WRAP QSR REVIEW FINDINGS

In July 2012 the Quality Improvement Section of the Los Angeles County Department of Children and Family Services (DCFS), with the collaboration of the Los Angeles County Department of Mental Health (DMH) and Katie A. Panel, conducted a Quality Service Review (QSR) of 20 children in Wraparound Tier II. Wraparound is an integrated, multi-agency, community-based process of ensuring that children thrive in permanent homes with informal supports. Los Angeles County has provided Wraparound to families and their children with multiple needs since 1998.

QSR is an innovative case review process designed to stimulate change to improve practice performance by evaluating key outcomes for children and families. Unlike an audit that is compliance-based and focused on the individual, QSR centers on opportunities for practice development system wide. QSR specifically measures the quality of interactions between all parties of the child welfare system; DCFS, DMH, Wraparound, community service providers, the legal system, etc. with the family and their informal supports. The QSR process provides a "big picture" view of case practice that recognizes the unique role and involvement of not only the Wraparound team, but all other key players that are significant to the children and families reviewed.

LA County Wraparound[1]

In FY 2010-11, Wraparound in Los Angeles County provided support to 4,248 children and their families, a 40% increase from the previous year. Tier II Wraparound was launched in 2009. Tier II children have an open DCFS case, full scope Medi-Cal, and a mental health need or behaviors that place them or others at risk of harm. The monthly Wraparound case rate for Tier II children is $1,250 (compared to $4,184 for Tier I). In the past year, total Tier II enrollment increased from 966 to 2,031 (Tier I enrollment increased from 2,068 to 2,217). At the time of the Wrap QSR, there were about 1,300 open Tier II Wraparound cases in 34 different contract agencies throughout the County.[2] Of the Tier II cases, 51% were male and 49% were female. The average age of Tier II children was 13 (the average age of Tier I children was 15). Tier II children were 62% Hispanic, 27% African American and 8% Caucasian. At the time of their enrollment in Wraparound, 70% of Tier II children were either at home or with a relative and 30% were in a foster home, group home or juvenile detention. At the time of graduation, 84% were at home, placed with a relative or living independently. The average length of stay for Tier II children who graduated was 12 months; 77% of Tier II children had no out-of-home placements during the 12-month period after Wraparound graduation. The three largest diagnostic categories for children in Tier II Wraparound were Disruptive Disorder (30%), Mood Disorder (26%), and

[1] Data is from the February, 2012, Wraparound 2011 Annual Report.

[2] The providers and the number of Tier II children being served at the time of the review were: ALMA (27), Amanecer (15), Aviva (57), Bienvenidos (31), Children's Bureau (27), Child & Family Center (16), Child & Family Guidance Center (10), Children's Institute (78), Childnet (22), D'Veal (27), EMQ (29), Five Acres (37), Florence Crittenton (112), Foothill (31), Gateways (14), Hathaway-Sycamore (76), HELP Group (42), Hillsides (17), HVG-Bayfront (16), IMCE (36), LA Child Guidance (16), Masada (9), Olive Crest (15), Penny Lane (88), PIC (25), St. Anne's (18), SCHR (9), Starview (169), SFVCMHC (34), San Gabriel (30), SSG (56), Tarzana (16), Vista Del Mar (48), and Village Family Services (45).

Anxiety Disorder (11%); 21% had no mental health diagnosis at referral. Tier II graduates averaged a 55% decrease in the Child and Adolescent Functional Assessment Scale (CAFAS) scores (99 to 45). Of Tier II children, 404 graduated in 2011 and 317 were disenrolled; 60% of the disenrollments were because of early termination of court jurisdiction or move to another area and 40% were unsuccessful outcomes (usually the family chose not to continue).

Selection of the 20 Reviewed Cases

For the Wrap QSR, review cases were selected using a quasi random method from the population of open Wraparound Tier II cases within each of the 18 DCFS offices to ensure that each of the 18 DCFS offices and 20 different Wraparound providers were sampled. An agency servicing a catchment area was aligned with each office and then the cases were randomly selected to control for a representation of cases from each office and the requisite number of Wrap agencies. Backup cases were also randomly selected because of the likelihood that not all families would consent to or be available for the review. Last minute cancellations by families meant that Tier II Wraparound cases were included from 16 of the 18 DCFS offices with four offices having two randomly selected cases.[3] Nineteen of the 34 Wrap Agencies were represented in the sample.

The QSR Method

The review was conducted utilizing the QSR Protocol developed by Human Systems Outcomes, Inc., and refined specifically for Los Angeles County DCFS by a team of staff from DCFS, DMH and other stakeholders. QSRs using the protocol have been completed in all the DCFS offices (see baseline data at the end of this report). The protocol provides a specific set of indicators to examine the status of the child and parent/caregiver and to analyze the responsiveness and effectiveness of practice. Both status and practice indicators are scored using a six-point Likert scale. Score of 6 is considered an optimal (most favorable) score, and score of 1 is adverse (poor). Scores of 6 and 5 are considered “Optimal” and “Good” respectively and require maintenance; scores of 4 and 3 are considered “Fair” and “Marginal” and require refinement, and scores of 2 and 1 are considered “Poor” and “Adverse” and require improvement. Scores in the range of 6, 5, and 4 are considered “Acceptable”, and scores in the range of 3, 2, and 1 are considered “Unacceptable”. [4]

The indicators are scored by the reviewers using varying time parameters, focusing on events that have already occurred and/or on recent processes that have been and are continuing to occur at the time of review. The QSR Protocol provides ten qualitative indicators for measuring the current status of a focus child and the child’s parent and/or caregiver. Status is usually determined for the most recent 30-day period, unless stated otherwise in the indicator. Status indicators measure Safety; Stability; Permanency; Living Arrangement, Health/Physical Wellbeing; Emotional Wellbeing; Learning and Development; Family Functioning; Caregiver Functioning; and Family Connections.

Practice indicators measure the extent to which core practice functions are applied successfully by practitioners and others who serve as members of the child and family team, including the

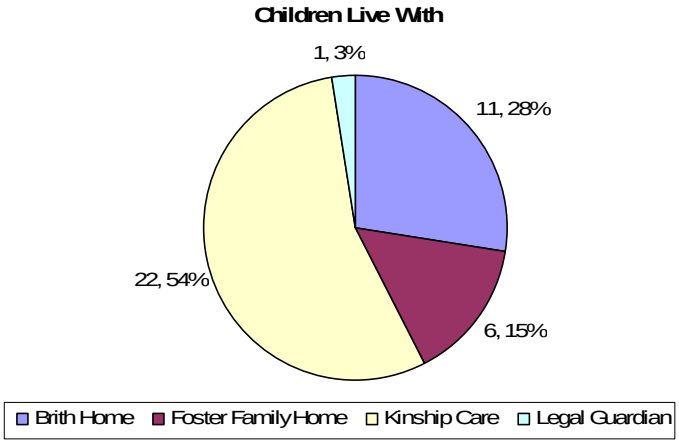
[3] Belvedere, Compton, El Monte, Glendora, Lancaster, Metro North, Pasadena, San Fernando Valley, Santa Clarita, Santa Fe Springs, South County, Torrance, Vermont, Wateridge, West LA, and West San Fernando Valley.
[4] For a detailed description of the indicator ratings, please see Appendix 2.

youth/family's informal supports. The timeframe for reviewing practice performance is the past 90 days. Practice indicators measure Engagement; Voice; Teamwork; Assessment-Child; Assessment-Family; Assessment-Caregiver; Long Term View; Planning; Supports and Services; Intervention Adequacy and Tracking and Adjustment. [5]

Each of the 20 cases was reviewed by a team of two reviewers who did a day and a half of interviews and scored the protocol together.[6] An average of 10 individuals were interviewed in each case review (a range of 7-13 interviews were done, usually including the DCFS CSW, child, caregiver, parent(s) if different from caregiver, Wrap Facilitator, Wrap Parent Partner, Wrap Child and Family Specialist, and some therapists; school was on vacation but some school staff were interviewed). In addition to giving feedback at the end of the review to the CSW and SCSW and presenting a case description attended by Wraparound providers, DCFS, DMH and the Panel, each team also prepared a 6-8 page detailed review summary, completed a Wraparound-specific questionnaire and submitted their scoring sheet.[7]

Overview of the 20 Review Cases

Of the 20 cases in the sample, 11 children were living in their birth home, 6 in a foster family home, 2 in a kinship care home, and 1 with a legal guardian while participating in Wraparound.

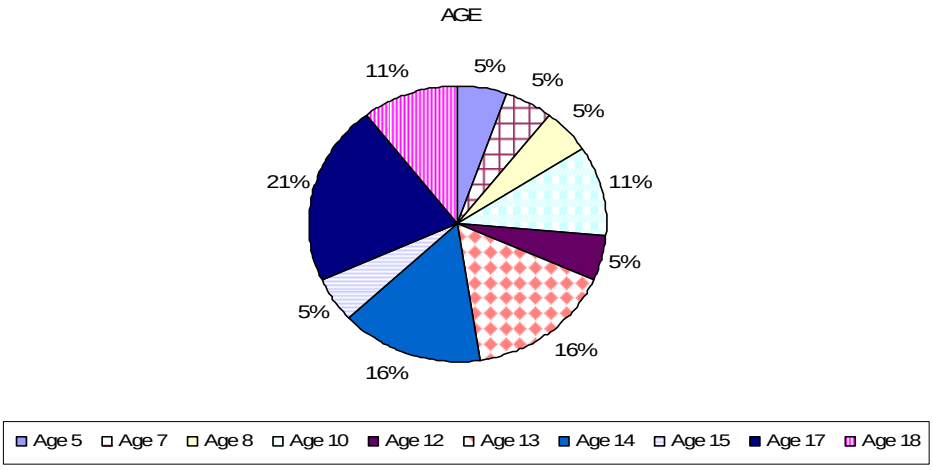


Of the 20 cases, 14 were male and 6 were female. The 20 cases ranged from 5-18 years old: 5 (1), 7 (1), 8 (1), 10 (2), 12 (1), 13 (3), 14 (3), 15 (1), 16 (1), 17 (4), and 18 (2).

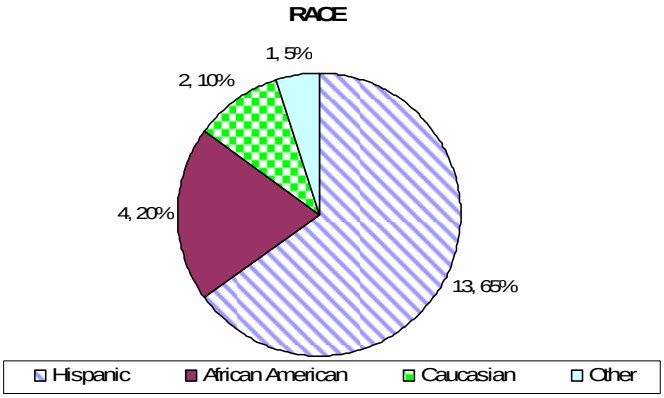
[5] For a detailed description of status and practice indicators see Appendix 1.

[6] The Wrap QSR was a remarkable collaborative process of designing and implementing the review: a total of 28 reviewers were involved in the 20 Wrap cases reviewed: DCFS QSR staff (11), DMH QSR staff (3), DCFS Wraparound staff (4), DMH Wraparound staff (1), other DMH (4), other DCFS (2), and Katie A. Panel (3); the Katie A. Panel members reviewed a total of 8 cases. There were 11 cases involving Spanish-language interviews and translators were used for 9 of those cases.

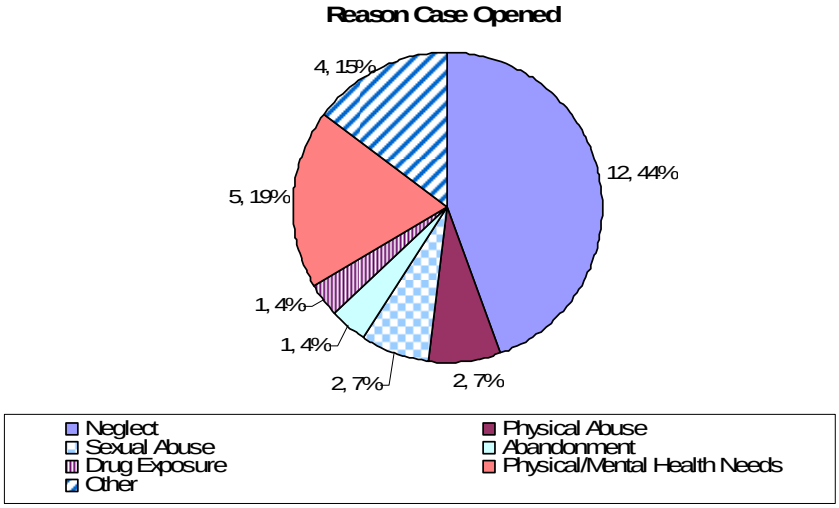
[7] Doing this first-ever multi-office, multi-provider countywide QSR was a monumental undertaking. The reviewers are grateful for the generosity of families, Wraparound providers, and DCFS and DMH interviewees—without their stories, practice and outcomes cannot be improved. We are also appreciative of the time and patience of the DCFS and DMH QSR staff and the DCFS and DMH Wraparound staff in arranging the complicated logistics of 193 interviews by 28 reviewers in 16 DCFS offices and 19 Wraparound providers.



Of the 20 cases, 13 were Hispanic, 4 were African American, 2 were Caucasian and 1 was other.



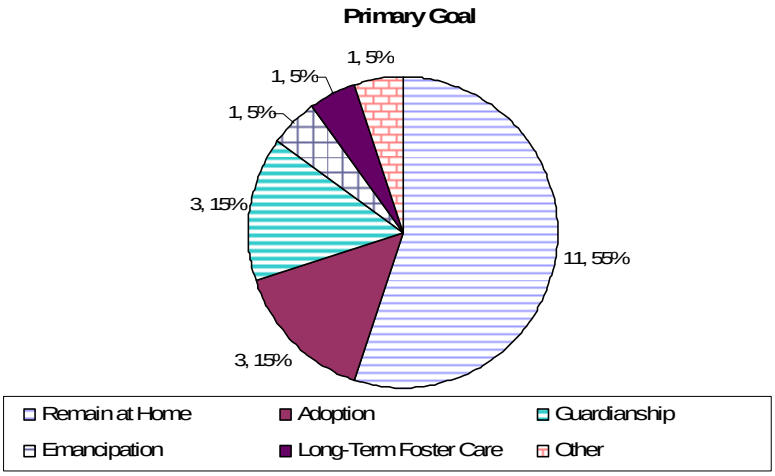
Of the 20 cases, 12 were open for neglect, 2 for physical abuse, 2 for sexual abuse, 1 for abandonment, 1 for drug exposure as a newborn, 5 for physical or mental health needs of the child, and 4 for other reasons.



Of the 20 cases, 3 had been open to DCFS less than a year, 7 for 13-18 months, 4 for 19-36 months, 4 for 37-60 months and 2 for more than 60 months. In the 20 cases, the average length

of time this CSW had been assigned to the case was 18 months, and the average number of caseworkers assigned to the case was 3. The average size of the caseload carried by the CSWs in the 20 reviewed cases was 30 cases.

The primary goal of the 20 cases was remain at home (11), adoption (3), guardianship (3), emancipation (1), long-term foster care (1), and other (1).



The 20 reviewed children had the following diagnoses (some had more than one): Depression-8 (including Major Depressive Disorder-2); ADHD-7; Anxiety-4; PTSD-2; Pervasive Developmental Disorder-1; Intermittent Explosive Disorder-1; Mood Disorder-1; Enuresis-2; Auditory Processing Disorder-1; and Phonological Disorder-1. Several youth had one or more psychiatric hospitalizations prior to Wraparound involvement.

Of the 20 reviewed children, 12 were not taking psychiatric medications. Eight were prescribed the following psychiatric medications (some were taking more than one): Celexa-1 (SSRI antidepressant); Concerta-1 (ADHD stimulant); Desmopressin-1 (bedwetting); Guanfacine-1 (ADHD nonstimulant); Lexipro-1 (SSRI antidepressant, antianxiety); Prozac-2 (SSRI antidepressant); Risperdal-1 (antipsychotic); Ritalin-1 (ADHD stimulant); Seroquel-1 (antipsychotic); Tenex-1 (bedwetting); and Vyvanse-2 (ADHD stimulant). Five were prescribed 1 psychiatric medication, 2 were prescribed 2 psychiatric medications, and 1 was prescribed 4 psychiatric medications.

Strengths Of Wraparound

The Wraparound QSR of 20 cases demonstrated the power of these intensive home-based services. Most of the reviewed children had complex mental health needs and many traumatic experiences, often with long histories of DCFS involvement. In all 20 cases, there was a functioning team with child, parent/caregiver, and Wraparound Facilitator, Wraparound Parent Partner and usually Wraparound Child and Family Specialist. Most children had therapists. In most cases, Wraparound was able to build on child and family strengths to get services quickly in place to support the child at home or in making a transition to a new home and/or school. Three brief success stories from the 20 reviewed cases provide a window on Wraparound services:

BB is a 10-year old Latino male living with his mother and three siblings. When BB was 8, he and his 11-year old sister were placed with their father when their mother was arrested with her boyfriend for drug sales and went to jail. Three months later their father had a drunk driving accident with the children in the car and the family was referred for Family Preservation Services. After nine months, BB's father had deteriorated and was not able to keep the children safe. BB and his sister were returned to their mother who was living with relatives and caring for her two youngest children. In addition to the painful breakup of his parents, the loss of his mother, mistreatment by his father, and changes in placement, BB was also affected by his father's rejection after they left his home. Although he was working at grade level in 4th grade, BB was easily frustrated and had unmanageable angry behavior at home and school culminating in possible expulsion for stabbing a classmate with a pencil. Wraparound helped BB's mother persuade the school not to expel him. After only three months of Wraparound, the reviewers observed numerous significant improvements, and BB and his mother were enthusiastically participating on the team and in services.

KG is a 7-year old African American male in a relative placement with two of his eight siblings. Since 2007 DCFS received 17 emergency response referrals for this family. The children were removed in 2009 because their father was incarcerated, their mother was abusing substances and the children had inadequate supervision and were exposed to sexual behavior. KG spent the first 8 months in care in an FFA home and then he and two siblings were placed with relatives. He was subsequently removed after being sexually victimized by his older sibling, but KG quickly returned after a safety plan was developed. Their father completed court-ordered programs, but because their mother did not and their parents wanted to stay together, TPR has been filed. His caregivers are identified as an adoptive resource for KG. KG receives TF-CBT once weekly from the Wraparound therapist who also offers conjoint therapy once a month. For awhile KG received TBS, and now the Wraparound Child and Family Specialist provides behavior guidance for KG several times a week. The Parent Partner provides weekly support to the caregivers for KG's behaviors. A year of Wraparound services has helped KG with his aggression, his school behavior has improved, and his work is above grade level.

MB is a 14-year old Latino male living with his mother, adult sister and her daughter in a one-bedroom. His family had 23 referrals to DCFS, and his mother received Voluntary Family Maintenance. On 3/11, his mother asked that MB be removed and he was placed in three foster homes prior to recent reunification. MB has a lengthy trauma history: loss of his father who was deported after he was convicted for sexually abusing MB's half-sister, finding out that his father sexually abused his sister from a court report; the loss of his mentally ill brother whose whereabouts are unknown; removal from his mother; and multiple placements in foster care. The CSW has had the case for five months and everyone agrees she goes above and beyond to help the family. Even though adoption was recommended, when the CSW received the case, she listened to MB and his mother about their desire for reunification. Wraparound has been involved with the family for a year; the Wrap Facilitator and the Child and Family Specialist each meet with the family weekly, and the Parent Partner meets with the mother at least once a week (often several times a week) to help her search for employment, secure funding sources, and improve her parenting skills. MB has had the same therapist for more than a year. He and his mother also participate in conjoint therapy. MB is

> smart and resilient - having missed most of the 7th grade, he was able to graduate from 8th grade and earn an award from the Board of Supervisors for the Most Improved in school.

In addition to these examples of outstanding engagement of children and families, two reviewed cases received the highest QSR score for teamwork:

> CM is a 13-year old Latina female living with her mother and older sister. The DCFS case was opened in 6/10 for emotional abuse by her mother who had become depressed when CM's father left. Voluntary Family Maintenance was initiated, three more referrals for physical and emotional abuse were substantiated, her father could not be found, and CM and her sister were placed in a foster home 40 miles from their mother in 11/10. In 1/11 CM and her sister were placed with relatives closer to their mother. CM became suicidal, and was hospitalized for two weeks for depression. The relationship between the initial CSW and mother was poor, but the CSW referred to Wraparound which had strong positive engagement with mother and children. The Wraparound team supported CM's mother's request for a different CSW.

In the other strong teamwork example, a parent rejected Family Preservation services, but when she met the Wraparound Parent Partner at a TDM, rapport was established. The Wraparound team attributes the ongoing communication within their team and the CSW for the success of this case: "It was just a matter of empowering mother to identify what she needed. As needs were identified, the right people were brought into the team. Having the CSW present at CFT meetings made the greatest impact. The case plan was family driven and the child and his mother really had voice and choice."

<u>Improvements In Wraparound Practice Recommended By The QSR Review</u>

Although many of the 20 reviewed Wrap cases showed strong engagement, teamwork, supports and services, the QSR revealed several areas requiring improvement.

Teamwork Issues

Despite the strong Wraparound teams functioning in most of the cases, there were three weaknesses in the formation of the team: the lack of involvement by CSWs, therapists, and the family's natural supports. The Child and Family Team (CFT) should be comprised of the "right people" as perceived by the child and the family and their supports (informal supports) to provide a safety net and support system (with the right professionals to include therapists and school staff). Building upon the child and family strengths and needs, members of the team have a shared understanding of the outcomes and functional life goals for the family in order to collectively plan services and evaluate results.

Seventeen of the reviewed cases scored between 2 and 4 on teamwork (highest=6). In nine of the cases, the CSW's lack of participation in the Child and Family Team meetings was reported as a major challenge. In eight of the cases, a significant challenge identified by the reviewers was the therapists' lack of participation in the Child and Family team meetings. The absence of a school staff person and a TBS were also noted as problems in several teams. The typical scenario in these cases was that the Wraparound team consisted of child, parent/caretaker, and Wraparound Facilitator, Parent Partner and Child and Family Specialist. Therapists who were not employed

by the Wraparound provider apparently never participated in team meetings, but in several cases Wraparound therapists were also absent from the teams or if they participated did not appear to be guiding the team.

"Most communication occurs between the Wrap staff and mother and separately between the Wrap Facilitator and CSW." (GR)

"There is limited sharing of information, and thus people are working in isolation. Some of the key players missing from the team are the CSW, therapist, psychiatrist, informal supports, and the transition coordinator or community worker." (FR)

"The child's therapist does not attend team meetings and, as a result, it has been difficult to integrate important information that comes out in the team meetings to establish a productive, trusting relationship with his therapist. It is critical at this point in the child's life that he gain more understanding of his feelings and that the interventions in therapy address his trauma history and match the child's short and long term goals. There also needs to be a greater presence and involvement of the CSW or other DCFS staff on the team at this critical time, in order to identify appropriate emancipation services for the youth and family." (AZ)

"There are critical players missing from the child and family team, and some team members are working in isolation and not communicating and collaborating to develop common goals. To date, the CSW has been unable to attend any Wraparound CFT meetings due to workload issues. It would be important, however, for the CSW to provide her input in solidifying a plan for safe case closure. TBS has attended some CFTs, but the therapist attended only one recent CFT. Although TBS has been working with BM at his school, communication with the teacher has been limited. The teacher reports that no one has given her information on the child and why he requires on-site support. His teacher is also involved in an afterschool program, which provides homework assistance and enrichment activities. The family does not have knowledge of this resource because the teacher has not been engaged. There has been no contact made by anyone on the child and family team with his family's natural supports." (BM)

"There has not been an opportunity for all of the various parties to communicate at the same time, to share information, concerns and successes. Teamwork is minimally adequate due to the CSW's absence from the communications involving the unified team. In addition, though the TBS worker and the child's therapist remain in communication with the Wraparound Facilitator, they have limited involvement in CFT meetings. Therapist and CSW did not participate in the past five weekly child and family team meetings; TBS participated in one; CFS participated in two. CFTs are usually attended by child, mother, PP and facilitator. The team would benefit from consultation with the child's therapist to gain a better understanding of the role of trauma in developing appropriate intervention strategies in the Plan of Care." (BB)

In several additional cases, the reviewers documented poor involvement of the child and family's natural supports with the team:

"Wrap Child and Family Team meetings most often consisted of the professionals on the team, the caregiver and the youth. Occasionally the CSW attended. The other people that were important to the youth, such as her "aunt" who lives across the street, and all the staff she is fond of from each of the programs that she participates in on a regular basis were missing. It is likely

that if these informal supports were regular team members, then the transition out of Wrap would not be so problematic." (IM)

"There is a lack of inclusion of all of the formal and informal supports in the team, and there is no on-going communication amongst everyone important to the family. Usually the child, his mother and the Wrap Facilitator, Parent Partner and Child and Family Specialist participate in team meetings weekly in the home. Informal supports – maternal uncles, cousin, former foster family, and church friends are not included in the team. Formal supports, such as individual and conjoint therapists, are not a part of the team and are not included in case planning activities. The individual therapist is from a different agency and has not participated in any CFTs and only recently found out there was a Wrap team in place. The child's sister, who is a great source of emotional support for him, has not been positively engaged by the team." (MB)

Understanding the Child and Family's Needs

Assessment and understanding is the degree to which the team has a shared understanding of the child and family's strengths, needs, and underlying issues. What must change for the child and family to have better overall well-being and improved family functioning? Having a better assessment and understanding of the child and family's underlying needs, as well as trauma-related and developmental-related needs will result in better informed intervention efforts.

Underlying Needs

Wraparound practice emphasizes the strengths and needs of the child and family. The Wraparound Plan of Care focuses on the needs of the child and family, and Child and Family Team meetings clarify who can do what to assist in their needs being met. One of the greatest strengths of Wraparound is the rapid focus on needs in the team meetings and initiating services and supports in response to those needs. In one of the success stories described above, the Wraparound Plan of Care listed underlying needs that were similar to the priorities seen by the reviewers:

- BB needs help dealing with anger in a positive way
- BB needs to feel loved and to have a sense of belonging.
- BB needs to control himself in a positive fashion at school.
- BB needs to feel safe in expressing his thoughts and feelings with his family which are part of the reason he often seems not to get along with his sister.
- BB's mother needs to feel respected and appreciated by him.

In many of the reviewed cases, the child's needs listed in the Wraparound Plan of Care were primarily the child's behaviors and the parent/caretaker's concrete needs (such as housing, employment, transportation, and advocacy support) and assisting the parent/caretaker in managing the child's behaviors. The reviewers found little attention to underlying needs as described in the DCFS/DMH Core Practice Model and the training and coaching provided by both agencies. The lack of involvement of therapists in many team meetings and misunderstanding of trauma (described below) contributed to this lack of clarity about underlying needs. The assessment of trauma and underlying needs must occur at the outset and an ongoing basis to assess the "big picture" situation and dynamic factors that impact the child and family in order to guide intervention. As one Wrap staff person described, "we work on the behavior and the therapist works on emotional issues."

These missing trauma-related and other underlying needs from the Wrap Plans of Care may account for only two of the 20 reviewed cases receiving the highest scores (one 5 and one 6) on assessment of the child. The following cases exemplify this issue of understanding the child's underlying needs:

FR is an 18-year old Latino male who just graduated from high school and has lived for 14 years in a non-relative foster home with his 19-year old college student sister. FR and his siblings came into care in 1997 due to physical abuse and lack of supervision by their mother. His two younger siblings were adopted; FR has not seen his mother in three years and has never known his father. Their caregiver had legal guardianship of FR in 2000, but it was terminated in 2011 due to his behavior. Wraparound was initiated in 1/12 when FR was skipping school, breaking household rules and stealing. The current focus of Wraparound has been FR's transition to adulthood, his running away from home, and his arrest for having sexual contact with his 15-year old girlfriend. FR's needs listed in the Wraparound Plan of Care were:

- For FR to make good decisions in the community; avoid stealing, be in school
- For FR to continue respecting his caretaker as the head of household
- For FR to explore his biological family when he's ready
- For FR to work towards emancipation from foster care system
- For FR to process his depression and anxiety in appropriate ways
- For FR to express his needs in appropriate ways
- For FR to comply with his caregiver's house rules and follow daily schedule
- For FR to earn credits to graduate from high school
- For FR to explore colleges and trade schools
- For FR to work part-time
- For FR to develop healthy relationships with peers
- For FR to obtain some work experience

The above list is practical and behavioral. Some "needs" listed may not be needs a teenager would appreciate but instead are demands of adults. Based on the information gathered during the reviews, some underlying needs thought to be missing from the Wrap Plan of Care were identified:

- FR needs to love himself and know that he is worthy of being loved.
- FR needs to feel secure knowing he has somewhere to live no matter what happens.
- FR needs to make sense of his history, particularly the loss of his family, and know that it is not his fault.
- FR needs to learn to trust others.
- FR needs to learn to voice his own opinions and thoughts and not worry about appeasing others.
- FR needs to feel respected as a young adult.
- FR needs to know that he capable of achieving success.

EM is a 14-year old Latina female living with her mother. For nine months since her mother left their father with EM and her sister due to domestic violence, they have been living in her maternal uncle's 2-bedroom apartment with him, his wife, and their three children. In 9/11 EM

was hospitalized for an overdose, with a history of cutting and depression, in reaction to her parents' arguments and father's alcohol use and criticism of her. EM and her family were enrolled in Wrap (at the same provider where she and her family had been receiving therapy) in 2/12. In the Wrap Plan of Care, EM's needs were listed as:

- Mom needs to know EM is safe
- Mom and Dad want to get closer to EM
- Mom needs to make sure EM can control her anxiety
- EM says she needs to know how to communicate better
- EM wants to be on a sports team

The reviewers were concerned with the lack of attention to her underlying needs such as:

- EM needs to understand how worried, hurt, angry and powerless she felt when her family had so many problems and how to express these feelings with the people she trusts rather than resorting to cutting herself or harming herself in other ways in order to soothe her anxiety.
- EM needs to learn how she, as the oldest daughter born to mono-lingual, undocumented, Spanish speaking parents will need to act as a cultural navigator for her parents without sacrificing her own emotional well-being in order to "fix" her family.

Trauma Treatment

In five of the reviewed cases, TF-CBT was being provided. In 11 of the 20 reviewed cases, the reviewers specifically noted that it was understandable that Wrap had a behavior focus at the outset, but that the children had needs requiring trauma treatment that was not being provided (although most of the children were seeing a therapist) and the parents/caregivers were not receiving sufficient guidance about how to respond to the children's trauma-related needs. Often in these cases, the reviewers found that the child's needs were poorly understood by the team.

The child in the success story above was originally diagnosed with ADHD, Oppositional-Defiant Disorder, Rule Out Depressive Disorder, and the reviewers concluded: "The therapist reported that his initial impressions of the child's symptoms seemed likely to be ADHD, but his current belief is that BB is suffering from trauma-related symptoms of depression stemming from numerous life disruptions. There is insufficient knowledge of the child's underlying feelings that may be driving the child's' inappropriate actions. BB has suffered tremendous trauma yet he has not been provided with information or the opportunity to ask questions. BB needs to have a developmentally appropriate understanding of what happened to his family (his mother's arrest and incarceration) and of his father's alcohol abuse. BB needs to be able to ask questions openly, express his feelings with his mother and be supported in this process."

In the case of EM, the 14-year old described above, the reviewers noted the lack of understanding by the team of EM's trauma-related needs: "EM has had significant traumatic experiences: her parents' arguments which intensified over the year prior to referral; her half brother's arrest in the home for marijuana sales; her father's verbal abuse towards her and her mother, denigrating her; witnessing domestic violence; being upset by her parents pulling her into their arguments; their separation; and EM's overdose and hospitalization. The effects of

these experiences were apparent in her depression, anger and worsening grades in school. The team's interventions were not driven by the therapist's insights and the therapist's work with EM was behaviorally based which appeared to have successfully taught EM some new coping skills, but did not help her or her family gain much insight into her underlying needs. Asked if she thought EM might benefit from doing a trauma narrative, her therapist said she had not considered TF-CBT.

TS is a 15-year old African American male whose D-Rate foster mother describes him as "soaring." He is the second oldest of 8 children with siblings ranging in age from 7 months to 17 years old. The family has a seven year history of involvement with DCFS due to substance abuse and domestic violence. When TS was 8 and the 6th child in the family was born positive for cocaine, his family received Voluntary Family Maintenance Services (VFM) for a year and the case was closed in 2006. In 2007, allegations of neglect were filed because the children were not attending school and Family Preservation Services were put in place. In 2008, his mother gave birth to her seventh child, and she and the infant tested positive for cocaine at the time of delivery; their father was in prison. All seven children were removed from their maternal grandmother who was caring for them but was incapacitated by a stroke. The four older boys in the family were placed together in a foster home from November 2008 until September 2011 when TS was asked to move due to angry outbursts. The three girls were initially placed in separate foster homes. Currently, one of the girls has been adopted, one is placed in a RCL 12 group home and one lives with an adult half sister. In 8/11, their mother gave birth to an eighth child who was also placed with their adult half sister whose home TS had been hoping to move into. His foster mother indicated that TS has made significant improvements in his behavior and his school work since coming to live with her approximately six months ago. TS lives within walking distance of his brothers who still live with his former foster mother and he visits often; he also visits his older half sister on weekends. The siblings have rarely been all together since they were detained in 2008. They have little contact with either parent. The Wrap team has focused on TS's "prosocial interpersonal skills" for more than a year. His new therapist wants to address his trauma-related needs. TS's Wrap Plan of Care includes the following needs:

NEED	STRATEGIES
▪ Be aware of surroundings & ignore peers ▪ Earn his own money ▪ Be respectful with adults	▪ Get home on time & take the major street only ▪ His foster mother will help him get his birth certificate & social security card & apply for a job ▪ Express his feelings ▪ His CFS & therapist will help him learn coping skills like walking away, deep breaths and counting to 10 to avoid talking back

The permanency of this home is at risk due to his foster parent and older sister not understanding his unmet trauma-related needs behind his problem behaviors. If the team meeting helped everyone define the unmet trauma-related needs behind his behaviors, then the Plan of Care could specifically state what team members will do to meet each of those needs. The following is an example of how TS's needs could be stated, and the role of his foster mother, sister, CFS and therapist in meeting his needs:

TS'S NEEDS (AGE 15)	SUPPORTS & SERVICES
▪ To make peace with not living with family & know his family loves him	▪ Seeing his siblings weekly ▪ His therapist helping him make a list of all his losses, grieve them, not blame himself that family cannot provide a home for him & feel lucky to have his foster mother ▪ His sister feeling proud of all she does for him ▪ His foster mother not feeling hurt by his wish for family
▪ To ask for what he wants & calm himself when he doesn't get it right away	▪ His therapist teaching him self-soothing ▪ His therapist helping him see why he gets so anxious when things are not in his control ▪ His therapist teaching his foster mother & sister what triggers his anxiety & how to help him calm himself
▪ To believe that he is smart & good at music	▪ His foster mother helping him get a job ▪ His therapist & CFS helping him change his self-talk ▪ His CFS recognizing accomplishments & guiding his foster mother, sister & teachers praising his talents ▪ His foster mother and CFS looking for singing instruction or other musical opportunities with him & considering an arts high school
▪ To feel he likeable and worthy of friends	▪ His therapist & CFS helping him change his self-talk ▪ His foster mother, sister, teachers & CFS praising his caring and friendliness & his pro-social friendships including encouraging activities with friends

Recognizing Developmental Needs

School. Seven of the 20 reviewed cases got a low score on Learning and Development because their needs in school were not adequately understood. The lack of school inclusion in the team is described in the Teamwork section above, but other examples are illustrative of children's unaddressed school-related needs:

> SG is a 16 year old Latina living with her mother, her brother and their maternal grandmother in her one-bedroom apartment in a retirement community since 1/12. Ten years ago SG's father was convicted of sexual abuse of his girlfriend's daughter. In 5/10 allegations of neglect were substantiated for SG and her brother, a Voluntary Family Maintenance case was opened and in 9/10 neglect and emotional abuse of SG by her mother resulted in placement. SG had seven placements and four schools while in care. SG's grades and attendance have been and continue to be poor. Academic testing completed in August 2011 indicated that SG was at an 11th grade level in Language Arts and a 5th grade level in Math. She does not have enough credits to start 10th grade.

DA is a 14-year old Caucasian male who lives in a foster/adoptive home. DA has been in 10 placements, in and out of child welfare in various counties and two states, and has reunified with his mother four times. His father has never been involved in DA's life. DA was born prenatally exposed to drugs and alcohol. When he was five years old, he was physically abused by his mother and exposed to substance abuse and domestic violence. The family became known to LA County DCFS in 2/10 due to his mother's mental health and substance abuse problems; DA was not going to school because he was worried about leaving his mother alone. DA was placed at age 12 in a foster home and said he knew he would not be reunifying with his mother this time. "The team would benefit to include school personnel since education is a strong area of need for DA. The school counselor stated that she was invited to one early CFT meeting and IEP meetings, but no one from school was invited to meet regularly at the weekly Wraparound meetings. As a result, the team was missing the support from the school because the school did not have the support from the team. Working together as a team would have helped to communicate what each party was doing and become more cohesive in developing and executing both short-term and long-term goals. Although Wraparound Child and Family Specialist (CFS) went to DA's school to observe him to see how to reduce his negative behavior, the information was not communicated to the school counselor. Therefore, the school counselor did not know that anyone came out to observe him and missed an opportunity to work together to help DA. The school counselor felt isolated from the team."

Other developmental needs. Three of the 20 reviewed cases had a low score on Learning and Development because they had speech and/or processing problems that were not being addressed. In a child welfare sample of 20 receiving intensive mental health services, it is surprising to find only one diagnosed with Pervasive Developmental Disorder, one with an Auditory Processing Disorder, and one with a Phonological Disorder (although perhaps within the seven diagnosed with ADHD there are children who also have executive function and other developmental deficits).

MS is a 17-year old African American male placed with his aunt who is his legal guardian. MS came to the attention of DCFS when he was born with cocaine in his system. He was placed in the home of his maternal grandmother. His mother died when he was 6; at that time his case was closed with legal guardianship with his grandmother. She died when he was 12, and DCFS placed him with his maternal aunt who had no other children. MS does not have a relationship with his father. MS has been receiving Wrap services for 18 months. The Wrap facilitator told the reviewers that they were exploring Job Corps for MS and that they will assist MS if he wants to enroll in a community college. MS recently graduated from high school and his aunt told reviewers that MS has to leave her home when he turns 18 soon. She wants MS to go into the military but he does not want to, and according to his IEP, his cognitive abilities are in the below average range. His IEP reflects a diagnosis of ADHD and auditory processing and sensory motor skills challenges. MS was described as being 17 years old chronologically but emotionally at a level of a 12 or 13 year old. Neither MS nor his aunt understands his cognitive limitations and how they have to be taken into account in planning for independence and employment.

Other clinical issues.

One reviewed youth prescribed medication had not been seen by a psychiatrist for six months. For several youth, there was a significant lack of agreement about diagnosis among the providers. The most concerning example was FR, an 18-year old described above. According to the most recent court report (3/12) FR was diagnosed with ADHD, Anxiety NOS, and Enuresis not due to a medical condition. The psychiatrist indicated FR has a diagnosis of ADHD and Conduct Disorder (2/12). FR's therapist stated FR has ADD and Mild Depression. FR has been in treatment for 10 years with the same therapist, who does not work for the Wraparound provider, does not participate in team meetings and who he sees every other week, but little is known about FR's presenting issues and the treatment goals. "FR's need to feel connected to his family is not being addressed, in part due to his inability to open up and trust others. FR indicates that he is only comfortable discussing his family with his sister, and he states that he mainly talks about his transition issues in therapy. It will be important for him to explore his past trauma issues, as they impact his self-perception and relationship with others." One 13-year old had diagnoses of ADHD and Enuresis and whether the prescription of Risperdal, Desmopressin and Guanfacine fits those diagnoses warrants consideration. Three of the 20 reviewed children had diagnoses that were older than a year and were being reconsidered but had not been officially changed. In one case, the Wraparound staff believed the teenager was prescribed a psychiatric medication but they did not know her diagnosis, the medication or whether she was taking it and assumed her therapist was knowledgeable about it.

Transition for The Future/Long Term View

One of the successes of Wraparound was the support provided to youth in transition from foster homes and hospitals to their family's homes. But only four of the 20 reviewed cases received scores of 5 or 6 on Long Term View. Long Term View is the degree to which there is a shared understanding among the team members of the outcomes and functional life goals for the child and family. Long term view encompasses protective capacities, desired behavior changes, and natural or community supports for the child and family to achieve and sustain adequate daily functioning and greater self-sufficiency. Long term view is fluid but should be developed in the beginning to address the specific needs of the family and take into account such transitions as placement moves, school changes, emancipation/independent living/life skills, and vocational preparation. Essentially, long term view incorporates various family, developmental, and life transitions.

In eight of the reviewed cases, the reviewers expressed concern that planning for transition to the future had not been adequate.

> RD is an 18-year old Latina female living with her parents, younger brother, and adult sister and her sister's boyfriend and two children. She was placed in 5/11 because her mother and father used inappropriate physical discipline "because of RD's combative and explosive behaviors;" she was failing in school, used substances, did not comply with house rules or curfew and was raped. She asked to live with her aunt who did not think she could manage RD, so she was placed in an out-of-county foster home, and then was moved after two weeks to an FFA home near her parents, and in 1/12 she returned home. For several years she had been involved with Full Service Partnership, and was diagnosed with depression, but, she is not prescribed psychiatric medication. According to Wraparound progress reports, the family has greatly improved in communicating their needs to one another. RD

appears more willing to compromise with her parents. RD's parents seem to be more understanding of RD's need for personal space and time out in the community. RD hopes to graduate from continuation high school in 2013 and her parents are supportive of this goal. Court terminated jurisdiction just prior to the review, and the family, DCFS, and Wraparound team agree on graduation from the program soon. The reviewers felt that RD's status will likely decline in the next six months: "RD does not appear to have age-appropriate self-management of emotions and behaviors. RD does not appear to have adequate independent and life skills nor has she developed the appropriate community supports and networks to prepare for adulthood. Although a referral was made to the Independent Living Program (ILP), RD ultimately did not qualify for ILP services because she was returned home. RD did receive some vocational preparation from the Wraparound team. Although RD has made much progress, it did not appear that she has adequately developed the coping skills necessary to help her in stressful and frustrating situations. The reviewers do not have confidence that success or progress made will be sustainable. Her mother expressed uncertainty of RD graduating from high school, and on the California Standards Test in 2010, RD performed Below Basic in Math and Far Below Basic in Language Arts. There is continuing tension between RD and her mother, and it seems that progress made by the family may be short-term with no long-term behavioral change."

DA, the 14-year old described above, also had special transition concerns requiring more attention: "Preparing and planning around transition is going to be the most immediate challenge as there are many transitions ahead for DA. He is entering high school and transitioning to a new school environment in less than a month. Once the adoption placement is completed in about a month, Wraparound Services will terminate. Such a sudden termination may cause regression in DA's behavior and family functioning. Preparing the family to be ready to terminate the supports and services is a process that should be occurring from the beginning of Wraparound support, but difficult to achieve when it is unclear if the family is going to adopt. Also, the nature of Wraparound services can be intensive and the focus is on complex issues with DA, not on terminating. When the Wraparound Services were referred for this family, the caregivers were unsure about adopting DA and DA was unsure of being adopted as it would mean letting go of his wish to be with his mother. Over the course of Wraparound intervention, the caregivers and DA have decided that adoption would be the best plan for them. The caregivers expressed a need for Wraparound support until adoption finalization, but transition services beyond that time are necessary."

AU is a 17-year old Latino male living with his mother and siblings; their family had 10 referrals to DCFS for neglect, physical abuse and domestic violence which were all inconclusive or unfounded. But in 2011 a voluntary case was opened due to his mother's difficulty in managing AU's anger and misbehavior. AU's mother felt engaged and supported by their Wraparound team including their clinician who provided individual and conjoint sessions. His therapist said '"he can now process his anger and manage his feelings and his volatility is almost gone." The Parent Partner provided coaching on how his mother could fill the parental role, use parental authority to give direction and establish a stable, emotionally safer home environment for AU and his siblings. "AU's mother would have benefited from domestic violence sessions and individual counseling to address some of her trauma, but the parent partner felt limited by funds to provide these additional services. AU is very behind in credits to graduate, and he is nervous about turning 18 and taking on adult responsibilities.

Given the trauma AU experienced in the home (DV between parents, unstable housing with frequent moves, loss of father followed by disinterested step-father, loss of older brother), trauma informed care for his depression would have naturally been a core feature of his service plan and an identified component for post-Wrap service. This case seemed to have closed a little prematurely and there is concern that the status for AU and his family is likely to decline. Although everybody seemed to agree that AU and his mother had addressed the issues that brought them into the system and it was safe to close the case, this family would have benefited from a couple more months of services. AU is facing major developmental tests: he does not want to be 18 and leaving home for the Job Corps without the supports that have helped to this point. AU could have benefited from the team's support through the Job Corp process and trauma therapy. Although the CSW agreed that the family could have benefited from further services, her belief was that the case needed to close because there was a court hearing and SDM indicated that the case should be closed (there were no safety concerns)." If the educators had been involved in the team, perhaps the school would have understood that his presumed lack of motivation was symptomatic of trauma; that he feared assuming responsibility for himself; that tardiness and incomplete assignments meant that moving him to a continuation school that required independent study and initiative would lead to more failure. The school might have understood that AU's interest in drawing and dreams of designing decorative patterns for skateboards was a strength, a passion to work with instead of seeing his art as graffiti.

Lack of community networks was identified as one of the problems in transition planning. Ideally, the team should have enough community supports to support the family when Wraparound plans for graduation. Weak informal supports were described above under teamwork, but for some children and families their absence significantly compromised the future.

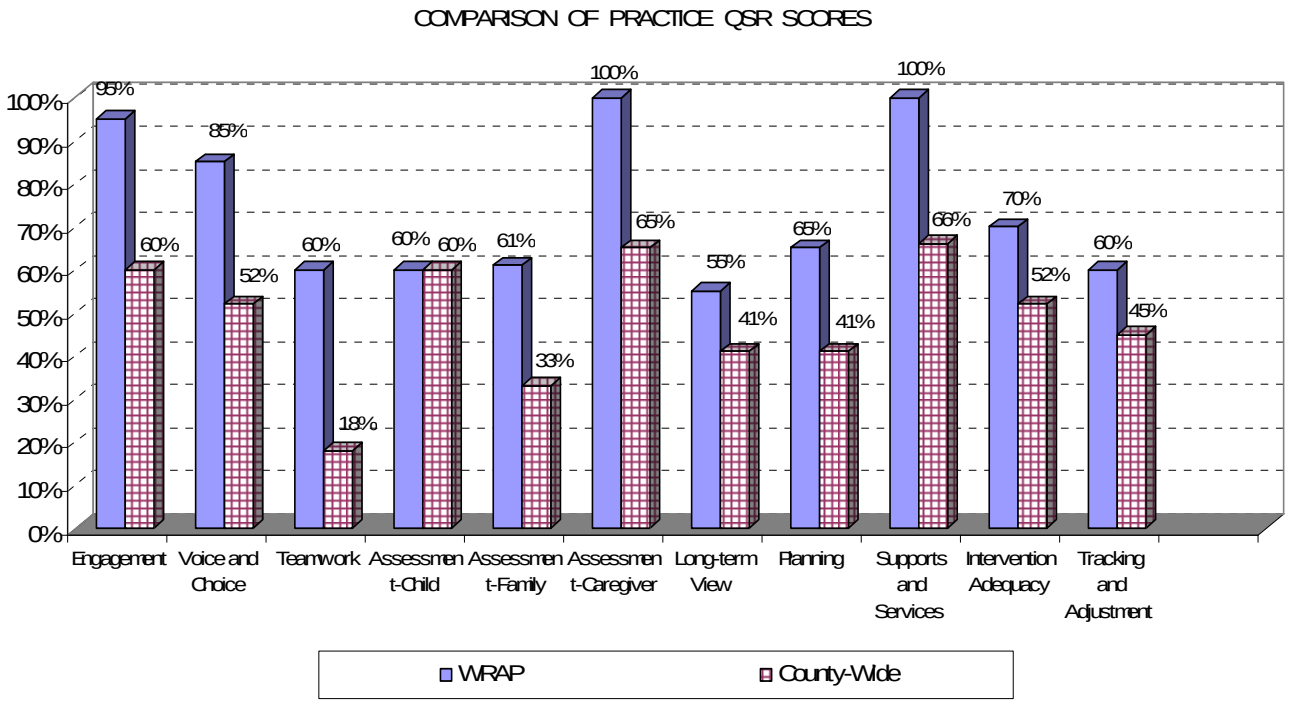
COMPARING REVIEWED WRAP CASE SCORES TO COUNTY-WIDE QSR SCORES

In comparison to county-wide QSRs from 18 DCFS offices between June, 2010 and August, 2012 (N=210), the 20 Wrap cases had generally higher scores on practice indicators (percent in the acceptable range)[8]:

Practice Indicators:

Practice Indicator	WRAP	County-Wide
Engagement	95%	60%
Voice and Choice	85%	52%
Teamwork	60%	18%
Assessment-Child	60%	60%
Assessment-Family	61%	33%
Assessment-Caregiver	100%	65%
Long-term View	55%	41%
Planning	65%	41%
Supports and Services	100%	66%
Intervention Adequacy	70%	52%
Tracking and Adjustment	60%	45%

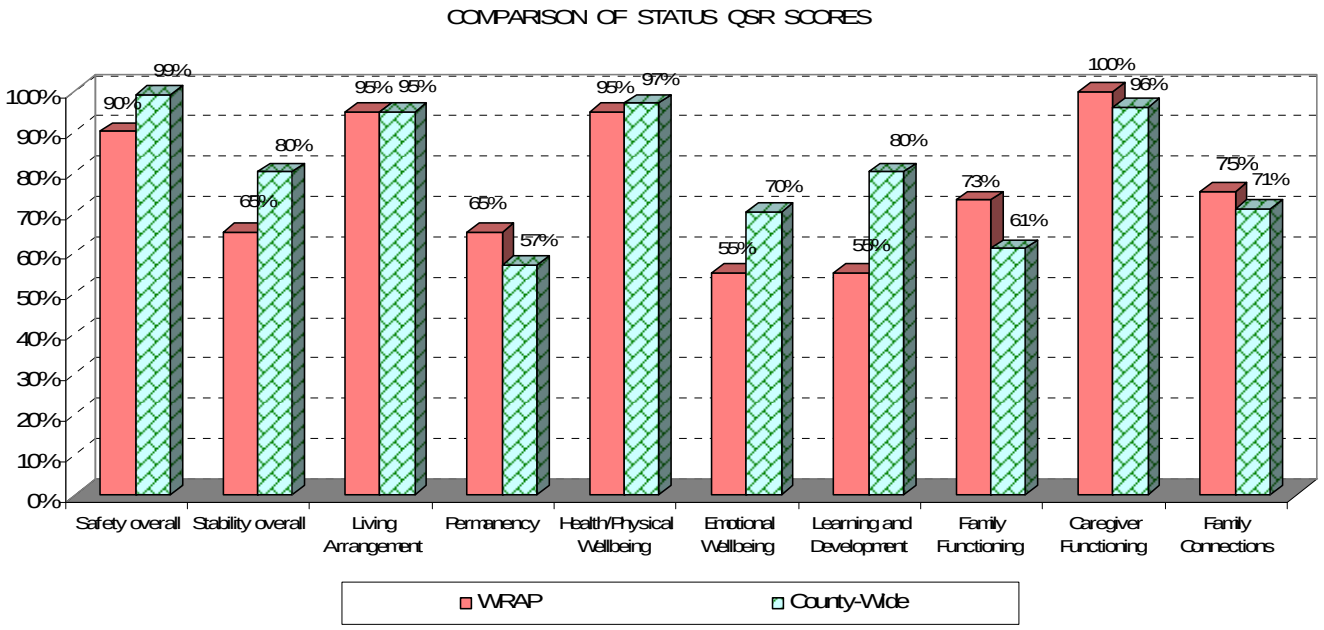
[8] Data from the QSR Report on the Wrap QSR by the Quality Improvement Section, August, 2012.



In comparison to county-wide QSRs from 18 DCFS offices between June, 2010 and August, 2012 (N=210), the 20 Wrap cases had some lower and some equivalent scores on status of the child indicators (percent in the acceptable range):

Status Indicators:

Status Indicator	WRAP	County-Wide
Safety overall	90%	99%
Stability overall	65%	80%
Living Arrangement (Overall)	95%	95%
Permanency	65%	57%
Health/Physical Wellbeing	95%	97%
Emotional Wellbeing	55%	70%
Learning and Development	55%	80%
Family Functioning	73%	61%
Caregiver Functioning	100%	96%
Family Connections	75%	71%



Some of these scores can be explained in two ways. The data tracked by the County and Katie A. Panel shows that class members (because of their high mental health needs) have more complex challenges, (all of the Wraparound youth had an intensive mental health need, which was not a requirement in the regional office QSR reviews). Furthermore, the Wraparound sample does not include children under the age of five like the countywide sample does, and we would expect the older population to have more emotional issues and school issues and generally be more challenging.

The Wraparound QSR practice and status scores above raise two important additional systemic concerns:

- Messages within and outside Wraparound appear to be hampering the creative tailoring of services and supports to build on the unique strengths and meet the unique needs of the child. Providers learn in training that individualized, creative interventions are central to Wraparound, but the review found that in most cases the Wraparound Parent Partner, Child and Family Specialist and Facilitator used their impressive skills as the primary interventions (plus whatever the school offered and, in some cases, TBS). It appeared that the "Whatever It Takes" mantra of Wraparound was being interpreted to mean "Whatever Wraparound staff can do."

- The finding from the cases reviewed is that LA Wraparound engaged families and provided concentrated supports so children remained in family homes. This is a significant achievement with children with complex mental health and school needs, often with long DCFS histories. However, in many of the reviewed cases, Wraparound did not appear to be functioning as an *intensive mental health intervention*. Trauma-related needs are not in most Plans of Care and most therapists are not providing trauma-related, clinical guidance to the teams, so it is not surprising that only half have emotional wellbeing in the acceptable range.

Recommendations

Recommendations from the Wraparound QSR require collaborative action and a system response. Concerns raised in the reviewed cases involve not only Wraparound but also DCFS and DMH practice. This is a shared practice model and a shared change process. Improved teamwork, a deeper appreciation of underlying needs, trauma treatment, and supports (formal and informal) and services pertaining to transitional planning contribute to better outcomes.

Teamwork:

- Teamwork could be enhanced by further strategizing about ways to engage "missing players" such as CSWs, therapists, school personnel, community supports and the family's natural supports. Innovations including use of technology (conference calling, web-based participation, etc.) would support participation and elevate the child and family team functioning. For instance, school staff participation in CFT meetings may increase if meeting were sometimes convened at the end of the school day at school.

Some CSWs, even with large caseloads, were enthusiastic participants in Wraparound Child and Family Team meetings. Others said they did not have the time to participate. Others said they would have to have a more flexible schedule to participate. Some Wrap providers proposed that since most team meetings occur in the home, a monthly meeting could be held at a time to coincide with the CSW's monthly visit to facilitate increased participation. It is also important to make CFT participation positive so CSWs do not feel blamed when they participate.

- Locating family members to whom connections have been lost—particularly fathers and extended family—is necessary to ensure full participation in CFTs.

- The Wraparound CFT must be measured against the standard of whether the **formation of the CFT** contains "lifetime family supports" and key professionals and whether the **functioning of the CFT** reflects a coordinated and unified effort around a Wraparound Plan of Care that specifies a long term view.
- Training and coaching curriculum that will support the vision and achievement of better practice.

Assessment and Understanding:

- More coaching on identifying underlying needs, particularly trauma-related needs, is necessary with Wraparound teams so that all participants—including CSWs, therapists and school staff—could improve their practice. Since LA County has a shared practice model and a shared change process, shared coaching for DCFS, DMH and providers is important.

- The Wrap Plan of Care format is not conducive to clear statements of underlying needs. Because it is organized by domain, the trauma-related needs that are important in an intensive mental health intervention may get buried. The domains approach typically leads to a long shopping list of unprioritized behavioral needs in the Wrap Plan of Care. The revision of the Wrap Plan of Care format would go hand-in-hand with additional coaching in identifying underlying needs, particularly trauma-related needs.

- Linkages to parent services, especially adult mental health services, were identified as an ongoing resource issue and important need to help parents meet their children's needs.

- Identification of a youth's need for permanence is an essential need to be addressed by the Child and Family Team and in the Wraparound Plan of Care.

- The role of the child's therapist on the team includes supporting all team members in understanding the needs behind the child's behaviors and applying that to their unique role in meeting the child's needs.

- Needs training that will enhance the Wraparound provider and County Wraparound staff's skills around underlying needs.

Innovative, Individualized Services:

- Tailoring unique supports and services to build on child and family strengths and meet needs is an essential part of Wraparound.

- Wrap ensures interventions that build on child and family strengths, meet needs and assist caregivers/family in meeting child needs to achieve the shared Long Term View.

- What the family's supports (extended family, community supports, etc.) provide are valued interventions and should be included in what is being done to build on child and family strengths and meet needs and assist caregivers/family in meeting child needs.

- Arranging trauma-responsive care that fits the child and family is not easy but is an important part of individualized services.

- The child's therapist not only provides treatment to the child and guidance to caregivers and family but also clarifies how TBS and others will meet the child's underlying needs.

- When Wrap is working with a child in an out-of-home placement and attachment to parents and other family is important for the Long Term View, Wrap and the child's therapist guide not only the caretaker but also the parent in meeting the child's underlying needs during visits.

- The residency status of the parent may restrict access to community resources, but Wraparound can assist these parents in locating special assistance.

Long Term View:

- The child's and family's needs, as articulated on the Wraparound Plan of Care, should be incorporated into case planning from the beginning and to ensure the long term view is shared by the team with concrete steps to achieve case plan goals and to sustain success beyond safe case closure. Part of teambuilding is helping all the participants have a shared understanding of Long Term View even though their roles are different.

- The quality of the Wraparound Plan of Care must be measured against the standard of whether it articulates shared outcomes and functional life goals (i.e. required protective capacities, sustainable supports, real emotional and behavioral changes), enabling the child, family and those helping them to see both the next step forward as well as the "end point" – providing a clear vision of the path ahead – guiding the intervention and change process.

- Inclusion of a family's natural supports is necessary, particularly when connections and supports do not exist already. Plans to develop meaningful connections and supports and repairing damaged connections are essential functions of the CFT and the Wraparound Plan of Care to promote legal and relational permanency. Alternatives must be developed in the event that the hoped-for permanent connection does not work out. The use of Family Finding is a critical need for youth who have not achieved legal permanency.

- Continuing intensive mental health services must be provided after Wraparound ends and the DCFS case closes. Clarifying how this can best occur, particularly through Intensive Care Coordination, is necessary. One aspect of continuity of mental health services is ensuring that the child and family understand why this assistance will be helpful after Wraparound ends and the DCFS case closes, despite the stigma associated with mental health care.

- For transition-age youth, the involvement of Youth Development Services may provide guidance and linkage to supports and services prior to and beyond case closure.

Systemic Changes:

- Several of the cases reviewed had a long history of either services or referrals with DCFS prior to their referral to Wraparound. Children were also referred to Wraparound following multiple placement failures and others when there was not much time left during their voluntary case designation. These cases and others where children had prior hospitalizations or numerous replacements could have benefited from earlier intensive mental health services. Referrals seemed to have come "far down the road" and perhaps using the co-located mental health providers could have helped refer the child earlier.

- When a psychiatrist or other provider is funded under contract with DMH, there is an administrative clinical oversight role that must be used when deficiencies in diagnosis and medication described in a few of the cases are identified.

- In some reviewed cases, DCFS school consultants worked effectively with CSWs, but they may not continue with cases, and follow-up by the CFT is essential. There is a need for a deeper understanding of the role that educational consultants play in addressing children's educational needs at the time of linkage, and the roles that they and other key players will have in any follow through that may be necessary.

- Improved system-wide understanding of the effectiveness of various models of trauma treatment, and greater availability of quality training for clinicians to provide trauma treatment is necessary.

- A better understanding of Wrap by CSWs and SCSWs will assist with earlier Wrap referrals and increased CFT involvement.

Implications of the Findings of the Wrap QSR for Wrap Redesign:

- Establish an expectation that CSWs will actively participate in the Wraparound process.

- Refine the role of the Interagency Screening Committees away from compliance driven oversight to a qualitative case consultation model. This will assist with trouble-shooting issues including engaging CSWs, therapists and school staff who may be challenging to engage to attend Child and Family Team meetings.

- Revise the Plan of Care to streamline the document and emphasize trauma-related and other underlying needs. In addition, allow the Child and Family team to prioritize the domains that are most important to the team. At the same time, the Plan of Care must be flexible and faithful to the spirit of Wraparound that the family is in charge and taking the time for them to understand underlying needs will be crucial for them to want them in the POC.

- Each Wraparound agency will be required to enhance their clinical supervision and coaching to identify and address trauma-related needs. Implement a Mental Health Status report to ensure there is administrative clinical oversight to track therapist participation, trauma-responsive practice and potential deficiencies in diagnosis or use of medication. Strengthening intensive mental health interventions and successfully meeting trauma-related needs will be essential as the County expands Wraparound in an effort to reduce psychiatric hospitalizations and group care placements.

- Clinical guidance for caregivers in how to meet underlying needs when responding to difficult behaviors will be essential for continued success.

- An approach for Wrap to support children while they are in group care in preparation for transition to a family home should be developed.

Implications of the LA Wrap QSR for Statewide Katie A. Planning:

- There is a common perception that therapist participation in CFT meetings should be limited due to restrictions in Medi-Cal claiming. The current claiming manual states that reimbursement is only approved for those activities that are related to a child's mental health needs. If a therapist can only be reimbursed for a portion of the time spent in a CFT meeting, it can present a financial barrier to mental health providers. Clarification in the State Medi-Cal Documentation and Claiming Manual is necessary overcome this barrier.

- In the new service language contained in the Katie A. State case, mental health participation in CFT meetings will be claimed to Intensive Care Coordination (ICC), and it will be critical that examples of mental health participation are included in the documentation manual in

order to give providers a clear sense of what kinds of CFT related services are able to be claimed to ICC.

- Multiple case plans (e.g. the DMH Client Coordination Plan, the DCFS Case Plan and the Wraparound Plan of Care) are a challenge to effective teaming and planning. These plans are rarely shared and don't have common goals for the child and family. The development of an Individual Care Plan that is a cross-system/multi–public agency plan will assist in reducing the silos that currently exist.

- Misperceptions about confidentiality and information sharing are barriers to forming a functional Child and Family Team. Clarification about sharing information within a CFT is crucial to statewide implementation.

APPENDICES

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APPENDIX 1

Quick Study Job Aid for Reviewers

QSR CHILD/YOUTH PROTOCOL: Listing of Status, Progress, and Practice Indicators

QSR INDICATORS

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

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

- **Practice indicators** measure the extent to which *core practice functions* are applied successfully by practitioners and others who serve as members of the child and family team (CFT). The core practice functions measured are taken from the CFT and provide useful case-based tests of performance achievement. The number of core practice functions and level of detail used in their measurement may evolve over time as advances are made in the state-of-the-art practice.

QSR CHILD & CAREGIVER STATUS INDICATORS

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

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

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

2. **STABILITY**: Degree to which: • The child's daily living, learning, and work arrangements are stable and free from risk of disruptions. • The child's daily settings, routines, and relationships are consistent over recent times. • Known risks are being managed to achieve stability and reduce the probability of future disruption. *[Timeframe: past 12 months and next 6 months]*

3. **PERMANENCY**: 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.

4. **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.

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

6. **EMOTIONAL WELL-BEING**: Consistent with age and ability, the degree to which the focus child is displaying an adequate pattern of: • Attachment and positive social relationships, • Coping and adapting skills, • Appropriate self-management of emotions and behaviors, • Resilience, • Optimism, • A positive self-image, and • A sense of satisfaction that his/her fundamental needs are being met.

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

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

7c. **PREPARATION FOR ADULTHOOD**: Degree to which the youth [according to age and ability] is: (1) meeting academic requirements for annual promotion and course completion leading to a high school diploma or equivalent; (2) gaining life skills, developing relationships and connections, and building capacities for living safely, becoming gainfully employed, and functioning successfully upon becoming independent of child services; - OR - (3) becoming eligible for adult services and with the adult system being ready to provide (without waiting or disruption) continuing care, treatment, and residential services that the youth will require upon discharge from services.

8. **FAMILY FUNCTIONING & RESOURCEFULNESS**: Degree to which the parents [with whom the child is currently residing or has a goal of reunification]: • Have the capacity to take charge of family issues, enabling family members to live together safely and function successfully. • Are able to provide the child with the protection, assistance, supervi-

sion, and support necessary for daily living. • Take advantage of opportunities to develop and/or expand a network of social and safety supports in establishing and sustaining family functioning and well-being.

9. **CAREGIVER FUNCTIONING:** Degree to which: • The substitute caregivers, with whom the child is currently residing, are willing and able to provide the child with the assistance, protection, supervision, and support necessary for daily living. • If any added supports are required in the home to meet the needs of the child and assist the caregiver, the supports are meeting the needs.

10. **FAMILY CONNECTIONS:** Degree to which family connections are maintained through appropriate visits and other means when children and family members are living temporarily away from one another, unless compelling reasons exist for keeping them apart.

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

QSR Practice Performance Indicators

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

1. **ENGAGEMENT:** Degree to which those working with the focus child and family (parents and other caregivers) are: • Relating with the child/youth, biological family, extended family, primary caregiver, and other team members for the purpose of building a genuine, trusting and collaborative working relationship. • Identifying a support system and/or finding family members who can assist with support and permanency for the focus child. • Developing and maintaining a mutually beneficial trust-based working relationship with the child and family that involves having unconditional positive regard, respect for diversity, an inclusive planning process, and the ability to understand and work through resistance to participating in services. • Focusing on the child and family's strengths and needs. • Being receptive, dynamic, and willing to make adjustments in scheduling and meeting locations to accommodate family participation. • Offering transportation and childcare supports, where necessary, to increase family participation in planning and support efforts.

2. **VOICE & CHOICE:** Degree to which the focus child, parents (including the non-custodial parent), family members, and caregivers are active ongoing participants (e.g., having a significant role, voice, choice, and influence) in shaping decisions made about child and family strengths and needs, goals, supports, and services.

3. **TEAMWORK:** Degree to which: (1) The "right people" for this child and family have formed a working Child and Family Team that meets, talks, and plans together. (2) The CFT has the skills, family knowledge, and abilities necessary to define the strengths and needs of this child and family and to organize effective services for this child and family, given the level of complexity of circumstances and cultural background of the child and family. (3) Members of the child and family's team collectively function as a unified team in planning services and evaluating results. (4) The decisions and actions of the team reflect a coherent pattern of effective teamwork and collaborative problem solving that builds upon child and family strengths and needs to benefit the child and family.

4. **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. [Need, as used in this indicator, is based on the *Framework for Assessing and Responding to Needs* presented in the introductory section of the practice performance domain.]

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

6. **PLANNING:** Degree to which a well-informed, well-reasoned, family-centered, team-driven planning process is being used to direct strategies and resources for: (1) meeting near-term child and family needs; (2) achieving child safety, well-being, and permanency outcomes; and (3) supporting and sustaining the family or permanent caregiver.

7. **SUPPORTS & SERVICES:** Degree to which the strategies, supports, and services planned the child and family are available on a timely and adequate basis to meet near-term child and family needs and to achieve the outcomes planned.

8. **INTERVENTION ADEQUACY:** Degree to which planned 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 meet near-term needs and achieve outcomes that fulfill the long-term view.

9. **TRACKING AND 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.

These nine core practice indicators, drawn from the Core Practice Model, define the focus and scope of inquiry into case practice for a focus child and the child's parents and/or caregivers.

SUMMING-UP ACROSS INDICATORS WITHIN DOMAINS

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

TIMEFRAMES AND RATING SCALES

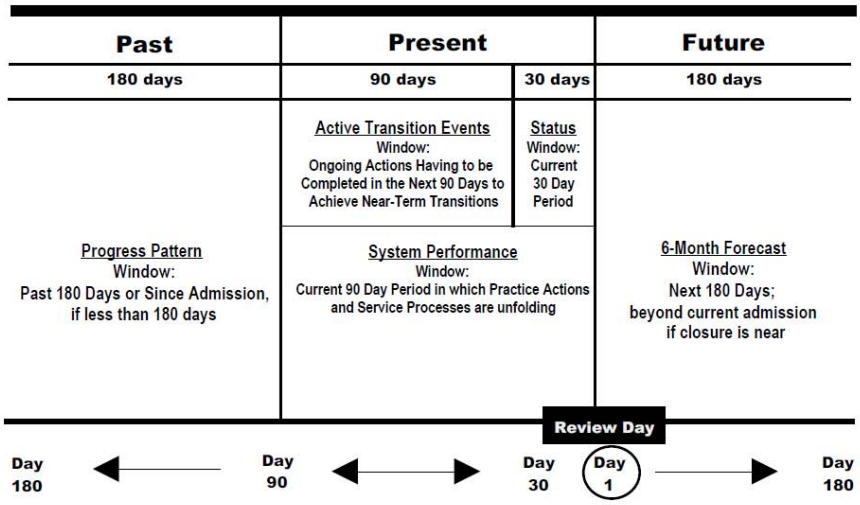
Timeframes for Review

Presented below is a display illustrating the timeframes used for rating indicators. QSR provides a point-in-time review that uses varying time parameters depending on the type of indicator being applied in a case review.

- The timeframe for *current status* indicators is generally 30 days unless stated otherwise in an indicator.
- The timeframe for reviewing *practice performance* is the past 90 days. These indicators focus on events that have already occurred recently and/or on recent processes that have been and are continuing to occur at the time of review.
- The *six-month prognosis* focuses on the near-term future looking forward 180 days from the time of the review.

The two displays presented on the next page illustrate and explain the logic of the 6-point rating scales used with the QSR indicators.

Timeframes of Interest in Case Reviews



APPENDIX 2

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.

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.

Improvement Zone: 1-2

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

2 = **POOR STATUS**. Status is and may continue to be poor and unacceptable. The 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..

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.

Improvement Zone: 1-2

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

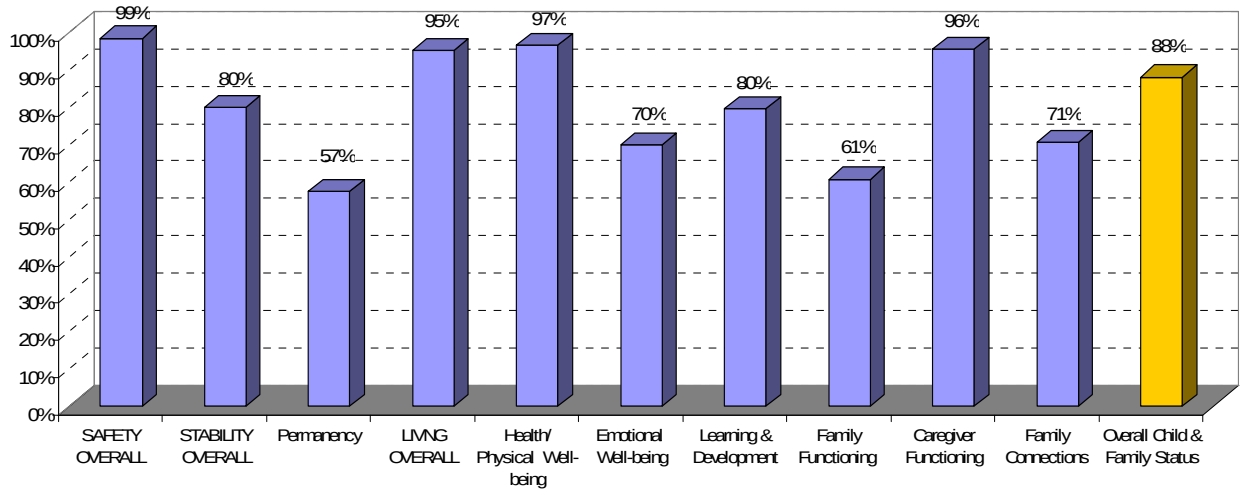
2 = **POOR PERFORMANCE**. Practice at this level is fragmented, inconsistent, lacking necessary intensity, or off-target. Elements of practice may be noted, but it is incomplete/not operative on a consistent basis.

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

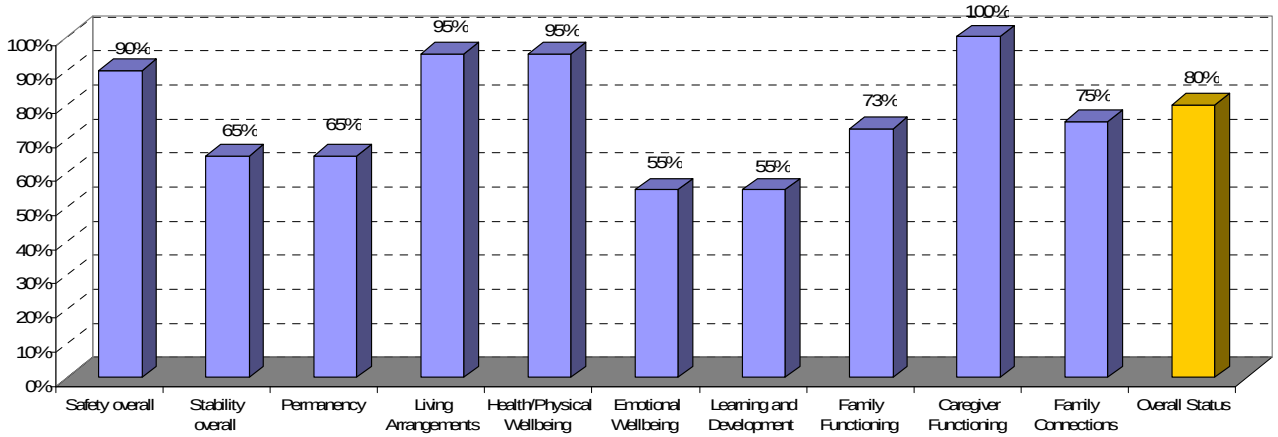
Unacceptable Range: 1-3

APPEDIX 3

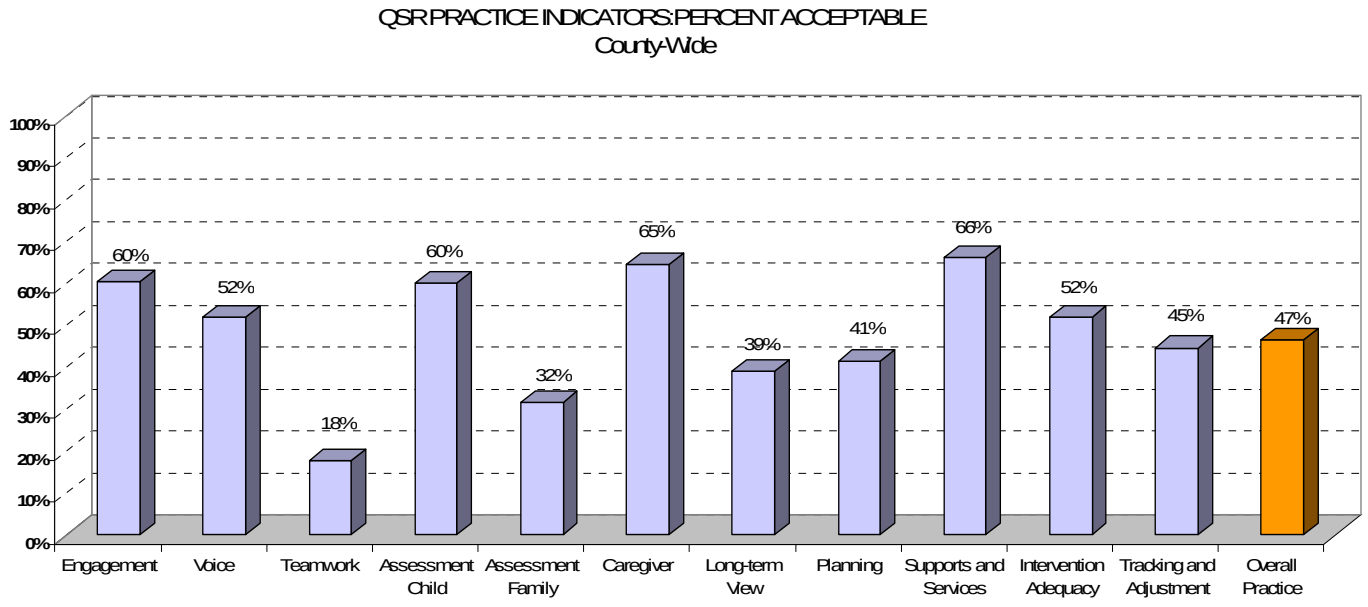
QSR STATUS INDICATORS PERCENT ACCEPTABLE : County-Wide

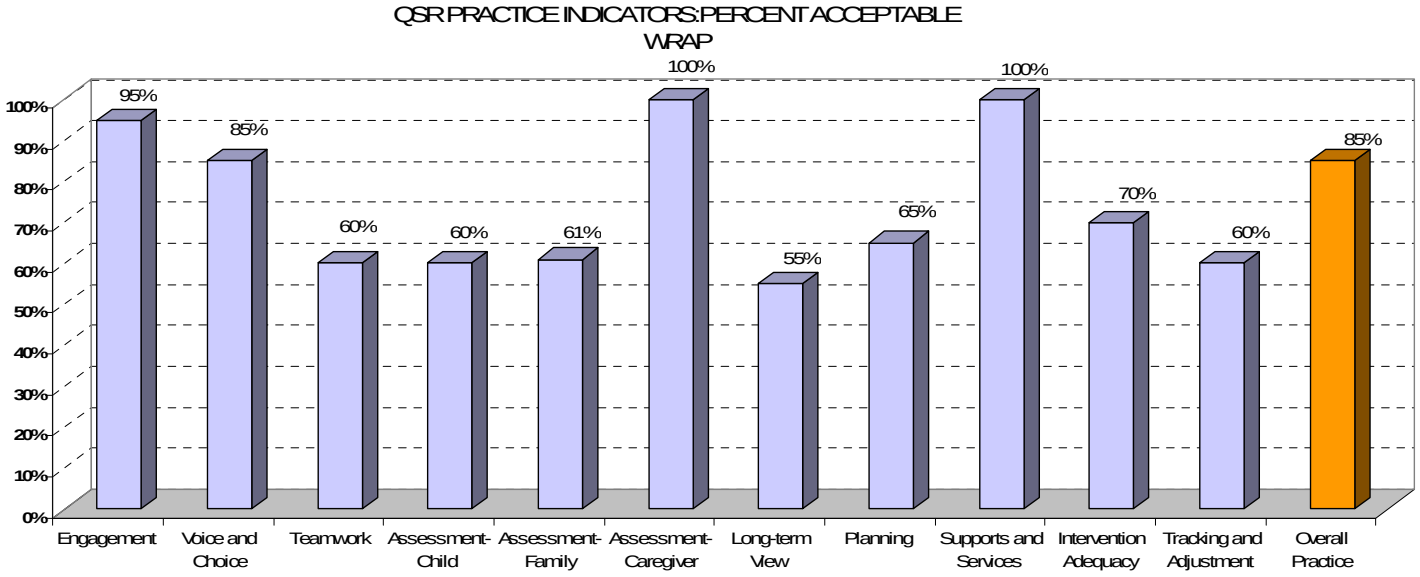


QSR STATUS INDICATORS PERCENT ACCEPTABLE : WRAP



APPENDIX 4


QSR PRACTICE INDICATORS: PERCENT ACCEPTABLE
County-Wide
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
52%
18%
60%
32%
65%
39%
41%
66%
52%
45%
47%
Engagement
Voice
Teamwork
Assessment Child
Assessment Family
Caregiver
Long-term View
Planning
Supports and Services
Intervention Adequacy
Tracking and Adjustment
Overall Practice


QSR PRACTICE INDICATORS: PERCENT ACCEPTABLE
WRAP
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
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95%
85%
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70%
60%
85%
Engagement
Voice and Choice
Teamwork
Assessment-Child
Assessment-Family
Assessment-Caregiver
Long-term View
Planning
Supports and Services
Intervention Adequacy
Tracking and Adjustment
Overall Practice