Quality Service Review
For a Child and Family

A Reusable Protocol for Examination of Family-Centered Services for a Child and Family

Field Use Version 2.2

Developed for Periodic Qualitative Case Reviews of

Safety, Permanency, and Well-Being Services Provided to Children and Families

For the
Virginia Department of Social Services
Division of Family Services

by
Human Systems and Outcomes, Inc.

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Quality Service Review for Children and Families

This protocol is designed for use in an in-depth case-based quality review process focused on child welfare practices involving CPS on-going and Permanency cases. It is used for: (1) appraising the current status of a child possibly having special needs (e.g., a foster child with a serious emotional disorder) in key life areas, (2) status of the parent/caretaker, and (3) performance of key system of care practices for the same child and family. The protocol examines recent results for children receiving services and their caregivers as well as the contribution made by local service providers and the system of care in producing those results. Review findings are used by local agency leaders and practice partners in stimulating and supporting efforts to improve practices used for children and youth and their families who are receiving child welfare in the State of Virginia.

These working papers, collectively referred to as the *Quality Service Review Protocol*, are used to support a professional appraisal of current status and system of care performance for individual children and their caretakers in a specific service area and at a given point in time. This is case-based review protocol, not a traditional measurement instrument designed with psychometric properties and should not be taken to be so. Localized versions of such protocols are prepared for and licensed to child-serving agencies for their use. These tools and processes, often referred to as the Quality Service Review or QSR are based on a body of work by Ray Foster, PhD and Ivor Groves, PhD of HSO.

Proper use of the *Quality Service Review Protocol* and other QSR processes requires reviewer training, certification, and supervision. Supplementary materials provided during training are necessary for reviewer use during case review and reporting activities. Persons interested in gaining further information about this process may contact an HSO representative at:

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Listed below is the table of contents for this QSR protocol. In addition to these materials, reviewers are provided a set of additional working papers that are used for reference and job aids used for particular tasks conducted during the review.

Acknowledgements

Design Team Participants

Introduction to the Quality Service Review Protocol

A Focus on Practice and Results

The QSR protocol and review processes use an in-depth case review method and practice appraisal process to find out how well children and their families are benefiting from services received and how well locally coordinated services are working for these children and families. Each child and family served is a unique "test" of the service system. Small, spot-checking samples drawn from local service sites are reviewed to determine child and parent/caretaker status, recent progress, and related system practice and performance results. The inquiry process is supported by a case review protocol that measures the performance of core practice functions (in the agency's practice model) in actual cases selected for an in-depth review.

The QSR views the unfolding of practice in the lives of children and families as highly interactive and dynamically complex rather than linear in nature. This means that practice performance is highly dependent on the present local conditions under which practice is occurring. The QSR process relates present case practice and results to local conditions and to the goodness-of-fit between the practice model used and the needs of the children and families who present for services. The QSR inquiry process *focuses on functional practice performance rather than simple compliance* with policies, procedures, and funding requirements.

QSR Drives Practice Learning and Action

The QSR uses a story-based process for learning and teaching about practice in actual cases. QSR provides a set of case review and practice advancement strategies used by practitioners and leaders to improve practice and results in their agencies. A QSR Protocol is connected directly to the agency's model of practice, strategies, and capacities for implementation, and measures of desired results and outcomes for children and families receiving services. Thus, the core content of a QSR protocol is anchored in and designed to test practice performance, capacity, and result at the point of practice transaction. The *practice point* is the place where and the moment when a child and family in need meet and work together with people who help the family meet needs. The philosophical basis for understanding the practice point, as used here, includes the following values and beliefs:

◆ Practice should be child-focused and family-centered. Families are full, active participants in every aspect of family change and service processes. The family provides the context for interventions with its children.

◆ Family team meetings should be used to organize and support the change process for the child and family.

◆ The family change/service process should be individualized, culturally competent, and strengths-based to build capacities for family independence.

◆ Family change efforts should work toward reaching defined outcomes related to family safety, well-being, child permanency, and family independence from the service system.

◆ Practice should be outcome-focused and results-driven.

◆ Change processes should be supportive of resiliency for children and supportive of recovery and relapse prevention for older youth and adults. Children should be served in their own community without having to leave their school and regular relationships for reasons of family safety or treatment.

◆ Family change efforts should embrace and use evidence-based practice strategies, where available and appropriate to the child and family.

◆ Where appropriate, services for children and families should be integrated and coordinated across providers, agencies, funding sources, and settings, including aligning the combination and sequence of change strategies being used across all interveners in the life of the child and family into a smooth process for the child and family.

◆ A well-integrated, coordinated service process for some families may require a service process that is inter-agency, community-based, and collaborative in operation.

◆ Outcomes should be routinely measured for the child, family, program, local system of care, and state-level systems. QSR is a measure of practice that can be used in this effort.

Context of QSR Use

The QSR is used as an organizational intervention, performance tracking, and system change process to stimulate teaching, measuring, and improving frontline practice and local conditions of practice in child-serving agencies. QSR protocols can be developed and used within a single agency (e.g., a child welfare agency) or can be designed for use across several service areas for which service integration and coordination is the primary interest. For example, QSR protocols have been designed and used for:

- Child welfare services.
- Special education services.
- Workforce development.
- Cross-program services in umbrella human services agencies.
- Early intervention services.
- Mental health services.
- Integrated system of care services.

Effective use of QSR is made by carefully connecting the measurement indicators designed into the QSR protocol to the agency's practice model. Case practice performance is measured through in-depth case reviews at local departments of social services. QSR's are used to measure performance and then to formally take action on results at the case level, unit level, and local department level.

Principles of *Appreciative Inquiry* and positive psychology are applied in the QSR process to make openness and safe learning possible for all participants. The focus is placed on the *system* rather than searching for what is wrong and who is responsible for errors. This is necessary to find what is working in practice presently and what things could be done even better in the future. Positive aspects of good practice are found and

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affirmed. Opportunities for practice development and capacity building are revealed to guide next step actions at each level. Success in making positive improvements in practice, results, and local conditions depends on leadership taken at each level. An agency cannot enforce its way to better practice and results; rather, positive changes must be championed and actively led by people who are committed to making such changes.

QSR Requirements for Leadership

Effective use of QSR for practice development, capacity building, and positive system change requires the understanding and commitment of leaders in various positions and locations in the agency. This includes supervisors, program managers, policy developers, practice consultants and trainers, resource developers, and executive leadership. QSR works to stimulate and support positive change when leaders own the process and actively use ongoing results to drive practice development and capacity-building efforts. Key aspects of such leadership involve:

- Setting and clarifying expectations about practice and results.
- Committing to modeling, mentoring, coaching of practice.
- Building adequate, stable frontline capacities to support practice.
- Providing flexible funding and use of uniquely designed supports.
- Ensuring that every frontline worker has what is needed every day to succeed (in safety, permanency, well-being) with the most challenging children and families.
- Using meaningful measures (e.g., QSR) applied with safe, positive, frequent feedback for affirmation, instruction, and next-step planning.
- Focusing intensively, continuously on practice performance and using results to move changes forward using positive strategies.

Success in any change effort depends on active, committed leadership.

Typical QSR Steps and Elements

QSR is designed to fit the interests, needs, and starting points of each agency. Once agency leaders are committed to understanding and using QSR for positive system change efforts, a design team process is used to create a local beginning version of the QSR protocol and process. Key stakeholders, members of the local community of practice, and end-users are represented on the design team. A beginning case review protocol is drafted and provided for technical review and revision. Local reviewer candidates are trained on the protocol. A database management program is created to compile and report case review findings. A small-scale pilot test is planned and conducted using the protocol. Expert mentors from other jurisdictions are used to model, mentor, and coach the inquiry and feedback processes for the local reviewer candidates. Case reviews are conducted using the protocol and stakeholder interviews are used to better conceptualize case review results from the local review site. Caseworker feedback sessions, mini-round teaching sessions for supervisors and practice champions, and a grand-round session are provided to inform participants and leaders on the process and use of results for next step planning.

Putting Knowledge Gained to Good Use

Knowledge gained through early testing and use is used to refine the protocol, review process, database management and reporting system, and the next step strategies used to stimulate practice development and capacity-building efforts. These early processes are facilitated by consultants and mentors provided by Human Systems and Outcomes, Inc. (HSO). Local capacities are developed and implemented to transfer the knowledge required to use QSR effectively from the developer to the local agency for ongoing use. Ongoing agency use includes building capacities to recruit, train, assign, supervise, and certify QSR reviewers to build a pool of qualified reviewers. Other key elements include developing and implementing capacities for scheduling and conducting ongoing QSR reviews at service sites and then effectively facilitating feedback processes that stimulate action, follow-through, and review of results.

A key use of QSR findings is the progressive refinement of the agency's practice model and provisions for training and support to implement the refinements. Another key use is the strategic use of findings to direct resource development and capacity-building efforts to ensure that front-line staff have what is needed every day to meet the needs of their most challenging children and families.

Virginia's Practice Model

The Virginia Children's Services System Practice Model sets forth a vision for the services that are delivered by all child-serving agencies across the Commonwealth, especially the Departments of Social Services, Juvenile Justice, Education, Behavioral Health, and Developmental Services and the Office of Comprehensive Services. The practice model is central to our decision making; present in all of our meetings; and in every interaction that we have with a child or family. Decisions that are based on the practice model will be supported and championed. Guided by this model, our process to continuously improve services for children and families will be rooted in the best of practices, the most accurate and current data available, and with the safety and well-being of children and families as the fixed center of our work.

We believe that all children and communities deserve to be safe.

1. Safety comes first. Every child has the right to live in a safe home, attend a safe school, and live in a safe community. Ensuring safety requires a collaborative effort among family, agency staff, and the community.

2. We value family strengths, perspectives, goals, and plans as central to creating and maintaining child safety, and recognize that removal from home is not the only way to ensure child or community 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.

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5. We separate caretakers 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 and child-driven practice.

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 and parents are heard, valued, and considered in the decision making regarding safety, permanency, well-being as well as in service and educational planning and in placement decisions.

2. Each individual's right to self-determination will be respected within the limits of established community standards and laws.

3. We recognize that family members are the experts about their own families. It is our responsibility to understand children 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 children and families make positive changes.

We believe that children do best when raised in families.

1. Children should be reared by their families whenever possible.

2. Keeping children and families together and preventing entry into any type of out-of-home placement 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.

We believe that all children need and deserve a permanent family.

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, or kinship care. Placement stability is not permanency.

3. 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.

We believe in paltering with others to support child and family success in a system that is family-focused, child-centered, and community-based.

1. We are committed to aligning our system with what is best for children and families.

   - Our organizations, consistent with this practice model, are 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.

   - We take responsibility for open communication, accountability, and transparency at all levels of our system and across all agencies. We share success stories and best practices to promote learning within and across communities and share challenges and lessons learned to make better decisions.

   - Community support is crucial for families in raising children.

2. We are committed to working across agencies, stakeholder groups, and communities to improve outcomes for the children and families we serve.

   - 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.

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- 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 help children and families achieve success in life, safety, life in the community, family-based placements, and lifelong family connections.

- We will communicate clearly and often with stakeholders and community members. Our communication must reinforce the belief that children belong in family and community settings and that system resources must be allocated in a manner consistent with that belief.

3. We are committed to working collaboratively to ensure that children with disabilities receive the supports necessary to enable them to receive their special education services within the public schools. We will collaboratively plan for children with disabilities who are struggling in public school settings to identify services that may prevent the need for private school placements, recognizing that the provision of such services will maximize the potential for these children to remain with their families and within their communities.

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.

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 organizations are focused on providing high quality, timely, efficient, and effective services.

4. Relationships and communication among staff, children, families, and community providers are conducted with genuineness, empathy, and respect.

5. The practice of collecting and sharing data and information is an ongoing part of how we continually learn and improve. We will use data to inform management, improve practice, measure effectiveness, and guide policy decisions. We strive to align our laws so that collaboration and sharing of data can be achieved to better support our children and families.

6. As we work with children, families, and their teams, we clearly share with them our purpose, role, concerns, decisions, and responsibility.

PRACTICE: CORE FUNCTIONS FOR FAMILY CHANGE

ENGAGING

The process of connecting with the child, mother, father, extended family, primary caretaker, and other team members for the purpose of building an authentic, trusting, and collaborative working relationship.

◆ Upon entry into the child welfare system, family engagement is required to accurately assess child safety and risk. Professionals involved with the family utilize engagement strategies, such as building rapport and acknowledging feelings, overcoming resistance, building trust, and remaining professional.

◆ Engagement is not a one-time effort to build rapport at the beginning of the case, but an ongoing process of staying delicately in step with the child and family in order to continue to build working relationships to support ongoing assessments, understanding, and service decisions throughout their involvement with the child welfare system.

◆ Child welfare practitioners and other service providers rely on the ability to develop mutually beneficial partnerships with individuals, children, and families in order to maintain their commitment and continuous participation in the planning process.

TEAMING

Teams are useful in gathering important information about strengths and needs that contribute to the overall assessment of a family's situation. Child welfare practitioners and other service providers providing support and services to the family can identify the risk of maltreatment before it occurs, respond to needs of safety promptly, and provide a range of services and supports for the family.

◆ TEAM FORMATION
  • Team formation means that the important people in this child and family's life have formed a working team that meets, talks, and plans together. Team members should include, but may not be limited to, available family members, the local child welfare caseworker and supervisor, any contracted service provider, health care providers, educational partners, and child and parent advocates.

  • Teamwork means everyone in the child's life agrees on the child's needs and is working to meet those needs individually and as a team. Teamwork starts in the first discussions with the family, often before there is a formal assessment or team. Teamwork means a flexible "whatever it takes" approach to tailoring services and supports uniquely to fit the child and family.

◆ TEAM FUNCTIONING
  • Team functioning means: (1) the team has the abilities and cultural competence to design effective supports and services to meet the child's needs and support the family in meeting the child's needs; (2) the team flexibly adjusts services and supports

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as the child's needs change; and (3) the team uses collaborative problem solving.

◆ TEAM PLANNING
- The team plan means the team makes plans reflecting the child and family's strengths, the child's needs, and the services to meet the child's needs and supports for the family in meeting the child's needs that all team members contributed to and use as their reference for their work. The voices of children are heard in identifying their needs and designing supports and services to fit these needs.

- Effective coordination, integration, and continuity in assessment and planning, organizing, and implementing services are essential to guide and adapt the family's needs and choices to find what works and to assist the family in becoming independent of the child welfare system.

ASSESSING & UNDERSTANDING

Assessment begins at the time of engagement. It is a continuous process of gathering and analyzing information that supports sound decision making. The family assessment is an essential part of empowering children and families through the identification of underlying needs, strengths, skills, protective capacities, and motivation for change. Effective assessments support team members' decision making and lead to crucial understanding of the dynamics of child maltreatment.

◆ Assessments focus on the child and family's strengths and specific needs and enhance their capacity to support the growth and development of all family members, adults and children. The needs of the child include emotional, attachment, social, safety, permanency, developmental, educational, and physical needs. The needs of the family include needs of a parent/caretaker in meeting the child's needs.

◆ Results of assessments inform and support team confidence in decisions about when to reunify or change the permanency goal of a child.

◆ Assessments inform case planning as they identify the unique needs of the child and form the basis for designing services and supports for the child and family.

◆ Assessments provide and inform the choice intervention strategies and supports available to the child and family to help the child and family make long-lasting changes that lead to desired outcomes of safety, permanency, and well-being.

LONG-LASTING BEHAVIORAL CHANGE that leads to INDEPENDENCE FROM THE CHILD WELFARE SYSTEM

◆ There is a shared understanding by all team members of the goals and outcomes that are necessary to achieve independence from the child welfare system. This process also defines clearly the end points for the journey of the child and family in the child welfare system.

◆ When the child and family situation has changed to meet the goals of safety, permanency, and well-being, it means that the child and family have: (1) reached suitable levels of stability, daily functioning, and well-being; (2) reliable protective capacities in place in the home; (3) demonstrated and sustained behavioral change that is long-lasting; (4) formal and informal supports in place to sustain and maintain long-lasting change; (5) resolved legal matters and complied with court orders; and (6) completed any other requirements. Taken together, these elements provide a *long-term view* of the outcomes to be achieved for and the pathways (e.g., reunification or kinship care) to be followed for achieving permanency, as well as safe and sustaining case closure.

PLANNING & IMPLEMENTING

Case planning is a cooperative effort in which the social worker assesses the child and family's needs in partnership with the family and other team members. Case planning is a process that involves developing a road map for moving the child to permanence promptly while also addressing his/her safety and well-being.

Effective planning and implementing requires staff to keep the family focused on key concerns and establish clear linkages between the identified needs, desired changes, and use of family strengths to reach the plan's goals. Case planning is developing a program of interventions that sufficiently address necessary behavioral change and move the child toward permanence.

◆ Case plan goals need to address the identified unmet needs of the child and family. Goals need to be behaviorally specific, realistic, time-limited, measurable, and understood by all involved in the planning process.

◆ Services and supports identified in case planning should purposely build on the strengths of the child and family, be tailored to the unique needs of the child and family, and be culturally competent.

◆ Services and supports identified in the case plan are to be formal and informal, as well as flexible, to make it possible for the family to meet the child's needs.

◆ Services and supports should be specifically designed to meet the child's needs and support the family as the child makes smooth transitions, such as moving into independence or returning home from residential care of a foster home, which may require a planned phase of more intense services.

◆ Case planning requires developing strategies (planned ways of achieving desired outcomes) for reducing safety threats in a family home and building protective capacities of families that are clearly specified in a written plan. Case planning involves child welfare practitioners and other service providers, working together with the family, to design strategies that assist the parent and child make successful life changes leading to permanency.

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TRACKING & ADAPTING

Tracking and adapting is a method utilized to ensure the plan is implemented with the necessary people, intensity, and quality and to determine whether services and supports are meeting the needs identified in the plan, which is critical to achieving the desired outcomes of safety, permanency, and well-being. A successful plan will meet the identified needs of the child and family, not complete a checklist of services. If supports and services do not appear to meet important identified child and family needs, the team is responsible for adapting the plan in a timely manner.

◆ Agency-provided services and supports to children and families should be sufficiently flexible to be adapted to the unique needs of each child and family.

◆ To remain relevant, the case plan must reflect changing circumstances for the child and family. Collaboration with the team to track and adjust the case plan as frequently as necessary to keep it relevant for the child and family is essential.

◆ When services and supports are not effective, the team should work together to refine them and/or to clarify a child's needs and redesign services and supports to meet the needs identified.

◆ The team routinely should ask questions addressing if services and supports are meeting the child's needs and supporting the family in meeting the child's needs, as well as determining what the team can do to resolve any problems in getting the right supports and services to the child and family.

◆ Strategies, interventions, and supports must be adapted in response to the changing needs of the child and family. Then, this adaption will be utilized to create a self-correcting process in which strategies and supports that work best for the family are identified and incorporated into the case plan.

◆ Services and supports put in place assure the child and family have a smooth, timely, and successful transition when changes occur, when families are reunited, or when cases are closed.

These principles and concepts of practice provide a useful foundation for the qualitative indicators designed to measure the performance of core practice functions the QSR Protocol.

QSR INDICATORS

The QSR Protocol provides reviewers with a specific set of indicators to use when examining the status of the child and caretaker and analyzing the responsiveness and effectiveness of the core practice functions prompted in the core practice model. Indicators are divided into two distinct domains: *status* and *practice performance*.

◆ **Status indicators** measure the extent to which certain desired conditions are present in the life of the child and the child's parents and/or caretakers—as seen over the past 30 days. Status indicators measure constructs related to *well-being* (e.g., safety, stability, and health) and *functioning* (e.g., the child's academic status and the caretaker's level of functioning). Changes in status over time may be considered the near-term outcomes at a given point in the life of a case.

◆ **Practice indicators** measure 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 core practice functions measured are taken from the team and provide useful case-based tests of performance achievement. The number of core practice functions and level of detail used in their measurement may evolve over time as advances are made in the state-of-the-art practice.

QSR CHILD & CARETAKER STATUS INDICATORS

This version of the QSR Protocol provides nine possible qualitative indicators for measuring the current status of a child and the child's parent and/or caretaker. Status is determined for the most recent 30-day period, unless stated otherwise in the indicator. A status measure could be viewed as a desired outcome for a child, parent, and/or caretaker who, at an earlier time, may have experienced significant difficulties in the area of interest.

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

1b. **SAFETY - Risk to Self/Others:** Degree to which: • The child avoids self-endangerment. • Refrains from using behaviors that may put others at risk of harm. *[For a child age three years and older]*

2. **STABILITY:** Degree to which: • The child's daily living, learning, and work arrangements are stable and free from risk of disruptions. • 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 disruption. *[Timeframe: past 12 months and next 6 months]*

3. **LIVING ARRANGEMENT:** Degree to which: • Consistent with age and ability, the child 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.

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4. PERMANENCY: Degree to which: • The confidence level of those involved (child, parents, caretakers, others) that the child is living with parents or other 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.

5. PHYSICAL HEALTH: Degree to which: • The child is achieving and maintaining positive health status. • And, 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.

6. EMOTIONAL WELL-BEING: 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, • Appropriate self-management of emotions and behaviors.

7a. EARLY LEARNING STATUS: Degree to which: • The child's developmental status is commensurate with age and developmental capacities. • The child's developmental status in key domains is consistent with age- and ability-appropriate expectations. *[For a child under 5 years of age]*

7b. ACADEMIC STATUS: Degree to which: • The child [according to age and ability] is: (1) regularly attending school, (2) placed in a grade level consistent with age or developmental level, (3) actively engaged in instructional activities, (4) reading at grade level or IEP expectation level, and (5) meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent. *[For a child age 5 years or older]*

8. PATHWAY TO INDEPENDENCE: Degree to which: • The youth [according to age and ability] is: • Gaining skills, education, work experience, connections, relationships, income, housing, and necessary capacities for living safely and functioning successfully independent of agency services, as appropriate to age and ability. • Developing long-term connections and informal supports that will support him/her into adulthood.

9. PARENT & CARETAKER FUNCTIONING: 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.

QSR provides a close-up way of seeing how individual children and families are doing in the areas that matter most. It provides a penetrating view of practice and what is contributing to results.

QSR Practice Performance Indicators

This version of the QSR Protocol provides eleven qualitative indicators for measuring certain core practice functions being provided with and for the child and the child's parents and/or caretakers. Practice performance is determined for the most recent 90-day period for cases that have been open and active for at least the past 90 days.

1a. ENGAGEMENT: 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. • Offering transportation and childcare supports, where necessary, to increase family participation in planning and support efforts.

1b. ROLE & VOICE: 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.

2. TEAMING: 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. • 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.

3. CULTURAL AWARENESS & RESPONSIVENESS: 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 of poverty, urban and rural dynamics, faith and spirituality, child culture, etc.). • 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. **NOTE**: *This is applied to all families.*

4. ASSESSMENT & UNDERSTANDING: 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" situa-

Introduction to the Quality Service Review Protocol

tion 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. (6) The path and pace by which permanency will be achieved for a child who is not living with nor returning to the family of origin.

5. **LONG-TERM VIEW:** Degree to which: • There are stated, shared, and understood safety, well-being, and permanency outcomes and functional life goals for the child and family. • 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.

6. **PLANNING PROCESS:** Degree to which the planning process: • Is individualized and matched to the child's and family's present situation, preferences, near-term needs, and long-term view for safe case closure. • 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.

7. **PLANNING FOR TRANSITIONS & LIFE ADJUSTMENTS:** 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.

8. **RESOURCE AVAILABILITY:** 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 informal and formal) necessary to meet individual needs in the child's plans 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 use by the child and family on a timely and adequate basis.

9. **INTERVENTION ADEQUACY:** 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.

10. **MAINTAINING QUALITY CONNECTIONS:** 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 living away from one another.

11. **TRACKING & ADJUSTMENT:** 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.

These core practice indicators, reflecting the agency's practice model, define the focus and scope of inquiry into case practice for a child and the child's parents and/or caretakers.

Summing-Up Across Indicators within Domains

The QSR Protocol provides directions to reviewers for determining an overall status child and family status rating and overall practice performance rating in a case for which a review has been completed for all of the indicators in each domain. Each domain (status and practice) has key criteria for determining the minimum conditions under which Overall Status and Overall Performance are deemed acceptable. For example, the status of the child cannot be regarded as acceptable if the child is unsafe or persons in the child's daily settings are not safe from the child. Likewise, the overall practice performance domain would not be considered acceptable in a case where any of the following five core practice functions were found to be inadequate: engagement, assessment, teaming, planning, or intervention adequacy. More information regarding the sum-up process for the two review domains is provided in Section 4 of this protocol.

General Review Information

Persons using this protocol should have completed the classroom training program (12 hours). Candidate reviewers will be using the protocol in a shadowing/mentoring sequence involving two consecutive case review situations conducted in the field with an inter-rater agreement check made with the second case. The trainee's first case analysis and ratings, feedback session with frontline staff, oral case presentation, and first case write-up should be coached by a qualified mentor reviewer. With the recommendation of the mentor reviewer, trainees who have successfully completed these steps will be granted review privileges on a review team. Trainees may be certified as mentor reviewers after four cases and attending a one day QSR mentor training.

Users of this protocol should remember the following points:

◆ The case review made using this protocol is a *professional appraisal* of the: (1) status of a child and parent/caretaker on key indicators and (2) adequacy of performance of essential service functions for that child and parent/caretaker. Each child served is a unique and valid point-in-time "test" of frontline practice performance in a local system of care.

Introduction to the Quality Service Review Protocol

◆ Reviewers are expected to use *sound professional judgment, critical discernment of practice*, and *due professional care* in applying case review methods using this protocol and in developing child status, recent progress, and practice performance findings. Conclusions should be based on objective evaluation of pertinent evidence gathered during the review.

◆ Reviewers are to apply the following timeframes when making ratings for indicators: (1) child and parent/caretaker status ratings should reflect the dominant pattern found over the past 30 days and (2) service system practice and performance item ratings should reflect the dominant pattern/flow over the past 90 days.

◆ IT IS IMPERATIVE THAT REVIEWERS "CALL IT AS THEY SEE IT" and reflect their *honest and informed appraisals* in their ratings and report summary. When a reviewer mentions a concern about a participant in the oral debriefing, that same problem is reflected in the reviewer's ratings, and noted in the written case summary.

◆ Report any suspected abuse/neglect to the review site leader immediately. The reviewer and site leader will identify appropriate authorities and report the situation.

◆ If, while reviewing the case records and conducting the interviews, the reviewer determines the *need to interview an individual not on the review schedule*, the reviewer should request that the interview be arranged, if possible. It may be possible to arrange a telephone interview when a face-to-face interview cannot be made.

◆ *Before beginning your interviews*, read the participant's service plan(s); any psychological, psychiatric; court documents; and recorded progress notes for at least the past 90 days. Make notes for yourself of any questions you have from your record review, and obtain the answers during your interviews from the relevant person(s). You may have questions that need to be answered by the caseworker before you begin your interviews.

◆ Gather information for the *descriptive section of the QSR Profile or Roll-Up Sheet* from the caseworker and records. Be sure to note the child and family's strengths and needs, as well as any medications; diagnoses; and any chronic health, mental health, or behavioral problems that require special care.

◆ Thoroughly complete the review for each status and practice indicator contained in the protocol. Using an indicator description and probes, the reviewer collects facts related to the construct being measured. The reviewer assembles the fact pattern evident in the case and records it in the QSR Workbook.. Using the rating guidance provided, the reviewer selects the rating scale level that best fits the fact pattern assembled, following the training and other job aids provided during the course of making ratings.

◆ Apply the *6-point rating scale* for status and practice performance for each indicator. Mark the appropriate ratings in the QSR *Roll-Up Sheet*. The rating scales are explained below.

◆ The reviewer completes a *Roll-Up Sheet* for each case reviewed and delivers it on or before the assigned time to the person collecting the completed forms. The reviewer ensures that the information on the form is complete and accurate before submitting the form.

◆ After completing the *Roll-Up Sheet* the reviewer prepares the *Feedback Organizer*, a working paper, to get ready for the feedback session with the caseworker and supervisor. The feedback organizer is designed to help the reviewer prepare for the role of the wise and gentle teacher when providing safe, affirming, accurate, and useful feedback about the accomplishments, practice strengths and challenges, and next-step opportunities for moving the case forward. The information shared during the feedback session should be consistent with the roll-up sheet and feedback organizer for later use by frontline staff involved with the case and by others who will use the information for a written report and practice development purposes.

◆ The *workbook* is used to capture qualitative information to support the ratings for the case. Do not use proper names. For example, use "the person" instead of "Mary", "the caseworker" instead of "Ms. Smith." If you rate any examination as inadequate (i.e., rating of 1-3), please explain this in the workbook. Use the case write-up section as the structure for presenting cases during the oral debriefing.

◆ A completed *QSR Roll-Up Sheet* for each case assigned to the reviewer will be given to the review site leader at the announced day and time so that the information can be used to roll-up results for the sample and site. Check the review schedule for the week to determine when these items are due to the site leader.

◆ The *workbook* will be submitted to the review site leader at the mini-rounds. Also, turn in the interview schedule for each case. Please indicate on the schedule if a planned interview was not done and the reason; for example, cancellation, no-show, could not find the location.

QSR Interpretative Guide for Status Indicator Ratings

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 person in this area [taking age and ability into account]. The person doing great! Confidence is high that long-term needs or outcomes will be or are being met in this area. [6 month sustained pattern or since admission if < 6 months]

5 = **GOOD STATUS**. Substantially and dependably positive status for the person in this area with an ongoing positive pattern. This status level is consistent with attainment of long-term needs or outcomes in area. Status is "looking good" and likely to continue. [3 month sustained pattern or since admission if < 3 months]

Acceptable Range: 4-6

Refinement Zone: 3-4

Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

4 = **FAIR STATUS**. Status is minimally or temporarily sufficient for the person to meet short-term needs or objectives in this area. Status has been no less than minimally adequate at any time in the past 30 days, but may be short-term due to changing circumstances, requiring change soon. [30 days adequate status]

3 = **MARGINAL STATUS**. Status is mixed, limited, or inconsistent and not quite sufficient to meet the person's short-term needs or objectives now in this area. Status in this area has been somewhat inadequate at points in time or in some aspects over the past 30 days. Any risks may be minimal.

Improvement Zone: 1-2

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

2 = **POOR STATUS**. Status is and may continue to be poor and unacceptable. The person may seem to be "stuck" or "lost" with status not improving. Any risks may be mild to serious.

1 = **ADVERSE STATUS**. The person's status in this area is poor and worsening. Any risks of harm, restriction, separation, regression, and/or other poor outcomes may be substantial and increasing.

Unacceptable Range: 1-3

QSR Interpretative Guide for Practice Indicator Ratings

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 person in this function area. This level of performance is indicative of exemplary practice and results for the person. [6 month pattern or since admission if less]

5 = **GOOD PERFORMANCE**. At this level, the system function is working dependably for this person, under changing conditions and over time. Effectiveness level is consistent with meeting long-term needs and goals for the person. [3 month sustained pattern or since admission if less than 3 months]

Acceptable Range: 4-6

Refinement Zone: 3-4

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

4 = **FAIR PERFORMANCE**. This level of performance is minimally or temporarily sufficient to meet short-term need or objectives. Performance may be time-limited, somewhat variable, or require adjustment soon due to changing circumstances. [30+ day continuing pattern. Some refinement is indicated]

3 = **MARGINAL PERFORMANCE**. Practice at this level may be under-powered, inconsistent or not well-matched to need. Performance is insufficient for the person to meet short-term needs or objectives. [With refinement, this could become acceptable in the near future.]

Improvement Zone: 1-2

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

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

1 = **ADVERSE PERFORMANCE**. Practice may be absent or not operative. Performance may be missing (not done). - OR - Practice strategies, if occurring in this area, may be contra-indicated or may be performed inappropriately or harmfully.

Unacceptable Range: 1-3

Introduction to the Quality Service Review Protocol

Rating Scales Used in the QSR

The QSR protocol uses a 6-point rating scale as a "yardstick" for measuring the situation observed for each indicator. [See the two rating scale displays presented on the previous page.] Each rating level describes conditions at one of six points along a continuum that ranges from high to low as follows: 6 - Optimal, 5 - Good, 4 - Fair, 3 - Marginal, 2 - Poor, and 1 - Adverse or Absent.

The general timeframes for rating indicators for levels 4 = 30 days, 5 = 90 days, and 6 = 180 days to reflect the durability of status conditions or practice performance over times. These time parameters help reviewers clearly and consistently define conditions necessary for a particular rating value. Greater clarity in rating values increases inter-rater reliability. The rating levels are explained in general terms for the Status and Practice Domains as follows.

Status Indicator Ratings

Presented below are general definitions of the rating levels and timeframes applied for the child and family status indicators. The general interpretations for these ratings are defined as follows:

- **Level 6** - Optimal and Enduring Status. The person's status situation has been generally optimal [best attainable taking age, health, and ability into account] with a consistent and enduring high quality pattern evident, without being less than good (level 5) at any point or any essential aspects over the past 6 months or since admission, if less. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally optimal and enduring, never dipping below level 5 at any moment. Confidence is high that long-term outcomes will be or are being met in this area.

- **Level 5** - Good and Stable Status. The person's status situation has been substantially and consistently good with indications of stability evident, without being less than fair (level 4) at any moment or in any essential aspect over the past 3 months. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally good and stable, never dipping below level 4 at any moment. This level is consistent with eventual satisfaction of needs or attainment of long-term outcomes in the area.

- **Level 4** - Minimally Adequate to Fair Status. The person's status situation has been at least minimally adequate at all times over the past 30 days, without being inadequate at any point or any essential aspect over that time. The situation may be dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed pattern may not endure or may have been less than minimally acceptable in the recent past, but not within the past 30 days.

- **Level 3** - Marginally Inadequate Status. The person's status situation has been somewhat limited or inconsistent over the past 30 days or longer, being inadequate at some moments in time or in some

essential aspect(s) over this recent period. The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have endured more than 30 days being less than minimally acceptable in the recent past but at a level where refinement is indicated rather than improvement.

- **Level 2** - Substantially Poor Status. The person's status situation has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s). The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured or may have been inadequate and unacceptable in the recent past and is substantially inadequate.

- **Level 1** - Adverse or Poor and Worsening Status. The person's status situation has been substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation presenting a great need for immediate improvement at the present time. The observed pattern be poor and gradually worsening status or may have recently become unacceptable and dramatically worsening.

Service System Performance Indicator Ratings

The same general logic is applied to the practice performance indicator rating levels as is used with the status indicators. The general interpretations for practice performance indicator ratings are defined as follows:

- **Level 6** - Optimal and Enduring Performance. The service system practice/system performance situation observed for the person has been generally optimal [best attainable given adequate resources] over the past 6 months with a consistent and enduring pattern evident, without ever being less than good (level 5) at any point or in any essential aspect. The practice situation may have had brief moments of minor fluctuation, but performance in this area has remained generally optimal and stable. This excellent level of performance may be considered "best practice" for the system function, practice, or attribute being measured in the indicator and worthy of sharing with others.

- **Level 5** - Good and Stable Performance. The service system practice/system performance situation observed for the person has been substantially and consistently good with indications of stability evident for the past 3 months, without being less than fair (level 4) at any moment or in any essential aspect. The situation may have had some moments of minor fluctuation, but performance in this area has remained generally good and stable. This level of performance may be considered "good practice or performance" that is noteworthy for affirmation and positive reinforcement.

- **Level 4** - Minimally Adequate to Fair Performance. The service system practice/system performance situation observed for the

INTRODUCTION TO THE QUALITY SERVICE REVIEW PROTOCOL

person has been at least minimally adequate at all times over the past 30 days or longer, without being inadequate (level 3 or lower) at any moment or in any essential aspect over that time period. The performance situation may be somewhat dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed performance pattern may not endure long term or may have been less than minimally acceptable in the recent past, but not within the past 30 days. This level of performance may be regarded as the lowest range of the acceptable performance spectrum that would have a reasonable prospect of helping achieve desired outcomes given that this performance level continues or improves. Minor refinement efforts are indicated at this level of performance at this time.

- **Level 3** - Marginally Inadequate Performance. The service system practice/system performance situation observed for the person has been somewhat limited or inconsistent, being inadequate at some moments in time or in some essential aspect(s) over the past 30 days or longer. The situation may be somewhat dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have been less than minimally acceptable (level 3 or lower) in the recent past and somewhat inadequate. This level of performance may be regarded as falling below the range of acceptable performance and would not have a reasonable prospect of helping achieve desired outcomes. Substantial refinement efforts are indicated at this time.

- **Level 2** - Substantially Poor Performance. The service system practice/system performance situation observed for the child or parent has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s) over the past 30 days or longer. The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured for a while or may have become inadequate and unacceptable in the recent past and is substantially inadequate. This level of inadequate performance warrants prompt attention and improvement.

- **Level 1** - Absent, Adverse, or Poor Worsening Performance. The service system system performance situation observed for the child or parent has been missing, inappropriately performed, and/or substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. This level of absent or adverse performance warrants immediate action or intervention to address the gravity of the situation.

Section 2

Child & Family Status Indicators

Well-being & Functioning

Reminders for Reviewers

The reviewer should follow these directions when applying a status indicator to a case situation being reviewed:

1. **Focus on the central construct measured in each indicator.** While two constructs may be logically related (e.g., stability and permanency), the reviewer is to focus on the central matters related to each specific indicator and follow the probe and rating guidance provided for each indicator.

2. **Stay within the time-based observation windows associated with each indicator.** For most indicators, status is measured over the past 30 days unless stated differently for particular indicators. *Status Indicator 1b - Safety from Risks to Self/Others* and *Status Indicator 2 - Stability* have observation windows that differ from the 30-day rule.

3. **Rate indicators based on events that have occurred or conditions that were present within the time-based observation window**. Theorizing about events that might have occurred but did not is not a factual basis for rating. With the exception of *Status Indicator 2 - Stability*, future possibilities about events that may occur are not considered in rating current status. The 6-Month Prognosis is used to reflect expectations or concerns about future prospects.

Status Review 1a: Safety from Exposure to Threats of Harm

Focus Measure

SAFETY FROM EXPOSURE TO THREATS OF HARM: Degree to which: • The child is free of abuse, neglect, and exploitation by others in his/her place of residence, school, and other daily settings. • The child's parents and/ or caretakers provide the attention, actions, and supports necessary to protect the child from known threats of harm in the home.

Core Concepts

Safety is the primary and essential focus that informs and guides all decisions made from intake through case closure. The focus is on identifying safety factors, present and/or impending danger, protective capacities and working with caretakers to supplement protective capacities through safety interventions. A child is considered safe when there is a balance between known safety factors and the identification of protections that are put into place by all responsible persons. This includes the capability and reliability of parents and/or out-of-home caretakers, school personnel, child care providers and others having immediate responsibility for the child in recognizing safety factors. Reviewers take into account not only the safety factor but also the effectiveness of any safety intervention (e.g., no-contact orders, safety plans, after-school child supervision plans) put into place to protect the child. This does not imply an absolute protection from all possible risks to life or physical well-being. The child should be free from known and manageable safety factors in his/her daily settings. This means the child is free from abuse and neglect, including freedom from intimidation and unwarranted fears that may be intentionally induced by parents, caretakers, other children, or treatment staff for reasons of manipulation or control. The child should have food, shelter, and clothing adequate to meet basic physical needs as well as adequate care and supervision of parents/caretakers, as appropriate to the child's age and developmental needs. A child who is presently in danger of or who lives in fear of assault, exploitation, humiliation, hostility, isolation, or deprivation may be in danger of suicide, disability, mental illness, co-dependent behavior patterns, learning problems, low self-esteem, and perpetrating similar harm on others. Freedom from harm is an essential condition for child well-being and development.

Fact Pattern

1. Is the child currently or has the child recently been a victim of abuse, neglect, or exploitation in the home or community? • Does the parent/ caretaker present a pattern of abuse, neglect, or exploitation of the child? • How many reports have been made over the life of the case and/or in the past 18 months? • Were they substantiated? • What is the present status over the past 30 days?

2. Is the child fearful, intimidated, or in present or impending danger in any of his/her current daily settings and activities?

   ☐ Family home (including unsupervised visitation in the family home prior to reunification)
   ☐ Out-of-home living arrangement (e.g., foster home or group home)
   ☐ School (including early intervention, Head Start, K-12 grade school, alternative education program, vocational training)
   ☐ Work (including a work experience program, apprenticeship placement, part-time job, supported employment)
   ☐ After school (e.g., an informal neighbor child-sitting arrangement or an after-school program at the Boys & Girls Club)
   ☐ Weekend (including the use of a child's "free time" in and around the home while away from organized activities)
   ☐ Play (including informal neighborhood play activities and organized activities, such as sports, clubs, church activities)
   ☐ Treatment for mental illness or addiction (including any setting in which seclusion or restraint may be used)
   ☐ Detention (including locked detention)

> **NOTE:**
>
> *Self-endangerment, as a risk of harm, is addressed in Indicator 1b: Risk to Self/Others.*

3. Does the child have his or her immediate food, clothing, shelter, and medical/mental health needs met? • Are physical living conditions hazardous or threatening to the safety or well-being of the child? • Did the caretaker use excessive discipline or excessive physical force? [Are the parent/ caretaker's methods of discipline appropriate for this child?]

4. Does the child receive an appropriate level of care and supervision from parents/caretakers and other adults, relative to age and special needs? • Do the parents/caretakers recognize and support the child's strengths?

5. Is the child's care or supervision situation currently compromised by the parent/caretakers' pattern of violent behavior, abuse/addiction to drugs and/or alcohol, mental illness/emotional instability, criminal activity, developmental status, cognitive ability, or domestic violence?

6. What informal supports and resources is the family now using to keep the children safe? • What recent protective capacities are now in place that help the family to better recognize risks of harm and to protect the children in the home from those risks?

STATUS REVIEW 1A: SAFETY FROM EXPOSURE TO THREATS OF HARM

7. How reliable are any protective strategies (e.g., no-contact order, safety plan) used to keep the child and/or family free from harm? • Is the caretaker willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment? Is there evidence of a healthy relationship between caretaker and child. • Is the caretaker aware of and committed to meeting the needs of the child. • Does the caretaker have a history of effective problem solving?

8. Does the caretaker have a willingness to recognize the problems and factors placing the child in imminent danger? • Does the caretaker have the cognitive, physical, and emotional capacity to participate in safety interventions. • Are parents/caretakers aware of any threats of harm to the child? • How reliable are parents/caretakers in recognizing threats of harm and taking steps to protect the child from those threats? • Are known threats of harm being managed effectively for the child?

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child   Rating Level

◆ **Optimal Safety.** Findings show an excellent safety situation for the child. The child has a threat-free living situation at home with fully reliable and competent parents/caretakers who protect the child well at all times. Any protective strategies used are fully operative and dependable in maintaining excellent conditions. The child is free from harm in other daily settings, including at school and in the community. At home and/or in other settings, the child is free from abuse, neglect, exploitation, and/or intimidation.

6
☐ Fam. Home
☐ Subst. Home
☐ School
☐ Other settings

◆ **Good Safety.** Findings show a good situation for the child. The child has a generally threat free living situation at home with reliable and competent parents/caretakers who protect the child well under usual daily conditions. Any protective strategies used are generally operative and dependable in maintaining acceptable conditions. The child is generally free from threats in other daily settings, including at school and in the community. At home and/or in other settings, the child is free from abuse, neglect, exploitation, and/or intimidation.

5
☐ Fam. Home
☐ Subst. Home
☐ School
☐ Other settings

◆ **Fair Safety.** Findings show an acceptable situation that is free from imminent threat of abuse or neglect for the child. The child has a fairly safe living arrangement with the present parents/caretakers. The child is at least fairly free from serious threats in other daily settings including at school and in the community. At home and/or in other settings the child may have very limited exposure to intimidation. Any protective strategies have been recognized and utilized in reducing threats of harm.

4
☐ Fam. Home
☐ Subst. Home
☐ School
☐ Other settings

◆ **Marginal Safety.** Situation indicates somewhat inadequate protection of the child from abuse or neglect which poses an elevated threat of harm for the child. Any protective strategies used may have been recognized but not utilized in reducing threats of harm. The child may be exposed to somewhat elevated threats of harm in his/her home and/or in other daily settings possibly at school and in the community. At home and/or in other settings the child may be exposed to occasional intimidation and fear of harm. Concerted action is needed in this area.

3
☐ Fam. Home
☐ Subst. Home
☐ School
☐ Other settings

◆ **Poor Safety.** Situation indicates substantial and continuing threats of harm for the child. At home and/or in other daily settings the child may sometimes experience abuse, neglect, exploitation, or intimidation. Any protective strategies used may not have been recognized or utilized in reducing threats of harm. The child may be exposed to substantially elevated threats of harm in his/her home and/or in other daily settings possibly at school and in the community. At home or in other settings the child may be exposed to frequent or serious intimidation and fears of harm. Concerted and immediate action is needed in this area.

2
☐ Fam. Home
☐ Subst. Home
☐ School
☐ Other settings

◆ **Adverse Safety.** Situation indicates serious and worsening threats or harm for the child. A pattern of abuse, neglect, exploitation, or intimidation by persons in the current daily life of the child may be undetected or unaddressed in the home and/or in other daily settings. Any protective strategies used may not be implemented or effective when used leaving the child at threat of continuing any worsening harm. Caretakers refuse to protect the child. The child may be exposed to continuing and increasingly serious intimidation abuse and/or neglect. Concerted and immediate action is needed in this area.

1
☐ Fam. Home
☐ Subst. Home
☐ School
☐ Other settings

Status Review 1b: Safety from Risk to Self/Others

Focus Measure

SAFETY FROM RISK TO SELF OR OTHERS: Degree to which the child: • Avoids self-endangerment. • Refrains from using behaviors that may put others at risk of harm.

Core Concepts: This Indicator Applies to a Child Age 3 Years or Older

Throughout development, children learn to follow rules, values, norms, and laws established in the home, school, and community, while learning to avoid behaviors that can put themselves or others at risk of harm. This indicator examines the child's choices, decisions, subsequent behaviors, and activities, and whether or not those choices engage him/her in risky or potentially harmful activities. It addresses behavioral risks, including self-endangerment/suicidality and risk of harm to others. It considers the child's engagement in lawful community behavior and socially appropriate activities and avoidance of risky and illegal activities, such as alcohol/substance abuse.

For younger children, examples of potentially harmful activities include:
- Running away or leaving supervision for extended periods
- Extreme tantrums that may result in harm to self or others
- Aggressive biting or pulling hair
- Hitting others or fighting
- Playing with fire
- Cruelty to animals

For older youth, examples of potentially harmful activities include:
- Suicidality, self-mutilation, or other forms of self-injurious behaviors (e.g., self-cutting, pica, head-banging, huffing chemicals, over-dosing)
- Placing him/herself in dangerous environments and situations or neglecting essential self-care requirements for maintaining well-being
- Running away (adolescents)
- Serious property destruction, including fire setting
- Gang affiliation and related activities
- Neglecting critical care requirements (e.g., insulin injections)
- Stealing
- Bulimia and or anorexia
- Abuse of alcohol/addictive substances
- Provoking behaviors related to poor social judgment that result in harm
- Dangerous thrill-seeking activities
- Use of weapons
- Sexual promiscuity

If the youth is already involved with the criminal justice system, the focus should be placed on:
- Avoiding re-offending
- Following rules, societal norms, and laws

NOTE: Time scales for ratings 4 and 5 in this indicator differ from the usual rating time scales in that both ratings use a three-month time window.

Fact Pattern

1. Does the child present a pattern of self-endangering behaviors or danger to others? • If so, what are these behaviors and how are these behaviors being managed to keep people protected from such behaviors?

2. Has the child made suicidal gestures, threatened suicide, or had a suicide attempt? • Is a **SELF-HARM SAFETY PLAN** provided?

3. Is this child presently making decisions and/or choosing to participate in activities (including illegal gang activities) that would cause harm to him/herself or others? • Are the child's behaviors in the community likely to lead to arrest and/or detention or adult incarceration?

4. Does the child have a history of making decisions and behaving responsibly and appropriately that results in avoiding behaviors that would cause harm to him/herself or others? • Has the child been supported to identify and use his/her personal strengths?

5. Does this child regularly associate with peers known for engaging in illegal or high risk activities? • Does this child engage in any high risk behaviors, including running away, robbery, car theft, drug use/sale, having unprotected sex, or prostitution?

6. Is there a recorded history, through either school guidance/disciplinary issues, arrest records, or mandatory community service records, of the child engaging in harmful, illegal, or very risky activities? • Is the child involved with the juvenile justice system?

7. If the child is involved with the juvenile justice system, is he/she actively participating with the court's plans and avoiding reoffending? • How is the child modifying daily activities and peer members to avoid reoffending and to become a "good citizen"?

Status Review 1b: Safety from Risk to Self/Others

8. Does the child cause harm to him/herself by biting, pulling hair, head-banging, having severe tantrums, self-mutilation, bingeing on alcohol, or inhaling toxic vapors to get high?

9. Has any harm actually occurred within the past six months? If so, what happened? • Are steps being taken to prevent or reduce the probability of repeated injury?

10. Is the child presently placed in a congregate care or detention setting? • Has redirection or de-escalation been used, as appropriate? • Has a restraint procedure plan been developed and used? • Has seclusion or restraint been used within the past 90 days to prevent harm to self or others? • Has use of any emergency control techniques been reduced over the past 90 days? • Have crisis services or 911 been called because of this child's behavior recently?

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

ALTERNATIVE TIME SCALE USED FOR RATINGS IN THIS INDICATOR. This indicator is designed to look retrospectively over the past six months for a rating of 6 and over the past three months for ratings 4 and 5. This indicator is not applied to infants and toddlers under the age of three years.

Description of the Behavioral Risk Status Observed for the Child | Rating Level

◆ **Optimal Status.** The child is optimally and consistently avoiding behaviors that cause harm to self, others, or the community. This child may have no history, diagnosis, or behavior presentations that are consistent with behavioral risk and is continuing this pattern. Or, the child may have had related history, diagnoses, or behavior presentations in the past but has not presented risk behaviors at any time over the **past six months**. Behavioral risk status is excellent.

6
☐ Risk to self
☐ Risk to others

◆ **Good Status.** The child is generally and substantially avoiding behaviors that cause harm to self, others, or the community. This child may have a very limited history, diagnosis, or behavior presentations that are not significant now. Or, the child may have had significant history, diagnoses, or behavior presentations in the past but has not presented the risk behaviors at any time over the **past three months**. Behavioral risk status is good.

5
☐ Risk to self
☐ Risk to others

◆ **Fair Status.** The child is usually avoiding behaviors that cause harm to self, others, or the community but rarely may present a behavior that has low or mild risk of harm. The child may have had related history, diagnoses, or behavior presentations in the past but may have presented risk behaviors at a declining or much reduced level over the **past three months**. Behavioral risk status is minimally adequate to fair.

4
☐ Risk to self
☐ Risk to others

◆ **Marginal Status.** The child is somewhat avoiding behaviors that cause harm to self, others, or the community but occasionally may present a behavior that has low to moderate risk of harm. The child may have had related history, diagnoses, or behavior presentations in the past but may have presented risk behaviors at a somewhat lower risk or reduced level of harm over the **past 30 days**. Behavioral risk status is somewhat limited or inconsistent and worrisome. Concerted action is needed in this area.

3
☐ Risk to self
☐ Risk to others

◆ **Poor Status.** The child is presenting behaviors that may cause harm to self, others, or the community. These possibly frequent presentations of behavior could have a moderate to high risk of harm. The child may have had related history, diagnoses, or behavior presentations in the past and may be presenting risk behaviors at a serious and continuing level of harm over the **past 30 days**. Behavioral risk status is poor and a potential for harm is present. Concerted action is needed in this area.

2
☐ Risk to self
☐ Risk to others

◆ **Adverse Status.** The child is presenting a pattern of increasing and/or worsening behaviors that may cause harm to self, others, or the community. These increasingly frequent or severe presentations of behavior have a moderate to high risk of harm. The child may have had related history, diagnoses, or behavior presentations in the past and may be presenting risk behaviors at a serious and worsening level of harm over the **past 30 days**. The potential for harm is substantial and increasing. Concerted action is needed in this area.

1
☐ Risk to self
☐ Risk to others

NA
☐ Risk to self
☐ Risk to others

◆ **Not Applicable.** The child is under three years of age.

Status Review 2: Stability

Focus Measure

STABILITY: Degree to which: • The child's daily living, learning, and work arrangements are stable and free from risk of disruptions. • 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 disruption. *[Timeframe: past 12 months and next 6 months]*

Core Concepts   *[STABILITY = CONTINUITY & NORMAL LIFE-STAGE CHANGES • INSTABILITY = DISRUPTIVE CHANGES IN A CHILD'S LIFE]*

Stability and continuity in a child's living arrangement, school experience, and social support network provide a foundation for normal child development. Continuity in caring relationships and consistency of settings and routines are essential for a child's sense of identity, security, attachment, trust, and social development and sense of well-being, The stability of a child's life will influence his/her ability to learn life skills, solve problems, negotiate change, assume responsibilities, judge and take appropriate risks, form healthy relationships, work as a member of a group, and develop a sense of caring and conscience. Many life skills, character traits, and habits grow out of enduring relationships the child has with key adults in his/her life. Changes in a child's life may be disruptive of established attachments and developmental pathways. Disruptions may lead to traumatic losses, major adjustment stresses, and developmental setbacks. When, for reasons of child protection, psychiatric treatment, or juvenile justice services, a child is in a temporary setting or unstable situation, prompt and active measures should be taken to restore the child to a stable situation. While change is a part of life, the focus in this review is on determining the degree of the <u>child's stability now and in the immediate future</u>. The indicator rating reflects the likelihood that near-term changes in the child's environment and living situation may occur that would be disruptive of the child's relationships and routines.

NOTE: A *DISRUPTION** is a child's unplanned move to a more restrictive setting and/or to another home. The reason may be foster home placement problems, a sudden psychiatric episode, or other similar situations in which the child does not return to the same home following treatment. An educational move is considered disruptive if the child changes school due to a home disruption or if the school placement is changed for any reason (other than grade-level transitions or provision of temporary specialized educational services) to a more restrictive educational setting. Normal age-related transitions from elementary to middle or to high school are not disruptions. A brief hospitalization for acute care is not a disruption, if the child returns to the same home following discharge.

 NOTE: Time scales for ratings 4, 5, and 6 in this indicator differ from the usual rating time scales.

> **NOTE:**
>
> **Track disruptions over the past 12 months and predict disruptions over the next 6 months.**

Fact Pattern

1. How long has the child lived in the current home and attended the current school or daytime activity?

2. How many out-of-home placements has this child had in the past 12 months? • For what reasons? • Of the placement changes, how many have been planned? • How many have been made to unite the child with siblings/relatives, move to a less restrictive level of care, or make progress toward the planned permanency outcome (e.g., reunification or TPR/adoption)?

3. Is the child living in a permanent home? • If continued instability is present, is it caused by unresolved permanency issues?

4. Are probable causes for disruption of home, school, or work present?

    *   Parent/caretaker's history of frequent moves, relapses, hospitalizations, or possible incarceration
    *   Change in adults living in the home
    *   Behavioral problems and discipline issues at home or at school
    *   Parent/caretaker's inability to provide the appropriate level of care or supervision

5. Are any known changes in the child's home or school expected to occur in the next six months? Such a change could involve a discharge from residential treatment or detention to a new home or school. • Did the child change school placements in the past 12 months due to DSS involvement?"

6. Are there present indications that the child or youth may runaway from home, school, or treatment placement?

7. What steps are being taken, if necessary, to prevent future disruptions and/or to achieve stable living, learning, and working environments and settings for this child?

Status Review 2: Stability

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

ALTERNATIVE TIME SCALE USED FOR RATINGS IN THIS INDICATOR. This indicator looks retrospectively over the past 12 months and prospectively over the next six months to assess and project the relative stability of the child's home and school settings and relationships. This is the only QSR indicator that uses a prospective dimension. A 12-month "opportunity window" is used to track recent life disruptions for the child in ratings 4, 5, and 6 to establish any movement pattern over that time period that has occurred. Prognosis for future disruption in the next six months is based on the pattern observed over the past 12 months (an ongoing movement pattern may be likely to continue in the near future) and on likely near-term events that would have high probability of causing a disruption. Please note that the retrospective time period of interest is counted backward from the day of review. For example, the past 30 days would be counted backward from the date of the case review..

Description of the Status Situation Observed for the Child   Rating Level

◆ **Optimal Stability.** The child has optimal stability in home settings and enjoys positive and enduring relationships with parents/primary caretakers, key adult supporters, and peers. There is no history of instability over the past 12 months and little likelihood of future disruption*. Only age-appropriate changes are expected in school settings.

6
☐ Home setting
☐ School setting

◆ **Good Stability.** The child has substantial stability in home and school settings with only planned changes and no more than one disruption* in either setting over the past 12 months with none in the past six months. The child has established positive relationships with parents/primary caretakers, key adult supporters, and peers in those settings. Only age-appropriate changes in school settings are expected within the next six months. Any known risks are now well-controlled.

5
☐ Home setting
☐ School setting

◆ **Fair Stability.** The child has minimally acceptable stability in home and school settings with only planned changes and no more than one disruption* in settings within the past 12 months and none in the past 90 days. The child has established positive relationships with parents/primary caretakers, key adult supporters, and peers in those settings. Only age-appropriate school changes may be expected in the next six months. Future disruption (unplanned moves) appears unlikely (probability <50%) within the next six months.

4
☐ Home setting
☐ School setting

◆ **Marginally Inadequate Stability.** The child has inadequate stability in home and/or school settings over the past 12 months with more than one disruption* within the past six months and none in the past 60 days. The child may not feel secure in the living arrangement and disruptions may have resulted in changes of parents/primary caretakers, key adult supporters, and peers in those settings. Further disruptions may occur within the next six months (probability >50%). Causes of disruption are known.

3
☐ Home setting
☐ School setting

◆ **Poor Stability.** The child has substantial and continuing problems of instability in home and/or school settings with multiple disruptions* in settings within the past 12 months and at least one change in the past 60 days. The child may feel insecure and concerned about his/her situation. Multiple, dynamic factors are in play, creating a "fluid pattern of uncertain conditions" in the child's life, leading to ongoing instability. Intervention efforts to stabilize the situation may be limited or undermined by current system of care difficulties.

2
☐ Home setting
☐ School setting

◆ **Adverse Stability.** The child has serious and worsening problems of instability in home and/or school settings with multiple disruptions* in settings within the past 12 months and at least one change in the past 30 days. The child's situation seems to be "spiraling out of control." The child may be in temporary containment and control situations (e.g., detention or crisis stabilization) or a runaway. There is no foreseeable next placement with levels of supports and services expressed by service staff or providers. The child may be expelled from school.

1
☐ Home setting
☐ School setting

◆ **Not Applicable.** This indicator may not apply to the school setting when the child is under the mandatory school attendance age or when the older youth has completed a school program and is not presently enrolled in an educational or vocational program.

NA
☐ School setting

Status Review 3: Living Arrangement

Focus Measure

LIVING ARRANGEMENT: Degree to which: • Consistent with age and ability, the child 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.

Core Concepts

The child's home is the one that the child has lived in for an extended period of time. For children who are not in out-of-home care, this home can be with the parents, informal kinship care resources, adoptive parents, or a guardian. For children in out-of-home care, the living arrangement can be a resource family setting or a congregate care setting if it is the only setting that can meet the child's needs. The child's home community is generally the area in which the child has lived for a considerable amount of time and is usually the area in which the child was living prior to removal. The community is a basis for a child's identity, culture, sense of belonging, and connections with persons and things that provide meaning and purpose for the child. Whenever safe, the child should remain in the home with his/her family. If the child must be temporarily removed from the home, the child should live, whenever possible, in an informal kinship placement arrangement. Some children with special needs may require temporary services in therapeutic settings, which must be the least restrictive, most appropriate, and inclusive living arrangement necessary to meet needs.

Fact Pattern

1. Is the child living in his or her family home (with parents, informal kinship arrangement, adoptive parents or guardian)? • If not, does the child's current living arrangement facilitate the child's connections to his/her culture, community, faith, extended family, and social relationships? • Are these connections meaningful to the child?

   - Is the child's home an appropriate environment for the child?
   - Are the parents (or other out-of-home caretakers) able to meet the child's daily needs for care and nurturing?
   - Does the child have any special needs (medical, behavioral, cognitive, etc.)? • If so, does the parent have the capacity and supports necessary to address the special needs?

2. If the child is in out-of-home placement, the following points should be considered in determining the appropriateness of the setting: *[Consider appropriateness of the living arrangement with the Indian Child Welfare Act, Multi-Ethnic Placement Act, and Adoptions and Safe Family Act.]*

   - Is the child living in his/her community (neighborhood and community close to home of parent, in his/her school district, and where he/she can continue extra-curricular activities)? • Is this home consistent with the child's language and culture?
   - Does the placement provide appropriate continuity in connection to home, school, faith-based organization, peer group, extended family, and culture?
   - Is the child placed with the non-custodial parent or relatives? If not, are there clear reasons why not?
   - Is the child placed with siblings? If not, are there clear reasons as to why this was not appropriate based upon the needs of the child?
   - Is the placement conducive to maintaining family connections and does the out-of-home caretaker support these activities?
   - Does the child feel safe and well cared for in this setting? • Does the team believe this is the best place for this child at this time?
   - Should reunification not be possible, would the out-of-home caretaker be able and willing to provide for permanency?
   - Is the living arrangement able to meet the child's developmental, emotional, behavioral, and physical needs and does it provide for appropriate levels of supervision and supports?
   - Do the out-of-home caretakers encourage the child to participate in activities that are appropriate to his/her age and abilities (sports, creative activities, etc.) and support socialization needs with peers and others?

3. Is a congregate setting the least restrictive and most inclusive setting that can meet the child's's needs? Consider the following matters:

   - Does the child feel safe and well cared for in this setting? • Is the child placed with children in his/her same age group? • Is this the least restrictive and most inclusive setting that is able to meet the child's needs? • Is the placement working on a goal to transition child to a less restrictive setting? • If youth is 16+ and reunification services have ended, is the placement providing transitional living skills to prepare youth for independent living? • Does the placement provide for the appropriate level of supervision, supports, and therapeutic services? • Does the placement provide for family connections and linkages to the community? • Is the placement providing services and resources to support a transition back to the home of parent?

STATUS REVIEW 3: LIVING ARRANGEMENT

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

This indicator applies to the child's current living situation, where the child will sleep tonight. *This may be the home of the birth family or a substitute care home. If the child is living in a substitute care home and is having unsupervised weekend visits (in the past 30 days) in the birth family home, then both settings are rated. If parent rights have been terminated, then the birth family home rating does not apply.*

Description of the Status Situation Observed for the Child | Rating Level

◆ **Optimal Status.** The child is living in the most appropriate setting to address his/her needs. The living arrangement is optimal to maintain family connections, including the child's relationship with the siblings and extended family members. The setting is able to entirely provide for the child's needs for emotional support, educational needs, family relationships, supervision, and socialization and addresses special and other basic needs. The setting is optimal for the child's age, ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential care center, the child is in the least restrictive environment necessary to address his/her needs and there is an active plan to transition child to a lower level of care or home of parent.

6
☐ Parent home
☐ Subst. home

◆ **Good Status.** The child is living in a setting that substantially meets his/her needs. The living arrangement substantially provides the conditions to maintain family connections, including the relationships with the siblings and extended family members. The setting provides the necessary educational needs, family relationships, supervision, supports, and services to provide substantially for the child's emotional, social, special, and other basic needs. The setting is substantially consistent with the child's age, ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential care center, the child is in the least restrictive environment necessary to address his/her needs and there is an active plan to transition child to a lower level of care or home of parent.

5
☐ Parent home
☐ Subst. home

◆ **Fair Status.** The child is living in a setting that is minimally consistent with his/her needs. The living arrangement minimally provides the conditions necessary to maintain family connections, including the relationship with the siblings and extended family members. The setting minimally provides the necessary educational needs, family relationships, supervision, supports, and services to address the child's emotional, social, special, and other basic needs. The setting is minimally consistent with the child's age ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential care center, the child is in the least restrictive environment necessary to address his/her needs and there is an active plan to transition child to a lower level of care or home of parent.

4
☐ Parent home
☐ Subst. home

◆ **Marginal Status.** The child is living in a setting that only partially addresses his/her needs. The living arrangement is partially inconsistent with the conditions necessary to maintain family connections, including relationships with the siblings and extended family members. The setting only partially provides for the necessary educational needs, family relationships, supervision, supports, and services to address the child's emotional, social, special, and other basic needs. The setting is partially consistent with the child's age, ability, culture, language, and faith-based practices. If the child is in a group home or residential care center, the child is not in the least restrictive setting. The level of care or degree of restrictiveness may be slightly higher or lower than necessary to address the child's needs and there is no plan to replace child to a more appropriate setting. Concerted action is needed in this area.

3
☐ Parent home
☐ Subst. home

◆ **Poor Status.** The child is living in a substantially inadequate home or setting. The living arrangement inadequately addresses conditions necessary to maintain family connections. The necessary level of educational needs, family relationships, supervision, supports, and services to address the child's needs are inadequate. The setting is inconsistent with the child's age, ability, culture, language, and faith-based practices. If the child is in a group home or residential care center, the setting is not the least restrictive. The level of care or degree of restrictiveness is substantially more or less than necessary to meet the child's needs and there is no plan to replace child to a more appropriate setting. Concerted action is needed in this area.

2
☐ Parent home
☐ Subst. home

◆ **Adverse Status.** The child is living in an inappropriate home or setting for his/her needs. The living arrangement does not provide for family and community connections. The necessary level of educational needs, family relationships, supervision, supports, and services to address the child's needs is absent. If the child is in a group home, detention facility, or residential care center, the environment is much more restrictive than is necessary to meet the child's needs while protecting others from the child's behavioral risks. Or, the child may be on runaway status, homeless, residing in a homeless shelter, or in temporary shelter care for more than 30 days and there is no plan to replace child to a more appropriate setting. Concerted action is needed in this area.

1
☐ Parent home
☐ Subst. home

◆ **Not Applicable.** The setting does not apply in this case.

NA
☐ Parent home
☐ Subst. home

STATUS REVIEW 4: PERMANENCY

Focus Measure

PERMANENCY: Degree to which: • The confidence level of those involved (child, parents, caretakers, others) that the child is living with parents or other 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.

Core Concepts

Every child is entitled to a safe, secure, appropriate, and permanent home. Permanency is achieved when the child is living successfully in a family situation that the child, parents, caretakers, and other stakeholders believe will endure lifelong. Permanency, commonly identified with the meaning of "family" or "home," suggests not only a stable setting, but also stable caretakers and peers, continuous supportive relationships, and a necessary level of parental/caretaker commitment and affection. Evidence of permanency includes resolution of custody, adequate provision of necessary supports for the caretaker, and the achievement of stability in the child's home and school settings. Thus, safety, stability, and adequate caretaker functioning are co-requisite conditions of permanency for a child. The case should have identifiable steps which will move the child to stability and permanency. Because of the nature of congregate settings, with frequent turnover of out-of-home caretakers, time-limited stays, ever-changing peers, conditional commitment, and unreliable personal caring relationships, placements in congregate settings are rarely judged to achieve an acceptable permanency rating. An exception to this would be if a child is still placed in a congregate setting at the time of review, but everyone is ready to move the child to a safe, appropriate, and permanent family setting and the team agrees that the new placement and plan will produce permanency.

NOTE: This indicator applies to the child regardless of whether the child is presently living with the parent at home or living with a caretaker at the time of review.

Fact Pattern

1. Is the child living with caretakers that the child, caretakers, and caseworker believe will endure until the child reaches maturity and beyond?

    *   Is the child satisfied with this home?
    *   Is the caseworker satisfied with this home?
    *   Are all legal barriers to achieving permanency resolved? (e.g., child is legally free for adoption)
    *   Are caretakers capable, supported, and satisfied?
    *   Does the caretaker accept/understand the legal responsibilities of caring for this child?

2. If the child does not live with permanent caretakers yet and the permanency goal is reunification, are reunification services being provided?

    *   Is the parent acquiring, demonstrating, and sustaining required behavioral changes necessary to parent the child?
    *   Is there a clear permanency plan? Is it being implemented?
    *   Do the child, family, and team support the permanency plan?
    *   Is there concurrent planning (formal or informal)?
    *   How is the child engaged in reunification planning efforts?
    *   How is the child being prepared for permanency?
    *   Is the child engaged in the concurrent planning efforts?
    *   What is the likelihood that of reunification in the near future?

3. If the child does not live with permanent caretakers yet and the permanency goal is adoption, is the permanency plan being implemented?

    *   Is an adoptive/kinship placement being actively sought?
    *   Were there reasonable efforts to local a possible kinship placement?
    *   Are fit and willing kin available as a permanency resource?
    *   Are any current or past caretakers available as a permanency resource?
    *   What does the child say about the permanency choices? • Does the child agree with the permanency choices? • Was the child involved in making the permanency choice?

STATUS REVIEW 4: PERMANENCY

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

<u>Description of the Status Situation Observed for the Child</u>   <u>Rating Level</u>

◆ **Optimal Status.** The child has optimal/certain permanence. The child has achieved legal permanency and/or lives in a family setting about which the child, out-of-home caretakers, and all team members have evidence will endure lifelong. If the child lives at home with his/her parents, identified risks have been eliminated and stability has been sustained over time.

6 ☐

◆ **Good Status.** The child has substantial/promising permanence. The child lives in a family setting (his/her own or that of an caretaker) that the child, parents, caretakers, and team members have confidence will endure lifelong. A plan is implemented that is expected to achieve safety, stability, and legal permanence. If in a resource family, there is agreement that adoption/kinship care issues will be imminently resolved. For children old enough to make a responsible judgment, the child and caretaker (in all cases) are committed to the plan. A primary and concurrent goal has been developed and implemented and team members are aware of the steps necessary to achieve each plan.

5 ☐

◆ **Fair Status.** The child has minimally acceptable to fair permanence. The child lives in a family setting that the child, parents, caretakers, caseworker, and team members expect with short term agency support, will endure until the child reaches maturity. They are successfully implementing a well-crafted plan that supports that expectation because safety and stability are being achieved. If in an adoptive family, adoption issues are being resolved. - OR -The child is still living in a temporary placement, but the child, parents, caretakers, and team members are ready to move the child to a safe, appropriate, and permanent family setting. Readiness for permanency is evident, because a realistic and achievable child and family plan is being implemented, a permanent home has been identified, and the transition is being planned. The team agrees that the prospective placement and plan will produce permanency, because the child is receiving what the child needs for implementing the actual permanency goal and the parents or future permanent caretaker is becoming prepared for receiving the child. For children old enough to make a responsible judgment, the child, parent and/or caretaker (in all cases) are committed to the plan. A primary and concurrent goal has been developed and implemented and team members are aware of the steps necessary to achieve this plan.

4 ☐

◆ **Marginal Status.** The child has somewhat inadequate/uncertain permanence. The child lives in a home that the child, out-of-home caretakers, caseworker, and some other team members are hopeful could endure lifelong, and they are working on crafting a plan that supports that hope by attempting to achieve safety and stability. - OR - The child is living on a temporary basis with an out-of-home caretaker, but likelihood of reunification or finding another permanent home remains uncertain. If in an adoptive family, adoption/kinship care issues are being assessed. Any concurrent pathways used may be somewhat slower or more troublesome than foreseen. For a child old enough to make a responsible judgment, the child and out-of-home caretaker (in all cases) may be considering the plan. The concurrent goal is being implemented inconsistently. Concerted action is needed in this area.

3 ☐

◆ **Poor Status.** The child has substantial and continuing problems of unresolved permanence. The child is living in a home that the child, out-of-home caretakers, and caseworker doubt could endure until the child becomes independent, due to safety and stability problems or failure to resolve adoption/kinship care issues, or because the current home is unacceptable to the child. - OR - The child remains living on a temporary basis with an out-of-home caretaker without a clear, realistic, or achievable permanency plan being implemented. Any concurrent pathways used may have stalled or failed. The concurrent goal is not being implemented. Concerted action is needed in this area.

2 ☐

◆ **Adverse Status.** The child has serious and worsening problems of unresolved permanence. The child is moving from home to home due to safety and stability problems or failure to resolve adoption/kinship care issues, or because the current home is unacceptable to the child. - OR - The child remains living on a temporary basis with an out-of-home caretaker without a clear, realistic, or achievable permanency plan being implemented. Concerted action is needed in this area.

1 ☐

Status Review 5: Physical Health

Focus Measure

PHYSICAL HEALTH: Degree to which: • The child is achieving and maintaining positive health status. • And, 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.

Core Concepts

Children should achieve and maintain their best attainable health status, consistent with their general physical condition when taking medical diagnoses, prognoses, and history into account. Healthy development requires that the child's basic needs for proper nutrition, clothing, shelter, and hygiene be met on a daily basis. Proper medical and dental care (preventive, acute, and chronic) is necessary for maintaining good health. Preventive health care should follow EPSDT (Early, Periodic, Screening, Diagnosis, and Treatment) guidelines and the VA Infant and Toddler Connection Programs (Part C, Early Intervention Services), as appropriate. This extends to reproductive health care education and services for youth to prepare and protect them from exposure to sexually transmitted diseases, and teen pregnancy, as appropriate.

Children prescribed medications on a continuous basis should be carefully monitored by a responsible adult. If the child requires any type of adaptive equipment or other special procedures, persons working with the child are provided instruction in the use of the equipment and special procedures. Should a child have a serious condition, possibly degenerative, the services and supports have been provided to allow the child to remain in the best attainable physical status given his/her diagnoses and prognoses.

Fact Pattern

1. Are the child's basic physical needs being met adequately on a daily basis?

   • Food, adequate nutrition, sleep, and daily exercise?
   • Sanitary housing that is free of safety hazards (considered for infants, toddlers, and young children)?
   • Daily care, such as hygiene, dental care, grooming, and clean clothing?
   • Based upon the child's age and developmental level, he/she has access to sex education and family planning services?

2. Is the child's achieving his/her optimal or best attainable health status?

   • Is appropriate preventive health care being provided as appropriate to the child's age (e.g., screenings, immunizations, etc.)?
   • Does the child miss school due to illness more than would be expected?
   • Does the child have any recurrent health problems such as infections, sexually transmitted diseases, colds, or injuries?
   • Does the child have recurrent health complaints, and if so, are they addressed (including dental, eye sight, hearing, etc.)?
   • Does the child appear to be underweight or overweight, and if so, has this been investigated?
   • Does the child use illegal substances or abuse prescription medication?
   • If the child has had a need for acute care services, were they provided appropriately?

3. Has the child maintained his/her best attainable health status, given any physical health diagnoses?

   • Receives appropriate follow-up, adaptive equipment, treatment and/or services as appropriate to meet their special needs.

4. If the child takes medication for health maintenance on a long-term basis, is the medication properly managed for the child's benefit?

   • A responsible adult should be monitoring the use of the medication, ensuring that it is taken properly, watching for signs of effectiveness or side effects, providing feedback to the physician, and making changes as warranted.

   • The child, at the level that she/he is capable, has been taught about his/her condition, understands how to self-manage the condition, understands the purpose and impact of the medication, and is able to self-administer his/her medication with supervision.

Status Review 5: Physical Health

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

<u>Description of the Status Situation Observed for the The Child</u>   <u>Rating Level</u>

◆ **Optimal Status.** The child is demonstrating excellent health, or if he/she has a chronic condition, is attaining the best possible health status that can be expected given the health condition. The child's growth and weight are well within age-appropriate expectations. Any previous or current health concerns have been met without any adverse or lasting impact, or there is no significant health history. Nutrition, exercise, sleep, and hygiene needs are fully met. This child appears to be in excellent physical health.

6 ☐

◆ **Good Status.** The child is demonstrating a good, steady health pattern, considering any chronic conditions. The child's growth and weight are generally consistent with age-appropriate expectations. Any previous or current health concerns have been met in which there may be no lasting impact, or there is no significant health history for this child. Nutrition, exercise, sleep, and hygiene needs are being substantially met. This child appears to be in good physical health.

5 ☐

◆ **Fair Status.** The child is demonstrating an adequate to fair level of health status, considering any chronic conditions. The child's physical health is somewhat close to normal limits for age, growth, and weight range. If existing, any previous or current health concerns are not adversely affecting functioning. Nutrition, exercise, sleep, and hygiene needs are usually being met. The child appears to be in fair physical health.

4 ☐

◆ **Marginal Status.** The child is demonstrating a limited, inconsistent, or somewhat inadequate level of health status. Any chronic condition may be becoming more problematic than necessary. The child's physical health is outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be adversely affecting functioning. Nutrition, exercise, sleep, and hygiene needs may be inconsistently met. The child appears to be in marginal health. Concerted action is needed in this area.

3 ☐

◆ **Poor Status.** The child is demonstrating a consistently poor level of health status. Any chronic condition may be becoming more uncontrolled, possibly with presentation of acute episodes. The child's physical health is significantly outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be significantly affecting functioning. Nutrition, exercise, sleep, and hygiene needs may not be being met, with significant impact on functioning. The child appears to be in poor physical health and physical health is not improving, rather, is remaining status quo. Concerted action is needed in this area.

2 ☐

◆ **Adverse Status.** The child is demonstrating a poor or worsening level of health status. Any chronic condition may be increasingly uncontrolled, with presentation of acute episodes that increase health care risks. The child's physical health is profoundly outside normal limits for age, growth, and weight ranges. If existing, any previous or current health conditions may be profoundly affecting functioning. Nutrition, exercise, sleep, and hygiene needs may not be being met, with profound impact. The child appears to be in poor physical health and his/her health status is declining. Concerted action is needed in this area.

1 ☐

Status Review 6: Emotional Well-Being

Focus Measure

EMOTIONAL WELL-BEING: 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,** • **Appropriate self-management of emotions and behaviors.**

Core Concepts

Emotional well-being is achieved when an individual's essential human needs are met in a consistent and timely manner. These needs vary across the life span, personal circumstances and unique individual characteristics. When these needs are met children are able to successfully attach to caretakers, establish positive interpersonal relationships, cope with difficulties, and adapt to change. They develop a positive self image and a sense of optimism. Conversely, problem behaviors, difficulties in adjustment, emotional disturbance, and poor achievement are the result of unmet needs. Abuse, neglect, loss and other trauma affect children's needs for safety, attachment, positive self-regard, and self-regulation. With the proper interventions and supports, aligned with the identified unmet needs and strengths of the child and family, these children can be helped to develop a sense of safety, self-control, self-satisfaction, mastery, and hopefulness.

For children ages birth to five, emotional well-being is characterized by a young child's developing capacity to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn, all within the context of family, community, and cultural expectations for young children. Emotional well-being for children ages birth to five is synonymous with healthy social and emotional development. Nurturing, protective, stable and consistent relationships are essential to young children's mental health. Thus, the state of adults' emotional well-being and life circumstances profoundly affects the quality of infant/caretaker relationships, thereby affecting the young child's emotional well-being.

For older children and youth, emotional well-being is exemplified by:

- A feeling of personal worth, a sense of belonging and attachment to family and friends as well as age appropriate social groups
- An ability to offer and accept nurturing positive relationships with family and peers and express affection within appropriate bounds of social behavior
- A realistic awareness of one's own personal strengths, attributes, accomplishments, and potentialities as well as one's limitations
- A developing ability to self-regulate emotions, express gratitude, delay gratification, and use age-appropriate levels of self-direction
- An increasing ability to recover from setbacks and handle frustration
- A sense of mastery wherein one is able to manage problems and handle conflicts
- An internalization of moral values, social norms, and rules that guide personal behavior
- A developing sense of purpose, optimism, and compassion for others

Fact Pattern

1. Does child have history of significant unmet needs:

   - History of abuse, neglect, other trauma
   - Lack of a consistent caretaker
   - Caretaker emotionally unavailable due to drug/alcohol abuse or psychiatric disorder
   - Multiple living arrangements
   - Severe poverty

2. If any Mental Health screening or assessments have been conducted, what were the concerns?

3. Has the child been diagnosed with a mental or developmental disorder? • Does the child have a history of psychiatric hospitalization or has he/she been prescribed psychotropic medication in the last 90 days? • Is there a history of suicidal ideation, gesture, or attempt or self-mutilation (e.g. cutting)?

4. Is the child at age appropriate grade placement in school? • Has the child been suspended or expelled from school within the last 90 days? • Is the child receiving acceptable grades in school?

5. Does the child have age appropriate positive peer relationships?

6. For older youth, are they making appropriate planning and preparation for transitions from dependence to independence?

STATUS REVIEW 6: EMOTIONAL WELL-BEING

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

<u>Description of the Status Situation Observed for the The Child</u>   <u>Rating Level</u>

◆ **Optimal Status.** The child is demonstrating an excellent and sustained pattern of emotional well-being. As appropriate to age and developmental stage, the child is generally exceeding expectations for: forming attachments and positive social relationships; coping and adapting skills; and, appropriate self-management of emotions and behaviors. An optimal pattern is evident from multiple sources.

6 ☐

◆ **Good Status.** The child is demonstrating a good and steady pattern of emotional well-being. As appropriate to age and developmental stage, the child is consistently meeting expectations for: forming attachments and positive social relationships; coping and adapting skills; and, appropriate self-management of emotions and behaviors. Most expectations in these areas are generally well met and no expectation is found to be unacceptable in recent times.

5 ☐

◆ **Fair Status.** The child is demonstrating a minimally adequate to fair pattern of emotional well-being. As appropriate to age and developmental stage, the child is at least minimally meeting expectations for: forming attachments and positive social relationships; coping and adapting skills; and, appropriate self-management of emotions and behaviors. Some variability may be noted in the child meeting these expectations. Meeting these expectations has been at least minimally adequate over the past 30 days and no expectation was unmet at any time in the past 30 days.

4 ☐

◆ **Marginal Status.** The child is demonstrating a limited, inconsistent, or somewhat inadequate pattern of emotional well-being. Any emotional problems may be becoming somewhat problematic. As appropriate to age and developmental stage, the child is inconsistently meeting less than adequate expectations for: forming attachments and positive social relationships; coping and adapting skills; and, appropriate self-management of emotions and behaviors. Evidence shows that expectations for at least some elements has been mildly to moderately inadequate at times in the past 30 days. Concerted action is needed in this area.

3 ☐

◆ **Poor Status.** The child is demonstrating a consistently poor pattern of emotional well-being. Any emotional problems may be becoming more uncontrolled, possibly with presentation of acute episodes. As appropriate to age and developmental stage, the child is not meeting expectations for: forming attachments and positive social relationships; coping and adapting skills; and, appropriate self-management of emotions and behaviors. A generally poor pattern is evident from multiple sources. Concerted action is needed in this area.

2 ☐

◆ **Adverse Status.** The child is demonstrating a poor or worsening level of emotional well-being. Any emotional problems may be increasingly uncontrolled, with presentation of acute episodes that increase behavioral risks. As appropriate to age and developmental stage, the child is not meeting expectations for or showing regression in: forming attachments and positive social relationships; coping and adapting skills; and, appropriate self-management of emotions and behaviors. A generally poor and worsening pattern is evident from multiple sources. Concerted action is needed in this area.

1 ☐

STATUS REVIEW 7A: EARLY LEARNING & DEVELOPMENT

Focus Measure

EARLY LEARNING STATUS: Degree to which: • The child's developmental status is commensurate with age and developmental capacities. • The child's developmental status in key domains is consistent with age- and ability-appropriate expectations.

Core Concepts: This Indicator Applies to a Child under the Age of 5 Years

Note: Because compulsory school attendance begins at age 5, Status Indicator 7a is applied to a child who is under age 6 and who is not yet attending a formal school program.

From birth, children progress through a series of stages of learning and development. The growth during this period is greater than any subsequent developmental stage. This offers great potential for accomplishments, but also creates vulnerabilities for the child if the child's physical status, relationships, and environments do not support appropriate learning, development, and growth. These developmental years provide the foundation for later abilities and accomplishments. Significant differences in children's abilities are associated with social and economic circumstances that may be impacting learning and development. The cumulative impact of multiple risk factors on development is well documented. Examples of risk factors are: having a parent who abuses substances, exposure to violence and trauma, inappropriate child care and nurturing, and living in a dangerous environment or community. Children served by child welfare systems are at very high risk for developmental delays and they often represent over 50% of the children under age five served through child welfare. Children with Fetal Alcohol Syndrome (FAS) and/or with inflicted brain injury may present significant developmental delays and learning problems. Because this developmental period is critical to the child's future social, emotional, and cognitive development, every attempt should be made to provide these children with early intervention services both within the home and in child care settings.

Fact Pattern

1. If this child is in the first 36 months of life, has this child been referred for screening of developmental delay or disability so that any indicated early intervention services can be provided to maximize the child's potential for growth and development?

2. If the child has had a developmental screening or assessment, does he/she show any developmental delays? • If so, to what degree and in what area? • Does this child present signs and symptoms of Fetal Alcohol Spectrum Disorder (FASD), effects of traumatic brain injury, or reactive behavior patterns associated with repeated exposures to physical abuse or significant early neglect by the parent or caretaker?

3. Does the child appear to be achieving the key development milestones at or above age-appropriate levels?

    •   Social/emotional development
    •   Cognitive development
    •   Physical/motor development
    •   Language development
    •   Self-care skills
    •   School readiness skills

4. Does the child actively participate in self-care, play, socialization, and cognitive activities that appear within the appropriate range of development? • If not, has the child been screened and evaluated for developmental delays or disabilities? • If so, what are the significant findings regarding the child's development path, pace, and potential?

5. If the child presents developmental delays or disabilities, is the child receiving early intervention services provided via an Individualized Family Support Plan (IFSP) if under 36 months of age or an Individual Educational Plan (IEP) if between the ages of 36 and 60 months? • If not, why not?

6. If early intervention services are provided, do the child and parents seem to be responding to the interventions as shown in such areas as improved interaction, acceptance of attempts to nurture, more spontaneous play, emergence of language, etc.?

STATUS REVIEW 7A: EARLY LEARNING & DEVELOPMENT

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Status Situation Observed for the Child, under age 5 years
Rating Level

◆ **Optimal Status.** The child's current developmental status is at or above age expectations in all domains, based upon normal developmental milestones.

6 ☐

◆ **Good Status.** The child's current developmental status is at age expectations in all domains, however, there may be one or two areas in which the child is not as strong and merits ongoing careful monitoring.

5 ☐

◆ **Substantial Status.** The child's current developmental status is near age expectations in most of the major domains and may be slightly below expectations in a few areas. If the child and caretaker is participating in early intervention programs either at home or in a child care environment, the child is making substantial gains and appears to be approaching age-appropriate expectations.

4 ☐

◆ **Marginal Status.** The child's developmental status is mixed, somewhat near expectations in some domains, but showing significant delays in others. If the child and caretaker is participating in an early intervention program either at home or in a child care program, the child is making moderate to slow developmental gains and may not be improving in some domains. Concerted action is needed in this area.

3 ☐

◆ **Poor Status.** The child's developmental status is showing significant delays in several areas as compared to age-appropriate expectations. If the child and caretaker are involved in an early intervention program, either at home or in a child care program, the child may be making gains but has such significant delays that it is not likely that the child will reach age-appropriate levels of functioning for some time. Concerted action is needed in this area.

2 ☐

◆ **Adverse Status.** The child's current developmental status is far below developmental milestones and there may be a decline in certain domains. The child and caretaker may be involved in early intervention programs, but the rate of improvement is no more than minimal and may be subject to periods of regression. Concerted action is needed in this area.

1 ☐

Review 7b: Academic Status

Focus Measure

ACADEMIC STATUS: Degree to which: • The child [according to age and ability] is: (1) regularly attending school, (2) placed in a grade level consistent with age or developmental level, (3) actively engaged in instructional activities, (4) reading at grade level or IEP expectation level, and (5) meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent.

Core Concepts: This Indicator is Applied to a Child 5 Years or Older (Except 6 and not attending school)

The child is expected to be actively engaged in developmental, educational, and/or vocational processes that are enabling the child to build skills and functional capabilities at a rate and level consistent with his/her age and abilities. This means that the child should be:

- Enrolled in an educational program, consistent with age and ability.
- Attending school regularly and at a frequency necessary to benefit from instruction and meet requirements for grade promotion, course completion, and entry into the next school or vocational program.
- Receiving instruction at a grade level consistent with the child's age [or ability, if the child is cognitively impaired].
- Reading at grade level, except when the child's instructional expectations and placement are altered via an Individual Educational Plan (IEP) to an alternative curriculum. When an IEP is directing the child's education via placement in an alternative curriculum, specialized instruction, and related services, the child should be performing at the level anticipated in the IEP.
- Actively and consistently participating in the instructional processes and activities necessary to acquire expected skills and competencies.
- Meeting requirements for grade-level promotion, completing courses and assessment requirements, and, where indicated in an IEP, fulfilling transition processes and requirements for making a smooth transition to the next school or vocational program.

This status review focuses on the child's current learning and academic status relative to access to, participation in, and fulfillment of basic educational requirements for entry into the next school or vocational program.

Note: If a child has an IEP and receives special education services, his/her IEP should specify whether this student is placed in the regular curriculum leading to high school graduation with a diploma or placed in an alternative curriculum leading to a different educational outcome.

Fact Pattern

1. Is this child enrolled in an educational program consistent with age and ability? • If not, why not?

2. Does the child's grade level match the child's age? • If not, why not?

3. Is the child assigned to the general education curriculum leading to a high school diploma? • If not, is the child receiving special education and related services in an alternative curriculum directed via an IEP? If the child is placed in an alternative curriculum, what the expected educational outcome?

4. Is the child actively and consistently engaged in the instructional processes and related activities necessary for acquisition of expected skills, competencies, and performances associated with curricular goals and objectives?

5. Is the child reading on grade level or at a level anticipated in an IEP?

6. Is the child meeting curriculum requirements necessary for promotion, course completion, and IEP-directed transitions? • If not, why not?

REVIEW 7B: ACADEMIC STATUS

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Status Situation Observed for the Child, age 5 years and older

Rating Level

◆ **Optimal Status.** The child is enrolled in a highly appropriate educational program, consistent with age and ability. The child has an excellent rate of school attendance ($\geq$95% attendance with no unexcused absences). The child's optimal level of participation and engagement in educational processes and activities is enabling the child to reach and exceed all educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading at or well above grade level or the level anticipated in an IEP. The child may be meeting or exceeding all requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program.

6

◆ **Good Status.** The child is enrolled in a generally appropriate educational program, consistent with age and ability. The child has a substantial rate of school attendance (e.g., $\geq$90 <95% attendance with no unexcused absences). The child's good level of participation and engagement in educational processes and activities is enabling the child to reach most educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading at grade level or the level anticipated in an IEP. The child may be meeting most requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program.

5

◆ **Fair Status.** The child is enrolled in a minimally appropriate educational program, consistent with age and ability. The child has a fair rate of school attendance (e.g., $\geq$85 <90% attendance with no unexcused absences). The child's fair level of participation and engagement in educational processes and activities is enabling the child to reach at least minimally acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading near grade level or the level anticipated in an IEP. The child may be minimally meeting core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program.

4

◆ **Marginal Status.** The child may be enrolled in a marginally appropriate educational or vocational program, or somewhat inconsistent with age and ability. The child may have an inconsistent rate of school attendance (e.g., $\geq$75 <85% attendance and may have tardy notes or unexcused absences). The child's limited level of participation and engagement in educational processes and activities may be hindering the child from reaching at least minimally acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading a year below grade level or somewhat below the level anticipated in an IEP. The child may not be meeting some core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. Concerted actions needed in this area.

3

◆ **Poor Status.** The child may be enrolled in a poor or inappropriate educational program, or inconsistent with age and ability. The child may have a poor rate of school attendance (e.g., <75% attendance and may have been truant). The child's poor level of participation and engagement in educational processes and activities may be preventing the child from reaching acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading two years below grade level or well below the level anticipated in an IEP. The child may not be meeting many core requirements for grade-level promotion, course completion, or successful transition to the next school or vocational program. Concerted actions needed in this area.

2

◆ **Adverse Status.** The child may be chronically truant, suspended, or expelled from school. The child may be three or more years behind in key academic areas, may be losing existing skills and/or regressing in functional life areas, and/or may be confined in detention without appropriate instruction or hospitalized. Concerted actions needed in this area.

1

Status Review 8: Pathway to Independence

Focus Measure

PATHWAY TO INDEPENDENCE: Degree to which: • The youth [according to age and ability] is: • Gaining skills, education, work experience, connections, relationships, income, housing, and necessary capacities for living safely and functioning successfully independent of agency services, as appropriate to age and ability. • Developing long-term connections and informal supports that will support him/her into adulthood.

Core Concepts

*NOTE: This indicator applies to any youth who is **age 14 or older and in foster care**. This indicator is looking for outcomes beyond formal independent living services.*

The goal of assisting a youth is to build capacities that enable a youth to live safely and to function successfully and independently following the conclusion of children's services. Indications that the youth is building necessary capacities should include the following areas:

- Knowing and using key life skills in solving basic problems related to daily living.
- Knowing and making good decisions about using drugs and alcohol, tobacco use and consequences of sexual behavior.
- Exploring various education, training and career options of interest to the youth.
- Reducing social isolation and building social networks that create supports, linkages, and opportunities, including identification of adults who will continue to support the youth after placement.
- Building job readiness skills and support for locating, obtaining and maintaining employment.
- Being actively involved in developing his/her service plans as well as planning other services provided at this point in the life of the case.

Building these capacities requires a a high standard of practice to ensure that youth has what in necessary to achieve and maintain adequate levels of well-being, functioning, fulfillment of adult roles, and social integration as a citizen in the community. *An alternative time scale is used for this indicator.*

Fact Pattern

1. Is the youth receiving services in the least restrictive, age appropriate, most family-like setting taking into account the youth's community, culture, educational, personal and familial connections?

2. If the youth 16 years or older, does the youth have an identified transitional living plan? • If not, when will these plans be developed?

3. If applicable, does the youth have a realistic budget that includes income and projected expenses that are expected after transition to adulthood?

4. Does the youth practice skills related to daily living (i.e. food preparation, laundry, cleaning, nutrition, time management, etc.)?

5. Has the youth had a voice in deciding current educational needs such as study skills, tutoring, IEP development (if appropriate)?

6. Does the youth have plans for any post secondary education or vocational training related to potential career goals? • If so, have they taken steps toward planning and support related to these goals?

7. Has the youth been an active participant in planning for their current physical, behavioral health and engagement with other community resources related to their overall well-being?

8. Does the youth have a plan for healthcare after discharge including physical and behavioral health and other community resources related to the youth's overall well-being?

9. Is the youth establishing positive and permanent connections with informal supports and resources in the extended family, neighborhood, spiritual community, and/or larger community?

10. Does the youth have in their possession, or access to, key documents such as social security card, birth certificate, photo identification, insurance cards, IEP, etc?

11. Has the youth gained knowledge of appropriate prevention skills related to alcohol and drugs, smoking and consequences of sexual behavior?

STATUS REVIEW 8: PATHWAY TO INDEPENDENCE

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

ALTERNATIVE TIME SCALE USED ON THIS INDICATOR: This indicator measures a youth's progress in developing independent living skills. It is designed to look retrospectively over the past 6 months for a rating of 6 and over the past 3 months for ratings 4 and 5. This variation in the time scale is used to provide a common 30-day window for good and substantial progress towards independent living skills (rating 5) or steadily increasing independent living skills (rating 4). A 30-day period would be too short to discern a clear pattern of developmental progress if skills continue to improve more and more frequently.

<u>Description of the Status Situation Observed for the Youth as Measured over the Past Six Months:</u>   <u>Rating Level</u>

◆ **Optimal Status.** The youth has been making excellent progress over the past 6 months in: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5)developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making excellent progress in: (1) developing a realistic budget; (2) acquiring affordable, quality housing; (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary; and, (4) having a voice in making decisions about his/her life goals, plans, and services.

6 ☐

◆ **Good Status.** The youth has been making good and substantial progress over the past 3 months: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making substantial progress in: (1) developing a realistic budget (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.

5 ☐

◆ **Fair Status.** The youth has been making adequate to fair recent progress over the past 3 months: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making fair progress in: (1) developing a realistic budget; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.

4 ☐

◆ **Marginal Status.** The youth has been making limited or inconsistent progress over the past 30 days: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making limited progress in: (1) developing a realistic budget; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary. Concerted action is needed in this area.

3 ☐

◆ **Poor Status.** The youth has been making slow, inadequate progress over the past 30 days: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is making little progress in: (1) developing a realistic budget; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary. Concerted action is needed in this area.

2 ☐

◆ **Adverse Status.** The youth has been making no progress over the past 30 days: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older adolescents, the youth is not progressing toward: (1) developing a realistic budget; (2) acquiring affordable, quality housing; and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary. Concerted action is needed in this area.

1 ☐

◆ **Not Applicable.** The child is under 14 years or is part of a CPS on-going case. Therefore, this indicator does not apply at this time.

NA ☐

Status Review 9: Parent & Caretaker Functioning

Focus Measure

PARENT & CARETAKER FUNCTIONING: 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.

Core Concepts

Parents/caretakers should have and use levels of knowledge, skills, and situational awareness necessary to provide their child with nurturance, guidance, age-appropriate discipline, and supervision necessary for protection, care, and normal development. Understanding the basic developmental stages that child experience, relevant milestones, expectations, and appropriate methods for shaping behavior is key to parental capacity to support their child's healthy growth and learning. Parenting child with unique medical, developmental, emotional, and/or behavioral challenges can require additional specialized knowledge and resources. Parents who are faced with extraordinary caregiving demands may require additional support, including relief and respite care. The goal of assisting a family who needs assistance with parental capacity is to ensure that the family receives the information, assistance, and/or training needed to demonstrate that they have the basic skills and supports necessary to meet their unique child's needs. Interventions should be an appropriate match to parent and child circumstances, learning styles, and culture.

Parents/caretakers need meaningful connections with family members, friends, neighbors, and others in their community to support their parenting ambitions and efforts. Family members and social networks provide caretakers with important supports, knowledge, linkages, and opportunities. Informal supports can be a family resource in many different ways around parenting issues:

- Gaining and using key life skills in solving basic problems related to daily living and parenting of the child.
- Finding ways to meet fundamental needs (e.g., income, housing, transportation, health care, food, child care).

Fact Pattern

NOTE: When applying this indicator, parents and/or any caretaker(s) should be rated. When scoring a mother/father, the reviewers should take the parents' capacities into consideration and rate each individually. If parental rights have been terminated, then the ratings for "mother" and "father" are marked N/A. If the child has been adopted, then the score for the adoptive parents would be marked under "mother" and/or "father."

1. Do the child's parent(s) and/or caretaker(s) have sufficient income and resources to provide basic necessities adequately, reliably, and consistently on a daily basis such as food, safe shelter, clothing, transportation, health care, and child care?

2. Do the parent(s) and/or caretaker(s) demonstrate that they have and actively use knowledge, skills and emotional capacity to take care of the child and protect the child from harm? • Do they make decisions and act in ways that are protective? • Are they emotionally connected to the child, sensitive to the child's needs and able to respond in ways that appropriately meet the child's needs?

3. Do the parent(s) and/or caretaker(s) have the ability, understanding, and willingness to engage with an informal support system that assists them with essential caregiving responsibilities, such as family members, close friends, helpful neighbors, informal social service organizations, faith based organizations, social clubs, and charitable organizations?

4. Do the parent(s) and/or caretaker(s) have the ability, understanding and willingness to engage with a formal support system that assists them with essential caregiving responsibilities, such as social service agencies, schools, medical providers, transportation, housing, law enforcement, and/or vocational training.?

5. Are the parent(s) and/or caretaker(s) meeting the child's special and/or regular educational needs by assuring school attendance, homework completion, parent/teacher conference attendance, attending school events, and participation in extracurricular activities?

6. Are there extraordinary demands placed on the parent(s) and/or caretaker(s) of this family, such as small child, high child/caretaker ratio, frail elderly, ill persons in the home, single parent family, social isolation, child with special health or medical conditions, or a child with a disability, which impact their ability to parent?

7. Do the parent(s) and/or caretaker(s) provide adequate supervision, nurturance, guidance and emotional support such as age-appropriate praise, affection, structure, discipline, and moral guidance as the child moves through their life stages?

STATUS REVIEW 9: PARENT & CARETAKER FUNCTIONING

8. Do the parent(s) and/or caretaker(s) adequately access the necessary services to meet the age-appropriate physical, dental and mental health needs of the child. • Are there any risk factors which impair a parent(s) and/or caretaker(s)' ability to parent, such as substance abuse, mental disability, domestic violence?

9. If the child is older, are the parent(s) and/or caretaker(s) able to assist with critical life decisions such as education, vocation, employment, sexuality, reproductive health care, religion, morality, or the use of addictive substances?

10. If the child is older, are in substitute care, do the parent(s) and/or caretaker(s) have the willingness and ability to maintain contact and a relationship while the child is out of the home? • Do the parents attend planned visitations with their child?

Status Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Status Situation Observed for the Child and Parent/Caretaker | Rating Level

◆ **Optimal Status.** The parent/caretaker demonstrates excellent and enduring parenting capacities on a reliable daily basis at or above that required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care and supervision. If the child has special needs, the parent/caretaker demonstrates optimal knowledge and excellent use of specialized skills and supports that may be required to meet the needs of the child.

6
☐ Mother
☐ Father
☐ Caretaker

◆ **Good Status.** The parent/caretaker demonstrates good and consistent parenting capacities on a reliable daily basis at or above that required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care and supervision. If the child has special needs, the parent/caretaker demonstrates good working knowledge and proficient use of specialized skills and supports that may be required to meet the needs of the child.

5
☐ Mother
☐ Father
☐ Caretaker

◆ **Fair Status.** The parent/caretaker demonstrates adequate to fair parenting capacities on a reliable daily basis at a level required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care and supervision. If the child has special needs, the parent/caretaker demonstrates at least adequate working knowledge and use of specialized skills and supports that may be required to meet the needs of the child.

4
☐ Mother
☐ Father
☐ Caretaker

◆ **Marginally Inadequate Status.** The parent/caretaker demonstrates a limited or inconsistent pattern of parenting capacities on a daily basis, sometimes or somewhat less than the level required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care and supervision. If the child has special needs, the parent/caretaker demonstrates somewhat inadequate working knowledge and ineffective use of specialized skills and supports that may be required to meet the needs of the child. Concerted action is needed in this area.

3
☐ Mother
☐ Father
☐ Caretaker

◆ **Poor Status.** The parent/caretaker demonstrates an inadequate pattern of parenting capacities some or most of the time, often less than the level required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care and supervision. If the child has special needs, the parent/caretaker demonstrates somewhat inadequate knowledge and ineffective use of specialized skills and supports that may be required to meet the needs of the child. Concerted action is needed in this area.

2
☐ Mother
☐ Father
☐ Caretaker

◆ **Adverse Status.** The parent/caretaker demonstrates a seriously inadequate pattern of parenting capacities most of the time, offering much less than the level required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care and supervision. If the child has special needs, the parent/caretaker lacks working knowledge and ineffectively uses specialized skills and supports that may be required to meet the needs of the child. Concerted action is needed in this area.

1
☐ Mother
☐ Father
☐ Caretaker

◆ **Not Applicable.** The child does not have a mother, father, or caretaker to be reviewed at this time.

NA
☐ Mother
☐ Father
☐ Caretaker

Section 3

Practice Performance Indicators

Reminders for Reviewers

The reviewer should follow these directions when applying a practice performance indicator to a case situation being reviewed:

1. **Focus on the central construct measured in each indicator.** While two constructs may be logically related (e.g., engagement and teamwork or assessment and planning), the reviewer is to focus on the central matters related to each specific indicator and follow the probe and rating guidance provided for each indicator. For example, if a reviewer discovered that strong recent assessments were present but that planning did not reflect the most recent assessments, then the reviewer would rate the assessments as being strong and rate the planning as less than acceptable for not reflecting the most recent and important information. Assessment would not be rated lower because assessment findings were not reflected in the planning of appropriate strategies, supports, and services. Planning would not be rated higher because of the strong assessments.

2. **Stay within the time-based observation windows associated with each indicator.** Practice performance is measured over the past 90 days.

3. **Rate indicators based on events that have occurred or conditions that were present within the time-based observation window**. Theorizing about events that might have occurred but did not is not a factual basis for rating. The 6-Month Prognosis is used to reflect expectations or concerns about future prospects or the suspected future effects of any present insufficiencies in core practice functions.

4. **Follow the guidance provided in rating statements when selecting a rating value for measuring an indicator having multiple components or conditions to be met.** For example, in *Practice Indicator 5 - Long-Term View*, multiple conditions for safe case closure may be necessary in a case (e.g., certain protective capacities, behavioral changes, sustainable supports, or other court-ordered requirements) may be necessary to attain key outcomes within a case. *For a rating of 4*, there has to be at least a minimally adequate fit between the necessary conditions for safe case closure to be met and the assessed strengths, needs, underlying issues and life goals of the child and family involved. The preponderance of elements are found to be in the fair range or higher of practice performance with no essential elements found below minimal adequacy over the past 90 days.

PRACTICE REVIEW 1A: ENGAGEMENT EFFORTS

Focus Measure

ENGAGEMENT: 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. • Offering transportation and childcare supports, where necessary, to increase family participation in planning and support efforts.

Core Concepts

The central focus of this review 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.

NOTE: Practice Review 1.b: Voice and Choice of family members in shaping decisions may provide useful information to consider when rating Practice Review 1.a: Engagement Efforts. Remember that engagement focuses on practice activities that lead to and support an active and effective partnership with the child and family. When these engagement activities are effective, parent participation and satisfaction should be positive.

Fact Pattern

1. What outreach and engagement strategies are team members using to build a working partnership with the child and family? • Has the team offered special accommodations to the family as necessary to encourage and support engagement, participation, and partnership? • Are diligent efforts continuing to look for and find family members who can provide support and permanency for the child over the life of the case?

2. Do family members report being treated with dignity and respect? • Do they have a trust-based working relationship with those providing services?

3. How are the child and family involved in the ongoing assessment of their needs, circumstances, and progress? • Do the child and family routinely participate in the tracking and adjustment of the service arrangements?

4. Is the planning and implementation process child/family-centered and responsive to this family's particular cultural values? • Do the child and family routinely participate in the evaluation of the progress of the service process?

PRACTICE REVIEW 1A: ENGAGEMENT EFFORTS

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Practice Performance Situation for the Child and Family (rate persons as appropriate to the case under review)   Rating Level

◆ **Optimal Practice.** Excellent, culturally competent, outreach efforts are being used as necessary to find and engage the child, parents, all family members, and caretakers. Excellent accommodations provide for scheduling times and locations based on family convenience, support with transportation and child care, individualized problem solving, and time spent in whatever setting necessary to build the necessary relationship and rapport. Family engagement efforts are made consistently and persistently over time. Strong, positive working relationships between team members are evident in this case or high quality efforts have been made to engage key family members.

6
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Good Practice.** Good, consistent, culturally competent, outreach efforts are being used as necessary to find and engage the child, parents, most family members, and caretakers. Team members report specific, useful accommodations being used to provide scheduling times and places based on family convenience, support with transportation and child care, individualized problem solving, and time spent in settings necessary to build the necessary relationship and rapport. Family engagement efforts are made frequently, at least twice a month. Good working relationships between team members are evident in this case, or reasonable efforts have been made to engage key family members.

5
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Fair Practice.** Minimally adequate to fair outreach efforts are being used as necessary to find and engage the child, parents, some family members, and caretakers. Team members report some accommodations being offered to provide scheduling times and places based on family convenience, support with transportation and child care, individualized problem solving, and time spent in settings necessary to build the necessary relationship and rapport. Family engagement efforts are made occasionally, at least once a month. Fair working relationships between team members are evident in this case, or minimally adequate efforts have been made to engage the key people.

4
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Marginal Practice.** Limited and somewhat inadequate or inconsistent outreach efforts are being used as necessary to find and engage the child, parents, family members, and caretakers. Team members report few accommodations being offered to provide scheduling times and places based on family convenience, support with transportation and child care, individualized problem solving, and time spent in settings necessary to build the necessary relationship and rapport. Family engagement efforts are made sporadically, less than once a month. Mixed or marginally inadequate working relationships between team members may be evident in this case or reflective of a limited level of effort made to engage the key people involved in this case. Concerted action is needed in this area.

3
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Poor Practice.** Few, if any, reasonable efforts have been made by the team to increase the engagement and participation of the family, though a team member may report that they have made efforts to establish rapport with at least some members of the family. Mixed or inadequate working relationships between team members are evident in this case or reflective of an inadequate level of effort made to engage the key people involved in this case. Concerted action is needed in this area.

2
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Absent or Adverse Practice.** There were no efforts made to engage the family. Service planning and decision-making activities are conducted at times and places or in ways that prevent or severely limit effective child and family participation. Decisions are made without the knowledge or consent of the parents, the caretakers, or the child. Services may be denied because of failure to show or comply. Appropriate and attractive alternative strategies, supports, and services are not offered. Important information may not be provided to parents or caretakers. Procedural or legal safeguards may be violated. Concerted action is needed in this area.

1
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Not Applicable.** The child is unable, because of age or developmental stage, to participate. The birth parents are no longer part of the family team due to termination of parental rights. There is no domestic partner. There is no caretaker or congregate care provider.

NA

Practice Indicator 1b: Voice & Choice

Focus Measure

VOICE & CHOICE: 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.

Core Concepts

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.

Fact Pattern

1. To what degree does the family influence all phases of service?

2. To what degree is the family change process owned by family members and lead by the birth parent or caretaker? • How well does the agency encourage family member participation?

3. Do the child and family routinely participate in the assessment, planning, monitoring/modification of child and family plans, arrangements, and evaluation of results?

4. How involved are the child's parent(s)/caretaker in the child's medical, educational, and behavioral health meetings/appointments?

5. Are worker visits with the child and family sufficient to ensure safety, permanence, and well-being and promote achievement of the case goals?

Practice Indicator 1b: Voice & Choice

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

NOTE: This indicator applies to the birth parent and/or caretaker of the child. If the child is living with the birth parent at the time of review, then the birth parent is rated and the substitute care person is marked NA. If the child is living in a substitute care setting with a goal of reunification, then the birth parent is rated and the substitute care person is rated. If parental rights have been terminated, then the birth parent rating is marked NA and only the substitute care person is rated.

Description of the Focus Individual's Role and Voice (rate persons as appropriate to the case under review)

Rating Level

◆ **Optimal Practice.** Key family members are full and effective partner(s) on the team, fully participating in all aspects of assessment, service planning, implementation and monitoring, and evaluation of results for the child and family. The child and parent and/or caretaker (as appropriate) have a central and directive role, providing a voice that shapes the decisions made by the team on behalf of the child and family. Visits are of sufficient quality to move the case forward.

6
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Good Practice.** Key family members are substantial and contributing partners on the team, generally participating in most aspects of assessment, service planning, implementation and monitoring, and evaluation of results. The child and parent and/or caretaker (as appropriate) have a present and effective role, providing a voice that influences the decisions made by the team on behalf of the child and family. Visits are of sufficient quality to move the case forward.

5
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Fair Practice.** Key family members are fair participant(s) in some aspects of team decision making, minimally participating in some assessment, service planning, implementation and monitoring, and evaluation of results. The child and parent and/or caretaker (as appropriate) have a minimally effective role, providing a voice that suggests and affirms the decisions made by the team on behalf of the child and family. Visits are of adequate quality to move the case forward.

4
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Marginal Practice.** Key family members are limited or inconsistent participant(s) in a few aspects of assessment, service planning, implementation and monitoring, and evaluation of results. The parent/caretaker may have limiting circumstances, may not have been offered accommodations or supports, or may not wish greater participation even with offered accommodations or assistance. The child and parent and/or caretaker (as appropriate) have a marginal role, providing a somewhat passive voice that acknowledges or accepts decisions made by the team on behalf of the child and family. Visits are not of sufficient quality to move the case forward. Concerted action is needed in this area.

3
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Poor Practice.** Key family members seldom participate(s) in any aspects of assessment, service planning, implementation and monitoring, and evaluation of results. The parent/caretaker may have challenging circumstances, may not have been offered acceptable accommodations or supports, or may not wish greater participation even with offered accommodations or assistance. The child and parent and/or caretaker (as appropriate) have a missing or silent role. Visits are of not sufficient quality to move the case forward. Concerted action is needed in this area.

2
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Absent or Adverse Practice.** Key family members have not participated in any aspects of assessment, service planning, implementation and monitoring, and evaluation of results. The parent/caretaker may be experiencing overwhelming life circumstances, without the benefit of special accommodations for support or participation. The child may be receiving services in a placement setting, or alternative educational placement situation and is detached from all previously established connections. Concerted action is needed in this area.

1
☐ Child
☐ Mother
☐ Father
☐ Caretaker
☐ Other

◆ **Not Applicable.** The child and parent, caretaker and/or other key person cannot exercise a voice and choice at this time.

NA

Practice Review 2: Teaming

Focus Measure

TEAMING: 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. • 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.

Core Concepts *[UNITY OF EFFORT, COMMONALITY OF PURPOSE, AND EFFECTIVENESS IN PROBLEM-SOLVING = SUCCESSFUL TEAMWORK]*

This review 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.

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.

Fact Pattern

1. How were available family members, informal supports, child welfare professionals, and outside stakeholders invited to be part of the team?

2. Have all of the family team members participated in information sharing, planning, decision making, and evaluating results?

3. Does the family team know who the family leader is? • Is the family satisfied with the functioning of the team? • Can the caretaker or older child request a team meeting at anytime?

4. Does the family team have a unified and comprehensive strength based understanding that is working toward common goals and objectives leading towards case closure for the child and family?

5. Does the family team have the necessary skills to work effectively with the child and family?

6. Are family team members committed to ensuring the delivery of services and resources for the child and family?

7. Are all members of the family team being responsible for initiating contact to share information and communicating as a team?s

8. Has the family team worked together to create and implement a comprehensive and individualized service plan for the child and family?

9. Does the family team have access to informal resources and flexible funding for concrete family needs?

10. Does the family team have a pattern of effective teamwork, commitment, and good outcomes for the child and family?

11. Are family team meetings conducted at crucial points through the life of the case ("(i.e., determination of high or very high risk, after removal from the home, prior to change in placement, prior to change in goal, and at the request of a parent/caseworker/child)?

PRACTICE REVIEW 2: TEAMING

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Practice Performance Situation Observed for the Child and Family Team   Rating Level

◆ **Optimal Practice.** Formation: All of the people who provide support and services for this child and family have been identified and formed an excellent working team. The team has excellent skills, family knowledge, cultural awareness and abilities necessary to organize effective services for the child and family. All of the family team members are optimally organized and able to shift leadership roles as needed, remain in timely, ongoing communication, and are accountable for ensuring a common purpose. Functioning: The team has an excellent pattern of having a unified and comprehensive strength based understanding that is clearly working toward common goals and objectives leading towards safe case closure for the child/family. The team has shown a consistency in their ability to assess, plan, implement and prepare for safe case closure.

6
☐ Formation
☐ Functioning

◆ **Good Practice.** Formation: Most of the people who provide support and services for this child and family have been identified and formed an adequate to fair working team. The team has good skills, family knowledge, cultural awareness and abilities necessary to organize effective services for the child and family. All of the family team members are substantially organized and generally able to shift leadership roles as needed, remain in timely, ongoing communication, and are accountable for ensuring a common purpose. Functioning: The team has a good and dependable pattern of having a unified and comprehensive strength based understanding that is working toward common goals and objectives leading towards safe case closure for the child/family. The team has shown a general consistency in their ability to assess, plan, implement and prepare for safe case closure.

5
☐ Formation
☐ Functioning

◆ **Fair Practice.** Formation: Some of the people who provide support and services for this child and family have been identified and formed a working team. The team is adequate to fair in their skills, family knowledge, cultural awareness and abilities necessary to organize effective services for the child and family. Family team members are fairly organized and usually able to shift leadership roles as needed, remain communication, and are accountable for ensuring a common purpose. Functioning: The team has a pattern of having a somewhat unified and comprehensive strength based understanding that is working to some extent toward common goals and objectives leading towards safe case closure for the child/family. The team has shown an adequate consistency in their ability to assess, plan, implement and prepare for safe case closure.

4
☐ Formation
☐ Functioning

◆ **Marginally Inadequate Practice.** Formation: Some of the people who provide support and services for this child and family have been identified and formed a working team. The team is marginal in their skills, family knowledge, cultural awareness and abilities necessary to organize effective services for the child/family. Family team members are somewhat insufficiently organized and inconsistently shift leadership roles as needed, remain communication, and are accountable for ensuring a common purpose. Functioning: The team has a pattern of having a somewhat unified understanding that is working to some extent toward goals and objectives leading towards safe case closure for the child and family. The team has shown a limited consistency in their ability to assess, plan, implement and prepare for safe case closure. Concerted action is needed in this area.

3
☐ Formation
☐ Functioning

◆ **Poor Practice.** Formation. There is no evidence of a formed or functional family team for this child and family with all interveners working independently and in isolation from one another. The action and decisions made by the group are inappropriate and adverse. Concerted action is needed in this area. Persons working with the family are insufficiently organized and not accountable for ensuring a common purpose and communication between team members. Functioning: There is not a unified understanding working toward goals and objectives leading towards safe case closure for the child/family. Persons may often function independently. Actions reflect an infrequent or rare pattern of team work. Concerted action is needed in this area.

2
☐ Formation
☐ Functioning

◆ **Absent or Adverse Practice.** There is no evidence of a formed or functional family team for this child and family with all interveners working independently and in isolation from one another. The action and decisions made by the group are inappropriate and adverse. Concerted action is needed in this area.

1
☐ Formation
☐ Functioning

Practice Review 3: Cultural Awareness & Responsiveness

Focus Measure

CULTURAL AWARENESS & RESPONSIVENESS: 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 of poverty, urban and rural dynamics, faith and spirituality, child culture, etc.). • 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. *NOTE: This is applied to all families.*

Core Concepts

"Culture" is broadly defined. Focus is placed on whether the child's and family's culture has been assessed, understood, and accommodated. Making sensitive cultural accommodations involves a set of strategies used by practitioners to individualize the service process to improve the goodness-of-fit between family members and providers who work together in the family change process. Many families may require simple adjustments due to differences between the family and providers. Such simple adjustments are a routine part of engagement, assessment, planning, and service provision. A family's identity may shape their world view and life goals in ways that must be understood and accommodated in practice, [e.g., Racial, tribal, ethnic; Sexual Orientation; Class, income/poverty; Environmental; Gang membership; Dietary Customs; Religious/Spiritual affiliations; and/or Other (i.e. such as deaf, visually impaired, military culture)]. Reviewers should consider the requirements of two federal laws (i.e., **ICWA** - Indian Child Welfare Act and **MEPA** - Multi-Ethnic Placement Act), as appropriate, to the child and family under review.

Each child and family has their own unique identities, values, beliefs, and world views that shape their ambitions and life choices. Children and families may require use of specialized accommodations and culturally competent supports in order to successfully engage, educate, assist, and support a family moving through a change process to family independence and sustainable, safe case closure by the system, as child welfare agencies serve an increasing proportion of children and families outside the majority culture. Accommodations include valuing cultural diversity, understanding how it impacts family functioning in a different majority culture, and adapting service processes to meet the needs of culturally diverse children and their families. Properly applied in practice, cultural accommodations reduce the likelihood that matters of language, culture, custom, identity, value, or belief will prevent or reduce the effectiveness of family change efforts.

Domains of Cultural Competence are: • Values and attitudes that promote mutual respect. • Communication styles that show sensitivity and non-judgmental stance. • Community and active consumer participation in developing evaluation of policies, practices, and interventions that builds on cultural understandings. • Physical environment including settings, dietary needs, materials, and resources that are culturally and linguistically responsive. • Policies and procedures that incorporate cultural and linguistic principles, multi-cultural practices, and locations of diverse populations.• Population-based clinical practice that avoids misapplication of scientific knowledge and stereotyping groups. • Training and professional development in culturally competent practice.

Fact Pattern

1. Are the child and family's cultural identity and related needs identified?

2. Are assessments performed appropriate for the family's background?

3. Do the service providers respect family beliefs and customs? • Where indicated, are tribal laws and customs respected and ICWA requirements met?

4. Is there a need for the team to be of the same cultural background as this family? • Does the team have adequate knowledge of cultural issues relevant to service delivery for this child and family? • If not, what is missing or misunderstood?

5. If the child or parent/caretaker has a primary language that is other than English, are translator services provided, and how is reliability of translator ensured?

6. Has the family team explored natural, cultural, or community supports appropriate for this child and family? Examples of possible supports include: spiritual advisors or traditional healers.

7. How does the family identify its own culture? • How has culture been assessed in this case? • What impact, if any, do any cultural differences play on engagement and team work in this case? • How sensitive to cultural issues is the team in this case? • Are cultural differences impeding working relationships with this child and family? • How have cultural conflicts been resolved?

Practice Review 3: Cultural Awareness & Responsiveness

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

<u>Description of the Practice Performance Situation Observed for the Child and Family Team</u>   <u>Rating Level</u>

◆ **Optimal Practice.** The family's cultural identity has been assessed thoroughly and with cultural sensitivity, and specialist services are provided in a culturally appropriate manner for this child and family on a consistent and reliable manner with the child and family being asked for their feedback throughout service. The child and family's cultural identity is recognized and well understood, and services are flexibly tailored to meet related needs. Family cultural beliefs and customs are fully respected and well accommodated in service processes. All assessments use culturally appropriate language that is not judgmental and limitations or potential cultural biases are recognized and noted. Service providers are fully knowledgeable about issues related to the child and family's identified culture and shape treatment planning and delivery appropriately by ensuring the child and family have an active voice in service planning. Other natural community helpers important to the child and family's culture are included in service planning and delivery. Service providers have ensured optimal cultural understanding and responsiveness by seeking feedback, suggestions, and meeting with community contacts who are similar or a familiar to the culture of the child and family. Service delivery and planning has illustrated that interventions were designed to fit the client's cultural needs rather than requiring or demanding the client to change and fit the system.

6
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Good Practice.** The child's and family's cultural identity is recognized and services generally address related needs. Feedback is sought from the child and family about its effectiveness. Family cultural beliefs and customs are respected and taken into consideration for planning services. Most assessments are culturally appropriate and limitations or potential cultural bias is recognized. Other natural community helpers important to the child"s culture are acknowledged and information is obtained from them.

5
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Fair Practice.** The child's and family's cultural identity is recognized and the providers acknowledge this in the assessment, planning process, and service delivery. The child and family's cultural beliefs, identity, and customs are usually acknowledged and services are planned in an effort to avoid violations. For example, the provider might acknowledge and reach out to other natural community helpers important to the child and family's culture and works with the child and family to integrate those supports.

4
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Marginal Practice.** The child's and family's cultural identity is recognized and the providers acknowledge that assessment, treatment planning, or services are not a good fit but is seeking to improve these processes for the child and family. There may be evidence of cultural accommodations by the provider/agency in some cases, although it is limited or inconsistent for the child and family. Concerted action is needed in this area.

3
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Poor Practice.** The child's and family's cultural identity is not recognized in the service process. If needed, translation and/or specialist services were sought but were difficult to secure through the provider/agency. Thus, no useful translation and/or special provisions are made for cultural accommodations with this child and family. Concerted action is needed in this area.

2
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Absent or Adverse Practice.** There is no evidence of cultural recognition or accommodation in this case. No assessments were sought that could have assisted service delivery with the child and family. There has been no attempt by service providers to understand and accommodate possible cultural needs of the child and family. The child and family's cultural identity may be treated with disrespect and their customs, values and beliefs may be ignored, stereotyped, treated as irrelevant or deemed inferior. Assessment, treatment planning, or service delivery processes do not seek to get feedback at any point in time from the child and family about their cultural beliefs and customs. Concerted action is needed.

1
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Not Applicable.** There is no such person participating in this case.

NA

Practice Review 4: Assessment & Understanding

Focus Measure

> **ASSESSMENT & UNDERSTANDING: 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. (6) The path and pace by which permanency will be achieved for a child who is not living with nor returning to the family of origin.**

Core Concepts

Effective assessments supporting team-based reasoning lead to essential understandings in an ongoing process that informs the choice of intervention strategies and supports used to help the child and family make changes that lead to desired outcomes. As appropriate to the situation, a combination of clinical, functional, educational, and informal assessment techniques should be used to determine the strengths, needs, underlying issues, and future goals of the child and family.

Once gathered, the information should be analyzed and synthesized to form a functional assessment or "big picture understanding" of the child and family. Assessment techniques, both formal and informal, should be appropriate for the child's age, ability, culture, embraced faith, language or system of communication, and social ecology. New assessments should be performed promptly when planned goals are met or are not being met, when emergent needs or problems arise, or when changes are necessary.

Continuing assessments and understandings direct modifications in strategies, services, and supports for the child and family as conditions change. Maintaining a useful big picture understanding is a dynamic, ongoing process. The focus here is placed on understanding the family's situation well enough to help the family make positive life changes.

Fact Pattern

1. What are the critical issues (i.e. strengths, needs, safety threats/factors, risk factors, caretaker capacities, behaviors, underlying issues, etc.) that exist for the child and family?

2. How well does the social worker and team know and understand the strengths and needs of this child and family?

3. How well are child and family stressors recognized? • How are these understood within the context and culture of this child and family?
   - Earlier life traumas, losses, disruptions
   - Learning problems affecting school or job performance
   - Subsistence challenges of the family
   - Risks of harm, abuse, or neglect
   - Developmental delays or disabilities
   - Court-ordered requirements/constraints
   - Co-occurring disabling conditions
   - Physical and/or behavioral health concerns
   - Recent tragedy, loss, victimization
   - Problems of attachment and bonding
   - Recent life transitions and adjustments to new conditions
   - Extraordinary caregiver burdens

4. What observations, formal assessments, or evaluations have been obtained? • Are assessments appropriate for this child and family? • Is there evidence that assessment is a dynamic, continuous learning process? • Is there evidence that the child/family assessment evolved over the course of the life of the case and impacted decision-making and planning?

5. How well does the assessment and understanding process reveal the big picture situation for any substitute caretakers and permanency resources (e.g., relatives and foster parents who may become the permanency caretaker for the child)? • If there are different views of the child, family and/or substitute caretakers/permanency resources, what would it take for them to form a common vision and understanding?

6. Does the assessment support a long-term view of the child and family leading to independence from service system involvement and supports?

Practice Review 4: Assessment & Understanding

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

NOTE: If parental rights have been terminated and the parent(s) has no contact with the child or the parent(s) is/are deceased, then this indicator would be marked NA for the parent(s). If the child has been adopted, then the mother and/or father option would be scored on the adoptive family.

<u>Description of the Practice Performance Situation Observed for the Child and Family</u>   <u>Rating Level</u>

◆ **Optimal Practice.** Assessment of child/family functioning, life circumstances, underlying issues and support systems are comprehensively and progressively understood by the team. Knowledge necessary to understand the child and family's strengths, needs, and choices is continuously updated and used to keep the big picture understanding current and comprehensive. Present strengths, risks, and underlying needs requiring intervention or supports are fully recognized and understood. Necessary conditions for improved functioning and independence from the system are fully understood and used to select effective change strategies

6
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Good Practice.** Assessment of child/family functioning, life circumstances, most underlying issues, and support systems are generally and progressively understood by the team. Information necessary to understand the child and family's strengths, needs, and choices is frequently updated and used to keep the big picture understanding fresh and useful. Present strengths, risks, and underlying needs requiring intervention or supports are substantially recognized and well understood. Necessary conditions for improved functioning and independence from the system are generally understood and used to select promising change strategies.

5
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Fair Practice.** Assessment of child/family functioning, life circumstances and support systems are at least adequately identified and periodically understood by some participants of the team. Information necessary to understand the child and family's strengths, needs, and choices is periodically updated and used to keep the big picture understanding fairly useful. Some strengths, risks, and underlying needs requiring intervention or supports are minimally recognized and understood. Necessary conditions for improved functioning and independence from the system are at least minimally understood and used for some possible change strategies.

4
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Marginal Practice.** Assessment reveals only a limited understanding of the child/family functioning, life circumstances, and support systems by some members of the team. Information necessary to understand the child and family's strengths, needs, and choices is limited and occasionally updated. Present strengths, risks, and underlying needs requiring intervention or supports are partly understood on a limited or inconsistent basis. Necessary changes in behavior or conditions are somewhat recognized but may not be usefully interpreted to support change strategies used

3
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Poor Practice.** Assessment is insufficient and/or inconsistent. Understanding of child/family functioning, life circumstances and support systems may be obsolete, erroneous, or inadequate. Information necessary to understand the child and family's strengths, needs, and context is poorly or inconsistently updated. Uncertainties exist about present conditions, risks, and underlying needs requiring intervention or support. Necessary changes in behavior or conditions may be confused or contradictory. Dynamic conditions may be present that could require a fundamental reassessment of the child and family's situation.

2
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Absent or Adverse Practice.** Current assessments are absent or incorrect and miss critical events and decisions. Some adverse associations between the current situation, the child's bio/psycho/social/educational functioning, and the parent's functioning and support system may have been made. Glaring uncertainties and conflicting opinions exist about things that must be changed for needs and risks to be reduced and the child to function adequately in normal daily settings. A new and complete assessment should be made and used now for this case to move forward.

1
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Not Applicable.** Parental rights have been terminated and parent(s) has no contact with the child; Parent(s) is/are deceased. Or, there is no substitute caretaker in the case at this time.

NA
☐ Mother
☐ Father
☐ Caretaker

Practice Review 5: Long-Term View

Focus Measure

LONG-TERM VIEW: Degree to which: • There are stated, shared, and understood safety, well-being, and permanency outcomes and functional life goals for the child and family. • 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.

Core Concepts

What are the existing barriers that prevent the child and family from achieving their vision? What must change? What pathway will lead to stability and permanency? How will the child, parent, and interveners together know when progress is being made and when desired outcomes and goals have been achieved -- so that interventions can be safely concluded? In a broad sense, *having a long-term view of stability and permanency enables the child, family, and those helping them to see both the next step forward and the end-point on the horizon -- thus, providing a clear vision of the path ahead.* This review focuses on the specification and use of the outcomes and goals that must be attained by the child and family (birth, adoptive, or relative) to achieve stability, adequate functioning, permanency, and other outcomes necessary for the child and family to achieve their desired improvements and goals.

As necessary for the child and family to achieve adequate functioning and independence, a statement of specific outcomes and goals to be achieved is necessary to guide the interventions and change process. This statement frames a *long-term vision* for adequate and sustaining functioning and well-being for the child and family. It defines the *destination points of the journey of change* by framing necessary outcomes/end points and goals for the child/family to function successfully with improved well-being. Achieving such outcomes and goals involves intervention processes commensurate in scope and intensity with the range of needs and family-specific context presented by the child and family. Thus, goals or necessary outcomes for a child and family with extensive needs might include: (1) situational stability, (2) safety/management of risks, (3) skills and behaviors for daily functioning in essential life activities and roles, (4) concurrent alternatives to permanency, (5) sustainable supports, (6) resiliency/coping for children, (7) recovery/relapse prevention for older youth and adults, (8) independence from system involvement, (9) successful transitions and life adjustments, (10) improved self-sufficiency.

As appropriate to the child and family under review, these goals may span health/behavioral health care, child welfare, special education, addiction treatment, and juvenile justice services. This implies that interveners together must understand and coordinate their change requirements, strategies, and interventions used to achieve necessary results and outcomes for the child and family. Specification of these conditions defines what must be achieved for the child and family to function adequately and to benefit from interventions that help improve daily functioning and overall well-being.

Fact Pattern

1. If this child and/or parent requires treatment for psychiatric or addiction problems, are outcomes for achievement of stability, improved functioning, symptom management, recovery, and relapse prevention and overall improved well-being clearly specified and understood by all involved?

2. If this child and family is involved with child protective services and/or juvenile court (probation/parole), have the interveners, working in partnership with the child and family, defined conditions for timely completion of court requirements and supported the achievement of necessary behavior changes, the resolution of outstanding legal requirements or constraints, and any other conditions for achieving family independence? • How well is the parent supported and helped to ensure understanding of these conditions? • Does the plan reflect family strengths and preferences in strategies and approaches to the necessary changes?

3. If appropriate, is there a concurrent plan that is being used in the event that the current parent is unable to meet the agreed-upon conditions for family preservation or reunification? • Does the concurrent plan provide appropriate conditions for selection of prospective adoptive parents or relatives, especially for a child having special needs? • Does it prepare the parents, caretaker, and child for adoption?

4. Where appropriate, is an older youth's developmental goals, planned identification and use of strengths, and educational trajectory consistent with achieving optimal self-sufficiency and independence given the capacities of the youth? • Is there a guiding view for planning services and providing supports that provides for the youth's transition to independent living, new housing, and adequate income as appropriate to the youth's capacities? • Does it set goals aimed at the child's success after making the transitions and life adjustments that will be necessary upon reaching the age of majority?

5. If the youth is age 16 years or older, is there a planned trajectory that guides his/her transition for getting from school to work, to independent/supported living, and to any necessary adult services? • What are the conditions necessary for independence from supports and services that have been set for this youth and used in planning services? • Will the youth's current trajectory likely lead to greater independence, social integration, and community participation?

PRACTICE REVIEW 5: LONG-TERM VIEW

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

<u>Description of the Practice Performance Situation Observed for the Child and Family</u>   <u>Rating Level</u>

◆ **Optimal Specification of Outcomes.** An excellent set of well-reasoned and well-specified safety, well-being, and permanency outcomes for the child and family is fully known, understood, and supported by all involved. These goals are diligently used to guide intervention efforts. Commensurate with the child and family situation and encompassing all interests involved in the intervention process, the scope and detail of the end outcomes and requirements fully fits the scope and nature of change to be accomplished by the child and family, including satisfaction of any and all court requirements. The permanency outcomes and end requirements are fully reflective of the understood child/family situation and what must change for the intervention process to be concluded successfully.

6

◆ **Good Specification of Outcomes.** A good and sufficient set of well-reasoned and well-specified safety, well-being, permanency outcomes and life for the child and family is substantially known, understood, and supported by all involved. These goals are substantially used to guide intervention effort. Commensurate with the child and family situation and encompassing all interests involved in the intervention process, the scope and detail of the end outcomes and requirements substantially fits the scope and nature of change to be accomplished by the child and family, including satisfaction of any and all court requirements. The permanency outcomes and end requirements are generally reflective of the understood child/family situation and what must change for the intervention process to be concluded successfully.

5

◆ **Fair Specification of Outcomes.** A minimally adequate to fair set of safety, well-being, permanency outcomes for the child and family is somewhat known, understood, and supported by those involved. These goals are at least minimally used to guide intervention and change. Somewhat commensurate with the child and family situation and encompassing most interests involved in the intervention process, the scope and detail of the end outcomes and requirements minimally fits the scope and nature of change to be accomplished by the child and family, including satisfaction of any and all court requirements. The permanency outcomes and end requirements are at least minimally reflective of the understood child/family situation and what must change for the intervention process to be concluded successfully.

4

◆ **Marginally Inadequate Specification of Outcomes.** A marginal, somewhat inadequate set of safety, well-being, permanency outcomes for the child and family is somewhat known and understood by some of those involved. Goals are limited and inconsistent in guiding intervention and change. Somewhat inconsistent with the child and family situation and encompassing only some interests involved in the intervention process, the scope and detail of the end outcomes and requirements inadequately fits the scope and nature of change to be accomplished by the child and family, including satisfaction of any and all court requirements. The permanency outcomes are limited in their reflection of the understood child/family situation and miss some important aspects of what must change for the intervention process to be concluded successfully.

3

◆ **Poor Specification of Outcomes.** A poorly reasoned, inadequate, or incomplete set of safety, well-being, permanency outcomes for the child and family is confusing for those involved. These goals are insufficient for guiding intervention and change. Major gaps exist in defining outcomes or reflecting important legal requirements that must be resolved before the intervention process can be concluded.

2

◆ **Absent or Adverse Specification of Outcomes.** There is no common direction, outcome, or requirement to guide services that is accepted and used by those involved in intervention and change processes. The future trajectory is obscure or ambiguous and interveners may be working in isolation with divergent or conflicting intentions. Goals may not address permanency outcomes or other requirements that would apply to determine readiness for closure. Conflicting goals and tacit expectations, if implemented, could lead to poor results or possible adverse consequences for the child or family.

1

Practice Review 6: Planning for Safe Case Closure

Focus Measure

PLANNING PROCESS: Degree to which the planning process: • Is individualized and matched to the child's and family's present situation, preferences, near-term needs, and long-term view for safe case closure. • 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.

Core Concepts

To be effective, a child and family planning process should: (1) be based on a big picture understanding of accurate and recent assessments that explain near-term needs and underlying issues that must be addressed in order to bring about essential family changes; (2) reflect the views and preferences of the child and family; (3) be directed toward the achievement of conditions necessary for family independence and sustainable safe case closure -- as defined in the Long-Term View; (4) be coherent in design and practical in the use of formal and informal resources; (5) be culturally appropriate; and, (6) be modified frequently, based on changing circumstances, experience gained, and progress made toward meeting necessary conditions for safe case closure.

Specific focal points include those strategies specified for meeting desired outcomes related to: (1) child safety, well-being, and permanency and (2) stabilizing, supporting, and sustaining the family or permanent caretaker for the child.

The written child and family service plan is the collective intentions of the child and family team that states the path, processes, and outcomes of family change to be followed. If applicable, this should include a written *safety plan with present capacities for effective implementation*. Family team members should work collaboratively to unify their efforts to develop a coherent set of purposes and processes to help the child and family become successful. The child and family plan specifies the goals, roles, strategies, resources, and schedules for coordinated provision of assistance, supports, supervision, and services for the child and family. The focus of this indicator is placed on the planning process, not on any one plan document since a child and family may have numerous plans related to various programs and providers. The reviewer should remember that planning is an ongoing team-based process for specifying and organizing intervention strategies and directing resources toward the accomplishment of defined outcomes set forth in the long-term view for the child and family.

Fact Pattern

1. How well are the child and family engaged and participating in planning? • Are strategies and services tailor-made and assembled uniquely for this child and his/her parents? • How well does the current mix of strategies and services match the child/family situation, cultural background, and expressed preferences? • Are strategies and services based on need rather than on availability?

2. If the child presents developmental delays or disabilities, is the child receiving early intervention services provided via an Individualized Family Service Plan (IFSP) if under 36 months of age or an Individual Educational Plan (IEP) if between the ages of 36 and 60 months? • If not, why not? Are the appropriate early intervention services accessible and available to meet the child's identified needs?

3. How well are change strategies, interventions, and supports matched to the family changes necessary for achieving family independence and for sustaining family functioning and well-being following safe case closure?

4. When applicable, are the concurrent plans individualized to the child/family and do they maximize potential results and minimize conflicts?

5. Are all members of the family team involved in the planning process and contributing to plan revisions? • Do team members share a common understanding and big picture view of this child and family and what it will take to achieve successful results and outcomes?

6. Are the roles, assigned responsibilities, commitments, and timelines clear and agreed upon by the key parties for this child and family? • Are there dependable working relationships among the key parties?

7. To what degree is daily practice actually driven by the service planning process? • Does the service plan have a sense of urgency in working toward resolution and closure?

PRACTICE REVIEW 6: PLANNING FOR SAFE CASE CLOSURE

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Practice Performance Situation Observed for the Planning Process

Rating Level

◆ **Optimal Practice.** An excellent planning process is used that is fully individualized and relevant to child and family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning is well-reasoned, building on accurate understandings from recent assessments and fully reflecting the Long Term View. Change strategies, interventions, and supports are optimally organized into a holistic and coherent service process providing a sensible combination and sequence of strategies, interventions, and supports uniquely matched to the child/family's situation and preferences. Strategies and services based on need rather than on availability. Planned strategies, interventions, and supports optimally fit the family's situation and change requirements so as to maximize potential results and prevent conflicts and inconveniences. Planning adapts immediately to changes in life circumstances and includes a viable concurrent plan. To be optimal, plans should include an individualized and current safety plan with present capacities for effective implementation, if applicable.

6
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Good Practice.** A good and consistent planning process is used that is generally individualized and relevant to child and family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning is thoughtful, building on accurate understandings from recent assessments and substantially reflecting the Long Term View. Change strategies, interventions, and supports are well-organized into a holistic and coherent service process providing a useful combination and sequence of strategies, interventions, and supports well matched to the child/family's situation and preferences. Planned strategies, interventions, and supports substantially fit the family's situation and change requirements so as to enhance potential results and minimize conflicts and inconveniences. Planning adapts quickly to changes in life circumstances and includes an identifiable concurrent plan. To be determined to be substantial, plans should include a generally individualized and current safety plan with developed capacities for effective implementation, if applicable.

5
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Fair Practice.** An adequate to fair planning process is used that is somewhat individualized and relevant to child and family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning somewhat builds on basic understandings from assessments and adequately reflects the Long Term View. Change strategies, interventions, and supports are somewhat organized into a useful service process providing a combination and sequence of strategies, interventions, and supports somewhat matched to the child/family's situation and preferences. Planned strategies, interventions, and supports adequately fit the family's situation and change requirements so as to support potential results and reduce conflicts and inconveniences. Planning adapts periodically to changes in life circumstances and includes a potential concurrent plan. To be fairly acceptable, the plan should include a somewhat individualized and current safety plan, if applicable.

4
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Marginal Practice.** A limited or inconsistent planning process is used that is somewhat individualized and relevant to child and family needs and to family changes that must be made. Planning reflects limited understandings from assessments and marginally reflects the Long Term View. Change strategies, interventions, and supports are somewhat disorganized into a limited or possibly under-powered service process providing possible inconsistent or inadequate strategies, interventions, and supports somewhat mismatched to the child/family's situation and preferences. Planned strategies, interventions, and supports don't well fit the family's situation and change requirements and may limit potential results and increase conflicts and inconveniences. Planning adapts occasionally and/or inconsistently to changes in life circumstances and a concurrent plan is not fully established. The plan includes a somewhat individualized safety plan but is not current to the present circumstances. Concerted action is needed in this area.

3
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Poor Practice.** A substantially inadequate planning process is used that is neither individualized nor relevant to child and family needs and to family changes that must be made. Planning reflects poor understandings from assessments and may not reflect the Long Term View. Change strategies, interventions, and supports are substantially disorganized, limited or possibly under-powered and may be mismatched to the child/family's situation and preferences. Poorly planned strategies, interventions, and supports may not fit the family's situation and change requirements, may fail to yield results, and may cause unnecessary conflicts and inconveniences. Planning may not adapt to changes in life circumstances and a concurrent plan has not yet been addressed with all team members. The plan includes a safety plan but is neither individualized nor current to the present circumstances. Concerted action is needed in this area.

2
☐ Child
☐ Mother
☐ Father
☐ Caretaker

◆ **Adverse or Absent Practice.** Planning works toward divergent, vague, and/or conflicting goals. Basic strategies, interventions, and supports may not be addressed. The fit between the child/family situation and the service mix is unacceptable and strategies, interventions, and/or supports may be woefully inadequate to meet identified needs. Child/family preferences did not influence the selection of supports and services. The planning process does not adapt to any changes in life circumstances and no concurrent plan exits. No safety plan may exist, where needed. Concerted action is needed in this area.

1
☐ Child
☐ Mother
☐ Father
☐ Caretaker

PRACTICE REVIEW 7: PLANNING FOR TRANSITIONS & LIFE ADJUSTMENTS

Focus Measure

TRANSITION PLANNING: 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.

NOTE: This indicator applies only to a child and/or family now transitioning through a significant life change and adjustment process (e.g., reunification with the birth family; parent's release from prison, parent returning to the workforce, child's change in school setting; older youth living independently) or that will begin a major life change and adjustment process within the next three months for which transition planning should now be occurring.

Core Concepts

A child/family moves through several critical transitions over the course of childhood and adolescence (e.g., from preschool to kindergarten, from school to school or from high school to college, work or adult services). Some children may experience removal from their birth family for child protection or treatment reasons. Some may be reunified with the birth family, placed with kin, or adopted by a family. Requirements for future success have to be determined and provided currently to achieve later success. These requirements should be used in setting strategic goals and in planning services. Meeting conditions for sustainable, safe case closure often depends on smooth transitions followed by successful life adjustments in the new setting and/or circumstances. Well-coordinated efforts in assisting the child through significant transitions are essential for success. Follow-along tracking may be required for an adjustment period (beyond the honeymoon period in placement changes). Special coordination efforts may be necessary to prevent breakdowns in services and to prevent any adverse effects transition activities may have on the child and family. To be effective, transition plans and arrangements have to produce successful transitions as determined after the change in settings actually occurs. The reviewer should remember that transition planning is an ongoing team-based process for designing and organizing transitions, life changes, and for adjusting strategies and directing resources toward the accomplishment of defined outcomes set forth in the long-term view for the child and family.

Fact Pattern

1. Is the child moving through a current transition and life adjustment phase? • Is the child/family anticipating a major transition within the next three months? • If so, is there a well planned and supported transition and life adjustment process provided to ensure success?

2. Has the child/family team identified the child's next critical transition? • If so, what transition plans are being made to accomplish a smooth transition? • Are necessary transitional and follow-along adjustment plans being individually tailored to meet the identified need(s)? • Are timely sequencing and supports used appropriately to provide follow-along support for successful life adjustments in the child's normal daily settings (home and school) and life activities?

3. Do permanency plans for this child indicate that the agency has used or considered using trial home visits to facilitate transition and return from out-of-home care? • How is the family involved in implementing important aspects of the child's life change and adjustment and any necessary changes needed in the home and care giving arrangements to achieve successful reintegration of the child into the life of the family?

4. If this child has a history of difficult transitions or placement changes, how is this knowledge being used to improve transitions?

5. If a transition is imminent, is a well-staged transition plan or articulation process currently being implemented for this child/family?

6. Is this child/family currently experiencing adverse consequences of a recent transition or change in placement? • If so, what are the reasons, and what is being done about it?

7. For what period of time is the child being closely monitored following a transition in home or school? • How well are follow-along supports being used to track the child and those supporting the child through the life change and adjustment process?

8. Is the transition support plan comprehensive enough to cover the full scope of the child's life change effects and adjustment needs?

9. Where appropriate, are timely and necessary transition steps being planned and implemented for older youth moving to needed adult services?

PRACTICE REVIEW 7: PLANNING FOR TRANSITIONS & LIFE ADJUSTMENTS

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

NOTE: This review applies only to a child/family now transitioning through a significant life change and adjustment process (e.g., reunification with the birth family; change in school setting; living independently) or who will begin a major life change and adjustment process within the next three months.

<u>Description of the Practice Performance Situation Observed for Applicable Strategy Areas for Achieving Safety & Permanency</u> <u>Rating Level</u>

◆ **Optimal Planning.** The child/family's current/next transition has been planned, staged, and implemented consistent with the child's planned movement and adjustment requirements. What the child/family should know, be able to do, and have as supports to be successful after the transition occurs is being developed now. If a transition to another setting (or return to home and school) is imminent, all necessary arrangements for supports and services are being made to assure that the child is successful following the move. If the child has made a transition within the past six months, the child is fully stable and successful in his/her daily settings. **6** ☐

◆ **Good Planning.** The child/family's next transition has been identified and discussed. What the child/family should know, be able to do, and have as supports to be successful are planned and being addressed. If a transition to another setting (or return to home and school) is imminent, substantial arrangements for supports and services are being made to assist the child during and after the move. If the child has made a transition within the past three months, the child is generally stable and successful in his/her daily settings. **5** ☐

◆ **Fair Planning.** The child/family's next transition has been identified. What the child/family should know, be able to do, and have as supports to be successful are known and being used for planning. If a transition to another setting (or return to home and school) is imminent, basic arrangements for supports and services are in place to adequately assist the child during and after the move. If the child has made a transition within the past 30 days, the child is adequately stable in his/her daily settings and is not at risk of disruption due to transition and life adjustment problems. **4** ☐

◆ **Marginally Inadequate Planning.** The child/family's next transition has been identified. What the child/family should know, be able to do, and have as supports to be successful have not been adequately assessed and few plans have been made. If a transition to another setting (or return to home and school) is imminent, few or partial arrangements for supports and services are in place to assist the child/family during and after the move. If the child has made a transition within the past 30 days, the child may be experiencing mild transition problems in his/her daily settings and is at low risk of disruption. Concerted action is needed in this area. **3** ☐

◆ **Poor Planning.** The child/family's next transition has not been addressed. If a transition to another setting (or return to home and school) is imminent, no adequate arrangements for supports and services are in place to assist the child/family during and after the move. If the child has made a transition within the past 30 days, the child/family may be experiencing substantial transition problems in his/her daily settings and is at moderate to high risk of disruption. Concerted action is needed in this area. **2** ☐

◆ **Absent or Adverse Planning.** The child/family's next transition has not been considered. If a transition to another setting (or return to home and school) is imminent, arrangements for supports and services are not in place to assist the child/family during and after the move. If the child/family has made a transition within the past 30 days, the child may be experiencing major transition problems in his/her daily settings and is at high risk of disruption. Concerted action is needed in this area. **1** ☐

◆ **Not Applicable.** Identification efforts reveal no evidence of needs to be addressed for transition services for this child/family at this time. This review indicator is deemed not applicable to this child/family. **NA** ☐

PRACTICE REVIEW 8: RESOURCE AVAILABILITY

Focus Measure

RESOURCE AVAILABILITY: 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 informal and formal) necessary to meet individual needs in the child's plans 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 use by the child and family on a timely and adequate basis.

Core Concepts

An array of informal and formal supports and services is necessary to implement the treatment and support strategies planned for the child and family. To respond to unique needs, supports may have to be created or assembled in special arrangements. Such unique and flexible support arrangements may wrap services* around a child in his/her home or school setting so as to avoid placement in more restrictive settings away from home and school. Some services may be unit-based (e.g., 6 units of brief therapy) while others may be placement-based (e.g., 90-day treatment program). Supports can range from volunteer reading tutors to after-school supervision, adult mentors, recreational activities, and supported employment. Supports may be voluntarily provided by friends, neighbors, and churches or secured from provider organizations. Professional treatment services may be donated, offered through health care plans, or funded by government agencies. A combination of supports and services may be necessary to support and assist the child and family. For interveners to exercise professional judgment and for the family to exercise choice in the selection of treatment services and supports, an array of appropriate alternatives should be locally available. Such alternatives should present a variety of socially or therapeutically appropriate options that are readily accessible, have power to produce desired results, be available for use as needed, and be culturally compatible with the needs and values of the family. An adequate array of services includes social, health, mental health, educational, vocational, recreational, and organizational services, such as service coordination. An adequate array spans supports and services from all sources that may be needed by the family. Selection of basic supports should begin with informal family network supports and generic community resources available to all citizens. Specialized and tailor-made supports and services should be developed or purchased only when necessary to supplement rather than supplant readily available supports and services of a satisfactory nature. Unavailable resources should be systematically identified to enable the network to meet the need.

** Use of unique, flexible, multiple service arrangements may be necessary to prevent placement by increasing the range and intensity of services in a child's home or school - OR - to return a child from residential treatment to his/her home and school successfully. Such use may require blending of funding across sources and bending of agency traditions that would limit or prevent success in individual case situations. **If placement is being used or continued** when a unique, flexible service arrangement (i.e., "wraparound") would likely be successful in keeping a child in home and school or in returning a child to home and school, then availability of flexible, wraparound resources may be inadequate to meet the child's current needs.*

Fact Pattern

1. Are all important needs matched with appropriate supports and services for this family? • Will supports shift from formal to informal over time?

2. Are resources matched to intervention and support strategies addressed in plans? • Is each intervention strategy and related resources for implementation therapeutically appropriate for the child and family? • Is each service and support readily accessible when needed? • Were any of the supports and services tailor-made or assembled uniquely for this child or family? • Are they sustainable as needed over time? • If not, what is missing?

3. Have informal supports been developed or uncovered and used at home and in the community as a part of the service process? • Is the combination of informal and formal supports and services used for this family sufficient for the child and family members to do well? • Is the combination of supports and services used for/by this family dependable and satisfactory from their point of view?

4. To what extent are informal resources of the family, extended family, neighborhood, civic clubs, churches, charitable organizations, local businesses, and general public services (e.g., recreation, public library, or transportation) used in providing supports for this family?

5. Is the family team taking steps to locate or develop or advocate for previously unknown or undeveloped resources? • Is the child on a waiting list for services?

6. Did practitioners on the child/family's team have appropriate service options from which to choose when selecting recommended professional services? • Did the family have appropriate and preferred options from which to choose when selecting supports and services? Has the child or family been denied services?

7. Has the family team taken steps to identify resource gaps for the child and family?

PRACTICE REVIEW 8: RESOURCE AVAILABILITY

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Practice Performance Situation Observed for the Child and Family   Rating Level

◆ **Optimal Resources.** An excellent array of supports and services is helping the child and family reach optimal levels of functioning necessary for them to make progress toward outcomes and ending requirements. A highly dependable combination of informal and, where necessary, formal supports and services is available, appropriate, used, and seen as very satisfactory by the family. The array provides a wide range of options that permits use of professional judgment about appropriate treatment interventions and family choice of providers.

6 ▢

◆ **Good Resources.** A good and substantial array of supports and services is helping the child and family reach favorable levels of functioning necessary for them to make progress toward outcomes and ending requirements. A usually dependable combination of informal and formal supports and services is available, appropriate, used, and seen as generally satisfactory by the family. The array provides a narrow range of options that permits use of professional judgment and family choice of providers. The service team is taking steps to mobilize additional resources to give the family greater choice and/or provide resources to meet particular family needs.

5 ▢

◆ **Fair Resources.** A fair array of supports and services is available to the family to reach minimally acceptable levels of functioning necessary for them to make fair progress toward outcomes and ending requirements. A set of supports and services is usually available, somewhat appropriate, used, and seen as minimally satisfactory by the family. The array provides few options, limiting professional judgment and family choice in the selection of providers. The service team is considering taking steps to mobilize additional resources to give the family greater choice and/or provide resources to meet particular family needs but has not yet taken any steps.

4 ▢

◆ **Marginally Inadequate Resources.** A somewhat limited array of supports and services may not be readily accessible or available to the family. A limited set of supports and services may be inconsistently available and used but may be seen as partially unsatisfactory by the family. The array provides few options, substantially limiting use of professional judgment and family choice in the selection of providers. The service team has not yet considered taking steps to mobilize additional resources to give the family greater choice and/or provide resources to meet particular family needs.

3 ▢

◆ **Poor Resources.** A very limited array of supports and services may be inaccessible or inconsistently available to the family. Few supports and services may be available and used. They may be seen as generally unsatisfactory by the family. The array provides very few options, preventing use of professional judgment and family choice in the selection of providers. The service team has not considered taking steps to mobilize additional resources or may not be functioning effectively.

2 ▢

◆ **Absent or Adverse Resources.** Few, if any, necessary supports and services are provided at this time. They may not fit the actual needs of the family well and may not be dependable over time. Because informal supports may not be well developed and because local services or funding is limited, any services may be offered on a "take it or leave it" basis. The family may be dissatisfied with or refuse services, and results may present a potential safety risk to family members. The service team may be powerless to alter the service availability situation or the child and family may lack a functioning service team.

1 ▢

PRACTICE REVIEW 9: INTERVENTION ADEQUACY

Focus Measure

INTERVENTION ADEQUACY: 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.

Core Concepts

The purpose of intervention is facilitating successful changes that meet near-term family needs and achieve child safety, well-being, and permanency while stabilizing, supporting, and sustaining the family or permanent caretaker for the child. Where indicated by requirements of the case, adequate intervention efforts pursue concurrent permanency alternatives, deliver crisis response strategies, support transitions and life adjustments, resolve legal issues, and provide safe case closure with sustaining supports for the family/permanent caretaker or for the older youth transitioning to adulthood. To be effective, interventions should be delivered at a level of intensity and consistency required to produce life changes that meet identified needs and achieve outcomes planned for the child and family.

The focus of this review is determining the extent to which implementation of interventions, supports, and services with the child and family demonstrates that these efforts are commensurate with the changes required for child and family success. The reviewer should consider what is required to meet near-term needs and achieve planned outcomes in this case. Considerations should include:

— **Sufficient Power** -- Providing interventions at necessary levels of intensity, duration, coordination, consistency, and continuity to produce the changes necessary for the child and family that are consistent with the desired results.

— **Beneficial Effects** -- Providing a pattern of changes that shows satisfaction of near-term needs and progress being made toward attainment of desired outcomes as evidence that interventions are producing *beneficial effects*. Lack of expected progress suggests that planned strategies are either the wrong strategies or that the right strategies are being poorly delivered or that efforts may be underpowered.

NOTE: In children's services, the historical approach to family change was to "match service to need." As a result, a caseworker would refer a child or parent to a service without clear definition of the changes to be made or the timetable for their accomplishment. The match of service to need was not precise, too often failing to yield timely, desired results. In the new era of evidence-based practice, greater precision is required to "match strategies to outcomes." This approach requires that: (1) strategies are precisely matched to changes to be made as defined by desired outcomes; (2) interventions are powered appropriately for making and sustaining change; and (3) change is measured to test strategies for effectiveness and for the management of the change process via results-driven decision making.

Fact Pattern

1. What specific strategies are being used in the change process for this child and family? • What is required for precise delivery (for desired effect) for each strategy? • How well are resources matched to the strategies that are to meet near-term needs and achieve planned outcomes? • Are resources available on a timely, adequate and convenient local basis to deliver the planned strategies, supports, and service planned in this case? • If not, what resources or services are missing or inadequate to meet the outcomes planned for the child and family in the long-term view?

2. Is the level of intensity, duration, coordination, and continuity commensurate with what is required for successful and sustained child/family change? • If not, are current service authorization rules or limitations leading to discontinuity or inadequacy of effect? • Do the strategies match the changes to be made? • If not, what is missing?

3. Are service providers adequately trained, prepared, coordinated, and supervised? • Who supervises and approves clinical behavioral health interventions?

4. Are any and all urgent needs met in ways that protect the health and safety of the child or, where necessary, protect others from the child?

5. Are there any change strategies for this child/family that cannot be adequately actioned with precision, resourced, coordinated, or delivered with continuity? • If yes, what and why?

6. To what degree is daily practice actually driven by the intervention planning process?

PRACTICE REVIEW 9: INTERVENTION ADEQUACY

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

<u>Description of the Practice Performance Situation Observed for the Child and Family</u>   <u>Rating Level</u>

◆   **Optimally Powered Intervention.** An excellent combination, sequence, and power of current interventions is helping the child and family reach optimal levels of functioning necessary for them to make progress and improve functioning and well-being. An excellent combination of informal and, where necessary, formal supports and interventions is provided with excellent precision and with fully commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is entirely sufficient to quickly and fully meet near-term needs and reach planned outcomes.

6 ▢

◆   **Good Intervention.** A good combination, sequence, and power of current interventions is helping the child and family reach good and substantial levels of functioning necessary for them to make progress and improve functioning and well-being. A dependable combination of informal and, where necessary, formal supports and interventions is provided with good precision and with substantially commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is generally sufficient to quickly and fully meet near-term needs and reach planned outcomes.

5 ▢

◆   **Minimally Adequate to Fair Intervention.** A fair combination, sequence, and power of current interventions is somewhat helping the child and family reach at least minimally adequate to fair levels of functioning necessary for them to make progress and improve functioning and well-being. A minimally adequate combination of informal and, where necessary, formal supports and interventions is provided with some precision and with at least minimally adequate levels of intensity, duration, continuity, and coordination. The power of intervention is minimally adequate sufficient to meet important near-term needs and eventually reach planned outcomes.

4 ▢

◆   **Marginally Inadequate Intervention.** A somewhat underpowered combination and sequence of current interventions is limiting the child and family from reaching levels of functioning necessary for them to make progress and improve functioning and well-being. A marginally inadequate combination of informal and, where necessary, formal supports and interventions is provided with little precision and at somewhat inadequate levels of intensity, duration, continuity, and coordination. The power of intervention is somewhat insufficient to meet important near-term needs and reach planned outcomes in a reasonable amount of time.

3 ▢

◆   **Substantially Underpowered Intervention.** A very limited combination, sequence, and power of current interventions is not helping the child and family reach levels of functioning necessary for them to make progress and improve functioning and well-being. A poor and insufficient combination of informal or formal supports and interventions is provided without precision and without adequate levels of intensity, duration, continuity, and coordination. The power of intervention is not sufficient to meet important near-term needs and reach planned outcomes in a reasonable amount of time.

2 ▢

◆   **Absent or Adverse Intervention. EITHER:** Currently planned interventions are not implemented. **- OR -** The wrong interventions are being implemented without desired effect and/or with adverse effects. **- OR -** Potentially successful interventions could be provided but are too underpowered to achieve desired effects.

1 ▢

PRACTICE REVIEW 10: MAINTAINING QUALITY CONNECTIONS

Focus Measure

MAINTAINING QUALITY CONNECTIONS: 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 living away from one another.

NOTE: If the child is residing with a parent and siblings, then NA would be marked as the appropriate rating option.

Core Concepts

This indicator measures the quality of relationships between the child and his/her family members and other important people in the child's life. The quality of these relationships depends on opportunities for positive interactions; emotionally supportive, mutually beneficial connections; and engaging in nurturing exchanges with one another. When this occurs, it promotes the preservation of families and the successful reunification of the child and his/her parents or their natural support.

When children are living away from their parents and/or siblings, they should be provided opportunities for frequent and appropriate contact with one another and with other important people in their lives. This indicator is rated for the mother, father, siblings, extended family, and other persons important in the life of the child. Unless specific circumstances suggest it is unsafe or inappropriate, visits and other forms of contact should be provided and encouraged in order to maintain or develop family ties and relationships.

Visits should be conducted in locations conducive to family activities and offer 'quality time' for advancing or maintaining relationships among family members. Visits and/or other techniques such as phone calls, letters, and/or exchange of photos should be used when safe and appropriate to do so to enable both parents, siblings, relatives and other important people in the child's life to maintain family ties.

NOTE: Visits should never be withheld as a punishment or used as an incentive for compliance with rules or expectations.

Fact Pattern

1. Are ongoing efforts to identify and locate family members and other important people in child's life being made?

2. Are family or child's supports' visits and appropriate interactions occurring now? If so, are visits:

    *   Frequently occurring?
    *   Therapeutically appropriate?
    *   Conducive to "quality time" in relationship building?
    *   Located in a convenient and least restrictive setting?
    *   Rescheduled in a timely manner?
    *   Increasing in frequency and duration and decreasing in supervision, if appropriate?
    *   Being used to assess reunification appropriateness?

3. Are other forms of family contact, interactions, or connecting strategies being used (e.g., phone calls, letters, family photos), when appropriate?

4. What supports are being provided to parents, beneficial connections, resource parents (e.g., transportation), and case planners (e.g., overtime or flextime for supervised visits) to facilitate and assist visits?

5. Is there an effort to integrate the parents or beneficial connections into the child's life (e.g., doctor's appointments, teacher conferences at school, sporting events, etc.)?

6. Do the parents or beneficial connections and the child describe one another in positive terms and identify ways in which they have been able to enhance the quality of their relationship with one another?

7. Is there any evidence that visits have been withheld as a punishment or used as an incentive for compliance or "good behavior" at any time within the past 90 days in this case? • If so, explain this situation in oral and written reports made for this case.

PRACTICE REVIEW 10: MAINTAINING QUALITY CONNECTIONS

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

<u>Description of the Practice Performance Situation Observed for the Child and Family</u>   <u>Rating Level</u>

◆ **Optimal Practice.** Fully effective family connections are being excellently maintained for all family members through appropriate visits and other connecting strategies. All appropriate family members have regular and, where appropriate, increasingly frequent visits and interactions. Excellent strategies are in place to effectively build and maintain positive interactions, providing emotional support between the child and his/her family and important people.

6
☐ Mother
☐ Father
☐ Siblings
☐ Other

◆ **Good Practice.** Generally effective family connections are being substantially well maintained for all family members through appropriate visits and other connecting strategies. All appropriate family members have regular visits and interactions. Good strategies are generally effective in building and maintaining positive interactions and providing emotional support between the child and his/her family and important people.

5
☐ Mother
☐ Father
☐ Siblings
☐ Other

◆ **Fair Practice.** Fairly effective family connections are being at least adequately maintained for all family members through appropriate visits and other connecting strategies. All appropriate family members have periodic visits and interactions (every other week). Fairly adequate strategies are in place to support building and maintaining positive interactions, providing emotional support between the child and his/her family and important people.

4
☐ Mother
☐ Father
☐ Siblings
☐ Other

◆ **Marginal Practice.** Family connections are being at least marginally maintained for most family members through visits and other connecting strategies. Some appropriate family members have periodic visits and interactions (occurring less than every other week). Inconsistent and/or somewhat inadequate strategies are limiting building and maintaining positive interactions and providing emotional support between the child and his/her family and important people. The may be some evidence that visits may have been withheld as a punishment or used as an incentive at least once in the past 90 days. Concerted action is needed in this area.

3
☐ Mother
☐ Father
☐ Siblings
☐ Other

◆ **Poor Practice.** Family connections are being inconsistently maintained for some family members through visits and other connecting strategies. Some appropriate family members have occasional visits/interactions. Some members may have very limited, inconsistent, or no contact or connections. Substantially inadequate strategies are limiting building and maintaining positive interactions and providing emotional support between the child and his/her family and important people. The may be some evidence that visits may have been withheld as a punishment or used as an incentive more than once in the past 90 days. Concerted action is needed in this area.

2
☐ Mother
☐ Father
☐ Siblings
☐ Other

◆ **Absent or Adverse Practice.** Family connections are fragmented, declining in frequency or quality, or inappropriate for family members. Appropriate and necessary visits are not occurring with sufficiency to maintain family connections (or visits are withheld as punishment or used as an incentive). Some visits may be therapeutically inappropriate or unsafe for one or more family members. The may be some evidence that visits may have been withheld as a punishment or used as an incentive more than once in the past 90 days. Concerted action is needed in this area.

1
☐ Mother
☐ Father
☐ Siblings
☐ Other

◆ **Not Applicable.** If the child is residing with a parent and/or siblings, this indicator would be scored as NA (Not Applicable).

NA

PRACTICE REVIEW 11: TRACKING & ADJUSTMENT

Focus Measure

TRACKING & ADJUSTMENT: 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.

Core Concepts

An ongoing examination process should be used by the family team to track service implementation, check progress, identify emergent needs and problems, and modify services in a timely manner. Gathering information, performing ongoing assessments, and tracking provide necessary information. Adjustment leads to change processes that make the intervention process responsive and, ultimately, effective for the child and family. The planned intervention strategies should be modified when outcomes are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The team should play a central role in gathering information, monitoring and modifying planned strategies, services, supports, and results. Team members in the child/family change process should apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services. This learning and change process is necessary to find what works for the child and family. Learning "what works" is a continual process, which requires the team to ask: How are the child and family doing? Has their situation changed? Have new needs emerged? Are supports and services being delivered as planned? Are providers dependable? How well are the mix, match, and sequence of supports and services working? How well do these arrangements actually fit the child and family? Are any crisis/safety plans effective? Are advance arrangements for transitions being accomplished? Are desired results being produced? What things need to be changed?

NOTE: Effective tracking requires maintaining ongoing situational awareness. Effective adjustments depends upon understanding and acting on what is working and not working in helping the family meet conditions for safe case closure.

Fact Pattern

1. How well is the family team really finding what works for this child and family?

2. How is the child/family progress monitored by the team (e.g., face-to-face contacts, telephone contact, and meetings with family, child, service providers, reviewing reports from providers, etc.)?

3. How well are the status and progress of the child/family being tracked and adjusted by the team in the following areas? • Consider how well:

    *   Ongoing assessment is used to determine if present and impending threats to child safety have emerged/reemerged.
    *   Parent/caretaker protective capacities are tracked and evaluated
    *   Enhancement of protective capacities is/are mitigating the safety threats/factor.
    *   Development and demonstration of required child and/or parent behavior changes are occurring.
    *   Securing of adequate and sustainable supports necessary for child/family functioning.
    *   Concurrent planning and active efforts are occurring to attain child permanency.
    *   Meeting any special needs of persons (children/parents) in the home.
    *   Achieving successful transitions and life adjustments.
    *   Resolving any outstanding issues necessary for sustainable, safe case closure.

4. Is the implementation of planned supports and services being tracked? • Is progress or lack of progress being identified and noted?

5. Are detected problems or breakdowns in service design or delivery being reported and addressed promptly? • Are identified needs and problems being acted on?

6. Are the child/family plan(s) and strategies modified as needs arise and goals are met to keep the plan relevant and effective and moving toward safe case closure? • Are these strategies being used modified if no progress is observed? • Are failed strategies promptly recognized and abandoned and then quickly replaced with those strategies next most likely to work? • If not, why not?

7. How well are transitions anticipated, staged, tracked, problem-solved, and sustained?

8. Is the court advised of permanency progress in a timely fashion? • Are any requests to revise court orders pursued in a timely manner?

PRACTICE REVIEW 11: TRACKING & ADJUSTMENT

Practice Rating Description that Best Fits the Fact Pattern Observed in this Case

Description of the Practice Performance Situation Observed for the Child and Family

Rating Level

◆ **Optimal Practice.** The strategies, supports, and services being provided to the child and family are highly responsive and fully appropriate to changing conditions. Continuous monitoring, tracking, and communication of child/family status and service results are occurring and shared between all team members. Timely and appropriate adaptations are being made. Highly successful modifications are based on a rich knowledge of what things are working and not working for the child and family.

6
☐ Tracking
☐ Adjustment

◆ **Good Practice.** The strategies, supports, and services being provided to the child and family are substantially responsive to changing conditions. Frequent monitoring, tracking, and communication of child/family status and service results are occurring and are shared between most team members. Generally successful adaptations are based on a basic knowledge of what things are working and not working for the child and family.

5
☐ Tracking
☐ Adjustment

◆ **Fair Practice.** The strategies, supports, and services being provided to the child and family are adequately responsive to changing conditions. Periodic monitoring, tracking, and communication of child/family status and service results are occurring and are shared between some team members. Usually successful adaptations to supports and services are being made.

4
☐ Tracking
☐ Adjustment

◆ **Marginal Practice.** Intervention strategies, supports, and services being provided to the child and family are partially responsive to changing conditions. Occasional monitoring with limited or inconsistent communication of child status and service results are occurring. Limited or marginally inadequate adaptations are based on isolated facts of what is happening to the child and family. Their status may be adequate in some areas but unacceptable in others. Mild to moderate problems may be evident. Concerted action is needed in this area.

3
☐ Tracking
☐ Adjustment

◆ **Poor Practice.** Poor strategies, supports, and services are provided to the child and family and are not always responsive to changing conditions. Limited monitoring, poor communications, and/or an inadequate child and family team is/are often unable to function effectively in planning, providing, monitoring, or adapting services. Few sensible modifications may be planned or implemented. Child and family status may be marginal or poor in several areas. Limited tracking and adjusting has the potential to lead to poor child/family outcomes. Concerted action is needed in this area.

2
☐ Tracking
☐ Adjustment

◆ **Absent or Adverse Practice.** Strategies, supports, and services are limited, undependable, or conflicting for the child and family. Little or no monitoring or communications may be occurring and/or an inadequate child and family team is unable to function effectively in planning, providing, monitoring, or adapting services. Current supports and services may have become non-responsive to the current needs of the child and family. The service process appears to be *out of control*. Child and family status may be generally poor and possibly worsening. Due to the failure to track and adjust, the child/family faces poor outcomes. Concerted action is needed in this area.

1
☐ Tracking
☐ Adjustment

Section 4

Overall Patterns

OVERALL RATINGS FOR THE STATUS & PRACTICE SECTIONS

GENERAL DIRECTIONS

The QSR Protocol provides directions to reviewers for determining an Overall Child and Family Status Rating and Overall Practice Rating in a case for which a review has been completed for all of the indicators in each section. Each section (status and practice) has guidance for determining conditions under which Overall Status and Overall Practice Performance are deemed acceptable. For example, the status of the child cannot be regarded as acceptable if the child is found to be unsafe in her/ his daily settings. Provided in the list that follows are general rules-of-thumb used by reviewers. This guidance is used when selecting an overall rating pattern that best fits the aggregate ratings for a child and family being reviewed.

OVERALL CHILD AND FAMILY STATUS RATING

General guidance is provided to assist QSR reviewers when selecting one of six possible rating categories for reporting the Overall Rating for the Status Section for the child being reviewed. This rating provides an answer to the question: *Overall, how well is the child and family/ caretaker doing at the time of the review?*

Presented below are descriptions of six possible aggregate rating patterns for status indicators that may be found in a case under review. These general descriptions are offered to guide QSR reviewers in making their selections of overall status ratings so reviewers will be consistent in their work and so users of QSR findings will be aware of the manner in which overall ratings are determined.

Selecting the Overall Status Rating category is based on the aggregate pattern found for the applicable status indicators in a case. The aggregate pattern is taken into account by the reviewer after assuring that the child is **SAFE** -- *that is, having ratings of 4 or higher for all applicable settings on Status Indicator 1a - Exposure to Threats of Harm and to self and others on Status Indicator 1b - Risk to Self/Others.*

The general interpretations for these overall ratings are defined as follows:

- **Level 6 - Optimal Overall Status**. At level 6, the child is SAFE. The preponderance of applicable indicator ratings in the status domain are rated 6. All status ratings for the child are in the 4-6 range.

- **Level 5 - Good Overall Status**. At level 5, the child is SAFE. The preponderance of applicable indicator ratings in the status domain are rated in the 5-6 range. No status indicator is rated lower than 3.

- **Level 4 - Fair Overall Status**. At level 4, the child is SAFE. The preponderance of applicable indicator ratings in the status domain are rated in the 4-5 range. No status indicator is rated lower than 2.

- **Level 3 - Marginal Overall Status**. At level 3, the child may have some occasional safety concerns of a mild nature and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 3-4 range.

- **Level 2 - Poor Overall Status**. At level 2, the child may have some significant safety concerns and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 2-3 range.

- **Level 1 - Adverse and Worsening Overall Status**. At level 1, the child and/or family situation may pose serious and worsening safety threats and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 1-2 range.

The reviewer uses the rating patterns and ranges noted on the completed QSR Roll-Up Sheet for the child to determine the rating category above that best describes the overall status situation observed at the time of review.

Overall Ratings for the Status & Practice Sections

Overall Case Practice Rating

General guidance is provided to assist QSR reviewers when selecting one of six possible rating categories for reporting the Overall Rating for the Practice Section for the child and family being reviewed. This rating provides an answer to the question: *Overall, how well is case practice working for the child and family at the time of the review?*

Presented below are descriptions of six possible aggregate rating patterns for practice indicators that may be found in the case under review. These general descriptions are offered to guide QSR reviewers in making their selections of overall practice ratings so reviewers will be consistent in their work and so users of QSR findings will be aware of the manner in which overall ratings are determined.

Selecting the Overall Practice Rating category is based on the aggregate pattern found for the applicable practice indicators in a case. The general interpretations for these overall ratings are defined as follows:

- **Level 6 - Optimal Overall Practice**. At level 6, the preponderance of applicable indicator ratings in the practice domain are rated 6. All practice ratings for the child are in the 4-6 range.

- **Level 5 - Good Overall Practice**. At level 5, the preponderance of applicable indicator ratings in the practice domain are rated in the 5-6 range. No practice indicator is rated lower than 3.

- **Level 4 - Fair Overall Practice**. At level 4, the preponderance of applicable indicator ratings in the practice domain are rated in the 4-5 range. No practice indicator for the child is rated lower than 2.

- **Level 3 - Marginal Overall Practice**. At level 3, the preponderance of applicable indicator ratings in the practice domain may be rated in the 3-4 range for the child. Some indicators may be rated in the 1-2 range.

- **Level 2 - Poor Overall Practice**. At level 2, the preponderance of applicable indicator ratings in the practice domain may be rated in the 2-3 range for the child. Many indicators may be rated in the 1-2 range.

- **Level 1 - Absent or Adverse Overall Practice**. At level 1, the preponderance of applicable indicator ratings in the practice domain may be rated in the 1-2 range for the child with many falling into the 1 rating.

The reviewer uses the rating patterns and ranges noted on the completed QSR Roll-Up Sheet for the child to determine the rating category above that best describes the overall case practice situation observed. The Overall Practice Rating is used to reflect the level of service system performance for the child at the time of review.

Compelling Reasons For Giving an Alternative Section Rating

The patterns of aggregate ratings suggested to guide a QSR reviewer to an overall status and practice ratings are meant to be used under general conditions. If, in the course of a review, the reviewer finds a rare and complex situation that, by its unusual nature, strongly points to a different rating interpretation, the reviewer should present the evidence and compelling reasons that a higher or lower domain rating should be given.

The presentation of evidence and compelling reasons should be made to the QSR team and team leader. If the team concurs with the reviewer's recommendation and if the leader so directs, the reviewer may report a rating that fairly fits the situation found although it departs from the rating guidance offered above.

Six-Month Forecast

Forecasting the Trajectory of the Child's Expected Future Course

Determination of the Overall Child & Family Status Pattern and the Overall Practice Performance Pattern for the child is based on the observed current patterns as they emerge from the recent past. When making a six-month forecast, the reviewer speculates on whether the child's overall status pattern projected six months forward from the date of the review will likely remain at a high level (if currently at a high level), improve to higher level, decline to a lower level, or remain at a low level (if currently at a low level). The projection method builds on **known facts, historic patterns, and recent tendencies** known about the child's current status, child and family circumstances, present practice levels, and local conditions at the service site. Forming a six-month forecast is based on **predicable future events** (e.g., the child being discharged from residential treatment and returned to home and school within the next 60 days) and **informed predictions** (e.g., probability of termination of parental rights in a case that has a poor prognosis for reunification for a child who has been in care for 22 months) about the expected course of change over the next six months, grounded on known current status and practice performance as well as knowledge of tendency patterns found in case history.

Example: If a case were being reviewed in the last quarter of the school year (April), then the trajectory point for consideration is the first quarter (October) of the next school year. Suppose that the child being reviewed has demonstrated a pattern of serious, complex, and recurrent behavior problems that were just being brought under control within the past 45 days. [Overall Child Status = 4, meaning child status is minimally and temporarily acceptable; a fact]. Suppose that this child got into trouble with the law last summer [a fact], while out of school with no structured summer program [a fact], and while having inadequate supervision in the home [a fact]. Suppose this child is to be discharged from the residential treatment facility at the end of June [a fact], but has no transition plan for returning to home and school [a fact], no planned summer program to keep the child out of trouble [a fact], continuing problems at home [a fact], and no contact or planning with the neighborhood school expected to admit and serve the child when school begins in August [a fact]. Based on what is now known about this child, what is the probability that the child's status in six months (October) will: (1) Improve from a 4 to a higher level? (2) Stay about the same at level 4? or (3) Decline to a level lower than 4? Given this set of case facts plus the child's tendency patterns described in recent history, most reviewers would make an informed prediction that the case trajectory would be downward and that the child's status is likely to decline. One may "hope" for a different trajectory and a more optimistic situation, but *hope is not a strategy* to change the conditions that are likely to cause a decline. Based on the reviewer's six-month forecast for a case, the reviewer offers practical "next step" recommendations to alter an expected decline or to maintain a currently favorable situation over the next six months.

Based on what is known about this case and what is likely to occur in the near-term future, make an informed prediction of the forecast in this case. *Assume that the service system's practice performance continues doing business as usual when making the six-month prediction.* Mark the appropriate alternative future statement in the space provided for the Six-Month Prognosis on the roll-up sheet. The facts that lead the reviewer to this view of case trajectory should be reflected in the reviewer's findings and recommendations.

Six-Month Forecast

Based on the child's **current overall status**, recent progress, the current level of **overall practice performance**, and **events expected to occur over the next six months**, is this child's overall status expected to maintain at a high level, improve to a higher level, remain about the same, decline over the next six months, or remain at low level six months from now? (check only one)

☐ **MAINTAIN at a CURRENTLY HIGH STATUS LEVEL (5-6 range)**

☐ **IMPROVE to a level HIGHER than the current overall status**

☐ **CONTINUE at the SAME STATUS LEVEL — status quo**

☐ **DECLINE to a level LOWER than the current overall status**

☐ **REMAIN at a CURRENTLY LOW STATUS LEVEL (1-2 range)**

Section 5

Reporting Outlines

Reviewer's Outline for a 10-Minute Mini-Rounds Presentation

Outline Elements   **Reviewer's Notes**

1. Core Story of the Child and Family (2 minutes)

- Reason for services (Why are we involved with this child and family?)
- Goals that focus interventions provided (What are we trying to achieve in the case?)
- Strengths and needs of the child and family
- Services provided and by which agencies

2. Child and Caretaker Status (3 minutes)

- Overall child and caretaker status finding
- Status rating patterns
- Progress made over the past six months
- Problems

3. System Practice and Performance (3 minutes)

- Overall system performance finding
- Performance rating patterns
- What's working now in this case
- What's not working and why
- Six-month forecast

4. Next Steps (1 minute)

- Important and doable "next steps"
- Any special concerns or follow-up indicated

5. Reflection Question (1 minute)

- *What does this Story Teach Us about Practice?*

Total Presentation Time (10 minutes)

Group Questioning of Presenter (3-5 minutes)

Written Case Review Summary

Child/Caretaker Status Summary

Facts about the Child and Family Reviewed

- Agency or Office
- Child's Assigned Number
- Reviewer's Name
- Review Date
- Date of Report
- Child's Placement

Persons Interviewed during this Review

Indicate the number and role (child, caretaker, caseworker, therapist, teacher, etc.) of the persons interviewed.

Facts About the Child and Family [About 150 words]

- Family composition and situation
- Agencies involved and providing services
- Reasons for services
- Services presently needed and received

Child's Current Status [About 250 words]

Describe the current status of the child and family using the status review findings as a basis. If any unfavorable status result puts the child at risk of harm, explain the situation. Mention relevant historical facts that are necessary for an understanding of the child and family's current status. Use a flowing narrative to tell the "story" and make sure that the "story" supports and adequately illuminates the Overall Status rating.

Caretaker's Status [About 150 words]

Because the status of the child often is linked to the status of the family, indicate whether the family is receiving the supports necessary to adequately meet the needs of the child and maintain the integrity of the home.

Factors Contributing to Favorable Status
[About 100 words]

Where status is positive, indicate the contributions that child resiliency, family capacities, and uses of natural supports and generic community services made to the results.

Factors Contributing to Unfavorable Status
[About 100 words]

Describe what local conditions seem to be contributing to the current status and how the child may be adversely affected now or in the near-term future, if status is not improved.

System Performance Appraisal Summary

Describe the current performance of the service system for this child and family using a concise narrative form. Mention any historical facts or local circumstances that are necessary for understanding the situation.

What's Working Now
[About 250 words]

Identify and describe which service system functions are now working adequately for this child and family. Briefly explain the factors that are contributing to the current success of these system functions.

What's Not Working Now and Why
[About 150 words]

Identify and describe any service system functions that are not working adequately for this child and family. Briefly explain the problems that appear to be related to the current failure of these functions.

Six-Month Forecast/Stability of Findings
[About 75 words]

Based on the current service system performance found for this child, is the child's overall status likely to improve, stay about the same, or decline over the next six months? Take into account any important transitions that are likely to occur over this time period. Explain your answer.

Practical Steps to Sustain Success and Overcome Current Problems
[About 100 words]

Suggest several practical "next steps" that could be taken to sustain and improve successful practice activities over the next six months. Suggest practical steps that could be taken to overcome current problems and to improve poor practices and local working conditions for this child and family in the next 90 days.

Report Length
Usually, the case summary usually should not exceed four typed pages, depending on the complexity of the case and the extent of supports and services being provided by various agencies.