2012 Report on Children and Youth

Served by the District of Columbia Department of Mental Health

June 2012

Presented to the District of Columbia Department of Mental Health

by
Human Systems and Outcomes, Inc.

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Executive Summary

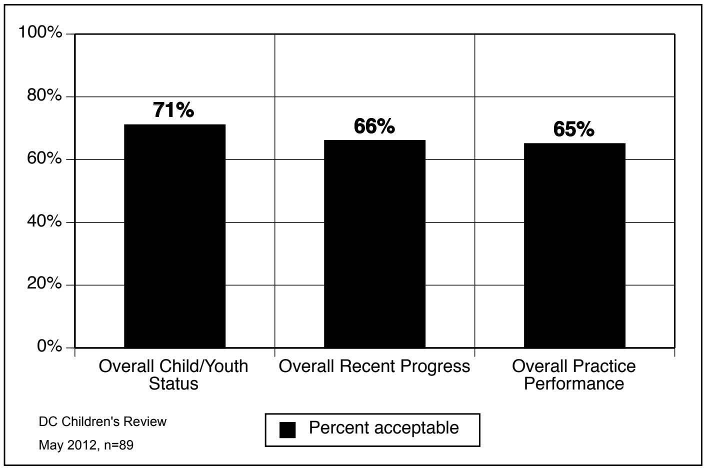
The Human Systems and Outcomes, Inc. review of services for a randomly selected sample of youth receiving services in the District of Columbia public mental health system was conducted using a qualitative review process: Community Services Review (CSR). The CSR is based heavily on the face-to-face interviewing 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, therapist, psychiatrist, teachers and school personnel, probation officers, child welfare worker, group home workers, behavioral specialists, etc. There were 565 people interviewed as part of the CSR this year, with an average of 6.3 interviews occurring per youth reviewed. Reviews were completed over a three-week period of time between May 7 and May 25, 2012, and included 89 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 core service agency (CSA) staff, judiciary, Child and Family Services Administration, and Department of Mental Health leadership and staff.

Overall Summary of Findings

Overall, the findings (as shown in the graph below) from the 2012 review of 89 youth showed that 71% of them had favorable status and 66% were making adequate progress. Sixty-five percent were receiving at least minimally adequate services from the mental health system.

While this is good improvement over past results, there continues to be variability in the consistency and quality of services provided across CSAs.

2012 Overall Review Results



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

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 2012 review, 56% of the 89 youth reviewed had an acceptable child status rating and an acceptable practice performance rating, placing them in outcome category 1. This is a 10% increase in Outcome 1 over 2011. There were eight youth (9%) in outcome category 2. In 2011, 13% of the youth were in Outcome 2. This category represents children whose needs are so great or complex that despite the diligent practice performance of the service system, the overall status of the child or youth is still unacceptable. Fifteen percent or 13 children and youth were in outcome category 3. Outcome 3 contains those review sample members whose status was acceptable at the time of the review, but reviewers could not see evidence that the system was performing consistently and current practice performance is limited, inconsistent, or inadequate at this time. In 2011, 31% of the youth reviewed were in this outcome category. Eighteen youth, or 20% 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 twice as many youth in this category than in the 2011 review.

Case Review Outcome Categories

Status of Child/Family in Individual Cases

Acceptability of Service System Performance in Individual Cases	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/family, ongoing services acceptable. **56% (50 cases)**	**Outcome 2:** Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **9% (8 cases)**	**65%**
Unacceptable System Performance	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **15% (13 cases)**	**Outcome 4:** Poor status for child/family, ongoing services unacceptable. **20% (18 cases)**	**35%**
	71%	**29%**	

DC Children's Review
May 2012, n=89

Conclusions and Recommendations

The review process this year continued to show 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.
- The beginnings of improved integration of effort across components of DMH, such as children's programs, the CSR unit, and quality improvement.

- CSAs that continue to see and use 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.
- CSA leadership that are committed to providing quality services, and who are struggling to align high quality practice with viable business practices.

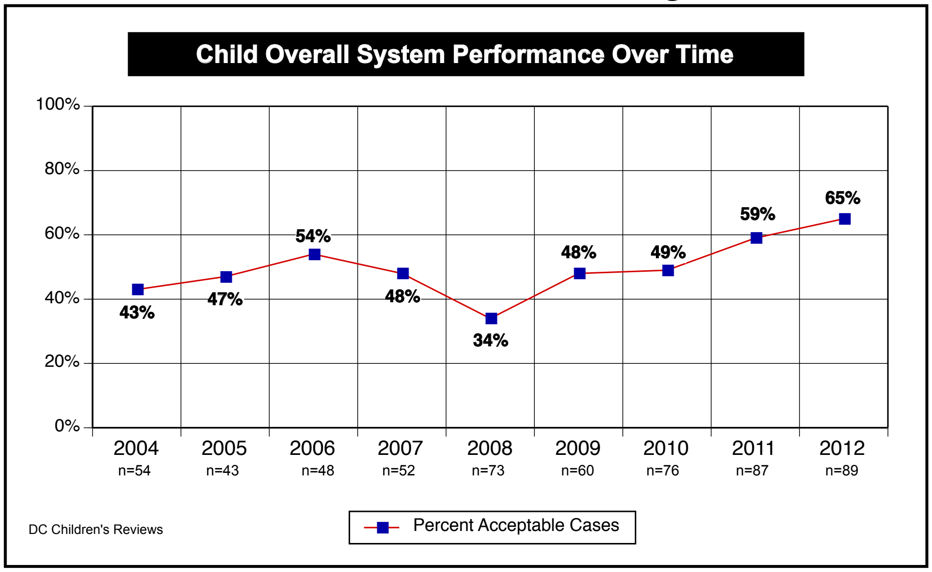
DMH has accomplished a great deal in improving the quality and consistency of services provided to children. It is now faced with the challenge of how to make refinements and motivate both DMH staff and the CSAs to strive for world-class performance. It will take fully coordinated efforts on the part of the DMH team and the CSA leadership to raise the consistency and quality of services from the current 65% to 70% range to the desired 85% to 95% range of high quality and consistency. This would mean that instead of having roughly two out of three children served with high consistency and quality, closer to nine out of ten children would be served with diligence and thoughtful quality. That is a high standard that few systems meet or can sustain.

Recommendations

It is recommended that careful consideration be given to identifying refinements that can be made that would support service delivery staff to perform with even more consistency. Questions to consider include: What are the critical steps to be taken from this point that will sustain and improve our current performance? How can we use DMH resources to work in a concerted and synergistic effort towards this goal? How can we collaborate with educational and other child-serving agencies to make refinements that will make a significant difference in improved communication at the child/intervener level?

- DMH should continue to support the integration and adoption of the practice expectations and CSR process into CSA functions and processes.
- DMH needs to ensure that the CSR unit is able to support the ongoing use of CSR in the CSAs and the unit needs to begin to conduct small targeted CSR reviews on a regular and timely basis. These reviews should be done in coordination with the Office of Quality Improvement and program areas.
- It would be helpful to brainstorm with the other child-serving agencies to determine what specifically can be done in the next 12 months to improve collaboration and communication at the child level across agencies.
- DMH has implemented a juvenile court diversion program and continues to reduce the use of residential placements both within and outside the district. These programs may result in a greater number of higher need, older children being served in the community. DMH may need to consider what specific steps need to be taken to increase the skills and services in the community that are necessary to most effectively serve these children in the community. This may also include the need for more CBI, wrap-around, and MST services.
- 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; however, 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.

Overall Child Practice Performance Ratings 2004-2012



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Background and History

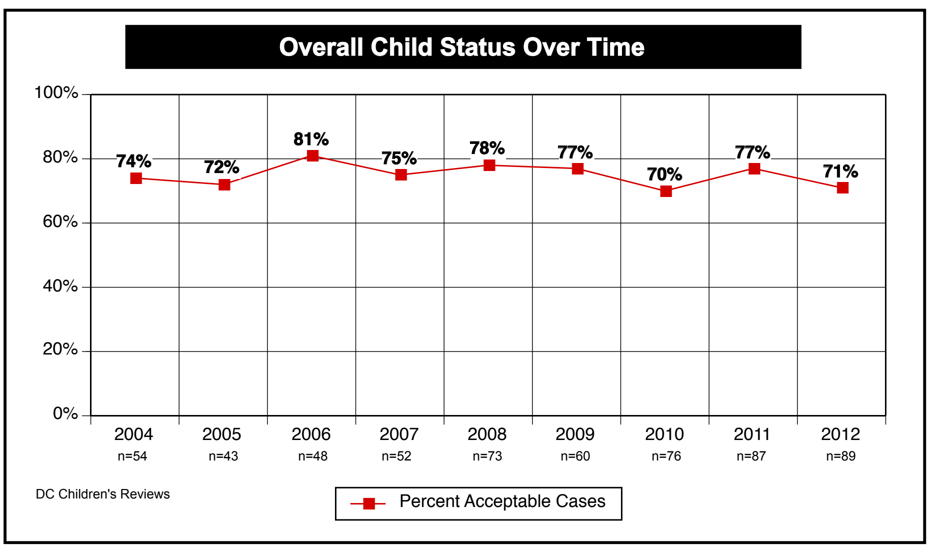
The Final Court-Ordered Plan for Dixon, et al v. Gray, et al [March 28, 2001] required that performance measures be developed and used for measuring practice performance. The court-ordered Exit Criteria and Method [September 21, 2001] set forth further detail for measurement requirements pertaining to consumers, including children and youth:

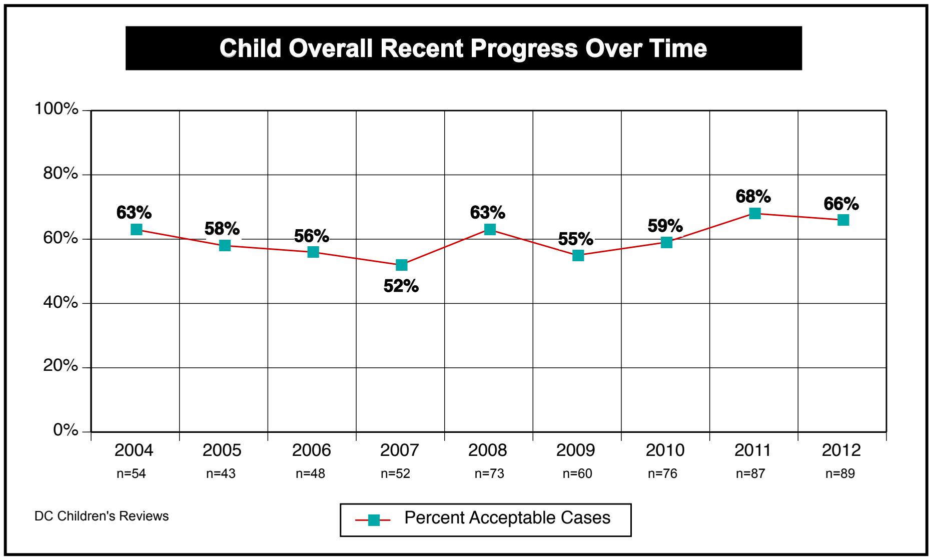
- ♦ Consumer service reviews will be conducted using stratified samples.
- ♦ Annual reviews will be conducted by independent teams.
- ♦ Annual data collection on individuals will include consumer and family interviews, record reviews, staff interviews, caregiver interviews, and analysis of data.
- ♦ 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.

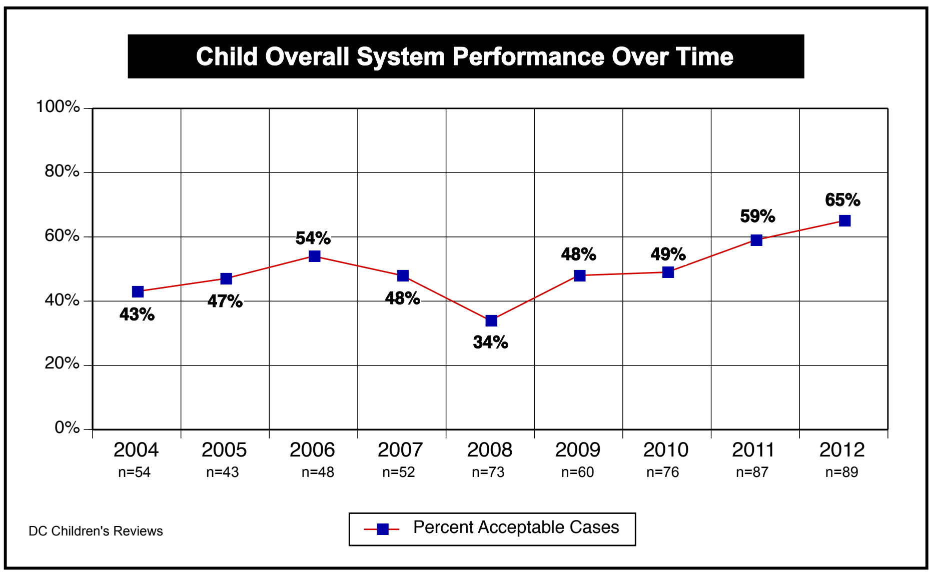
In 2012, the District of Columbia and the Department of Mental Health (DMH) entered into a Settlement Agreement that ended the 37-year old *Dixon* class-action lawsuit. During the last ten years of the lawsuit, the District and DMH were required to satisfy certain criteria; two of those criteria were designed to measure the public mental health system's performance on an annual basis. The Community Service Review or CSR protocols were developed by Human Systems and Outcomes, Inc. (HSO) as a measuring tool and used to measure performance for the adult and child system since 2003. Based upon data from prior reviews, as well as satisfactory completion of other exiting criteria, the District was able to substantially meet the requirements for adult services prior to the end of the lawsuit; however, it was determined that the child/youth system was in need of additional system improvement. As part of the Settlement Agreement, the District agreed to contract with HSO for the next two years for continued support to conduct the children and youth CSRs and consultation for targeted interventions with the providers and with DMH as it moves to more frequent, provider-specific CSRs.

The initial Community Service Review was completed during March 2003, with reviews occurring every year since. Multi-year data comparison shows consistent overall child status ratings in the mid 70% to low 80% range, as illustrated in the graph below. Multi-year comparison for practice shows overall system performance hovering around 47% until 2010. There was an outlier year in 2008 when the sample size was increased to n=73 and overall system performance rated as 34%. In 2011, scores started to trend upward with an overall system performance score of 59%, and 65% in 2012.

The following graphs display the child status, child progress, and practice performance ratings over nine years—2004 through 2012.







2012 Children's Review

The design of the 2012 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 initially was contracted by the Dixon Court Monitor, and then in 2012, by DMH. Logistical preparation and organization of the on-site case review activities was completed by the Far Southeast Family Strengthening

Collaborative (FSFSC) and the DMH CSR unit. HSO expresses their deep thanks to the FSFSC and the CSR unit for setting up the large number of individual child reviews.

Context for the 2012 Review

A major system change process has been occurring in the District of Columbia for children's mental health services since 2006. 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 high quality performance across core service agencies (CSAs), providers, community partners, and other child-serving agencies. The expectation is that each child and family served receive individually determined quality services according to the practice principles of the integrated System of Care

Over the last six years, leadership at DMH focused on a number of system change initiatives: defining and supporting teaming, contracting of CSAs, identification of a wraparound provider, development of crisis mobile outreach, large transition of consumers from the public provider DCCSA to community-based CSAs, addition of the CSR unit to DMH, introduction of several evidence-based practices to include Family Functional Therapy and High Fidelity Wrap Around, targeted practice-improvement and integration consultation to CSAs, development of DMH practice principles, juvenile diversion program, and development of a combined CSR/QSR (Quality Service Review) protocol with the Child and Family Services Administration (CFSA).

Overview of the Child Service Review Process

The review of services for children, youth, and families is conducted through an individual, case-based review process. This process yields both qualitative and 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 that is based heavily on the face-to-face interviewing of all service providers and persons involved with a youth, such as the child, parents or guardian, and key team members, such as a CFSA social worker or 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 have a significant role, or who provide support to the youth or family, may also be interviewed. These adults can include other family members, community members, coaches, pastor and church members, and babysitters or respite/caregivers.

For 2012, 89 reviews were completed over a three-week period. Reviewers trained to standard by HSO trainers completed the child reviews. HSO-affiliated personnel conducted 34 reviews and DMH staff completed 55 reviews. Each review conducted included a second "shadow" reviewer who participated in the review process either for training purposes or as an observer.

Changes to the Review Process

There were no fundamental changes to the review process during the 2012 review; however, 24 youth, also in the care or custody of CFSA, were co-reviewed by experienced reviewers from CFSA or the Center for the Study of Social Policy (CSSP) using another protocol (QSR) that had been developed for CFSA by HSO. Data were collected using both the QSR and the CSR protocols for these youth.

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.

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 regarding how teams should proceed. Positive response to the feedback process has been consistently received. 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 2012 reviews, 81% of the reviews included feedback to the CSA team. Fifty-five of the feedback sessions included a supervisor, and many sessions included a clinical director, CEO, and other team members.

The Sample for Children and Youth

The targeted number of children and youth to review was determined to be 86. A stratified random sample of 94 youth (84 youth plus roughly a 10% oversampling) and replacement names were drawn from the DMH eCURA data system for youth receiving services between October 1, 2011 to January 31, 2012. 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-four youth were replaced in the original sample to make up the final number of 91 scheduled reviews. Reviews were completed for 89 of the 91 scheduled reviews, with two reviews dropping out during the review weeks due to not being able to locate the guardians and/or youth; reviewers did not feel they had enough information to complete the roll-up and protocol. 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 unduplicated population served during this time period was reported to be 2208 children, an increase of 49 youth from 2011.

Core Service Agencies

According to the information supplied to HSO by the DMH eCURA system, there were a total of 2208 children who received a billed-for service between October 1, 2011 and January 31, 2012, 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 discontinuing services and 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, 2011 to January 31, 2012
According to the eCURA Data System

Core Service Agency	# In Population	# In Sample	# Reviewed
1. First Home Care Corporation	715	26	25
2. Community Connections, Inc.	343	14	14
3. Universal Health Care Management	203	8	9
4. Hillcrest Children's Center	206	8	8
5. Inner City Family Services	135	6	6
6. Life Enhancement	120	4	4
7. MD/DC Family Resource Center	112	4	4
8. Family Matters	99	4	5
9. Life Stride, Inc./ Affordable Behavioral Consultants	77	3	2
10. Launch, LLC	66	3	4
11. PSI	48	2	2
12. Fihankra Place, Inc.	36	2	2
13. Latin American Youth Center	12	1	1
14. Mary's Center	11	0	0
15. Family Preservation	9	1	1
16. Mental Health Services Division	8	1	0
17. Youth Villages	7	2	2
18. Other (includes two agencies)	1	0	0
Totals	2208	89	89

*Includes the oversample of ten youth.

Age and Gender of Youth

When selecting the sample for the 2012 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 2012

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	529	24%	21	24%	20	22%
10-13	786	36%	32	36%	29	33%
14+	891	40%	36	40%	40	45%
Totals	2208	100%	89	100%	89	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	901	41%	36	40%	41	46%
Male	1307	59%	53	60%	48	53%
Totals	2208	100%	89	100%	89	100%

Children and Families Included in the Review

The target number of reviews was met this year as data were gathered for 89 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. For the 2012 review, 44 youth replacements were made for a variety of reasons, most were no longer receiving services (24 youth) or declined to participate (17 youth). The sampling timeframe used to select children and families for the review can impact the number of replacements made to the original sample. Three of the youth and families could not be located to request consent to participate in the review. **Display 3** shows the general reasons for replacement and the number of youth replaced.

Display 3
Reason for Youth Replacement in Review Sample

Reason for Replacement	# of Youth Replaced
Declined to participate	17
Discharged from services/inactive	24
Difficulty locating authorized signature	3
Total Replacements	44

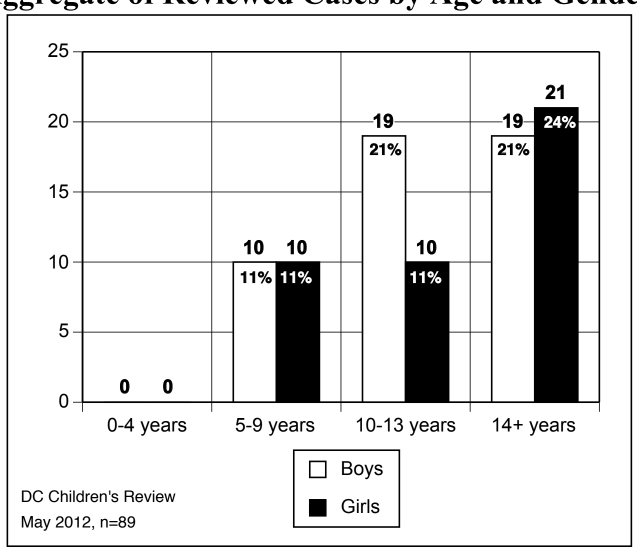
Description of the Children and Youth in the Review Sample

A total of 89 child and family reviews were completed during May 2012. 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 89 children and youth distributed by both age and gender. As shown in this display, boys made up 53% of the youth reviewed and girls made up 46% of the youth reviewed. There were 12% more females reviewed this year compared to 2011. Children under age ten comprised 22% of those reviewed (20 youth). This is a 9% decrease from 2011. Twenty-nine children (32%) were in the 10-13-year-old age group, and 45% (40 youth) were in the 14+-year-old age group. In 2011, 34% were in the 10-13-year old age group and also in the 14+-year-old age group. Ninety-eight percent of the youth reviewed were of African-American ethnicity and 2% were of Latino-American descent. One family had Spanish as the primary language spoken at home.

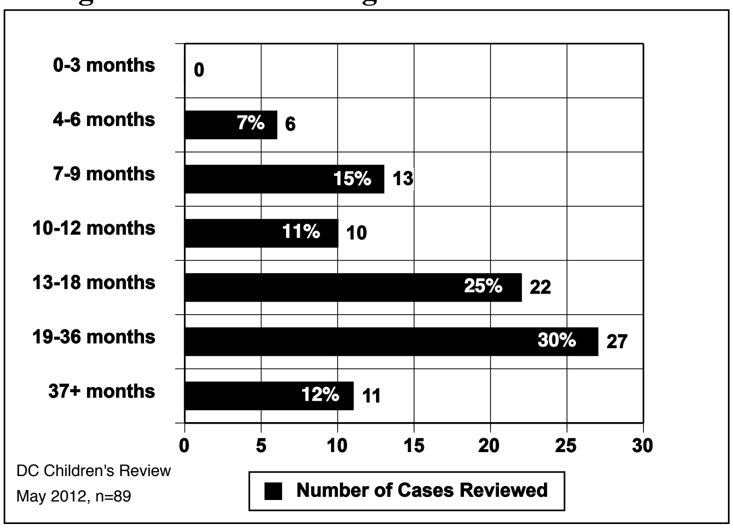
Display 4
Aggregate of Reviewed Cases by Age and Gender



<u>Length of Mental Health Services</u>

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, 42% or 38 of the youth had been receiving services for 19 months or longer, which is comparable to the youth in the 2011 review. Twenty-nine youth (33%) had been receiving services for 12 months or less, a 7% decrease from 2011.

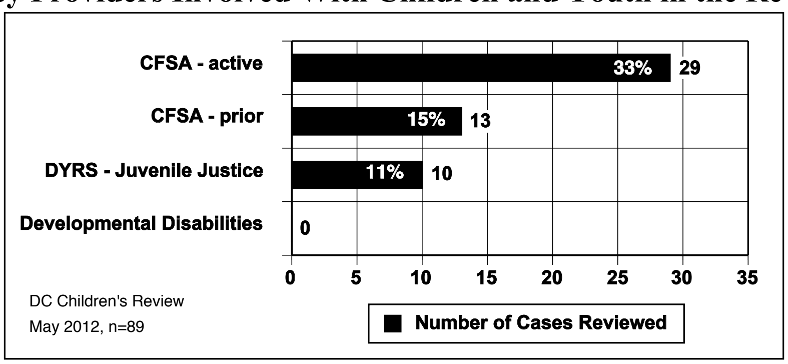
Display 5
Length of Time Receiving Mental Health Services



Other Agency Involvement

Some children and youth in the review sample were also receiving services from other major child-serving agencies, such as CFSA and the Department of Youth Rehabilitation Services (DYRS). **Display 6** presents the number of youth identified as being served by these other key agencies. Of the 35 youth served by one or more of these agencies, 29 were currently involved with CFSA, representing 33% of the youth reviewed and comparable to 32% in 2011. Thirteen youth, or 15%, had previous involvement with CFSA (oversight discontinued or closed). This year, eight youth (9%) in the review were involved with DYRS, also comparable to the 2011 youth review. Again this year, there were no youth reviewed that were involved with developmental disabilities.

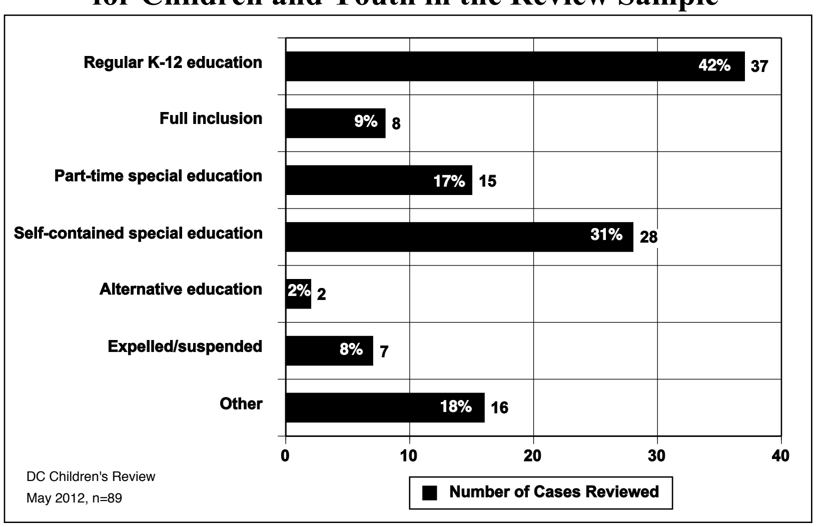
Display 6
Other Agency Providers Involved With Children and Youth in the Review Sample



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-seven youth (42%) were in regular K-12 educational settings. Fifty-one youth (57%) were receiving some type of special educational service, either full inclusion (eight youth; 9%), part-time special education services (15 youth; 17%), or in a self-contained special education setting (28 youth; 31%). Two youth (2%) were in an alternative education setting. Sixteen youth (18%) were in "other" settings, of which seven youth were listed by reviewers as a Level 5 or Level 4 school while additional youth were noted as regular education with behavioral supports, ESL track, or pullout supports. When compared to 2011, the most notable difference is in the number of children in self-contained special education settings, which doubled this year to 28 in 2012 from 14 in 2011.

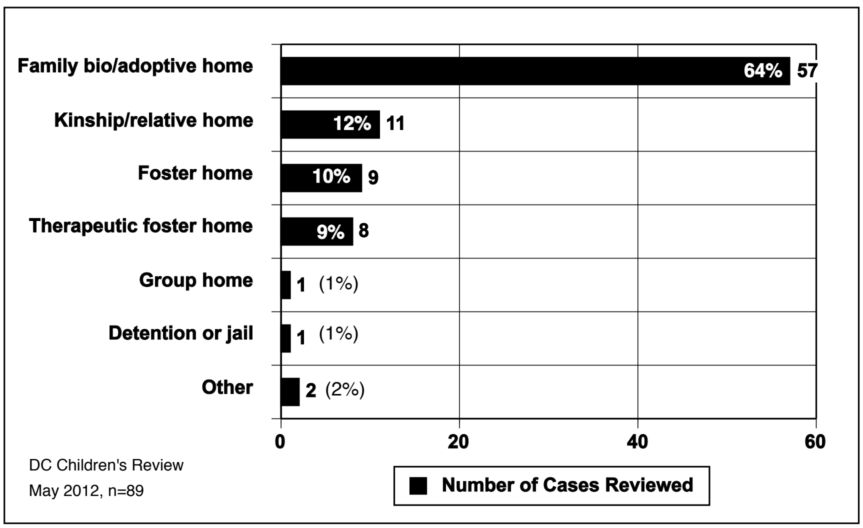
Display 7
Types of Educational Services/Placements or Educational Status for Children and Youth in the Review Sample



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. Again this year, the majority of the youth reviewed were living with biological or adoptive family (57 youth; 64%), with an additional 11 youth (12%) living with relatives or in kinship placement. The remaining youth were living outside of the family/kinship home with nine (10%) living in a foster home, eight (9%) living in a therapeutic foster home, and one (1%) each in a group home, detention, in a residential substance abuse treatment program with the parent, and in an informal arrangement with godparents.

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 youth in the review have experienced, over their lifetimes, 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). Forty-six youth (52%) in the 2012 review had no placement changes in their lifetime. Twenty-five youth (28%) had one placement. Fourteen youth (16%) had 3-5 different placements and two youth (4%) each had 6-9 placements and 10 or more lifetime placements. There was a 10% decrease in 2012 in youth having no placement changes, with a 5% increase each in youth having 1-2 and 3-5 placement changes.

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	46	52%
1-2 placement changes	25	28%
3-5 placement changes	14	16%
6-9 placement changes	2	2%
10 or more placement changes	2	2%
Totals	89	100%

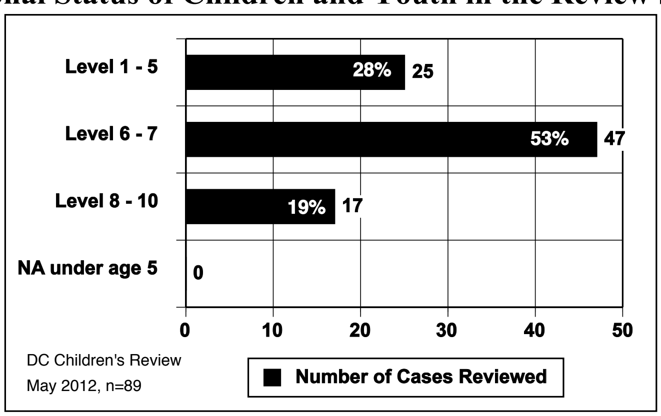
Functional Status and Level of Need

Functional Status

Display 10 provides the distribution of the review sample across functioning levels for the 89 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 CSR protocol to determine youth level of functioning. The scale is based on and similar to the Child Global Assessment of Functioning Scale (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-five 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 2012 review were in the mid-level range, with 47 youth (53%) in this range. The remaining youth currently had less severe impairment in functioning and required minimal support (17 youth or 19%). There is a 6% increase in youth in the 8-10 level when compared to the 2011 results.

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. There was a notable increase in the number and percent of youth 14 years or older in the Low Level of Functioning 1-5 range, indicating an increase in the presence of complex, older, transitioning youth in the review. This can be attributed to the difference in the sample compared to past reviews.

Display 11
Level of Functioning Ratings for Children and Youth in the 2012 Review Sample Compared to the 2011 Review Sample

Age Ranges	Low Level of Function 2012 (1-5)	Low Level of Function 2011 (1-5)	Moderate Level of Function 2012 (6-7)	Moderate Level of Function 2011 (6-7)	High Level of Function 2012 (8-10)	High Level of Function 2011 (8-10)	Total in the 2012 Review	Total in the 2011 Review
5-9 Yrs Old	2 (2%)	11 (13%)	13 (15%)	15 (17%)	5 (6%)	1 (1%)	20	27
10-13 Yrs Old	10 (11%)	8 (9%)	14 (16%)	20 (23%)	5 (6%)	2 (2%)	29	30
14 Yrs or Older	13 (15%)	5 (6%)	20 (22%)	17 (20%)	7 (8%)	8 (9%)	40	30
Totals	25 (27%)	24 (28%)	47 (53%)	52 (60%)	17 (20%)	11 (12%)	89	87

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 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 8 or higher)
Medium Need: Intensive outpatient or wraparound services (CGAF 6-7)
High Need: Residential or partial hospitalization placement (CGAF 5 or less)

Fifty-three percent (53%) of the 89 children and youth reviewed were receiving services in the medium level of need range.

Level of Care

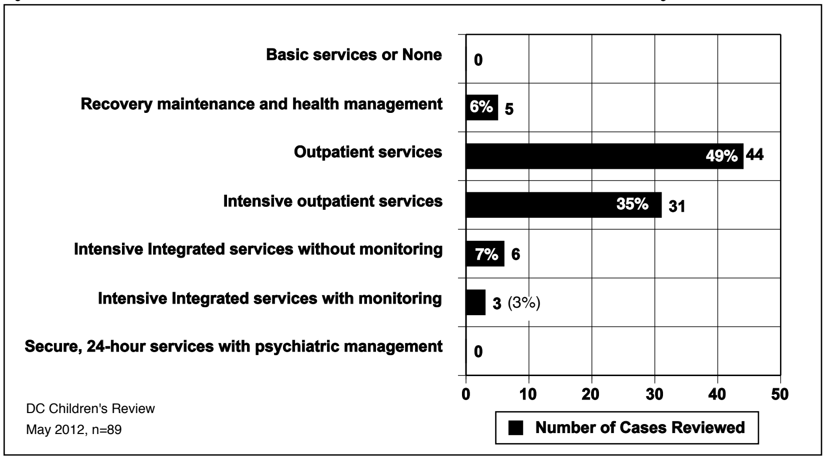
The CALOCUS scale was used to identify the level of mental health care the child should be receiving according to evaluative criteria in the CALOCUS decision matrix. This scale provides seven different levels of care ranging from basic or preventive-level services to secure, 24-hour care with psychiatric 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 89 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 2012 youth reviewed showed 49% of the youth receiving outpatient-level services and 35% receiving intensive outpatient services.

When 2012 CALOCUS ratings are compared to those of the 2011 review, the percentage of use of outpatient services increased slightly by 4%. There was a lower percentage of youth in this year’s review receiving intensive outpatient services: 35% versus 41% in 2011 However, it should also be noted that in 2012, 17 youth in the 14+ age group were receiving intensive outpatient services compared to 2011 when ten youth in the 14+ age group were receiving intensive outpatient services.

Display 12

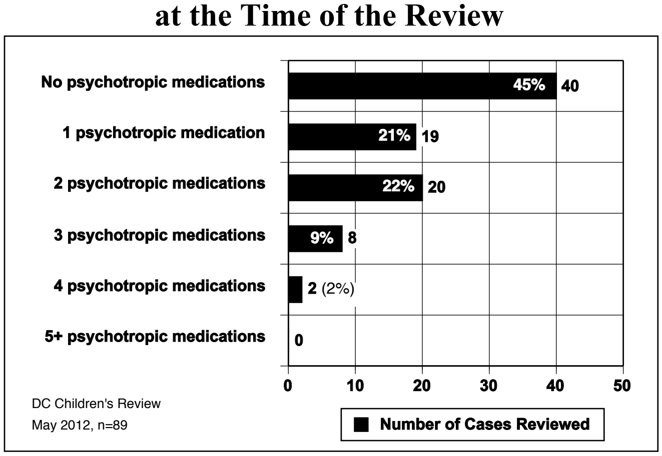
CALOCUS for Range of Services Received by Children and Youth in the Review Assessed by Reviewers



<u>Medications</u>

The number of psychotropic medications prescribed for children and youth in the 2012 review were counted and reported by reviewers. Forty-nine youth were prescribed psychotropic medications (**Display 13**). Of those 49, 21% percent (19 youth) were prescribed one medication, 22% (20 youth) two medications, 9% (eight youth) three psychotropic medications, and 2% (two youth) four medications. Compared to the youth who were prescribed medications in 2011, there was an 8% decrease in youth prescribed only one psychotropic medication and a 4% increase in the percentage of youth prescribed three medications and four medications (2% each).

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

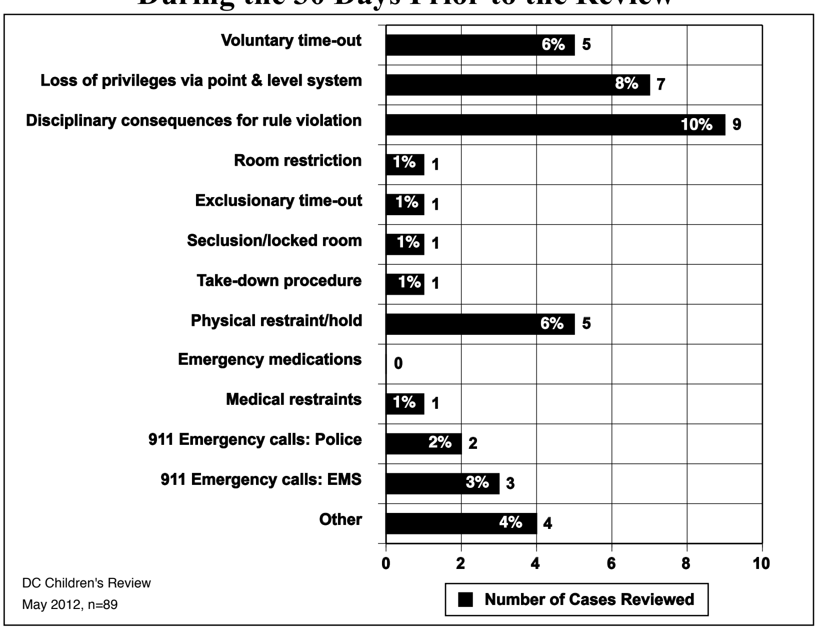


Special Procedures

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 2012 review are attributed to a relatively small number of children. This year, 40 occurrences of a special procedure were noted in the 30 days prior to the review, compared to 26 occurrences in 2011. Oftentimes, youth experiencing this type of intervention have more than one special procedure used in order to prevent harm.

The highest occurrence of a special procedure is that of consequences for rule violations (nine or 10%), with loss of privilege via point or level system being next with seven or 8%. Six youth, or 7%, had a take-down procedure or restraint; a 6% increase from 2011.

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 89 children and youth in May 2012 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." For the purposes of the Dixon exit criteria, a second interpretive requirement 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 versus unacceptable interpretive frameworks will be used for the following presentations of aggregate data.

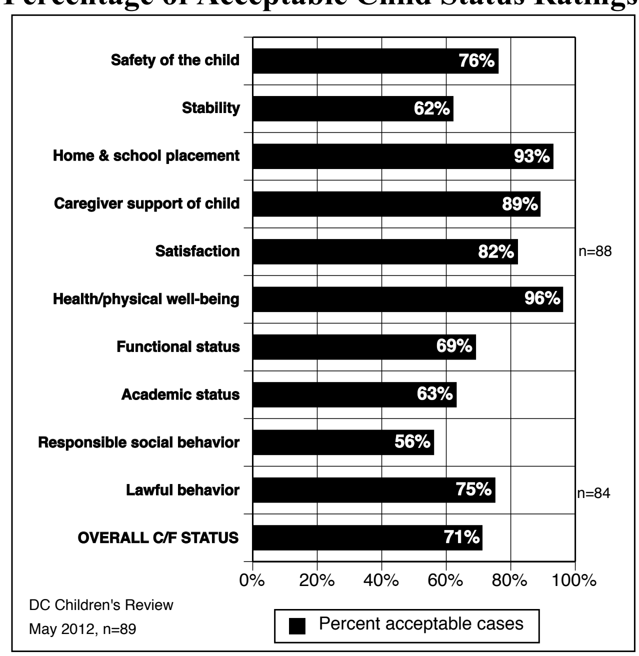
Interviews

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 565 persons were interviewed for the 89 children and youth reviewed this year. The number of interviews ranged from a low of three persons in one case to a high of 13 persons in another case. The average number of interviews was 6.3.

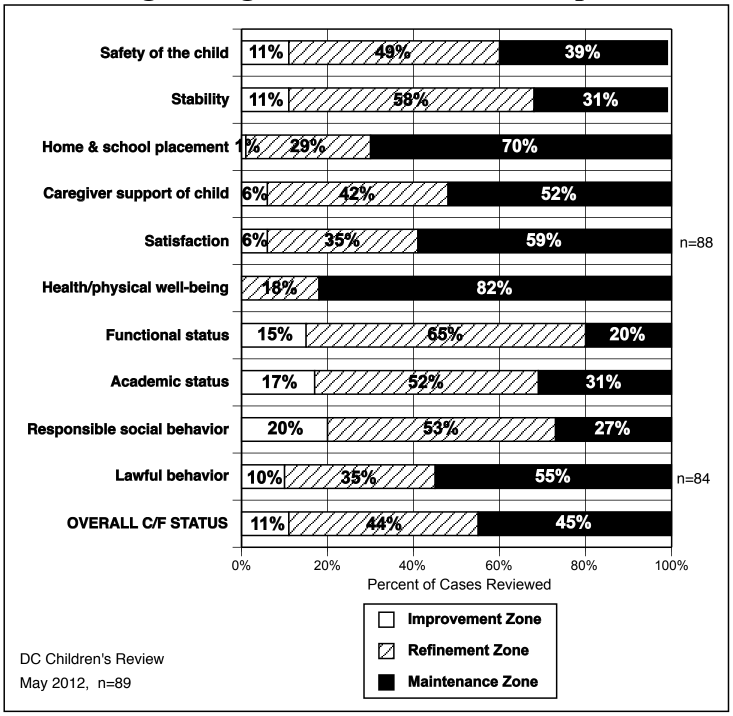
Child Status Results

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, both displays are derived from the same data.

Display 15
Percentage of Acceptable Child Status Ratings



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



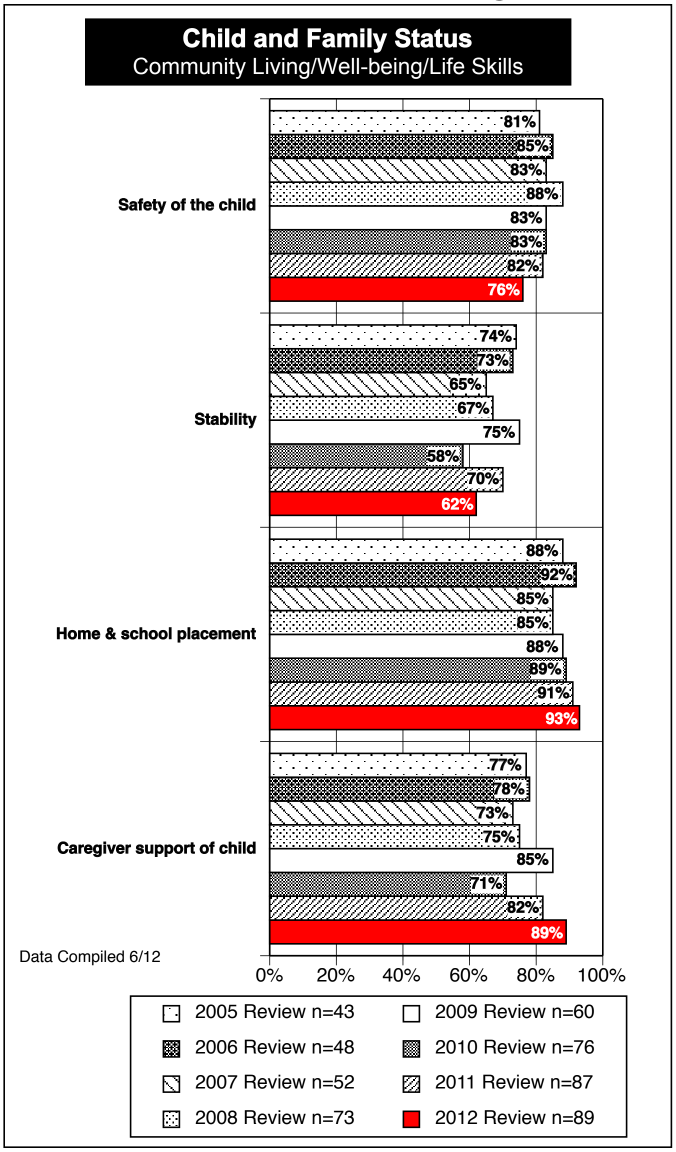
Overall Child Status. The protocol provides a scoring rubric for combining rating values across the items deemed applicable to the child or youth being reviewed to produce an "overall child status rating." Indicators are weighted, with the safety indicator being a "trump" indicator (if safety is rated a 3 or lower, in the unacceptable zone, the overall child status rating becomes the same rating as the safety rating). Of the 89 youth participating in the review, 71% were found to have acceptable overall status. The overall child status scores were distributed across the zones as follows: 11% needed immediate attention and were in the improvement zone, 44% were in the refinement zone, and 45% were in the maintenance zone. When compared to overall ratings of child status for the 2011 review, the 2012 data show a slight increase of youth in the improvement zone and a small decrease of youth in the maintenance zone. **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 relatively safe, with 76% of the youth reviewed found acceptable in this area, a 6% decline when compared to 2011 (82%). Youth are healthy and have regular access to medical care (96%

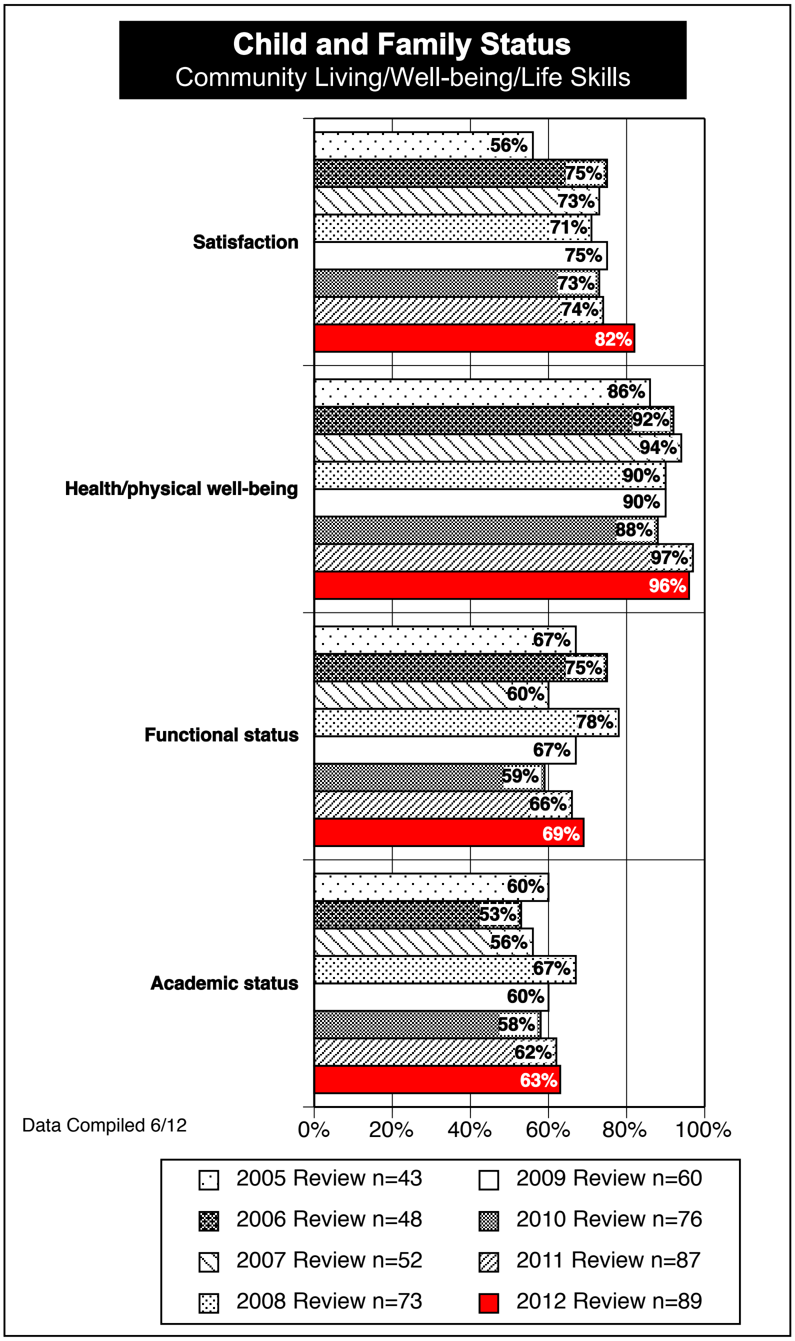
acceptable). Ninety-three percent of the youth reviewed were placed in appropriate home and school settings. Caregivers are supportive of youth with 89% having at least minimally acceptable ratings in this area, and parents/caregivers are satisfied with services (82%).

The four lowest scoring indicators this year were identified in stability, academic, functional, and responsible behavior status, with some scores comparable to 2011 scores in these areas. Sixty-two percent of the youth were found to have an acceptable pattern of stability, an 8% decrease from the 70% acceptable ratings in 2011. Sixty-three percent of the youth reviewed were found to have acceptable academic status, compared with 62% in 2011. The functional status indicator was rated 69%, compared to 66% last year. The responsible behavior status indicator was rated acceptable for 56% compared to 63% in 2011.

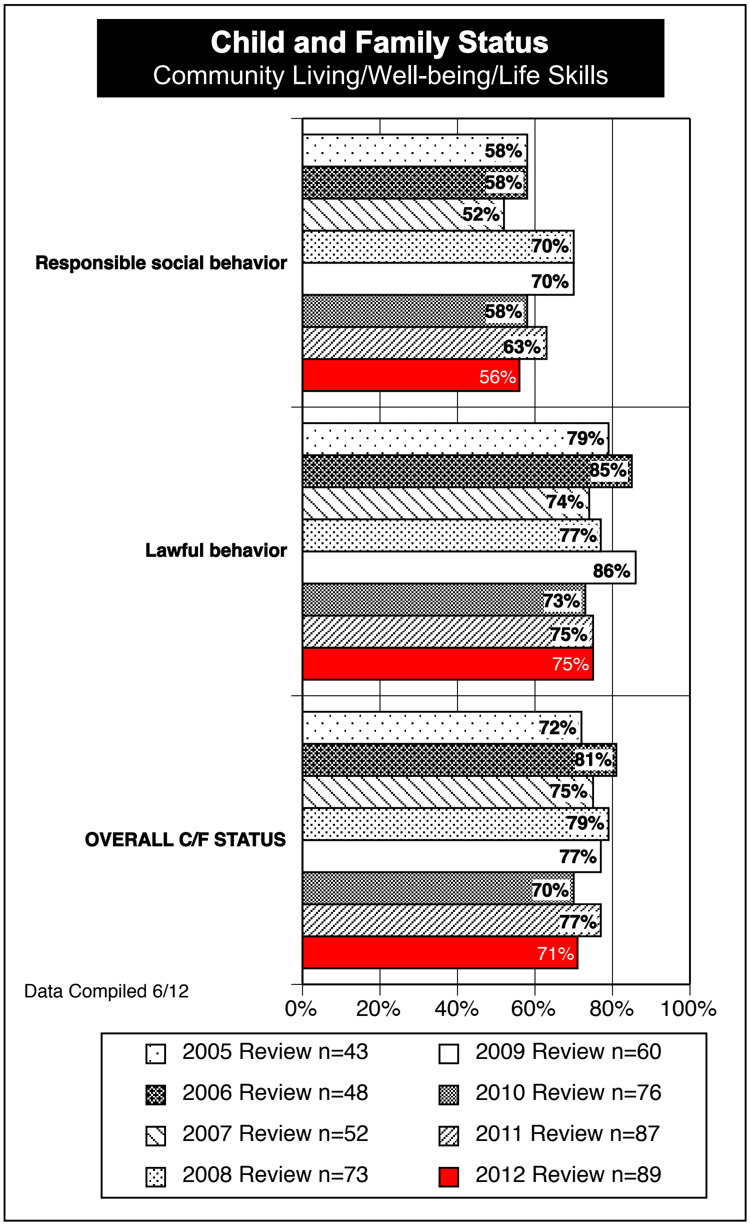
Display 17
Overall Child Status Results for Eight Reviews



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



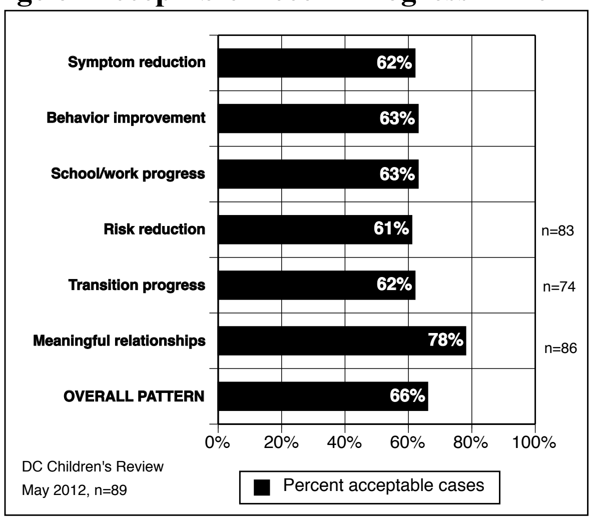
Display 17 (continued)
Overall Child Status Results for Eight Reviews



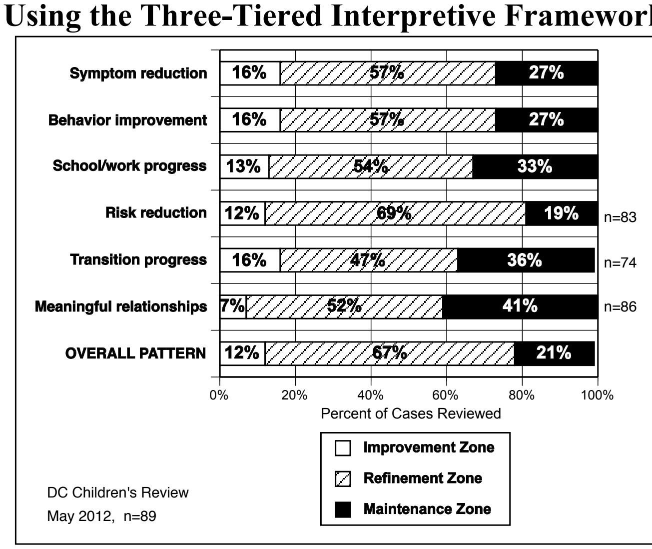
Recent Progress Patterns Showing Change Over Time

The CSR Protocol provides six indicators that enabled reviewers to examine recent progress in specific areas of treatment focus in the 2012 review. The timeframe for assessing recent progress is 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 66% of the 89 youth reviewed. This result is similar to the findings in 2011. Overall progress pattern ratings were distributed among the three-tiered zones as follows: 12% were found to need improvement, 67% were in the refinement zone, and 21% were in the maintenance zone.

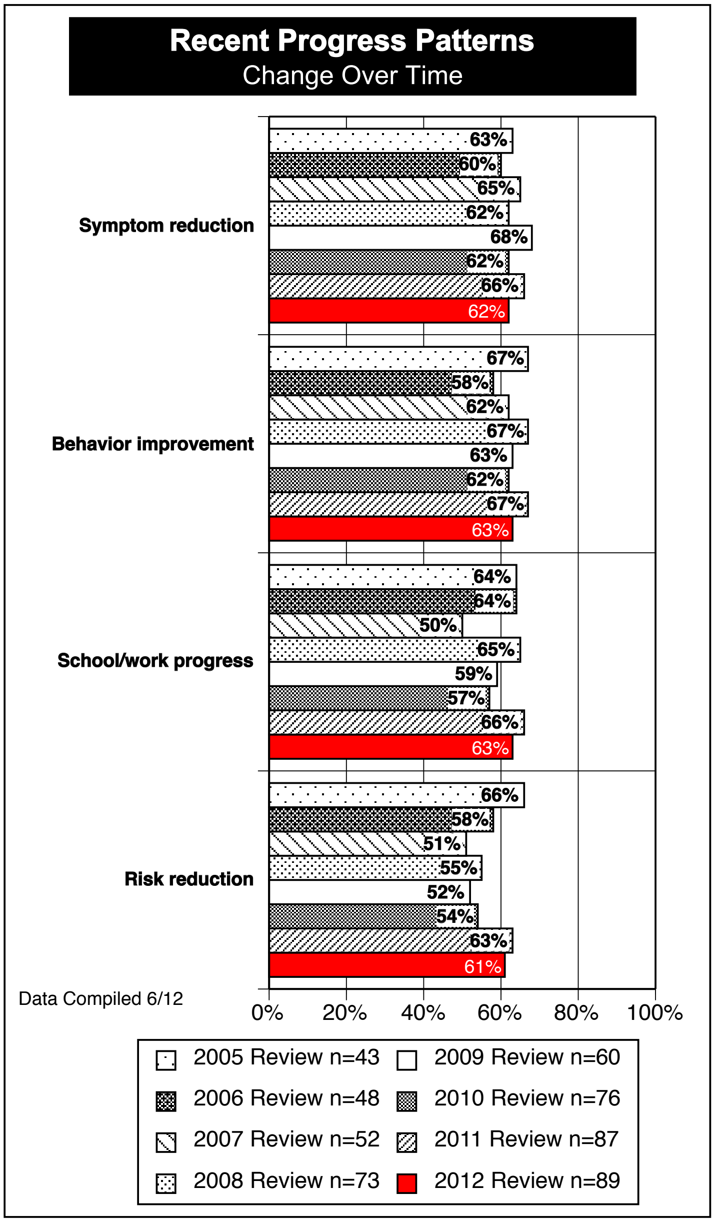
Again this year, progress toward meaningful relationships was the indicator with the highest rating. Seventy-eight percent of the 86 youth to whom this indicator applied had at least minimally acceptable progress in this area, comparable to 80% in 2011. Symptom reduction, the extent to which psychiatric symptoms are being reduced for the child or youth, declined with 62% having acceptable progress, compared to 66% in 2011. Progress in school or work settings decreased by 3% from 66% acceptable in 2011 to 63% acceptable in 2012.

Transitions were identified as applicable for 74 of the 89 children and youth in the review sample this year, 15 more youth than last 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 62% of these 74 youth. This is similar to 2011 where 61% of the 59 applicable youth had acceptable progress on transitions.

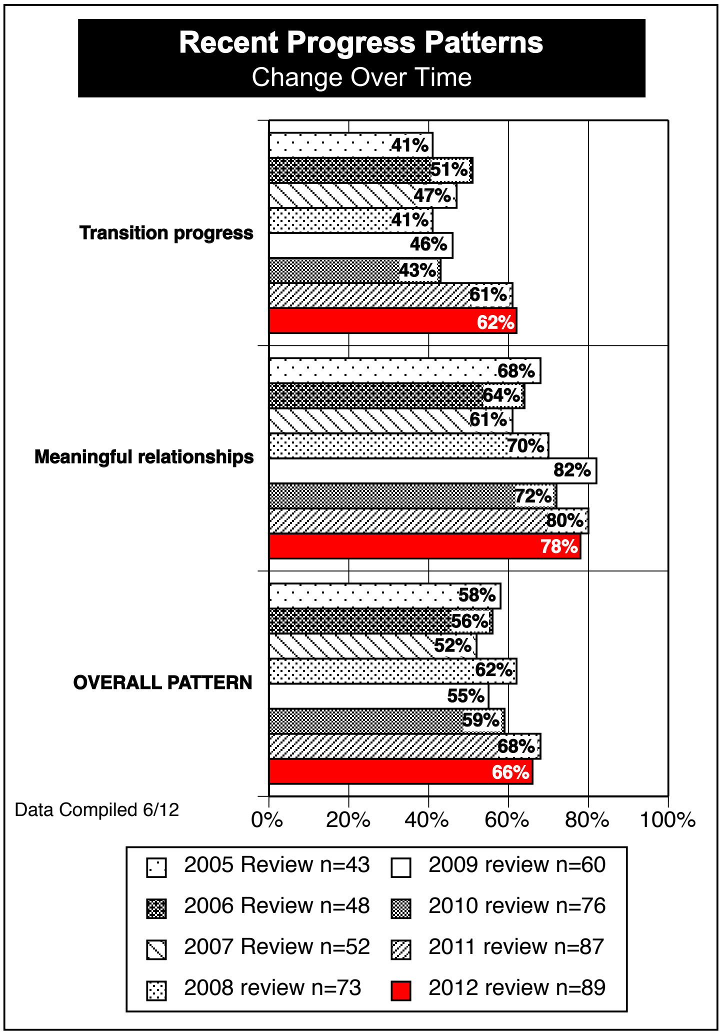
The three-tiered breakdown of the overall progress shows a shift toward the improvement zone in 2012 with score comparison to 2011 as follows: improvement zone-12% versus 8% in 2011; refinement zone-67% versus 70% in 2011; maintenance zone-12% versus 21% in 2011.

Display 20 shows the data for eight reviews on progress indicators. Overall, the results are comparable to 2011, with the overall progress pattern of youth being highest again this year.

Display 20
Overall Child Progress Pattern Results for Eight Reviews



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



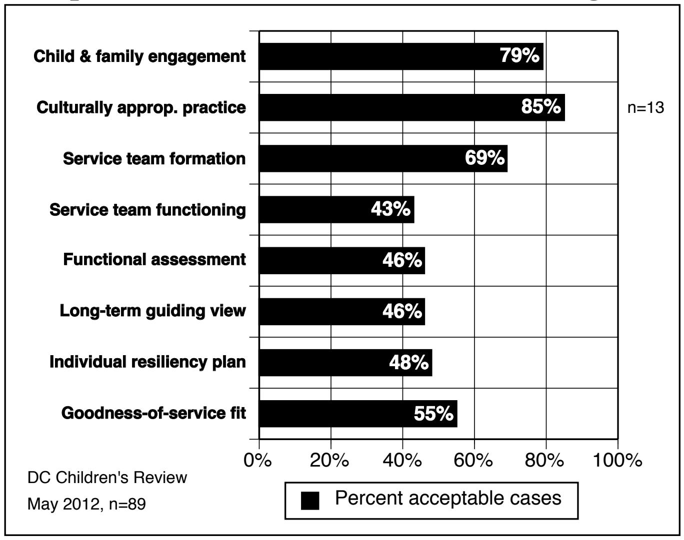
Child-Specific Performance of Practice Functions

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.

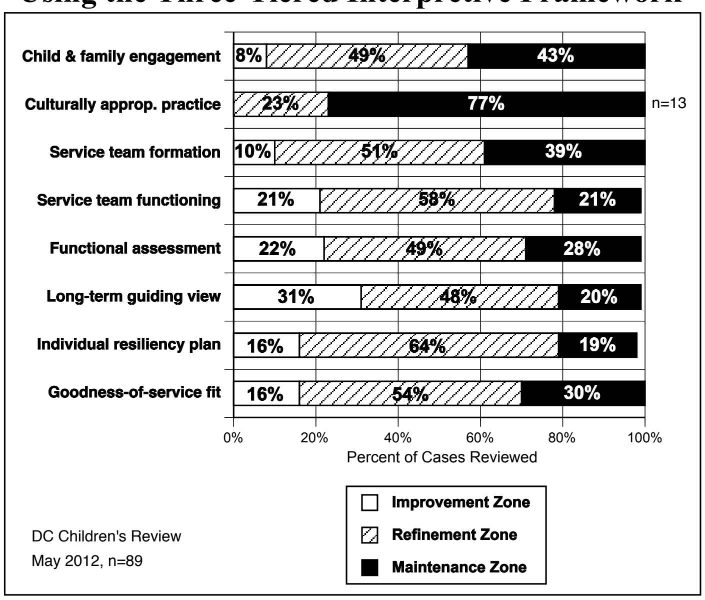
Practice Performance: Planning Treatment

Findings for the first set of indicators are presented in **Displays 21 and 22** and summarized below. 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. **Display 35** provides the eight-year history of practice performance ratings.

Display 21
Percentage of Acceptable Practice Performance: Planning Treatment Ratings



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



Child and Family Engagement. Engagement of a youth and family in planning and service implementation is one of the foundations of strong practice in a System of Care and is identified as one of the essential 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 again this year by 11% (79% versus 68% in 2011). There are also differences in the three-zone distribution, with a large increase in the refinement zone (32% in 2011 versus 49% in 2012) matched by a large decrease in the improvement zone (21% in 2011; 8% in 2012) and a very slight (4%) decrease of youth in the maintenance zone. There is substantial improvement in overall engagement efforts and results, with a greater percentage of youth and families being fully engaged in services, with a significant decrease in youth and families in the improvement zone.

<u>Culturally Appropriate Practice</u>. 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 13 youth and acceptable for 85% of these. This is a 10% change in practice performance in this area when compared to the 2011 CSR results where 75% of the applicable 12 youth had service providers who made appropriate cultural accommodations to children and their families.

<u>Service Team Formation and Functioning</u>. The formation and functioning of the youth and family team, in coordination with all other planning, assessment, and treatment processes the child and family are involved with, is the 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, communicating and 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. Acceptable team formation, meaning that all necessary personnel involved with the youth and family participate on the team at least through regular communication, was found in 69% of the 89 youth who participated in the 2012 CSR. This is an increase of 12% from last year. When these data are disaggregated and viewed across the three zones, 51% of the cases were rated in the refinement zone for team formation, 39% were in the maintenance zone (a 13% increase from 2011), and 10% were in the improvement zone (a 10% decrease from 2011).

Strong teaming is a process, rather than a discreet event, and strong team processes include a flow of communication and information among members in a timely manner, members working together to plan and provide interventions, and a respectful and reciprocal relationship with the child and parents. 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 was found acceptable for 43% of the youth reviewed in 2012, a 6% decrease from 2011. There is a shift in the three-zone distribution with a 7% increase in the maintenance zone from 14% in 2011 to 21% in 2012, and a decrease in both the refinement and the maintenance zones. Despite an overall decline in the team functioning score, there are more youth in the maintenance zone, which indicates a positive trend.

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. Additionally, this indicator measures a team's understanding of what dynamic factors need to change in order for youth and families to have sustainable progress and supports that facilitate safe case closure and prevent future need for formal services. 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 46% of the youth reviewed, a 9% decrease from the 2011 review. When the team does not understand the needs and context of the child and family and what the result will likely be if the status quo continues, then it is very difficult to develop and deliver an effective set of interventions. The assessment and understanding function of teaming continues to lack in-depth diagnostic assessment as part of the clinical intake process, contextual awareness, as well as the ongoing process of clinical reasoning and questioning. Teams/providers frequently have no concept of what should be accomplished or resolved over the next 6 to 12 months to improve the status of the child. As a result, plans are frequently superficial or incomplete.

<u>Planning</u>. 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. Prior to 2010, planning had been challenged as acceptable ratings were on a downward trend; however, scores for 2010 and 2011 improved. In 2012, planning decreased by 8% to 48% acceptable. The 2012 data show a 5% decrease in youth in the improvement zone (16% versus 21% in 2011) and a 3% increase in the maintenance zone. This trend is positive; however, there continues to be difficulty with development of goals that are individualized, measurable, clearly defined, and tangible.

<u>Goodness-of-Service Fit</u>. 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 past reviews, the combination and sequencing of

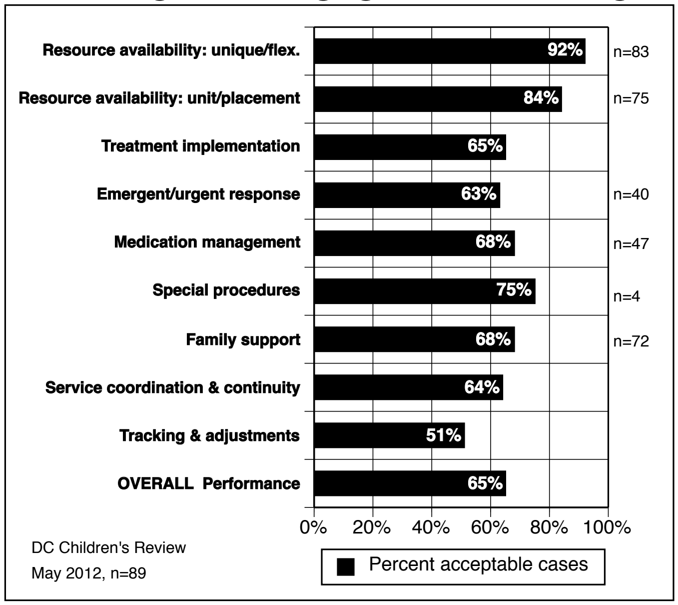
supports and services was found to be acceptable for approximately half of the children and families served, with this indicator peaking in 2011 with two-thirds (66%) of the youth reviewed having acceptable practice in this area. For the 2012 review, there was an 11% decrease, with 55% of youth reviewed having at least minimally acceptable practice.

Findings this year across the key indicators for planning treatment indicate a mixed trend and variability in achieving strong practice in these eight core areas of practice. There is considerable variability across CSAs with some CSAs providing more consistent, stronger teaming, assessment, and planning, and others continuing to struggle to provide a meaningful and effective assessment, planning, and teaming process. There continues to be a need to work with CSAs, providers, and other child-serving agencies to insure that there is a strong commitment to developing a shared deep understanding of the needs of each child and family served and to communicate effectively about the changing context and situations that affect that child and family on a timely basis.

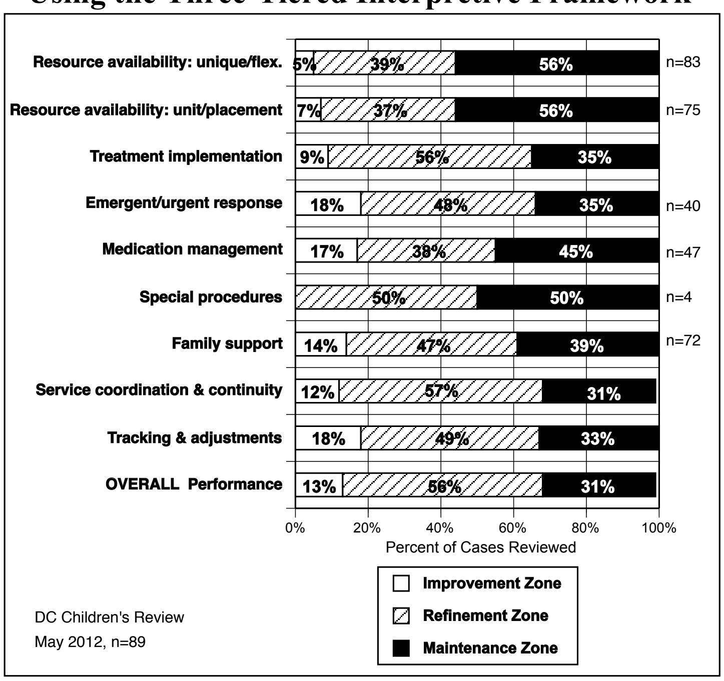
Practice Performance: Providing and Managing Treatment

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 eight-year history of the ratings for these indicators can be found in **Display 35**.

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 2012 review, with a 9% improvement in unit-based (n=75) and a 15% improvement in flexible resources (n=83). For both sub-indicators, the scores shifted from the improvement zone by 6-8% into the refinement and maintenance zones.

These results suggest that the availability of resources in the District continues to improve and is not a primary barrier to treatment implementation. CSWs and providers are not only more aware of resources, they are also accessing and linking families to resources more often.

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 2012 was acceptable for 65% of the youth reviewed. Distribution across the three zones shifted from the improvement zone (18% in 2011; 9% in 2012) with fewer youth needing improvement and more youth in the refinement zone (45% in 2011; 56% in 2012).

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 40 youth this year and acceptable for 63%. This is a 21% improvement from the 2011 review, and the largest increase of any status, progress, and system/practice indicator. The three-tiered distribution shows a 18% increase in youth in the maintenance zone (17% in 2011; 35% in 2012) and 20% less in the improvement zone (38% in 2011; 18% in 2012).

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 decisions regarding medication management and changes. 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 is historically an area of strength in practice; however, there is a slight decline of 5% this year from 73% to 68% acceptable practice (n=47). Demographic data presented above shows 40 youth prescribed medications. The three-tiered analysis shows a 9% shift from the maintenance zone towards the improvement zone when compared to 2011 (improvement zone-8% in 2011 versus 17% in 2012; refinement zone-39% in 2011 versus 38% in 2012; maintenance zone-53% in 2011 versus 45% in 2012). One of the most commonly observed challenges in this area is that the child is not taking prescribed medications and/or parents are not supportive of medications and practitioners are not aware of the lack of medication compliance nor are they developing appropriate alternative options.

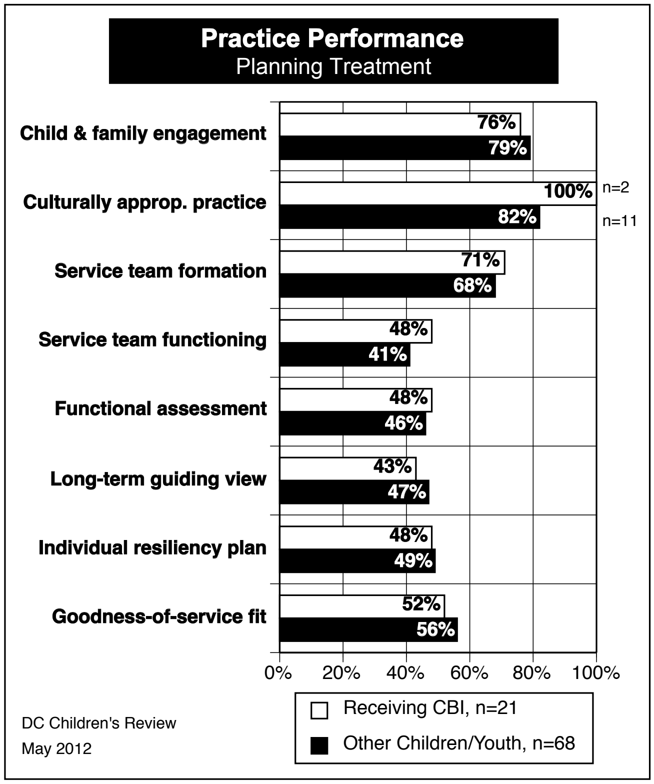
Tracking and Adjustment. The tracking, adjustment, and modification of services and supports are essential to achieving and sustaining positive gains. This process requires that a team be formed, have an adequate understanding of the youth and family, and be communicating and working with each other. Practice in this area declined by 6%, with 51% of the youth reviewed having acceptable ratings (57% in 2011). There was an increase in the percentage of youth in the maintenance zone—29% in 2011 compared to 33% in 2012; 45% in the refinement zone in 2011 compared with 49% in 2012; and 26% in the improvement zone in 2011 compared to 18% in 2012.

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 65% of the children and youth included in the review, a 6% increase from the 2011 results. The 2012 review shows an 11% shift of youth from the improvement zone to the maintenance zone (improvement zone-21% in 2011 versus 11% in 2012; maintenance zone-32% in 2011 versus 43% in 2012), further illustrating that practice improvement is on a steady, upward trajectory.

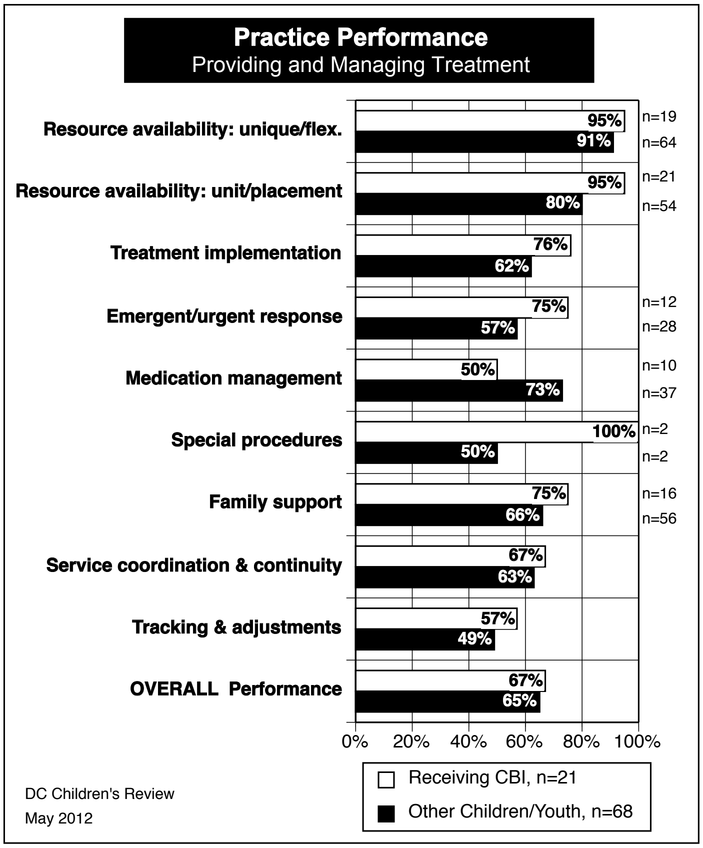
Comparison of CBI Services

Twenty-one youth were receiving CBI (community-based intervention) or MST (multi-systemic therapy) services in the 2012 CSR, over double the number in the 2011 review where ten children were receiving these services. Four youth were receiving intensive wraparound services, two of which were also receiving CBI services and are included as CBI in the graph below. The other two youth receiving wrap services were included in the non-CBI group for comparison. The following **Display 25** shows the practice scores for the children and youth in the 2012 review who were receiving CBI/MST services and compares these scores to the children and youth who were not receiving CBI services. Overall practice for the CBI children (67%) was comparable to the non-CBI children (65%). Most notable were the results for team functioning (48% CBI; 41% non), treatment implementation (76% CBI; 62% non), urgent response (75% CBI; 57% non), medication management (50% CBI; 73% non), and tracking and adjustment 57% CBI; 49% non).

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

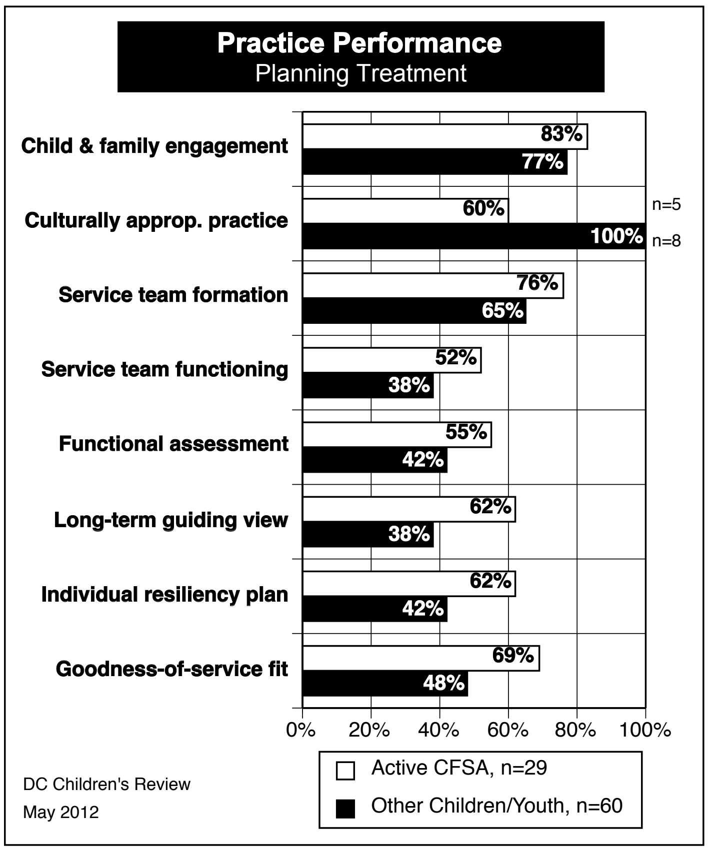


Comparison of CFSA and Non-CFSA Ratings

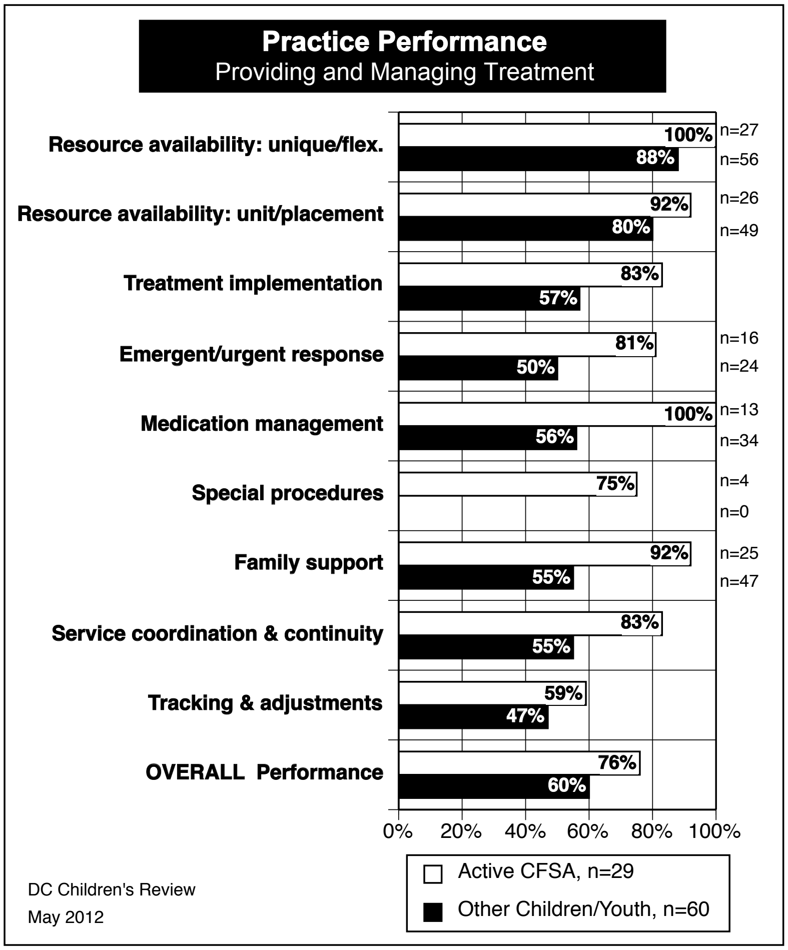
Twenty-nine youth were also currently involved with CFSA during the time of the 2012 review. Overall, youth involved in CFSA scored higher on status, progress, and system performance indicators as shown in **Display 26**. Overall status for CFSA youth was 72% acceptable compared to 70% for youth not involved with CFSA. Overall progress pattern rated 72% acceptable also for CFSA youth, compared with 63% acceptable for non-CFSA youth. Likewise, overall system performance was also stronger for CFSA youth with 76% having acceptable overall practice versus 60% for non-CFSA youth. It should also be noted that CFSA youth are mostly served by one or two of the largest CSAs. These CSAs have focused on improving the quality and consistency of practice by developing internal processes, strengthening the supervision of practice, and providing additional training.

Specific system indicators also illustrate big differences in scores as follows: team functioning CFSA 52% vs. non-CFSA 38%; treatment implementation-CFSA 83% vs. non-CFSA 57%; family support-CFSA 92% vs. non-CFSA 55%; service coordination-CFSA 83% vs. non-CFSA 55%.

Display 26
Percentage of Acceptable Practice Performance:
CFSA vs. Non-CFSA Children and Youth

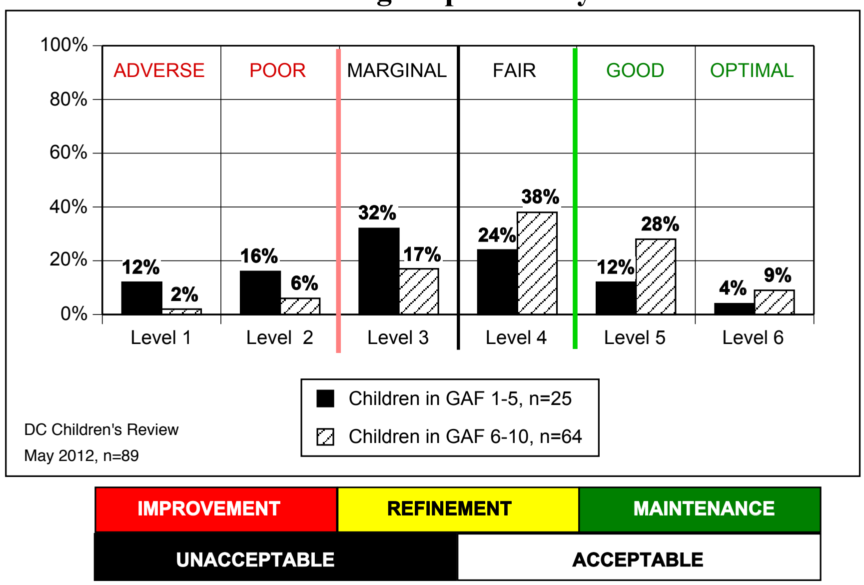


Display 26 (continued)
Percentage of Acceptable Practice Performance:
CFSA vs. Non-CFSA Children and Youth

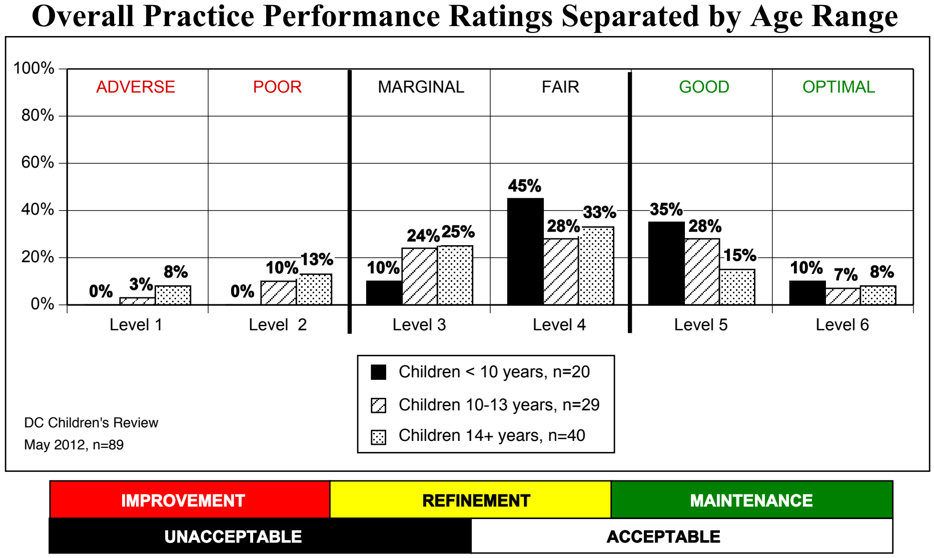


In **Appendix C** of this report are agency-by-agency results for the children and families reviewed. **This agency-by-agency comparison should be interpreted with caution, since review sample sizes for some of the provider agencies are extremely small**. **Generalizations regarding specific agency practice 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 27** provides the overall practice performance ratings separated by the child's general level of functioning. **Display 28** provides the overall practice performance ratings separated by age range.

Display 27
Overall Practice Performance Ratings Separated by Level of Functioning Range



Display 28
Overall Practice Performance Ratings Separated by Age Range

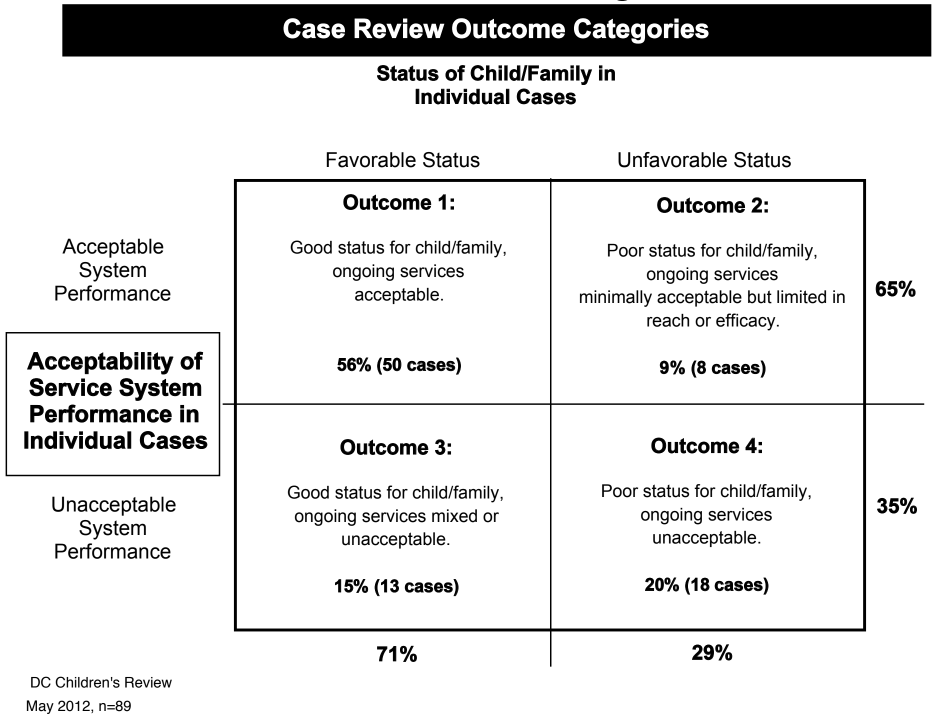


Review Outcome Categories

Children who were reviewed 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 29** indicates, 56% or 50 of the 89 youth reviewed were in outcome category 1, a 10% improvement from 2011. Outcome 1 is the desired situation for all children and families receiving services. There were eight youth (9%) 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. Fifteen percent or 13 youth children and youth were in outcome category 3, compared to 31% or 27 youth in 2011. Outcome 3 contains those review sample members whose status was favorable 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, 18 youth or 20% of the review sample were in outcome category 4, compared to nine youth or 10% in the 2011 review. Outcome 4 is the most unfavorable combination as the child's status is unfavorable and practice performance is inadequate. There were twice as many youth in this outcome category than in the 2011 review.

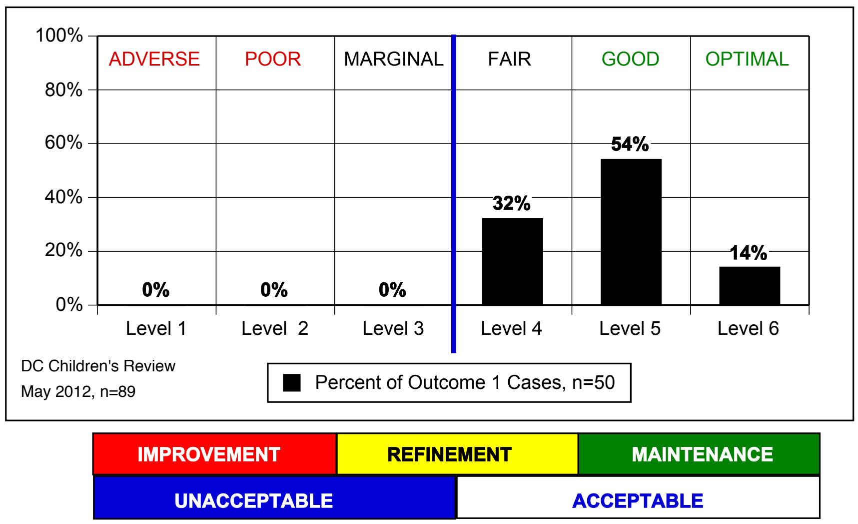
Display 29
Case Review Outcome Categories



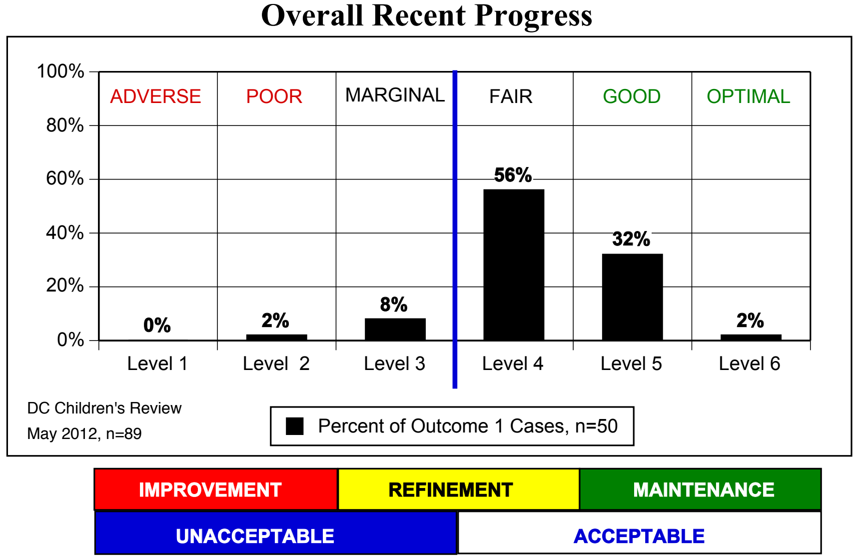
Displays 30 to 33 show the distribution of scoring on the six-point scale for the children who were in each of the outcomes shown in Display 29. For example, for outcome 1, the charts in Displays 30a, 30b, and 30c show the distribution of child status ratings, progress ratings, and practice performance ratings, respectively. Display 30a shows that 32% of the 50 children in outcome 1 had overall status indicators rated 4-fair, 54% rated 5-good, and 14% rated 6-optimal. Sixty-eight percent of these 50 youth had a status rating in the maintenance zone with 5-good or 6-optimal, compared to 73% in 2011. Display 30c shows that practice efforts for these youth shifted towards refinement, with 52% having overall practice ratings of 4-fair, and 48% having overall practice ratings of 5-good or 6-optimal. In 2011, 60% of the youth in this outcome category had an overall practice rating in the maintenance zone.

The breakdown for Outcome 4, Display 33c shows 39% of the 18 youth rated in the improvement zone with a rating of 1-adverse or 2-poor for overall practice and 61% in the refinement zone with a rating of 3-marginal. This is a 28% increase in the percentage of youth in the refinement zone when compared to 33% in 2011. Although practice is unacceptable for these youth, this illustrates positive practice improvement with youth moving from the maintenance zone to the refinement zone.

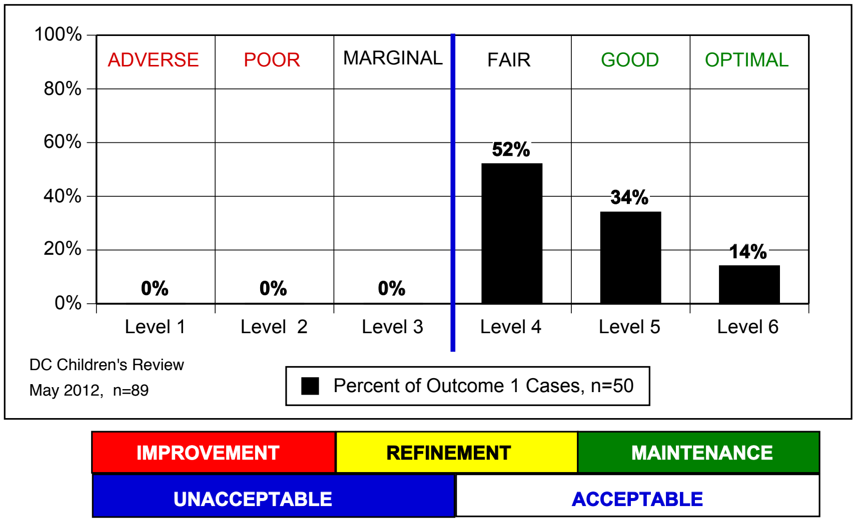
Display 30a
Outcome 1
Overall Child/Youth Status



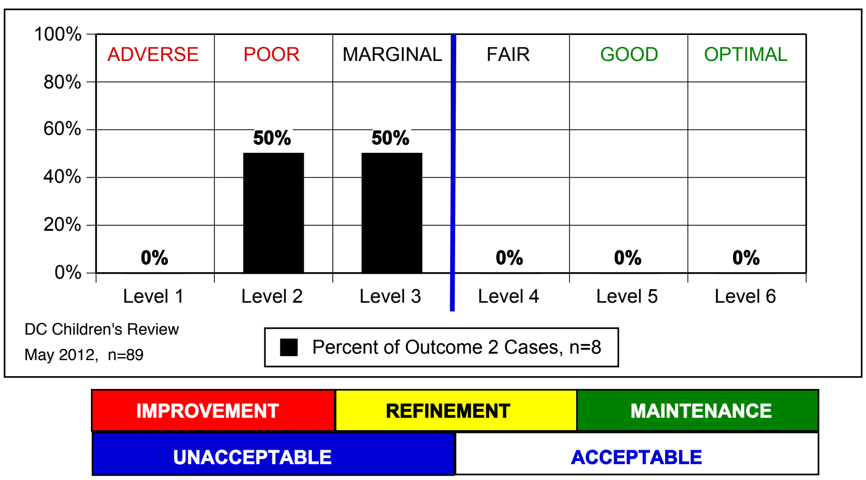
Display 30b
Outcome 1
Overall Recent Progress



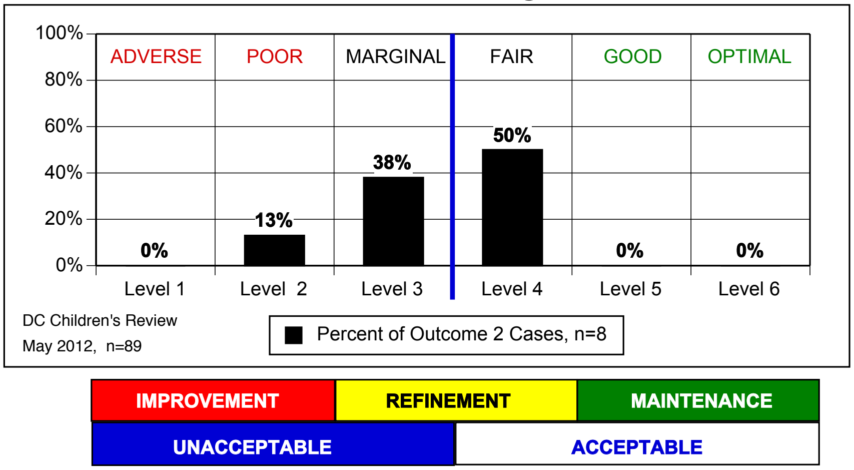
Display 30c
Outcome 1
Overall Practice Performance



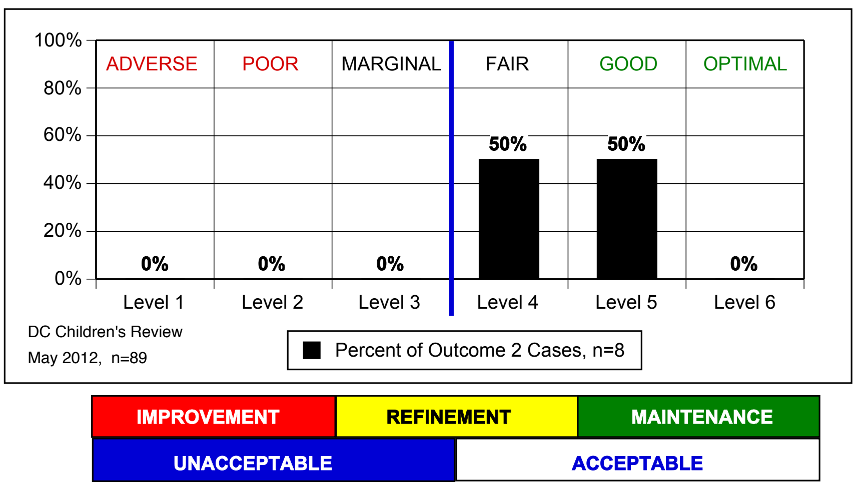
Display 31a
Outcome 2
Overall Child/Youth Status



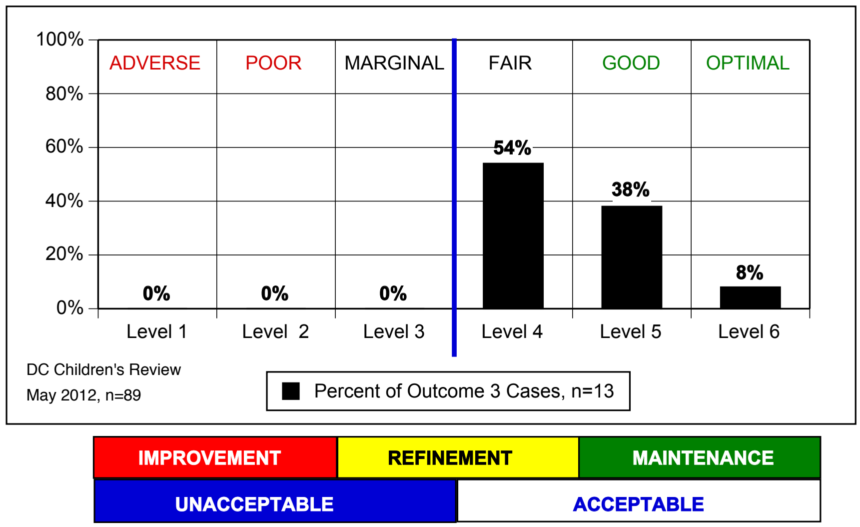
Display 31b
Outcome 2
Overall Recent Progress



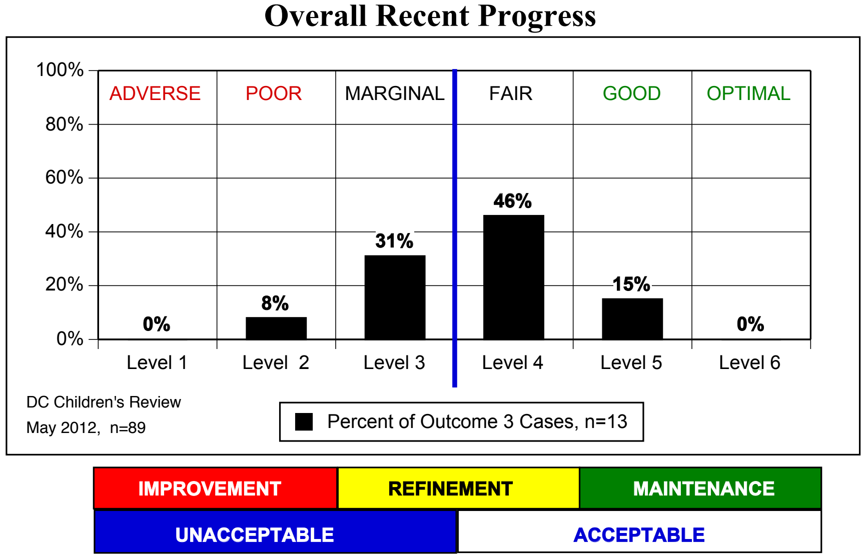
Display 31c
Outcome 2
Overall Practice Performance



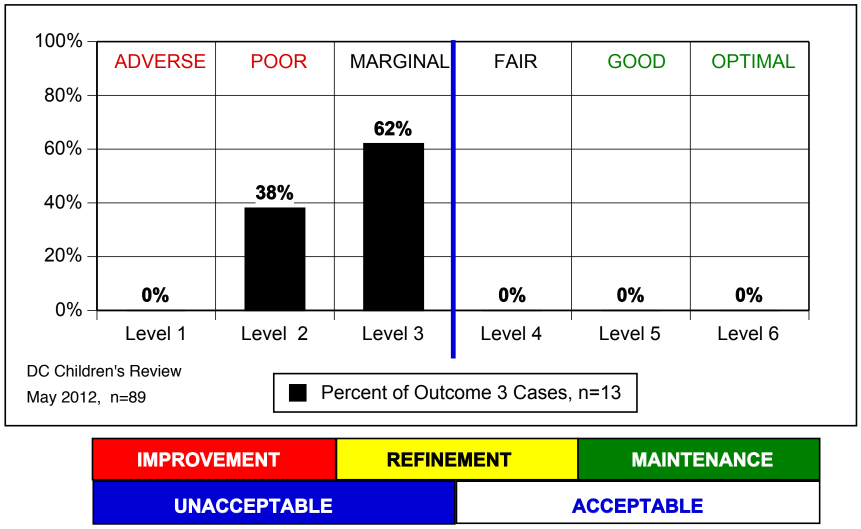
Display 32a
Outcome 3
Overall Child/Youth Status



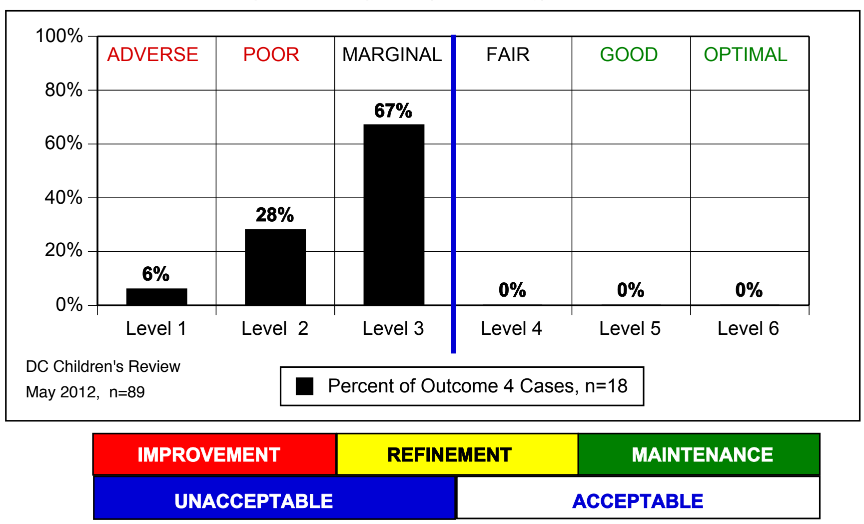
Display 32b
Outcome 3
Overall Recent Progress



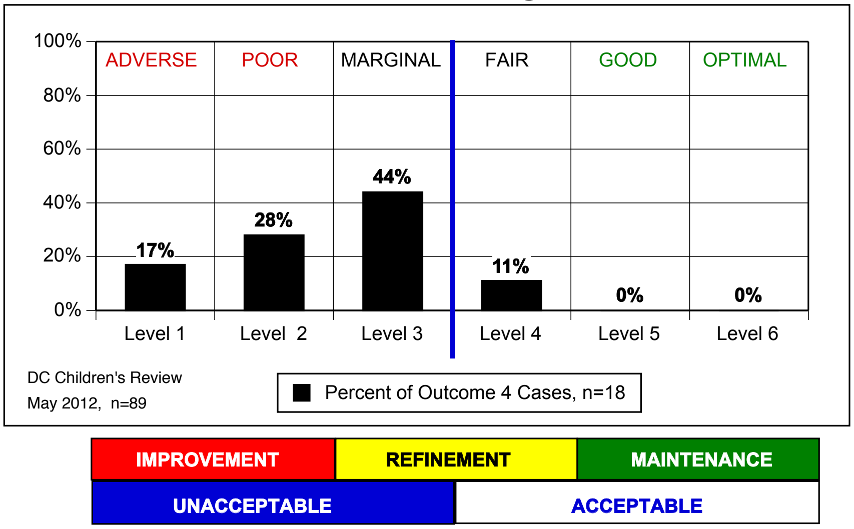
Display 32c
Outcome 3
Overall Practice Performance



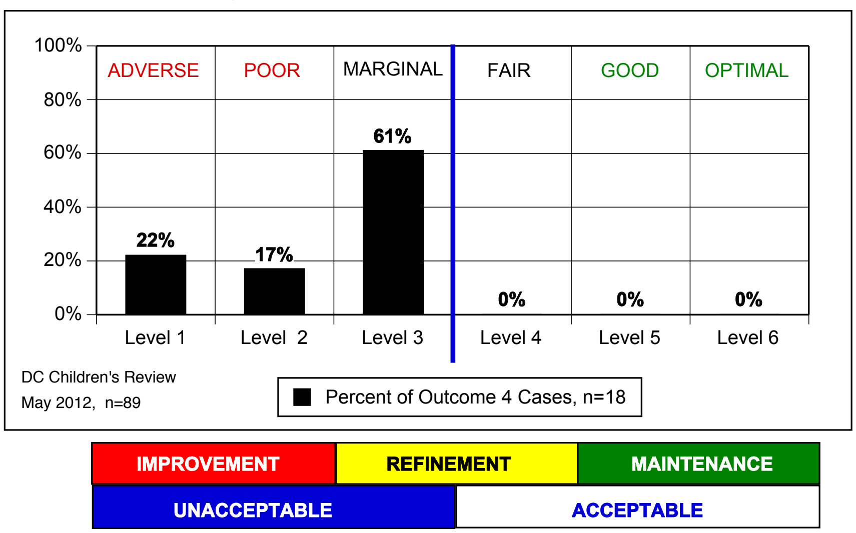
Display 33a
Outcome 4
Overall Child/Youth Status



Display 33b
Outcome 4
Overall Recent Progress



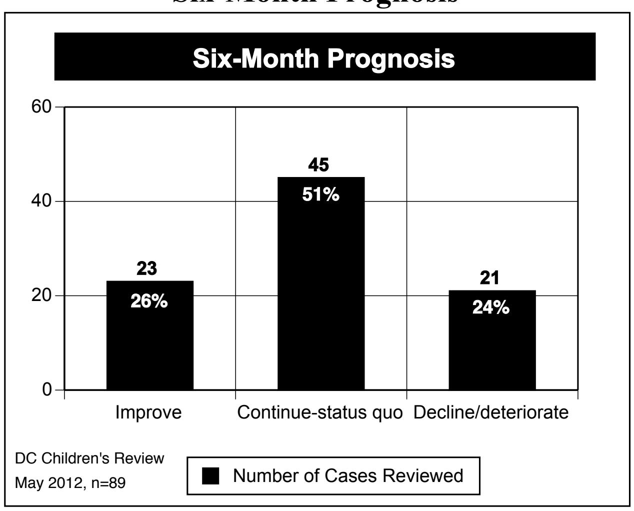
Display 33c
Outcome 4
Overall Practice Performance



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 34** 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, 45 (51%) were expected to remain about the same, and 21 (24%) were expected to decline or experience deterioration of circumstances over the next six months. The prognosis of improve was the same for youth in the 2011 review. However, there was a 6% increase in youth expected to decline in the next six months.

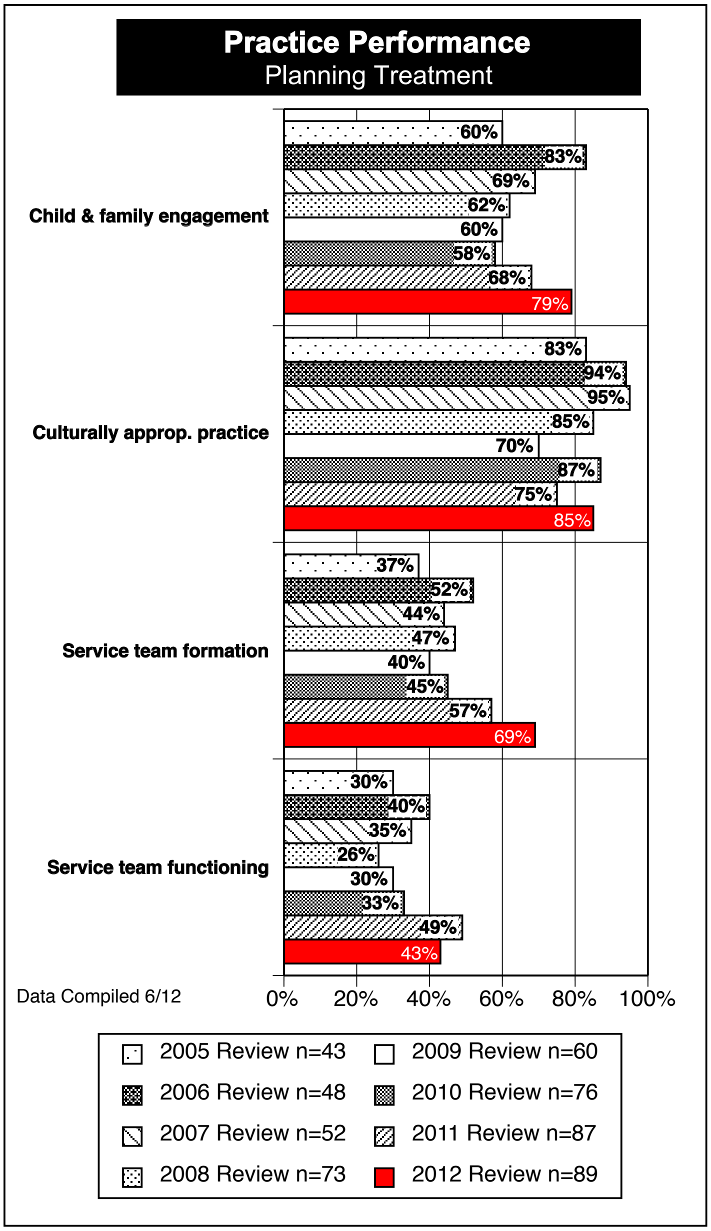
Display 34
Six-Month Prognosis



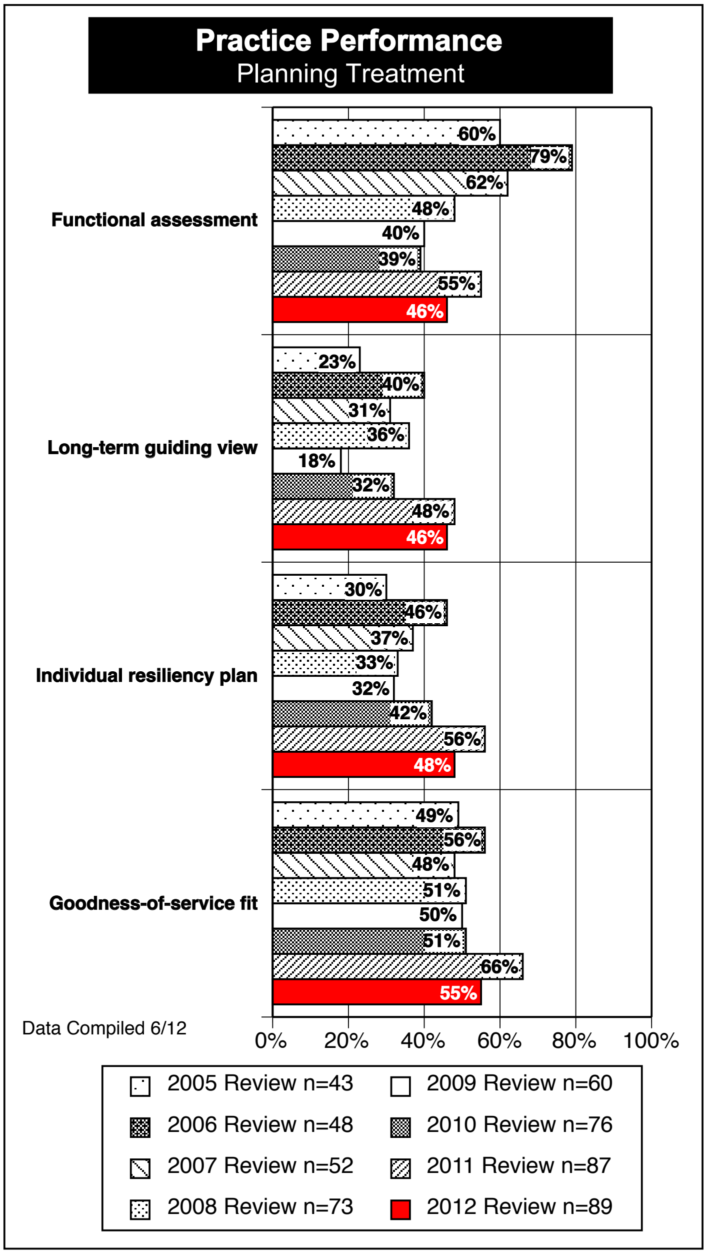
Overall, the results of the 2012 CSR data show that consistency and quality of practice continues to improve. The overall percentage of children who are provided services with the quality, coordination, consistency, and diligence necessary to achieve progress and improvements in children has improved by 6% since the 2011 review and by 31% since the lowest overall acceptable practice score of 34% in the 2008 review. However, there is still considerable variability when one examines the scores across practice domains. It should also be noted that this year, the age of the children in the sample was somewhat shifted toward the older youth. The older youngsters also were the largest age group in the low functioning category. The CSR reviews conducted both in the district and elsewhere show that older children and particularly older children with higher needs are the most difficult for systems to service effectively with high quality coordinated practice. The data in this year's sample are reflective of the challenges presented by older youth with significant service needs.

Display 35 shows the results for practice performance for eight of the ten years in which CSRs have been conducted. The data trends do not show real significant improvement in the consistent implementation of quality services until the 2011 review. 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 underlying issues and diagnostic assessment, identifying a long-term guiding view for each child served, 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, had shown very little improvement in the years up to 2010. Significant improvement between 2010 and 2011 as reflected in the CSR overall measurements was continued in this year's review.

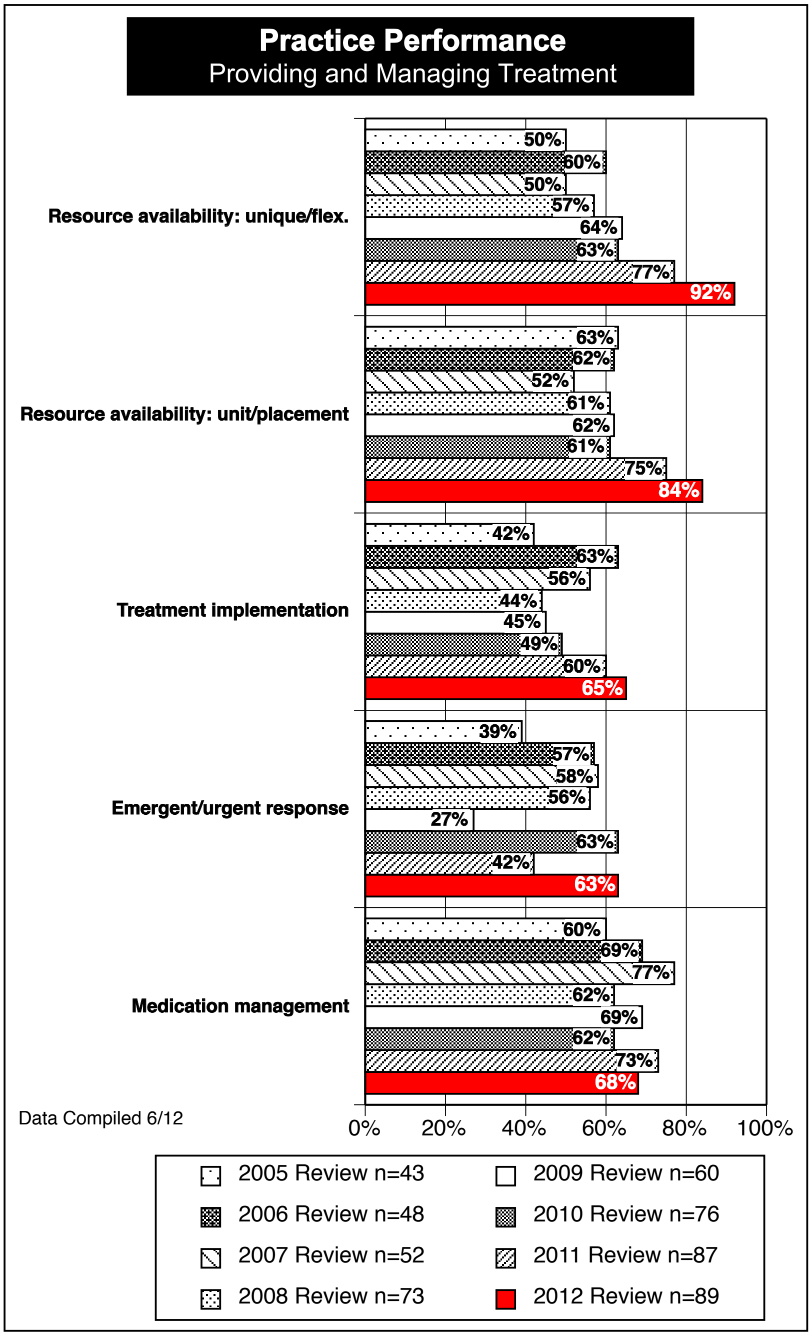
Display 35
Overall Child Practice Performance Results for Eight Reviews



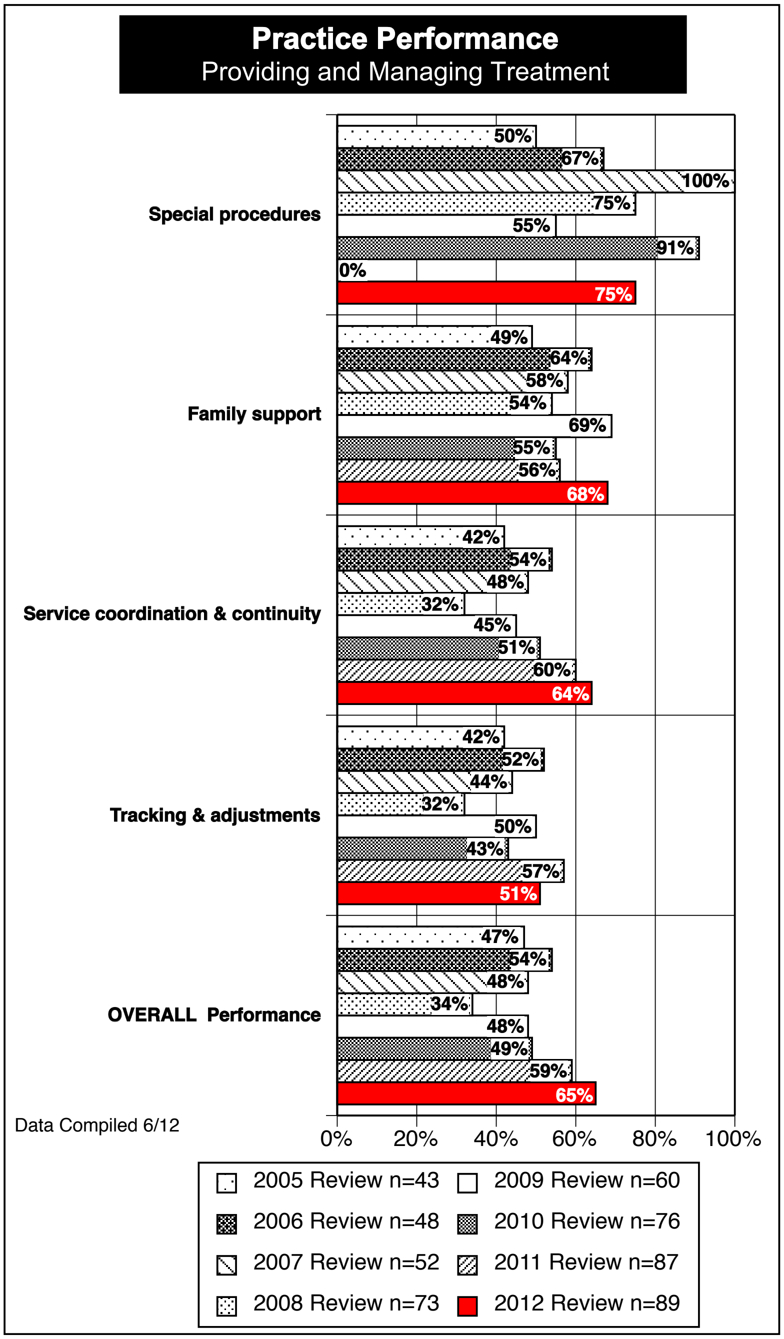
Display 35 (continued)
Overall Child Practice Performance Results for Eight Reviews



Display 35 (continued)
Overall Child Practice Performance Results for Eight Reviews

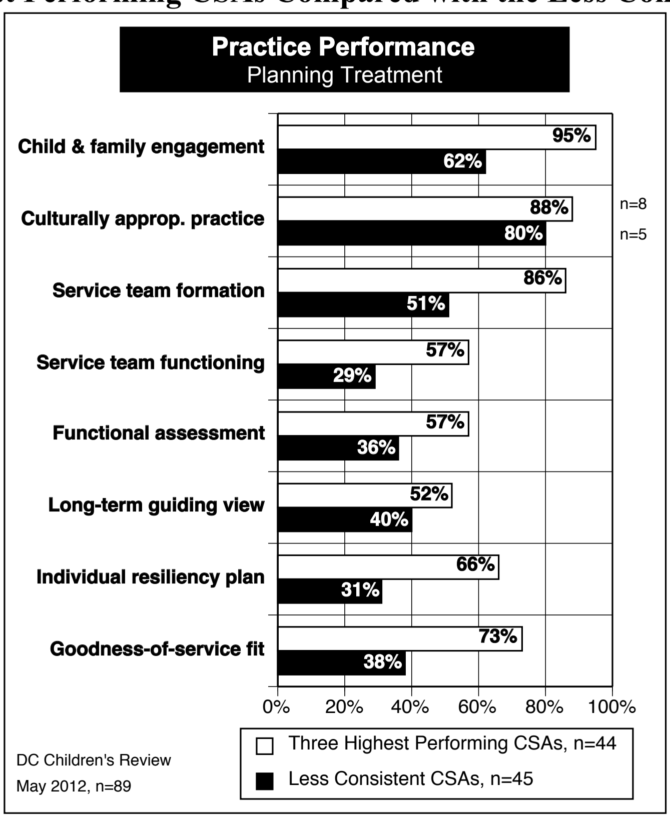


Display 35 (continued)
Overall Child Practice Performance Results for Eight Reviews

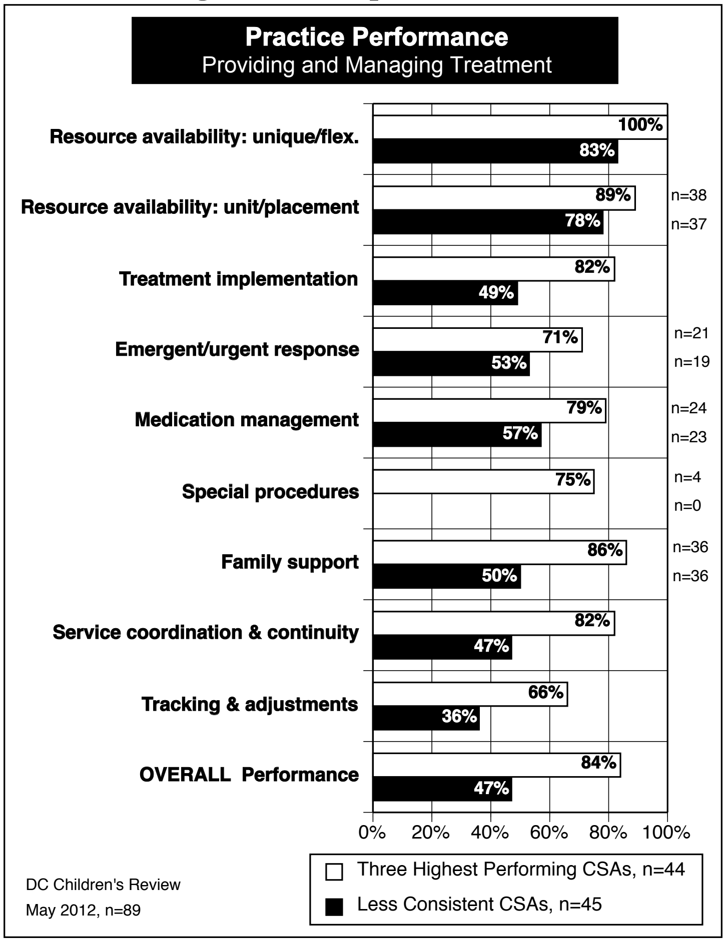


Examination of the individual CSA data shows great variability across the CSAs. Some CSAs have dramatically improved the quality and consistency of services over the last couple of years. Fortunately, these have been the larger providers of children's services and, specifically, include First Home Care and Community Connections. There continues to be great variability in the consistency of delivery of high quality services among the smaller agencies. Displays 36-39 show the system performance data for the three top performers compared to all other CSAs. (See Appendix D for the complete comparison data). Examination of the performance data at the domain level (Displays 36 and 37) or at the overall level (Displays 38 and 39) shows that there is dramatic difference in the quality and consistency of performance in some CSAs. The overall performance levels was 84% system performance for the three CSAs with the highest quality and consistency compared to 47% for the aggregate performance of the CSAs with greater variability in the quality and consistency of practice.

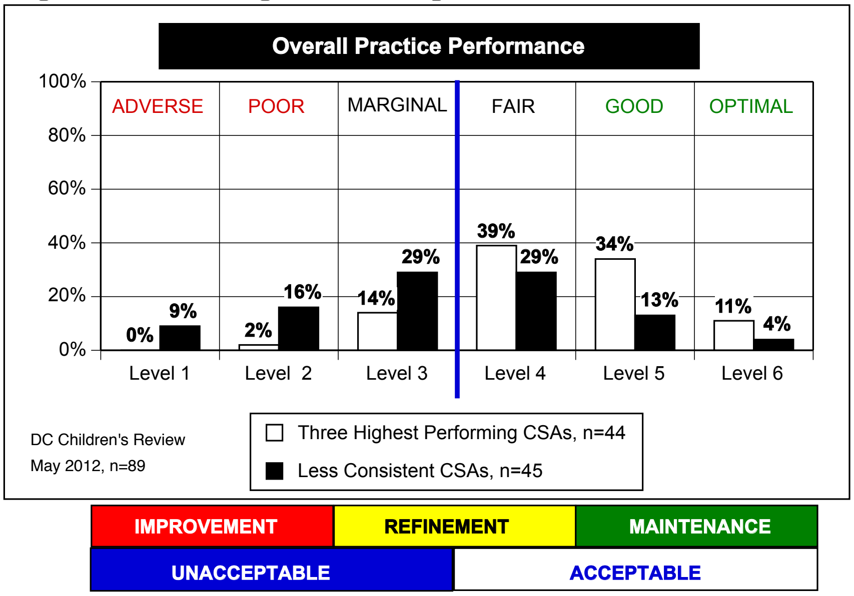
Display 36
Percentage of Acceptable Practice Performance: Planning Treatment Ratings
Three Highest Performing CSAs Compared with the Less Consistent CSAs



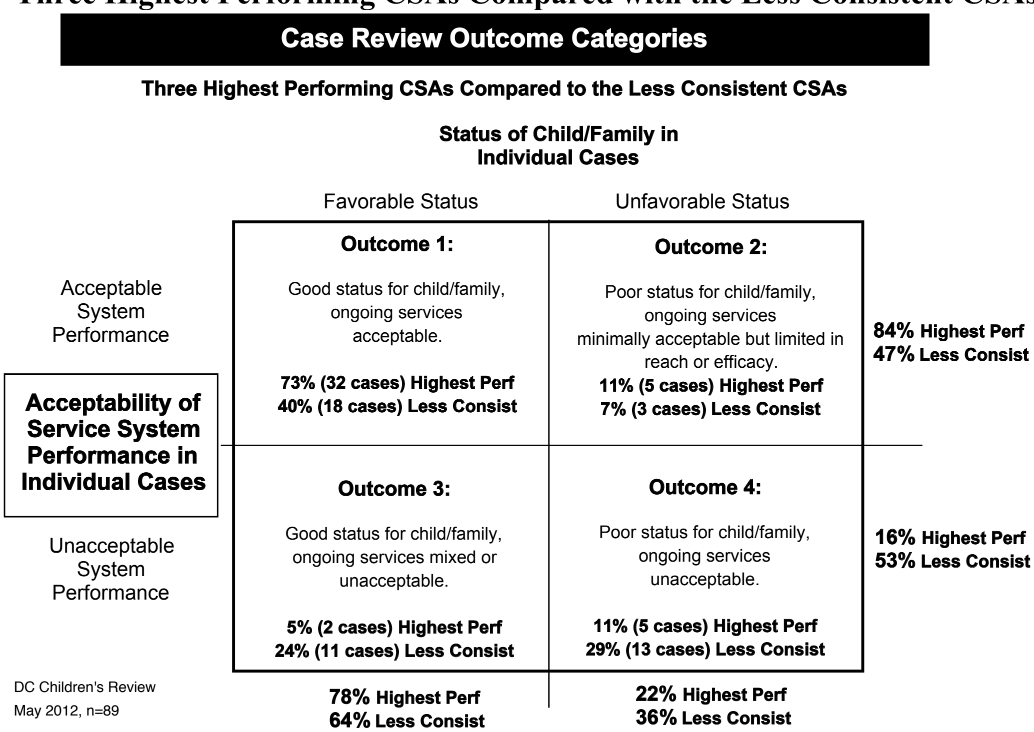
Display 37
Percentage of Acceptable Practice Performance:
Providing and Managing Treatment Ratings
Three Highest Performing CSAs Compared with the Less Consistent CSAs



Display 38
Overall Practice Performance
Three Highest Performing CSAs Compared with the Less Consistent CSAs



Display 39
Case Review Outcome Categories
Three Highest Performing CSAs Compared with the Less Consistent CSAs



Qualitative Summary of Child Review Findings: Themes and Patterns Noted in the Individual Reviews and in the Stakeholder Interviews

The findings discussed above 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 89 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.

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 2012 review of services for children and youth. Specific areas of strengths and opportunities for improvement are described separately. In addition to the child and family reviews, a small number of stakeholder interviews and focus groups were conducted with 56 persons who are involved with children's services in the District. The information gleaned from these discussions is included in the discussion of themes and patterns. Overall, four focus groups were conducted over a one-week period of time and included CSA staff, judiciary, CFSA, and DMH leadership and staff.

- A majority of the youth reviewed this year were found to be safe from harm (by self or others) and abuse/neglect (76%), were in an appropriate home and school placement (93%), and were experiencing good health (96%).
- There is an increase in the acceptable overall system and practice rating by 6% when compared to the 2011 review of children's services..
- Prognosis for youth reviewed in 2012 showed more youth who were likely to decline in the next six months; 18% in 2011 and 24% in 2012. Although there were the same percentage of youth likely to improve over the same time period; 26% in both 2011 and 2012. This pattern is likely the result of the number of 14-year-old and older youth in the sample this year who were lower functioning and presented greater challenges.
- Characteristics and distribution of older youth in the review sample differ from the population and sample. Specifically, there are 5% more youth age 14 and older in the review

than in the population and 5% more females in the review than in the population. The level of functioning of youth is lower in 2012, with 9% more youth age 14+ in the low level of functioning, thus requiring more intensive, higher levels of service. In prior reviews, the numbers of older children have been proportionate to the percentage in the population or smaller. For example, there were ten more older youth in this year's sample than there were last year and their service needs were greater.

The most evident theme again this year, as in the past few reviews, is the variability across CSAs in providing consistent, high quality services. Strengths 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. Some agencies are lacking basic infrastructure, such as regular, frequent, structured clinical leadership meetings, while other agencies continue to use contracted or part-time providers. The use of contractors presents significant challenges for supervision, accountability, and coordination of services. Another factor is the extent to which management recognizes that it is their responsibility to promote high quality practice and that they must establish methods of measuring the consistency and quality of practice. The message that quality practice is the priority and expectation needs to be clearly stated by both DMH and CSA leadership. It is also necessary that management make sure that supervisors are concentrating on clinical quality of work during supervision and not just administrative matters, such as billable hours. In an effort to promote high quality practice, DMH provided technical assistance to six CSAs who participated in on-site training and consultation to strengthen and improve practice. The on-site training and consultation also focused on structuring supervision to support staff clinically, as well as a means to integrate practice expectations.

Strengths Observed During the Reviews

- The Department has embarked on several initiatives, including a juvenile diversion program, targeted supports for youth in the 0-6 age range, and the development and adoption of practice expectations. Practice expectations have also been imbedded in DMH policy, thus requiring contractors of services to adhere to these expectations. This is an important step by DMH in communicating that high quality practice is the priority. The DMH children's staff has worked hard and diligently to build a comprehensive array of services and to work with schools, court, juvenile justice, and CFSA to strengthen services and to provide them to children birth to 21 years. While they still do not have sufficient capacity in all areas, they have made significant progress.

- CHAMPS mobile crisis services continue to be viewed as very positive and responsive services to help children remain safely in the community and to maintain their placements. Emergent/urgent response was the indicator with one of the largest improvements, with a 21% increase in percentage of youth having acceptable practice in this area.
- The development of teams (team formation-69%) has improved, with engagement of families, youth, and community partners continuing to be strong (79% acceptable engagement). The functioning of teams and communication between mental health teams and community partners has improved; however, team functioning still represents one of the biggest challenges to achieving consistent high quality services.
- Coordination and continuity also yielded improvement in 2012 with a 4% increase in acceptable practice in this area, 60% in 2011 and 64% in 2012, with 31% of youth in the maintenance zone with a rating of 5-good or 6-optimal. However, one out of three children is still not receiving adequate coordination and continuity of services.
- Results for 2012 showed a large improvement in the area of family support; from 56% in 2011 to 68% in 2012. It should be noted that this indicator was found applicable for about the same number of youth in both years; 70 youth in 2011 and 72 youth in 2012.
- There is improvement in practice overall, with 66% of the youth having at least minimally acceptable practice. Over the past few years, there has continued to be an upward trend in the quality and consistency of services to youth and families.

Challenges Observed During the Reviews

- There continue to be challenges with supporting strong teaming functions, such as communication and face-to-face meetings. Teams 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. Although service coordination and continuity improved somewhat, many review debriefings yielded examples of CSWs not accessing, or feeling empowered to access, more intensive services for a youth or family or clinical support for themselves.

- There was inconsistency in the process of assessing the needs, strengths, or appropriate strategies necessary to impact change. There continued to be instances of 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 not fully understood. The understanding and assessment process as a practice function was weak and not used to drive treatment planning or in determining strategies for addressing youth and family needs.
- Teams were lacking clinical formulation of key underlying issues that needed to be addressed and conceptualization of the critical path and strategies necessary to achieve agreed-upon positive outcomes and long-term goals. Providers also were not looking closely at what dynamics for the youth or in the home needed to change in order for progress to be made and sustained, and for families to no longer require formal services. Teams are not recognizing when teens are essentially out of control of parents and are not participating in treatment in a meaningful way.

Issues Pertaining to CSWs in Particular

- There continue to be system-wide discrepancies in regard to the role and function of CSWs. Many reviews this year had CSWs providing support solely or primarily in the school setting, with several instances of youth in Level 5 education settings receiving CSW services in that environment.
- As noted above, CSWs appeared to not be aware of the need to access more intensive, clinical services for youth and families, and lacked knowledge and empowerment to do so when they were aware of this need. Many youth reviewed required more services, or their situations were at a higher level of complexity and need than could be significantly impacted by CSW supports alone.

- It is clear that CSWs are committed to youth and families, and are working very hard to provide quality services and positively impact the lives of youth and families despite challenges in communities, CSAs, and the larger system.

Stakeholders

- CFSA continues to express the need for timely access to services for children and families not in care, as well as timely delivery of services once needs have been identified. They would also like more timely access to higher intensity services, such as CBI and other evidence-based services. CFSA leadership recognizes that progress has been made but also knows that the CFSA children continue to show great need. They would like to see better tracking of the quality of services in progress notes and communication about "no shows" and treatment planning meetings. First Home Care provides a significant number of mental health services and foster care services in the District, and discussion raised the possibility of focusing on the children served by this agency that are clients of both CFSA and DMH in order to work on improvements in the communication and coordination of processes involved in assessment, teaming, and access to needed services.
- Family court was most appreciative of the work of Ms. Black and her staff and particularly of the juvenile diversion program. One area of ongoing concern is the children moving between hospital and community settings and the level of supports they are receiving when they return to the community.
- Some CSAs continue to want to receive feedback from reviewers and team leaders on their performance both at the child review and CSA level so they can make improvements in both practice and the supervision of practice. There are some significant positive examples and also some significant lower performing outliers.

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 and as shown in Displays 36-39 as discussed above. Fortunately, there are some CSAs who have improved the quality and consistency of their services significantly, with additional CSAs eager and invested in obtaining training and technical guidance on how to improve services. If DMH is to provide high quality consistent services across the district, then they are going to have to continue to address the variability of performance at the provider level.

Conclusions and Recommendations

The review process this year continued to show 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.
- The beginnings of improved integration of effort across components of DMH, such as children's programs, the CSR unit, and quality improvement.
- CSAs that continue to see and use 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.
- CSA leadership that are committed to providing quality services, and who are struggling to align high quality practice with viable business practices.

DMH has accomplished a great deal in improving the quality and consistency of services provided to children. It is now faced with the challenge of how to make refinements and motivate both DMH staff and the CSAs to strive for world-class performance. It will take fully coordinated efforts on the part of the DMH team and the CSA leadership to raise the consistency and quality of services from the current 65% to 70% range to the desired 85% to 95% range of high quality and consistency. This would mean that instead of having roughly two out of three children served with high consistency and quality, closer to nine out of ten children would be served with diligence and thoughtful quality. That is a high standard that few systems meet or can sustain.

Recommendations

It is recommended that careful consideration be given to identifying refinements that can be made that would support service delivery staff to perform with even more consistency. Questions to consider include: What are the critical steps to be taken from this point that will sustain and improve our current performance? How can we use DMH resources to work in a concerted and synergistic effort towards this goal? How can we collaborate with educational and other child-serving agencies to make refinements that will make a significant difference in improved communication at the child/intervener level?

- DMH should continue to support the integration and adoption of the practice expectations and CSR process into CSA functions and processes.
- DMH needs to ensure that the CSR unit is able to support the ongoing use of CSR in the CSAs and the unit needs to begin to conduct small targeted CSR reviews on a regular and timely basis. These reviews should be done in coordination with the Office of Quality Improvement and program areas.
- It would be helpful to brainstorm with the other child-serving agencies to determine what specifically can be done in the next 12 months to improve collaboration and communication at the child level across agencies.
- DMH has implemented a juvenile court diversion program and continues to reduce the use of residential placements both within and outside the district. These programs may result in a

greater number of higher need, older children being served in the community. DMH may need to consider what specific steps need to be taken to increase the skills and services in the community that are necessary to most effectively serve these children in the community. This may also include the need for more CBI, wrap-around, and MST services.

- 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; however, 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.

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 Far Southeast Family Strengthening Collaborative and the DMH CSR unit 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.

Unacceptable Range: 1-3

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.

CSR Interpretative Guide for Practice Performance

Maintenance Zone: 5-6

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

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

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

Acceptable Range: 4-6

Refinement Zone: 3-4

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

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

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

Unacceptable Range: 1-3

Improvement Zone: 1-2

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

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

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

Appendix C

Appendix C

This agency-by-agency comparison should be interpreted with caution, since sample sizes for some of the provider agencies are extremely small. **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/Life Stride n= 2 DC Child Review May 2012

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	2	100%	0%	50%	50%
Stability	2	100%	0%	50%	50%
Home & school placement	2	100%	0%	0%	100%
Caregiver support of child	2	100%	0%	0%	100%
Satisfaction	2	50%	0%	100%	0%
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%	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%	50%	50%
Behavior improvement	2	100%	0%	50%	50%
School/work progress	2	100%	0%	50%	50%
Risk reduction	2	100%	0%	100%	0%
Transition progress	2	50%	0%	100%	0%
Meaningful relationships	2	100%	0%	50%	50%
Overall Progress	2	100%	0%	100%	0%

CSR/Child Status and Performance Profile

Affordable Behavioral Consultants/Life Stride n= 2 DC Child Review May 2012

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

CSR/Child Status and Performance Profile

Community Connections n= 14 DC Child Review May 2012

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	14	79%	14%	64%	21%
Stability	14	57%	21%	43%	36%
Home & school placement	14	93%	0%	29%	71%
Caregiver support of child	14	93%	7%	36%	57%
Satisfaction	14	71%	0%	43%	57%
Health/Phy well-being	14	100%	0%	21%	79%
Functional status	14	64%	14%	79%	7%
Academic status	14	43%	14%	64%	21%
Responsible social behavior	14	57%	21%	64%	14%
Lawful behavior	14	71%	7%	36%	57%
Overall C & F Status	14	71%	14%	50%	36%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	14	71%	21%	64%	14%
Behavior improvement	14	57%	21%	57%	21%
School/work progress	14	57%	21%	64%	14%
Risk reduction	14	64%	14%	71%	14%
Transition progress	12	50%	17%	58%	25%
Meaningful relationships	14	71%	7%	50%	43%
Overall Progress	14	71%	14%	79%	7%

CSR/Child Status and Performance Profile

Community Connections n= 14 DC Child Review May 2012

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	14	93%	0%	71%	29%
Culturally appropriate practice	2	50%	0%	50%	50%
Service team formation	14	86%	0%	57%	43%
Service team functioning	14	50%	0%	71%	29%
Functional assessment	14	57%	21%	50%	29%
Long-term guiding view	14	43%	21%	64%	14%
IRP	14	57%	7%	79%	14%
Goodness-of-service fit	14	79%	0%	71%	29%
Resource avail.: unique/flex.	14	100%	0%	36%	64%
Resource availability: unit/place.	13	100%	0%	38%	62%
Treatment implementation	14	79%	0%	71%	29%
Emergent/urgent response	6	67%	17%	83%	0%
Medication management	10	90%	0%	40%	60%
Special procedures	1	0%	0%	100%	0%
Familty support	13	92%	0%	69%	31%
Service coord. & continuity	14	86%	0%	71%	29%
Tracking & adjustment	14	71%	0%	71%	29%
Overall Practice Performance	14	86%	0%	79%	21%

CSR/Child Status and Performance Profile

Family Matters n= 5

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

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

CSR/Child Status and Performance Profile

Family Matters n= 5

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

CSR/Child Status and Performance Profile

Family Preservation n= 1 DC Child Review May 2012

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

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

CSR/Child Status and Performance Profile

Family Preservation n= 1 DC Child Review May 2012

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

CSR/Child Status and Performance Profile

Fihankra Place n= 2 DC Child Review May 2012

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	2	50%	0%	50%	50%
Stability	2	50%	0%	50%	50%
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%	0%	100%
Functional status	2	50%	0%	100%	0%
Academic status	2	50%	50%	0%	50%
Responsible social behavior	2	0%	50%	50%	0%
Lawful behavior	2	100%	0%	100%	0%
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%	0%	100%	0%
School/work progress	2	50%	0%	50%	50%
Risk reduction	2	0%	50%	50%	0%
Transition progress	1	0%	0%	100%	0%
Meaningful relationships	2	100%	0%	100%	0%
Overall Progress	2	0%	0%	100%	0%

CSR/Child Status and Performance Profile

Fihankra Place n= 2 DC Child Review May 2012

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

CSR/Child Status and Performance Profile

First Home Care n= 25 DC Child Review May 2012

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	25	80%	12%	44%	44%
Stability	25	64%	8%	56%	36%
Home & school placement	25	100%	0%	20%	80%
Caregiver support of child	25	100%	0%	40%	60%
Satisfaction	25	96%	0%	24%	76%
Health/Phy well-being	25	96%	0%	16%	84%
Functional status	25	68%	16%	60%	24%
Academic status	25	80%	4%	56%	40%
Responsible social behavior	25	68%	20%	48%	32%
Lawful behavior	23	74%	0%	43%	57%
Overall C & F Status	25	80%	12%	32%	56%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	25	64%	12%	60%	28%
Behavior improvement	25	76%	4%	60%	36%
School/work progress	25	80%	8%	48%	44%
Risk reduction	23	83%	9%	65%	26%
Transition progress	23	78%	13%	35%	52%
Meaningful relationships	24	88%	8%	46%	46%
Overall Progress	25	80%	12%	56%	32%

CSR/Child Status and Performance Profile

First Home Care n= 25 DC Child Review May 2012

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	25	100%	0%	28%	72%
Culturally appropriate practice	4	100%	0%	0%	100%
Service team formation	25	92%	4%	24%	72%
Service team functioning	25	68%	8%	52%	40%
Functional assessment	25	56%	24%	24%	52%
Long-term guiding view	25	56%	24%	44%	32%
IRP	25	68%	8%	52%	40%
Goodness-of-service fit	25	72%	4%	44%	52%
Resource avail:uniqe/flex	23	100%	0%	26%	74%
Resource availability:unit/place.	20	85%	5%	30%	65%
Treatment implementation	25	88%	0%	36%	64%
Emergent/urgent response	13	77%	23%	23%	54%
Medication management	13	69%	23%	31%	46%
Special procedures	2	100%	0%	50%	50%
Familty support	18	78%	6%	44%	50%
Service coord.& continuity	25	80%	0%	44%	56%
Tracking & adjustment	25	64%	8%	36%	56%
Overall Practice Performance	25	84%	4%	36%	60%

CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 8 DC Child Review May 2012

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	8	88%	13%	63%	25%
Stability	8	38%	13%	88%	0%
Home & school placement	8	63%	0%	50%	50%
Caregiver support of child	8	75%	0%	75%	25%
Satisfaction	7	71%	29%	14%	57%
Health/Phy well-being	8	100%	0%	25%	75%
Functional status	8	75%	13%	50%	38%
Academic status	8	50%	13%	63%	25%
Responsible social behavior	8	63%	13%	63%	25%
Lawful behavior	8	63%	13%	38%	50%
Overall C & F Status	8	63%	13%	63%	25%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	8	63%	13%	63%	25%
Behavior improvement	8	63%	13%	63%	25%
School/work progress	8	50%	13%	63%	25%
Risk reduction	7	57%	29%	43%	29%
Transition progress	8	75%	25%	50%	25%
Meaningful relationships	7	86%	0%	71%	29%
Overall Progress	8	63%	13%	63%	25%

CSR/Child Status and Performance Profile

Hillcrest Children's Center n= 8 DC Child Review May 2012

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	8	38%	38%	50%	13%
Culturally appropriate practice					
Service team formation	8	25%	38%	50%	13%
Service team functioning	8	25%	50%	50%	0%
Functional assessment	8	13%	38%	63%	0%
Long-term guiding view	8	38%	63%	38%	0%
IRP	8	13%	25%	75%	0%
Goodness-of-service fit	8	38%	38%	63%	0%
Resource avail.: unique/flex.	7	57%	29%	57%	14%
Resource availability: unit/place.	7	57%	14%	71%	14%
Treatment implementation	8	25%	50%	50%	0%
Emergent/urgent response	3	33%	33%	67%	0%
Medication management	1	0%	0%	100%	0%
Special procedures					
Familty support	6	17%	33%	67%	0%
Service coord. & continuity	8	25%	38%	63%	0%
Tracking & adjustment	8	13%	38%	63%	0%
Overall Practice Performance	8	25%	38%	63%	0%

CSR/Child Status and Performance Profile

Inner City Family Services n= 6 DC Child Review May 2012

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

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	6	33%	17%	83%	0%
Behavior improvement	6	33%	33%	50%	17%
School/work progress	6	50%	0%	100%	0%
Risk reduction	5	20%	0%	100%	0%
Transition progress	1	0%	0%	100%	0%
Meaningful relationships	5	60%	20%	40%	40%
Overall Progress	6	33%	17%	83%	0%

CSR/Child Status and Performance Profile

Inner City Family Services n= 6 DC Child Review May 2012

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	6	67%	33%	67%	0%
Culturally appropriate practice	1	100%	0%	0%	100%
Service team formation	6	33%	33%	67%	0%
Service team functioning	6	17%	50%	50%	0%
Functional assessment	6	33%	33%	67%	0%
Long-term guiding view	6	33%	33%	67%	0%
IRP	6	33%	17%	83%	0%
Goodness-of-service fit	6	0%	17%	83%	0%
Resource avail.: unique/flex.	6	67%	17%	67%	17%
Resource availability: unit/place.	5	60%	20%	60%	20%
Treatment implementation	6	50%	17%	83%	0%
Emergent/urgent response					
Medication management	4	50%	50%	50%	0%
Special procedures					
Familty support	5	60%	0%	100%	0%
Service coord. & continuity	6	33%	33%	67%	0%
Tracking & adjustment	6	33%	33%	67%	0%
Overall Practice Performance	6	33%	33%	67%	0%

CSR/Child Status and Performance Profile

Latin American Youth Services n= 1 DC Child Review May 2012

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

CSR/Child Status and Performance Profile

Latin American Youth Services n= 1 DC Child Review May 2012

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

CSR/Child Status and Performance Profile

Launch LLC n= 4 DC Child Review May 2012

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

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	4	100%	0%	50%	50%
Behavior improvement	4	75%	25%	75%	0%
School/work progress	4	75%	25%	50%	25%
Risk reduction	3	100%	0%	33%	67%
Transition progress	4	50%	0%	50%	50%
Meaningful relationships	4	75%	0%	25%	75%
Overall Progress	4	75%	0%	50%	50%

CSR/Child Status and Performance Profile

Launch LLC **n= 4** **DC Child Review May 2012**

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

CSR/Child Status and Performance Profile

Life Enhancement Services n= 4 DC Child Review May 2012

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

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

CSR/Child Status and Performance Profile

Life Enhancement Services n= 4 DC Child Review May 2012

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

CSR/Child Status and Performance Profile

MD/DC Family Resources n= 4 **DC Child Review May 2012**

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

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

CSR/Child Status and Performance Profile

MD/DC Family Resources n= 4 DC Child Review May 2012

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	4	50%	0%	75%	25%
Culturally appropriate practice					
Service team formation	4	75%	0%	100%	0%
Service team functioning	4	25%	0%	75%	25%
Functional assessment	4	50%	0%	100%	0%
Long-term guiding view	4	50%	25%	75%	0%
IRP	4	25%	0%	100%	0%
Goodness-of-service fit	4	25%	0%	75%	25%
Resource avail:uniqe/flex	3	100%	0%	3%	6%
Resource availability:unit/place.	4	100%	0%	25%	75%
Treatment implementation	4	100%	0%	50%	50%
Emergent/urgent response	1	100%	0%	0%	100%
Medication management	1	100%	0%	100%	0%
Special procedures					
Familty support	3	100%	0%	67%	33%
Service coord.& continuity	4	100%	0%	75%	25%
Tracking & adjustment	4	25%	25%	50%	25%
Overall Practice Performance	4	75%	0%	75%	25%

CSR/Child Status and Performance Profile

PSI Services n= 2 DC Child Review May 2012

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

CSR/Child Status and Performance Profile

PSI Services n= 2 DC Child Review May 2012

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

CSR/Child Status and Performance Profile

Universal Health Care n= 9 DC Child Review May 2012

Child & Family Status	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Safety of the child	9	44%	22%	44%	33%
Stability	9	67%	11%	56%	33%
Home & school placement	9	89%	11%	22%	67%
Caregiver support of child	9	78%	22%	22%	56%
Satisfaction	9	78%	11%	33%	56%
Health/Phy well-being	9	100%	0%	11%	89%
Functional status	9	56%	33%	56%	11%
Academic status	9	89%	11%	56%	33%
Responsible social behavior	9	33%	22%	67%	11%
Lawful behavior	8	75%	25%	38%	38%
Overall C & F Status	9	44%	22%	44%	33%

Recent Progress	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Symptom reduction	9	67%	11%	67%	22%
Behavior improvement	9	67%	22%	67%	11%
School/work progress	9	67%	11%	44%	44%
Risk reduction	9	44%	0%	78%	22%
Transition progress	8	63%	13%	50%	38%
Meaningful relationships	9	56%	11%	67%	22%
Overall Progress	9	67%	11%	78%	11%

CSR/Child Status and Performance Profile

Universal Health Care n= 9 DC Child Review May 2012

Current Practice Performance	Cases Applicable	Percent Acceptable	Improvement	Refinement	Maintenance
Child & family engagement	9	67%	11%	56%	33%
Culturally appropriate practice	1	0%	0%	100%	0%
Service team formation	9	67%	0%	78%	22%
Service team functioning	9	22%	22%	78%	0%
Functional assessment	9	44%	11%	56%	33%
Long-term guiding view	9	56%	33%	33%	33%
IRP	9	22%	22%	67%	11%
Goodness-of-service fit	9	56%	33%	44%	22%
Resource avail.: unique/flex.	9	100%	0%	56%	44%
Resource availability: unit/place.	7	100%	0%	43%	57%
Treatment implementation	9	44%	0%	78%	22%
Emergent/urgent response	7	57%	14%	57%	29%
Medication management	5	60%	0%	40%	60%
Special procedures					
Familty support	7	71%	14%	29%	57%
Service coord. & continuity	9	44%	22%	67%	11%
Tracking & adjustment	9	44%	33%	33%	33%
Overall Practice Performance	9	56%	11%	67%	22%

CSR/Child Status and Performance Profile

Youth Villages n= 2 DC Child Review May 2012

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

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

CSR/Child Status and Performance Profile

Youth Villages n= 2 DC Child Review May 2012

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

Appendix D

Aggregated Performance of the Three Highest Performing CSAs on Child Status, Child Progress, and System Performance Compared with the Aggregated Ratings Across the Less Consistent CSAs

Three Highest Performing CSAs (with 5 or more cases) = 44 Cases or 49% of the total children/youth reviewed

Less Consistent CSAs = 45 Cases or 51% of the total children/youth reviewed

Overall Status and Practice
Three Highest Performing CSAs (with 5 or more cases)

CSR/Child Status and Performance Profile - Provider Frequency

# of kids **14** DC Child Review May 2012

Provider	Overall Status	Overall Practice	Number
Community Connections	71%	86%	14

CSR/Child Status and Performance Profile - Provider Frequency

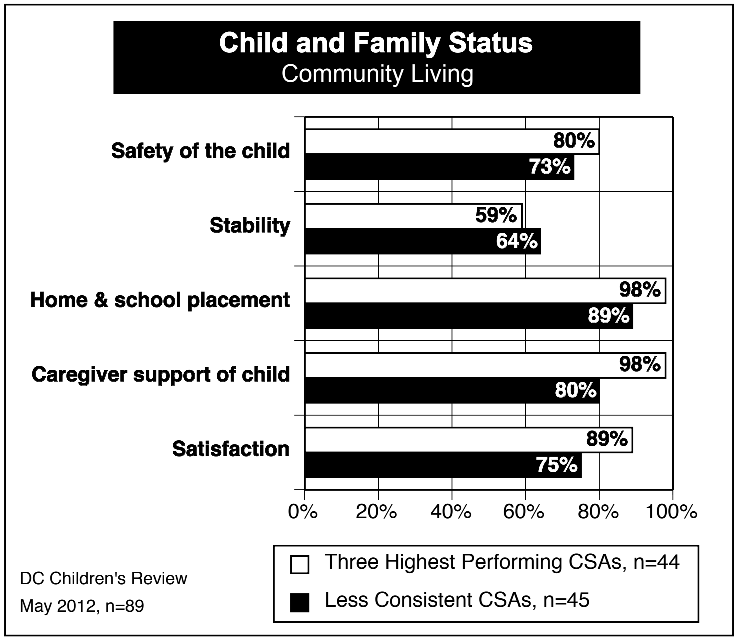
# of kids **5** DC Child Review May 2012

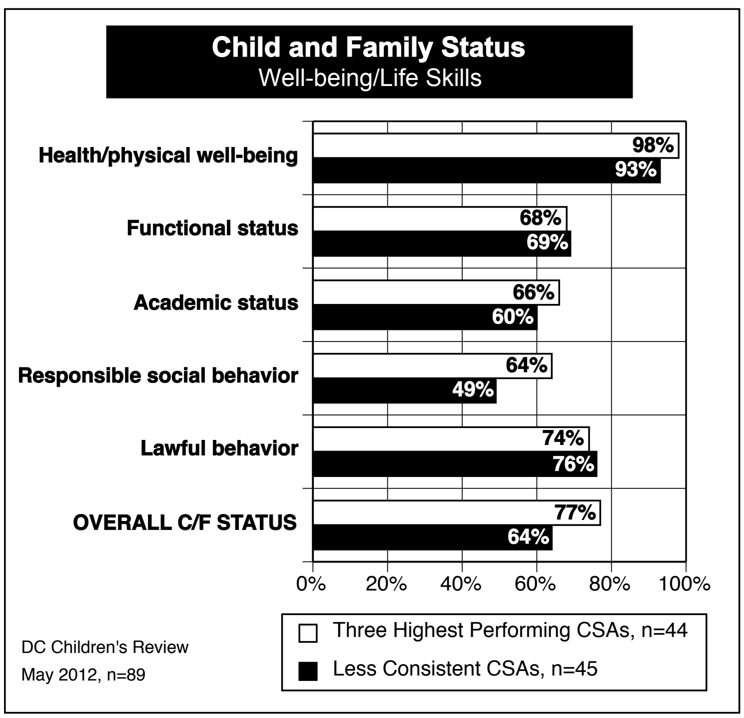
Provider	Overall Status	Overall Practice	Number
Family Matters	80%	80%	5

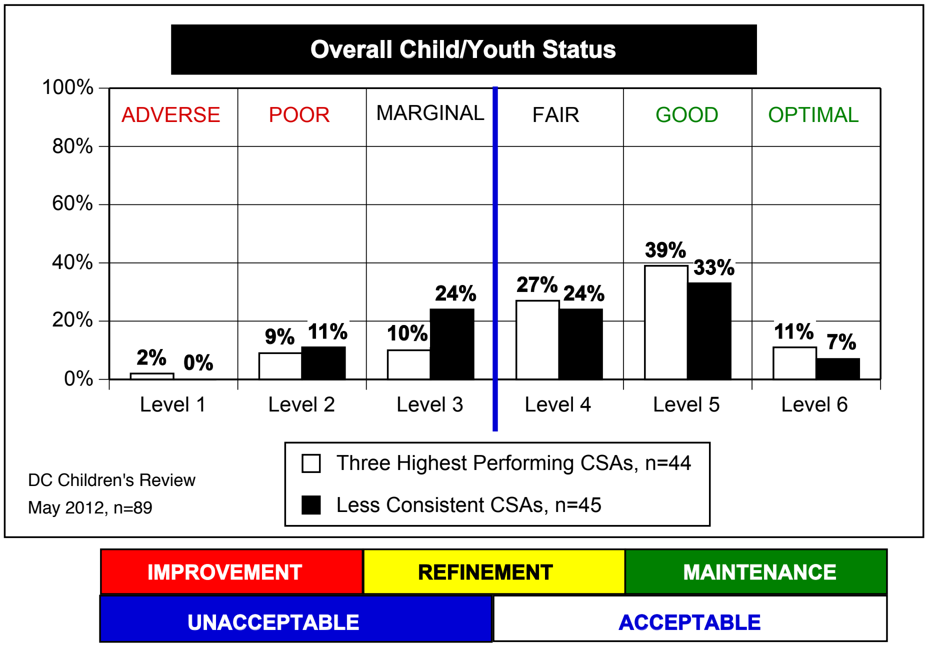
CSR/Child Status and Performance Profile - Provider Frequency

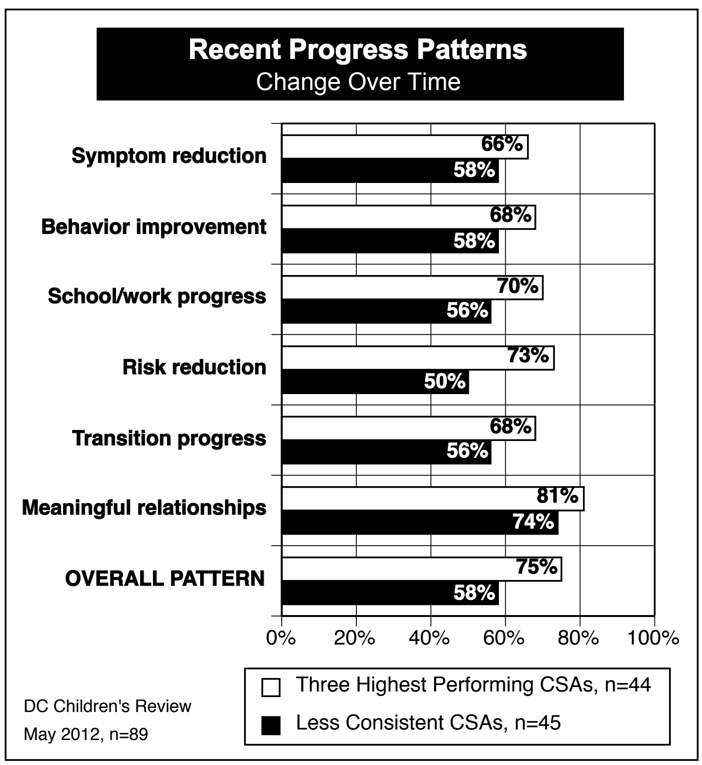
# of kids **25** DC Child Review May 2012

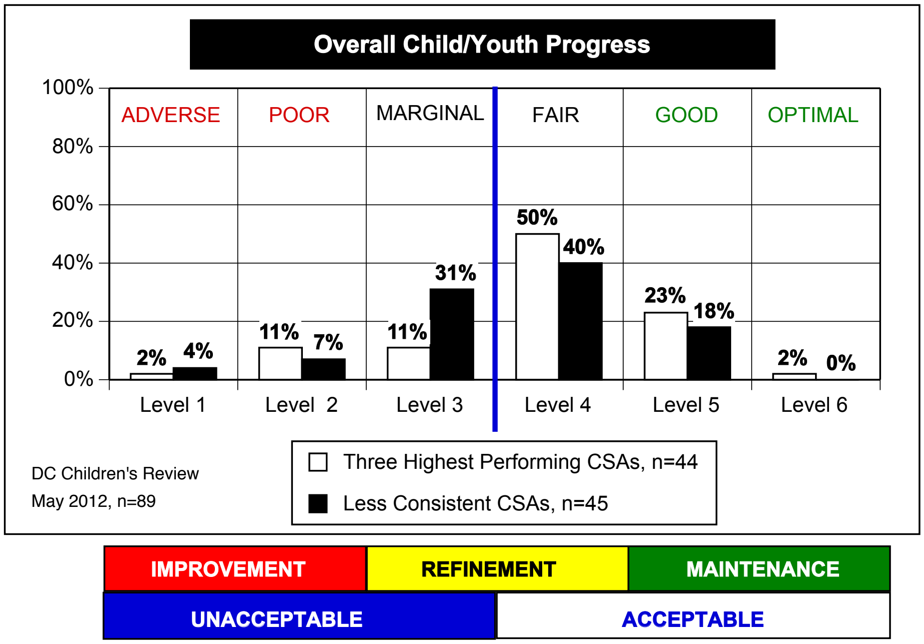
Provider	Overall Status	Overall Practice	Number
First Home Care	80%	84%	25

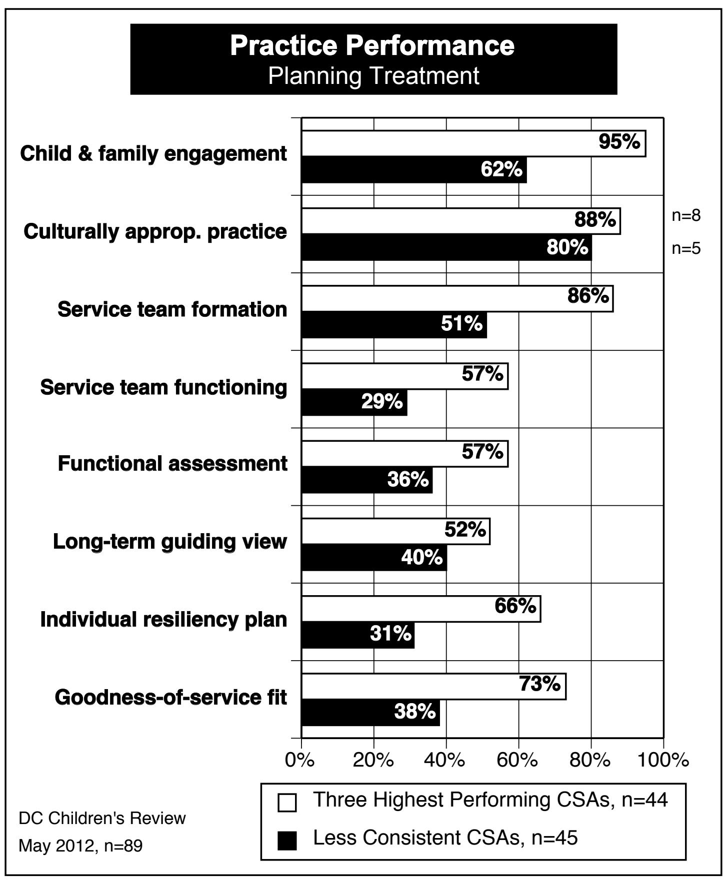

Child and Family Status
Community Living
Safety of the child
80%
73%
Stability
59%
64%
Home & school placement
98%
89%
Caregiver support of child
98%
80%
Satisfaction
89%
75%
0%
20%
40%
60%
80%
100%
Three Highest Performing CSAs, n=44
Less Consistent CSAs, n=45
DC Children's Review
May 2012, n=89

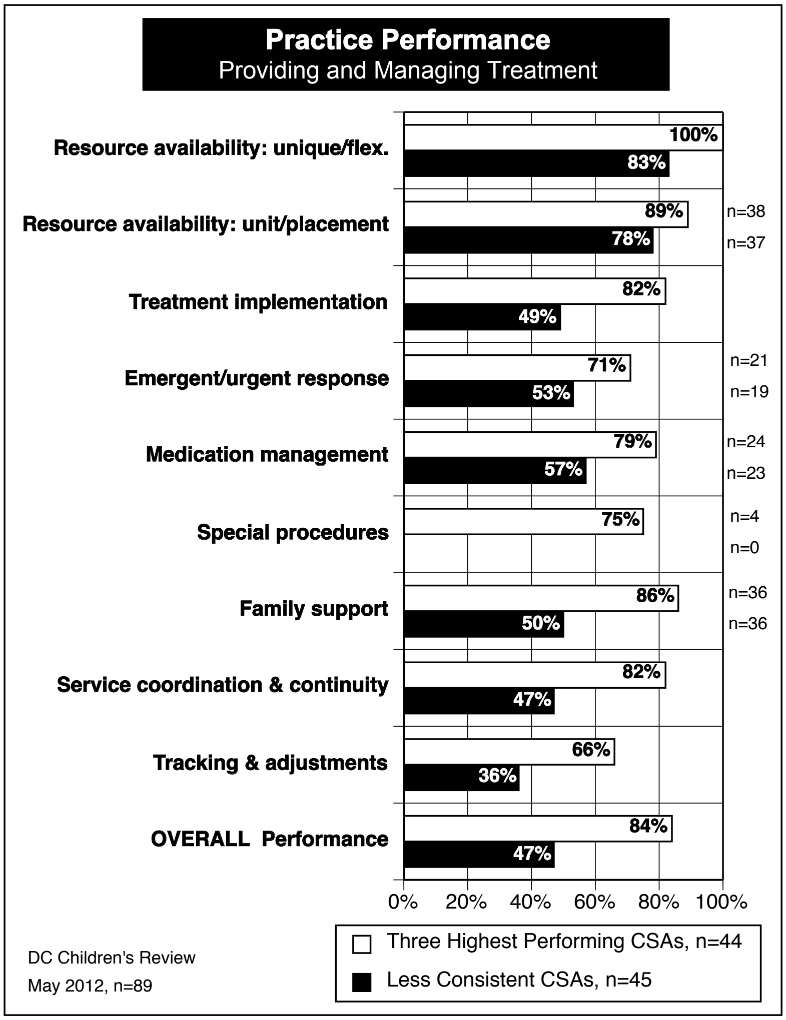

Child and Family Status
Well-being/Life Skills
Health/physical well-being
98%
93%
Functional status
68%
69%
Academic status
66%
60%
Responsible social behavior
64%
49%
Lawful behavior
74%
76%
OVERALL C/F STATUS
77%
64%
0%
20%
40%
60%
80%
100%
Three Highest Performing CSAs, n=44
Less Consistent CSAs, n=45
DC Children's Review
May 2012, n=89

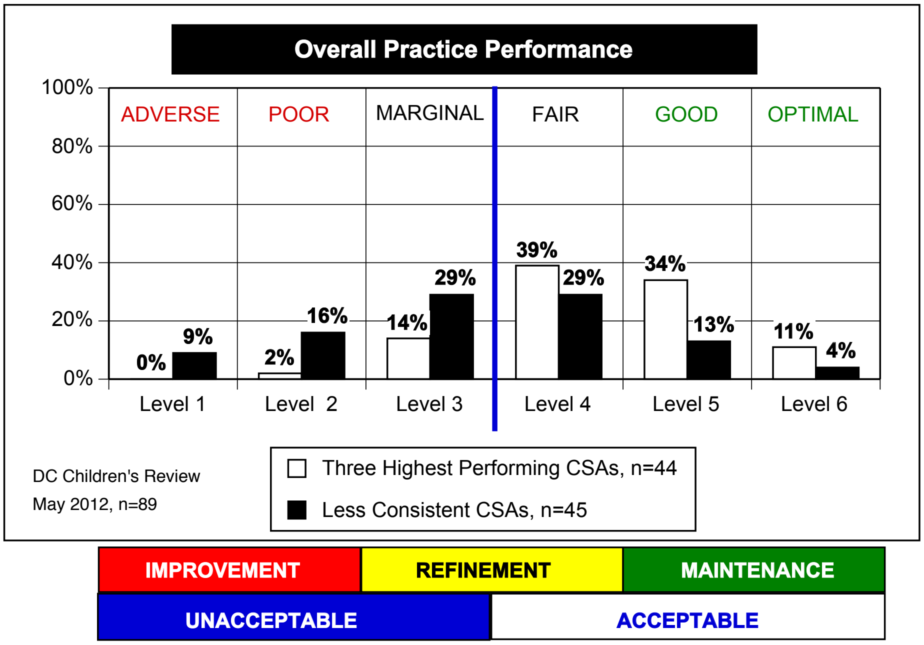

Overall Child/Youth Status
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
2%
0%
9%
11%
10%
24%
27%
24%
39%
33%
11%
7%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
Three Highest Performing CSAs, n=44
Less Consistent CSAs, n=45
DC Children's Review
May 2012, n=89
IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE


Recent Progress Patterns
Change Over Time
Symptom reduction
66%
58%
Behavior improvement
68%
58%
School/work progress
70%
56%
Risk reduction
73%
50%
Transition progress
68%
56%
Meaningful relationships
81%
74%
OVERALL PATTERN
75%
58%
0%
20%
40%
60%
80%
100%
Three Highest Performing CSAs, n=44
Less Consistent CSAs, n=45
DC Children's Review
May 2012, n=89


Overall Child/Youth Progress
100%
80%
60%
40%
20%
0%
ADVERSE
POOR
MARGINAL
FAIR
GOOD
OPTIMAL
2%
4%
11%
7%
11%
31%
50%
40%
23%
18%
2%
0%
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
DC Children's Review
May 2012, n=89
Three Highest Performing CSAs, n=44
Less Consistent CSAs, n=45
IMPROVEMENT
REFINEMENT
MAINTENANCE
UNACCEPTABLE
ACCEPTABLE


Practice Performance
Planning Treatment
Child & family engagement
95%
62%
Culturally approp. practice
88%
80%
n=8
n=5
Service team formation
86%
51%
Service team functioning
57%
29%
Functional assessment
57%
36%
Long-term guiding view
52%
40%
Individual resiliency plan
66%
31%
Goodness-of-service fit
73%
38%
0%
20%
40%
60%
80%
100%
DC Children's Review
May 2012, n=89
Three Highest Performing CSAs, n=44
Less Consistent CSAs, n=45


Practice Performance
Providing and Managing Treatment
Resource availability: unique/flex.
100%
83%
Resource availability: unit/placement
89%
78%
n=38
n=37
Treatment implementation
82%
49%
Emergent/urgent response
71%
53%
n=21
n=19
Medication management
79%
57%
n=24
n=23
Special procedures
75%
n=4
n=0
Family support
86%
50%
n=36
n=36
Service coordination & continuity
82%
47%
Tracking & adjustments
66%
36%
OVERALL Performance
84%
47%
0%
20%
40%
60%
80%
100%
Three Highest Performing CSAs, n=44
Less Consistent CSAs, n=45
DC Children's Review
May 2012, n=89



Case Review Outcome Categories

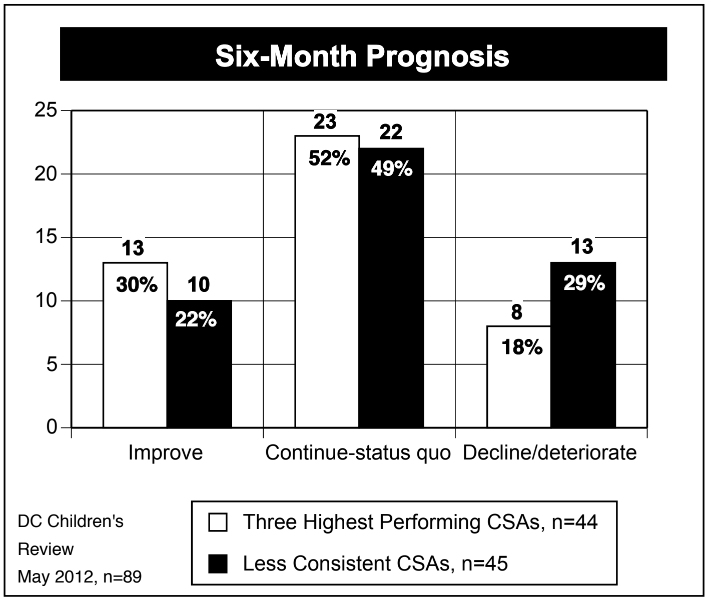
Three Highest Performing CSAs Compared to the Less Consistent CSAs

Status of Child/Family in Individual Cases

Acceptability of Service System Performance in Individual Cases

	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for child/family, ongoing services acceptable. **73% (32 cases) Highest Perf** **40% (18 cases) Less Consist**	**Outcome 2:** Poor status for child/family, ongoing services minimally acceptable but limited in reach or efficacy. **11% (5 cases) Highest Perf** **7% (3 cases) Less Consist**	**84% Highest Perf** **47% Less Consist**
Unacceptable System Performance	**Outcome 3:** Good status for child/family, ongoing services mixed or unacceptable. **5% (2 cases) Highest Perf** **24% (11 cases) Less Consist**	**Outcome 4:** Poor status for child/family, ongoing services unacceptable. **11% (5 cases) Highest Perf** **29% (13 cases) Less Consist**	**16% Highest Perf** **53% Less Consist**
	78% Highest Perf **64% Less Consist**	**22% Highest Perf** **36% Less Consist**	

DC Children's Review
May 2012, n=89


Six-Month Prognosis
25
20
15
10
5
0
13
30%
10
22%
23
52%
22
49%
8
18%
13
29%
Improve
Continue-status quo
Decline/deteriorate
DC Children's Review May 2012, n=89
Three Highest Performing CSAs, n=44
Less Consistent CSAs, n=45