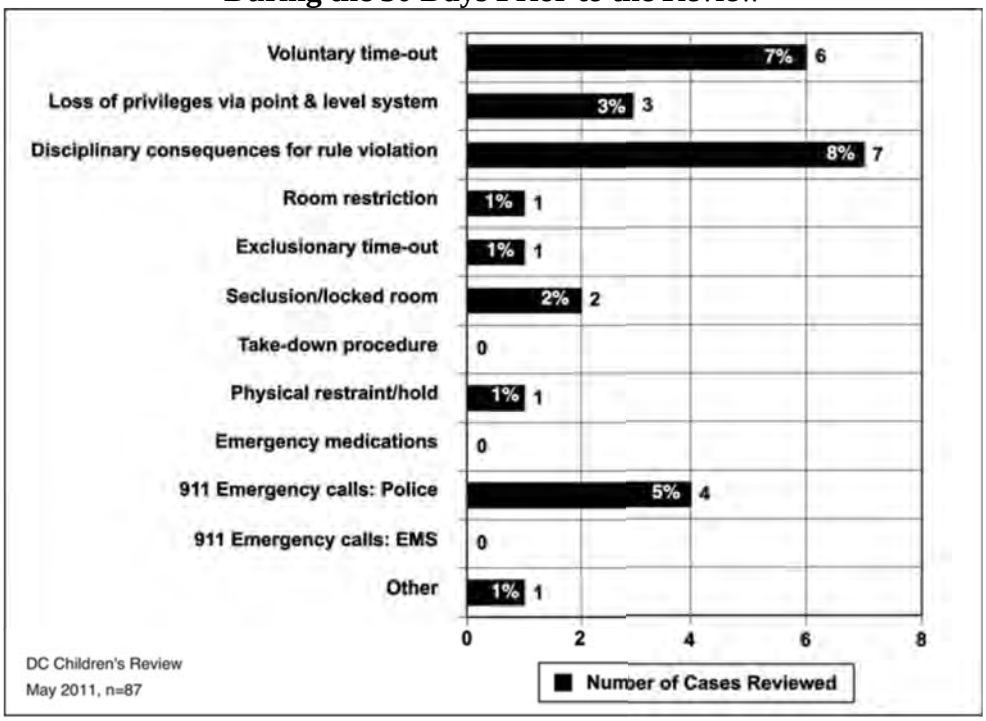


Special Procedures

Special procedures are used in certain situations to prevent harm but are not a form of therapy or treatment intervention. **Display 14** shows 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 2011 review are attributed to a relatively small number of children. This year, 26 youth had experienced a special procedure in the 30 days prior to the review. Oftentimes, youth experiencing this type of intervention have more than one special procedure used in order to prevent harm.

There was a decrease in the percentage of youth experiencing a loss of privileges via the point and level system: three youth or 3% in 2011; ten youth or 13% in 2010. There was also a decrease in the percentage of physical restraint/hold when compared to 2010: one youth (1%) in 2011; five youth (7%) in 2010.

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 87 children and youth in May 2011, 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

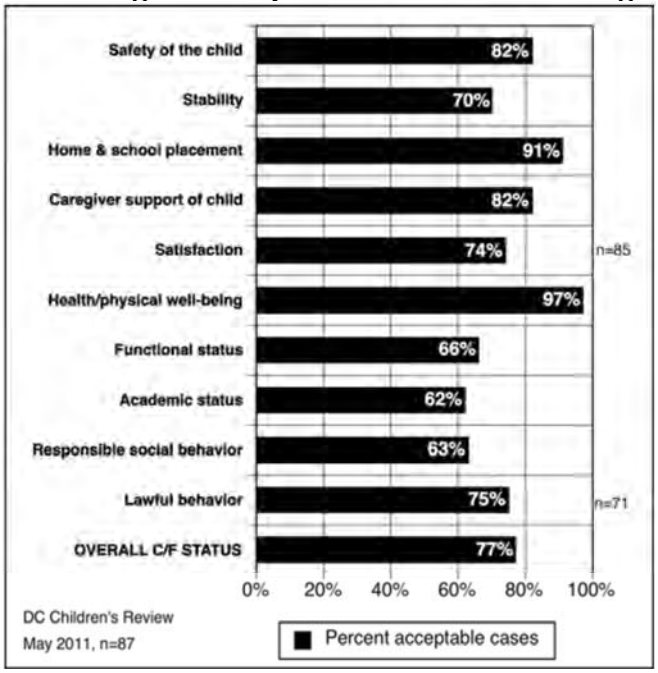
Review activities in each case included a review of plans and records as well as interviews with the child, caregiver, and others involved in providing services and supports. A total of 474

persons were interviewed for the 87 children and youth reviewed this year. The number of interviews ranged from a low of two persons in one case to a high of ten persons in another case. The average number of interviews was 5.4 (mean: 5.4; median: 6; mode: 5).

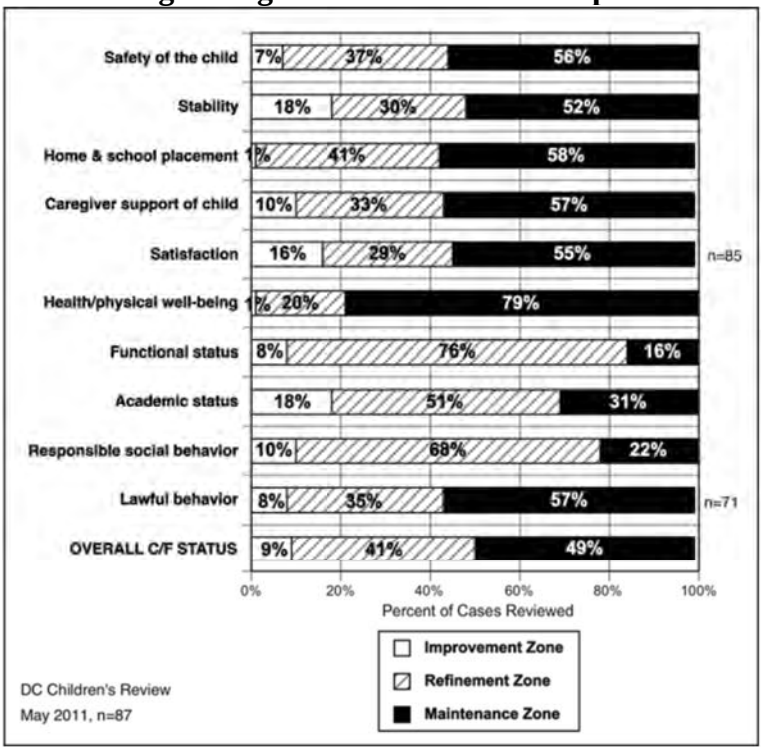
Child Status Results

Ten indicators related to the current status of the child or youth were contained in the CSR Protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. The next two displays present findings for each of the ten indicators. **Display 15** uses a "percent acceptable" format to report the proportion of the review 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



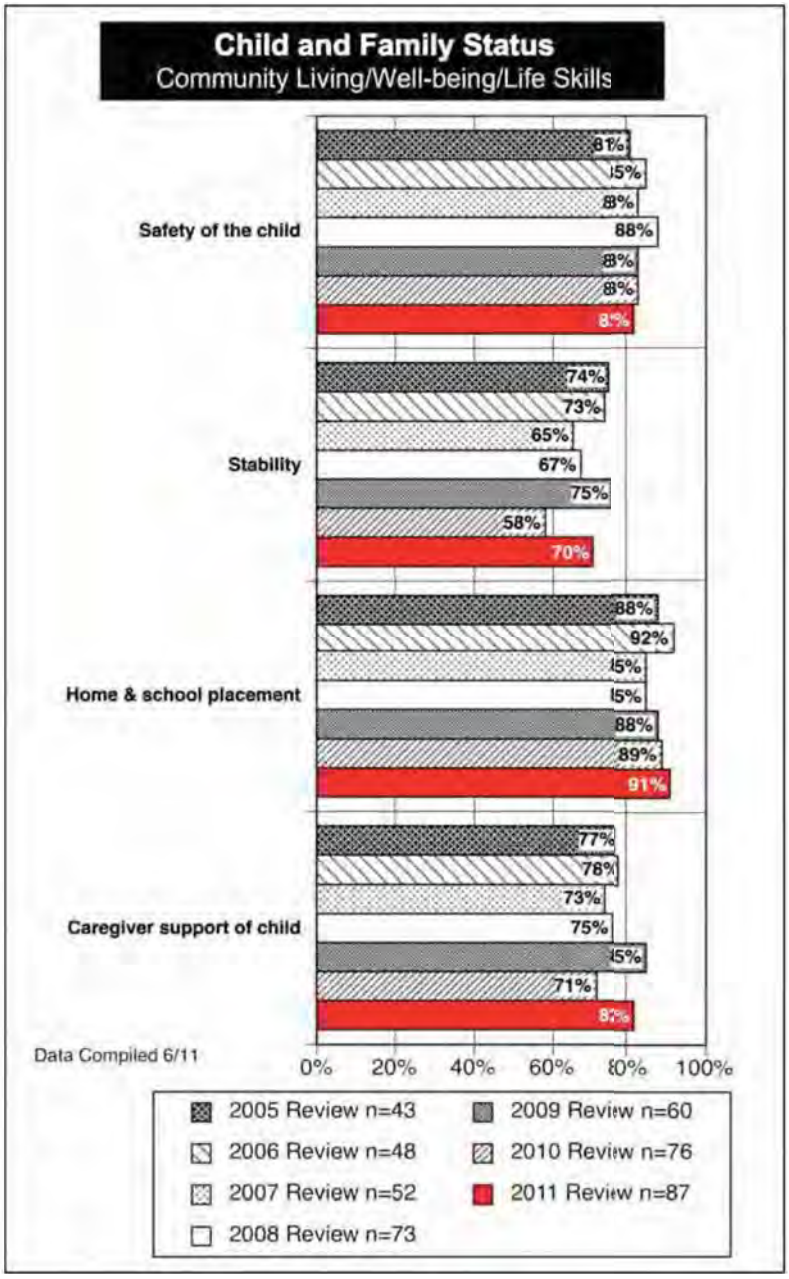
Overall Child Status. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall child status rating." Indicators are weighted accordingly, with the safety indicator being a "trump" indicator (if safety 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 87 youth participating in the review, 77% were found to have acceptable overall status. This is an increase of 7% from 2010. The overall child status scores were distributed across the zones as follows: 9% needed immediate attention and were in the improvement zone, 41% were in the refinement zone, and 49% were in the maintenance zone. When compared to overall ratings of child status for the 2010 review, the 2011 data show an increase of youth in the maintenance zone by 11% (38% in 2010), as well as a decrease in both the refinement zone (51% in 2010) and the improvement zone (11% in 2010). **Display 17** shows the overall child status results for the reviews since 2005. Overall child status ratings have been stable, with overall scores ranging from 70% to a high of 81% achieved in 2006.

There are several indicators of child well-being that rated strongly this year. Youth were found to be safe, with 82% of the youth reviewed found acceptable in this area. Youth are also, for the most part, healthy and have regular access to medical care (97% acceptable). Ninety-one 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 (68% family/adoptive and 17% in kinship care). Safety is similar for youth reviewed in 2010 (83% acceptable in 2010), while physical health and home/school placement were higher (physical health-88% in 2010; home/school placement-89% in 2010).

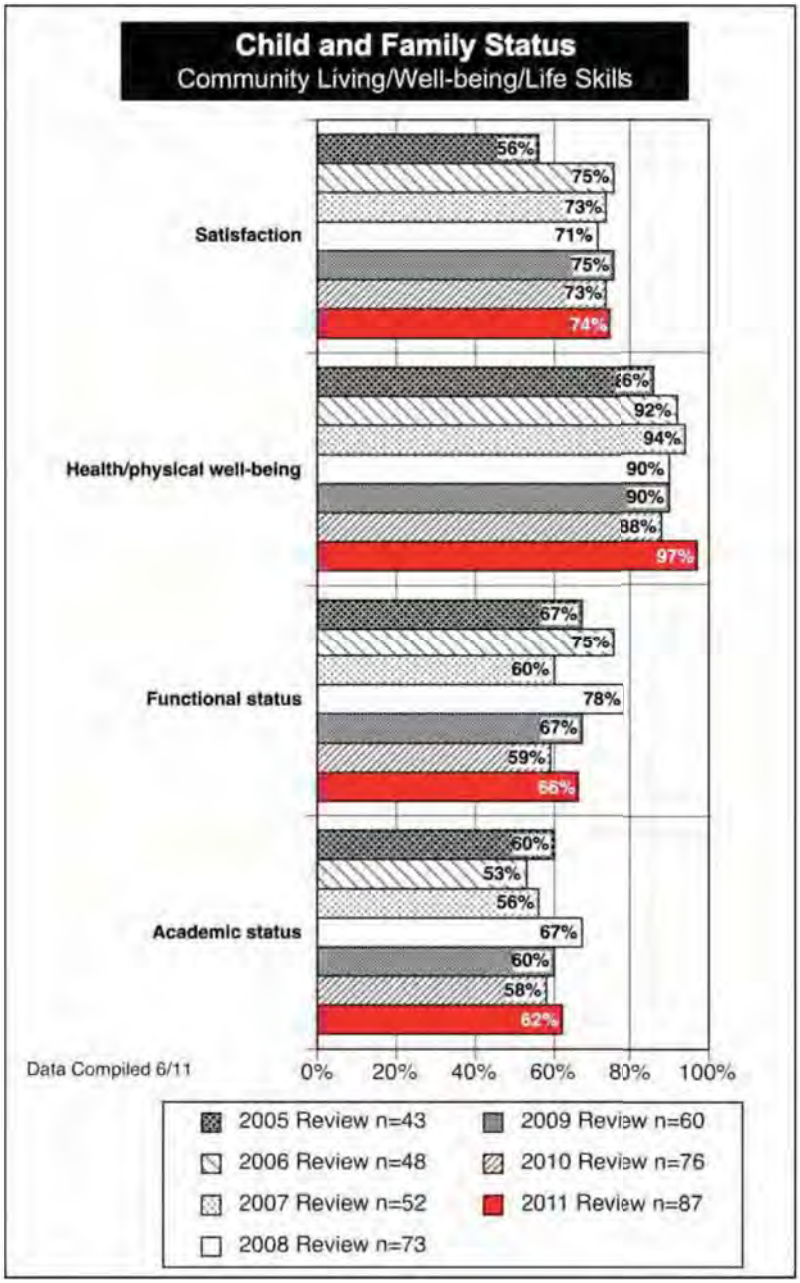
Again in the 2011 review, the three lowest scoring indicators were identified in academic, functional, and responsible behavior status, although scores in these areas were improved from 2010. Sixty-two percent of the youth reviewed were found to have acceptable academic status, with 18% requiring immediate attention and in the improvement zone, 51% in the refinement zone, and 31% in the maintenance zone. The functional status indicator was rated 66% acceptable, with 8% in the improvement zone, 76% in the refinement zone, and 16% in the maintenance zone. The responsible social behavior status indicator was rated acceptable for 63% of the youth reviewed this year, with 10% in the improvement zone, 68% in the refinement zone, and 22% 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 12% increase over the 2010 review (70% acceptable in 2011; 58% acceptable in 2010). Caregiver support of the child also reflected a similar increase, with an 11% improvement from 2010 (82% acceptable in 2011; 71% acceptable in 2010).

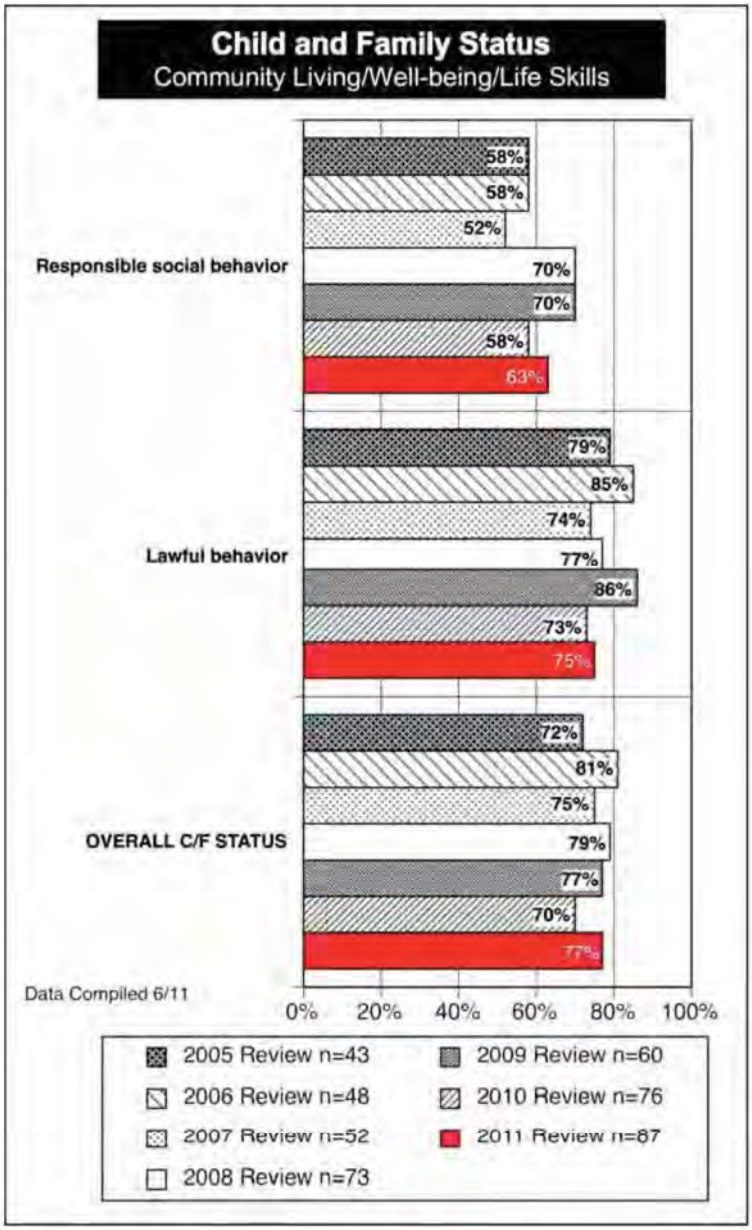
Display 17
Overall Child Status Results for Seven Reviews



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



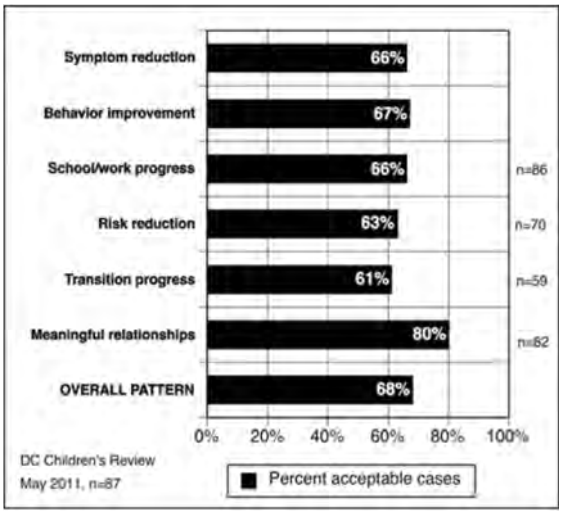
Display 17 (continued)
Overall Child Status Results for Seven Reviews



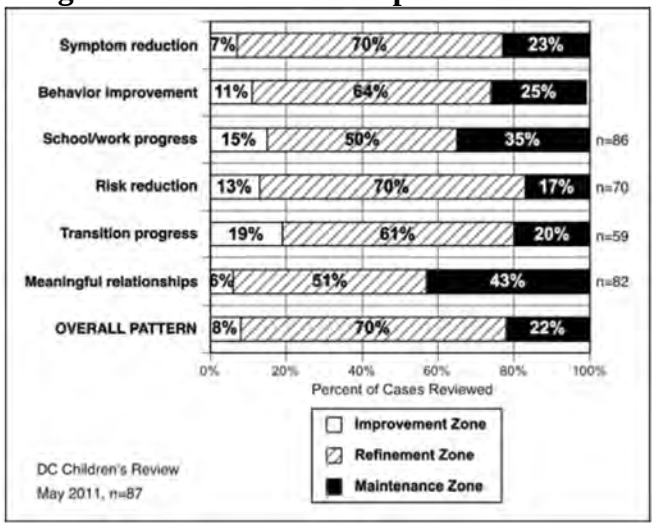
Recent Progress Patterns Showing Change Over Time

The CSR Protocol provided six indicators that enabled reviewers to examine recent progress on specific areas of treatment focus that was noted for the youth in the 2011 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



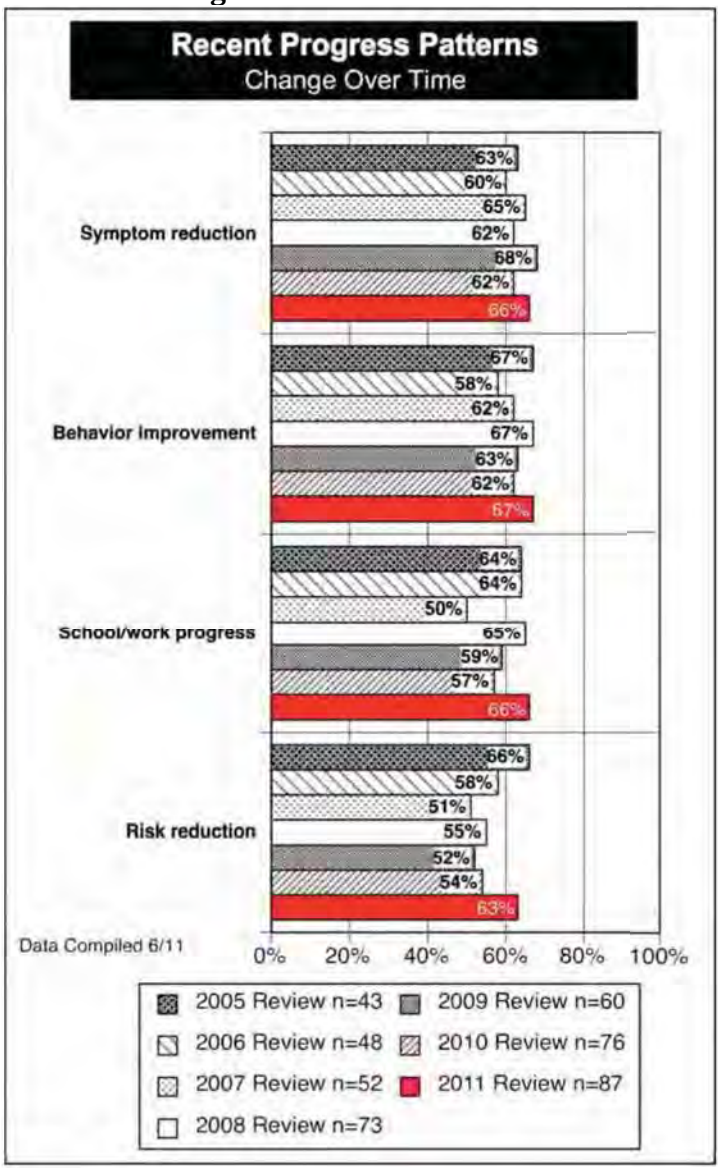
Overall Progress Pattern. Reviewers determined an overall progress pattern for each review sample member based on an assessment of the general patterns of progress across each of the applicable indicators during the past six months. Based on this process, the overall progress pattern was acceptable for 68% of the 87 youth reviewed. This is a 9% increase from last year (59% in 2010). Overall progress pattern ratings were distributed among the three-tiered zones as follows: 8% (13% in 2010) were found to need improvement, 70% (63% in 2010) were in the refinement zone, and 22% (24% in 2010) were in the maintenance zone.

Progress toward meaningful relationships was the indicator with the highest rating again this year with 80% of the 82 youth to whom this indicator applied having acceptable progress in this area. Seventy-two percent had acceptable progress in this area in 2010. Symptom reduction, the extent to which psychiatric symptoms are being reduced for the child or youth, also showed an increase with 66% having acceptable progress, compared to 62% in 2010. Progress in school or work settings improved by 9% from 57% acceptable in 2010 to 66% acceptable in 2011 for the 86 youth to whom this indicator was applicable.

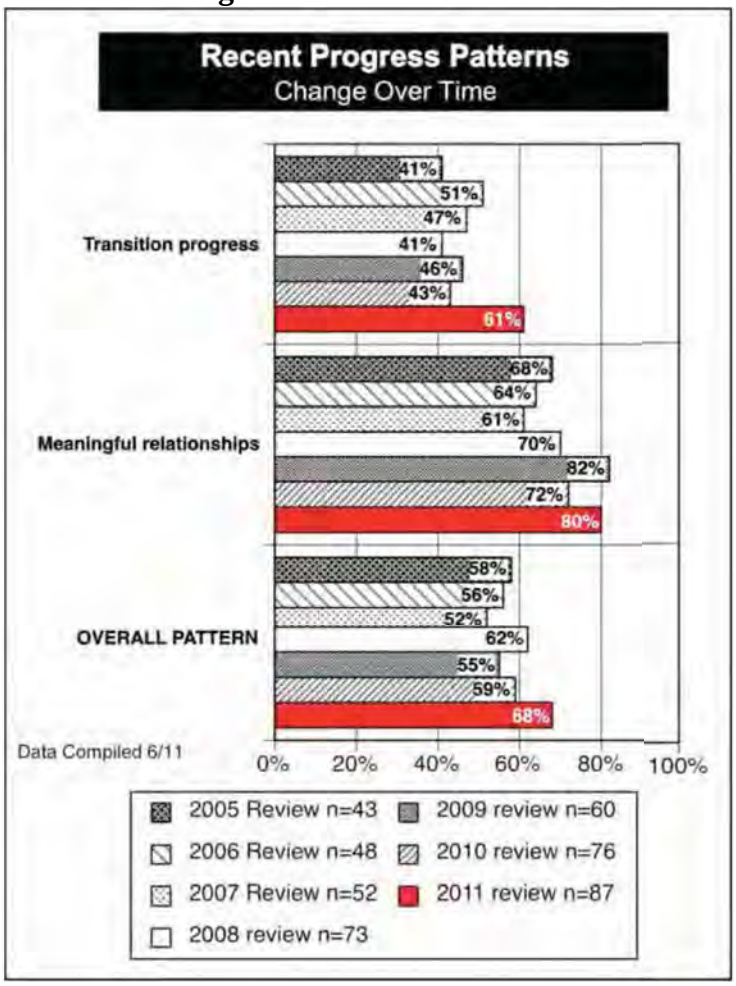
Transitions were identified as applicable for 59 of the 87 children and youth in the review sample this year. If the child had not experienced any transitions within the previous six months, or there were no known transitions in the near future, then this indicator was marked as not applicable. Progress toward smooth and successful transitions was acceptable for 61% of these 59 youth. This is an increase of 18% when compared to 43% acceptable transition progress in 2010, and is the largest percentage of change in the youth progress indicators.

Display 20 shows the data for seven reviews on progress indicators. Overall, the results are comparable, with the overall progress pattern of youth being highest this year.

Display 20
Overall Child Progress Pattern Results for Seven Reviews



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



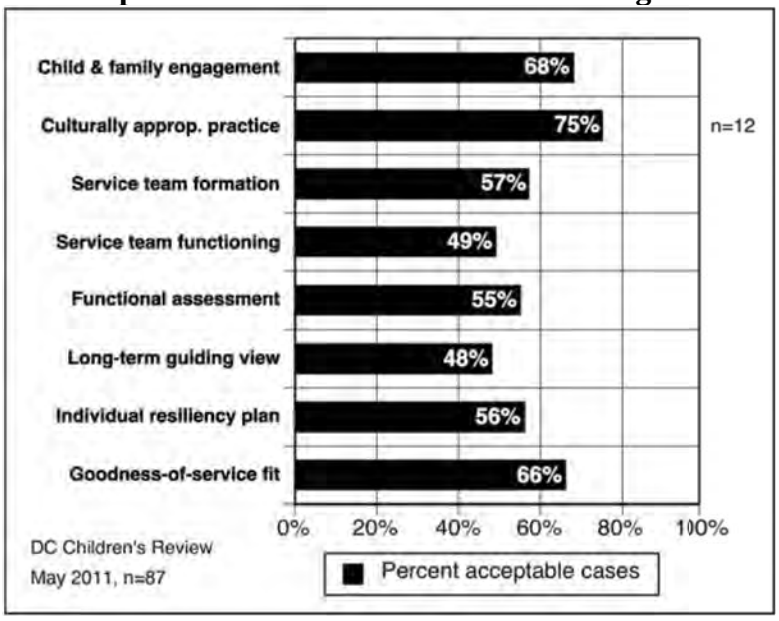
Child-Specific Performance of Practice Functions

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. It should be noted that the particular indicators identified as strengths or as opportunities for improvement are described in detail below, although data on all indicators are included in the graphs.

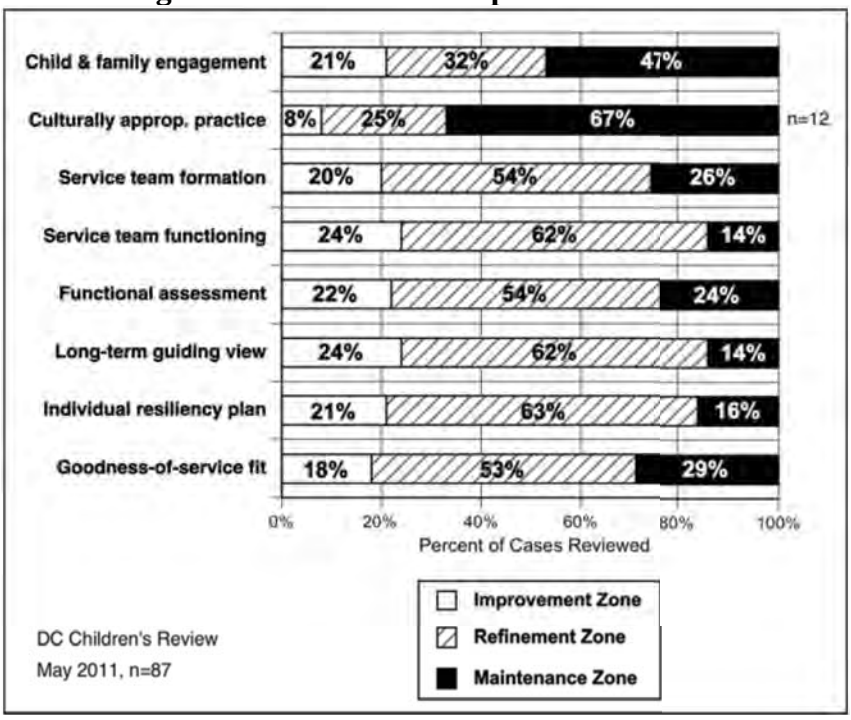
Practice Performance: Planning Treatment

Findings for the first set of indicators are presented in **Displays 21 and 22** and summarized below. **Display 34** provides the seven-year history of practice performance ratings. Findings improved by 10-16% in all indicators in this sub-section, with the exception of culturally appropriate practice.

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 and is identified as one of the common components in effective practice. 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. Practitioners 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 improved this year by 10% (68% versus 58% in 2010). There are differences also in the three-zone distribution with an 18% increase of youth in the maintenance zone: 47% in 2011 and 29% in 2010. There are fewer youth in the refinement zone this year: 32% in 2011 versus 51% in 2010, and roughly the same number in the improvement zone for both years (21% in 2011; 20% in 2010). There is improvement in overall engagement efforts and results, with a greater percentage of youth and families being fully engaged in services.

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. This indicator was found applicable for 12 youth and acceptable for 75% of these 12 youth. There is a 12% change in practice performance in this area when compared to the 2010 CSR results where in 20 of 23 case situations (87%), service providers made appropriate cultural accommodations to children and their families.

Service Team Formation and Functioning. The formation and functioning of the IRP team, in coordination with all other planning, assessment, and treatment processes the child is involved with, 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 with complex needs 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 at least through regular communication, was found in 57% of the 87 youth who participated in the 2011 CSR. This is an increase of 12% from last year. When these data are disaggregated and viewed in terms of ratings across the three zones, 54% of the cases were rated in the refinement zone for team formation (an 11% increase from 2010), 20% were in the improvement zone (12% decrease from 2010), and roughly the same percentage as 2010, 26%, were in the maintenance zone.

Strong team processes include a flow of communication and information among members in a timely manner, working together to plan and provide interventions, and involve developing a respectful and reciprocal relationship with the child and parents. Teaming is a process, rather than simply an event comprised of a meeting of family and professionals to design the provision of services. Teams need to be cohesive and able to discern which aspects of teaming to execute at particular times, such as when to meet face-to-face and how to use resources or team members strategically. Service team functioning improved by 16% this year and was found acceptable for 49% of the youth reviewed. There is a shift in the three-zone distribution with increased percentages in the refinement zone (62% in 2011; 55% in 2010) and maintenance zone (14% in 2011; 12% in 2010), and a decrease in the improvement zone (24% in 2011; 33% in 2010).

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. This practice function has a direct impact on other aspects of practice, such as planning and the identification and implementation of treatment interventions. Teams were found to have acceptable understanding for 55% of the youth reviewed, a 16% increase from the 2010 review. Although again this year, 76% of the review population was rated as needing either refinement or improvement in the assessment and understanding indicator, there was an 8% shift from the improvement zone to the refinement zone, further indicating improvement in this practice area. Assessments, in general, continued to lack in-depth diagnostic assessment as part of the clinical intake process. Some teams struggled with fully understanding underlying issues, such as trauma, or lacked situational case awareness and a sense of urgency. However, this improved during the 2011 review.

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 and for the youth and family to be able to function long-term without system involvement or formal supports. 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 48% of the children and youth reviewed had a long-term view that could be articulated by service providers compared to 32% in 2010. As with the two previous indicators, there is a shift in the percentage of youth from the improvement zone (24% in 2011; 42% in 2010) to the refinement zone (62% in 2011; 45% in 2010). The representation in the maintenance zone differed by only 1% (14% in 2011; 13% in 2010). Service providers are not consistently identifying an end-point for services, a pro-active approach to working with the youth, and the need to prepare an older youth for independent living or what successful youth/family functioning without services would look like.

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 short- and 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. In past years, planning had been challenged as acceptable ratings were on a downward trend. However, scores for 2010 and 2011 have greatly improved with 42% acceptable in 2010 and 56% acceptable this year. The 2011 data show a 14% increase from 2010. For 84% of the cases reviewed this year, refinement or improvement was indicated, and although there is a greater percentage in the refinement zone (63% in 2011; 54% in 2010), there are also fewer youth in the maintenance zone (16% in 2011; 20% in 2010). There were issues 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 and a lack of clearly defined, measurable goals.

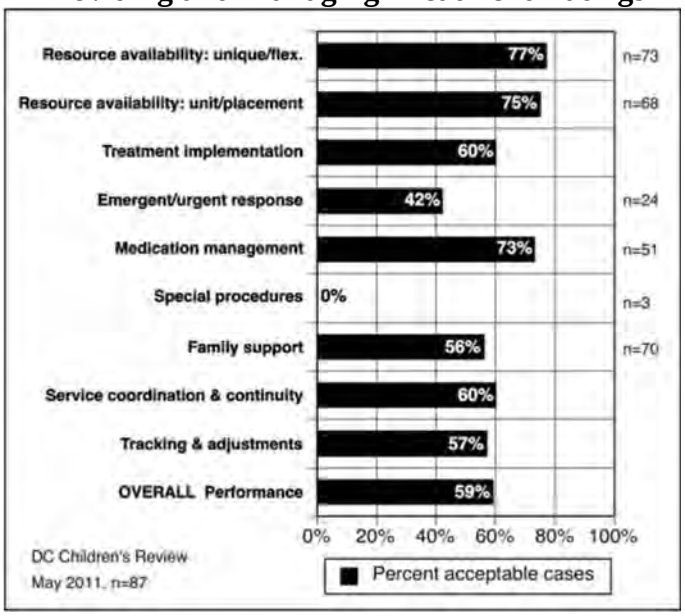
Goodness-of-Service Fit. All planned elements of therapy, special education, assistance, and support for the child and family should fit together into a sensible combination and sequence that is individualized to match the child and family's particular situation. Goodness of fit is directly related to understanding the situation 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, as well as in prior reviews, the combination and sequencing of supports and services was found to be acceptable for approximately half of the children and families served. For the 2011 review, data continued on its upward trend for this indicator as well, with two-thirds (66%) of the youth reviewed having acceptable practice in this area, an increase of 15% from the 2010 review (51% acceptable).

Findings this year across the key indicators for planning treatment indicate a positive trend toward achieving strong practice in these eight core areas of practice. Despite improvement percentages in the double-digits, there continues to be a need for focused efforts in working with families in ways that are culturally sensitive and appropriate; the formation and functioning of teams; the understanding of youth and families holistically and diagnostically; and the development of clear, measurable goals and objectives.

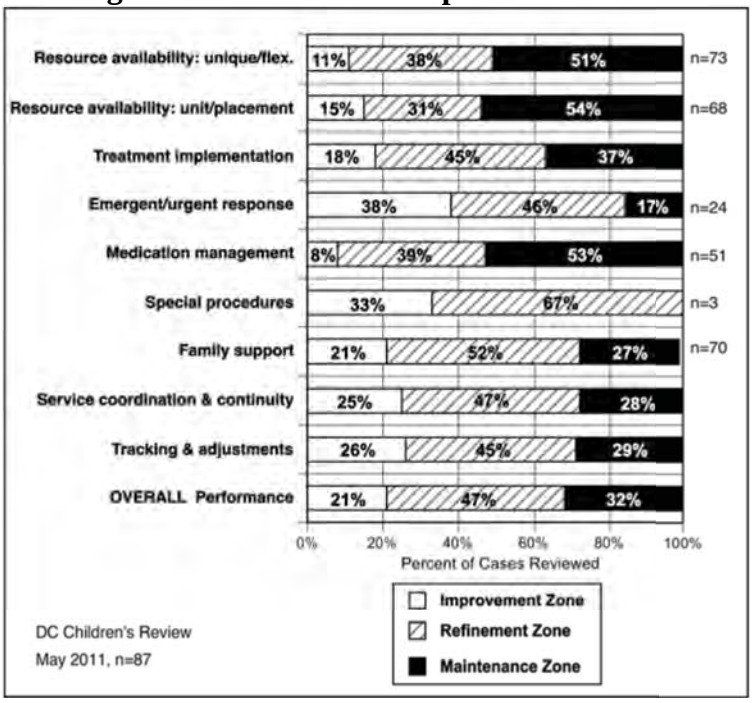
Practice Performance: Providing and Managing Treatment

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. Again, it should be noted that the particular indicators identified as strengths, as opportunities for improvement, or with the greatest degree of change are described in detail below, although data on all indicators are included in the graphs. The seven-year history of the ratings for these indicators can be found in **Display 34**.

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 is one of the stronger areas again in the 2011 review, with 14% improvement in each sub-indicator. Seventy-seven percent of the 73 youth to which this indicator applied had acceptable availability of flexible resources, such as wrap services or community support. Forty-nine percent were rated as needing refinement or improvement and 51% were in the maintenance zone, a 14% upward shift compared to 2010. Seventy-five percent (n=68) had adequate access to unit or placement-based services, such as therapy, with 46% needing refinement or improvement and 54% in the maintenance zone, a 17% upward shift in this area.

These results suggest that the availability of resources in the District continues to improve and is not a primary barrier to treatment implementation, although there were more instances this year where managed care organization processes impeded access to treatment resources.

Treatment Implementation. Acceptable treatment implementation includes timely, dependable, and consistent actions by service providers; supports and services delivered at the needed intensity to address priority needs; and frontline workers (e.g., therapists, CSWs, case managers) who receive the support and supervision necessary to fulfill their responsibilities. Treatment implementation in 2011 was acceptable for 60% of the youth reviewed, an improvement over 2010 where there was 49% acceptable practice in this area. Distribution across the three zones shifted from the improvement zone with fewer youth needing improvement or refinement and 37% in the maintenance zone versus 22% in 2010.

Emergent/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. 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 applicable for 24 youth this year (2010 n=35) and acceptable for 42%. This is a 21% decline from the 2010 review with 18% more youth in the improvement zone. Due to the low number of applicable youth and a higher review sample size, the change in score is not necessarily seen as significant, but as descriptive. Many of these youth lacked an organized plan for accessing supports beyond dialing 911 or going to the emergency room, or that did not contain steps for de-escalation or accessing ChAMPS to prevent crisis.

Medication Management. Use of psychotropic medications is one of many treatment modalities that may be used in treating a child with mental health problems and should be coordinated with other aspects of treatment and intervention. The effects and side effects of medication use should be assessed, tracked, and used to inform decision making. 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 again this year and an area of practice that continues to improve. Although early data indicated that 50 youth were prescribed medications, 51 youth were receiving medication management services, meaning that one youth was meeting regularly with a psychiatrist regarding medication; however, this youth was not prescribed medications at the time of the review. Seventy-three percent of these 51 youth had acceptable medication management practices (62% acceptable in 2010), with 53% requiring maintenance only (41% in the maintenance zone in 2010). One of the most commonly observed challenges in this area is that the child is not taking prescribed medications but practitioners are not aware of the lack of medication compliance nor are they developing appropriate options.

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. Practice in this area improved by 14%, with 57% of the youth reviewed having acceptable ratings (43% in 2010). As with many of the other indicators, there was an increase in the percentage of youth in the maintenance zone—29% in 2011 compared to 22% in 2010; 45% in the refinement zone in 2011 compared with 46% in 2010; and 26% in the improvement zone in 2011 compared to 32% in 2010.

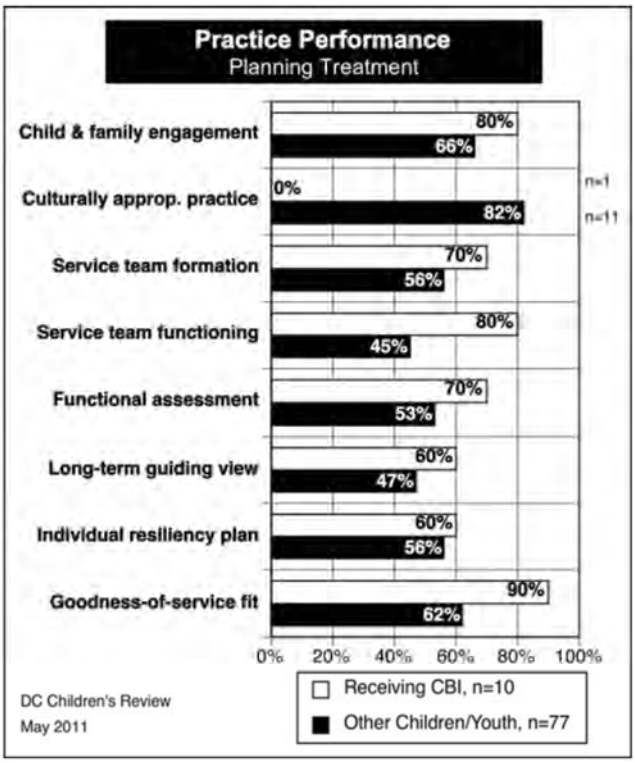
Overall Practice Performance. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall practice performance rating." Applying this rubric resulted in the determination that overall practice performance was rated as adequate (rating levels 4, 5, and 6) in 59% of the children and youth included in the review, a 10% increase from the 2010 results. In 2011, 21% were in the improvement zone, 47% in the refinement zone, and 32% in the maintenance zone. Comparatively, in 2010 29% of the children or youth reviewed were in the improvement zone, 53% were in the refinement zone, and 18% were in the maintenance zone. The most noticeable change is in the maintenance zone with 14% more youth in this zone in 2011. A reasonable overall observation is that practice improved significantly between 2010 and 2011, overall and in specific areas of practice.

Comparison of CBI Services

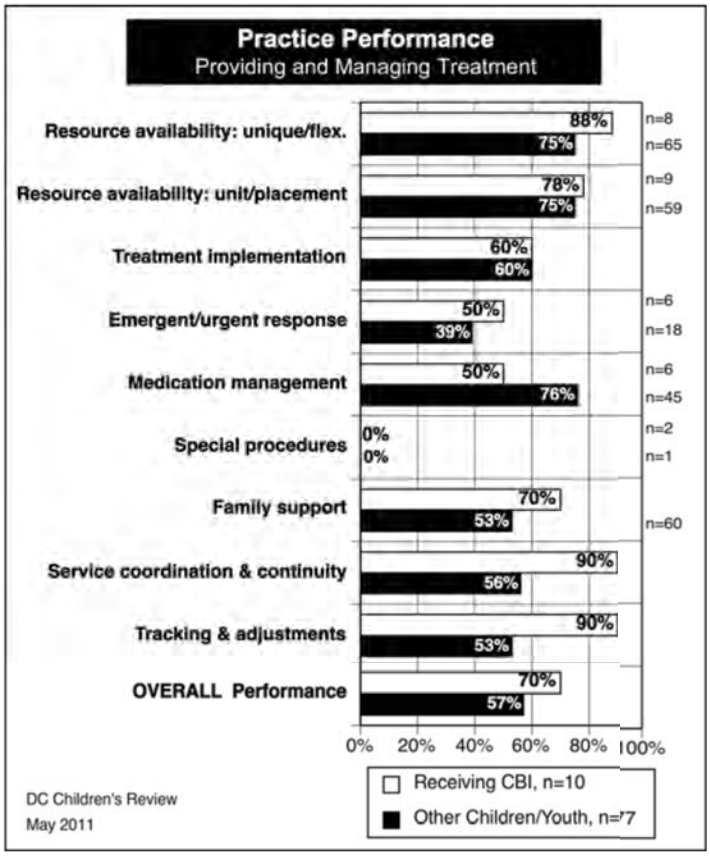
Ten children receiving CBI services were reviewed this year; these ten children were from four agencies. Due to this low number, the data will be presented comparatively. The following **Display 25** shows the practice scores for the children and youth in the 2011 review who were receiving CBI services and compares these scores to the children and youth who were not receiving CBI services. Practice for the CBI children was generally stronger than for the non-CBI children. Most notable were the results for team formation, team functioning, and service coordination. Seventy percent of the CBI youth had acceptable practice performance in team formation, 80% had acceptable team functioning, and 90% had acceptable service coordination. This compares to 56% acceptable team formation, 45% acceptable team functioning, and 56%

acceptable service coordination for the non-CBI youth. Overall, 70% of the CBI children rated as acceptable for overall practice performance compared to 57% of the non-CBI children.

Display 25
Percentage of Acceptable Practice Performance:
CBI vs. Non-CBI Children and Youth



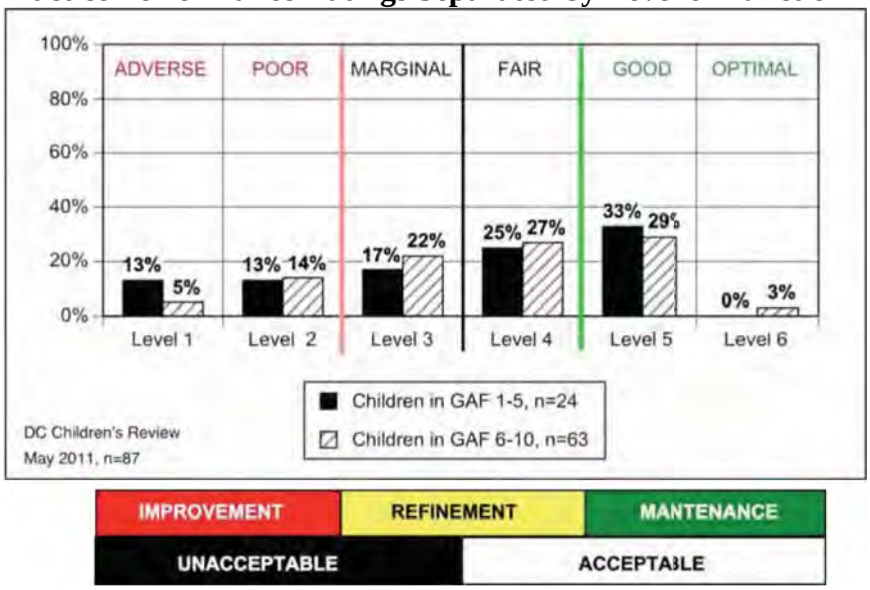
Display 25 (continued)
Percentage of Acceptable Practice Performance:
CBI vs. Non-CBI Children and Youth



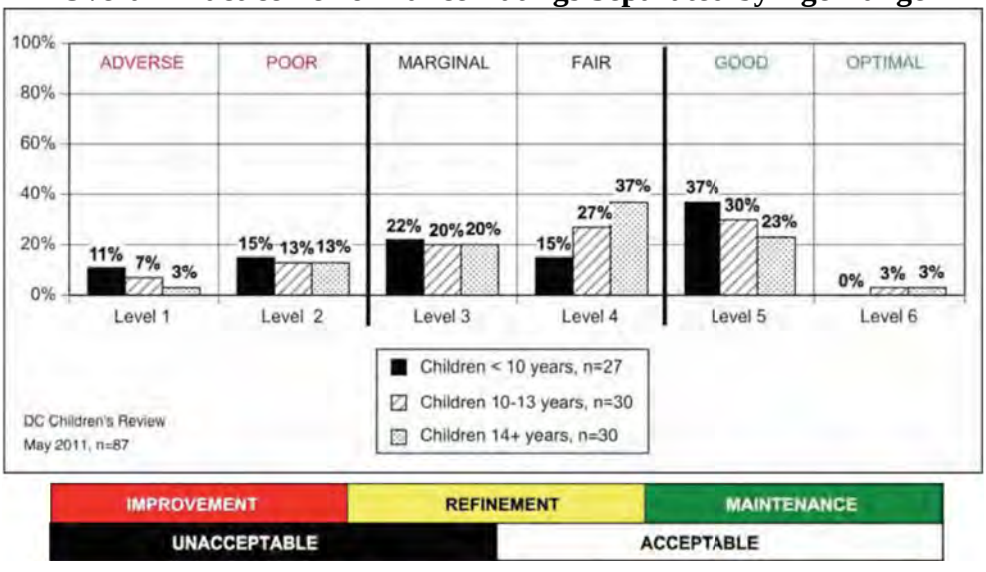
In **Appendix C** of this report are agency-by-agency results for the children and families reviewed. **This agency-by-agency comparison should be interpreted with caution, since review sample sizes for some of the provider agencies are extremely small**. **Generalizations regarding specific agency practice should not be made based on the individual case review results due to the small review sample sizes for the agency-specific findings**, rather the small review samples of children and youth are illustrative of practice 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 this year's review results. **Display 26** provides the overall practice performance ratings separated by

the child's general level of functioning. **Display 27** provides the overall practice performance ratings separated by age range.

Display 26
Overall Practice Performance Ratings Separated by Level of Functioning Range



Display 27
Overall Practice Performance Ratings Separated by Age Range

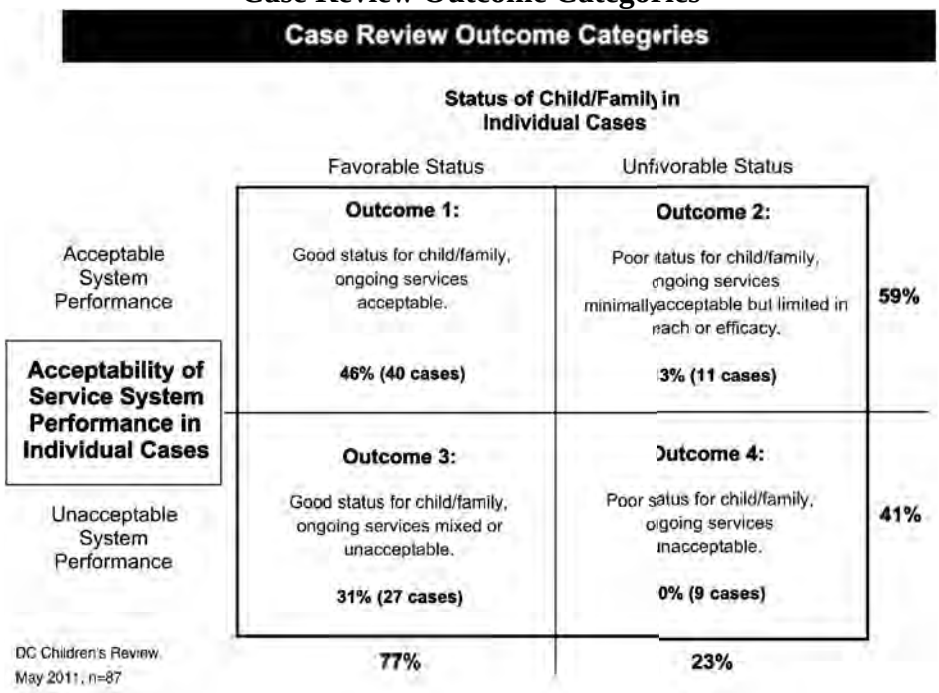


Case Review Outcome Categories

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 practice 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 practice performance." These categories are used to create the following two-fold table.

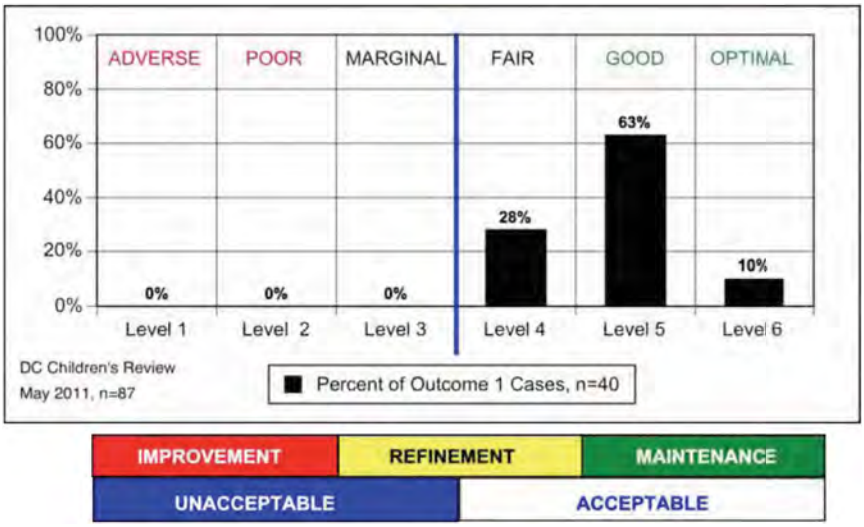
As **Display 28** indicates, 46% or 40 of the 87 youth reviewed were in outcome category 1. Outcome 1 is the desired situation for all children and families receiving services. There were 11 youth (13%) in outcome category 2. This category represents children whose needs are so great or complex that despite the best practice efforts and diligent practice performance of the service system, the overall status of the child or youth is still unacceptable. Thirty-one percent or 27 children and youth were in outcome category 3. Outcome 3 contains those review sample members whose status was favorable at least at the time of the review but who were receiving less than acceptable practice 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 practice performance is limited, inconsistent, or inadequate at this time. For many of these children, focused efforts in one area of practice likely could result in the child progressing into the outcome 1 category. This year, nine youth or 10% of the review sample were in outcome category 4, compared to 17 youth or 22% in the 2010 review. Outcome 4 is the most unfavorable combination as the child's status is unfavorable and practice performance is inadequate. There were 12% fewer youth in this outcome category than in the 2010 review.

Display 28
Case Review Outcome Categories

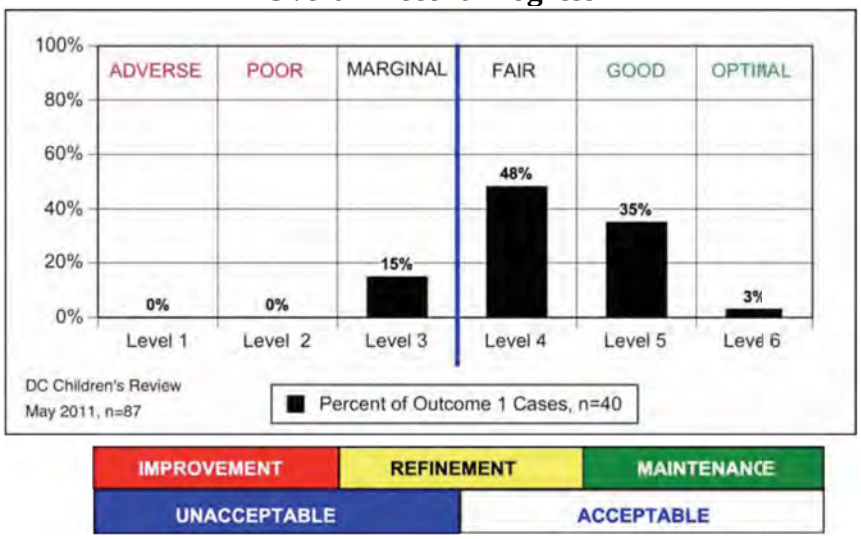


Displays 29 to 32 show the distribution of scoring on the six-point scale for the children who were in each of the outcomes shown in Display 28. For example, for outcome 1, the charts in Displays 29a, 29b, and 29c show the distribution of child status ratings, progress ratings, and practice performance ratings, respectively. Display 29a shows that 28% of the 40 children in outcome 1 had overall status indicators rated 4-fair, 63% rated 5-good, and 10% rated 6-optimal. Seventy-three percent of these 40 youth had a status rating in the maintenance zone with 5-good or 6-optimal, compared to 55% in 2010. Display 29c shows that practice efforts for these youth also improved, with 60% having overall practice ratings of 5-good or 6-optimal. In 2010, 42% of the youth in this outcome category had an overall practice rating of 5-good, with no youth having a 6-optimal overall rating for practice. Review of the remaining charts for the other outcome categories shows the high degree of consistency and trends 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 practice 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.

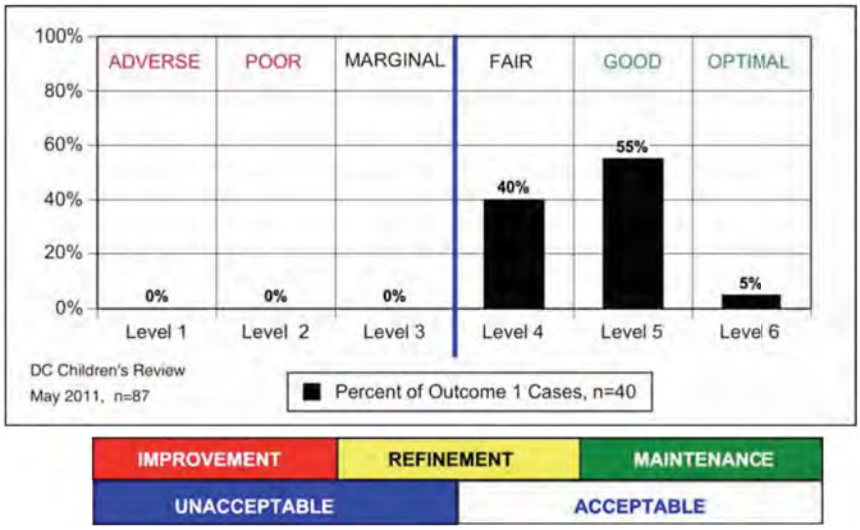
Display 29a
Outcome 1
Overall Child/Youth Status



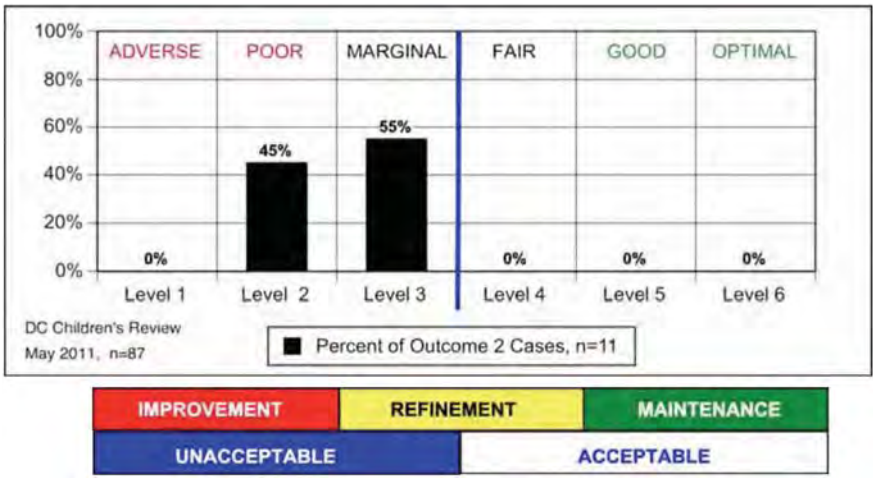
Display 29b
Outcome 1
Overall Recent Progress



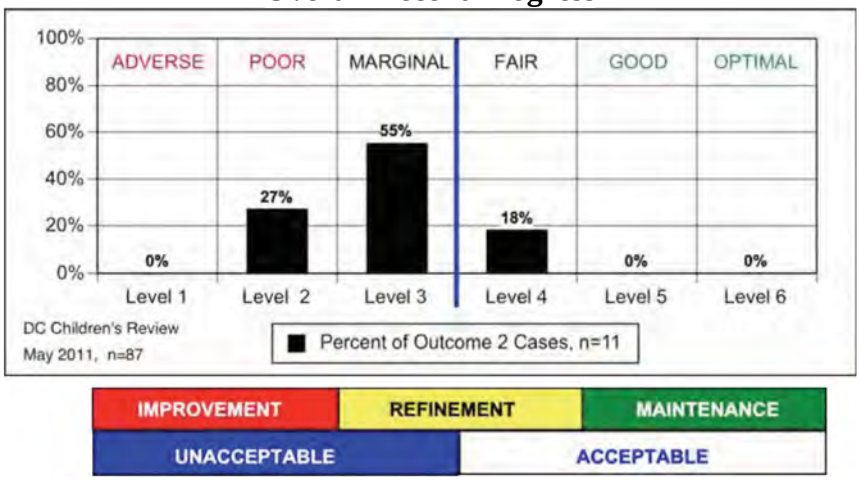
Display 29c
Outcome 1
Overall Practice Performance



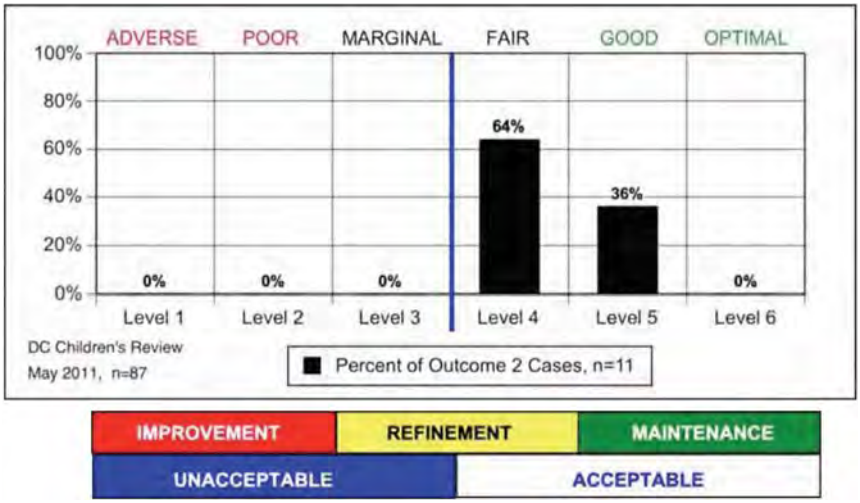
Display 30a
Outcome 2
Overall Child/Youth Status



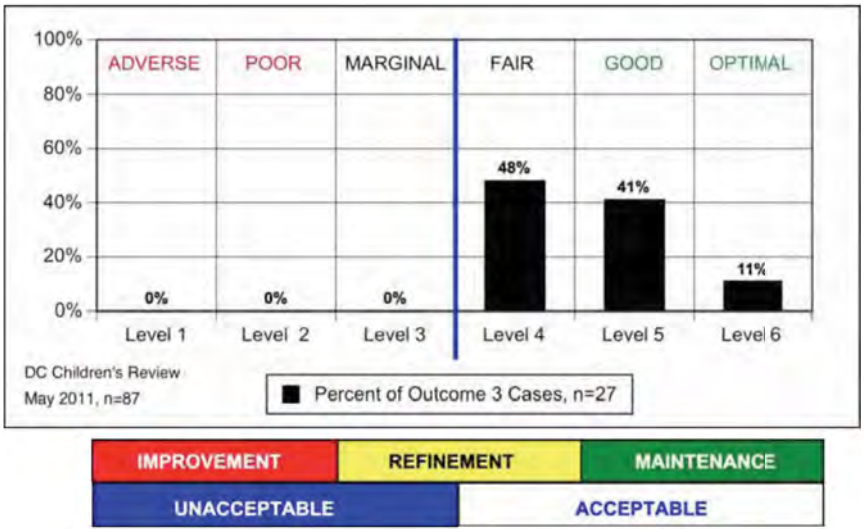
Display 30b
Outcome 2
Overall Recent Progress



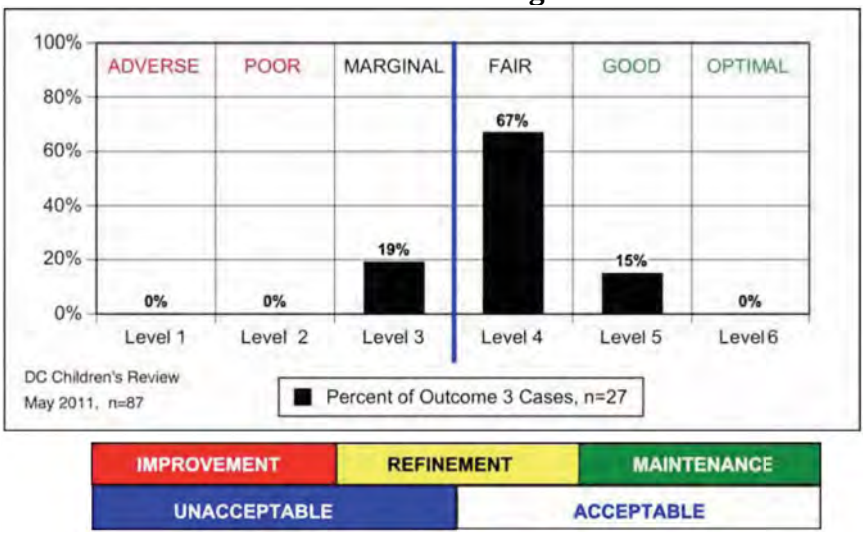
Display 30c
Outcome 2
Overall Practice Performance



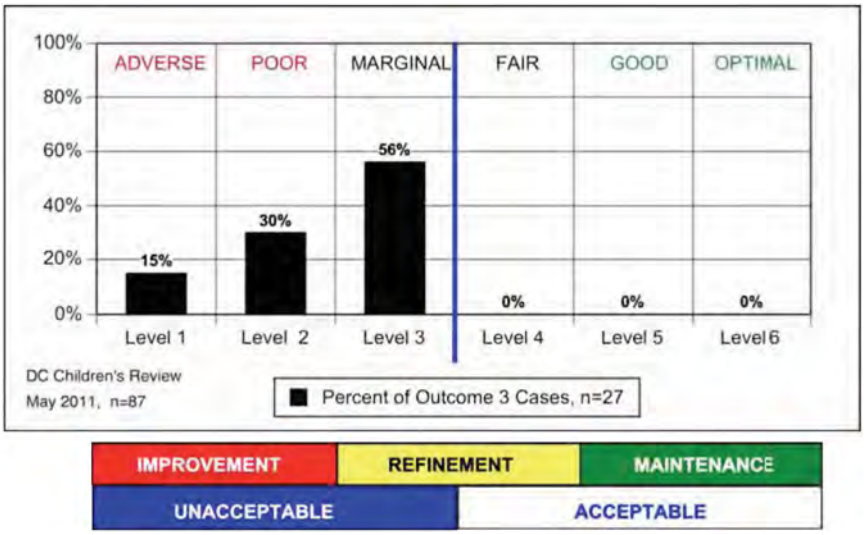
Display 31a
Outcome 3
Overall Child/Youth Status



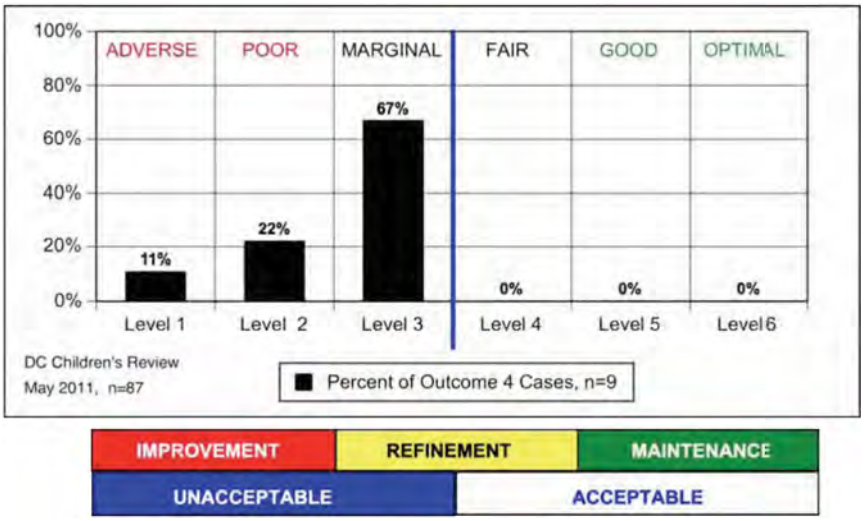
Display 31b
Outcome 3
Overall Recent Progress



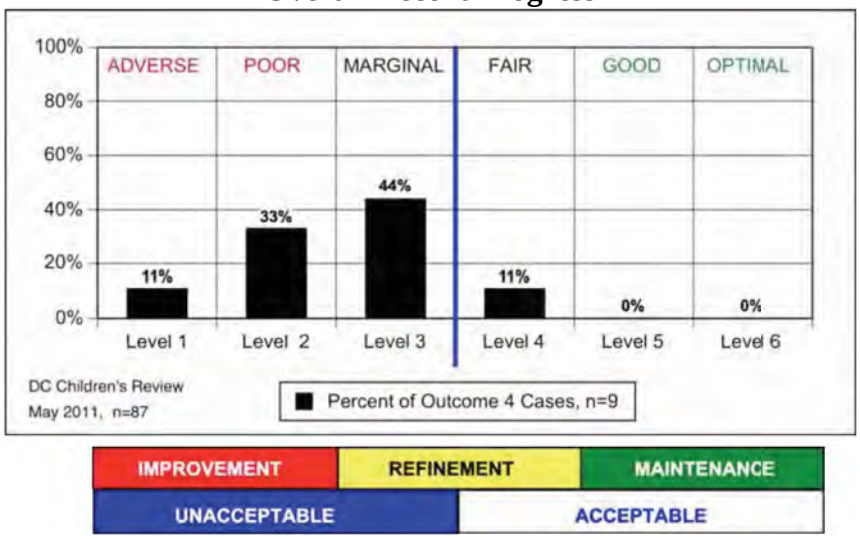
Display 31c
Outcome 3
Overall Practice Performance



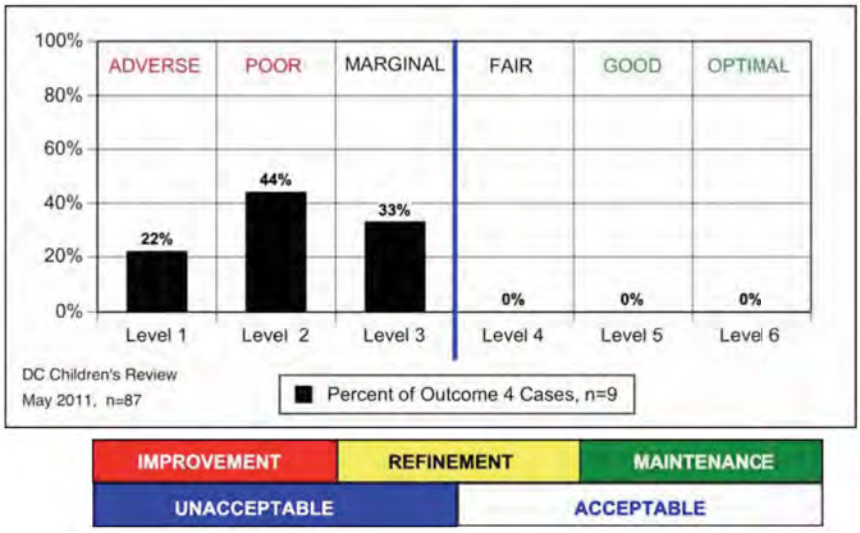
Display 32a
Outcome 4
Overall Child/Youth Status



Display 32b
Outcome 4
Overall Recent Progress



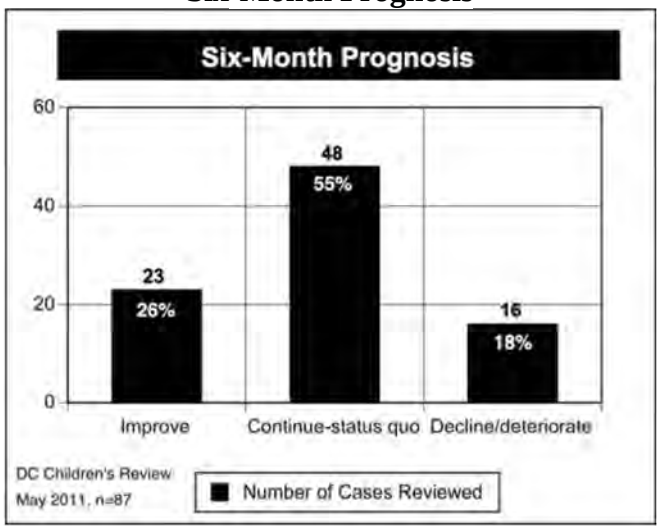
Display 32c
Outcome 4
Overall Practice Performance



Six-Month Prognosis

Reviewers provide a six-month prognosis for each member of the review 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 33** presents the six-month prognosis offered by reviewers for all children and youth in the review. As the display indicates, 23 youth (26%) were expected to improve, 48 (55%) were expected to remain about the same, and 16 (18%) were expected to decline or experience deterioration of circumstances over the next six months. The prognosis of status quo was the same for youth in the 2010 review. However, there was a significant decrease in the number of youth expected to decline in the next six months (18% in 2011 compared to 30% in 2010) as well as a significant increase in youth expected to improve (26% in 2011 versus 14% in 2010).

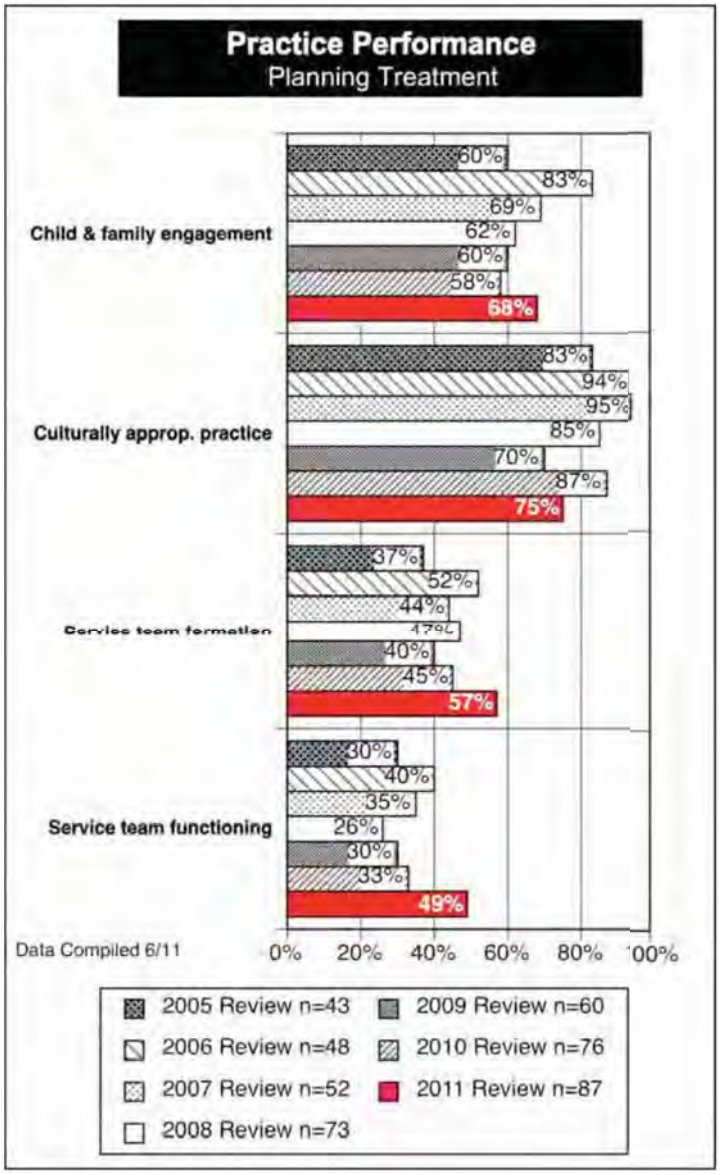
Display 33
Six-Month Prognosis



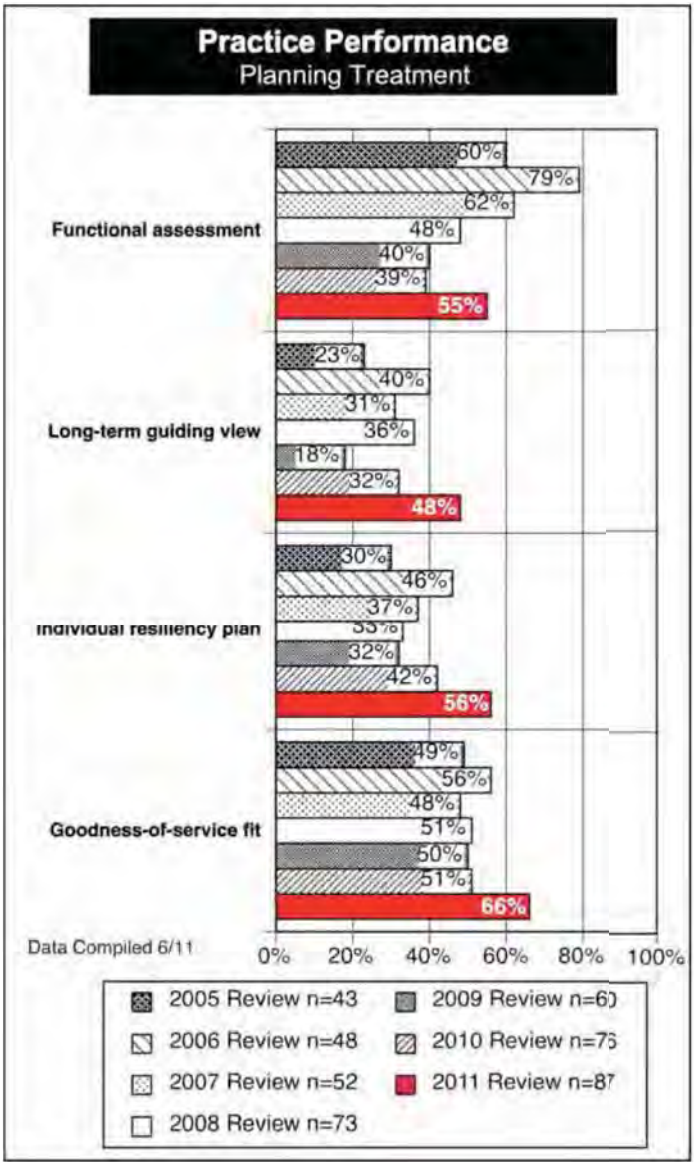
Overall, the results of the 2011 CSR data show that consistency and quality of practice has improved in the past year. The percentage of children who are provided services with the quality, coordination, consistency, and diligence necessary to achieve progress and improvements in children has improved by 10% since the 2010 review and by 25% since the lowest overall acceptable practice score of 34% in the 2008 review. However, DMH will need to continue focused efforts to improve practice in order to reach an overall acceptable practice rating of 80%.

Display 34 shows the results for practice performance for seven of the nine years in which CSRs have been conducted. The data trends do not show that significant improvement occurred in the consistent implementation of quality services until the 2011 reviews. As noted earlier and as illustrated below, challenges continue in the practice areas of team formation and functioning, working with families in ways that are culturally sensitive and appropriate, understanding of underlying issues and diagnostic assessment, identifying a long-term guiding view, and the development of individual plans that are youth and family-driven and that contain descriptive, measurable goals. In spite of significant improvement in systemic issues and progress in coordination and communications across child-serving agencies, the overall quality and consistency of actual practice with children and families, as shown by a random sample of children selected across the system, has shown very little improvement in the past seven years. Significant improvement between 2010 and 2011 as reflected in the CSR measurements was seen in this current review. Examination of the individual CSA data shows great variability across the CSAs and that some CSAs have dramatically improved the quality and consistency of services over the last couple of years. Fortunately, these have been the larger providers of children's services and specifically includes First Home Care and Community Connections.

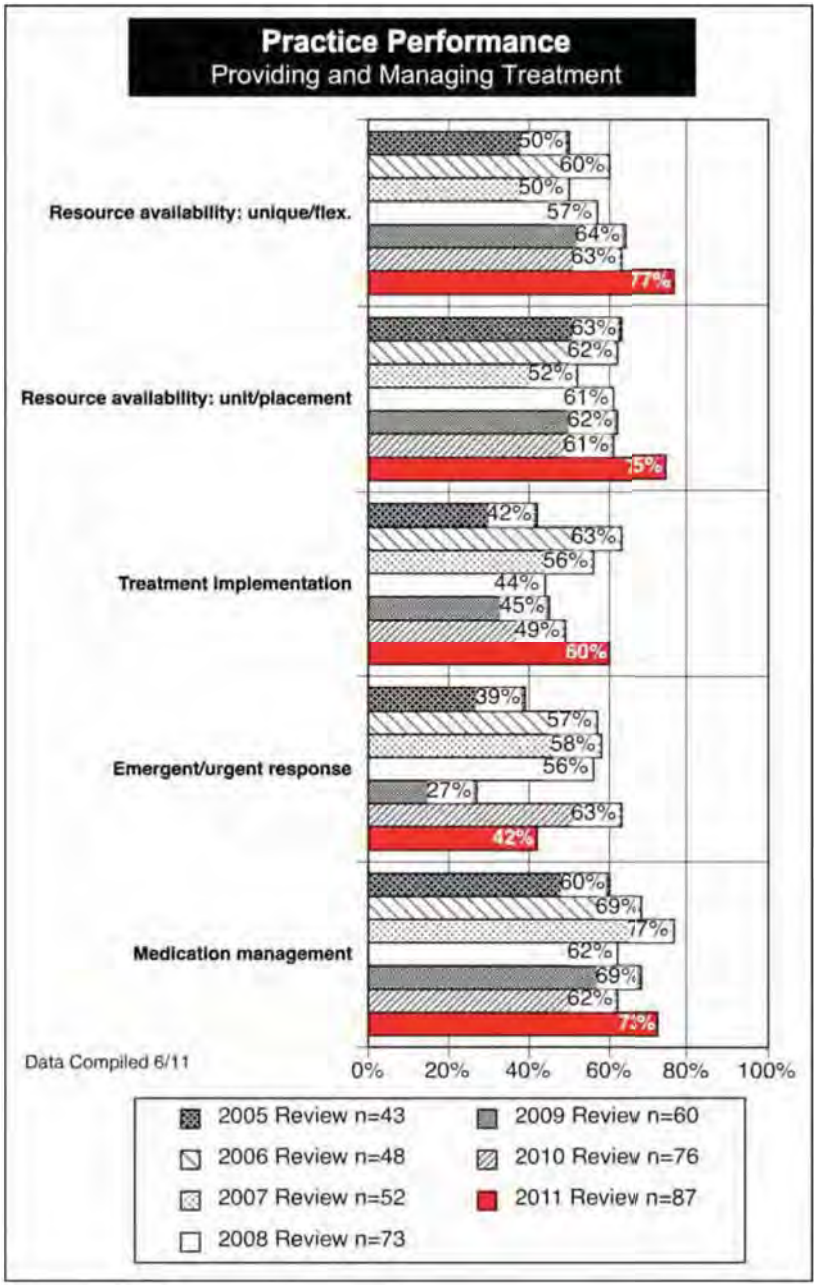
Display 34
Overall Child Practice Performance Results for Seven Reviews



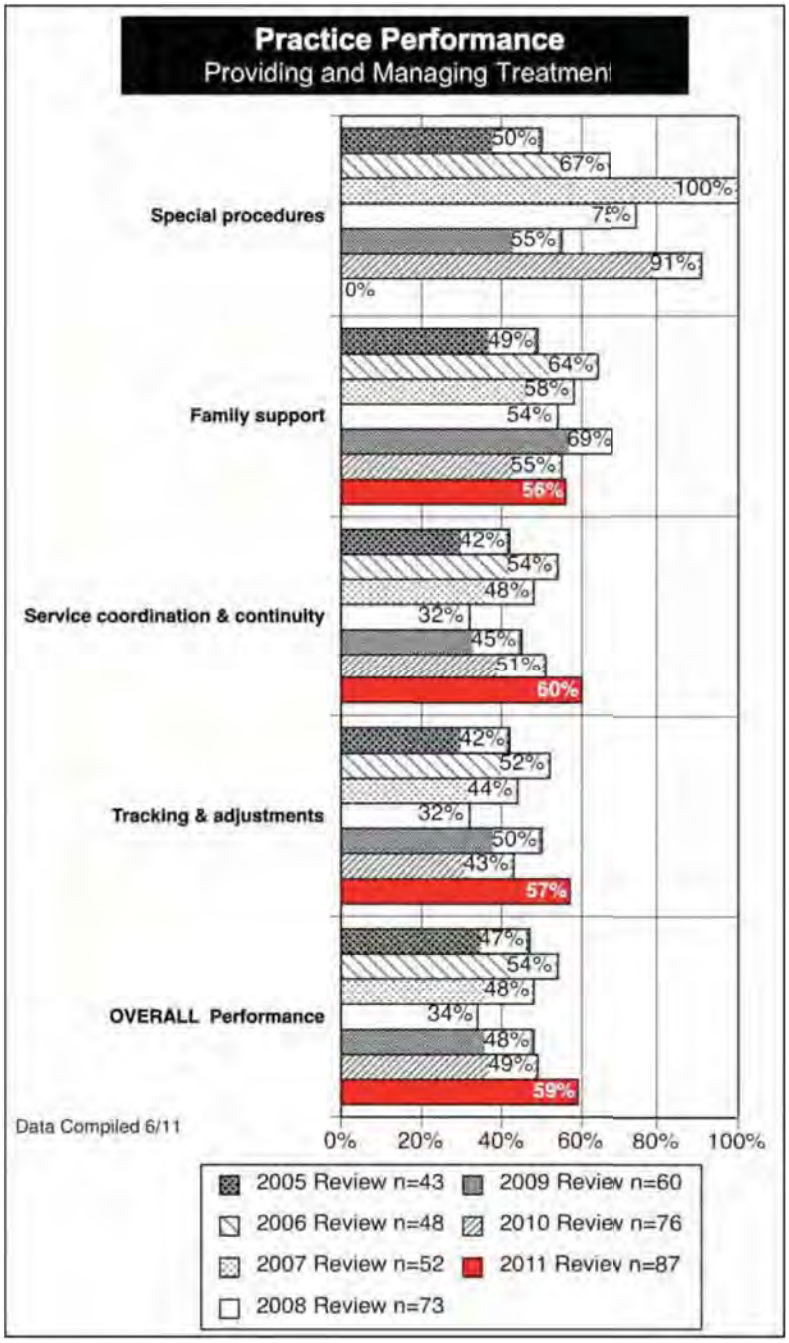
Display 34 (continued)
Overall Child Practice Performance Results for Seven Reviews



Display 34 (continued)
Overall Child Practice Performance Results for Seven Reviews



Display 34 (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 87 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 review sample. The following is a list and general discussion of systemic themes and patterns gathered from the 2011 review of services for children and youth. Specific areas of strengths and opportunities for improvement are described separately.

- A majority of the youth reviewed this year were found to be safe from harm (by self or others) and abuse/neglect (82%), were in an appropriate home and school placement (91%), and were experiencing good health (97%).
- There is an increase in acceptable overall ratings for child status-7% increase; child progress-9% increase; and practice performance-10% increase, when compared to the 2010 review of children's services.
- Prognosis for youth reviewed in 2011 also improved with a decrease in the percentage of youth projected to decline (18% in 2011; 30% in 2010) and an increase in youth projected to improve (26% in 2011; 14% in 2010).

The most evident theme this year, as in the past few reviews, is the variability across CSAs in providing consistent, high quality services. Strength and challenges were not observed consistently in each of the agencies reviewed. Some of the factors that contribute to this variability are how the agency is structured. That is do they have mostly in-house staff compared to being very dependent on contractors. The use of contractors presents significant challenges for supervision and coordination of services. Another factor is the extent to which management recognizes that it is there responsibility to promote high quality practice and that

they must establish methods of measuring the consistency and quality of practice. It is also necessary that management make sure that supervisors are concentrating on clinical quality of work during supervision and not administrative matters such as billable hours.

Strengths Observed During the Reviews

- Medication management was rated acceptable for 73% of the youth reviewed, an 11% improvement from 2010. Fifty-one of the 87 youth (58%) were receiving medication management services, an increase from 36 of the 76 youth (47%) in 2010. Strong psychiatry services were reported at two agencies in particular: MHSD and Community Connections. In some CSAs, there was frequent communication between psychiatrists and CSWs.
- ChAMPS mobile crisis services are viewed as very positive and responsive services to help children remain safely in the community and to maintain their placements.
- There was a noticeable presence of strong internal school teams this year, which significantly contributed to improved child status.
- The functioning of teams and communication between mental health teams and community partners is on an upward trajectory but still represents one of the biggest challenges to achieving consistent high quality services.
- There were reports of better coordination and communication between providers when siblings are also receiving services, especially when siblings receive services from the same CSA. In some CSAs that serve adults and children, much better coordination was observed when children and parents were both served in the same agency. However, this was inconsistent across providers, regardless of whether or not the parent/caregiver is receiving services from the same CSA as the youth.
- There was improvement in all but three areas of practice (cultural appropriateness, special procedures, and emergent/urgent response). When there is a problem with planning for emergent/urgent response. it is usually a failure to identify the risk or to develop a safety or contingency plan to address an emergent problem.

Challenges Observed During the Reviews

- There were some youth and families continuing to have difficulties accessing therapy or CSW services in a timely manner. There were reports of a long wait time to start therapy and psychiatric or specialty services, such as intensive in-home services. It was also reported and observed that some teams lack appropriate intensity or urgency when implementing services.
- Payment structure and limitations with Medicaid/DMH make it difficult to be a therapist. The role of the therapist is even less defined in the system than the role of the CSW. There is no motivation or interest to provide therapy in the District due to economics—not a good reimbursement rate.
- The system continues to lack a clear expectation regarding trauma-informed treatment and assessment. However, there are plans to train another group of therapists in trauma-focused CBT and to better coordinate the training with CSA clinical directors.
- There was inconsistency in the quality of psycho-social assessments, with superficial diagnostic assessment at intake that was not necessarily based on comprehensive understanding of youth symptomatology. In many instances, the functioning of the family was overlooked or misunderstood. The understanding and assessments process as a practice function was weak and not used to drive treatment planning.
- Teams were lacking clinical formulation of the key underlying issues that needed to be addressed in order to achieve an agreed-on positive outcome or long-term goals. They were also inconsistent when sharing information; were not adequately teaming around youth and families; and were not asking questions when aspects of practice, such as diagnosis, academic functioning, risk, medications, and caregiver or youth behaviors did not make sense.

Issues Pertaining to CSWs in Particular

- CSWs are the glue in teams and are defined differently across the system. In some CSAs, CSWs are providing outstanding services and teaming. On the other hand, some are lacking clinical direction and are not connecting together important pieces of working with a family. There is some lack of understanding, training, and supervision around education issues and the importance that academic functioning has for children's well-being. Some CSWs continue to

work in silos and are not fully inserting themselves into schools and not teaming consistently with school personnel. Many CSWs report that much of their work is reactive to the problem of the moment rather than proactive and well planned. The most effective CSWs have transitioned to a more proactive and planned approach to practice with each child and family.

- Overall, there is a strong feeling that CSW services in the community are a strength and have improved. CSWs are out in the community more so this year. In general, CSWs are getting good information and bridging gaps, such as with transportation and linkage to community supports. Some agencies have focused on hiring CSWs with clinical training, and these appear to have a better grasp of clinical issues and the necessity for engagement and teaming.

Stakeholder and Focus Group Observations

In addition to the child and family reviews, which included interviews with 474 persons, stakeholder interviews and focus groups were conducted with 56 persons who are involved with children's services in the District. The following themes emerged from the stakeholder interviews. Overall, ten focus groups were conducted over a two-week period of time and included CSA staff and management, DMH senior staff, CFSA, DYRS staff, and Magistrate Judge Goldfrank.

- Some CSAs are investing time and training for frontline staff in understanding and executing an articulated practice model. Other CSAs have a very weak supervision and staff development model. Staff report increased focused attention on identifying family strengths and working with the family to set goals. 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 but sometimes works very well.
- Areas of service access that continue to be challenging include timely delivery of the first service for CFSA in-home children, after-school programming, housing for youth ages 18-21 years and waiting lists for individual therapists with specific skills and knowledge. There is a lack of African-American male therapists that are considered most effective with African-American male youths. CFSA reports that accessing CBI can be difficult because of all the justifications required. Access to residential services when really needed for a person in crises can be too slow. It was reported that at the child level, the details of mental health and

CFSA interface continue to be highly variable. Sometimes it works well and other times it does not. DYRS reported that they were not having problems accessing services. This may be because of the diversion program and court involvement. They also reported, however, that they are not often invited to participate on child mental health teams.

- It is widely acknowledged that ChAMPS, the mobile crisis unit, is working well and has been continuing to improve. Schools are benefitting from this service and some improved teaming with schools has been noted as a result.
- The children's leader, Ms. Black, is acknowledged as doing an excellent job in problem-solving issues related to barriers to improving practice. She has been meeting with clinical leadership in each of the CSAs. She has also been holding solution-focused roundtable meetings on a regular basis.
- Issues continue to be raised regarding the timeliness of the paneling process for individual therapists.
- It was reported again this year that children are entering foster placements in Maryland, creating challenges for service providers and CFSA workers 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.
- Regular meetings continue to occur between the DMH Director of Child and Youth Services, her staff, and the courts to problem-solve issues. The focus this year has been on the juvenile diversion program.
- The CSWs continue to experience significant turnover. Depending on the agency they work for, some CSWs continue to feel major pressure around billable hours and perceive major barriers to doing the right practice and meeting their billable hours. Drive times continue to be a major issue to reaching children in outlying areas.
- As reported last year, this issue continues to be raised regarding CBI. 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.
- Concern was expressed that more work needs to be done to coordinate entry and discharge to and from acute psychiatric hospitalization with regard to medication continuity, and follow-

up and support for community placement and communication between ChAMPS, the CSA, and the admitting and discharge hospital.

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, as was true last year, it is apparent that there is wide variability of performance across providers. This is clearly evident in the data for individual providers in Appendix C. Fortunately, there are some CSAs who have improved the quality and consistency of their services significantly. 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. **Appendix D** contains the aggregated performance of the top three providers on child status, child progress, and practice 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 this year continued to show significant improvement at the system level and identified many strengths in the District's system for children's mental health services. These included the following:

- Leadership in DMH that is committed to both CSAs and other child-service agencies, such as child welfare, public education, and DYRS, 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.
- A few CSAs continue to see 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. They continue to report that the multiple and redundant documentation requirements take inordinate time and can be a significant barrier to timely provision of services.

Recommendations

- DMH should strongly consider requiring either through contractual, certification, or Medicaid quality improvement requirements that CSAs must develop internally a process for practice development and feedback to CSWs and other clinicians about the quality of practice.
- Continue to work on two recommendations from last year.
  1. 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.
  2. 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.

Improving the quality and consistency of mental health services to children continues to be a pressing need in the district. Much progress has been made, but the complex challenges of children in the context of their families and as well as their own needs, combined with the number of child-serving agencies involved in these children and families' lives, require continued effort to improve the communication around the provision of services to each and every child and family. CSAs vary greatly in their organization and capacity to provide meaningful supervision and feedback to their CSWs and therapists. DMH must continue to work with each provider to ensure that it can provide appropriate high quality services. DMH needs to complete the children's mental health plan that is in development at the earliest opportunity and work with Medicaid, managed care organizations (MCOs), and other child-serving agencies to ensure that there is a coherent overall mental health system for children that provides timely and responsive services, including primary care services, regardless of each child's specific context

and presentation of need. In order to meet these pressing needs, DMH needs to ensure that Ms. Black and her team have the necessary staff to carry out this critical work.

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 Far Southeast Family Strengthening Collaborative for their support and commitment in organizing and managing the logistics for the process.

Appendix A

Community Services Review For a Child and Family

Questions to be Answered

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

Produced for Use by the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

March 2004

Questions Concerning the Status of the Child and Family

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

Community Living

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

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

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

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

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

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

Health & Well-being

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

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

Development of Life Skills

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

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

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

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

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

Questions Concerning Progress

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

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

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

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

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

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

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

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

Questions Concerning Performance of Key Service Delivery Systems

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

Planning Treatment & Support

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

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

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

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

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

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

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

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

Providing Treatment & Support

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

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

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

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

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

14. **FAMILY SUPPORT:** • Are the caregivers in the child's home receiving the training, assistance, and supports necessary for them 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= 1 DC Child Review May 2011

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

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

CSR/Child Status and Performance Profile

Affordable Behavioral Consultants n= 1 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

Community Connections n= 12 DC Child Review May 2011

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	12	67%	8%	50%	42%
Stability	12	50%	17%	58%	25%
Home & school placement	12	92%	0%	58%	42%
Caregiver support of child	12	75%	17%	25%	58%
Satisfaction	12	83%	8%	17%	75%
Health/Phy well-being	12	100%	0%	0%	100%
Functional status	12	58%	8%	92%	0%
Academic status	12	67%	8%	33%	58%
Responsible social behavior	12	67%	8%	83%	8%
Lawful behavior	7	86%	14%	14%	71%
Overall C & F Status	12	67%	8%	42%	50%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	12	58%	0%	92%	8%
Behavior improvement	12	67%	0%	83%	17%
School/work progress	12	83%	0%	33%	67%
Risk reduction	10	80%	0%	80%	20%
Transition progress	7	71%	14%	57%	29%
Meaningful relationships	11	73%	0%	55%	45%
Overall Progress	12	67%	0%	83%	17%

CSR/Child Status and Performance Profile

Community Connections n= 12 DC Chilc Review May 2011

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	12	92%	0%	25%	75%
Culturally appropriate practice	1	100%	0%	0%	100%
Service team formation	12	92%	0%	42%	58%
Service team functioning	12	67%	0%	67%	33%
Functional assessment	12	83%	0%	42%	58%
Long-term guiding view	12	75%	8%	75%	17%
IRP	12	92%	0%	42%	58%
Goodness-of-service fit	12	83%	8%	33%	58%
Resource avail:uniqe/flex	11	82%	9%	27%	64%
Resource availability:unit/place.	8	75%	13%	13%	75%
Treatment implementation	12	83%	0%	25%	75%
Emergent/urgent response	5	60%	20%	60%	20%
Medication management	10	80%	10%	20%	70%
Special procedures					
Family support	12	75%	8%	58%	33%
Service coord.& continuity	12	92%	8%	25%	67%
Tracking & adjustment	12	92%	8%	17%	75%
Overall Practice Performance	12	92%	8%	25%	67%

CSR/Child Status and Performance Profile

Family Matters n= 5 DC Child Review May 2011

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

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	5	80%	0%	40%	60%
Behavior improvement	5	60%	0%	40%	60%
School/work progress	5	60%	0%	60%	40%
Risk reduction	4	100%	0%	75%	25%
Transition progress	4	75%	25%	0%	75%
Meaningful relationships	5	100%	0%	0%	100%
Overall Progress	5	80%	0%	40%	60%

CSR/Child Status and Performance Profile

Family Matters n= 5 DC Chilc Review May 2011

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

CSR/Child Status and Performance Profile

Family Preservation n= 2 DC Child Review May 2011

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

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

CSR/Child Status and Performance Profile

Family Preservation n= 2 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

Fihankra Place n= 3 DC Child Review May 2011

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

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

CSR/Child Status and Performance Profile

Fihankra Place n= 3 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

First Home Care n= 28 DC Child Review May 2011

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	28	82%	7%	39%	54%
Stability	28	68%	18%	29%	54%
Home & school placement	28	86%	4%	36%	61%
Caregiver support of child	28	82%	14%	25%	61%
Satisfaction	27	85%	0%	33%	67%
Health/Phy well-being	28	96%	0%	21%	79%
Functional status	28	64%	4%	79%	18%
Academic status	28	57%	25%	57%	18%
Responsible social behavior	28	54%	11%	68%	21%
Lawful behavior	24	75%	4%	50%	46%
Overall C & F Status	28	79%	11%	39%	50%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	28	64%	7%	71%	21%
Behavior improvement	28	64%	14%	57%	29%
School/work progress	27	56%	15%	63%	22%
Risk reduction	24	63%	17%	75%	8%
Transition progress	20	55%	25%	65%	10%
Meaningful relationships	28	82%	7%	64%	29%
Overall Progress	28	68%	7%	75%	18%

CSR/Child Status and Performance Profile

First Home Care n= 28 DC Child Review May 2011

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	28	82%	0%	39%	61%
Culturally appropriate practice	5	40%	20%	40%	40%
Service team formation	28	68%	7%	57%	36%
Service team functioning	28	57%	7%	86%	7%
Functional assessment	28	57%	14%	71%	14%
Long-term guiding view	28	61%	7%	75%	18%
IRP	28	64%	4%	86%	11%
Goodness-of-service fit	28	75%	0%	71%	29%
Resource avail.: unique/flex.	24	83%	0%	46%	54%
Resource availability: unit/place.	21	86%	0%	33%	67%
Treatment implementation	28	68%	0%	68%	32%
Emergent/urgent response	8	63%	0%	75%	25%
Medication management	12	83%	8%	42%	50%
Special procedures	1	0%	100%	0%	0%
Familty support	23	57%	13%	52%	35%
Service coord. & continuity	28	71%	4%	71%	25%
Tracking & adjustment	28	64%	18%	57%	25%
Overall Practice Performance	28	71%	4%	61%	36%

CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 6 DC Child Review May 2011

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	6	67%	17%	17%	67%
Stability	6	33%	50%	17%	33%
Home & school placement	6	83%	0%	83%	17%
Caregiver support of child	6	67%	17%	50%	33%
Satisfaction	6	100%	0%	17%	83%
Health/Phy well-being	6	83%	17%	0%	83%
Functional status	6	67%	33%	50%	17%
Academic status	6	17%	67%	17%	17%
Responsible social behavior	6	33%	33%	50%	17%
Lawful behavior	5	40%	40%	40%	20%
Overall C & F Status	6	67%	33%	50%	17%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	6	33%	33%	50%	17%
Behavior improvement	6	33%	33%	50%	17%
School/work progress	6	33%	67%	17%	17%
Risk reduction	6	50%	33%	50%	17%
Transition progress	6	50%	33%	50%	17%
Meaningful relationships	6	67%	17%	67%	17%
Overall Progress	6	33%	33%	50%	17%

CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 6 DC Child Review May 2011

Current Practice Performance	Cases Applicable	Percent Acceptable	mprovement	Refinement	Maintenance
Child & family engagement	6	67%	17%	50%	33%
Culturally appropriate practice					
Service team formation	6	67%	0%	67%	33%
Service team functioning	6	83%	0%	83%	17%
Functional assessment	6	67%	33%	50%	17%
Long-term guiding view	6	50%	17%	83%	0%
IRP	6	50%	17%	67%	17%
Goodness-of-service fit	6	83%	0%	83%	17%
Resource avail:uniqe/flex	5	80%	0%	80%	20%
Resource availability:unit/place.	4	75%	0%	75%	25%
Treatment implementation	6	67%	0%	67%	33%
Emergent/urgent response	2	0%	100%	0%	0%
Medication management	4	50%	0%	75%	25%
Special procedures					
Familty support	6	67%	0%	67%	33%
Service coord.& continuity	6	100%	0%	83%	17%
Tracking & adjustment	6	83%	0%	67%	33%
Overall Practice Performance	6	67%	0%	83%	17%

CSR/Child Status and Performance Profile

Latin American Youth Services n= 1 DC Child Review May 2011

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

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

CSR/Child Status and Performance Profile

Latin American Youth Services n= 1 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

Mary's Center n= 1 DC Child Review May 2011

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

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

CSR/Child Status and Performance Profile

Mary's Center n= 1 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

Maryland Family Resources n= 4 DC Child Review May 2011

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

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

CSR/Child Status and Performance Profile

Maryland Family Resources n= 4 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

Mental Health Services Division n= 2 DC Child Review May 2011

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

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

CSR/Child Status and Performance Profile

Mental Health Services Division n= 2 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

PSI Services n= 2 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

PSI Services n= 2 DC Child Review May 2011

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%	100%	0%	0%
Goodness-of-service fit	2	0%	100%	0%	0%
Resource avail.: unique/flex.	2	0%	100%	0%	0%
Resource availability: unit/place.	2	0%	100%	0%	0%
Treatment implementation	2	0%	100%	0%	0%
Emergent/urgent response	1	0%	100%	0%	0%
Medication management	1	100%	0%	0%	100%
Special procedures					
Familty support	2	0%	100%	0%	0%
Service coord. & continuity	2	0%	100%	0%	0%
Tracking & adjustment	2	0%	50%	50%	0%
Overall Practice Performance	2	0%	100%	0%	0%

CSR/Child Status and Performance Profile

Scruples Corporation n= 5 DC Child Review May 2011

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	5	80%	0%	40%	60%
Stability	5	100%	0%	20%	80%
Home & school placement	5	100%	0%	20%	80%
Caregiver support of child	5	100%	0%	20%	80%
Satisfaction	5	60%	40%	40%	20%
Health/Phy well-being	5	100%	0%	40%	60%
Functional status	5	80%	0%	80%	20%
Academic status	5	100%	0%	40%	60%
Responsible social behavior	5	80%	0%	60%	40%
Lawful behavior	4	75%	0%	25%	75%
Overall C & F Status	5	80%	0%	20%	80%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	5	100%	0%	60%	40%
Behavior improvement	5	100%	0%	60%	40%
School/work progress	5	100%	0%	60%	40%
Risk reduction	4	75%	0%	50%	50%
Transition progress	2	100%	0%	50%	50%
Meaningful relationships	4	75%	0%	50%	50%
Overall Progress	5	100%	0%	60%	40%

CSR/Child Status and Performance Profile

Scruples Corporation n= 5 DC Child Review May 2011

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

CSR/Child Status and Performance Profile

Universal Health Care n= 8 DC Child Review May 2011

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	8	88%	0%	63%	38%
Stability	8	63%	25%	25%	50%
Home & school placement	8	88%	0%	50%	50%
Caregiver support of child	8	75%	13%	63%	25%
Satisfaction	8	50%	38%	38%	25%
Health/Phy well-being	8	100%	0%	25%	75%
Functional status	8	50%	13%	88%	0%
Academic status	8	63%	13%	63%	25%
Responsible social behavior	8	63%	0%	100%	0%
Lawful behavior	6	67%	0%	50%	50%
Overall C & F Status	8	63%	0%	75%	25%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	8	63%	0%	88%	13%
Behavior improvement	8	75%	13%	88%	0%
School/work progress	8	63%	13%	63%	25%
Risk reduction	6	33%	0%	100%	0%
Transition progress	6	33%	17%	83%	0%
Meaningful relationships	7	86%	0%	71%	29%
Overall Progress	8	63%	13%	88%	0%

CSR/Child Status and Performance Profile

Universal Health Care n= 8 DC Child Review May 2011

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	8	25%	50%	38%	13%
Culturally appropriate practice	1	100%	0%	0%	100%
Service team formation	8	13%	63%	25%	13%
Service team functioning	8	13%	88%	13%	0%
Functional assessment	8	25%	63%	38%	0%
Long-term guiding view	8	13%	88%	13%	0%
IRP	8	13%	75%	25%	0%
Goodness-of-service fit	8	25%	63%	25%	13%
Resource avail.: unique/flex.	7	29%	43%	43%	14%
Resource availability: unit/place.	6	33%	50%	33%	17%
Treatment implementation	8	13%	63%	38%	0%
Emergent/urgent response	2	0%	100%	0%	0%
Medication management	6	50%	0%	67%	33%
Special procedures					
Family support	5	0%	100%	0%	0%
Service coord. & continuity	8	13%	88%	13%	0%
Tracking & adjustment	8	0%	88%	13%	0%
Overall Practice Performance	8	13%	88%	13%	0%

CSR/Child Status and Performance Profile

Youth Villages n= 2 DC Child Review May 2011

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

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

CSR/Child Status and Performance Profile

Youth Villages n= 2 DC Child Review May 2011

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

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

Three Top Providers (with 5 or more cases) = 45 Cases or 52% of the total child/youth reviewed

The Rest of the Providers = 42 Cases or 48% of the total child/youth reviewed

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

CSR/Child Status and Performance Profile - Provider Frequency

# of kids **12** DC Child Review May 2011

Provider	Overall Status	Overall Practice	Number
Community Connections	67%	92%	12

CSR/Child Status and Performance Profile - Provider Frequency

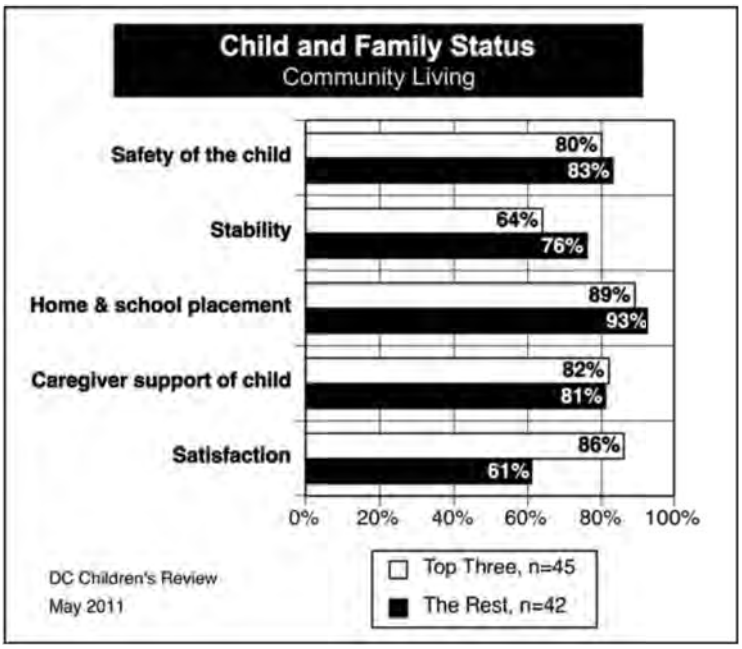
# of kids **5** DC Child Review May 2011

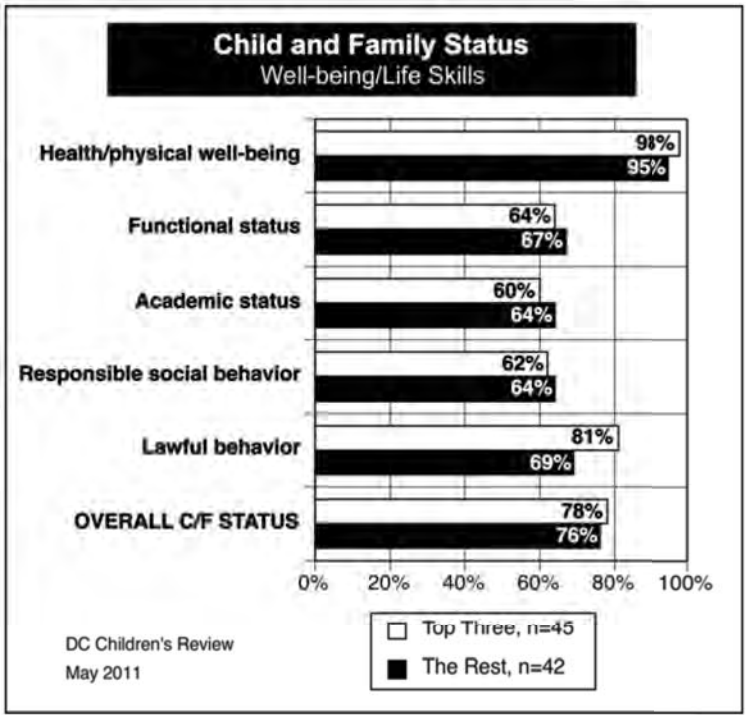
Provider	Overall Status	Overall Practice	Number
Family Matters	100%	80%	5

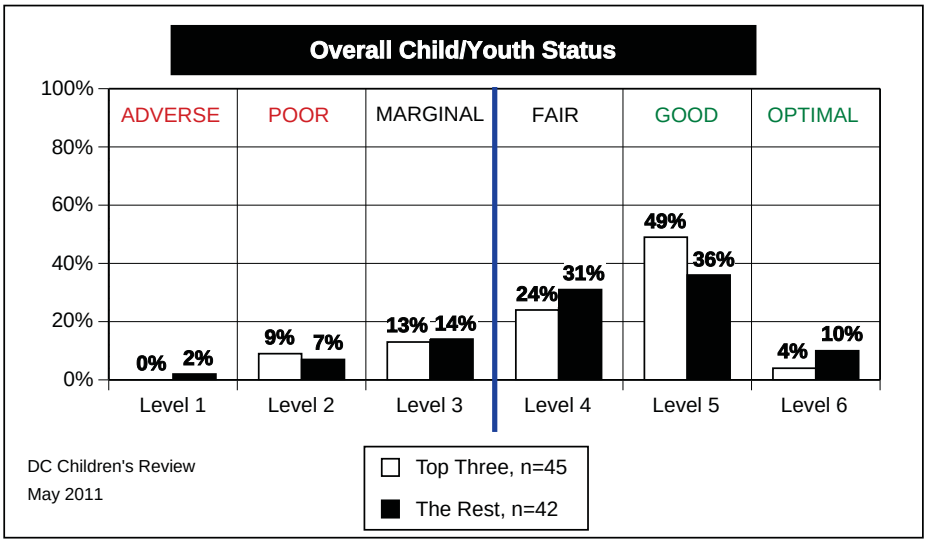
CSR/Child Status and Performance Profile - Provider Frequency

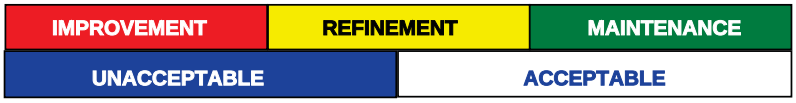
# of kids **28** DC Child Review May 2011

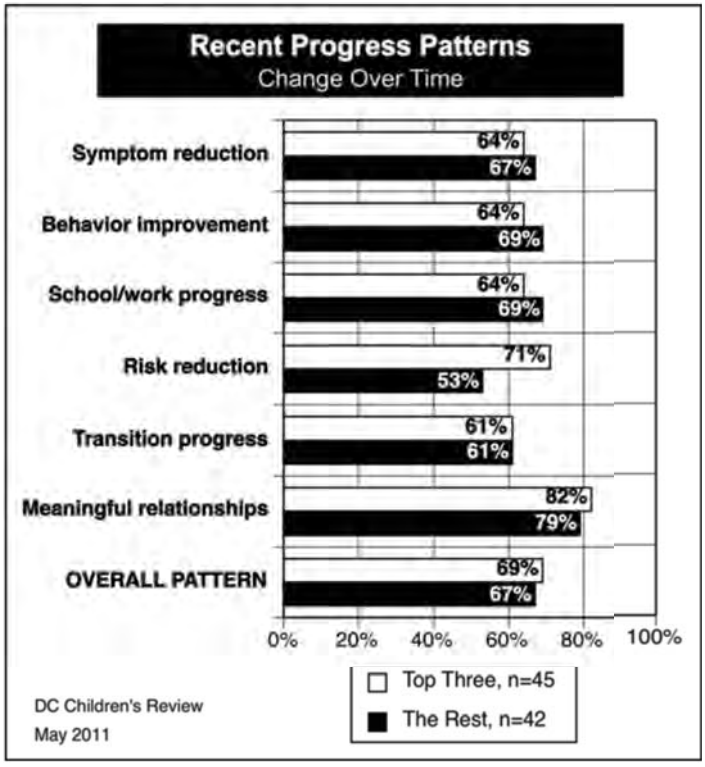
Provider	Overall Status	Overall Practice	Number
First Home Care	79%	71%	28

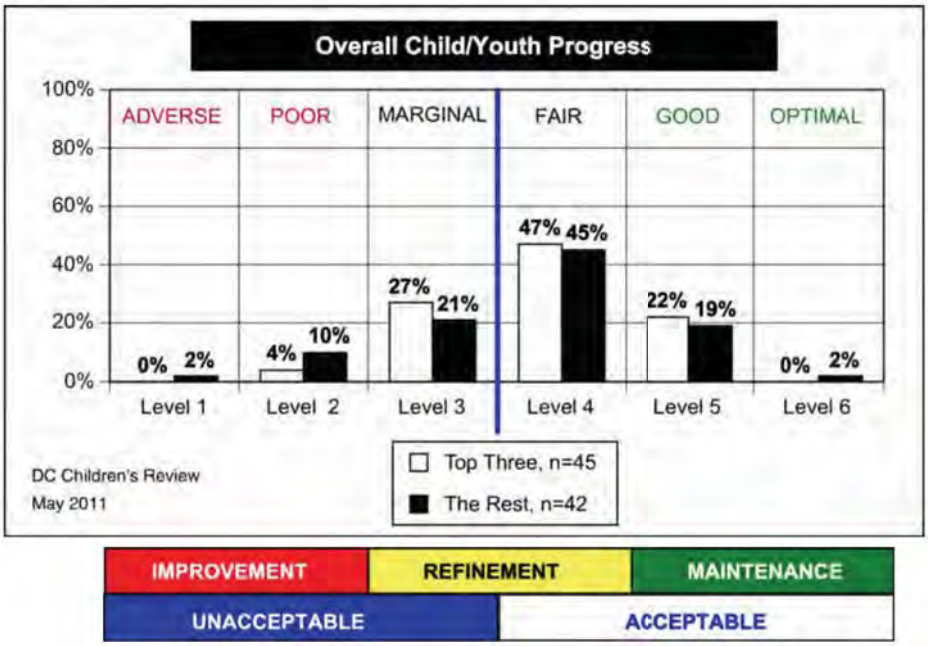

Child and Family Status
Community Living
Safety of the child
80%
83%
Stability
64%
76%
Home & school placement
89%
93%
Caregiver support of child
82%
81%
Satisfaction
86%
61%
0%
20%
40%
60%
80%
100%
DC Children's Review
May 2011
Top Three, n=45
The Rest, n=42

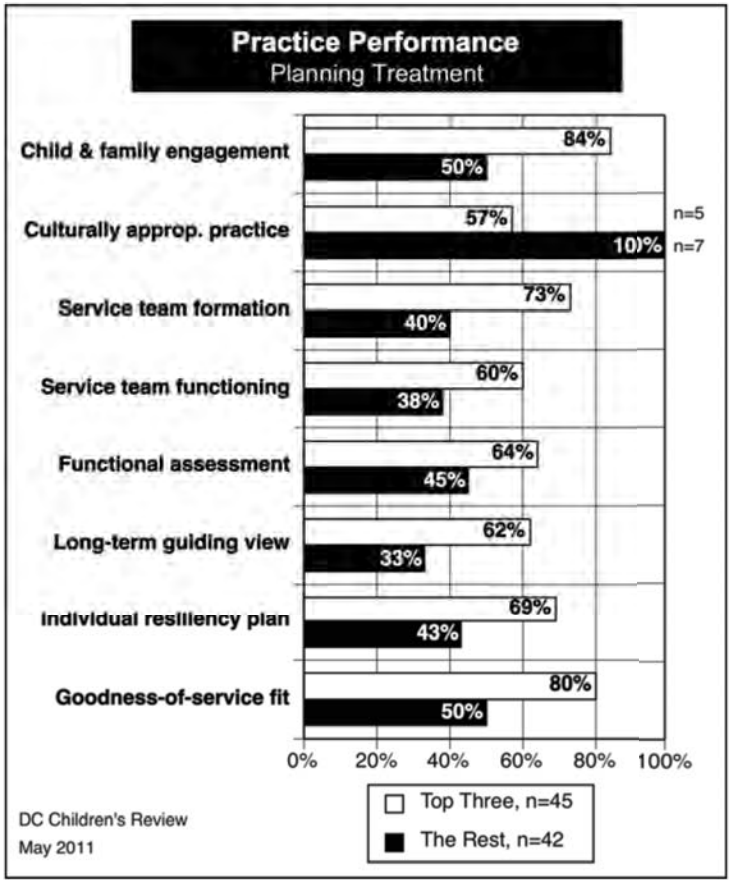

Child and Family Status
Well-being/Life Skills
Health/physical well-being
98%
95%
Functional status
64%
67%
Academic status
60%
64%
Responsible social behavior
62%
64%
Lawful behavior
81%
69%
OVERALL C/F STATUS
78%
76%
0%
20%
40%
60%
80%
100%
DC Children's Review
May 2011
Top Three, n=45
The Rest, n=42

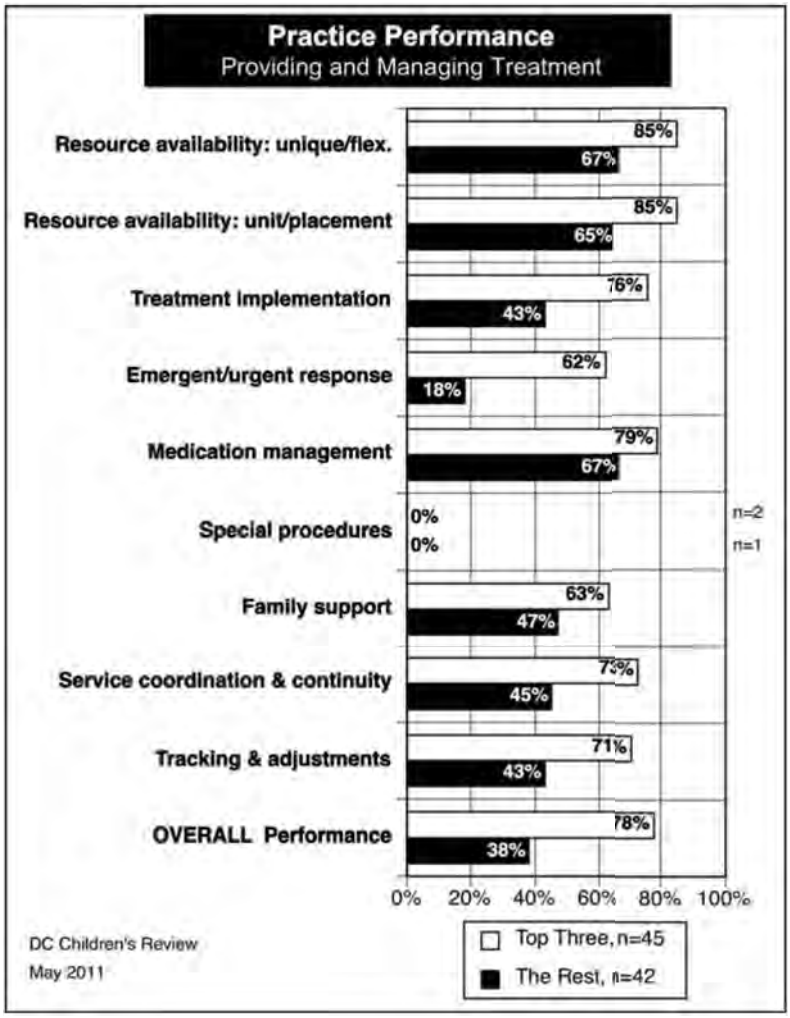

Overall Child/Youth Status
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
0%
2%
9%
7%
13%
14%
24%
31%
49%
36%
4%
10%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
DC Children's Review
May 2011
Top Three, n=45
The Rest, n=42

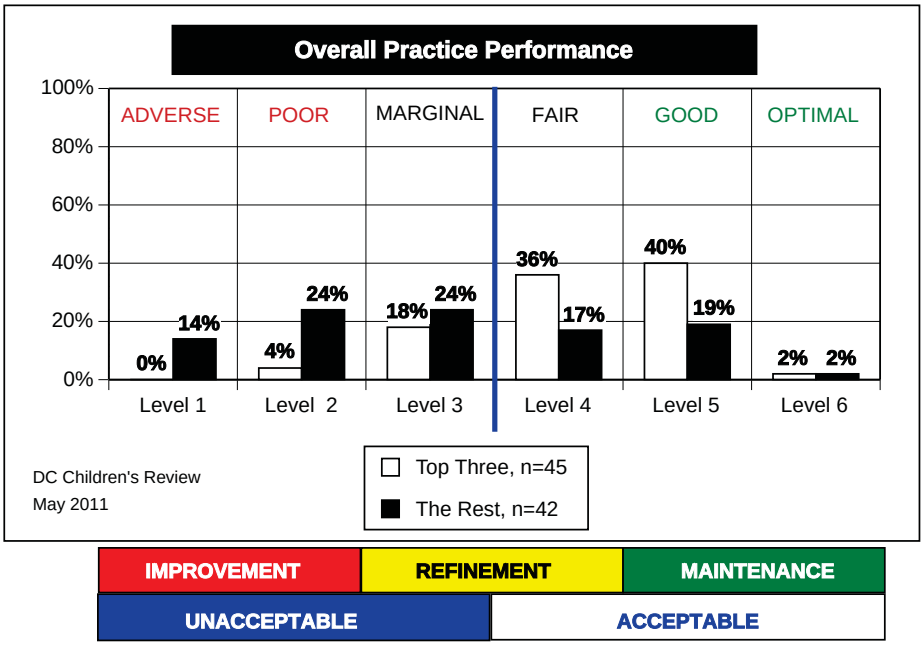

IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE

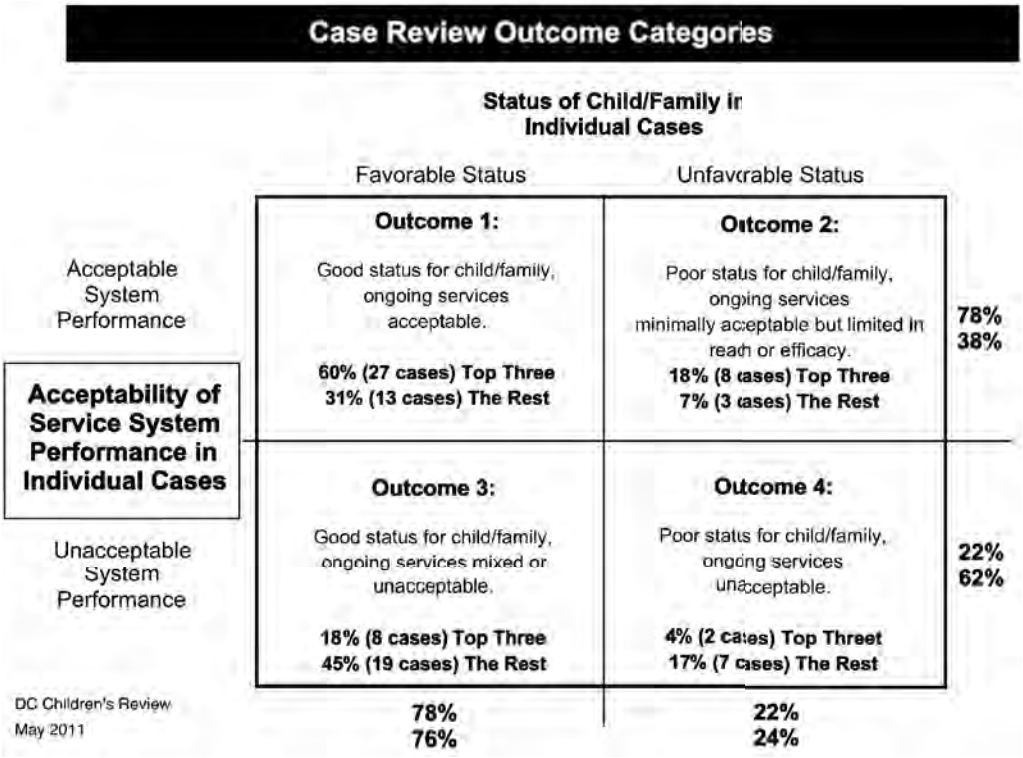

Recent Progress Patterns
Change Over Time
Symptom reduction
64%
67%
Behavior improvement
64%
69%
School/work progress
64%
69%
Risk reduction
71%
53%
Transition progress
61%
61%
Meaningful relationships
82%
79%
OVERALL PATTERN
69%
67%
0%
20%
40%
60%
80%
100%
DC Children's Review
May 2011
Top Three, n=45
The Rest, n=42

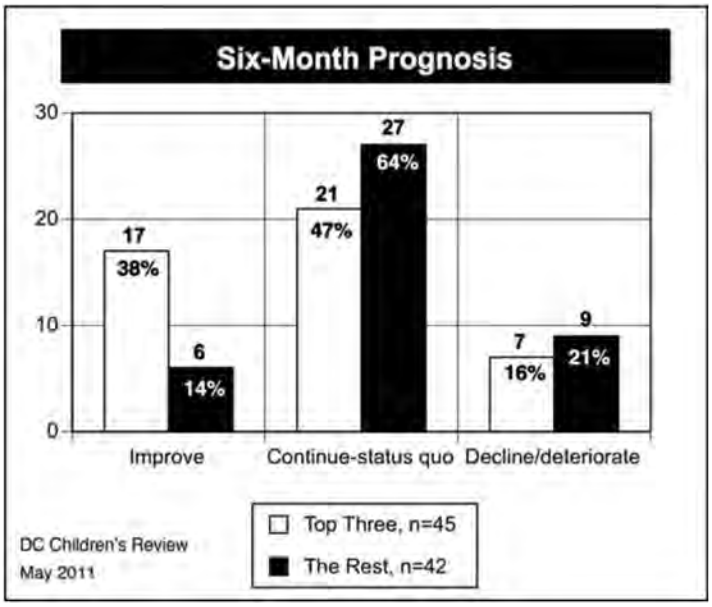

Overall Child/Youth Progress
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
0% 2%
4% 10%
27% 21%
47% 45%
22% 19%
0% 2%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
Top Three, n=45
The Rest, n=42
DC Children's Review
May 2011
IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE


Practice Performance
Planning Treatment
Child & family engagement
84%
50%
Culturally approp. practice
57%
10%
n=5
n=7
Service team formation
73%
40%
Service team functioning
60%
38%
Functional assessment
64%
45%
Long-term guiding view
62%
33%
Individual resiliency plan
69%
43%
Goodness-of-service fit
80%
50%
0%
20%
40%
60%
80%
100%
Top Three, n=45
The Rest, n=42
DC Children's Review
May 2011


Practice Performance
Providing and Managing Treatment
Resource availability: unique/flex.
85%
67%
Resource availability: unit/placement
85%
65%
Treatment implementation
76%
43%
Emergent/urgent response
62%
18%
Medication management
79%
67%
Special procedures
0%
0%
n=2
n=1
Family support
63%
47%
Service coordination & continuity
73%
45%
Tracking & adjustments
71%
43%
OVERALL Performance
78%
38%
0% 20% 40% 60% 80% 100%
DC Children's Review
May 2011
Top Three, n=45
The Rest, n=42


Overall Practice Performance
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
0%
14%
4%
24%
18%
24%
36%
17%
40%
19%
2%
2%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
DC Children's Review
May 2011
Top Three, n=45
The Rest, n=42
IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE


Case Review Outcome Categories
Status of Child/Family in Individual Cases
Favorable Status
Unfavorable Status
Acceptable System Performance
Unacceptable System Performance
Acceptability of Service System Performance in Individual Cases
Outcome 1:
Good status for child/family, ongoing services acceptable.
60% (27 cases) Top Three
31% (13 cases) The Rest
Outcome 2:
Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy.
18% (8 cases) Top Three
7% (3 cases) The Rest
Outcome 3:
Good status for child/family, ongoing services mixed or unacceptable.
18% (8 cases) Top Three
45% (19 cases) The Rest
Outcome 4:
Poor status for child/family, ongoing services unacceptable.
4% (2 cases) Top Three
17% (7 cases) The Rest
78%
38%
22%
62%
78%
76%
22%
24%
DC Children's Review
May 2011


Six-Month Prognosis
30
20
10
0
17
38%
6
14%
21
47%
27
64%
7
16%
9
21%
Improve
Continue-status quo
Decline/deteriorate
Top Three, n=45
The Rest, n=42
DC Children's Review
May 2011