

# **QUALITY SERVICE REVIEW FOR A CHILD AND FAMILY**

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**A REUSABLE PROTOCOL FOR EXAMINATION OF  
SYSTEM OF CARE SERVICES FOR A CHILD AND FAMILY**

**DESIGN TEAM VERSION**

**DEVELOPED FOR PERIODIC REVIEWS OF**

**SAFETY, PERMANENCY, AND MENTAL HEALTH SERVICES  
FOR CHILDREN AND FAMILIES**

**SERVED BY THE  
LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND 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 dependency and concurrency for a child in care. It is used for: (1) appraising the current status of a focus child possibly having special needs (e.g., a foster child with a serious emotional disorder) in key life areas, (2) status of the parent/caregiver, and (3) performance of key system of care practices for the same child and family. The protocol examines recent results for children in protective care 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 and children’s mental health services in Los Angeles County.

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 caregivers 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:



**2107 Delta Way  
Tallahassee, Florida 32303-4224**

Phone: (850) 422-8900

Fax: (850) 422-8487

<http://www.humansystemsandoutcomes.com>

# INTRODUCTION TO THE QUALITY SERVICE REVIEW PROTOCOL

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# INTRODUCTION TO THE QUALITY SERVICE REVIEW PROTOCOL

## A FOCUS ON PRACTICE AND RESULTS

The QSR protocol uses an in-depth case review method and practice appraisal process to find out how children and their families are benefiting from services received and how well locally coordinated services are working for children and families. Each child/family served is a unique “test” of the service system. Samples of children are reviewed to determine child and parent/caregiver status, recent progress, and related system practice and performance results.

## QUESTIONS EXPLORED VIA QSR

Questions about how children and families are doing include:

- ◆ Is the child safe from manageable risks of harm caused by others or by him/herself? Is the child in a safe, stable home?
- ◆ Are the child’s basic physical and health needs met?
- ◆ Is the child doing well in school? Making academic progress?
- ◆ Is the child doing well emotionally and behaviorally?
- ◆ Are the parents/caregivers able and willing to assist, support, and supervise the child reliably on a daily basis?
- ◆ Is the child making progress in key life areas and are parents/caregivers satisfied with services being received?

Positive answers to these questions show that children and families served and service providers are doing well. When negative patterns are found, improvements can and should be made to strengthen frontline practice, local services, and results.

Questions about how well the service system is working include:

- ◆ Do the child’s parents/caregivers, clinicians, teachers, and service providers share a “big picture” understanding of the child and family situation and their strengths and needs so that sensible supports and services can be planned?
- ◆ Do these “practice partners” share a long-term view of how services will enable the child and family to function successfully in their daily settings (e.g., home and school)?
- ◆ Does sensible service planning select strategies and organize interventions, supports, and services necessary to bring about improved functioning and well-being?
- ◆ Are the strategies, supports, and services provided in a timely, competent, and culturally appropriate manner?

- ◆ Are services integrated across providers and settings to achieve positive results for the child while strengthening the functional capacities of the family?
- ◆ Are the child’s caregivers getting the training and support necessary for them to be effective parents while keeping the home safe and stable for the children?
- ◆ Are the child and family’s services being coordinated effectively across settings, providers, and agencies?
- ◆ Are the supports and services provided reducing any risks and improving safety and family functioning? Is a sustainable support network being built with and for the family?
- ◆ Are services and results monitored frequently with services modified to reflect changing needs and life circumstances? Are services effective in improving well-being and functioning while reducing risks of poor outcomes?

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.

## WHAT’S LEARNED THROUGH THE QSR

The QSR involves case reviews, observations, and interviews with key stakeholders and focus groups. Results provide a rich array of learnings for next step action and improvement. These include:

- ◆ Detailed stories of practice and results and recurrent themes and patterns observed across children and families reviewed.
- ◆ Deep understandings of contextual factors that are affecting daily frontline practice in the agencies being reviewed.
- ◆ Quantitative patterns of child and family status and practice performance results, based on key measures.
- ◆ Noteworthy accomplishments and success stories.
- ◆ Emerging problems, issues, and challenges in current practice situations explained in local context.
- ◆ Monitoring reports revealing the degree to which important requirements are being met in daily frontline practice.
- ◆ Critical learning and input for next-step actions and for improving program design, practice models, and working conditions for frontline practitioners.

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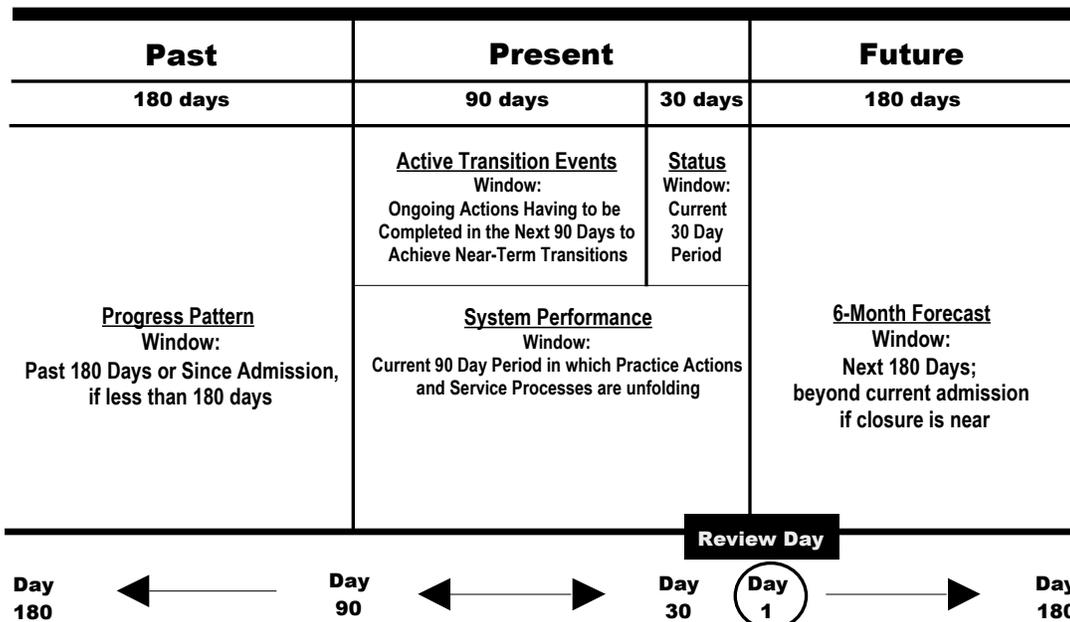
## GENERAL INFORMATION

Persons using this protocol should have completed the classroom training program (12 hours). Candidate reviewers should 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 front-line staff, oral case presentation, and first case write-up should be coached by a qualified mentor. With the recommendation of the mentor, trainees who have successfully completed these steps will be granted review privileges on a review team under the supervision of the team leader and the case judge who approves written reports. Trainees may be certified after three successful reviews and successfully meeting the rating standards set by the expert review panel on the certification simulation. Any other users of this protocol should be certified reviewers. 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 focus child and parent/caregiver on key indicators; (2) recent progress made on applicable change indicators; and (3) adequacy of performance of essential service functions for that child and parent/caregiver. Each focus child served is a unique and valid point-in-time "test" of frontline practice performance in a local system of care.

- ◆ 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/caregiver status ratings should reflect the dominant pattern found over the past 30 days; (2) progress pattern ratings on applicable items should reflect change occurring over the past 180 days (or since admission if less than 180 days); and (3) service system practice and performance item ratings should reflect the dominant pattern/flow over the past 90 days. [See display provided below.]
- ◆ Apply the *6-point rating scale* for status, progress, and practice performance for each examination. Mark the appropriate ratings in the protocol, then transfer the ratings to the QSR Profile Sheet also referred to as the "roll-up sheet." The rating scales are explained on pages 6-8.
- ◆ 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

## Timeframes of Interest in Case Reviews



## INTRODUCTION TO THE QUALITY SERVICE REVIEW PROTOCOL

debriefing, that same problem should be reflected in the reviewer's ratings in the protocol examination booklet and noted in the written summary.

- ◆ Report any *risks of harm* or possible abuse/neglect to the review team leader immediately. The reviewer and team leader will identify appropriate authorities and report the situation.
- ◆ If, while reviewing the case record material 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/care coordinator before you begin your interviews.
- ◆ Gather information for the *demographic section* of the QSR Profile from the caseworker and records. Be sure to note medications; diagnoses; and any chronic health, mental health, or behavioral problems that require special care.
- ◆ Thoroughly complete the *examination section* of the protocol. Be sure each summative question rating matches the rating you enter on the QSR Profile Sheet.
- ◆ The *written case summary* in the protocol should be organized by section and submitted electronically. Please write in complete sentences. 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 written summary. Use the case write-up section as the structure for presenting your cases during the oral debriefing.
- ◆ The completed *Profile Sheet* and the *Agreement Check* for the case assigned to the reviewer MUST be given to the review team 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 team leader. If the reviewer is directed to fax the roll-up sheet(s) to HSO for processing, the fax number to be used is 850/422-8487.
- ◆ The *written case summary* will be returned to the QSR

Coordinator not later than the Friday of the week following the field-work activities. The report should be emailed. 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.

### 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 at the end of this section.] The general timeframes for rating indicators are: (1) for child/youth and parent status indicators, the reviewer focuses on the past 30 days and (2) for system performance indicators, the reviewer focuses on the past 90 days. Progress indicators address child/youth change over the past 180 days.

These time parameters will help reviewers clearly and consistently define conditions necessary for a particular rating value. Greater clarity in rating values increases inter-rater reliability. The general rating values to use are explained in the sections that follow. Most QSR indicators follow these time parameters exactly. Exceptions to the general rules are found in the Stability and Behavioral Risk Indicators.

### CHILD AND CAREGIVER INDICATOR RATINGS

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

- **Level 6 - Optimal and Enduring Status.** The child/youth or parent/caregiver status situation has been generally optimal [*best attainable taking age 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. 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 needs or outcomes will be or are being met in this area—perhaps reaching the level indicated for stepping down services in this status area.
- **Level 5 - Good and Stable Status.** The child/youth or parent/caregiver 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 that time period. 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 status level is consistent with eventual satisfaction of major needs or attainment of long-term outcomes in the area.
- **Level 4 - Minimally Adequate to Fair Status.** The child/youth or parent/caregiver status situation has been at least minimally adequate at all times over the past 30 days, without being inadequate at any

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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 child/youth or parent/caregiver status situation has been somewhat limited or inconsistent over the past 30 days, being inadequate at some moments in time or in some essential aspect(s) over this time 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 or may have been less than minimally acceptable in the recent past and somewhat inadequate.
- **Level 2 - Substantially Poor Status.** The child/youth or parent/caregiver 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 substantially inadequate.
- **Level 1 - Adverse or Poor and Worsening Status.** The child/youth or parent/caregiver 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 or a great need for immediate improvement at the present time. The observed pattern may have endured or may have recently become unacceptable, substantially inadequate, and worsening.

### SERVICE SYSTEM PERFORMANCE INDICATOR RATINGS

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

- **Level 6 - Optimal and Enduring Performance.** The service system practice/system performance situation observed for the child/youth or parent has been generally optimal [*best attainable given adequate resources*] 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 child/youth or parent 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. 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 child/youth or parent has been at least minimally adequate at all times over the past 30 days, 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. Some 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 child/youth or parent has been somewhat limited or inconsistent, being inadequate at some moments in time or in some essential aspect(s) over this time period. The situation may be 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/youth or parent has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect (s) recently. 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 substantially inadequate. This level of inadequate performance warrants prompt attention and improvement.
- **Level 1 - Absent, Adverse, or Poor Worsening Performance.** The service system practice/system performance situation observed for the child/youth 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.

## 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 & ENDURING STATUS.** The best or most favorable status presently attainable for this individual in this area [taking age and ability into account]. The individual is continuing to do great in this area. Confidence is high that long-term needs or outcomes will be or are being met in this area.
- 5 = **GOOD & CONTINUING STATUS.** Substantially and dependably positive status for the individual in this area with an ongoing positive pattern. This status level is generally consistent with attainment of long-term needs or outcomes in area. Status is "looking good" and likely to continue.

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 at least minimally or temporarily sufficient for the individual 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.

**Improvement  
Zone: 1-2**

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

- 3 = **MARGINAL INADEQUATE STATUS.** Status is mixed, limited, or inconsistent and not quite sufficient to meet the individual'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.
- 2 = **POOR STATUS.** Status is and may continue to be poor and unacceptable. The individual may seem to be "stuck" or "lost" with status not improving. Any risks may be mild to serious.
- 1 = **ADVERSE STATUS.** The individual'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 & ENDURING PERFORMANCE.** Excellent, consistent, effective practice for this individual in this function area. This level of performance is indicative of well-sustained exemplary practice and results for the individual.
- 5 = **GOOD ONGOING PERFORMANCE.** At this level, the system function is working dependably for this individual, under changing conditions and over time. Effectiveness level is consistent with meeting long-term needs and goals for the individual.

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 in this area may be no less than minimally adequate at any time in the past 30 days, but may be short-term due to change circumstances, requiring change soon..

**Improvement  
Zone: 1-2**

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

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

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# INTRODUCTION TO THE QUALITY SERVICE REVIEW PROTOCOL

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## ORGANIZATION OF THIS PROTOCOL BOOKLET

This protocol booklet is organized into the following sections:

- ◆ **Introduction:** This first section of the protocol provides a basic explanation of the review process and protocol design.
- ◆ **Child Status Indicators:** The second section provides the eight child status indicators used in the review.
- ◆ **Parent/Caregiver Status Indicators:** The third section provides the four parent/caregiver indicators used in the review.
- ◆ **Practice Performance Indicators:** The fourth section provides the eight core practice function indicators and five specialized practice indicators used in the review.
- ◆ **Overall Patterns:** The fifth section provides the working papers that the reviewer uses to determine the overall patterns for the areas of child status, parent/caregiver status, progress, and practice performance domain. In addition, this section includes the instructions for making the six-month forecast.
- ◆ **Reporting Outlines:** The sixth section provides the outlines that reviewers are to use in developing and presenting the ten-minute oral summary of case findings and the written summary report to be submitted following the review.



SECTION 2

**CHILD STATUS INDICATORS**

**Well-being & Functioning**

1.	Safety:	
	A: Exposure to Threats of Harm	12
	B: Behavioral Risk to Self/Others	14
2.	Stability Pattern	16
3.	Permanency Prospects	18
4.	Living Arrangement	20
5.	Health/Physical Well-being	22
6.	Emotional Well-being	24
7.	Learning & Development	26



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

### Focus Measure

**SAFETY - The 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 parents and caregivers provide the attention, actions, and supports necessary to protect the child from known risks of harm in the home.

### Core Concepts

Freedom from harm is a state of child well-being that exists in the balance of interactions between any known risks of harm and necessary protections put into place by parents and/or out-of-home caregivers, teachers, baby sitters, and others having immediate responsibility for the child. Thus, the capability and reliability of the parents (and other responsible persons) in recognizing risks of harm and protecting the child from those risks must be considered by reviewers. This consideration extends to the effectiveness of any protective strategies (e.g., no-contact orders, safety plans, after-school child supervision plans) put into place to keep a child free from known risks. 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 risks of harm 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, caregivers, 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/caregivers, as appropriate to the child's age and developmental needs. A child who is at risk of harm or who lives in fear of assault, exploitation, humiliation, hostility, isolation, or deprivation may be at risk 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.

### Probes: Determine from Informants, Observations, Plans, and Records

1. Is the child currently or has the child been a victim of abuse, neglect, or exploitation in the home or community?
2. Does the parent/caregiver 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?
3. Is the child fearful, intimidated, or at high risk of harm 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 youth 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)
4. 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? • Are the parent/caregiver's methods of discipline appropriate for this child?
5. Does the child receive an appropriate level of care and supervision from parents/caregivers and other adults, relative to age and special needs? • Do the parents/caregivers recognize and support the child's strengths?
6. Is the child's care or supervision situation currently compromised by the parent/caregivers' pattern of violent behavior, abuse/addiction to drugs and/or alcohol, mental illness/emotional instability, criminal activity, developmental status, cognitive ability, or domestic violence?
7. What informal supports and resources is the family now using to keep the children free from harm? • What recent family changes are now in place that help the family to better recognize risks of harm and to protect the child/children in the home from those risks?
8. How reliable are any protective strategies (e.g., no-contact order, safety plan) used to keep the child and/or family free from harm?

**NOTE:**

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





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

9. Are parents/caregivers aware of any risks to the child? • How reliable are parents/caregivers in recognizing risks of harm and taking steps to protect the child from those risks? • Are known risks being managed effectively for the child?

### Description and Rating of the Focus Child's Current Status

#### Description of the Status Situation Observed for the Child

- ◆ **Optimal Safety.** Findings show an **excellent situation** for the child. The child has a nearly risk-free living situation at home with fully reliable and competent parents/caregivers 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.
- ◆ **Good Safety.** Findings show a **good situation** for the child. The child has a generally low-free living situation at home with reliable and competent parents/caregivers 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 risk 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.
- ◆ **Fair Safety.** Findings show a **minimally adequate to fair situation** in being free from imminent risk of abuse or neglect for the child. The child has a minimally safe living arrangement with the present parents/caregivers. Any protective strategies used are at least minimally adequate in reducing risks of harm. The child is at least minimally free from serious risks 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.
- ◆ **Marginally Inadequate Safety.** Situation indicates **somewhat inadequate protection** of the child from abuse or neglect, which poses an elevated risk of harm for the child. Any protective strategies used may be somewhat limited or inconsistent in reducing risks of harm. The child may be exposed to somewhat elevated risks 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.
- ◆ **Substantially Inadequate Safety.** Situation indicates **substantial and continuing risks 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 be implemented or effective when used in reducing risks of harm. The child may be exposed to substantially elevated risks 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.
- ◆ **High Safety Risk.** Situation indicates **serious and worsening risks of 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 risk of continuing and worsening harm. The child may be exposed to continuing and increasingly serious intimidation, abuse, and/or neglect.
- ◆ **Not Applicable.** The child does not live in a substitute care home. - OR - The child no longer lives in or visits in the family home. - OR - The young child is under the age of five and not enrolled in a school program or any other early childhood education program and is kept at home during the day.

#### Rating Level

**6**

- Fam. Home
- Subst. Home
- School
- Other settings

**5**

- Fam. Home
- Subst. Home
- School
- Other settings

**4**

- Fam. Home
- Subst. Home
- School
- Other settings

**3**

- Fam. Home
- Subst. Home
- School
- Other settings

**2**

- Fam. Home
- Subst. Home
- School
- Other settings

**1**

- Fam. Home
- Subst. Home
- School
- Other settings

**NA**

- Fam. Home
- Subst. Home
- School
- Other settings



## CHILD STATUS REVIEW 1B: SAFETY FROM RISK TO SELF/OTHERS

### Focus Measure

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

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

Throughout development, children and youth 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 focus individual'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 individual'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:

- Running away (adolescents)
- Serious property destruction, including fire setting
- Gang affiliation and related activities
- Suicidality, self-mutilation, or other forms of self-injurious behaviors (e.g., pica, head-banging, eye-gouging)
- Placing him/herself in dangerous environments and situations or neglecting essential self-care requirements for maintaining well-being
- Neglecting dependent care requirements
- Stealing
- Bulimia and or anorexia
- Abuse of alcohol/addictive substances
- Dangerous thrill-seeking activities
- Use of weapons

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.

### Probes: Determine from Informants, Observations, Plans, and Records

1. Does the child/youth 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. Is this child/youth 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/youth's behaviors in the community likely to lead to arrest and/or youth detention or adult incarceration?
3. Does the child/youth 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/youth been supported to identify and use his/her personal strengths?
4. Does this child/youth regularly associate with peers known for engaging in illegal or high risk activities? • Does this child/youth engage in any high risk behaviors, including running away, robbery, car theft, drug use/sale, having unprotected sex, or prostitution?
5. Is there a recorded history, through either school guidance/disciplinary issues, arrest records, or mandatory community service records, of the child/youth engaging in harmful, illegal, or very risky activities? • Is the child/youth involved with the juvenile justice system?
6. If the child or youth is involved with the juvenile justice system, is he/she actively participating with the court's plans and avoiding reoffending? • How is the youth modifying daily activities and peer members to avoid reoffending and become a "good citizen"?
7. Has the child/youth made suicidal gestures, threatened suicide, or had a suicide attempt? • Does the child need/have a **SAFETY PLAN**?



## CHILD STATUS REVIEW 1 B: SAFETY FROM RISK TO SELF/OTHERS

8. Does the child/youth 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. If the child/youth currently has a current GAF score less than 50, what behaviors does he/she present that may put him/herself or others at risk of harm? • Has any harm actually occurred within the past 30 days? If so, what happened? • Are steps being taken to prevent or reduce the probability of repeated injury?
10. Is the child/youth presently placed in a specialized treatment or detention setting? • Has seclusion or restraint been used within the past 90 days to prevent harm to self or others? • If so, how frequently has seclusion or restraint been used and for what reasons? • Has use of any emergency control techniques been reduced over the past 90 days? • Has 911 been called because of this child/youth's behavior recently?

### Description and Rating of the Child's Current Status

**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 or to young children under the age of 36 months.*

Description of the Behavioral Risk Status Observed for the Child/Youth

Rating Level

- |  |  |
|--|--|
| <p>◆ <b>Optimal Behavioral Risk Status.</b> The child/youth is optimally and consistently avoiding behaviors that cause harm to self, others, or the community. This child/youth may have no history, diagnosis, or behavior presentations that are consistent with behavioral risk and is continuing this pattern. Or, the child/youth may have had related history, diagnoses, or behavior presentations in the past but has not presented risk behaviors at any time over the <b>past six months</b>. Behavioral risk status is excellent.</p>                            | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">6</div> <div style="margin-top: 5px;"> <input type="checkbox"/> Risk to self<br/> <input type="checkbox"/> Risk to others                 </div>  |
| <p>◆ <b>Good Behavioral Risk Status.</b> The child/youth is generally and substantially avoiding behaviors that cause harm to self, others, or the community. This child/youth may have a very limited history, diagnosis, or behavior presentations that are not significant now. Or, the child/youth may have had significant history, diagnoses, or behavior presentations in the past but has not presented the risk behaviors at any time over the <b>past three months</b>. Behavioral risk status is good.</p>  | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">5</div> <div style="margin-top: 5px;"> <input type="checkbox"/> Risk to self<br/> <input type="checkbox"/> Risk to others                 </div>  |
| <p>◆ <b>Fair Behavioral Risk Status.</b> The child/youth 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/youth 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 <b>past three months</b>. Behavioral risk status is minimally adequate to fair.</p>   | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">4</div> <div style="margin-top: 5px;"> <input type="checkbox"/> Risk to self<br/> <input type="checkbox"/> Risk to others                 </div>  |
| <p>◆ <b>Marginally Inadequate Behavioral Risk Status.</b> The child/youth 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/youth 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 <b>past 30 days</b>. Behavioral risk status is somewhat limited or inconsistent and worrisome.</p>                                 | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">3</div> <div style="margin-top: 5px;"> <input type="checkbox"/> Risk to self<br/> <input type="checkbox"/> Risk to others                 </div>  |
| <p>◆ <b>Poor Behavioral Risk Status.</b> The child/youth 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/youth 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 <b>past 30 days</b>. Behavioral risk status is poor and a potential for harm is present.</p>  | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="margin-top: 5px;"> <input type="checkbox"/> Risk to self<br/> <input type="checkbox"/> Risk to others                 </div>  |
| <p>◆ <b>Serious and Worsening Behavioral Risk Status.</b> The child/youth 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/youth 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 <b>past 30 days</b>. The potential for harm is substantial and increasing.</p> | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <div style="margin-top: 5px;"> <input type="checkbox"/> Risk to self<br/> <input type="checkbox"/> Risk to others                 </div>  |
| <p>◆ <b>Not Applicable.</b> The child is under three years of age.</p>   | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">NA</div> <div style="margin-top: 5px;"> <input type="checkbox"/> Risk to self<br/> <input type="checkbox"/> Risk to others                 </div> |



## CHILD STATUS REVIEW 3: STABILITY PATTERN

### Focus Measure

**STABILITY PATTERN - The 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]*

Any change in a child's life may be disruptive of established relationships and the familiar comforts, rhythms, and routines of a normal, stable life. While change is a part of life, the focus in this review is on determining the degree of stability now and in the immediate future for this child. The rating reflects the likelihood that changes in the child's environment and living situation may occur that are highly disruptive of the child's relationships and routines. The reason may be foster home placement problems, a sudden psychiatric episode, placement in residential treatment, or other similar situations in which the child does not return to the same home and/or school. An educational move is considered disruptive if the child changes schools 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. Repeated school suspensions or expulsion would be considered disruptive to a child's education. Normal age-related transitions from elementary to middle or to high school is not a disruption. A brief hospitalization for acute care is not a disruption, if the child returns to the same home following discharge.

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 solve problems, negotiate change, assume responsibilities, judge and take appropriate risks, form healthy relationships, work as a member of a group, and develop a "conscience." Many life skills, character traits, and habits grow out of enduring relationships the child has with key adults in his/her life. Building nurturing relationships depends on consistency of contact and continuity of relationships. For this reason, stability and continuity in the child's living arrangement and social support network is a foundation for normal child development. A child removed from his/her family home should be living in a safe and appropriate home. If, for reasons of child protection, psychiatric treatment, or juvenile justice services, this child/youth is in a temporary setting or unstable situation, then prompt and active measures should be taken to restore the child to a stable situation. **NOTE:** *Time scales for ratings 4, 5, and 6 in this indicator differ from the usual rating time scales.*

### Probes: Determine from Informants, Observations, Plans, and Records

1. Is the child living in a permanent home? • If continued instability is present, is it caused by unresolved permanency issues? • Is a concurrent permanency plan in place to minimize further disruption if efforts to achieve permanency fail? • If so, what is the permanency plan?
2. Does the child have a history of instability of living arrangements? • 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. Are probable causes for disruption of home, school, or work present?
  - Parent/caregiver's history of frequent moves
  - Change in adults living in the home
  - Behavioral problems and discipline issues between parent and child
  - Members of the household threatened by the child's behavior
  - Parent/caregiver's inability/unwillingness to provide appropriate level of care or supervision
4. Has the child had a change in living, learning, or working environments in the past year resulting from:
  - Removal from his/her home or from another out-of-home care setting for safety reasons?
  - Behavioral problems or emotional disorders?
  - Required out-of-home treatment for serious emotional disturbances?
  - Criminal involvement resulting in arrest, entry to custody, youth detention, or juvenile corrections?
  - Chronic health conditions requiring frequent or extended hospitalization?
5. Has this child ever run away from home, school, or placement? • If so, is this likely to reoccur within the next six months?
6. 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?

**NOTE:**

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



## CHILD STATUS REVIEW 3: STABILITY PATTERN

### Description and Rating of the Child's Stability Pattern

**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 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 focus 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.

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

5
- ◆ **Fair Stability.** The child has **minimally acceptable stability** in home settings with no more than one disruption in settings within the past 12 months and none in the past three months. The child has established positive relationships with parents/primary caregivers, 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
- ◆ **Marginally Stability.** The child has **inadequate stability** in home settings over the past 12 months with more than one disruption within the past six months and none in the past 30 days. The child may not feel secure in the living arrangement and disruptions may have resulted in changes of parents/primary caregivers, 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
- ◆ **Poor Stability.** The child has **substantial and continuing problems of instability** in home settings with multiple changes in settings within the past 12 months and at least in the past 30 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
- ◆ **Adverse Stability.** The child has **serious and worsening problems of instability** in home settings with multiple changes in settings within the past 12 months. 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



## CHILD STATUS REVIEW 4: PERMANENCY PROSPECTS

### Focus Measure

**PERMANENCY PROSPECTS - Degree of confidence held by those involved (child, parents, caregivers, others) that the child/youth is living with parents or other caregivers 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: This Indicator Applies to a Focus Child in Out-of-Home Care having Permanency Goals of Reunification and/or Guardianship or Adoption

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 or out-of-home caregivers, 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 out-of-home caregivers and peers, continuous supportive relationships, and a necessary level of parental/caregiver commitment and affection. Evidence of permanency includes resolution of guardianship, necessary supports for caregivers, and stability in the child’s home and school settings. Families and children are entitled to permanency in a timely manner. Ideally, a child removed from his/her family home should be living in a safe, appropriate, and permanent home within 12 months of removal with no more than a single interim placement. Evidence of permanency includes resolution of guardianship, adequate provision of necessary supports for the out-of-home caregiver, and the achievement of stability in the child’s home and school settings. Thus, safety, stability, and adequate caregiver functioning are corequisite conditions of permanency for a child or youth. Because of the nature of congregate settings, with frequent turnover of out-of-home caregivers, 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. Intensive services and timely family reunification should be provided, where indicated. Other permanency strategies should be implemented immediately when reunification is determined not to be possible. Such a determination should be made in a timely manner after appropriate intensive services and any planned reunification efforts have proven unsuccessful or inappropriate. Where appropriate, termination of parental rights and adoption should be accomplished expeditiously. 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 current placement and plan will produce permanency.

### Probes: Determine from Informants, Observations, Plans, and Records

1. Is the child living with parents or out-of-home caregivers the child, parents/caregivers, and child welfare worker believe will endure lifelong?
  - Do the primary permanency and concurrent goals appear to be appropriate, given the circumstances? • What does the child say about permanency choices?
  - If this is an older youth free for adoption, is long-term foster care with independent living as the alternative path to permanency being followed?
2. If the child is residing with a parent, adoptive parent, or permanent out-of-home caregiver, for the identified home of the child:
  - Are legal steps to achieve permanency completed? • How much progress is being made in meeting conditions necessary for safe case closure?
  - Do they understand and commit to the responsibilities for rearing the child? • Is the family adapting to embrace the child as a new member?
  - Are they incorporating the child’s family of origin, traditions, and culture into the new family’s arrangements?
3. If the child does not live with permanent out-of-home caregivers yet and the permanency goal is reunification, are the parents and child successfully resolving concerns to get the child safely home?
  - 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?
  - Does the child, family, and child welfare worker support the permanency plan? • What does the child say about permanency choices?
4. If the child does not live with permanent out-of-home caregivers yet and the permanency goal is adoption or guardianship, is preparation for adoption/guardianship timely and appropriate?
  - Is an alternative family identified or being actively recruited and developed? • Do the child, family, and child welfare worker support the permanency plan?
  - Have relatives, current out-of-home caregivers, and past out-of-home caregivers been approached about providing permanency?
  - Is the child aware of and becoming prepared for adoption/guardianship? • What does the child say about permanency choices?
5. Is the scope and pace of achieving permanency consistent with ASFA timelines? • If there have been delays, have adjustments been made to better address permanency? • What are the necessary conditions for safe case closure and what progress is being made in meeting these conditions?



## CHILD STATUS REVIEW 4: PERMANENCY PROSPECTS

6. Do family members, current out-of-home caregivers, the child, and the team have and know about a concurrent plan? • Are back-up steps being taken to ensure timely permanency for the child if the current plan is halted or fails?

### Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child

Rating Level

- ◆ **Optimal Status.** 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 caregivers, 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**

 Reunification  
 Guard/Adoptn
- ◆ **Good Status.** Child has **substantial/promising permanence.** The child lives in a family setting (his/her own or that of an out-of-home caregiver) that the child, out-of-home caregivers, caseworker, and core team members have confidence will endure lifelong. A plan is implemented that supports that confidence because safety and stability have been achieved. If in a resource family, there is agreement that adoption/guardianship issues will be imminently resolved. For a child old enough to make a responsible judgment, the child and out-of-home caregiver (in all cases) are committed to the plan.

**5**

 Reunification  
 Guard/Adoptn
- ◆ **Minimal to Fair Status.** Child has **minimally acceptable to fair permanence.** The child lives in a family setting that the child, out-of-home caregivers, caseworker, and core team members expect 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/guardianship issues are being resolved. - **OR** - The child is still living in a temporary placement, but the child, out-of-home caregivers, caseworker, and other 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 for. 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 out-of-home caregiver is becoming prepared for receiving the youth. For a child old enough to make a responsible judgment, the child and out-of-home caregiver (in all cases) are committed to the plan.

**4**

 Reunification  
 Guard/Adoptn
- ◆ **Marginally Inadequate Status.** Child has **somewhat inadequate/uncertain permanence.** The child lives in a home that the child, out-of-home caregivers, 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 caregiver, but likelihood of reunification or finding another permanent home remains uncertain. If in an adoptive family, adoption/guardianship 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 caregiver (in all cases) may be considering the plan.

**3**

 Reunification  
 Guard/Adoptn
- ◆ **Poor Status.** Child has **substantial and continuing problems of unresolved permanence.** The child is living in a home that the child, out-of-home caregivers, and caseworker doubt could endure until the child becomes independent, due to safety and stability problems or failure to resolve adoption/guardianship 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 caregiver without a clear, realistic, or achievable permanency plan being implemented. Any concurrent pathways used may have stalled or failed.

**2**

 Reunification  
 Guard/Adoptn
- ◆ **Adverse Status.** 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/guardianship 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 caregiver without a clear, realistic, or achievable permanency plan being implemented.

**1**

 Reunification  
 Guard/Adoptn
- ◆ **Not Applicable.** The child is not in out-of-home care or reunification is no longer a permanency option.

**NA**



## CHILD STATUS REVIEW 5: LIVING ARRANGEMENT

### Focus Measure

**LIVING ARRANGEMENT - Degree to which:** • Consistent with age and ability, the focus child is in the most appropriate/least restrictive living arrangement, consistent with the child's needs 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 a child who is not in out-of-home care, this home can be with the parents, relatives (informally arranged by family), adoptive parents, or a guardian. For a child in out-of-home care, the living arrangement can be in family foster care, therapeutic foster care, group home, or residential treatment. 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. A child's home community is the least restrictive, most appropriate, inclusive setting in which the child spends his/her time on a daily basis. 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, with siblings and relatives or in his/her home community. 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 the child's needs and circumstances.

### Probes: Determine from Informants, Observations, Plans, and Records

1. Is the child living in his or her family home? • 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 caregivers) 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 a temporary out-of-home living arrangement, the following points should be considered in determining the appropriateness of the setting: *[Consider the appropriateness of the living arrangement with ICWA, MEPA, and ASFA, as applicable to the child.]*
  - Is the child living in his/her home community (neighborhood and community close to friends, in his/her school district, and where he/she can continue extracurricular 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 caregiver support these activities?
  - Does the child feel safe and well cared for in this setting?
  - Should reunification not be possible, would the out-of-home caregiver be able and willing to provide for permanency? • Is this home consistent with ICWA?
  - 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 caregivers 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. If the child is living in a group care (more than five children) or residential care center, the reviewer should consider the following items.
  - Does the child feel safe and well cared for in this setting?
  - Is this the least restrictive and most inclusive setting that is able to meet the child's needs?
  - Is the child placed with children in his/her same age group?
  - 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 home community?
  
4. Does the child, parents, out-of-home caregivers, therapists, and child welfare worker believe that this is the best place for the child to be living?

## CHILD STATUS REVIEW 5: LIVING ARRANGEMENT

### Description and Rating of the Child's Current Status

*This indicator applies to the child's current living situation, where the child or youth 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

- |  |   |
|--|---|
| <p>◆ <b>Optimal Living Arrangement. The child is living in the most appropriate setting to address his/her needs.</b> 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.</p>   | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">6</div> <p style="margin: 0;"> <input type="checkbox"/> Birth home<br/> <input type="checkbox"/> Subst. home                 </p>  |
| <p>◆ <b>Good Living Arrangement. The child is living in a setting that substantially meets his/her needs.</b> The living arrangement substantially provides the condition 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.</p>  | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">5</div> <p style="margin: 0;"> <input type="checkbox"/> Birth home<br/> <input type="checkbox"/> Subst. home                 </p>  |
| <p>◆ <b>Fair Living Arrangement. The child is living in a setting that is minimally consistent with his/her needs.</b> 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.</p>  | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">4</div> <p style="margin: 0;"> <input type="checkbox"/> Birth home<br/> <input type="checkbox"/> Subst. home                 </p>  |
| <p>◆ <b>Marginally Inadequate Living Arrangement. The child is living in a setting that only partially addresses his/her needs.</b> 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.</p> | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">3</div> <p style="margin: 0;"> <input type="checkbox"/> Birth home<br/> <input type="checkbox"/> Subst. home                 </p>  |
| <p>◆ <b>Poor Living Arrangement. The child is living in a substantially inadequate home or setting.</b> 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.</p>  | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <p style="margin: 0;"> <input type="checkbox"/> Birth home<br/> <input type="checkbox"/> Subst. home                 </p>  |
| <p>◆ <b>Adverse Living Arrangement. The child is living in an inappropriate home or setting for his/her needs.</b> 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/youth's behavioral risks. Or, the child/youth may be on runaway status, homeless, residing in a homeless shelter, or in temporary shelter care for more than 30 days.</p>  | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div> <p style="margin: 0;"> <input type="checkbox"/> Birth home<br/> <input type="checkbox"/> Subst. home                 </p>  |
| <p>◆ <b>Not Applicable.</b> The setting does not apply in this case.</p>   | <div style="background-color: black; color: white; padding: 5px; font-weight: bold; font-size: 1.2em; margin: 0 auto; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;">NA</div> <p style="margin: 0;"> <input type="checkbox"/> Birth home<br/> <input type="checkbox"/> Subst. home                 </p> |

## CHILD STATUS REVIEW 6: HEALTH/PHYSICAL WELL-BEING

### Focus Measure

**HEALTH/PHYSICAL WELL-BEING - Degree to which the focus child is achieving and maintaining his/her best attainable health status, given any disease diagnosis and prognosis that the child may have.**

### Core Concepts

The goal for children is to achieve and maintain their best attainable health status when taking medical diagnoses, prognoses, and history into account. The child's basic needs for proper nutrition, clothing, shelter, and hygiene should be met on a daily basis. Proper medical and dental care (preventive, acute, and chronic) is necessary for maintaining good health. Preventive and primary health care should include periodic examinations, immunizations, dental hygiene, and screening for possible developmental or physical problems. This extends to reproductive health care education and services for youth to prepare and protect them from making poor life choices, exposure to sexually transmitted diseases, and teen pregnancy. Children should be allowed access to alternative health care appropriate to their culture and preferences.

A responsible adult should assure that the medications are taken as prescribed, that the effects of the medications (including side effects) are monitored, and that there is a mechanism to provide feedback with the physician on a regular basis. For children who are developmentally capable, the child should understand his/her condition, how to self-manage issues associated with the condition, the purpose of his/her medication, how to manage or report side effects of the medication, and how to self-administer. 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. Children who are obese should be receiving dietary guidance and other appropriate supports.

### Probes: Determine from Informants, Observations, Plans, and Records

1. Are the child's **basic physical needs** being met adequately on a daily basis? • (If NOT, this may an indication of NEGLECT, a failure to provide critical care to the child. (See *Child Status Review 1: Safety*.)
  - Food, adequate nutrition, sleep, and daily exercise at a level necessary to balance the child's height and weight within a healthy range?
  - Sanitary housing that is free of safety hazards?
  - Daily care, such as hygiene, dental care, grooming, and clean clothing?
2. Is the child achieving his/her optimal or best attainable health status? Does the child have a primary care physician/medical home?
  - Are the child's immunizations complete and up to date?
  - 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 disease, colds, or injuries?
  - Does the child have recurrent health complaints, and if so, are they addressed (including dental, eyesight, hearing, etc.)?
  - Does the child appear to be underweight or overweight, and if so, has this been investigated?
  - Does the child use illegal substances?
  - 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?
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 is responsible for 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.
5. OPTIONAL CONSIDERATION: If the child is age ten or older, is the child/youth being provided reproductive health care education and services to prepare and protect (e.g., administration of the new HPV vaccine for girls to reduce the chances of cervical cancer) the child/youth from making poor life choices, exposure to sexually transmitted diseases, and teen pregnancy?

## CHILD STATUS REVIEW 6: HEALTH/PHYSICAL WELL-BEING

### Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child

Rating Level

- ◆ **Optimal Health Status.** 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 Health Status.** 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/youth. Nutrition, exercise, sleep, and hygiene needs are being substantially met. This child appears to be in good physical health.

5
- ◆ **Fair Health Status.** Child is demonstrating a minimally adequate to fair level of health status, considering any chronic conditions. The child/youth'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
- ◆ **Marginally Inadequate Health Status.** 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/youth'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, or mixed, physical health.

3
- ◆ **Poor Health Status.** 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/youth'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.

2
- ◆ **Worsening Health Status.** 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/youth'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.

1

## CHILD STATUS REVIEW 7: EMOTIONAL WELL-BEING

### Focus Measure

**EMOTIONAL WELL-BEING - Consistent with age and ability, the degree to which:**

- The focus child is presenting adequate levels of emotional, cognitive, and behavioral development and adjustment, as evidenced by adequate adjustment, attachment, coping skills, and self-control.
- The focus child is achieving an adequate level of functioning in daily settings and activities, consistent with age and ability.

### Core Concepts: This Indicator Applies to a Focus Child of Age 2 Years or Older

Positive life adjustments, appropriate coping skills, self-management, a sense of gratitude, and a higher ratio of positive to negative thoughts are essential to adequate daily functioning in a child's life. Well-being begins with having a sense of person, purpose, personal worth, and emotional connections. Children and their caregivers should have identified the child's strengths and encourage the frequent use of the strengths in achieving desired goals. From birth through adolescence, the child learns to respond, enjoy, and cope with his/her relationships and environment. Children who develop resiliency obtain the ability to address their day-to-day challenges with a sense of self-efficacy. The very young child develops strong attachments and is able to engage in reciprocal interactions with others. As the child matures, he/she learns how to play cooperatively, uses language to express emotion, and begins to self-regulate emotions. The older child/adolescent develops the ability to experience the full range of emotions within normal limits of intensity and duration. The child/youth enjoys his/her interactions with peers and has close friendships and meaningful relationships with adults. The child/youth is able to give and receive affection in an appropriate manner and understands the limits/boundaries associated with healthy relationships. The child learns to cope with ongoing and various stresses of life in a socially acceptable manner. Emotional well-being for a child or youth:

- Has a feeling of personal worth, a sense of belonging, and attachment to family and friends as well as affiliation with age-appropriate social groups.
- Is able to give and accept nurturing positive relationships with family members, peers and accept and express affection within safe and appropriate boundaries of social behavior.
- Is realistically aware of own positive strengths, attributes, accomplishments, and potentialities, as well as areas that may be limitations and uses them in appropriate and varied ways.
- Is learning to self-regulate, express gratitude, delay gratification, and use age-appropriate levels of self-direction and control in daily activities and relationships.
- Recovers quickly from being upset and is able to handle frustration.
- Has a sense that he/she can manage his/her problems and handle issues effectively.
- Has internalized values, norms, and rules in a way that will help with appropriate growth.
- Can deal with ambiguity and conflicting viewpoints without overreaction or presentation of self-isolating behaviors.
- Is able to positively identify with adults as appropriate role models and appropriately seeks assistance from adults.

Behavioral functioning addresses the manner in which the child interacts with others and his/her environment on a current daily basis. The child/youth must handle the daily life events without becoming disruptive or displaying behaviors that interfere with his/her ability to fulfill his/her expectations and responsibilities. The child/youth's behavior can range from superior handling of issues with very few negative interactions to having very serious problems managing him/herself in multiple settings. If the child has been diagnosed with an emotional disturbance, the child may be functioning in a range that prohibits completion of many daily activities. For a child/youth, positive behavioral functioning means that he/she:

- Does not participate in disruptive behaviors in the home, school, or community. This involves active self-regulation and impulse control in school/social activities.
- Is free of any behaviors that would interfere in his/her performance of the age-appropriate daily tasks and expectations.
- Demonstrates good judgment regarding age-appropriate activities of childhood or adolescence that he/she chooses to be involved in.
- Uses time in a constructive manner, consistent with academic or social norms, expectations, and rules at home, at school, and in the community.
- Is able to articulate his/her own wants and needs and is able to take meaningful steps to address those issues.
- If the child has been diagnosed with an emotional disturbance, the child is learning how to self-manage his/her behaviors and is using the necessary skills to function well in the school, home, and community on a daily basis.

### Probes: Determine from Informants, Observations, Plans, and Records

1. What is this child's level of emotional, cognitive and behavioral well-being and life adjustment? • Is it consistent with the child's age and ability? • As appropriate to age and ability, does the child report having a sense of identity, personal worth, purpose in life, and acceptance by and affiliation with others? • Is the child demonstrating personal responsibility for daily interactions, habits, and attitudes as appropriate to his/her age and ability?
2. How is the child adjusting to change and to any adverse life circumstances causing stress in his/her life? • Is the child currently engaging in positive emotional, cognitive, and constructive behavior at school, at home, and in the community?
3. Does the child have a diagnosed psychiatric disorder using the DSM? • If so, has the child received education about this diagnosis and how to better manage related signs and symptoms? • Is treatment resulting in both symptom reduction and improved positive functioning?



## CHILD STATUS REVIEW 7: EMOTIONAL WELL-BEING

4. What is the frequency of contact between the child and core members of his/her family and social network?
5. To what extent is the social network integrated in meeting the social/emotional needs of the child/youth? • To what extent do members of the social network provide reliable positive relationships?

### Scale for Rating the Child's Status

*EMOTIONAL WELL-BEING STATUS. To what degree is the child demonstrating his/her **best attainable level of emotional development** (e.g., life adjustment, coping, hopefulness, self-direction, self-regulation, delayed gratification; sense of personal worth, attachment, affiliation, resilience) and **daily behavioral functioning in normal activities**, taking into account the child's age, trauma history, psychiatric or substance use history, or diagnoses/prognoses, (e.g., mental retardation, autism, developmental trauma disorder or post-traumatic stress disorder, bi-polar disorder) presented by the child? **Emotional development and behavioral functioning should be considered together when rating this indicator.** Self-endangerment and risk to others are addressed in Child Status Review 2: Behavioral Risk. Apply this indicator to children and youth above the age of two years.*

#### Description of the Status Situation Observed for the Child

#### Rating Level

- |   |   |
|---|---|
| <p>◆ <b>Optimal Well-being Status.</b> Consistent with age and ability, the child is demonstrating excellent emotional development in all key areas of social/emotional development and life adjustment. The child may be demonstrating excellent daily functioning. The child may show excellent behavioral status in all key life areas.</p>  | <p><b>6</b> <input type="checkbox"/></p>  |
| <p>◆ <b>Good Well-being Status.</b> Consistent with age and ability, the child is demonstrating a good and substantial level of emotional development in most areas of social/emotional development and life adjustment. The child may be demonstrating a good, steady level of daily behavioral functioning in most key functional life areas.</p>   | <p><b>5</b> <input type="checkbox"/></p>  |
| <p>◆ <b>Fair Well-being Status.</b> Consistent with age/ability, the child is demonstrating a minimally/temporarily adequate level of emotional development. The child may be having problems adjusting in one area and is showing signs of distress in one area of emotional responsiveness or adaptations. The child's emotional development is minimally acceptable. The child may be demonstrating a minimally/temporarily adequate to fair level of daily behavioral functioning. The child may be functioning fairly well in his/her home and environment but may be having problems in one area of daily functioning. The child may have some disruptive behaviors or internalizing behaviors that are under minimally adequate control or may be showing rare, minor problems. The child's behavioral functioning is at least minimally satisfactory to fair at the moment, but may be at some risk of decline.</p> | <p><b>4</b> <input type="checkbox"/></p>  |
| <p>◆ <b>Marginally Inadequate Status.</b> Consistent with age and ability, the child is demonstrating a limited or inconsistent level of emotional development. The child may be having adjustment problems in several areas. The child may be showing distress in several areas of emotional responsiveness or adaptations. The child may be demonstrating a limited or inconsistent level of behavioral functioning in daily settings. The child is showing some emerging or continuing behavioral problems in the home, school, or community and may be exhibiting behaviors that interfere with several areas of daily functioning. The child may not be responding well to attempts to address disruptive behaviors or internalizing behaviors.</p>  | <p><b>3</b> <input type="checkbox"/></p>  |
| <p>◆ <b>Poor Well-being Status.</b> Consistent with age and ability, the child is demonstrating a consistently poor level of emotional development. The child may show no progress or improvement in areas of social/emotional development and life adjustment. The child is demonstrating a consistently poor level of behavioral functioning in daily settings and may show no progress or improvement in functional status.</p>  | <p><b>2</b> <input type="checkbox"/></p>  |
| <p>◆ <b>Worsening Well-being Status.</b> Consistent with age and ability, the child is demonstrating a poor and worsening level of emotional development. Rather than meeting adjustment expectations, the child's social/emotional development may be regressing. The child is demonstrating a poor and worsening level of behavioral functioning in daily settings and activities. The child's functional behavioral status may be declining.</p>   | <p><b>1</b> <input type="checkbox"/></p>  |
| <p>◆ <b>Not Applicable.</b> The child is under age two years; this indicator cannot be meaningfully applied at this time.</p>   | <p><b>NA</b> <input type="checkbox"/></p> |



## CHILD STATUS REVIEW 8A: EARLY LEARNING & DEVELOPMENT

### Focus Measure

**EARLY LEARNING - 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 Focus Child under the Age of 5 Years

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) may present significant developmental delays and learning problems. Since 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. (Please see *Indicators of Typical Developmental Ages 1-3 Years included in the packet*).

### Probes: Determine from Informants, Observations, Plans, and Records

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) or Developmental Trauma Disorder?
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 interventional 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.?

## CHILD STATUS REVIEW 8A: EARLY LEARNING & DEVELOPMENT

### Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child, under age 5 years	Rating Level
<p>◆ <b>Optimal Developmental Status.</b> The child's current developmental status is at or above age expectations in all domains, based upon normal developmental milestones. <i>[Sustained pattern for at least the last six months or since admission]</i></p>	<div style="display: flex; align-items: center; justify-content: center;"> <div style="background-color: black; color: white; padding: 5px 10px; font-weight: bold; margin-right: 5px;">6</div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Good Developmental Status.</b> 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. <i>[Sustained pattern for at least the last three months or since admission if less]</i></p>	<div style="display: flex; align-items: center; justify-content: center;"> <div style="background-color: black; color: white; padding: 5px 10px; font-weight: bold; margin-right: 5px;">5</div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Minimally Adequate to Fair Developmental Status.</b> 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 caregiver 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. <i>[Sustained pattern for at least the past 30 days]</i></p>	<div style="display: flex; align-items: center; justify-content: center;"> <div style="background-color: black; color: white; padding: 5px 10px; font-weight: bold; margin-right: 5px;">4</div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Marginally Inadequate Developmental Status.</b> The child's developmental status is mixed, somewhat near expectations in some domains, but showing significant delays in others. If the child and caregiver 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. <i>[A mildly inadequate and possibly inconsistent pattern over the past 30 days]</i></p>	<div style="display: flex; align-items: center; justify-content: center;"> <div style="background-color: black; color: white; padding: 5px 10px; font-weight: bold; margin-right: 5px;">3</div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Poor Developmental Status.</b> The child's developmental status is showing significant delays in several areas as compared to age-appropriate expectations. If the child and caregiver 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. <i>[A present dynamic pattern of concern]</i></p>	<div style="display: flex; align-items: center; justify-content: center;"> <div style="background-color: black; color: white; padding: 5px 10px; font-weight: bold; margin-right: 5px;">2</div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Adverse Developmental Status.</b> The child's current developmental status is far below developmental milestones and there may be a decline in certain domains. The child and caregiver 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. <i>[A continuing dynamic pattern of growing concern]</i></p>	<div style="display: flex; align-items: center; justify-content: center;"> <div style="background-color: black; color: white; padding: 5px 10px; font-weight: bold; margin-right: 5px;">1</div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>

## STATUS REVIEW 8B: LEARNING & DEVELOPMENT

### Focus Measure

**LEARNING STATUS - Degree to which the focus child [according to age and ability] is: (1) regularly attending school, (2) 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 Focus Child 5 Years or Older

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.

### Probes: Determine from Informants, Observations, Plans, and Records

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? • If not, is the child receiving special education and related services in an alternative curriculum directed via an IEP?
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?

## STATUS REVIEW 8B: LEARNING & DEVELOPMENT

### Description and Rating of the Child's Current Academic Status

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

Rating Level

- ◆ **Optimal Learning 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. *[Sustained pattern for at least the last six months]*

6
- ◆ **Good Learning 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. *[Sustained pattern for at least the last three months]*

5
- ◆ **Minimally Adequate to Fair Learning 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. *[Sustained pattern for at least the past 30 days]*

4
- ◆ **Marginally Inadequate Learning 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. *[A mildly inadequate and possibly inconsistent pattern over the past 30 days or longer]*

3
- ◆ **Poor Learning 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. *[A present dynamic pattern of concern]*

2
- ◆ **Adverse Learning 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. *[A worsening dynamic pattern of growing concern]*

1



SECTION 3

**CAREGIVER STATUS INDICATORS**

**Parent/Caregiver Status Indicators (Over the Past 30 Days)**

1a. Protective Capacities	32
1b. Congregate Caregiving	34
2. Family Resources & Supports	36
3. Role & Voice in Service Decisions	38



## CAREGIVER STATUS REVIEW 1A: PROTECTIVE CAPACITIES

### Focus Measure

**CAREGIVER PROTECTIVE CAPACITIES - Degree to which:**

- The parents or caregivers with whom the focus child is currently residing are willing and able to provide the child with the protection, supervision, guidance, and support necessary for daily living and child development.
- Where necessary added supports are provided in the home to meet any special needs of the child and assist the caregivers, these required supports are reliably meeting the needs.

### Core Concepts

**[FOR A CHILD LIVING WITH A BIRTH PARENT, RELATIVE, FOSTER PARENT, ADOPTIVE PARENT, OR LEGAL GUARDIAN]** The focus child's birth parents or current custodial parents are considered to be the primary caregivers for the child. The primary caregivers responsible for the child should have the **capacity, availability, and willingness** to meet the child's basic care and development needs reliably on a daily basis. This expectation applies to a child who may have extraordinary physical, emotional, and/or behavioral needs and life problems to be met at home. Such a child may increase demands on the time, attention, skills, financial resources, and patience required of caregivers for the child's supervision, physical care, training, and direction. Added caregiver training, in-home supports, respite care, and material assistance may be necessary to meet the needs of the child and extend the capacities of the caregiver. Caregivers should be able to recognize and positively support a child's strengths. When the child's primary caregiver has functional limitations (physical or mental), added supports provided in the home by other family members or paid providers may be used to overcome those functional limitations or added caregiving demands and to meet the special needs of the child. Expectations of adequate caregiver functioning and support apply to children living in a bio-family home, relative home, kinship home, foster home, or adoptive home. Caregiver Status Review 1a does not apply to group or institutional settings (use Caregiver Status 1b instead).

### Probes: Determine from Informants, Observations, Plans, and Records

- Can the present caregiver **perform necessary parenting functions reliably** on a consistent daily basis and create a positive atmosphere and secure environment in the home?
  - Does the caregiver perform parenting functions willingly, adequately, and consistently on a daily basis for this child and for other children at home?
  - Is the home free of hazards that might endanger the children?
  - Are all children in the home adequately supervised? Is the caregiver able to arrange for adequate child care?
  - Are the children attending school on a daily basis and doing their homework?
  - Are substitute caregivers attending parent-teacher conferences and special school events?
  - Does the caregiver use praise, affection, emotional support, and age-appropriate discipline?
  - Is the caregiver accessing and using necessary community resources?
  - Does the caregiver follow the service plan, attend required meetings, and transport the child to his/her appointments?
  - Does the caregiver/staff meet this child's parenting needs and/or special needs?
- Is there anything that might **impair the caregiver's functioning**?
  - There are exceptional care demands in the home (such as small children, high child/caregiver ratio, frail elderly, ill persons in the home, single parent family, social isolation).
  - The caregiver has problems of substance abuse.
  - The caregiver has a physical or mental disability.
  - The caregiver has a history of domestic violence or exploitation.
- If the caregiver's functioning is not adequate, to what degree are **adequate protective capacities and supports** in place to protect the focus child and other children in the home from threats of harm?
- If the child is in **therapeutic foster care**, do the foster parents receive adequate assistance to address the child's special needs?



## CAREGIVER STATUS REVIEW 1A: PROTECTIVE CAPACITIES

### Description and Rating of the Caregiver's Support of the Child

Description of the Status Situation Observed for the Child and Caregiver (Birth Parent and/or Substitute Caregiver)

Rating Level

- ◆ **Optimal.** The child receives **excellent caregiving** in his/her current home and benefits from competent, consistent, and caring parenting. Where necessary, any extraordinary demands placed on the caregiver are balanced with training, practical assistance, support, and relief to meet the needs of the child and maintain the stability of the home. Such supports are both functional and of optimal intensity to assist the caregiver with extraordinary demands. If caregiver supports and services are necessary, they are fully effective in meeting the need.

**6**  
 Fam. parent  
 Sub. caregiver
- ◆ **Good.** The child receives **good caregiving** in his/her current home and has generally competent and caring parenting. Where necessary, most of the extraordinary demands placed on the caregiver are supported with training, practical assistance, and relief to meet the needs of the child and maintain the stability of the home. Such supports are functional and of sufficient intensity to assist the caregiver with extraordinary demands. If caregiver supports and services are necessary, they are substantially adequate and consistent in meeting the need.

**5**  
 Fam. parent  
 Sub. caregiver
- ◆ **Minimally Adequate to Fair.** The child receives **minimally adequate to fair caregiving** in his/her current home and has minimally competent and caring parenting. Where necessary, any extraordinary demands placed on the caregiver or functional limitations of the caregiver are aided with training, practical assistance, in-home supports, and possibly protective supervision to meet the needs of the child and maintain the stability of the home. Assistance to the caregiver is minimally adequate for meeting extraordinary demands. There is minor concern regarding the stability of the placement. If caregiver supports and services are necessary, they are minimally adequate and consistent in meeting the need.

**4**  
 Fam. parent  
 Sub. caregiver
- ◆ **Marginally Inadequate.** The child is experiencing **minor problems in caregiving adequacy** in his/her current home involving caregiving availability, attitude, consistency, or capacity. Where necessary, any extraordinary demands placed on the caregiver are not being adequately supported with the necessary training, practical assistance, and relief to meet the needs of the child and maintain the stability of the home. Caregiver supports are inconsistent or of not enough intensity to meet extraordinary demands. Additional caregiver supports may not be available, dependable, or effective. There may be some concern about the stability of the placement. Some important needs may be infrequently unmet.

**3**  
 Fam. parent  
 Sub. caregiver
- ◆ **Poor.** The child has **substantial and continuing problems of caregiving adequacy** in his/her current home involving caregiving availability, attitude, consistency, or capacity. Although necessary, extraordinary demands placed on the caregiver are not adequately supported with training, practical assistance, and relief to meet the needs of the child and maintain the stability of the home. Necessary supports are lacking in scope or intensity to meet the needs of the caregiver and/or child. There is growing concern regarding stability with placement disruption seen as possible. Consequences of the unmet needs to the child may be of substantial concern.

**2**  
 Fam. parent  
 Sub. caregiver
- ◆ **Adverse.** The child has **serious and worsening problems of caregiving adequacy** in his/her current home involving caregiving availability, attitude, consistency, or capacity. Although necessary, the caregiver is not receiving any useful or effective support, despite extraordinary demands placed on the caregiver. There is serious concern regarding stability and placement disruption is likely. Consequences of the unmet needs to the child may be of great immediate concern.

**1**  
 Fam. parent  
 Sub. caregiver
- ◆ **Not Applicable.** Either the birth parent is no longer in the permanency picture or there is no substitute caregiver at this time so only one parent/caregiver applies in this case at this time. - **OR** - The child/youth lives in a congregate setting. Caregiver Status Review 1b was applied.

**NA**  
 Fam. parent  
 Sub. caregiver

## CAREGIVER STATUS REVIEW 1B: GROUP CAREGIVER SUPPORT OF THE CHILD

### Focus Measure

**GROUP CAREGIVER SUPPORT OF THE CHILD - Degree to which the child's primary caregivers in the group home or facility provide for the child's care, education and development adequately on a consistent daily basis.**

### Core Concepts

**[FOR A CHILD LIVING IN A GROUP HOME OR RESIDENTIAL FACILITY]** The focus child's group home should have one or more primary caregivers who are **willing, available, and able** to parent the child daily by:

- Meeting the child's basic needs for food, shelter, clothing, hygiene, and health care.
- Following through at the group home on developmental or therapeutic interventions required for a special needs child.
- Meeting the child's basic emotional needs through praise, affection, emotional support, and age-appropriate discipline.
- Providing adequate supervision, feedback about behavior, corrective instruction, and logical consequences for misbehavior.
- Knowing the child's strengths, friends, pattern of activities, and whereabouts and providing oversight in reducing risk situations.
- Providing guidance and moral reasoning as the child moves through life stages and works through typical life problems.
- Assisting with the child's education by ensuring daily school attendance, assisting with homework and special projects.
- Encouraging and supporting the child's participation in extracurricular activities.
- Attending parent-teacher conferences, planning special services, and attending special school events.

These are routine primary caregiver activities that meet a child's needs for health, safety, love, attention, caring, development, socialization, and education. They also provide a basis for developing conscience, character, and good habits essential for personal responsibility. Primary caregiver activities should be done on an age-appropriate basis for the child in a group home. The primary focus of this exam is on caregiver-provided supports necessary for the child to be ready to learn, participate in school activities, and benefit from educational opportunities. The group home should have a positive and supportive atmosphere and environment.

### Probes: Determine from Informants, Observations, Plans, and Records

1. Who is the primary caregiver in the group home for this child (afternoon, evening, and weekend shifts)?
2. Are the child's basic and special needs met on a consistent daily basis?
3. Does the child come to school ready to learn and to participate?
4. Is the child attending school on a daily basis?
5. Does the child complete homework and special project assignments?
6. Is the child encouraged and supported in participating in extracurricular activities provided through the school or community organizations?
7. Do the child's caregivers attend teacher conferences, IEP meetings, and other activities related to the needs and progress of the child?
8. Do the primary caregivers spend time with the child on a regular basis in support of school and education-related activities?
9. Are the child's emotional needs met through praise, affection, emotional support, and age-appropriate discipline?
10. Do caregivers know the child's friends, activity patterns, and whereabouts and provide oversight necessary to reduce risks of harm to the children?
11. Do the caregivers provide adequate supervision, feedback about behavior, corrective instruction, and logical consequences for misbehavior, including the child's school behavior and academic performance?
12. As the child develops through his/her adolescence and teenage years, are caregivers able to assist him/her with making critical life decisions regarding education, vocation, sexuality, religion, morality, or the use of substances?

## CAREGIVER STATUS REVIEW 1B: GROUP CAREGIVER SUPPORT OF THE CHILD

13. Do caregivers provide positive rewards, feedback about behavior, and corrective instruction and use logical consequences for correcting misbehavior?
14. Are supports and services being provided to assist caregivers in the group home? • If so, do these seem to be adequate in meeting the needs of the child and caregivers? • Do caregivers have access to sufficient and ongoing training?

### Description and Rating of Child/Caregiver's Current Status

<u>Description of the Status Situation Observed for the Child and Current Caregiver</u>	<u>Rating Level</u>
<p>◆ <b>Optimal Caregiving.</b> The child's basic and special needs are consistently met. Caregivers provide affection, discipline, logical consequences, and moral upbringing. The child always comes to school prepared and ready to learn; participates fully in the life of the school, including extracurricular activities; and is benefiting from his/her educational opportunities as shown through excellent academic achievement. Caregivers participate fully in teacher conferences, planning services, and special events. The child is assisted with homework, tutoring as needed, special assignments, and participation in extracurricular activities.</p>	<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 2px 5px; margin-right: 5px;"><b>6</b></div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Good Caregiving.</b> The child's basic and special needs are generally met. Caregivers usually provide affection, discipline, logical consequences, and moral upbringing. The child usually comes to school prepared and ready to learn; participates occasionally in the life of the school, including extracurricular activities; and is benefiting from his/her educational opportunities as shown through satisfactory academic achievement. Caregivers usually participate in teacher conferences and planning meetings. The child is usually assisted with homework and participation in extracurricular activities.</p>	<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 2px 5px; margin-right: 5px;"><b>5</b></div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Minimally Adequate to Fair Caregiving.</b> The child's basic and special needs are minimally met. Caregivers provide affection and discipline. The child comes to school minimally prepared and ready to learn, participates in a few extracurricular activities, and is benefiting from his/her educational opportunities as shown through fair academic achievement. Caregivers occasionally participate in teacher conferences and planning meetings. The child is minimally assisted with homework and extracurricular activities.</p>	<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 2px 5px; margin-right: 5px;"><b>4</b></div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Marginally Inadequate Caregiving.</b> The child's basic and special needs are inconsistently met. Caregivers provide inconsistent affection and/or inadequate or inappropriate discipline. Caregivers seldom participate in teacher conferences and planning meetings. The child occasionally comes to school prepared and ready to learn, may participate in extracurricular activities, and is benefiting little from his/her educational opportunities as shown through poor academic achievement. The child is inconsistently or inadequately assisted with homework or extracurricular activities. Follow-through with special interventions is limited. Minor support problems are present.</p>	<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 2px 5px; margin-right: 5px;"><b>3</b></div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Moderate and Continuing Problems in Caregiving.</b> The caregiver may be unable to meet the caregiving demands within the home for some period of time. Basic care of children, supervision, and assistance lapse for extended periods of time. The child rarely comes to school prepared and ready to learn. Any benefit from his/her educational opportunities is questionable, as shown through poor academic achievement. The child is likely to be doing poorly in school, sick, absent, truant, suspended, or expelled. Discipline may be absent, inappropriate, or excessive. Moderate support problems and their consequences are present.</p>	<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 2px 5px; margin-right: 5px;"><b>2</b></div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Serious and Worsening Problems in Caregiving.</b> The caregiver may be frequently absent or unable to perform parenting responsibilities within the home for extended periods of time. There is serious concern regarding basic care, supervision, and assistance for the children. The child does not come to school prepared and ready to learn and is not benefiting from his/her educational opportunities, as shown by failing academic performance. The child is most likely doing poorly in school, sick, absent, truant, suspended, or expelled. Discipline is absent, inappropriate, or excessive. Serious support problems and their consequences are present.</p>	<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 2px 5px; margin-right: 5px;"><b>1</b></div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>
<p>◆ <b>Not Applicable.</b> The child/youth lives in a small home setting. Caregiver Status Review 1a was applied.</p>	<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 2px 5px; margin-right: 5px;"><b>NA</b></div> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div>

## CAREGIVER STATUS REVIEW 2: FAMILY RESOURCES & SUPPORTS

### Focus Measure

**FAMILY RESOURCES & SUPPORTS: The degree to which:**

- **Income Adequacy:** The focus parent is accessing the economic supports for which he/she is eligible (e.g., TANF, SSI, WIC) and the income and economic supports adequately cover the family's living requirements (i.e., shelter, food, clothing, transportation, and health care/medicine, childcare) on a consistent basis to ensure stability.
- **Income Control / Self-Management:** The focus parent has skills sufficient for meeting the family's basic needs, managing income and other resources successfully, and maintaining a stable living arrangement.
- **Living Situation Adequacy and Stability:** The current living arrangement provides the focus parent and his/her family with sufficient space and adequate living conditions for stable and sustainable family functioning.
- **Informal Supports:** The focus parent is -- 1) securing adequate levels of informal supports provided by family, friends, neighbors, or other supporters who will help him/her manage adequately on an enduring basis and 2) engaged with an informal support system that assists him/her in meeting essential caregiving responsibilities.

### Core Concepts

The focus parent requires adequate income to provide the basic necessities of life for his/her family. The focus parent may be seeking gainful employment, have career goals and aspirations, and/or may be eligible for a variety of economic benefits and sources of income. Among these economic benefits are TANF, Child Support, Supplemental Security Income (SSI or SSDI, VA), Medicaid, HUD Section-8 Housing Subsidy, Food Stamps, transportation vouchers, and possibly other income supports. In addition, the focus parent requires basic skills in managing resources to ensure that the parent can provide for his/her family's basic necessities on a consistent basis. These skills would include budget planning/management, housekeeping skills, and meal planning/preparation. While some families may be living on a temporary basis with other family members or in specialized housing (homeless shelter, domestic violence shelter, transitional living arrangement, etc.), the goal is adequate, stable, and permanent housing for the focus parent and his/her family. Together, income and housing arrangements should ensure that the family can achieve and maintain a reasonable degree of stability and minimal adequacy in income, housing, nutrition, and health care. Case management services and support efforts should ensure that families receive the information and/or assistance needed to access job training and/or employment opportunities; potential income, health, and housing supports.

### Probes: Determine from Informants, Observations, Plans, and Records

1. What are the basic income requirements for the family? What is the parent's current income situation? Is the parent's present income sufficient to meet the basic living requirements of his/her children and adults living in the home and family unit? If not, what else is needed?
2. Is the parent employed and earning an adequate level of income to supply basic necessities for the family? If not, is the parent engaged as appropriate in activities necessary for job readiness, education, or training and/or securing sources of economic assistance?
3. Does the parent have the necessary skills and/or supports for managing income so that basic minimum needs are consistently met for those in the home and family members living in the home? Does the parent need added support for managing household finances and resources? What are the family's needs for transportation and are the needs being met? What are the needs for childcare? Is the parent able to provide for it? Is childcare adequate for the child(ren)?
4. What are the parent's basic housing needs? Is the current living arrangement adequate to meet the family's needs for shelter, including an environment free from health hazards (e.g., lead paint) and having dependable utilities and heat during winter months?
5. Is the parent performing necessary household management functions adequately, reliably, and consistently to ensure that:
  - o Conditions in the home are at least minimally safe, sanitary, and hazard free?
  - o Meal planning and preparation are adequate for proper nutrition and health maintenance?
  - o Food storage is free from health hazards (e.g., spoilage, vermin, and contamination)?
  - o Basic health/hygiene requirements are met (e.g., diapers, laundry of children's clothes, hygiene supplies for bathing)?
  - o Clothing of children in the home is adequate for typical local weather conditions and for school attendance (e.g., school uniforms)?
  - o Children's health care needs are met (e.g., immunizations; urgent care needs; managing chronic health problems, such as asthma)

## CAREGIVER STATUS REVIEW 2: FAMILY RESOURCES & SUPPORTS

### Description and Rating of the Parent/Caregiver's Current Status

Description of the Status Situation Observed for the Parents or Caregivers

Rating Level

- ◆ **Optimal Family Resources.** The parent's/caregiver's earned income and/or economic supports fully and dependably cover the family's basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, childcare). The parent's/caregiver's is fully accessing, receiving, and optimally managing the economic supports for which he/she is eligible. The parent's/caregiver's has excellent economic security and skills more than sufficient for meeting the family's basic needs and maintaining a stable living arrangement for the children. Living space and conditions are excellent. Informal supports are excellent in helping the parent/caregiver meet caregiving responsibilities at a high, consistent level.

**6**  
 Fam. parent  
 Sub. caregiver
- ◆ **Good Family Resources.** The parent's/caregiver's earned income and/or economic supports generally and dependably cover the family's basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, childcare). The parent's/caregiver's is generally accessing, receiving, and acceptably managing the economic supports for which he/she is eligible. The parent's/caregiver's has a good level of economic security and skills that are generally sufficient for meeting the family's basic needs and maintaining a stable living arrangement for the children. Living space and conditions are good. Informal supports are effective in helping the parent/caregiver meet caregiving responsibilities a good and substantial level.

**5**  
 Fam. parent  
 Sub. caregiver
- ◆ **Fair Family Resources.** Earned income and/or economic supports are minimally adequate to cover the parent/caregiver and his/her family's basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, childcare). The parent's/caregiver's is minimally accessing, receiving, and/or minimally managing the economic supports for which he/she is eligible. The parent/caregiver has a minimal to fair level of economic security and skills that are minimally adequate for meeting the family's basic needs and maintaining a stable living arrangement for the children. Living space and conditions are minimally adequate to fair. Informal supports are adequate in helping the parent/caregiver meet caregiving responsibilities a fair level.

**4**  
 Fam. parent  
 Sub. caregiver
- ◆ **Marginally Inadequate Family Resources.** The parent's/caregiver's earned income and/or economic supports are somewhat/sometimes inadequate to cover the family's basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, childcare). The parent/caregiver is marginally accessing, receiving, and/or inadequately managing the economic supports for which he/she is eligible. The parent/caregiver has a marginal or inconsistent level of economic security and skills that are somewhat inadequate for meeting the family's basic needs and maintaining a stable living arrangement for the children. Living space and conditions are marginal and somewhat problematic. Informal supports maybe marginal in helping the parent/caregiver meet caregiving responsibilities in a limited or inconsistent manner.

**3**  
 Fam. parent  
 Sub. caregiver
- ◆ **Substantially Inadequate Family Resources.** The parent's/caregiver's earned income and/or economic supports are substantially inadequate to cover the family's basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, childcare). The parent/caregiver is not accessing, receiving, and/or is poorly managing the economic supports for which he/she is eligible. The parent/caregiver has an inadequate level of economic security and skills that are insufficient for meeting the family's basic needs and maintaining a stable living arrangement for the children. Living space and conditions are poor or problematic. Informal supports maybe poor or highly variable and not in helping the parent/caregiver meet caregiving responsibilities.

**2**  
 Fam. parent  
 Sub. caregiver
- ◆ **Adverse/Worsening Family Resources.** The parent's/caregiver's earned income and/or economic supports are grossly inadequate to cover the family's basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, childcare). The parent/caregiver is not accessing, receiving, and/or is unable to manage the economic supports for which he/she is eligible. The parent/caregiver lacks economic security and/or skills sufficient for meeting the family's basic needs and maintaining a stable living arrangement for the children. Living space and conditions are poor or problematic. Informal supports maybe inadequate and declining or not available to the caregiver under present conditions.

**1**  
 Fam. parent  
 Sub. caregiver
- ◆ **Not Applicable.** EITHER: 1) There is no substitute parent involved at this time - OR - 2) The child is not returning to the family parent. Therefore, this indicator does not apply this person at the time of review.

**NA**  
 Fam. parent  
 Sub. caregiver

## CAREGIVER STATUS INDICATOR 3: ROLE & VOICE

### Focus Measure

**ROLE & VOICE:** The degree to which the focus individual is an active ongoing participant (e.g., having a significant role, voice, and influence) in shaping decisions made about intervention goals, strategies, and services.

### Core Concepts

The appropriateness of **Role and Voice** to the case is determined by consideration of the focus individual's developmental stage (age and/or mental capacity). The focus individual (if appropriate to the case) should be a full and effective partner on the team of service providers, fully participating in all aspects of assessment, service planning, implementation, monitoring, and evaluation of results. Ownership, leadership, full participation, commitment, and follow-through by the focus individual are essential to creating a workable and effective change process for him/her.

The focus individual should have an active role in developing goals and objectives, as well as in the development and implementation of plans. His/her role 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 following through on interventions.

### Probes: Determine from Informants, Observations, Plans, and Records

1. To what degree is the focus individual in control of the intervention/change process?
2. How well is the focus individual fulfilling a lead role in advocating for needs, supports and services? If a caregiver is representing the needs of the focus individual, how was this person selected? Can the caregiver speak freely and express his/her wants and needs? Do others listen?
3. At what level is the focus individual's voice heard and used to influence key decisions? Does the focus individual understand and accept any non-negotiable requirements or conditions necessary for safety and well-being?
4. How often does the focus individual attend team meetings and other activities?
5. Are there factors that substantially and repeatedly prevent or reduce the caregiver's opportunity or ability to function as an advocate? If so, what are these factors? What supports are provided to enhance the caregiver's role and voice in decisions?
6. If there are factors that substantially and repeatedly impede the caregiver's opportunity or ability to function effectively in matters related to the focus individual's service needs, has the agency offered special accommodations or supports to the caregiver to facilitate his/her effective participation? If so, have they been accepted by the caregiver and has this improved his/her participation? If accommodations or supports have not been offered, why not?

## CAREGIVER STATUS INDICATOR 3: ROLE & VOICE

### Rating of the Individual's Current Role and Voice in Decision Making

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

Rating Level

- ◆ **Optimal Role & Voice.** The focus individual is a full and effective partner on the team of service providers, fully participating in all aspects of assessment, service planning, implementation, monitoring and evaluation of results. The focus individual (as appropriate) has a central and directive role, providing a voice that shapes the course and pace of decisions.

**6**

Focus child  
 Fam. parent  
 Sub. caregiver
  
- ◆ **Good Role & Voice.** The focus individual is a substantial contributing partner on the team of service providers, generally participating in most aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The focus individual (as appropriate) has a present and effective role, providing a voice that influences the course and pace of decisions made by the team.

**5**

Focus child  
 Fam. parent  
 Sub. caregiver
  
- ◆ **Fair Role & Voice.** The focus individual minimally participates in some aspects of team decision making, assessment, service planning, implementation, monitoring, and evaluation of results. The focus individual (as appropriate) has a minimally effective role, providing a voice that suggests and affirms the course and pace of decisions made by the team.

**4**

Focus child  
 Fam. parent  
 Sub. caregiver
  
- ◆ **Marginally Inadequate Role & Voice.** The focus individual is a limited or inconsistent participant in a few aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The focus individual may have limiting circumstances, may not have been offered accommodations or supports, or may not wish greater participation even when offered accommodations or assistance. The focus individual (as appropriate) has a marginal role, providing a somewhat passive voice that acknowledges or accepts the course and pace of decisions made by the team of service providers.

**3**

Focus child  
 Fam. parent  
 Sub. caregiver
  
- ◆ **Substantially Inadequate Role & Voice.** The focus individual seldom participates in any aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The focus individual may have challenging circumstances, may not have been offered acceptable accommodations or supports, or may not wish greater participation even when offered accommodations or assistance. The focus individual (as appropriate) has a missing or silent role and a missing or passive voice that tacitly accepts or possibly rejects the course and pace of decisions made by the team of service providers.

**2**

Focus child  
 Fam. parent  
 Sub. caregiver
  
- ◆ **No Role & Voice.** The focus individual has not participated in any aspects of assessment, service planning, implementation, monitoring, and evaluation of results within the past six months or since the last team meeting (whichever is the more recent time event). The focus individual may be experiencing overwhelming life circumstances, without the benefit of special accommodations for support or participation. *Note: If the focus individual requires an advocate but does not have an advocate, then the focus individual would be considered to be without a role or voice in decisions being made about him/her.*

**1**

Focus child  
 Fam. parent  
 Sub. caregiver
  
- ◆ **Not Applicable.** The focus individual cannot exercise a role and voice at this time. - OR - Either the birth parent or substitute caregiver is not involved in this case at this time.

**NA**

Focus child  
 Fam. parent  
 Sub. caregiver



**SECTION 4A**

**PRACTICE PERFORMANCE INDICATORS**

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## PRACTICE REVIEW 1: ENGAGEMENT OF THE CHILD & FAMILY

### Focus Measure

**ENGAGEMENT - Degree to which those working with the focus child and family are:** • Developing and maintaining a mutually beneficial trust-based working relationship with the child and family. • Focusing on the child's and family's strengths and needs. • Being open, receptive, and willing to make adjustments in scheduling and meeting locations to accommodate family participation. • Offering transportation and childcare supports, where necessary, to increase family engagement and participation in treatment and support efforts.

### Core Concepts

The central focus of this review is on the diligence shown by the team in taking actions to 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 providers and children and families. To be successful, the child and family's team must:

- Engage a child and family meaningfully in all aspects of the service process,
- Recognize their strengths and focus on developing the positive attributes as well as reducing deficits in order to build and maintain rapport and a trusting relationship.
- When appropriate and/or necessary, thoughtfully and respectfully conclude the relationship when circumstances require change or the intervention goals are achieved.

**Engagement strategies will reflect the family's language and cultural background** and, in some situations, will balance family-centered and strength-based practice principles with use of protective authority. Best practice teaches that providers should: (1) Approach the family from a position of respect and cooperation. (2) Engage the family around strengths as well as concerns for the health, safety, education, and well-being of the child. (3) Focus on child/family strengths (e.g., personal strengths, culture, traditions, and values) as building blocks for services. (4) Help the family achieve a clear understanding of their strengths, needs, and risks for the child and/or family. (5) Help the family define what it can do for itself and where the child and family need help. (6) Engage the child and family in decision making about the choice of interventions and the reasons why a particular intervention might be effective. This must include discussion of the logistics of getting to and participating in interventions in a manner that is practicable and feasible for the family. It may be necessary for the team to change the meeting time, location, participation, and process to help a family participate.

**NOTE: Caregiver Status Review 3: Role and Voice in Shaping Decisions may provide useful information to consider when rating Practice Review 1: Engagement of the Child & Family.** Remember that engagement focuses on the 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.

### Probes: Determine from Informants, Observations, Plans, and Records

1. What outreach and engagement strategies are service providers using to build a working partnership with the child and family? • Are special accommodations made as necessary to encourage and support participation and partnership?
2. Can all members of the team identify, acknowledge, and support the use of family strengths?
3. How well engaged are the child and family in the service process at this time? • Are they satisfied with their relationships with key providers?
4. Do the child and family demonstrate enthusiasm about their interactions with service providers? • Do they report being treated with dignity and respect? • Do they have a trust-based working relationship with those providing services?
5. 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 monitoring/modification of the service arrangements?
6. 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 1: ENGAGEMENT OF THE CHILD & FAMILY

### Description and Rating of Practice Performance

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

Rating Level

- ◆ **Optimal Engagement Efforts.** Persons involved in the service process, including the family, report that key family members and/or the child's substitute caregiver(s) are full, effective, and ongoing partners in all aspects of assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services and results. If age ten or older and capable, the child fully participates in planning goals, deciding on service arrangements, and shaping the service process to support and achieve life ambitions. - **OR** - Excellent outreach efforts are used as necessary to engage difficult-to-reach family members, including scheduling time and location 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. The engagement efforts are made consistently and persistently over time.

**6**
  
- ◆ **Good Engagement Efforts.** Persons involved in the service process, including family members, report and the record shows that the team has a strong, respectful partnership with the family and that they actively work to make arrangements so that the family can be full participants. Team members and the family both report that the family is fully engaged and a satisfied member of the team. - **OR** - The team can identify many steps, strategies, and efforts that have been used to increase the family engagement and involvement that have been made over time.

**5**
  
- ◆ **Minimally Adequate to Fair Engagement Efforts.** Persons involved report and service records show that some family members and/or the child's substitute caregiver(s) are usual, ongoing partners in basic aspects of assessment, planning services, making service arrangements, monitoring, and evaluating services and results. If age ten or older and capable, the child sometimes assists in planning goals, deciding on service arrangements, and shaping the service process to support and achieve life ambitions. The family basically supports the change process unfolding for them. - **OR** - Some outreach efforts are used as necessary to engage difficult-to-reach families and that the record shows a goal and efforts by the team to constructively engage the family.

**4**
  
- ◆ **Marginally Inadequate Engagement Efforts.** Some persons involved report that some family members and/or the child's substitute caregiver(s) occasionally participate to a limited degree in service planning and annual evaluation activities. If age ten or older and capable, the child is allowed to participate in planning life goals, deciding on service arrangements, and shaping the service process to support and achieve life ambitions. The child and family may report having a somewhat uncertain or possibly strained relationship with service providers. - **OR** - The family has not been interested either because of dissatisfaction with the system or other reasons. Limited or inadequate outreach efforts have been made in sporadic efforts to engage difficult-to-reach family members. The team members do not know why the family will not engage in the process or have made assumptions that may not be accurate of the actual situation.

**3**
  
- ◆ **Poor Engagement Efforts.** Some persons involved report that few family members and/or the child's substitute caregiver(s) ever participate even to a limited degree in service planning and annual evaluation activities. The child and family may report having a poor or possibly conflicted relationship with service providers. - **OR** - No 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.

**2**
  
- ◆ **No Engagement Efforts.** 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 caregivers, 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 caregivers. Procedural or legal safeguards may be violated.

**1**



## PRACTICE REVIEW 2: TEAMWORK

### Focus Measure

- **TEAM FORMATION - Degree to which: (1) The “right people” for this child and family have formed a working team that meets, talks, and plans together. (2) The team has the skills, family knowledge, and abilities necessary to organize effective services for this child and family, given their level of complexity and their cultural background.**
- **TEAM FUNCTIONING - Degree to which: (1) Members of the child and family’s team collectively function as a unified team in planning services and evaluating results. (2) The decisions and actions of the team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the child and family as revealed in present results.**

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

This review focuses on the **structure, performance, and effective communication** of the child and family service team in collaborative problem solving, providing effective services, and achieving positive results with the child and family. The team is composed of the case or care manager, family members, interveners, and other persons as identified by the family. Parents/caregivers, professionals, paid service providers, faith leaders, and other friends and supporters from the family, school, or neighborhood may comprise a service/support team for the child and family. Broad team representation may be recommended to assure that a **necessary combination** of technical skills, cultural knowledge, and personal interests and contributions are formed and maintained for the child and family. Collectively, the team should have the technical and cultural competence, family knowledge, authority to act in behalf of funders and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs. Members of the team should have the time available to fulfill commitments made to the child/family. Team functioning and decision-making processes should be consistent with the principles of family-centered strength-based practice and system of care operating principles.

**Evidence of effective team functioning lies in its performance over time and in the results it achieves for the child and family.** The focus and fit of services, authenticity of relationships and commitments, unity of effort, dependability of service system performance, and connectedness of the child and family to critical resources all derive from the functioning of the family team. Present child status, family participation and perceptions, and achievement of effective results are important indicators about the functionality of the family team and should be taken into account when making this review. **NOTE:** *In some cases, mental health practitioners or support providers may join teams formed by other child-serving agencies rather than creating another team when a functional team already exists for a child and family. Thus, mental health providers may join school-based teams, child and family teams formed by the child welfare agency, or multi-agency system of care care teams.*

### Probes: Determine from Informants, Observations, Plans, and Records

1. Are parents/caregivers partners along with professionals, funders, and others in planning and guiding services? • Are persons with similar backgrounds to the family members of the team? • Which members did the family invite to participate? • Does the family believe that these are the “right people” for them?
2. Is the family satisfied with the functioning of the team? • Can the child or family request a team meeting at any time? • Is a trained team facilitator used, if indicated? • Do all parties believe that they are fully aware of how the child and family are progressing (including the child, if age appropriate)?
3. Does the team have a common conceptualization of the needs of the family? • Do the goals and objectives set by the team reflect the values of the family?
4. Do team members commit and ensure dependable delivery of services and resources for the child/family? • Are all members of the team kept fully informed of the status of the child and family and the implementation of planned services?
5. Are team decisions coherent in design with efforts unified across all service agencies involved with the child and family? • Does the team have and use flexible funding, informal resources, and generic services as appropriate to planned goals and case closure requirements, strategies, and activities?
6. Do team actions and decisions reveal a pattern of consistent and effective problem solving for this child and family? • What are the present results?

## PRACTICE REVIEW 2: TEAMWORK

### Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Child and Family's Team

Rating Level

- ◆ **Optimal Teamwork.** FORMATION: All of the “right people” for this child and family form an excellent working team that meets, talks, and plans together. The team has excellent skills, family knowledge, and abilities necessary to organize effective services for a child/family of this complexity and cultural background. FUNCTIONING: Team members collectively function as a fully unified and consistent team in planning services and evaluating results. Actions and communications of the family team fully reflect an excellent pattern of effective teamwork and collaborative problem solving that optimally benefits the child and family. The family is fully involved in the team.

**6**

 Formation  
 Functioning
- ◆ **Good Teamwork.** FORMATION: Most of the “right people” for this child and family have formed a good, dependable working team that meets, talks, and plans together. The team has good and necessary skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. FUNCTIONING: Team members generally function as a substantially unified and consistent team in planning services and evaluating results. Actions and communications of the family team consistently reflect a substantially coherent pattern of effective teamwork and generally collaborative problem solving that generally benefits the child and family. The family is fully involved in the team.

**5**

 Formation  
 Functioning
- ◆ **Minimally Adequate to Fair Teamwork.** FORMATION: Some of the “right people” for this child and family have formed a minimally adequate to fair working team that meets, talks, and plans together. The team has minimally adequate to fair skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. FUNCTIONING: Members of the family team members may function as a somewhat unified and consistent team in planning services and evaluating results. Actions of the family team usually reflect a fairly coherent pattern of effective teamwork and somewhat collaborative problem solving that at least minimally benefits the child and family. The family is fully involved in the team.

**4**

 Formation  
 Functioning
- ◆ **Marginally Inadequate Teamwork.** FORMATION: Some of the “right people” for this child and family have formed a marginal working group that occasionally meets, talks, and plans together. The group has limited or inconsistently used skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. FUNCTIONING: Members may function as a somewhat splintered and inconsistent group in planning services and evaluating results. Actions of the group usually reflect a somewhat incoherent pattern of teamwork and limited collaborative problem solving that seldom benefits the child and family. The family is only marginally involved in the team.

**3**

 Formation  
 Functioning
- ◆ **Poor Teamwork.** FORMATION: Few, if any, of the “right people” for this child and family may seldom meet, talk, and plan together. Persons involved with the family may have few or inconsistently used skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. FUNCTIONING: Persons may often function independently of the child/family and/or in isolation of other team members in planning services and evaluating results. Actions reflect an infrequent or rare pattern of teamwork or collaborative problem solving. This situation may limit benefits for the child and family. The family may not be involved in all aspects of the team.

**2**

 Formation  
 Functioning
- ◆ **Absent or Adverse Teamwork.** EITHER: There is no evidence of a functional team for this child and family with all interveners working independently and in isolation from one another. - **AND/OR** - The actions and decisions made by the group are inappropriate, adverse, and/or antithetical to the guiding principles of family-centered practice and system of care integration and coordination of services across agencies for the child and family.

**1**

 Formation  
 Functioning

## PRACTICE REVIEW 3: ASSESSMENT & UNDERSTANDING

### Focus Measure

**ASSESSMENT & UNDERSTANDING - Degree to which those involved with the child and family understand: (1) Their strengths, needs, risks, 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) What must change for the child/family to have better overall well-being and improved family 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, risks, 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 finding what works.

### Probes: Determine from Informants, Observations, Plans, and Records

1. How well does the case manager and/or team understand this child and family? • Does the case manager and team know why this child and family are open to services? • Does the team know what it will take to reach independence and successful outcome(s)? • What is working or not working now or in the recent past for this child and family?
  - How well are the strengths, needs, risks, and preferences of the child and caregiver known and understood by those involved (team)?
  - How well does the team understand what may be required for: (1) situational stability, (2) safety, (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) permanency, and (11) achieving clearly specified conditions for safe case closure?
  
2. How well are child and family stressors recognized? • How are these matters understood within the context and culture of this child and family?
 

<ul style="list-style-type: none"> <li>• Earlier life traumas and disruptions</li> <li>• Risks of harm, abuse, or neglect</li> <li>• Co-occurring disabling conditions</li> <li>• Problems of attachment and bonding</li> </ul>	<ul style="list-style-type: none"> <li>• Learning problems affecting school or job performance</li> <li>• Developmental delays or disabilities</li> <li>• Physical and/or behavioral health concerns</li> <li>• Recent life transitions and adjustments to new conditions</li> </ul>	<ul style="list-style-type: none"> <li>• Subsistence challenges of the family</li> <li>• Court-ordered requirements/constraints</li> <li>• Recent tragedy, loss, victimization</li> <li>• Extraordinary caregiver burdens</li> </ul>
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3. What observations, data, formal assessments, or evaluations have been obtained? • Are assessments appropriate for this child and family? • Are assessments conducted in natural settings and during everyday activities? • Have assessment facts been interpreted to form a useful understanding? • Is there evidence that assessment is a dynamic, continuous learning process? • How has team understanding evolved over the life of the case?
  
4. Are child and family strengths, needs, risks, and issues understood in a useful manner to support decisions about what works and what to do next?
  
5. Does the assessment include a long-term view of the child and family leading to independence from service system involvement and supports?
  
6. Do the assessments include the consideration of the youth's history of abuse (physical and/or sexual) and use of any special procedures, such as seclusion and restraints?
  
7. Has the youth received an assessment for suicide risk, especially for the following:
 

<ul style="list-style-type: none"> <li>• Youth's diagnosis with depression?</li> <li>• Impulse control disorder?</li> <li>• Substance/alcohol abuse?</li> </ul>	<ul style="list-style-type: none"> <li>• Bipolar disorder?</li> <li>• History of suicidal ideations, plans, or attempts?</li> <li>• During commencement or termination of antidepressants, new admissions, discharges, or change in clinical status?</li> </ul>
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## PRACTICE REVIEW 3: ASSESSMENT & UNDERSTANDING

### Description and Rating of Practice Performance

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

Rating Level

- ◆ **Optimal Assessment and Understanding.** The child and parent’s functioning and support systems are comprehensively understood. Knowledge necessary to understand the child and family’s strengths, needs, and context 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**

Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Good Assessment and Understanding.** The child and parent’s functioning and support systems are generally understood. Information necessary to understand the child and family’s strengths, needs, and context 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**

Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Fair Assessment and Understanding.** The child and parent’s functioning and support system are minimally understood. Information necessary to understand the child and family’s strengths, needs, and context 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 somewhat understood and used for some possible change strategies.

**4**

Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Marginally Inadequate Assessment and Understanding.** The child and parent’s functioning and support system are marginally understood. Information necessary to understand the child and family’s strengths, needs, and context 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 interpreted and expressed.

**3**

Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Poor, Incomplete, or Inconsistent Assessment and Understanding.** Knowledge of the child and parent’s functioning and support system 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**

Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Absent, Incorrect, or Adverse Assessment and Understanding.** Current assessments used for planned services are absent or incorrect. 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 must be made and used now for this case to move forward.

**1**

Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Not Applicable.** The birth parents are no longer involved due to divorce, termination of parental rights, death of parent, incarceration, deportation, or other case circumstances. There is no kinship, foster, or adoptive family involved or the child is placed or presently resides in a congregate care setting with no plan for reunification or adoption.

**NA**

Birth family  
 Sub. caregiver

## PRACTICE REVIEW 4: LONG-TERM VIEW / FAMILY OUTCOMES & LIFE GOALS

### Focus Measure

**OUTCOMES & GOALS - Degree to which there are stated, shared, and understood permanency outcomes and functional life goals for the child and family that specify required protective capacities, desired behavior changes, sustainable supports, and other accomplishments necessary for the child and family to achieve adequate daily functioning, well-being, and greater self-sufficiency. [Current goals guiding planned interventions over the past 90 days]**

### Core Concepts

What must change for the child and family to get better and do better in life? How will the child, parent, and interveners together know when progress is being made and when desired outcomes and goals have been achieved? 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 for the journey of change by framing necessary outcomes 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.

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 guardianship) to achieve stability, adequate functioning, permanency, and other outcomes necessary for the child and family to achieve their desired improvements and goals.

### Probes: Determine from Informants, Observations, Plans, and Records

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, supported the achievement of necessary behavior changes, 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 guardians, especially for a child having special needs? • Does it prepare the parents, caregiver, and child for adoption/guardianship?
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 youths 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 14 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 4: LONG-TERM VIEW / FAMILY OUTCOMES & LIFE GOALS

### Description and Rating of Practice Performance

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

#### Rating Level

◆ **Optimal Specification of Outcomes & Goals.** An excellent set of well-reasoned and well-specified permanency outcomes and life improvements for the child and family is fully known, understood, and supported by all involved. These goals are diligently used to guide intervention and change. 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**

Focus child  
 Birth family  
 Sub. caregiver

◆ **Good Specification of Outcomes & Goals.** A good and sufficient set of well-reasoned and well-specified permanency outcomes and life improvements for the child and family is substantially known, understood, and supported by all involved. These goals are substantially used to guide intervention and change. 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**

Focus child  
 Birth family  
 Sub. caregiver

◆ **Fair Specification of Outcomes & Goals.** A minimally adequate to fair set of permanency outcomes and life improvements 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**

Focus child  
 Birth family  
 Sub. caregiver

◆ **Marginally Inadequate Specification of Outcomes & Goals.** A marginal, somewhat inadequate set of permanency outcomes and life improvements 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**

Focus child  
 Birth family  
 Sub. caregiver

◆ **Poor Specification of Outcomes & Goals.** A poorly reasoned, inadequate, or incomplete set of permanency outcomes and improvements 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**

Focus child  
 Birth family  
 Sub. caregiver

◆ **Absent, Ambiguous, or Adverse Specification of Outcomes & Goals.** 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**

Focus child  
 Birth family  
 Sub. caregiver

◆ **Not Applicable.** The birth parents are no longer involved due to divorce, termination of parental rights, death of parent, incarceration, deportation, or other case circumstances. - **OR** - There is no kinship, foster, or adoptive family involved or the child is placed or presently resides in a congregate care setting with no plan for reunification or adoption.

**NA**

Birth family  
 Sub. caregiver



## PRACTICE REVIEW 5: PLANNING FOR SAFETY & PERMANENCY

### Focus Measure

**PLANNING: Degree to which a well-reasoned, family-centered strategy planning process is used for achieving:**

**A. SAFETY by recognizing, controlling and managing threats of harm while building and sustaining protective capacities of the parents in the home and family situation.**

**B. PERMANENCY by 1) Reunifying the child and parent, replacing the entering parent with another, or achieving independence for an older youth; and 2) Supporting and evaluating the stability and success of the child and family in a potentially permanent home to ensure family sustainability as a condition for safe case closure.**

### Core Concepts

**A. PLANNING SAFETY STRATEGIES:** Strategies (planned ways of achieving outcomes) for eliminating or minimizing impending danger threats in a family home and building protective capacities of caregivers should be well-conceived and specified in a written safety plan. A safety plan refers to a written arrangement between parents/caregivers that establishes how safety threats will be managed. For a safety plan to be sufficient, safety strategies put in place must specifically correspond to the identified threats. Strategies in the safety plan are implemented and active as long as impending danger threats exist and parent/caregiver protective capacities are insufficient to assure child safety. The safety plan clearly defines impending danger threats and how these threats will be managed, the roles and responsibilities of formal and informal supports used to manage safety, and the availability and suitability of those involved in the plan. Protective strategies in the safety plan are designed along a continuum of least to most intrusive intervention: in-home safety strategies to out-of-home safety strategies. Provisions for protection and safety must be sustainable in the home and family situation following safe case closure.

**B. PLANNING PERMANENCY STRATEGIES:** The focus of this review is placed on how well change strategies of the child/family change process are designed by those involved to help the parent and child make successful life changes leading to permanency. Strategies for permanency for a child or youth removed from his/her home include:

- Setting and achieving permanency goals for having an appropriate, permanent home/family situation for a child removed from the home of origin within a timely manner.
- Achieving reunification, guardianship, or permanent placement with relatives, where such options are appropriate and achievable.
- Actively working concurrent alternative strategies to permanency when a birth family reenters for repeat maltreatment or when the prognosis for permanency and family sustainability with the entering family is poor.
- Achieving timely and appropriate adoption of the child when reunification, guardianship, or placement with relatives is not possible.
- Achieving a timely and successful transition of an older APPLA youth from foster care to independent living when adoption is not desired or possible.
- Maintaining stability and achieving permanency via long-term care arrangements for an APPLA youth with severe disabilities, including transition to necessary and appropriate adult long-term care services.

For each change to be made by the parent and/or child, one or more strategies are selected to achieve family changes linked to conditions for independence from the child welfare system and permanency for the child.

### Probes: Determine from Informants, Observations, Plans, and Records

1. Is the caseworker and family aware of any current safety threats? • Does the safety plan use least intrusive means to control danger threats?
2. What are the strategies for controlling safety threats and do those services effectively match with how safety threats are manifested in the family? • How well are conditions for safety management (including safety plans) integrated into the stated conditions for safe case closure?
3. Are the formal/informal supports/providers identified in the safety plan aware of their role and responsibility in assuring for child safety? • Are they available and accessible at the level needed to control for child safety? • Will the family be able to sustain safe conditions with informal supports?
4. In cases where there is an out-of-home safety plan, is it clear to the family and team members what must occur for the child to return home accompanied with an in-home safety plan? • If self-endangerment are concerns for this child and family, how well are safety/crisis strategies addressed?
5. What is the permanency plan and sequence for this child? • Do planning efforts drive strategies and actions for promoting family change by:
  - Setting and modifying the child's permanence plan? • Are these goals consistent with stated conditions for safe case closure?
  - Development and use of a concurrent permanence plan? • Which agencies are/should be involved with each of these strategies?
  - Justification for ensuring permanency efforts are consistent with ASFA? • What change strategies are being used for attainment of permanency?
6. Which of the following permanency plans (primary and concurrent) have strategies and actions now planned and being implemented:
  - Reunification and/or testing the success of a recent reunification? • Adoption?
  - Guardianship with a relative? • Transition to independent living and emancipation for an older youth?
  - Long-term placement with a relative? • Long-term care with transition to adult services for a disabled child/youth?

## PRACTICE REVIEW 5: PLANNING FOR SAFETY & PERMANENCY

### Description and Rating of Practice Performance

This indicator is rated for the **primary plan** (e.g., family preservation or reunification) and **concurrent plan** (e.g., adoption or guardianship).

#### Description of the Practice Performance Situation Observed for Applicable Strategy Areas for Achieving Safety & Permanency

#### Rating Level

- ◆ **Optimal Planning.** An excellent, well-reasoned, continuous strategy planning process is being fully and effectively used to provide for: SAFETY - Protective capacities and conditions to keep children safe and 2) PERMANENCY - Reunifying the child and parent, replacing the entering parent with another, or successful independence for a youth; searching for, finding, eliminating, and approving a relative or another replacement to be the permanent caregiver; resolving any legal barriers to permanency. Planning provides for precise use of stated strategies, actions, timelines, and an accountable person for each service used in managing safety and achieving permanency. Where necessary, strategies may be fully aligned and actions well-integrated across providers and funding sources. Daily practice is being fully driven by well-reasoned planning, bringing a great sense of urgency to actions to achieve results. *[High quality sustained pattern for at least the last 6 months or since admission if less than 6 months]*

6

 Safety  
 Permanency
  
- ◆ **Good Planning.** A generally well-reasoned ongoing strategy planning process is being substantially and consistently used to provide for: SAFETY - Protective capacities and conditions to keep children safe and 2) PERMANENCY - Reunifying the child and parent, replacing the entering parent with another, or successful independence for a youth; searching for, finding, eliminating, and approving a relative or another replacement to be the permanent caregiver; resolving any legal barriers to permanency. Planning provides for thoughtful use of strategies, actions, timelines, and an accountable person for each service used. Where necessary, strategies may be substantially aligned with actions generally integrated across providers and funding sources. Daily practice is being substantially driven by the planning and management process, bringing a good sense of urgency to actions. *[Good quality sustained pattern for at least the last 3 months or since admission if less than 3 months]*

5

 Safety  
 Permanency
  
- ◆ **Fair Planning.** A somewhat reasoned, periodic strategy planning process is at least minimally adequate in providing for: SAFETY - Protective capacities and conditions to keep children safe and 2) PERMANENCY - Reunifying the child and parent, replacing the entering parent with another, or successful independence for a youth; searching for, finding, eliminating, and approving a relative or another replacement to be the permanent caregiver; resolving any legal barriers to permanency. Planning provides for minimal to fair use of strategies, actions, timelines, and an accountable person for each service used. Where necessary, strategies may be minimally aligned with actions somewhat integrated across providers and funding sources. Daily practice is being somewhat driven by the planning and management process, bringing a minimal to fair sense of urgency. *[Minimally adequate to fair pattern, past 30 days - never inadequate at any point]*

4

 Safety  
 Permanency
  
- ◆ **Marginal Planning.** A marginally reasoned, inadequate strategy planning process is somewhat limiting provisions for: SAFETY - Protective capacities and conditions to keep children safe and 2) PERMANENCY - Reunifying the child and parent, replacing the entering parent with another, or successful independence for a youth; searching for, finding, eliminating, and approving a relative or another replacement to be the permanent caregiver; resolving any legal barriers to permanency. Planning provides for limited use of safety strategies, actions, timelines, and an accountable person for each service used. Where necessary, strategies may be marginally aligned with actions inconsistently integrated. Daily practice is being inadequately driven by team planning, bringing a limited or inconsistent sense of urgency. *[Somewhat inadequate pattern, past 30 days or longer]*

3

 Safety  
 Permanency
  
- ◆ **Poor Planning.** A poorly reasoned, inadequate strategy planning and management process is generally failing to provide for: SAFETY and/or PERMANENCY. Planning does not provide for adequate use of safety or permanency strategies, actions, timelines, and, an accountable person for each service. Where necessary, strategies may not be aligned with actions nor integrated across providers and funding sources. Daily practice is not being driven by the planning process. *[Significantly inadequate, dynamic pattern of concern, past 30 days or longer]*

2

 Safety  
 Permanency
  
- ◆ **Absent, Ambiguous, or Misdirected Planning. EITHER:** No clear strategy planning and management process is operative or effective at this time to provide for: SAFETY and/or PERMANENCY. - **OR** - Team planning and management activities are substantially misdirected, conflicting, or insufficient in thought or detail to control threats to child safety or to achieve permanency. *[Adverse, dynamic pattern of major concern, past 30 days or longer]*

1

 Safety  
 Permanency
  
- ◆ **Permanency Area Not Applicable.** The family is intact; removal has not occurred; and no presently known circumstance (e.g., parent at the end-stage of a terminal disease) indicates a need for permanency with a different parent or caregiver. Therefore, this review indicator is deemed not applicable in this case.

NA

 Permanency

## PRACTICE REVIEW 6: NECESSARY SERVICE RESOURCES

### Focus Measure

**NECESSARY SERVICE RESOURCES - Degree to which:**

- Supports, services, and resources (home-based and school-based, where indicated) necessary to implement change strategies and sustain positive changes are available when needed for/by the child and family.
- Any flexible supports and unique service arrangements (e.g., wraparound services) 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 (e.g., cognitive behavioral therapy) and placement-based resources (residential treatment) 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 adequate array of informal and formal supports and services** may be 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., six 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.*

### Probes: Determine from Informants, Observations, Plans, and Records

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 team taking steps to locate or develop or advocate for previously unknown or undeveloped resources? • Has the service team taken steps to identify resource gaps and notify the community? • 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?



## PRACTICE REVIEW 6: NECESSARY SERVICE RESOURCES

### Description and Rating of Practice Performance

**NOTE:** Rate **resources** being used in the service process for this child/youth and caregiver. Resources may also include family and friend resources, neighborhood resources, primary care services, faith-based community services, recreational services, educational services, child welfare services, and juvenile justice services.

Description of the Practice Performance Situation Observed for the Child/Youth 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**
  
- ◆ **Substantial 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**
  
- ◆ **Very Limited 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 7: INTERVENTION ADEQUACY

### Focus Measure

**INTERVENTION ADEQUACY - Degree to which change-related interventions, 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 achieve and maintain desired functional and supportive life goals and permanency outcomes set for this child and family.**

### Core Concepts

The purpose of intervention is to facilitate successful changes that lead to attainment of planned goals and outcomes. As may be necessary for the child and family to achieve desired outcomes, a specifically arranged combination and sequence of interventions may lead to: (1) situational stability, (2) reduction of symptoms or substance use, (3) planned behavioral outcomes including adequate daily functioning and use of necessary protective capacities, (4) sustainable supports, (5) resiliency/coping for children, (6) recovery/relapse prevention for older youth and parents, (7) independence for older youth, (8) successful transitions and adjustments, and (9) improved and sustained levels functioning and well-being necessary of safe case closure. To be effective, interventions should be delivered at a level of intensity and consistency required to produce life changes that met goals and outcomes planned for a child and family.

The central action principle of practice is to *find what works* in the life change process for the child and family. The purpose of this review is to determine the extent to which the implementation of change strategies/interventions being used with the child and family demonstrates that the planned interventions and supports are commensurate with the changes required for child and family success. The reviewer should consider what is required to meet planned goals in this case. Considerations should include:

- Level of intensity, duration, coordination, consistency, and continuity of service delivery revealing that interventions have *sufficient power* to produce the changes necessary for the child and family.
- Demonstration of progress toward attainment of desired outcomes and goals 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 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 change strategies to desired 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 demonstrated to test strategies for effectiveness and for the management of the change process via results-driven decision making.*

### Probes: Determine from Informants, Observations, Plans, and Records

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?
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 7: INTERVENTION ADEQUACY

### Description and Rating of Practice Performance

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

Rating Level

- ◆ **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 fully sufficient to quickly and fully reach or exceed all of the outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

**6**  
 Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Good and Substantial 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 generally reach most of the outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

**5**  
 Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Minimally Adequate to Fair Intervention.** A fair combination, sequence, and power of current interventions is somewhat helping the child and family reach 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 to reach some of the outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

**4**  
 Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **Marginally Inadequate Intervention.** A somewhat underpowered combination and sequence of current interventions is helping the child and family reach somewhat inadequate or inconsistent levels of functioning necessary for them to make progress and improve functioning and well-being. A marginal combination of informal and, where necessary, formal supports and interventions is provided with little precision and somewhat inadequate levels of intensity, duration, continuity, and coordination. The power of intervention is not sufficient to reach some of the most important outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

**3**  
 Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **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 adequate to reach many of the outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

**2**  
 Focus child  
 Birth family  
 Sub. caregiver
  
- ◆ **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 are provided but are underpowered to achieve desired effects.

**1**  
 Focus child  
 Birth family  
 Sub. caregiver

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## PRACTICE REVIEW 8: TRACKING & ADJUSTMENT

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### Focus Measure

**TRACKING & ADJUSTMENT - Degree to which those involved with the child and family are:**

- Carefully tracking the child's/family's intervention delivery processes, progress being made, changing family circumstances, and attainment of functional goals and well-being outcomes for the child and family.
- Communicating (as appropriate) to identify and resolve any intervention delivery problems, overcome barriers encountered, and replace any strategies that are not working.
- Adjusting the combination and sequence of strategies being used in response to progress made, changing needs, and knowledge gained from trial-and-error experience to create a self-correcting intervention process.

### Core Concepts

What's working now for this child and family? Are desired service results being produced? What things need changing? An ongoing tracking and adjustment process should be used to monitor service implementation, check progress, identify emergent needs and problems, and modify services in a timely manner. Tracking and adjustments provide the "learning" and "change" processes that make the treatment process "smart" and, ultimately, effective for the child and caregiver.

Intervention strategies, supports, and/or services should be modified when objectives 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 service coordinator, along with the team for the child and family as well as the child and family, should play a central role in tracking and adjusting intervention strategies, services, and supports. Members of the team (including the child and caregiver) should apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services.

The frequency and intensity of the tracking and adjustment process should reflect the pace, urgency, and complexity of child needs and case events. This learning and change process is necessary to find what works for the child and caregiver. Learning what works is a continuing process. Getting successful near-term results (that lead to desired outcomes) depends on a "smart" planning and adjustment process.

### Probes: Determine from Informants, Observations, Plans, and Records

1. How often is the status of the child and family monitored/reviewed?
2. How is treatment progress and the child's well-being monitored by the service coordinator and team (e.g., face-to-face contacts, telephone contact, and meetings with the family, child, service providers; reviewing reports from providers)?
3. How is implementation of treatment and service processes being tracked? • Is progress or lack of progress being identified and noted and communicated between team members?
4. Are detected problems being reported and addressed promptly?
5. Are identified needs and problems being acted on?
6. Is there a clear and consistent pattern of successful adaptive service changes that have been made in response to use of short-term results?
7. Is the intervention process modified as goals are met? • Are strategies modified if no progress is observed? • If no, why not?
8. Are intervention strategies, supports, and services updated as goals are met? • Are necessary plans and service authorizations updated or revised if no progress is observed? • If not, why not?
9. How does the service coordinator and team update and modify intervention strategies and necessary documents?

## PRACTICE REVIEW 8: TRACKING & ADJUSTMENT

### Description and Rating of Practice Performance

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

Rating Level

- ◆ **Optimal Tracking and Adjustment Process.** Intervention strategies, supports, and services being provided to the child and family are highly responsive and appropriate to changing conditions. Continuous or frequent monitoring, tracking, and communication of child status and service results to the team are occurring. Timely and smart adjustments 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**
  
- ◆ **Good Tracking and Adjustment Process.** Intervention strategies, supports, and services being provided to the child and family are generally responsive to changing conditions. Frequent monitoring (consistent case dynamics), tracking, and communication of child status and service results are occurring. Generally successful adaptations are based on a basic knowledge of what things are working and not working for the child and family.

**5**
  
- ◆ **Minimally Adequate to Fair Tracking and Adjustment Process.** Intervention strategies, supports, and services being provided to the child and family are minimally responsive to changing conditions. Periodic monitoring, tracking, and communication of child status and service results are occurring. Usually successful adaptations to supports and services are being made.

**4**
  
- ◆ **Marginally Inadequate Tracking and Adjustment Process.** Intervention strategies, supports, and services being provided to the child and family are partially responsive to changing conditions. Occasional monitoring and communication of child status and service results are occurring. Limited or inconsistent 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 are present.

**3**
  
- ◆ **Fragmented or Shallow Tracking and Adjustment Process.** Poor intervention strategies, supports, and services may be provided to the child and family and may not be responsive to changing conditions. Rare or shallow monitoring, poor communications, and/or an inadequate service team may be 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 poor in several areas. Serious ongoing problems continue unresolved.

**2**
  
- ◆ **Absent, Nonoperative, or Misdirected Tracking and Adjustment Process.** Intervention strategies, supports, and services may be limited, undependable, or conflicting for the child and family. No monitoring or communications may occur and/or an inadequate team (inadequate structure or functioning) may be 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 may be “*out of control*.” Child and family status may be generally poor or worsening. Serious and worsening problems persist without adequate attention or effective resolution.

**1**





**SECTION 4B**

**PRACTICE REVIEW**

<b>Specialized Practices (Past 90 Days, may not always apply)</b>	<b>Page</b>
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2. Transitions & Life Adjustments	62
3. Medication Management	64
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## SPECIAL PRACTICE REVIEW 1: CULTURAL COMPETENCE

### Focus Measure

**CULTURAL COMPETENCE - For the focus child and family, the degree to which:**

- Any significant issues of language and culture are being identified and addressed effectively by service providers.
- Services are provided in a culturally appropriate manner consistent with the family’s cultural and linguistic background.

### Core Concepts

As appropriate to the child and family served, services should be provided in a culturally competent manner. As used here, “culture” is an integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, and values that are unique to race, ethnicity, sexual orientation, religious background, or social group. Cultural competence includes:

- The capacity for people to increase their knowledge and understanding of cultural differences.
- The ability to acknowledge personal cultural assumptions and biases.
- The willingness to make changes in thought and behavior to address those biases.

To increase access and use of services by traditionally underserved populations, providers working directly with consumers should possess the skills and training to provide culturally competent services. Culturally and linguistically competent providers have knowledge of the communities they serve; value cultural diversity; consider how cultural factors might impact consumer functioning, symptom development, and behavioral health; and maintain flexibility to adapt services as necessary in order to better meet the needs of culturally diverse populations. Culturally competent service providers regularly assess their service provision through a process of formal and informal self, peer, and consumer evaluation. Culturally competent organizations have access to culturally appropriate treatment strategies (including traditional healing) and bilingual staff or interpreter services, and work to actively recruit and retain culturally competent behavioral health professionals who are willing and able to integrate cultural and linguistic competence into their standard operating procedures and are representative of the diversity of their consumer population.

**NOTE: Cultural competence is a cross-cutting attribute of practice that is applied, where appropriate, to all core practice functions (e.g., engagement, assessment, and planning).**

### Probes: Determine from Informants, Observations, Plans, and Records

1. Are the child and family’s cultural and linguistic needs identified?
2. Are assessments performed appropriate for the child’s background?
3. Do the service providers know and respect the child’s beliefs and customs?
4. Do the service provider and individual share the same cultural and/or linguistic background or does the service provider have adequate knowledge of cultural issues relevant to service delivery for this child and his/her informal supporters?
5. If the child and family has a primary language that is other than English, are bilingual or interpreter services provided?
6. Has the service team explored natural, cultural, or community supports appropriate for this child and family?
7. Has the family expressed any cultural preferences and desires for culturally adapted services?
  - Specific cultural issues identified and addressed are:
 

<ul style="list-style-type: none"> <li>• None identified after careful assessments</li> <li>• Ethnic</li> <li>• Gender</li> <li>• Sexual orientation</li> </ul>	<ul style="list-style-type: none"> <li>• Racial</li> <li>• Religious</li> <li>• Disability</li> <li>• Other</li> </ul>
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8. Are cultural differences impeding working relationships or service results with this child and his/her informal supporters?
  - What do they say?
9. If necessary, is the agency or facility able to decide when the rights and preferences of an individual will be limited by the rights and preferences of other individuals in the setting?





## SPECIAL PRACTICE REVIEW 1: CULTURAL COMPETENCE

### Description and Rating of Practice Performance

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

Rating Level

- ◆ **Optimal Cultural Competency.** The child's and family's cultural and linguistic identity are recognized, fully understood, and services are culturally adapted as necessary. Cultural beliefs and customs are fully respected and well integrated into all aspects of service provision. All assessments are culturally appropriate and the service provider's potential cultural biases are identified and acknowledged. Service providers are fully knowledgeable about issues related to the individual's identified culture and shape treatment planning and delivery appropriately. Service providers show evidence of considering all those who may be important to the individual's culture (e.g., family members, traditional healers) and attempts are made to include these individuals in service planning and delivery, at the request and invitation of the individual. As needed, interpreter services are provided in a culturally and linguistically appropriate manner. 6
  
- ◆ **Good Cultural Competency.** The child's and family's cultural and linguistic identity is recognized and services are generally culturally adapted as necessary. Cultural beliefs and customs are generally respected and taken into consideration for planning services. Assessments are generally conducted in a culturally appropriate manner and the service provider's potential cultural biases are identified and acknowledged. Service providers document attempts to advance their understanding of the individual's identified culture and there is evidence that the service provider has utilized resources relevant to the individual's cultural and linguistic identity in order to assist with treatment planning and service delivery. Those important to the individual's culture are acknowledged and information is obtained from them with the agreement of the individual. If needed, interpreter services are accessed. 5
  
- ◆ **Fair Competency.** The child's and family's cultural and linguistic identity is recognized and the provider acknowledges this in the assessment, treatment planning, and service delivery process. Cultural beliefs and customs are usually acknowledged and services are planned in an effort to be supportive. For example, the provider might acknowledge other natural community helpers important to the individual's culture and works with the individual to integrate those supports. If needed, interpreter services are usually available. 4
  
- ◆ **Marginal Cultural Competency.** The child's and family's cultural and linguistic identity is recognized and the provider acknowledges that while assessment, treatment planning, or services are not a good fit, they are seeking to improve these processes for just this individual. There may be evidence that the behavioral health provider/agency has attempted to integrate culturally adapted practices into their services, although it is limited or inconsistent for this individual. Cultural beliefs and customs are not viewed as relevant by the service provider to the assessment, treatment planning, or service delivery process. If needed, interpreter services are only sporadically available. 3
  
- ◆ **Poor Cultural Competency.** The child's and family's cultural and linguistic identity is not recognized in the service process by the service provider. Inappropriate assessment, treatment planning, or service delivery processes ignore the individual's cultural beliefs and customs. If needed, interpreter services may be limited or difficult to secure through the behavioral health system. Few, if any, provisions are made for understanding and incorporating the person's cultural beliefs and values. 2
  
- ◆ **Adverse Cultural Competency.** There is no evidence of cultural or linguistic recognition or the integration of culturally appropriate practices by behavioral health service providers in this case. The individual's cultural and linguistic identity may be treated with disrespect and his/her customs and beliefs may be ignored or treated as irrelevant. Inappropriate assessment, treatment planning, or service delivery processes ignore or violate the individual's cultural beliefs and customs. If needed, interpreter services are not provided by the behavioral health system. 1
  
- ◆ **Not Applicable.** The child does not identify any cultural or linguistic needs relevant for service system performance when asked by a service provider. NA



## SPECIAL PRACTICE REVIEW 2: TRANSITIONS & LIFE ADJUSTMENTS

### Focus Measure

**TRANSITIONS & LIFE ADJUSTMENTS - Degree to which:**

- The currently unfolding or next life change and transition for the child is being planned, staged, and implemented to assure a timely, smooth, and successful adjustment for the person after the change occurs.
- Transitional staging plans/arrangements are being made/implemented to assure a successful transition and life adjustment in daily settings.
- [If the child is returning to home and school following temporary placement in foster care, residential treatment, or detention] the transition staging and life adjustment efforts are working effectively for the child and family.
- There is follow-along support for the adjustment phase following the honeymoon stage to the point where adjustment is successful.

### Core Concepts

A person moves through many life transitions over the course of a lifetime. Emancipated youth enter adult life. Some adults having a serious mental illness move in and out of treatment settings. Other adults parenting minor children may lose them temporarily to the foster care system. Reunification of the children becomes a major transition and life adjustment for the parent and children. In later life, adults lose parents and life partners, requiring major life changes and adjustments. In old age, a time comes when former lifestyles and living arrangements may move to special care settings. Requirements for future success have to be determined and provided in advance of a change to achieve later success in transition and life adjustments. These requirements should be used in setting transition goals and in planning supportive services during the adjustment phase following transition.

Staging and coordination across service settings and providers is essential, especially when a person is served temporarily in a setting away from his/her home and job. Transition plans, problem-solving assistance, and supports may have to be provided. Special arrangements or accommodations may be required for success in a return setting or a new setting. Follow-along monitoring may be required for an adjustment period. Special coordination efforts may be necessary to prevent breakdowns in services and to prevent any adverse effects transition activities may have on the person. To be effective, transition plans and arrangements have to produce successful transitions as determined after the change in settings actually occurs.

### Probes: Determine from Informants, Observations, Plans, and Records

1. Is the child anticipating a major transition within the next few months? • Has the case manager or service coordinator identified the person's next critical transition? If so, what transition plans are being made to accomplish a smooth adjustment? • How are the transitional activities and events being carefully staged and arranged across settings, time, providers, and funding sources?
2. Do permanency plans for this child indicate that the child protection agency is using or is considering using trial home visits to facilitate transition from out-of-home care for family reunification? • If so, how are the child's mental health and/or addiction treatment staff coordinating efforts to ensure a safe, smooth, and successful reunification?
3. If this child has a history of difficult transitions following discharge from hospitalization or incarceration, how is this knowledge being used to improve transitions for this child?
4. If a transition is imminent, is a well-staged transition plan or articulation process currently being implemented for this child?
5. Is this child 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?
6. For what period of time, such as 60-90 days, is the child closely monitored following a transition in home or school to track the person and those supporting the person through the life change and adjustment process, including the predictable "honeymoon" and near-term "crises" of adjustment that often attend the movement and life adjustment process for a child or youth?

## SPECIAL PRACTICE REVIEW 2: TRANSITIONS & LIFE ADJUSTMENTS

### Description and Rating of Practice Performance

Description of the System Performance Situation Observed for the Child

Rating Level

- ◆ **Optimal Transitions.** The child's current/next transition has been implemented/planned consistent with the child's recovery goals. What the child 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 work) is imminent, all necessary arrangements (for supports and services) with persons in the receiving settings are being made to assure that the child is successful following the move. If the child has made a transition (or return) within the past six months, the child is fully stable and successful in his/her daily settings.

6
- ◆ **Good Transitions.** The child's next transition has been identified and discussed. What the child 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 work) is imminent, essential arrangements (for supports and services) with persons in the receiving settings are being made to assist the child during and after the move. If the child has made a transition (or return) within the past three months, the child is generally stable and successful in his/her daily settings.

5
- ◆ **Minimally Adequate to Fair Transitions.** The child's next transition has been identified. What the child 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 work) is imminent, basic arrangements (for supports and services) with persons in the receiving settings are minimally in place to assist the child during and after the move. If the child has made a transition (or return) within the past 30 days, the child is stable in his/her daily settings and is not at risk of disruption due to transition problems.

4
- ◆ **Marginally Inadequate Transitions.** The child's next transition has been identified. What the child should know, be able to do, and have as supports to be successful have not been assessed and no plans have been made. If a transition to another setting (or return to home and work) is imminent, few or partial arrangements (for supports and services) with persons in the receiving settings are in place to assist the child during and after the move. If the child has made a transition (or return) within the past 30 days, the child is experiencing mild transition problems in his/her daily settings and is at low risk of disruption.

3
- ◆ **Poor Transitions.** The child's next transition has not been addressed. If a transition to another setting (or return to home and work) is imminent, inadequate arrangements (for supports and services) with persons in the receiving settings are in place to assist the child during and after the move. If the child has made a transition (or return) within the past 30 days, the child is experiencing substantial transition problems in his/her daily settings and is at moderate to high risk of disruption.

2
- ◆ **Adverse Transitions.** The child's next transition has not been considered. If a transition to another setting (or return to home and work) is imminent, arrangements (for supports and services) with persons in the receiving settings are not in place to assist the child during and after the move. If the child has made a transition (or return) within the past 30 days, the child is experiencing major transition problems in his/her daily settings and is at high risk of disruption.

1
- ◆ **Not Applicable.** Identification efforts reveal no evidence of needs to be addressed for transition services for this child at this time. This review indicator is deemed **not applicable** to this child at this point in time.

NA

## SPECIAL PRACTICE REVIEW 3: MEDICATION MANAGEMENT

### Focus Measure

**MEDICATION MANAGEMENT - Degree to which:** • Any use of psychiatric/addiction control medications for this child/youth is necessary, safe, and effective. • The child/youth and parents have a voice in medication decisions and management. • The child/youth is routinely screened for medication side effects and treated when side effects are detected. • New atypical/current generation drugs have been tried, used, and/or appropriately ruled out. • The use of medication is being coordinated with other treatment modalities and with any treatment for any co-occurring conditions (e.g., seizures, diabetes, asthma, obesity).

### Core Concepts

Use of psychiatric/addiction control medications is one of many treatment modalities that may be used in treating a child having a serious emotional disorder or addiction. When use of such medications is deemed necessary and appropriate, it should conform to standards of good and accepted practice, including informed consent, consultation, most efficacious drug selection, consistency with medication protocols, demonstrated treatment response, and minimal effective dose. Effects and side effects of medication use should be assessed, tracked, and used to inform decision making. Any adverse side effects should be addressed and treated.

Use of medications should be coordinated with other modalities of treatment, including positive behavioral supports, behavioral interventions, counseling, skill development, and social supports. Continuity in medication regimes should be present across treatment settings. The child should have access to necessary specialized health care services, including treatment and care for any co-occurring conditions (e.g., seizures, asthma, diabetes, addiction, HIV). The purpose is to determine whether the child receives and benefits from safe medication practices. **This review does not apply to a child/youth who has not taken psychotropic medications within the past 90 days.**

### Probes: Determine from Informants, Observations, Plans, and Records

1. Does the child take a psychotropic/addiction control medication?
2. Is there a DSM-IV-R Axis I diagnosis to support each psychotropic medication?
3. Is use consistent with current treatment protocols?
4. Does the child know what each psychotropic/addiction control medication is as well as its intended benefits and possible risks?
5. If multiple psychotropic medications are used with the child, is there written justification by the physician? • Is the primary care physician informed of these medications?
6. Is the purpose for each medication documented and tracked to target symptoms or maladaptive behaviors? • Is each medication consistent with intended use?
7. Has a minimum effective dosage of each medication been determined or are steps being taken to do so? • Who is responsible for medication monitoring and screening for side effects?
8. Is there periodic evaluation of the child's response to treatment using data to track target symptoms or behaviors?
9. Is there quarterly screening of the child for adverse effects of medications? • If adverse effects have been found, have appropriate countermeasures been implemented?
10. Is medication use coordinated with other treatment modalities?
11. Does the child have access to specialized health care services? • Have coordinating staff consulted with other treating professionals (e.g., neurologists, psychiatrists) for a child having chronic and/or complex health care needs?
12. Is relapse prevention information available to the child? • Is educational information about medications, effects/side effects, and self-medication available?

## SPECIAL PRACTICE REVIEW 3: MEDICATION MANAGEMENT

### Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Child

Rating Level

- ◆ **Optimal Medication Management.** The child presents symptoms or behaviors that are responding well to current generation medications with no report of bothersome side effects. The child reports good compliance with the prescribed medications and is not requesting any changes at this time. Use of medications is well coordinated with other treatment modalities. The child and physician have an understanding about how he/she is to manage increases/decreases in medications. The child has full and timely access to high quality health care for any serious health co-occurring conditions.

6
- ◆ **Good Medication Management.** The child presents symptoms or behaviors that are responding fairly well to current generation medications but reports some mild side effects. The child reports that sometimes medications are not taken as prescribed. Use of medications is sometimes coordinated with other treatment modalities. The child and physician have an understanding about how he/she is to manage increases/decreases in medications. The child has full and timely access to high quality health care for any serious health co-occurring conditions.

5
- ◆ **Fair Medication Management.** The child is becoming stable on appropriate medication and presents some symptoms or behaviors of concern and complains of side effects. Use of medication is checked conversationally and staff hint at non-compliance. The child may refuse participation in medication education activities. Medication is minimally coordinated with other treatment modalities. The child has minimally adequate access to fair quality health care for any serious health co-occurring conditions, including specialists with a short waiting period.

4
- ◆ **Marginally Inadequate Medication Management.** The child presents symptoms or behaviors that may be responding somewhat to medications. Medication use may be inconsistent. Consents may not have been obtained. Screening for side effects may not be current or mild side effects may be noted but minimally treated. Use of medication is seldom coordinated with other treatment modalities. The child has somewhat limited access to fair-to-poor quality health care for any serious health co-occurring conditions and may receive most care from emergency rooms.

3
- ◆ **Poor Medication Management.** The child presents symptoms or behaviors that may not be responding to medications. Medication use may not be well documented or justified. Consents may be missing. Screening for side effects may not be current or moderate side effects may be noted. Use of medication is not coordinated with other treatment modalities. The child has inconsistent or very slow access to health care for any serious health co-occurring conditions. The child's physical or psychiatric status may be at risk due to inadequate health care for treating co-occurring conditions.

2
- ◆ **Absent or Adverse Medication Management.** The child presents increasing symptoms or behaviors that may not be responding to medications. Medication use may be undocumented, not justified, or experimental. Consents may be missing. Screening for side effects may not occur or serious side effects may be present and untreated. Use of medication is conflicting with other treatment modalities. The child has poor or no access to needed health care for any serious health co-occurring conditions. The child's physical or psychiatric status may be declining due to inadequate health care.

1
- ◆ **Not applicable:** The child does not now take psychotropic medications, nor has the child used such medications within the past 90 days. Therefore, this review does not apply.

NA

## SPECIAL PRACTICE REVIEW 4: CRISIS MANAGEMENT

### Focus Measure

**CRISIS MANAGEMENT - Degree to which there is timely provision of effective services to safely prevent or, if necessary, to safely manage any recurring behavioral, health, or safety crises for the focus child and family.**

### Core Concepts

Some children receiving child welfare and mental health services have recent histories of episodes in which a behavioral, health, or safety crisis has occurred and for whom crisis prevention and management services are required to protect the child's life or well-being. A **behavioral crisis** is one in which the child presents behaviors that put himself or others at risk of harm. For example, a child who suffers recurrent major depressive episodes, including a history of recent suicide attempts, would require crisis prevention and management services. A **health crisis** is one in which a chronic health condition suddenly becomes acute, putting the child's life at risk unless immediate medical care is provided. For example, a brittle insulin-dependent diabetic who lapses in medication management would require crisis prevention, monitoring, and management to avert coma or death. A **safety crisis** is a situation in which another person through intention and action or inaction puts the focus child at risk of injury or death. A battered woman in a violent domestic relationship who may be unable to keep a perpetrator from her home requires crisis prevention planning and use of protective capacities and strategies to keep a child safe.

The recurrent and risky nature of such situations requires advance planning of surveillance or monitoring of the child, preparation of the child and other reliable persons in that child's life to recognize and respond to early signs of a new episode, and taking preplanned actions to keep the child or others safe as the episode unfolds. Early steps in a crisis prevention/management plan could include calling early responders (e.g., police or EMS) and then taking near-term actions while awaiting the arrival of help. Steps in a child's crisis management plan may include following advance directives set by the parent.

Providing a crisis management capacity requires a planned crisis response capability, designed specifically for the child, that can be activated and implemented immediately at the onset of a new episode. A crisis response capability has to be prepared in advance, be made a part of the service plan or other appropriate crisis response plan, and have prepared persons in the child's daily settings to be ready to implement the crisis response plan and a follow-along mechanism that tracks the child and family through the crisis period. The urgency and significance of an emerging need or problem of the child should be met with a timely and commensurate service response (i.e., EMS in ten minutes, emergency within one hour, urgent within 24 hours). The primary concern here is whether the child, caregivers, and service workers have timely access to crisis management services necessary to detect the onset of an episode, respond on a timely basis, and effectively protect those involved from foreseeable and preventable harm.

*Note: Suicidality and self-endangerment for children with depression and bipolar disorders requires higher surveillance:*

- For the first six weeks of medication trials of SSRIs and other antidepressants
- For the first 30 days of new treatment
- During the discharge phase of treatment
- When there is a significant change in clinical status or sudden emotional loss

### Probes: Determine from Informants, Observations, Plans, and Records

1. Does the child have a recent history (past 12 months) of behavioral, health, or safety crises? • If not, this indicator may not apply. If so:
  - Did the episode involve harm caused to the focus child by another? If so, Status Indicator 1. Safety should be rated also.
  - Did the episode involve self-endangerment or harm to others? If so, Status Indicator 2. Behavioral Risk should be rated also.
2. Does this child have a crisis prevention/intervention plan? • If so, how was it designed? • What is the monitoring or surveillance plan? • Is there an alert procedure and crisis response plan for this child specified in the treatment plan or other relevant service documents? • Who is to respond to what cues using what strategies? • Does the plan include any advance directives set by the child? • Are the people who would send the alert and implement the crisis response plan aware of and ready to fulfill their assigned responsibilities?
3. Are crisis management services available when and as needed? • Have crisis services ever been denied? • If so, why?
4. Have the alert and crisis management processes been used in the past six months for this child or caregiver? • If yes, did they work effectively? • Were such services timely given the urgency of the situation? • Was any relevant advance care directive followed?
5. Does the crisis management plan address transitions? • Is it linked to any transition plan the child may have?

## SPECIAL PRACTICE REVIEW 4: CRISIS MANAGEMENT

### Description and Rating of Practice Performance

*Note: This indicator is rated NA when no need or use of a crisis response has been indicated over the past 12 months.*

Description of the Special Practice Situation Observed for the Child

Rating Level

- ◆ **Optimal Crisis Management.** All appropriate people in the focus child’s daily living, learning, work, and therapeutic settings are fully prepared to recognize early indicators of the onset of a crisis episode and to implement the alert, crisis intervention, and follow-along provisions of a well-tested and effective crisis plan for the child. Detection, alert steps, crisis intervention, and follow-along processes, if used in the past six months, performed in an excellent, reliable, and effective manner.

6
- ◆ **Good Crisis Management.** Key people in the focus child’s daily living, learning, work, and therapeutic settings are generally prepared and ready to recognize early indicators of the onset of a crisis episode and to implement the alert, crisis intervention, and follow-along provisions of the child’s plan. Plan provisions have been successfully tested via simulation or, if used in the past six months, worked reliably and acceptably well.

5
- ◆ **Fair Crisis Management.** Some people in the focus child’s daily living, learning, work, and therapeutic settings are minimally prepared to recognize early indicators of the onset of a crisis episode and to implement the alert, crisis intervention, and follow-along provisions of the child’s plan. Plan provisions are periodically reviewed with people responsible for implementation. If used recently, the crisis response was at least minimally successful in managing risks and keeping people safe.

4
- ◆ **Marginally Inadequate Crisis Management.** Some people in the focus child’s daily living, learning, work, and therapeutic settings are somewhat unprepared to recognize early indicators of the onset of a crisis episode and to implement the alert, crisis intervention, and follow-along provisions of the child’s plan. - **OR** - Plan provisions are not tested or periodically reviewed with persons responsible for implementation. - **OR** - If used recently, crisis response revealed some minor to moderate problems in managing risks at an acceptable level or in securing necessary crisis services in an acceptable manner.

3
- ◆ **Poor Crisis Management.** Key people in the child’s daily living, learning, work, and therapeutic settings are not adequately prepared to recognize early indicators of the onset of a crisis episode and to implement the alert, crisis intervention, and follow-along provisions of the child’s plan. - **OR** - Crisis plan provisions are unrealistic, incomplete, unrehearsed, or untested. - **OR** - If used recently, crisis response revealed substantial problems in managing risks at an acceptable level or in securing crisis services in an acceptable manner.

2
- ◆ **Absent and/or Adverse Crisis Management.** Key people in the child’s daily living, learning, work, and therapeutic settings are unprepared or unwilling to recognize early indicators of the onset of a crisis episode and to implement the alert, crisis intervention, and follow-along provisions of the child’s plan. - **OR** - A crisis plan and response is necessary for this child but currently does not exist (except to call 911). - **OR** - If used recently, the crisis response plan failed to manage risks adequately or to provide crisis supports or services in an acceptable manner.

1
- ◆ **Not Applicable.** The focus child has no history of psychiatric or medical crises or safety breakdowns within the child’s daily settings over the past 12 months. Therefore, this indicator does not apply at this time.

NA



## SECTION 5

**OVERALL PATTERNS**

<b>Results Patterns and Prognosis</b>		<b>Page</b>
1.	Overall Child/Youth Status Pattern	70
2.	Overall Caregiver Status Pattern	70
3.	Overall Practice Performance Pattern	71
4.	Six-Month Prognosis	72

**OVERALL CHILD AND FAMILY DOMAIN**

**OVERALL CHILD/YOUTH STATUS & CAREGIVER STATUS SCORING PROCEDURE**

There are seven child/youth indicators and three parent/caregiver indicators to be rated in the areas of Child/Youth Status and Parent/Caregiver Status. Each review produces a finding reported on a 6-point rating scale. An “overall rating” for each section is based on THE REVIEWER’S HOLISTIC IMPRESSION OF THE APPLICABLE INDICATORS. This overall ratings answer these questions:

- 1. Overall, how is the child/youth doing now?
- 2. Overall, how is the parent/caregiver doing now (in these areas)?

The reviewer considers the unique issues and present context for THIS CHILD/YOUTH and for THIS PARENT/CAREGIVER to arrive at the two overall status ratings. (1) Begin by marking the rating value for each status review item on the “roll-up sheet” being prepared for submission. (2) In formulating the overall rating, disregard any indicators deemed not applicable in forming the holistic impression. (3) Give weight to those applicable indicators judged to be most important at this time for this child/youth and parent/caregiver. (4) By focusing on the applicable indicators and judging which ones have the greatest importance to the child/youth and parent/caregiver at this time, determine an “overall rating” based on your general impression of the child’s status and the parent’s status and/or substitute caregiver’s status. (5) Mark the boxes indicating your overall ratings below. Report these rating values on the roll-up sheet prepared for this child/youth and parent/caregiver. The reviewer should remember that an overall rating cannot be higher than the highest rated indicator nor lower than the lowest rated indicator. It should be reflective of the trend or pattern observed among indicators with added weight to those of greater importance to the child and parent/caregiver at the time of review. The added weight given in this overall formulation must be explained by the reviewer in the oral and written reports provided for this child/youth.

CHILD STATUS INDICATORS [30-DAY PATTERN]							
STATUS INDICATORS	IMPROVE		REFINE		MAINT		NA
	1	2	3	4	5	6	
<b>CHILD/YOUTH</b>							
<b>1a. Safety: Exposure to Harm</b>							
a. Home - birth family	<input type="checkbox"/>						
b. Home - substitute care	<input type="checkbox"/>						
c. School / childcare	<input type="checkbox"/>						
d. Other setting	<input type="checkbox"/>						
<b>1b. Risk to self/others:</b>							
a. Risk to self	<input type="checkbox"/>						
b. Risk to others	<input type="checkbox"/>						
<b>2. Stability pattern</b>	<input type="checkbox"/>						
<b>3. Perm. prospects</b>							
a. Reunification	<input type="checkbox"/>						
b. Guardianship/Adoption	<input type="checkbox"/>						
<b>4. Living arrangement</b>							
a. Birth family home	<input type="checkbox"/>						
b. Substitute care home	<input type="checkbox"/>						
<b>5. Health/phy. well-being</b>	<input type="checkbox"/>						
<b>6. Emot. well-being</b>	<input type="checkbox"/>						
<b>7. Learning &amp; develop.</b>	<input type="checkbox"/>						
<b>OVERALL CHILD STATUS</b>	<input type="checkbox"/>						

CAREGIVER STATUS INDICATORS [30-DAY PATTERN]							
STATUS INDICATORS	IMPROVE		REFINE		MAINT		
	1	2	3	4	5	6	
<b>CAREGIVER</b>							
<b>1.a Protect. capacities</b>							
a. Family parent	<input type="checkbox"/>						
b. Subst. caregiver	<input type="checkbox"/>						
<b>1.b Congreg. care:</b>	<input type="checkbox"/>						
<b>2. Family resources:</b>							
a. Family parent	<input type="checkbox"/>						
b. Sub. caregiver	<input type="checkbox"/>						
<b>3. Role &amp; voice:</b>							
a. Focus child	<input type="checkbox"/>						
a. Family parent	<input type="checkbox"/>						
b. Sub. caregiver	<input type="checkbox"/>						
<b>OVERALL CAREGIVER STATUS</b>							
a. Family parent	<input type="checkbox"/>						
b. Sub. caregiver	<input type="checkbox"/>						

OVERALL SYSTEM PERFORMANCE DOMAIN

OVERALL PRACTICE PERFORMANCE SCORING PROCEDURE

There are eight **core practice function indicators** (1–8) and four possible **specialized practices** (1–4) in the area of Practice Performance. Each review produces a finding reported on a 6-point rating scale. An “overall rating” of practice performance is based on THE REVIEWER’S HOLISTIC IMPRESSION OF THE APPROPRIATE EXECUTION OF PRACTICE FUNCTIONS AND THE DILIGENCE IT SHOWS IN RESPONSE TO THIS CHILD AND FAMILY. This overall rating answer this question:

1. *Taking all applicable indicators into account and giving weight core practice functions, overall how is practice working now?*

Consider the fidelity with which each practice function is carried out and whether the intent of the function is being achieved. Overall, is the system taking the necessary actions to appropriately address the individual factors for this child and family that must be addressed if this child and family are to make progress toward positive outcomes? (1) Begin by transferring the rating value for each progress review item from the protocol exam pages to the portion of the roll-up sheet containing the display presented below. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) **Give weight to those practice performance indicators judged to be most important at this time for this child and family.** (4) Focusing on those applicable indicators having the greatest importance to the child and family at this time, determine an “overall rating” based on your general impression of the practice performance. (5) Mark the box indicating your overall rating on the roll-up sheet. The reviewer should remember that an overall rating cannot be higher than the highest rated indicator nor lower than the lowest rated indicator. It should be reflective of the trend or pattern observed among indicators with added weight to those of greater importance to the child and parent/caregiver at the time of review. The added weight given in this overall formulation must be explained by the reviewer in the oral and written reports provided for this child/youth.

SYSTEM/PRACTICE PERFORMANCE [90-DAY PATTERN]						
INDICATOR ZONES	IMPROVE		REFINE		MAINTAIN	NA
	1	2	3	4	5	6
<b>CORE PRACTICE FUNCTIONS</b>						
1. <b>Engagement</b>	<input type="checkbox"/>					
2. <b>Teamwork:</b>						
a. Formation	<input type="checkbox"/>					
b. Functioning	<input type="checkbox"/>					
3. <b>Assessment &amp; understanding:</b>						
a. Focus child	<input type="checkbox"/>					
b. Birth parent/family	<input type="checkbox"/>					
c. Substitute caregiver	<input type="checkbox"/>					
4. <b>LTV/ outcomes &amp; life goals</b>						
a. Focus child	<input type="checkbox"/>					
b. Birth parent/family	<input type="checkbox"/>					
c. Substitute caregiver	<input type="checkbox"/>					
5. <b>Planning</b>						
a. Safety	<input type="checkbox"/>					
b. Permanency	<input type="checkbox"/>					
6. <b>Necessary Resources</b>	<input type="checkbox"/>					
7. <b>Adequacy of intervention</b>	<input type="checkbox"/>					
8. <b>Tracking &amp; adjustment</b>	<input type="checkbox"/>					

SYSTEM/PRACTICE PERFORMANCE [90-DAY PATTERN]						
INDICATOR ZONES	IMPROVE		REFINE		MAINTAIN	NA
	1	2	3	4	5	6
<b>SPECIALIZED PRACTICES</b>						
1. <b>Cultural competence</b>	<input type="checkbox"/>					
2. <b>Transitions/life adjustments</b>	<input type="checkbox"/>					
3. <b>Medication management</b>	<input type="checkbox"/>					
4. <b>Crisis management</b>	<input type="checkbox"/>					
<b>OVERALL PRACTICE</b>	<input type="checkbox"/>					

**SIX-MONTH PROGNOSIS**

**ESTIMATING THE TRAJECTORY OF THIS CHILD’S EXPECTED COURSE**

Determination of current child status and service system performance is based on the observed current patterns as they emerge from the recent past. This method provides a **factual basis** for determination of current child status and service system performance. Forming a six-month forecast is based on **predictable future events** and **informed predictions** about the expected course of change over the next six months, grounded on known current status and system performance as well as knowledge of tendency patterns found in case history.

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 in April [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 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. Assume that system practice continues to do “business as usual.”

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. Mark the appropriate alternative future statement in the space provided below. The facts that lead the reviewer to this view of case trajectory should be reflected in the reviewer’s recommendations. Insert your determination in the appropriate space on the roll-up sheet.

**SIX-MONTH PROGNOSIS**

Based on the child’s current status on key indicators, recent progress, the current level of service system performance, and events expected to occur over the next six months, is this child’s status expected to maintain at a high level, improve to a higher level, remain about the same, or decline over the next six months? (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**



## SECTION 6

# REPORTING OUTLINES

<b>Type of Report</b>	<b>Page</b>
Oral Case Presentation Outline	74
Written Case Summary Outline	75



**REVIEWER’S OUTLINE FOR A 10-MINUTE ORAL CASE PRESENTATION**

**Outline Elements**

**Reviewer’s Notes**

**1. Core Story of the Child and Family (3 minutes)**

- Reason for services (Why are we involved with this child/youth 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 Caregiver Status (3 minutes)**

- Overall child/youth and caregiver status finding
- Status rating patterns by “color/action zones”
- Progress made over the past six months
- Problems

**3. System Practice and Performance (3 minutes)**

- Overall system performance finding
- Performance rating patterns by “color/action zones”
- 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

**Total Presentation Time (10 minutes)**

**Group Questioning of Presenter (3-5 minutes)**



## WRITTEN CASE REVIEW SUMMARY

### Child/Caregiver Status Summary

#### Facts about the Child and Family Reviewed

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

#### Persons Interviewed during this Review

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

#### Facts About the Child and Family [About 100 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.

#### Caregiver's Status [About 100 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 75 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

The summary should not exceed two-to-four typed pages, depending on the complexity of the case and the extent of supports and services being provided by various agencies.



