VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

Quality Service Review

First Annual Report

November 2010 to June 2012

Conducted by:

Continuous Quality Improvement Unit
Quality Assurance & Accountability
Division of Family Services
VA Department of Social Services

Report Issued

August 2012

QSR Reviewers – Quality Service Review is conducted by trained professionals from local departments of social services and the state Department of Social services. The contributions of these professionals are significant to the success of QSR and building the internal capacity for quality in child welfare in Virginia. We express our gratitude for their contributions.

Becker, Odessa
Bernard, Champana
Bird, Paulette
Britt, Emily
Cann, Jennifer
Carter, Teresa
Christian, Tonya
Corbett, Jennifer
Cressman, Natanya
Dewer, Natasha
Eves, Deborah
Faircloth, Linda
Ferguson, Ginny
Fitzgerald, Carla
Foley, Alisa
Gordon, Tiffany
Heath-Davidson, Gail
Hinton, Debbie
Holland, Wendy
Katzman, Rita
King, Vivian Jones
Lineberg, Jaimi
Lovelace, Sylvia
Lowry, Allison
Lusk, Jackie
Neal-Townsend, Caroline
Nelson, Melissa
Parente, Em
Parker, Lynn
Polk, Laura
Powell, Beverly
Roberts, Pearl
Rutledge, Jo
Shores-Flannery, Kristen
Sills, Kimberly
Simmons, Vernon
Slappey, Sandi
Smith, Sheila
Stovall, Sandra
Tavenner, Becky
King, Vivian Jones
Vassar, Nora
Vinroot, Rebecca
White, Mary Anne
White, Tania
Williams, Rhonda
Wilson, Mary
Zarris, Betty Jo

Agencies Reviewed –the following local departments of social services participated in a Quality Service Review and the results are represented in this report.

Albemarle DSS
Alexandria DCHS
Arlington County DHS
Bristol City DSS
Clarke County DSS
Chesapeake DHS
Chesterfield/Colonial Heights DSS
Franklin City DSS
Frederick County DSS
Isle of Wight DSS
Manassas City DFS
Manassas Park DSS
Norfolk DHS
Prince William County DSS
Richmond City DSS
Roanoke City DSS
Smyth County DSS
Southampton County DSS
Suffolk DSS
Washington County DSS
Winchester DSS

Continuous Quality Improvement Unit – in the Division of Family Services is responsible for the implementation of Quality Service Review.

Dorothy Hollahan, Quality Manager
Devon Beamon, Quality Analyst
Elizabeth Bowen, Quality Analyst
Courtenay Brooks, Quality Analyst
Judy Fogleman, Quality Analyst
Lytricia Toler, Quality Analyst

Table of Contents

Part I – Executive Summary

A. Introduction

This report describes the results for the quality assurance system for child welfare cases in Virginia for the first eighteen months of operation, November 2010 through June 2012. Quality Service Reviews (QSR) is a method of assessing the quality of practice to improve outcomes for children and families in safety, permanency and well being. The Virginia Department of Social Services (VDSS), Division of Family Services has conducted eleven QSRs for twenty-one local departments of social services, with representation from each of the five VDSS regions within the state.

With the support of Casey Family Programs, two organizations assisted in the development of the QSR process in Virginia. Human Systems and Outcomes, Inc. (HSO) designed the QSR protocol through a design meeting with Virginia professionals to be Virginia specific and operationalize the Virginia Children's Services Practice Model (**Appendix A**)**.** The Practice Model principles represented in the protocol include:

- Belief that all children and youth deserve a safe environment
- Belief in family, child and youth-driven practice
- Belief that children do best when raised in families
- Belief that all children and youth need and deserve a permanent family
- Belief in partnering with other to support child and family success in a system that is family–focused, child-centered and community based.

In order to establish a well-trained reviewer pool, the Child Welfare Policy and Practice Group was involved in the training of review team members and mentor trainers. QSR utilizes local child welfare professionals as reviewers who are trained and mentored on the indicators in the QSR Protocol.

QSR OVERVIEW

The QSR is an action-oriented learning process that provides a way of recognizing what is working or not working in case practice for children and families receiving services. The protocol tool guides professional appraisal of the status of a focus child receiving services, status of the parent/caretaker, and adequacy of performance of key service system practices for the focus child and family. The protocol uses an in depth case review method and to find out how children and their families are benefiting from services received and how well locally coordinated services are working for them.

The Virginia QSR Protocol asses practice in two domains: Child and Family Status and Practice Performance. The overall well-being and functioning of the child and family is evaluated in the Child and Family Status domain. The core practice functions are appraised in the Practice Performance domain. The indicators for each domain include:

Child and Family Status

- Safety
- Stability
- Living Arrangement
- Permanency
- Physical Health
- Emotional Well-Being
- Learning & Development
- Pathway to Independence
- Parent and Caretaker Functioning

Practice Performance

- Engagement and Voice & Choice
- Teaming
- Cultural Awareness & Responsiveness
- Assessment & Understanding
- Long-Term View for Safe Case Closure
- Planning for Safe Case Closure
- Planning Transitions & Life Adjustments
- Resource Availability
- Intervention Adequacy
- Maintaining Quality Connections
- Tracking & Adjustment

Methodology

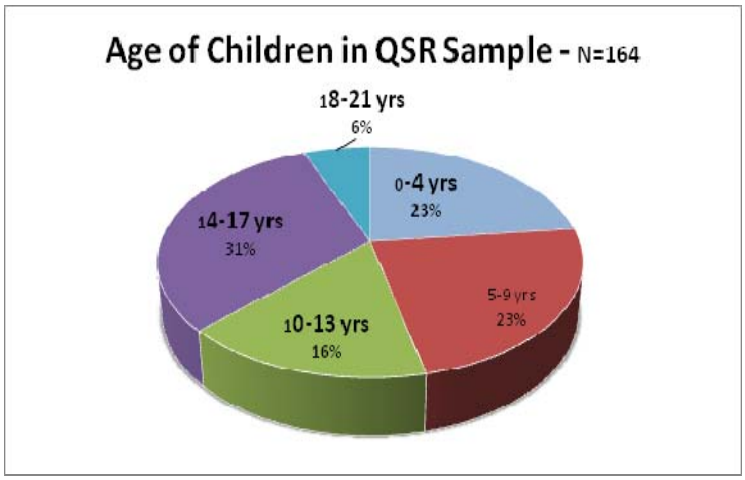
Each review involves the selection of a random sample of cases from Child Protective Services ongoing and Permanency cases in a local department of social services. These cases are reviewed through detailed interviews by trained reviewers with input from key case contributors. The interviewees for each case may include the case worker, foster parent, focus child and his/her family members, attorneys, therapeutic supports, school personnel, service providers and other persons associated with helping the family.

Specifically, each case review is conducted by two person review teams of Virginia professionals who have a working knowledge of Virginia's Children Services Practice Model and the QSR protocol. Reviewers have two days of classroom training on the protocol and then training continues through mentoring and coaching during an actual QSR. In this sample of 164 cases there were a total of 1,207 interviews conducted. The average number of interviews per case was 7.5 interviews and a range of 3 to 13 interviews per case across the sample.

Characteristics of Children in this Report

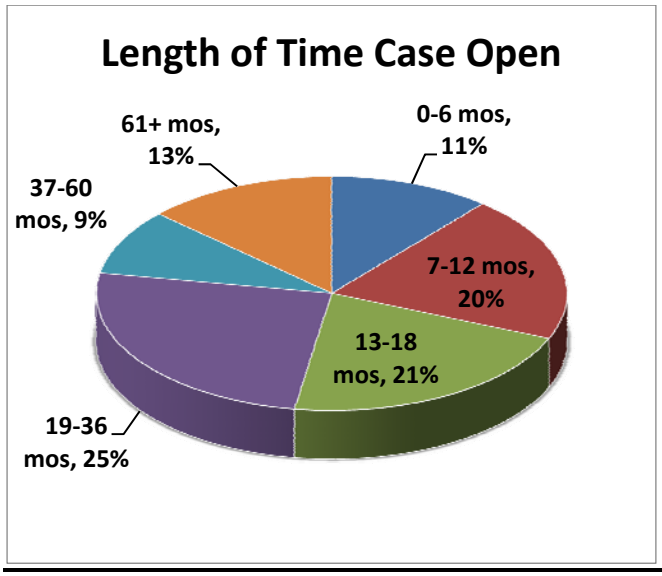
Sample cases for a QSR are selected randomly from CPS ongoing and Permanency cases using five categories for age. Additional sampling methodology includes a variance of permanency goals and insuring that a caseworker has only one case in the sample. This report covers a random sample of 164 cases. Characteristics of this sample include:

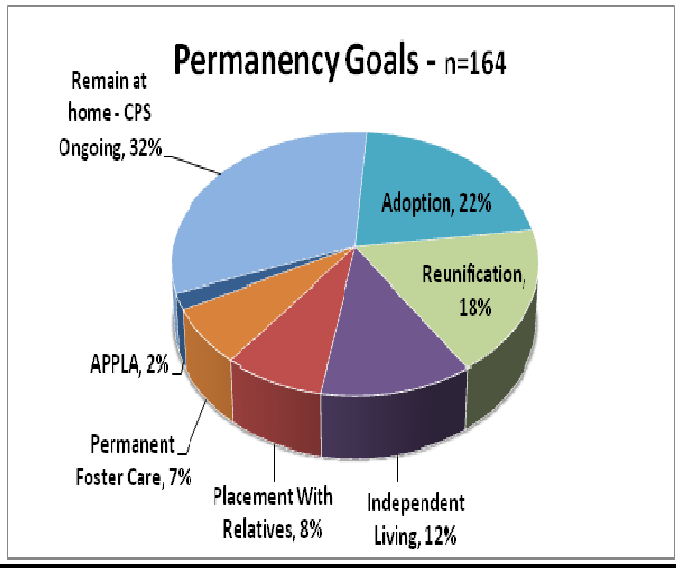
- 46 cases (28%) CPS ongoing cases and 119 cases (72%) were children in foster care or adoptive placements.
- 52% were male and 48% were female
- 39% White/Caucasian and 52% were Black/ African American, 7% Biracial, 2% Asian and 1% American Indian/Alaskan Native



Current Placement Types

Type of Current Placement	Number of cases	Percent
Birth Home	**46**	**28%**
Foster family home – non-relative	**44**	**27%**
Treatment foster home	**20**	**12%**
Kinship care home	**15**	**9%**
Adoptive Home	**13**	**8%**
Group home/Congregate care	**9**	**5%**
Residential care/treatment center	**7**	**4%**
Foster family home – relative	**5**	**3%**
On own-Independent living	**3**	**2%**
Detention	**2**	**1%**
Total	**164**	**100%**





Reason for Case Opening

As part of the case review, information was collected on the reason the case was opened for the focus child and family issues in the case when opened. The chart below represents the frequencies of the multiple issues identified for the various cases in the sample. Some cases had multiple reasons selected, thus the total numbers are larger than the total sample.

Reason for case opening – Focus Child	Number of cases
Neglect	95
Physical Abuse	37
Sexual Abuse	19
Physical or Mental Health Issues	18
Delinquency/CHINS/Truancy	17
Abandonment	14
Voluntary Custody/Entrustment	13
Drug Exposed Newborn	4
Medically Fragile	3
Substance abuse	3
Adoption Disruption	2

Reason for case opening – Family Issues	Number of cases
Neglect	69
Substance Abuse	68
Mental Health Issues	52
Housing/financial Issues	44
Domestic Violence	38
Failure to Protect	25
Incarceration of Parents	24
Court Imposed Services	16
Physical Health Issues	11

Agencies Involved

Information was collected on the number of agencies involved with the children and families reviewed. The chart below lists the agencies and community partners and the percent of cases in the sample that they were involved with the family. Multiple agencies were often involved with the family thus totals do not equal 100%.

Agencies Involved with Children & Families	Percent
CASA	69%
Mental Health	55%
Special Ed	38%
*Other	31%
Substance Abuse	19%
Juvenile Justice	10%
Residential Treatment	8%
State Court	8%
Adult Probation/Parole	7%
Developmental Disabilities	4%
Vocational Rehabilitation	2%

**Other includes: in-home services, therapeutic foster care services, mentoring, parent education services, victim witness, early intervention, and private providers.*

B. Overview of Results

The twenty indicators assessed using the QSR protocol are organized here as to the areas in which there is strong practice and areas in which there are opportunities to improve practice statewide.

Definitions and details on each of the QSR protocol indicators listed below can be found in the Detailed Results section of this report beginning on page 14 of this report

Areas of Strength – Child and Family Status Indicators

- Safety – Exposure to Threats of Harm
- Safety – Risk to Self/Other
- Living Arrangement
- Physical Health
- Learning/Academic Status.

Areas of Strength – Practice Performance Indicators

- Cultural Awareness and Responsiveness
- Resource Availability

Opportunities for Growth – Child and Family Status Indicators

- Stability
- Permanency
- Emotional Well-Being
- Pathway to Independence
- Parent and Caretaker Functioning

Opportunities for Growth – Practice Performance Indicators

- Engagement
- Voice and Choice.
- Teaming – Formation and Functioning
- Assessment and Understanding
- Long Term View
- Planning For Safe Case Closure
- Transitions and Life Adjustments
- Intervention Adequacy
- Maintaining Quality Connections
- Tracking and Adjustment

.

C. QSR Results – Implications for Practice

This report identifies strengths in practice and three identified themes as opportunities for improved practice, Engagement, teaming, and assessment and understanding indicators were found to be recurrent across the state and these issues offer significant implications for practice.

➢ Engagement

The Virginia Children's Services Practice Model is the foundation of the work we do and the QSR operationalizes this model. The Practice Model states Virginia shall be family focused with the belief in family, child, and youth driven practice. The QSR indicators for engagement and voice and choice measure the level of trust based relationships being built by the local department with families, and the families' engagement in service and case planning, as well as whether or not they have a voice and choice in decisions. These elements of engagement epitomize the family focus of the Practice Model. Results indicate casework practice is strong for engaging children and substitute caretakers but there is an opportunity to improve practice on engagement for mothers and

fathers. The lack of engagement with parents can negatively impact client progress and successes. When families are engaged for planning and service delivery, child and family status outcomes can be improved and cases can move closer to permanency.

- **Teaming**

Teaming, both formation and functioning, is about the identified child, family, family supports, and service providers meeting on a regular basis and sharing common goals of permanency and working towards accomplishing those goals. With quality teamwork and good communication among the team members occurring, a clear, long term view for the child is formed and thus the planning for safe case closure and permanency is better, faster, and more successful.

Results indicate that while some cases had Family Partnership Meetings, there is an overall lack of ongoing teaming in case practice. Results showed service providers in some cases holding different information and working toward conflicting goals. When teaming with the appropriate team members occurs on a regular basis, this can be avoided. With the practice of strong engagement of all parties, teaming is successful.

- **Assessment & Understanding**

The QSR evaluates whether or not there is adequate assessment of the child and family needs and whether everyone on the team understands what needs to occur to respond to the assessments. Results indicate that while resources appear to be available, children and families are not being linked with the appropriate services due to lack of or inadequate assessment of needs. When comprehensive quality assessments occur, the appropriate services can be identified and the ongoing work of the team can monitor, track and adjust services to fit the needs of the child and family.

- **Strengthening Families- Mothers and Fathers**

With opportunities present in relation to performance indicators for parents, a linkage is made to the strengthening families initiative of VDSS. Results indicate that in some cases parents have not consistently been engaged and included in case planning and they report feeling as though they do not have a voice in decisions made for their children and families. It is of interest to note that fathers are noticeably absent or on the periphery of the cases reviewed and are not fully engaged. Mothers and fathers are often not fully assessed for their issues and needs and thus limited or inadequate services are provided to support them for improved outcomes for children and permanency. The results of these reviews also revealed that maintaining connections for children in foster care with their parents, siblings and extended families is also an opportunity for improvement.

These results reveal the significant opportunity for identification, engagement, and inclusion of mothers and fathers in case practice. Doing so will align with the efforts of VDSS to strengthen families and improve outcomes for children.

- **Summary**

These three indicators and additional focus on mothers and fathers will impact outcomes for children and families. By enhancing core practices in areas of engagement, teaming, and assessment and understanding overall, other areas such as permanency, long-term view, and planning for safe case closure can be impacted. These issues above are the significant opportunities identified through the QSR in this review period. The next step in the QSR is the System Improvement Plan and many local agencies are addressing these issues in that next step.

D. Next Steps after a Quality Service Review

System Improvement Plan – Local Department Action

- **System Improvement Plan Process**

A System Improvement Plan (SIP) is the next step after a QSR and is comprised of a series of action plans to improve practice and outcomes for children and families. There is a dual purpose of the local department SIP: 1) to outline how the LDSS will adjust their services/practice in response to the QSR results in order to improve their outcomes as reported in Critical Outcomes Report and Safe Measures, and 2) to serve as a mechanism for VDSS to report on progress made on both local and state levels to improve outcomes for children and families as outlined in VA's federal Program Improvement Plan in response to VA's 2009 CFSR.

Initial QSR results are shared with the caseworker and supervisor of each case reviewed and then overall results are shared with the locality at the end of the QSR week. After the receipt of the final written report, a Next Steps Meeting with the LDSS and Regional Consultants is facilitated by Continuous Quality Improvement (CQI) state staff.

The purpose of the Next Steps meeting is to discuss the results of the QSR, the analysis by the local department, and to identify priorities for practice change and improvement that will impact outcomes for children and families. Some of these areas may include regulatory and policy compliance, casework processes, supervisory processes, case management, gaps in performance measures, training competencies, best practices and resource needs. The outcome of the meeting is two-fold. First, the prioritization and identification of one to three issues that the LDSS can commit to work on that will improve processes and outcomes. Second, the identification of steps towards solutions and the development of specific action plans.

After the Next Steps Meeting the LDSS completes a SIP which is forwarded to Regional Consultants and CQI staff. The LDSS reports on the status of the implementation and achievements in their SIP quarterly to the CQI Unit. On-going monitoring of the SIP is part of the ongoing technical assistant provided by Regional Consultants.

- **System Improvement Plan Status**

At the time of this report, ten SIPs have been submitted; seven of these are posted on SPARK, the VDSS website. In response to the trends identified in the practice performance indicators in the QSRs, the majority of the SIPs are addressing teaming and engagement. These plans contain action steps around policy, training, and the creation of tools. Assessment and Understanding is also an area being addressed in some SIPs, specifically surrounding comprehensive family assessments and the tracking and monitoring of services stemming from those assessments.

Many of the SIPs have identified certain Critical Outcome measures to monitor for impact as a result of the plans. Some of these measures include: increase% of discharge to permanency, decrease % of children in foster care for 24+ months, increase % of kinship placements, decrease % of youth in congregate care placements, and decrease % of youth entering foster care. Each locality is to submit quarterly progress reports in order to monitor improvement in practice and outcomes. A summary of issues identified and proposed action steps are as in the table below.

System Improvement Plan Contents	
Identified Issue	**Identified Action Steps**
Enhance Family Engagement	• Educate community (private providers, schools, etc.) on family engagement • Train staff & community on engaging fathers • Develop fatherhood engagement initiative • Create workgroup for fatherhood engagement workgroup • Identify and utilize Genogram software • Utilize ACCURINT/Family finding tools • Create/distribute parent involvement handbook when child enters foster care • Create/refine internal policy & procedures on engagement
Increase Team Formation & Function through increased understanding & effectiveness of team meetings	• Refine/update treatment team meeting policy & procedures • Create Family Team Meeting unit – conduct Family Partnership Meetings, Family Group Conferences & Family Finding • Hold team meetings every 90 days • Create system for documenting assessments & meetings • Create team meeting and member tracking tool • Educate community (private providers, schools, courts, etc.) on family engagement and in particular Family Partnership Meetings and best practice • Training for staff on conducting effective team meetings • Implement Family Partnership Meetings • Utilize Family Partnership Meeting debrief sessions • Hold monthly case staffing between CPS/FC staff
Assessment & Understanding	• Develop/implement protocol on assessment & ongoing monitoring • Create family assessment tool • Conduct comprehensive family assessment (train staff to do so)

Feedback Loop – VDSS Action

- **Feedback Protocol for System Improvement Plans**

The response to Quality Service Review for improved practice occurs on multiple levels: the individual caseworker, the local department through the development of System Improvement Plans and then on a state level through the Division of Family Services (DFS) and VDSS Local Programs Training Unit. This model is provided to standardize the feedback and analysis in the support of the SIP after a QSR. The basic model of process improvement includes five steps, Define, Measure, Analyze, Improve and Control. This model will be used to identify implications for policy, training and practice improvement in the child welfare system in Virginia to improve outcomes for children and families.

Key players in this process include the Quality Manager and Quality Analysts of the Continuous Quality Improvement (CQI) Unit who manage the QSR and the SIP developed by a local department of social services. These positions identify emerging issues on a local level.

The Quality Manager will on a six month basis develop a report of identified emerging issues related to policy, practice and training to be presented and discussed with the following stakeholders as appropriate.

- Division of Family Services Leadership Team
- Division of Family Services Training Manager in Local Programs Training
- Program Managers for Permanency, Child Protective Services, Prevention and Family Engagement

Program areas as appropriate will initiate training for practice change. The CQI Unit will report annually on the issues identified and any practice changes that various program areas have initiated to improve outcomes for children and families. Two examples of steps taken by VDSS include first, a revised curriculum on improved practice on family engagement for new local department of social services workers. Secondly a model is being created for the development of child and family team meetings creating a linkage between the current initiative of family partnership meetings and ongoing teaming as defined in the QSR teaming indicator.

➢ Training Initiative on Engagement of Families

Division of Family Services, in collaboration with Local Programs Family Services Training Unit, is addressing the opportunities for improvement identified in engagement and the implications for practice. In order to support this opportunity for improved practice, DFS offered a three day pilot training "Engaging Families and Building Trust-Based Relationships" for child welfare supervisors and senior workers on December 6, 7 and 8, 2011 at two training sites. Participation was targeted at supervisors, senior workers and curriculum developers and forty professionals attended the training. This training was offered through the support of Casey Family Programs and conducted by the nationally recognized Child Welfare Policy and Practice Group of Alabama. The Division of Family Services has used the content of the curriculum to make major revisions to CWS4020, *Introduction to Virginia's Family Partnership Meeting*, now called **Engaging Families and Building Trust-Based Relationships** which will be piloted in October of 2012 and available for state wide dissemination after that with the course included on the list of mandated courses for new staff. Some training topics include:

- Explore characteristics of family culture and information in policies and practices that support the engagement process with families.
- Practice specific engagement and trust building skills of exploring, focusing, and guiding
- Learn and practice solution-focused questions to surface family member's strengths, needs, culture, and solution patterns.
- Identify ways to formulate, evaluate and refine options with families.
- Learn to define and identify essential underlying needs that are often a description of the underlying conditions.
- Learn how to develop a working agreement with families and to utilize this agreement, core conditions and core helping skills to build a trusting relationship with families.

➢ Teaming Initiative – A Continuum of Practice

Program Managers in the Division of Family Services have collaborated to address the opportunities for teaming, building on the strengths already in place through the establishment of the Family Partnership Meetings (FPM). FPMs are one practice strategy for ensuring that family engagement, voice and choice and teaming are part of the agency's day to day case work practice in support of the Practice Model. However, FPMs are only one strategy and generally occur infrequently over the course of a case and, therefore, are not sufficient in and of themselves to ensure systems change. Teaming for the QSR indicators is about ongoing communication and meeting of family and service providers sharing a commonality of purpose in the delivery of services and planning for the child and family.

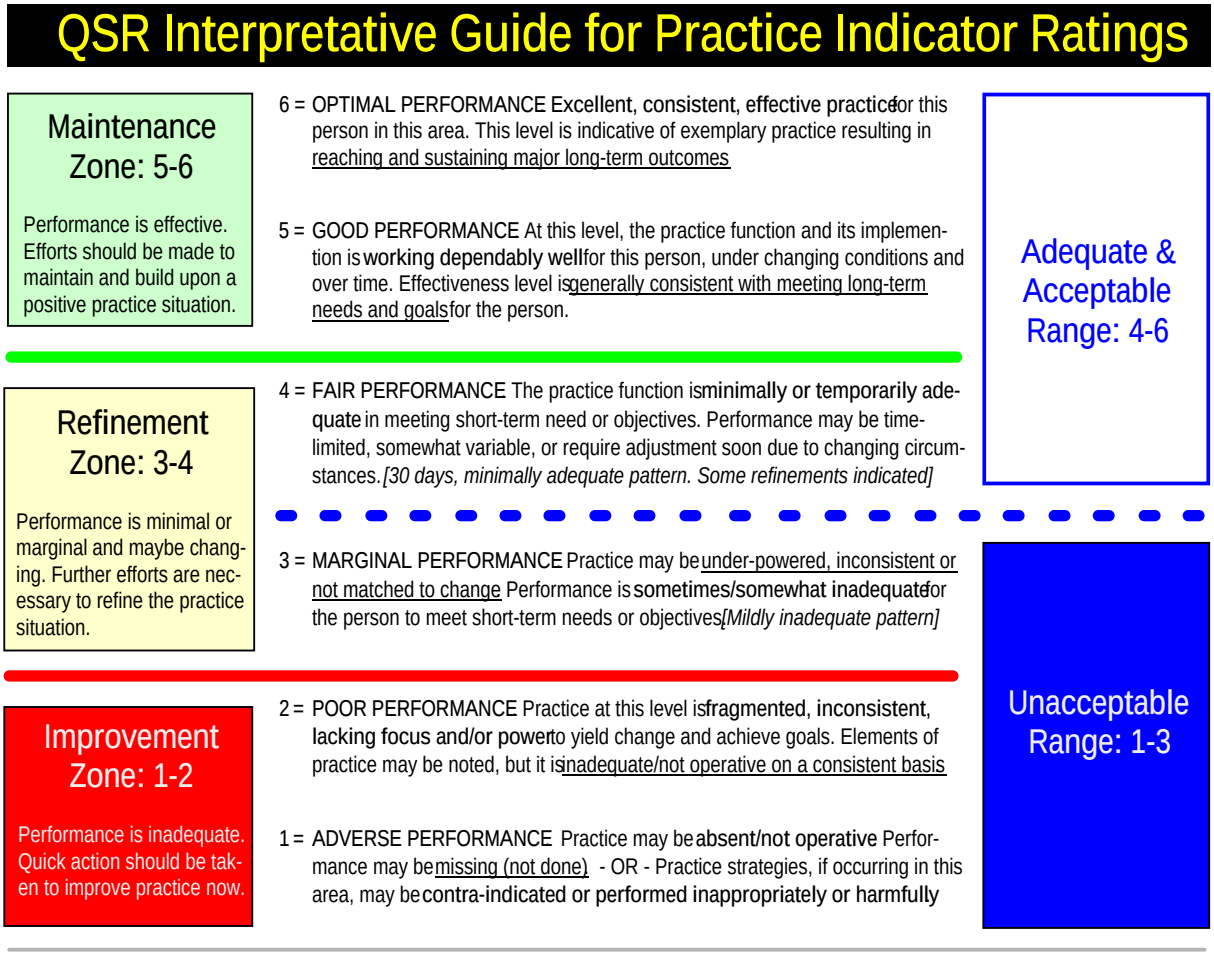
VDSS is proposing the use of regular Child and Family Team meetings as a continuation of the work of FPMs. This meeting would include the youth, parents, extended family and all service providers. It would provide a mechanism by which regular review of services and progress would be shared among all the individuals involved in the case and where the family's needs and preferences could routinely inform decision making. Tools are being created to assist supervisors in local agencies in order to clarify the purpose of both types of team meetings as well as when each is appropriate and how to implement and facilitate all meetings. This information is to be distributed in the fall of 2012 with a tool kit to support this model of child and family team meetings. Resources and tool kit will be developed and available on the agency SPARK page to support this practice improvement. Details of the comparisons of Family Partnership Meetings and Child and Family Team Meetings can be found in ***Appendix B.***

Part II – Detailed Results

Rating Scales

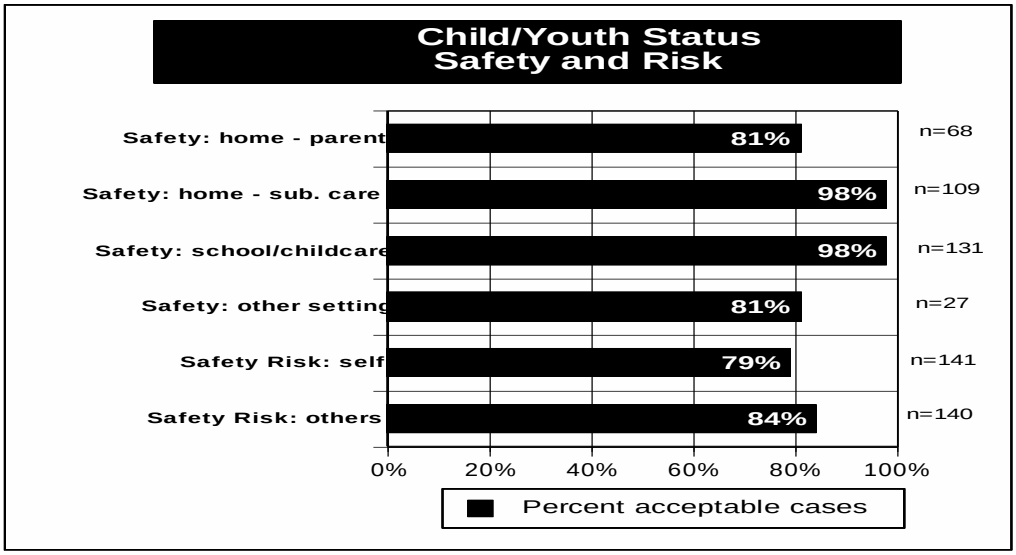
Each Child and Family Status indicator and Practice Performance indicator is scored using the 6 point scale listed below. This chart and scoring is used in two ways to report the results of a QSR. First, on the left of the chart are three zones for action and improvement. Each case is scored using the 1 to 6 scale. The maintenance zone for scores of 5 and 6 indicates that practice is where it should be for the indicator and efforts should be maintained. The refinement zone for scores of 3 and 4 indicates that practice has strengths and also opportunities for improvement. The improvement zone for scores of 1 and 2 indicates that practice is inadequate and concerted action should be taken to improve practice for the child and family.

Secondly, on the right of the chart is an overall rating of acceptable which includes scores of 4, 5, and 6 and unacceptable range with scores of 1, 2, and 3. This report presents the findings in the zones presented in the two categories from the right side of this chart, acceptable range of scores and often identified as strengths are between 4 and 6 and unacceptable often described as an opportunity for improvement are in the range of scores between 1 and 3.



A. Detailed Results – Child and Family Status Indicators

This group of indicators measures the extent to which certain desired conditions are present in the life of the child and child's parents and/or substitute caretakers. Status indicators measure constructs related to well-being (i.e. safety, stability and health) and functioning (i.e. the child's academic status and the caretaker's functioning). The bold font provides the indicator and definition.



Safety

1.a. Exposure to Threats of Harm: the degree to which the child is free from abuse, neglect, and exploitation by others in his/her place of residence, school and other daily settings. The child's parents and/or caretakers provided the attention, actions, and supports necessary to protect the child from known threats of harm in the home.

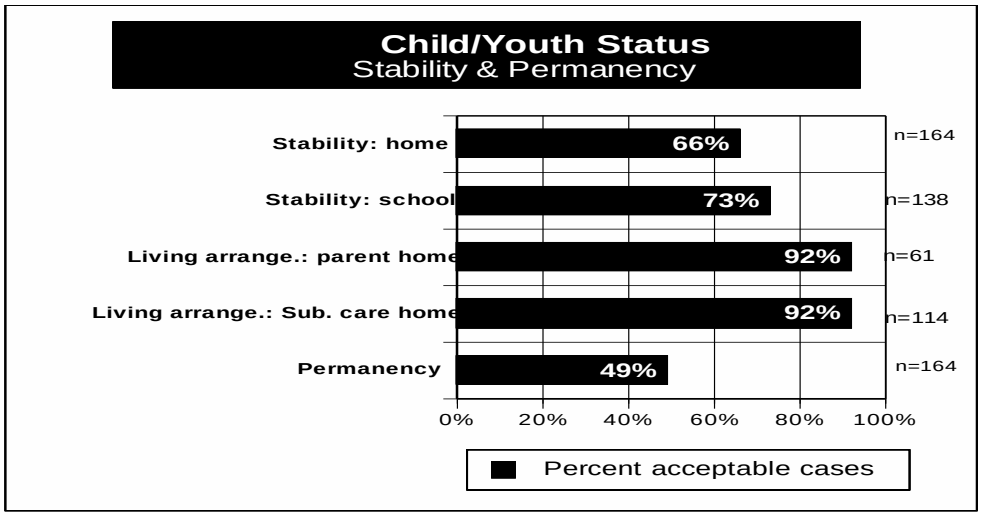
Results indicate that, overall, children are safe in their homes (81% home, 98% substitute home), community (81%), and schools (98%). Common patterns found for cases that scored in the acceptable zone during QSRs include: children have proper supervision by parents, caretakers, and school personnel. Safety measures, including safety plans, are in place as necessary; and parents and caretakers have protective abilities and appropriate skills to ensure safety.

The characteristics of cases with opportunities for improvement include: parental substance abuse, inadequate parenting skills of biological parents, poor sanitary conditions of the home, and lack of protection from threats of harm during unsupervised visits with biological parents and relatives.

1.b. Risk to Self/Others: The degree to which the child is avoiding self endangerment and or refraining from using behaviors that may put others at risk of harm?

In cases reviewed for risk to self, 79% are identified as strengths within the acceptable zone. These cases illustrate traits such as children with the ability to manage their emotions and reducing anger outbursts, and significant decrease in self-harm behaviors due to increase in coping skills. For risk to others, 84% of cases reviewed are within the acceptable zone. Children in these cases demonstrated the ability to reduce and minimize anger and aggression toward others.

Some patterns present in cases with opportunities included children with substance abuse issues, runaway behaviors and impulsive behaviors by the child, including physical aggression to others. Some children who have various disabilities display risky behaviors and were often unable to understand the risk of these behaviors to themselves or others.



2. Stability: the degree to which the child's daily living, learning, and work arrangements are stable and free from risk of disruption. The child's daily settings, routines, and relationships are consistent over recent times. Known risks are being managed to achieve stability and reduce the probability of future disruptions.

For stability in a child's home 66% were rated as a strength and for stability in schools and 73% of the cases were rated as a strength. Common patterns identified for these cases included: children with no changes in school or placement within the past 12 months; no future moves anticipated; school location has been maintained even with placement changes; and cases with the most recent moves as appropriate, planned step-down.

Themes present for cases in which there are opportunities regarding stability include, multiple home and school placements within past 12 months, and disruption of home and/or school anticipated within next 6 months. In the total sample of cases 26% of children had no placement changes in the past 12 months, 59% had 1-2 placement changes, and 13% had 3 or more placement changes.

3. **Living Arrangement: the degree to which the child, consistent with age and ability, is living in the most appropriate/least restrictive living arrangement, consistent with needs of the child for family relationships, assistance with any special needs, social connections, education, and positive peer group affiliation. If the child is in temporary out-of-home care, the living arrangement meets the child's needs to be connected to his/her language and culture, community, faith, extended family, tribe, social activities, and peer group.**

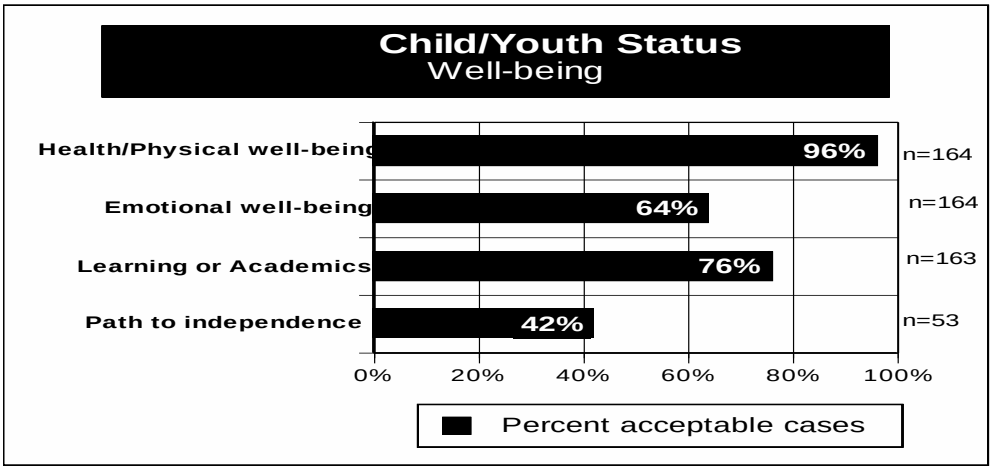
For cases rated for living arrangement for the child in their home, 92% were strengths and in substitute homes 92% were also rated as strengths. Examples of practice include; a child placement in the least restrictive setting that is consistent with their culture and provides for basic and special needs; children who are placed within their community, within their own neighborhood, and/or with siblings; and children who are placed with relatives and foster parents who are willing to facilitated visits with the child's family.

4. Permanency: the degree to which the confidence level of those involved (child, parents, caretakers, others) that the child is living with parents or caretakers who will sustain in this role until the child reaches adulthood and will continue onward to provide enduring family connections and supports in adulthood.

Some patterns of strength shown for permanency (49%) consist of events such as: children residing in their birth home; legal permanence has been achieved, i.e. adoption and relative custody; foster care is avoided due to relative placement; and all team members are working to achieve permanence for children.

The permanency indicator is impacted by where in the life of the case the review is conducted. Common patterns identified for cases where concerted action is needed regarding permanency at the time of review include: no final plan for permanent home has been identified; there is no progress with current permanency plan and there is no concurrent plan in place; permanency plans are unclear; and current permanency goal is not appropriate or

realistic. Permanency can be impacted by engagement, voice and choice, and teaming; enhancements in these areas will help establish permanency goals and move the case forward.



5. Physical Health: The degree to which the child is achieving and maintaining positive health status. If the child has a serious or chronic physical illness, the child is achieving his/her best attainable health status, given the disease diagnosis and prognosis.

Attention to physical health and medical needs of children is a strength in practice with 96% of cases scoring as a strength. Some characteristics in these cases include: children with current physical and dental exams and immunizations up to date; the child's growth and weight appear within age appropriate expectations; and in some cases complicated medical needs of the child are being monitored and child is in good health status considering chronic conditions.

6. Emotional Well-Being: The degree to which consistent with age and ability, the child is displaying an adequate pattern of attachment and positive social relationships, coping and adapting skills, and appropriate self-management of emotions and behaviors.

Results of cases for emotional well-being indicate that 64% of cases scored as strengths and exhibit the following characteristics: children who have been able to take lessons learned from therapy and apply them to their family and daily lives. Children have been stable for a period of time with emotions and behaviors and are developing good attachments; and children have gained appropriate coping skills.

Examples of cases that scored as opportunities include: children who become confused, disassociated and disoriented when faced with stressful situations; children who struggle with attachment, have poor social skills; and children with intense behaviors due to poor coping skills.

7. Learning & Development: The age of the child determines if this indicator is scored as "Early Learner", under the age of 5, or as "Academic Status", age 5 and older. The early learning indicator measures the degree to which the child's developmental status is commensurate with age and developmental capacities by assessing whether the child's developmental status in key domains is consistent with age- and ability- appropriate expectations.

The academic status indicator assesses the degree to which the child (according to age and ability) is regularly attending school; placed in a grade level consistent with age or developmental level; actively engaged in instructional activities; reading at grade level or IEP expectation level; and meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent.

For Learning and Development 76% of the cases scored as a strength. For children five years and under this indicator references speech, language, motor skills, and developmental milestones children appear to be on target developmentally. For academic status, strength characteristics include: children placed in appropriate school setting, receiving positive school reports and meeting requirements for promotion; the child has an

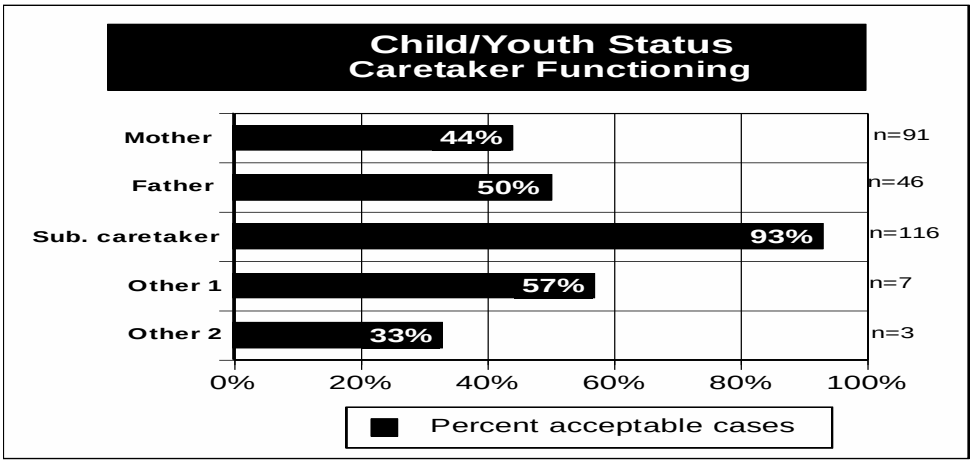
Individualized Educational Plan in place and is meeting all expectations; and the child attends school regularly with no unexcused absences.

Common patterns of opportunities found in cases include: the need for accommodations for academic delays has not been addressed;; children who are not attending school regularly and are not engaged in learning; children are not on grade level and are not meeting expectations of educational program; and children that have significant developmental delays and are not receiving services to address such delays.

8. Pathways to Independence (14 or older and in foster care): The degree to which, according to age and ability, the youth is gaining skills, education, work experience, connections, relationships, income, housing, and necessary capacities for living safely and functioning successfully independent of agency services. It also assesses whether the youth is developing long-term connections and informal supports that will support him/her into adulthood.

For children 14 and older in the sample 42% of the cases scored as a strength. Examples of practice for pathways to independence include: children who are learning good daily living skills such as household chores, budgeting, social skills, and obtaining employment; children who have developed long term relationships in the community; and Independent Living programs that are offered that children enjoy and benefit from.

For cases where concerted action is needed, case practice shows that transitional living plans are not completed and the youth has not had the opportunity to develop independent living skills that would ensure a successful transition into adulthood. Additionally, supports in the community have not been fully identified for the youth and the youth has been making limited or inconsistent progress in IL skills. Of the full sample, 32% of the children are applicable for the independent living indicator. Improved practice is needed for youth age 14 years old and older in foster care.



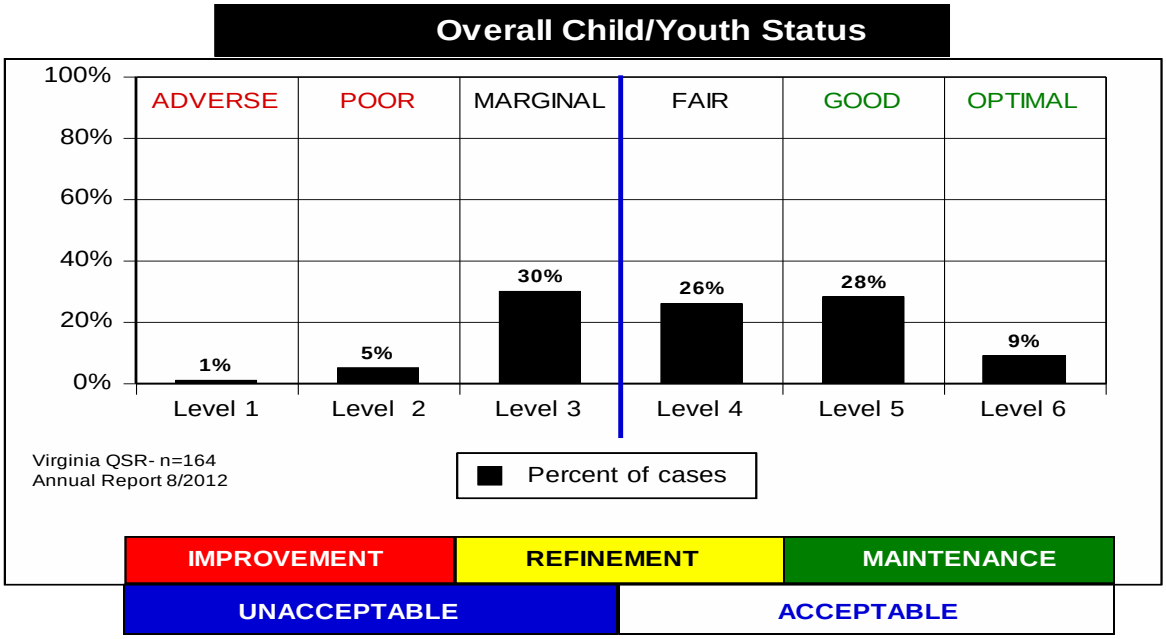
9. Parent & Caretaker Functioning: The degree to which the parent or caretaker with whom the child is currently residing and/or has a goal of permanency is/are willing and able to provide the child with the assistance, protection, supervision, and support necessary for daily living. If added supports are required in the home to meet the needs of the child and assist the parent or caretaker, the added supports are meeting the needs.

Results indicate that 44% of mothers, 50% of fathers, and 93% of substitute caretakers are within the acceptable zone. Some patterns found for these cases include: parents and caretakers that demonstrate adequate to excellent parenting capacities and possess knowledge and use of specialized skills to meet children's needs; parents have gained and demonstrated appropriate parenting skills; and parents and caretakers utilize formal and informal supports.

The characteristics of cases that scored as opportunities include: some parents' ability to maintain self-sufficiency is questionable because of significant issues of their own, and parents' limited knowledge/understanding of some appropriate parenting methods presents potential barrier to meeting all of children's needs. Additionally, parents and substitute caretakers utilize only formal supports or don't have informal supports in place or available to them. Neglect, substance abuse, mental health issues, housing/financial issues, and domestic violence are some big

issues facing families and affecting parenting capacities in these cases. Stronger assessment and understanding and delivery of services to address these needs can impact outcomes of parent and caretaker functioning.

Summary of Child and Family Status Indicators and Six Point Analysis



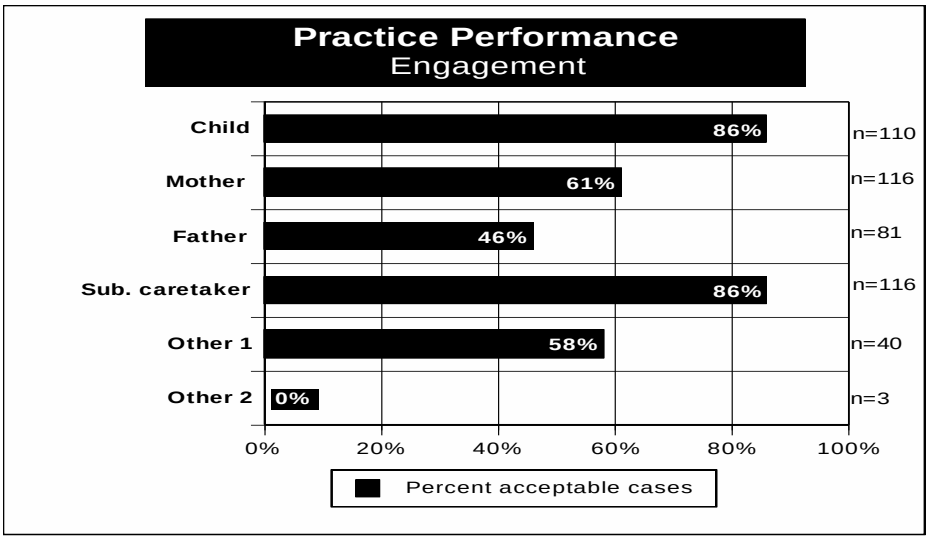
The chart above is a composite view of each of the nine indicators that make up the child and family status. This chart gives a visual of the three zones of scoring, Improvement, Refinement and Maintenance. The level ratings of 1 to 6 are used when scoring the case to determine if the case practice needs to be improved, refined, or maintained. Overall, child and family status indicators are faring well with 63% of the cases scoring in the acceptable range. Some practice refinement for those cases scoring in the level 3 would result in a significant impact to the overall Child and Family Status scores and improved outcomes for children and families.

Children are safe from abuse, neglect, and exploitation by others in their substitute homes, schools and other daily settings and they attempt to refrain from using behaviors that may put themselves or others at risk. Children are relatively stable in their home, out-of-home and school settings. The children reviewed in the sample are achieving and maintaining positive health status. The children are participating and meeting educational expectations as well as learning and utilizing independent living skills learned from the agencies independent living program.

Opportunities exist in increasing stability and enhancing emotional well being for children. Developing youth's independent living skills and abilities for functioning successfully independent of agency services would be of benefit as well. There is occasion to more fully affect parent and caretaker's functioning by assessing their underlying needs and providing appropriate supports and services. An opportunity also exists to key in on ensuring children establish permanency by identifying adults that will commit to sustaining their role until the child reach adulthood.

B. Detailed Results – Practice Performance Indicators

This group of eleven indicators measures the extent to which core practice functions are applied successfully by practitioners and others who serve as members of the child and family team. The bold font provides the indicator and definition.

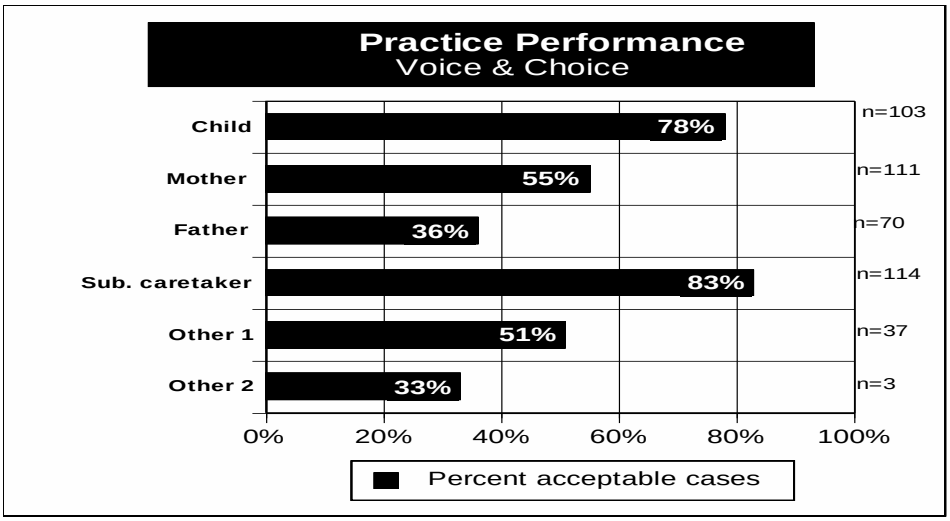


1a**. Engagement Efforts: The degree to which those working with the child and family (parents and other caretakers) are finding family members who can provide support and permanency for the child; developing and maintaining a culturally competent, mutually beneficial trust-based working relationship with the child and family; focusing on the child's and family's strengths and needs; being receptive, dynamic, and willing to make adjustments in scheduling and meeting locations to accommodate family participation in the service process, including case planning; and offering transportation and childcare supports, where necessary, to increase family participation in planning and support efforts.**

Engagement is assed for multiple individuals involved in the case. Substitute caretakers and children indicated they are the most engaged with caseworkers with 86% in the acceptable zone. Mothers (61%), fathers (46%), and others (58%), including grandparents and extended family, show they are slightly less engaged. Common patterns found for cases considered strengths during QSRs included: efforts that were made with the foster parents and parents to build a trusting relationship; parents that were fully engaged with the caseworker and service planning; extended family reported feeling involved and connected to the child's case; adjustments that were made for meeting times that met a parent's schedule; children reported feeling involved in their cases and caseworkers had one on one contact with the children.

The characteristics of cases considered opportunities include: parents, children, grandparents and foster parents that did not feel engaged in the case planning process; working relationships were not established with parents; little or no efforts to engage incarcerated parents and there was little or no contact with these parents.

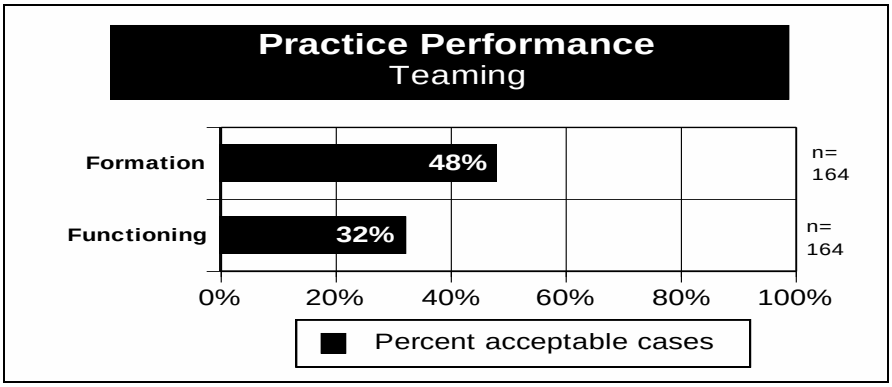
When families are engaged for planning and service delivery, child and family status outcomes can be improved and cases can move closer to permanency. Engagement is a core concept of the VA Practice Model, "We engage families in a deliberate manner" and engagement is the primary door through which we help children and families make positive changes".



1b. Voice & Choice: The degree to which the child, parents, family members, and caretakers are active ongoing participants (e.g., having a significant role, voice, choice, and influence) in shaping decisions made about child and family strengths and needs, goals, supports, and services.

Results from cases reviewed indicated that 83% of substitute caretakers, 78% of children, 55% of mothers and 36% of fathers had an active voice and choice in shaping case decisions. Others in these cases include grandparents and extended family. Common patterns of practice consist of: parents who are fully involved in the decision making process; children that feel they have a voice in planning their services; and foster parents who are able to express their opinions and needs.

Some themes present in cases that scored as opportunities include: parents that have no active voice in planning; decisions that are made without the notification or input of parents; families who report not being informed regarding case planning; and foster parents who are not heard in team meetings. Good scores for child and substitute caretakers are a result of good engagement efforts by the agency. Mothers, fathers and others (i.e. extended relatives) are not as engaged, thus their voice and choice is not as strong. By increasing interaction and communication with mothers and fathers, in other words engaging them and allowing their voice to be heard, we put the VA Practice Model into effect.



2. Teaming: The degree to which appropriate family team members have been identified and formed into a working team that shares a common "big picture" understanding and long-term view of the child and family. This indicator also assesses whether team members have sufficient craft knowledge, skills, and cultural awareness to work effectively with this child and family. Members of the family team have a pattern of working effectively together to share information, plan, provide, and evaluate services for the child and family. There is no fixed formula for team size or composition. The team should have the authority to act and ability to assemble supports and resources on behalf of the child and family. Teaming is broken into two areas: Formation and Functioning.

Team Formation:

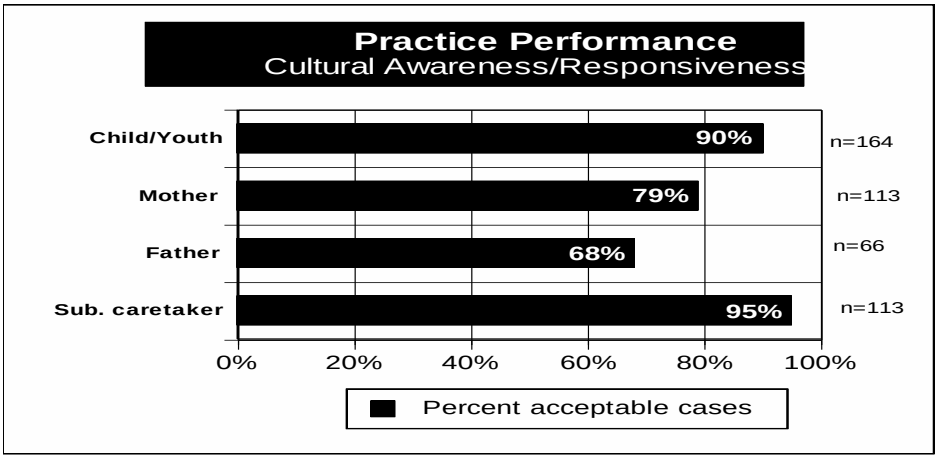
Results indicate that in 48% of the cases reviewed, team formation was found to be in the acceptable range and exhibited the following practice patterns: all team members were identified; teams included service provides in addition to family and other informal supports; parents were asked who they wanted on the team and teams were led by parents.

Some patterns present in cases that scored as opportunities include: cases where teams did not exist; teams with missing service providers and family supports who could positively impact the case; parents and foster parents that were not part of or include on the team; and teams were not organized for common goals or outcomes.

Team Functioning:
Results from cases reviewed indicate that 32% of cases were within the acceptable range regarding team functioning. Common patterns of sufficient practice include: team members who reported being kept informed; the caseworker developed a relationship with all team members; teams that met on a regular basis with consistent team members present throughout the life of the case and teams that shared and worked toward a common goal for the child and family.

Team functioning has been found to be an area for improvement across the state. For 67% of cases reviewed, it is found that concerted action is needed to move a case forward. Some themes present in cases that scored as opportunities included: cases in which teams with service providers work independently and unaware of each other's actions with the family; teams in which there was not a unified understanding of the child's long-term plan; and team members that did not have sufficient knowledge of the families.

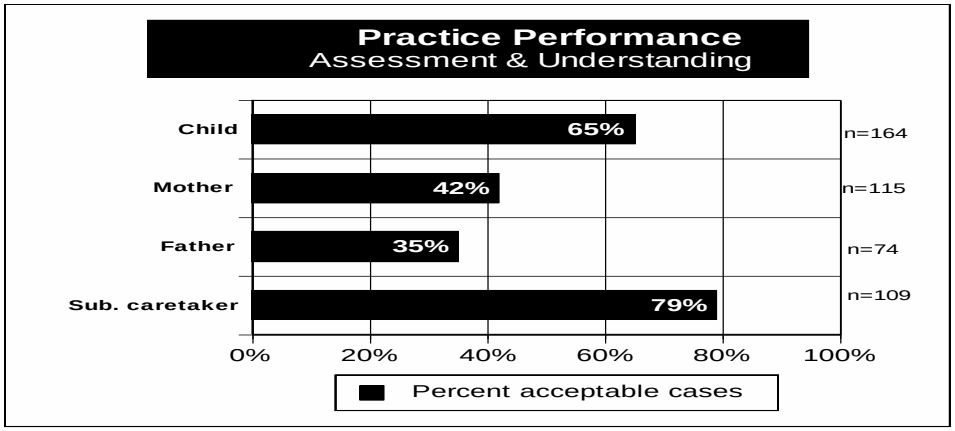
As stated in the VA Practice Model, "we are committed to working across agencies, stakeholder groups, and communities to improve outcomes for the children and families we serve". When teams are working effectively together, they are able to develop goals, strategies and interventions in support of a realistic permanency outcome for the child. By enhancing the functioning of a team, the outcomes for areas such as Long-Term View, Planning for Safe Case Closure, and Permanency will also be impacted.



3. Cultural Awareness & Responsiveness: The degree to which any significant cultural issues, family beliefs, and customs of the child and family have been identified and addressed in practice (e.g., culture or poverty, urban and rural dynamics, faith and spirituality, child culture, etc.) and, if necessary, whether the natural, cultural, or community supports appropriate for this child and family are being provided. Necessary supports and services provided are being made culturally appropriate via special accommodations in the engagement, assessment, planning, and service delivery processes being used with this child and family. This indicator is applied to all families.

Results indicate that cultural issues are addressed and are a strength for the four groups assessed: children (90%), substitute caretakers (95%), mothers (79%) and fathers (68%). Common patterns found for these cases include: children paired with therapists of the same gender and race; foster parents that encouraged and supported cultural, spiritual and biological family connections; service providers who were culturally appropriate to meet the needs of families and children and matched with families that can meet their language and cultural needs.

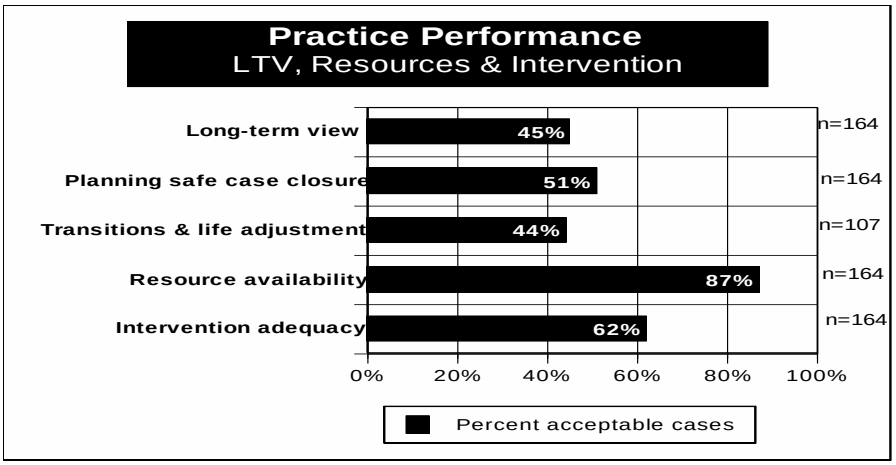
Examples of cases where opportunities exist include: foster parents who asked for and did not receive training on caring for a child of a different culture; no evidence of any attempts to address cultural issues or dynamics with children and adoptive families; children who did not have a sense of belonging in their placements and children's Native American tribes were not contacted.



4. Assessment & Understanding: The degree to which those involved with the child and family understand: (1) their strengths, needs, preferences and underlying issues; (2) what must change for the child to function effectively in daily settings and activities and for the family to support and protect the child effectively; (3) has developed an understanding of what things must change in order for the child and family to achieve timely permanence, and improve the child/family's well-being and functioning; (4) the "big picture" situation and dynamic factors impacting the child and family sufficiently to guide intervention; (5) the outcomes desired by the child and family from their involvement with the system; and (6) the path and place by which permanency will be achieved for a child who is not living nor returning to the family of origin.

Strengths for assessment and understanding include substitute caretakers (79%) and children (65%). Common patterns found for cases that scored in the acceptable range during QSRs include: comprehensive assessments that were completed on children allowing teams to identify underlying issues and prioritize services; foster parents that had a good understanding of the children for whom they were providing care; and children who had consistent therapists and services that were continually assessing needs in the delivery of services.

Assessment and understanding for mothers and fathers is an opportunity and results indicate that for 58% of mothers and 65% of fathers, concerted action is needed. The practice of these cases indicate: parents have not received any assessment for needs and service; there is limited understanding by the team of the child and/or parent's needs and appropriate services; and a lack of trauma informed assessments for some children and/or parents and delivery of trauma informed services. Stronger assessment and understanding of needs of parents will lead to better interventions and services, thus affecting caretaker functioning and ultimately impacting outcomes such as permanency.



5. Long-Term View: For the child and family the degree to which there are stated, shared and understood safety, well being, and permanency outcomes and functional life goals. These outcomes and goals specify required protective capacities, desired behavior changes, sustainable supports, and other accomplishments necessary for the child and family to achieve and sustain adequate daily functioning and greater self sufficiency necessary for safe case closure.

In 45% of cases the long- term view indicator is a strength. These cases reviewed indicate common patterns of practice including: a team that shares the same goal for the child and is working towards that goal; multiple ongoing strategies and services have been utilized to achieve the case goal; and the children were making progress towards their goals.

Some themes present in cases that scored as opportunities (55%) are: team members that have varied and different views on the long term goal for the child and family; cases where there was no defined long-term view; and cases where there is a shared understanding of the youth's ongoing needs however a strategic vision of how to meet these needs is not known and thus not developed.

6. Planning for Safe Case Closure: The degree to which the planning process is individualized and matched to the child and family's present situation, preferences, near-term needs, and long-term view for safe case closure. It provides a combination and sequence of strategies, interventions, and supports that are organized into a holistic and coherent service process providing a mix of services that fits the child's and family's evolving situation so as to maximize potential results and minimize conflicts and inconveniences.

Results from cases reviewed showed that cases within the acceptable range (51%) regarding planning for safe case closure have common patterns of practice including: all team members agree with the plan; the planning for the child was individualized and addressed the present situation and near-term needs; and the child and parents understand what is needed in order for the case to close.

Some themes present in cases that scored as opportunities are: plans that are not individualized to meet the needs of children and their families; plans that were reactionary instead of proactive and preventive; and there was a lack of planning by an organized team for a common goals for case closure.

7. Planning for Transitions & Life Adjustments: The degree to which the current or next life change transition for the child and family is being planned, staged, and implemented to assure a timely, smooth, and successful adjustment for the child and family after the change occurs. Plans and arrangements are being made to assure a successful transition and life adjustment in daily settings. There are well-planned follow-along supports provided during the adjustment period occurring after a major change is made in a child's life to ensure success in the home or school situation.

Results indicate that in 44% of cases, transitions and life adjustments are identified as a strength and planned for on a regular basis. Common patterns found for cases scored in the acceptable range during QSRs include: teams that identified transition needs and ensured plans were in place prior to the transition; when a change in caseworker occurs the current and new caseworkers meet with families prior to a change; current and new foster

parents who were included in transition planning; and children and caregivers who are prepared prior to a change in placement.

The characteristics of cases that scored as opportunities where concerted action is needed include: changes are imminent but no plans are in place to prepare the child and family; no preparation prior to children changing placements and or schools; children not being informed prior to changing placements; and families not being prepared for a child's change of goal.

8. Resource Availability: The degree to which supports, services, and resources (both informal and formal) necessary to implement change strategies are available when needed for/by the child and family. Any flexible supports and unique service arrangements (both formal and informal) necessary to meet individual needs in the child's plan are available for use by the child and family on a timely, adequate, and convenient local basis. Any unit-based and placement-based resources necessary to meet goals in the child's plans are available for sure by the child and family on a timely and adequate basis.

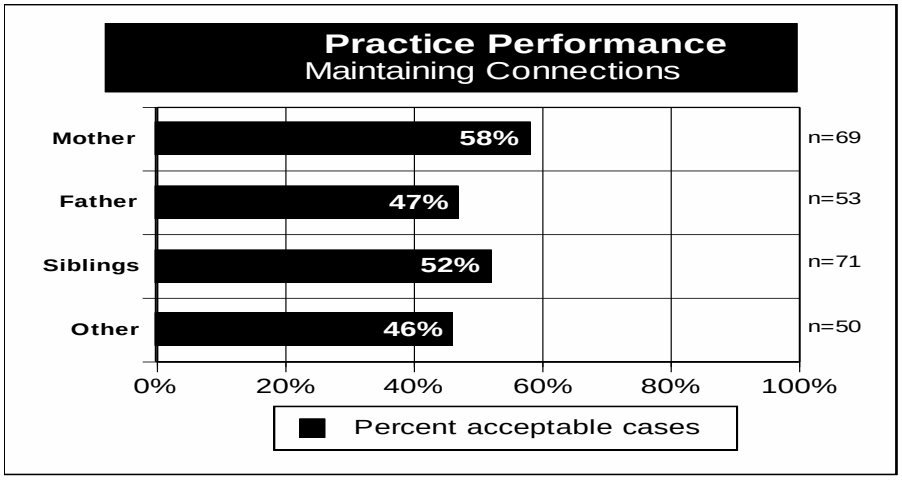
Results indicate that in the majority of cases (87%) there are sufficient resources available to meet the child's and family's needs. Common patterns found for these cases include: culturally competent resources that were available for families; providers were a good match to meet children's needs; and there were an abundance of flexible resources to meet the needs of children and families.

The characteristics of cases identified as an opportunity for improvement include: needed services are not available locally and there are limited or no culturally matched resources.

9. Intervention Adequacy: The degree to which planned and accessible intervention strategies, services, and supports being provided to the child and family have sufficient power (precision, intensity, duration, fidelity, and consistency) and beneficial effect to produce results necessary to meet near-term needs and achieve outcomes that fulfill the long-term view for safe case closure.

Cases reviewed for intervention adequacy indicate that 62% are considered a strength. Common patterns of practice include: services that are of sufficient power and duration to meet the needs of the children; the services match the needs of the children and parents; and services are moving the children towards permanency.

Review of practice in these cases that are opportunities indicates that: services are not at a sufficient level to meet the needs of the children; services are underpowered due to a lack of assessments; and services are not adequate to move the case forward towards planned goals and outcomes. These findings suggest that resources and interventions are available but not always appropriate or adequate; services are addressing symptoms and not getting to or understanding underlying needs of the children and families. Enrichment of assessment and understanding for a family will have some bearing on the outcomes for children and families once appropriate services are implemented.

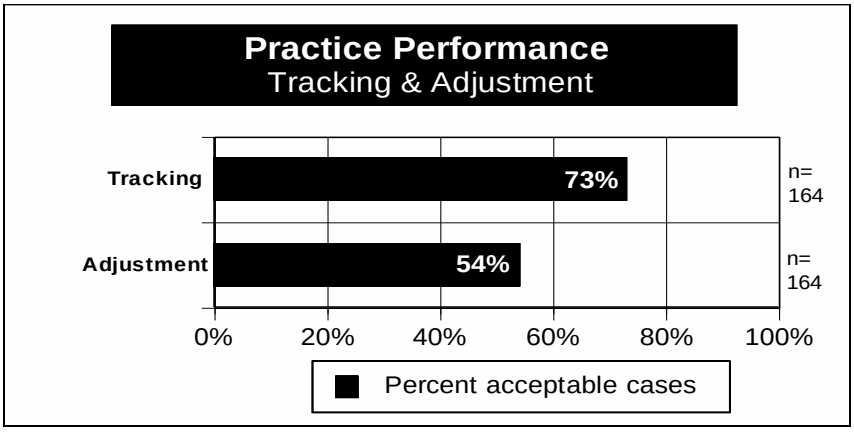


10. **Maintaining Connections: The degree to which interventions are creatively building and maintaining positive interactions and providing emotional support between the child and his/her parents,**

siblings, relatives, and other important people in the child's life, when the child and family members are temporarily away from each other.

Results indicate strengths for maintaining connections for mothers (58%), siblings (52%), fathers (47%), and others (46%) are in the acceptable range. Others include extended family including grandparents, cousins and aunts and uncles. Common patterns found for these cases during QSRs include: sibling groups placed together; regular visits between children and parents; children maintaining relationships with extended family; and children are able to stay connected through participation in religious observations, family functions, and family vacations.

Maintaining connections is an opportunity for all four groups assessed. The characteristics of cases where concerted action is needed include: siblings placed separately that have little or no contact; children who have no contact with parents; and children who do not have contact with maternal and paternal extended family.

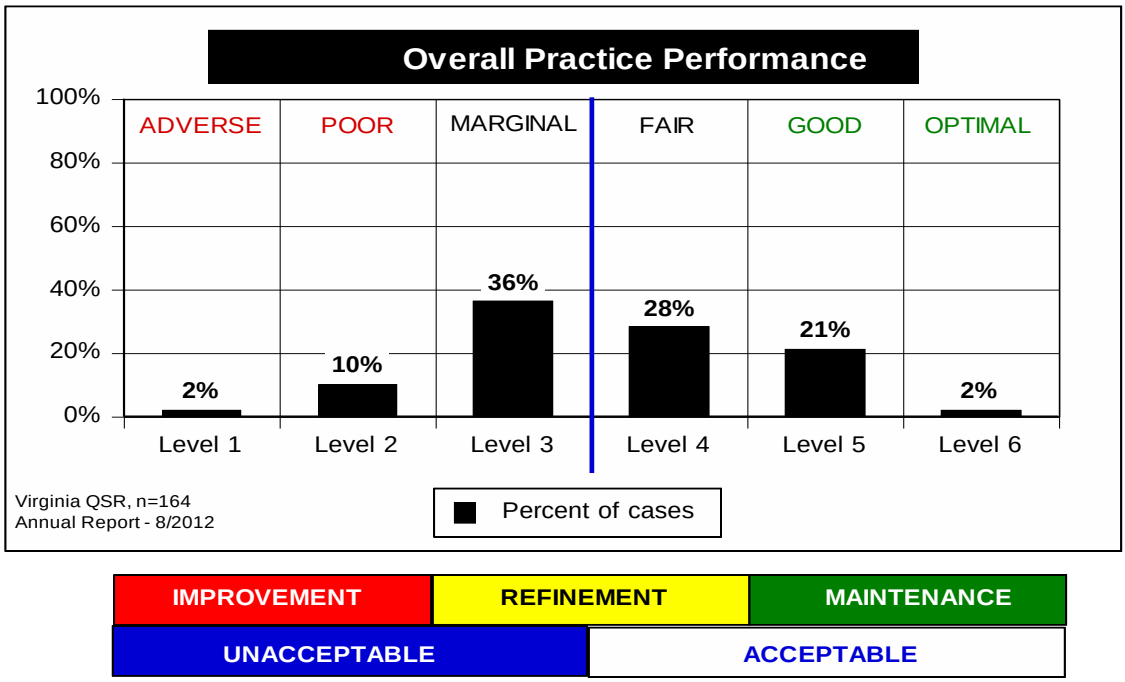


11. Tracking & Adjustment: The degree to which the team routinely monitors the child's and family's status and progress, interventions, and results and makes necessary adjustments. Strategies and services are evaluated and modified to respond to changing needs of the child and family. Constant efforts are made to gather and assess information and apply knowledge gained to update planned strategies to create a self-correcting service process that leads to finding what works for the child and family.

Results from cases reviewed show that cases within the acceptable range regarding tracking (73%) and adjustment (54%) have common patterns of practice including: services changed to meet children's needs throughout the life of their case; caseworkers demonstrate a sense of urgency in working with children; and teams are knowledgeable about changes in the children's cases.

Some themes present in cases included in the improvement zone are: case planning that did not change based on the recommendations of professional providers; services that did not begin in a timely manner; and cases that were open for several years with little progress. There is a correlation between strong teaming and tracking and adjustment. A strong team will monitor, track and adjust case progress or regression, thus affecting the application of services and ultimately impacting permanency

Summary of Practice Performance Indicators and Six Point Analysis



The chart above is a composite view on two levels of the rating of the eleven indicators that make up the practice performance. The level ratings of 1 to 6 are used when scoring the case to determine if the case practice needs to be improved, refined, or maintained. Overall, practice performance has 51% of cases within the acceptable range. With some practice reforms 36% of the cases at level 3, marginal, could move to the acceptable range to increase an overall practice performance rating of 87%

Agencies are faring well with cultural awareness and responsiveness with families served in that they are recognizing that families and caretakers have their own unique identities and have assessed their culture and have been accommodating when meeting their needs. In having the appropriate resources available for use in the immediate community, agencies and families are able to access what is needed to implement change and continue to respect cultural identities.

Opportunities exist in engagement and voice and choice, especially for fathers and mothers. There is occasion to develop teams with all appropriate members and to enhance the functioning of such teams as well. In doing so, assessment and understanding, long term view, and planning for safe case closure would be impacted which would be beneficial as these are areas of opportunity also. By routinely monitoring the status of children and families and making adjustments as necessary, the interventions and strategies provided may be more well-matched and beneficial to improving case status and outcomes; both of these areas offer opportunities for improvement. Finally, enhancement of maintaining quality connections, and increasing the interactions and connections between children and their families would improve outcomes and strength of the family.

While some good practice is in place and affecting each of these areas mentioned above, some practice appears to be underpowered and inconsistent, thus not matched to change and impacting outcomes for children and families. With attention to these areas, as some agencies are doing in their System Improvement Plans, progress can be made, change can occur, and outcomes impacted.

Appendix A

VIRGINIA CHILDREN'S SERVICES PRACTICE MODEL
Comparison to
Virginia's Quality Service Review Protocol

We believe that all children and youth deserve a safe environment.	Quality Service Review Protocol Elements
1. Child safety comes first. Every child has the right to live in a safe home. Ensuring safety requires a collaborative effort among family, agency staff, and the community.	▪ **Child & Family Status Indicators** o **1a -** Exposure of Threats to Harm o **1b -** Risk to Self/Others ▪ **Practice Performance Indicators** o **1a -** Engagement o **1b -** Role and Voice o **2 -** Teaming o **4** - Assessment and Understanding o **5 -** Long-Term View for Safe Case Closure o **6** - Planning for Safe Case Closure
2. We value family strengths, perspectives, goals, and plans as central to creating and maintaining child safety.	
3. In our response to safety and risk concerns, we reach factually supported conclusions in a timely and thorough manner.	
4. Participation of parents, children, extended family, and community stakeholders is a necessary component in assuring safety.	
5. We separate caregivers who present a threat to safety from children in need of protection. When court action is necessary to make a child safe, we use our authority with respect and sensitivity	
We believe in family, child, and youth-driven practice.	**Quality Service Review Protocol Elements**
1. Children and families have the right to have a say in what happens to them and will be treated with dignity and respect. The voices of children, youth and parents are heard, valued, and considered in the decision-making regarding safety, permanency, and well-being.	▪ **Practice Performance Indicators** o **1a -** Engagement o **1b -** Role and Voice o **2 -** Teaming o **3** Cultural Awareness and Responsiveness o **10 -** Maintaining Quality Connections
2. Each individual's right to self-determination will be respected.	
3. We recognize that family members are the experts about their own families. It is our responsibility to understand children, youth, and families within the context of their own family rules, traditions, history, and culture.	
4. Children have a right to connections with their biological family and other caring adults with whom they have developed emotional ties.	
5. We engage families in a deliberate manner. Through collaboration with families, we develop and implement creative, individual solutions that build on their strengths to meet their needs. Engagement is the primary door through which we help families make positive changes.	
We believe that children do best when raised in families.	**Quality Service Review Protocol Elements**

1. Children should be reared by their families whenever possible. **2.** Keeping children and families together and preventing entry into foster care is the best possible use of resources. **3.** Children are best served when we provide their families with the supports necessary to raise them safely. Services to preserve the family unit and prevent family disruption are family-focused, child- centered, and community-based. **4.** People can and do make positive changes. The past does not necessarily limit their potential. **5.** When children cannot live safely with their families, the first consideration for placement will be with kinship connections capable of providing a safe and nurturing home. We value the resources within extended family networks and are committed to seeking them out. **6.** When placement outside the extended family is necessary, we encourage healthy social development by supporting placements that promote family, sibling and community connections. **7.** Children's needs are best served in a family that is committed to the child. **8.** Placements in non-family settings should be temporary, should focus on individual children's needs, and should prepare them for return to family and community life.	▪**Child & Family Status Indicators** o **2 -** Stability o **3 -** Living Arrangement o **4 -** Permanency o **8 -** Pathway to Independence o **9 -** Parent and Caretaker Functioning ▪ **Practice Performance Indicators** o **1a -** Engagement o **1b-** Role and Voice o **2 -** Teaming o **3 -** Cultural Awareness and Responsiveness o **4** - Assessment and Understanding o **7** - Planning for Transitions and Life Adjustments o **8** - Resource Availability o **10** - Maintaining Quality Connections
We believe that all children and youth need and deserve a permanent family.	**Quality Service Review Protocol Elements**
1. Lifelong family connections are crucial for children and adults. It is our responsibility to promote and preserve kinship, sibling and community connections for each child. We value past, present, and future relationships that consider the child's hopes and wishes. **2.** Permanency is best achieved through a legal relationship such as parental custody, adoption, kinship care or guardianship. Placement stability is not permanency. **3.** All planning for children is focused on the goal of preserving their family, reunifying their family, or achieving permanency with another family. **4.** Permanency planning for children begins at the first contact with the children's services system. We proceed with a sense of urgency until permanency is achieved. We support families after permanency to ensure that family connections are stable.	▪**Child & Family Status Indicators** o **2-** Stability o **3 -** Living Arrangement o **4 –** Permanency ▪ **Practice Performance Indicators** o **1a -** Engagement o **4 -** Assessment and Understanding o **5 -** Long-Term View for Safe Case Closure o **6** - Planning for Safe Case Closure o **7 -** Planning for Transitions and Life Adjustments o **11** - Tracking and Adjustment

We believe in partnering with others to support child and family success in a system that is family- focused, child-centered, and community-based.	Quality Service Review Protocol Elements
1. We are committed to aligning our system with what is best for children, youth, and families.	▪**Child & Family Status Indicators** o **5 -** Physical Health o **6 -** Emotional Well-Being o **7a or 7b -** Early Learning Status/Academic Status ▪ **Practice Performance Indicators** o **1a** - Engagement o **2 -** Teaming o **8 -** Resource Availability o **9 –** Intervention Adequacy o **11 -** Tracking and Adjusting
2. Our organization, consistent with this *practice model*, is focused on providing supports to families in raising children. The *practice model* should guide all of the work that we do. In addition to practice alignment, infrastructure and resources must be aligned with the model. For example, training, policy, technical assistance and other supports must reinforce the model.	
3. We take responsibility for open communication, accountability, and transparency at all levels of our system. We share success stories and best practices to promote learning within and across communities and share challenges and lessons learned to make better decisions.	
4. Community support is crucial for families in raising children.	
5. We are committed to working across agencies, stakeholder groups, and communities to improve outcomes for the children, youth, and families we serve.	
6. Services to families must be delivered as part of a total system with cooperation, coordination, and collaboration occurring among families, service providers and community stakeholders.	
7. All stakeholders share responsibility for child safety, permanence and well-being. As a system, we will identify and engage stakeholders and community members around our *practice model* to improve services and supports.	
8. We will communicate clearly and often with stakeholders and community members. Our communication must reinforce the belief that children and youth belong in family and community settings and that system resources must be allocated in a manner consistent with that belief.	
We believe that how we do our work is as important as the work we do.	
1. The people who do this work are our most important asset. Children and families deserve trained, skillful professionals to engage and assist them. We strive to build a workforce that works in alignment with our *practice model*. They are supported in this effort through open dialogue, clear policy, excellent training and supervision, formal and informal performance evaluation and appropriate resource allocation.	▪ **Practice Performance Indicators** o **1b** - Role and Voice o **4** – Teaming o **8** – Resource Availability
2. As with families, we look for strengths in our organization. We are responsible for creating and maintaining a supportive working and learning environment and for open, respectful communication, collaboration, and accountability at all levels.	
3. Our organization is focused on providing high quality, timely, efficient, and effective services.	

4. Relationships and communication among staff, children, families, foster parents, and community providers are conducted with genuineness, empathy, and respect.	
5. The practice of collecting and sharing data and information is a non-negotiable part of how we continually learn and improve. We will use data to inform management, improve practice, measure effectiveness and guide policy decisions.	
6. As we work with children, families, and their teams, we clearly share with them our purpose, role, concerns, decisions, and responsibility.	

APPENDIX B

A CONTINUUM OF PRACTICE

FAMILY PARTNERSHIP MEETINGS TO ONGOING ENGAGEMENT AND TEAMING THROUGH THE LIFE OF THE CASE

VA DEPARTMENT OF SOCIAL SERVICES – DIVISION OF FAMILY SERVICES

The goal of all the program areas of the Division of Family Services is to support local agencies to utilize the Virginia Children's Services Practice Model as the foundation of their day to day work with children and families. These principles include;

- Belief that all children and youth deserve a safe environment
- Belief in family, child and youth-driven practice
- Belief that children do best when raised in families
- Belief that all children and youth need and deserve a permanent family
- Belief in partnering with other to support child and family success in a system that is family–focused, child-centered and community based.
- Belief that how we do our work is as important as the work we do.

Building on the Virginia Practice Model, the Quality Service Review provides description and measures for the practice indicators of family engagement, voice and choice for families and team formation and functioning have been shown to improve outcomes for children and families. Below are core concepts for these three indicators.

Core Concepts for Engagement

The central focus of Engagement is on the diligence shown by the team in taking actions to find, engage, and build rapport with children and families and overcome barriers to families' participation. Emphasis is placed on direct, ongoing involvement in assessment, planning interventions, provider choice, monitoring, modifications, and evaluation. Success in the provision of services depends on the quality and durability of relationships between agency workers, service providers, and children and families. To be successful, the child and family's team must:

- Engage a child and family meaningfully and dynamically in all aspects of the service process,
- Recognize their strengths and focus on developing the positive capacities, as well as addressing the diminished capacities in order to build and maintain rapport and a trusting relationship.
- When appropriate and/or necessary, thoughtfully and respectfully conclude the relationship when the case is closed or the intervention goals are achieved.

Strategies for effective case management should reflect the family's language and cultural background and should balance family-centered and strength- based practice principles with use of protective authority. Best practice teaches that team members should:

- Approach the family from a position of respect and cooperation.
- Engage the family around strengths and utilize those strengths to address concerns for the health, safety, education, and well-being of the child.
- Engagement of child and family in case planning and monitoring process, including establishing goals in case plans and evaluating the service process.
- Help the family define what it can do for itself and where the child and family need help.
- Engage the child and family in decision making about the choice of interventions and the reasons why a particular intervention might be effective. This includes discussion of the logistics of getting to and participating in interventions in a manner that is practicable and feasible for the family.

Core Concepts for Voice & Choice

The family change process belongs to the family. The child and family should have a sense of personal ownership in the plan and decision process. Service arrangements are made to benefit children and families by helping to create conditions under which the child can succeed in school and life. Service arrangements should build on the strengths of the child and family and should reflect their strengths, views and preferences. The parent and/or caretaker (as appropriate) have a central and directive role, providing a voice that shapes decisions made

by the team on behalf of the child and family. Emphasis is placed on direct and ongoing involvement in all phases of service: assessment, planning interventions, provider choice, monitoring, modification and evaluation.
The child and family should have an active role and voice in developing goals and objectives, as well as in the development and implementation of plans. This includes, but is not limited to:

- Knowing and explaining his/her strengths, needs, preferences, and challenges so that others may understand and assist.
  - Understanding, accepting, and working toward any non-negotiable conditions that are essential for safety and well-being.
  - Attending team meetings and shaping key decisions about goals, intervention strategies, special services, and essential supports.
  - Advocating for needs, supports, and services.
  - Doing any necessary follow through on interventions.
  - Providing quality and frequent visits between agency worker and the child, mother and father.
  - When ICWA (Indian Child Welfare Act) applies, active efforts are required to assure a role and voice for the tribe.
  - Child and family satisfaction may be a useful indicator of participation and ownership.

Core Concepts for Teaming

Teaming focuses on the formation and functional performance of the family team in conducting ongoing collaborative problem solving, providing effective services, and achieving positive results with the child and family. There is no fixed formula for team size or composition. Collectively, the team should have the authority to act and ability to assemble supports and resource in behalf of child and family. Team functioning and decision making processes should be consistent with principles of family centered practice and system of care operations. Unity in effort and commonality of purpose apply to team functioning. Present child status, family participation and perceptions, and achievement of effective results are important indicators about the functionality of the team.

Unity of effort, commonality of purpose, and effectiveness in problem-solving = successful teamwork

- **Formation** - Team members should include all available family members, child welfare social worker and supervisor, any contracted service provider, health care providers, educational partners, child and parent advocates. When applicable team members should also include mental health professionals, spiritual leaders, caretakers, Guardian ad Litems and CASA volunteers and others as identified. Collaboration among team members from different agencies is essential. Team composition should be competent and have the right balance of personal interest in the family, knowledge of the family, technical skills, cultural awareness, authority to act, flexibility to respond to specific needs, and time necessary to fulfill the commitment to the family.

- **Functioning** - Most importantly the teaming process must develop and maintain unity of effort among all team members. Team members should develop a unified vision of what would have to happen for the case to close. The team must assess, plan, implement and prepare for safe case closure.

Practice Strategies
For Engaging Families, Incorporating Voice and Choice in Decision Making and Teaming

The Family Partnership Meetings (FPM) are one practice strategy for insuring that family engagement, voice and choice and teaming are part of the agency's day to day case work practice. The FPM decision making model was adopted by the state because it incorporates these aspects of practice which have been strongly correlated with improved outcomes for children and families. However, Family Partnership Meetings are only one strategy and generally occur infrequently over the course of a case and, therefore, are not sufficient in and of themselves to insure systems change. Additional strategies are needed.

We are proposing the use of a regular Child and Family Team meeting as a continuation of the work of FPMs. This meeting would include the youth, parents, extended family and all service providers. It would provide a mechanism by which regular review of services and progress would be shared among all the individuals involved in the case and where the family's needs and preferences could routinely inform decision making. In the matrix which follows the FPM and Child and Family meeting are compared and contrasted. The opportunities for family engagement, incorporation of voice and choice and teaming are clear in both, but differences are also highlighted.

Comparison of FPM and CFTM	
Family Partnership Meetings (FPM)	**Child and Family Team Meetings (CFTM)**
Purpose: To involve birth families (parents and extended family members) in all critical case decisions and to insure a network of support for the child and the adults who cares for him/her.	**Purpose:** To involve birth families (parents and extended family members) in on-going case planning, monitoring and adjusting; to insure that all team members have access to all information about the case; to insure that all team members understand the goal(s) of service provision and the current plan to protect the child and to achieve permanency; and to insure a network of support for the child and the adults who cares for him/her.
When: At the point that a critical case decision must be made: potential child removal; potential child placement change (placement disruption or change in FC goal); or reunification.	**When**: Regularly or as often as needed, whichever is soonest. Ideally, meetings will be held at least quarterly and the next one will be scheduled at the end of the current one.
Who: family and extended family; youth; social worker; supervisor; family supports as identified by the family; providers (maybe); attorneys (maybe); CASA (maybe); community representative; FPM facilitator.	**Who:** family and extended family; youth; social worker; supervisor (maybe); family supports as identified by the family; resource family or placement representative; school representative; all treatment providers ; attorneys; CASA; Probation officer (if applicable), etc.
Logistics: scheduling to maximize parent and family participation; ideally held in neutral location; consider use of conference calling; and transportation and child care should be provided by LDSS.	**Logistics:** scheduling to maximize full team participation, including parents, resources parents and critical extended family members; usually held at LDSS or service provider office; consider use of alternative meeting space and/or conference calling; and transportation and child care should be addressed (meetings are scheduled in advance, so community based or natural resources can be engaged.)

Comparison of FPM and CFTM	
Family Partnership Meetings (FPM)	**Child and Family Team Meetings (CFTM)**
Values based upon: • All families have strengths • Families are the experts on themselves • Families can make well-informed decisions about keeping their children safe when supported • Outcomes improve when families are involved in decision making • A team is more capable of creative and high quality decision making than an individual	**Values based upon:** • All families have strengths • Families are the experts on themselves • Families can make well-informed decisions about keeping their children safe when supported • Outcomes improve when families are involved in decision making • A team is more capable of creative and high quality decision making than an individual
Stages of the Meeting/ Agenda: • Introduction: purpose and goal; introduction of participants; and meeting guidelines. • Identify the situation: Define the concern/ decision to be made. • Assess the situation: safety needs; risk concerns; strengths and supports; hx of services; participants' perception of the situation; and worker recommendation(s). • Develop ideas: brainstorm in three categories, placement/custody, actions to provide safety, and services to reduce risk. • Reach a decision: consensus based decision (if possible) and addressing agency safety concerns, action plan, and linkage to services. • Recap/closing: review of decision and who will do what; any questions.	**Stages of the Meeting/ Agenda**: • Introductions: names and roles • Review of progress: each team member (starting with parents) provides an update of progress made in the last month and which services have been completed and/or treatment goals have been met • Identification of concerns/ services needing adjustment: each member (starting with parents) addresses areas of concern and/or what is not working well or may need to be adjusted • Review of goal(s): team explores fit between progress, services and goals; team members (including family) make recommendations as to improving fit or clarifying goal(s); next steps identified • Action plan is developed • Next meeting is scheduled
Summary of Differences: • Led by a facilitator • Supervisor as well as social worker attend • Family participation is the most critical aspect • Extensive pre-work ensures family is engaged in the meeting process • Formal and informal supports are invited and are part of the team • Agenda and meeting process are standardized and more formal (reflect importance of decision being made) • Outcome is a particular case decision required at that point in the "life of the case"	**Summary of Differences:** • Led by social worker • Supervisor does not always attend • Parent participation is critical • Agenda is informal • Outcome is action plan for the next several months leading to permanency