

Quality Services Review (QSR) Protocol for a Child and Family

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

FLORIDA
DEPARTMENT OF
CHILDREN & FAMILIES
Protocol for Use by
Community Based Care Lead
Agencies

OFFICE OF
FAMILY & COMMUNITY
SERVICES
Developed for Periodic
Qualitative Case Reviews of
Safety, Permanency, and
Well-Being Services Provided
to Children and Families

Acknowledgement:
This tool is based on a body of
work by Ray Foster, PhD and
Ivor Groves, PhD of Human
Systems and Outcome, Inc.,
Tallahassee, Florida



Findings from Quality Services Review (QSR) results should be combined with existing quantitative data in order to provide meaning to the regularly reviewed performance data. Simply stated, data speaks, but "stories" teach.



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

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 a 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 Human Systems and Outcome, Inc., Tallahassee, Florida.**

FLORIDA DESIGN TEAM PARTICIPANTS

Listed below are the persons who served as members of the Design Team that contributed to this first working version of the Quality Service Review Protocol developed for the Florida Department of Children and Families. Members participated in a two-day design session in February 2011 that resulted in the protocol design that was technically reviewed, revised, pilot tested, refined, and used for measurement of practice performance beginning in FY 2011/2012. Knowledge gained from the QSR process will be used for the positive purposes of practice development and capacity building necessary for improving the quality of practice to achieve better results and outcomes for the children and families receiving services. Persons who participated in the design activities were:

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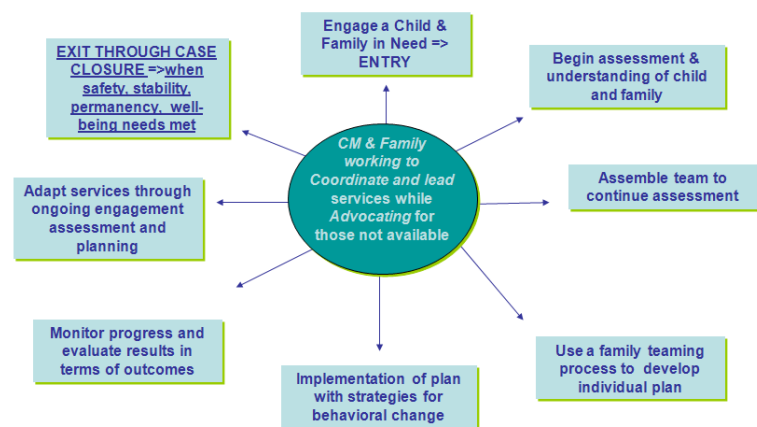
Chapter 1 Introduction

The goal of child welfare is to promote, safeguard and protect the overall well-being of children and families, to intervene on behalf of children who have been abused or neglected, and to work with children and families to assure that every child has a permanent, safe, and nurturing environment in which to achieve their maximum potential. Quality Assurance (QA) and Continuous Quality Improvement (CQI) activities are vital to ensuring case workers carry out the Department's mission to ensure the safety, well-being, and self-sufficiency of the people served.

The Florida child welfare system has adopted a practice framework that encompasses the range of the major aspects and activities of child welfare practice and service delivery. Core practice functions include: engaging families and assembling families' individual teams; assessing children and families strengths and needs; collaboratively developing and implementing case plans; involving and supporting parents and caregivers in decision making; and monitoring and modifying services. The following diagram highlights the relationship between core practice functions. Ultimately, these core practice functions, and the many initiatives, strategies, steps, interventions, approaches and activities within them, are intended to

drive the service delivery process to achieve the outcomes of ensuring child safety, strengthening family functioning, achieve permanency for children, and meet the children and families well-being needs.

A Practice Model Framework: And the Competencies Related to These Core Functions



The Quality Service Review (QSR) is a powerful self-evaluation tool, helping child welfare and social services agencies assess the effectiveness of their practices and the interventions provided to the families they serve. It helps agencies learn how families are doing and which service functions are working. Because the QSRs are directly tied to the core components of individualized practice - engagement, assessment, planning, implementation, and results - each QSR measures the degree to which true individualized and participatory practice is occurring with each individual family being reviewed.

During the QSR, a trained review team reads case documentation and interviews all parties involved in the case, most importantly the family, to qualitatively assess two broad categories - family status and system performance/case work practice. Within these two categories there are specific areas of interest including child safety, stability and parent/caregiver functioning, engagement, and teaming.

These intensive reviews usually occur in a short time frame to get a "snapshot" of how the family and practice supporting them are doing. Once the review is completed, a debriefing is held with the supervisor and workers to give feedback and recommendations about the case. In addition, themes, strengths, and areas of improvement are shared with the partnership's governing body and/or self-evaluation work group. Finally, the review team writes a "family story" to document what is going well with the family and service delivery and practical steps for improving what is not going well. These stories can be aggregated for content analysis and be an excellent strategy for putting standing data reports in the Florida Safe Families Network (FSFN) into context.

The QSR is intended to be a useful tool for practice improvement, not a "gotcha" or something that goes "on the shelf." Quality Service Reviews are a robust supplement - not replacement - to the quantitative data historically used by administrators and supervisors to determine how their local systems of care are functioning. Community-based care agencies should use the reviews in combination with other data to get a baseline measurement of practice and regularly complete QSRs to track progress and determine what training, local partnerships, and resources are needed for practice development.

The QSR process includes the following elements:

1. Intensive training of QSR reviewers;
2. Pre-review planning and preparation;
3. Conducting the QSR review with a focus on interviews of key case participants;
4. Determining the overall ratings;
5. Case worker / supervisor debriefing;
6. Grand Rounds Presentation; and
7. Written Case Summary.

The federal Administration for Children and Families requires states to develop and implement Child and Family Services Plans (CFSP) in order to receive federal funds under Title IV-B and other funding sources. As part of the CFSP, each state must describe their quality assurance system and report on how they will continually improve child welfare practices. State-level quality assurance systems are monitored through the federal Child and Family Services Review (CFSR) process. Florida's Quality Assurance (QA) system is tailored to specifically address state and local needs while also fulfilling the federal requirements.

This handbook provides procedural direction for Florida Quality Service Reviews (QSR). To ensure fidelity of the review, the process and ratings must be applied consistently. Data and information collected will provide local administrations a "window into practice" in real-time, and help focus quality improvement efforts at the local and state level.

Guiding Principles

1. Unified Purpose

Child welfare agencies primary responsibilities are to prevent child maltreatment, promote child and family well being, and aid and prepare teens in becoming constructive members of their communities.

2. Urgency of Child's Needs

Child welfare agency practice will be driven by a sense of urgency related to each child's unique needs for safety, permanence, stability, and well being.

3. Individualized Planning for permanency

Child welfare agencies will provide flexible, intensive, and individualized services to children and families in order to preserve, reunify, or create families.

4. Family-Centered Casework and Case Planning

Child welfare agencies will utilize a family-centered, case-planning model that encourages, respects, and incorporates input from the children and families it serves.

5. Systemic Continuity of Care

Child welfare agencies will work with communities, organizations, and institutions to build and maintain a seamless and effective system of service delivery that produces measurable, positive outcomes for children and families.

6. Constructive Organizational Culture

Child welfare agencies will model a constructive organizational culture that is culturally competent and will attract and sustain qualified, trained and competent staff.

7. Equal Access to Services

Child welfare agencies will provide the best available and appropriate services to all children in care without regard to age, race, religion, gender, disability, sexual orientation, or legal classification.

8. Reduction of Trauma to Child

Child welfare agencies will strive to recognize and minimize the trauma children experience while in the Department's care.

9. Best Interests of Child as Paramount

Child welfare agencies will consider the totality of circumstances to make decisions that are in the best interests of each child and will not apply any single principle or standard of practice that will result in a negative outcome for the child.

Chapter 2

Implementation of QSR Requirements

The in-depth case review findings from Quality Services Review (QSR) results should be combined with existing quantitative data (e.g. - FSN production reports) in order to provide meaning to the regularly reviewed performance data. Simply stated, data speaks, but "stories" teach. QSR results are not intended to be generalizable to all open cases, but rather to learn and understand themes and patterns that may not be readily identified from regularly produced data on all open cases. For example, placement stability data may tell us that 50% of children in foster care experience 2 or more placement changes within a year, but it is the individual QSR story of the one youth, who had five placement changes in a year and the subsequent impact on him/her, that teaches us about the implications for our child welfare practice. That one youth, whose #is part of the 50%, offers us meaning and insight that we may not have known by only looking at a "Dashboard" measure.

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

- **Status indicators** measure the extent to which certain desired conditions are present in the life of the child and the child’s parents and/or caregivers within a recent time frame. 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 capacities). Changes in status for a recent timeframe represent near-term outcomes at a given point in the life of a case.
- **Practice indicators** measure the extent to which *core practice functions* are applied successfully by practitioners and others who serve as members of the child and family team. The core practice functions measured 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.

The following table lists the Status and Practice Indicators used in the Florida QSR Model.

Child and Parent Status indicators	Practice Performance indicators
1. Safety from Exposure to Threats of Harm	20. Engagement Efforts
2. Child Vulnerability	21. Voice and Choice
3. Stability	22. Teaming
4. Living Arrangement	23. Assessing and Understanding
5. Permanency	24. Planning for Safe Case Closure
6. Physical and Dental Health	25. Planning Transitions and Life Adjustments
7. Emotional Well-being	26. Implementation
8. Early Learning and Development	27. Maintaining Quality Connections
9. Academic Status	28. Evaluating and Adjusting
10. Pathway to Independence	29. Psychotropic Medication Management
11. Parenting and Caregiver Functioning	
12-19 Reserved for later use	

Reviewer Training

To assure reviews and subsequent data collection are consistent, and to foster inter-rater reliability, all staff who conduct quality assurance reviews must be trained as a QSR reviewer. This requires reviewers participate in a specialized training curriculum within six months of being appointed into a dedicated QA position. Prior to training, staff should shadow QSRs.

Florida Quality Service Review
 Protocols for Child Welfare Case Management Reviews

The training is facilitated by the Office of Family and Community Services on a quarterly basis. Notices of upcoming training sessions and registration are posted in advance of each session on the Center for the Advancement of Child Welfare Practice, Quality Assurance web site.

Quarterly Review Sample Sizes

Community-based care (CBC) agencies must conduct In-depth QSRs on a minimum of cases each quarter using the QSR protocols and web based tool established by the Department. The QSR process will focus on child welfare practices involving ongoing cases. The review will appraise: the current status of a child in key life areas; the status of the parent/caregiver; and the performance of key system of care practices for the same child and family. The QSR protocol examines recent results for children receiving services and their caregivers as well as the contribution made by local service providers and the system of care in producing those results.

Quality Services Reviews per Quarter						
CBC	In-Home	Out-of-Home	Total	QSR Reviews	Children Served	QSR Reviews per Quarter
St. Johns County Commission	26	162	188	3	0-500	3
Kids First of Florida Inc	123	162	285	3	501-1000	4
CBC of Seminole	163	290	453	3	1001-1500	5
CBC of Brevard	342	432	774	4	1501-2000	6
YMCA South	225	863	1088	5	2001-2500	7
Partnership for Strong Families	493	623	1116	5	2501+	8
Child and Family Connections	314	803	1117	5		
United for Families	558	677	1235	5		
Children's Network of SW Florida	437	837	1274	5		
Community Partnership for Children	349	944	1293	5		
Big Bend CBC East/West	748	673	1421	5		
Kids Central, Inc.	528	976	1504	6		
Family Support Services	727	924	1651	6		
Heartland for Children Inc	756	1128	1884	6		
ChildNet Inc.	488	1492	1980	6		
CBC of Central Florida	1077	1382	2459	7		
Families First Network	1345	1119	2464	7		
Hillsborough KIDS, Inc.	659	1862	2521	8		
Eckerd Youth Alternatives Inc	1074	1793	2867	8		
Our Kids Inc	1471	1745	3216	8		
Total	11903	18887	30790	110		

As of 6/16/2011 per FSN Report "Children and Young Adults Active by Primary Worker"

Sampling Methodology

Each quarter, the Office of Family and Community Services will provide an extract for each CBC that lists all children who are eligible to be reviewed stratified by case management organization. The extract will be pulled the first week of the month that precedes the beginning of a new quarter. The extract will consist of all children who are open to ongoing services at the time of the query. All children will be assigned to a CBC's sampling population based on the CBC assignment of the primary worker as of the query date.

Once the sample is stratified by case management organization, the CBC will have the ability to further stratify by in home and out-of home or by permanency goal. In order to achieve this, the sample will not be a simple random sample from the entire extract. A purposive sample selection methodology will be used.

Decisions made to discard a randomly selected case from the review sample list must be approved by the CBC QA manager, who must also document the basis for the decision as it relates to the discard criteria. CBC QA managers must track the cases reviewed from quarter to quarter, discarding duplicate cases from subsequent samples. Children that meet any of the following criteria should be dropped from the sample population and the next random order child considered for replacement in the final master list of eight cases:

- a) Discard if the child has already been selected for review in this quarter.
- b) Discard if the child was in a case that was reviewed in any of the prior three (3) quarters.
- c) Discard if the child is on runaway status.
- d) Discard any sibling of a child included in the current sample OR in a case reviewed in any of the prior three (3) quarters.
- e) Discard if the child is in a case open only for continued adoption subsidy payments.
- f) Discard if child is in a case where Florida is on the receiving side of Interstate Compact placement.
- g) Discard additional cases assigned to the same caseworker.

Note: The following are specifically INCLUDED in the sample and do not constitute grounds for discard and replacement:

- Cases under courtesy supervision will be INCLUDED in the sample population and assigned to the CBC of the primary worker.
- Cases under in-home supervision and in out-of-home placements are INCLUDED in the sample population, and assigned to the CBC of the primary worker.
- Cases where Florida is the sending state on an Interstate Compact placement.

Assigning Cases and Review Preparation

The CBC QA manager will assign cases for review to trained QA specialists employed by the CBC. If the CBC uses staff from sub-contracted providers, the sub-contracted provider staff must be trained and must not review a case from his/her own agency. Additionally, if sub-contracted providers conduct reviews under this system, the CBC QA manager must carefully review their findings to ensure inter-rater reliability. CBCs are strongly encouraged to invite judges, GALs, and other community partners to shadow the reviews. Shadowing is a wonderful strategy to educate stakeholders about the child welfare system.

Reviews will be conducted in teams of two trained reviewers. The team must identify a team lead and determine each member's role and responsibility in preparing for the reviews. This includes:

- Identifying interviewees,
- Scheduling dates and time for the joint file review,
- Scheduling interviews with case participants, including directions to the different locales,
- Arranging for the debriefing with staff after the review is completed, and
- Writing the case review summary.

In addition, the team lead will work directly with the liaison from the CBC Lead Agency or the Case Management Organization (CMO) to obtain a signed Authorization to Release Information from the parent(s) or guardian as needed. A limited file review will be conducted prior to interviews, but reviewers may find it necessary to refer back to the file throughout the process. Becoming familiar with the circumstances of the case through a review of the record will enable the reviewer to explore pertinent issues with the person being interviewed. At a minimum, the team lead must ensure that the file review process includes a review of the following documents:

- Assessment of Safety/Risks/Needs,
- Recent contact case notes;
- Case Plans/Child and Family Team Meeting Documents,
- Court Reports, Judicial Review Reports,
- Evaluations such as the Comprehensive Behavioral Health Assessment, Child Protection Team Assessments, etc.

Case Interviews

Interviews should be conducted face-to-face. The identified team lead is usually the one responsible for interviewing the individuals involved in the case. A minimum of five people should be interviewed for each case. It is highly recommended that the first interview be conducted with the case manager and the supervisor. Interviewees should include the following, unless the individual is unavailable or completely unwilling to be interviewed and/or seen:

- The case manager and the supervisor,
- Any major service providers involved with the child or family. (e.g., therapist, OT, PT, nurse, etc. Where there are numerous service providers involved with a family, it may only be necessary to schedule interviews with those most recently involved, those most knowledgeable of the family, or those representing the primary services the family is receiving.),
- The Guardian ad litem,
- The school teacher or day care provider,
- The child (must always be seen and if age appropriate, interviewed),
- The child's parent(s),
- The child's foster parent(s) if the child is in foster care, and
- A member of the child and family's team.

If any of the above parties cannot be interviewed, the reason must be documented in the case review instrument. As needed on a case-by-case basis, other individuals who have relevant information on the case may also be interviewed, such as an advocate or mentor, other family members, or a member of the medical community.

Although all children must be seen, they must also be interviewed when age and developmentally appropriate. A preschool-age child may just be observed by the reviewer. Persons to be interviewed should be prepared in advance by the review team leader (or designee) so they understand the purpose of the interview. They should be assured that their participation is voluntary, but critical to the success of the review.

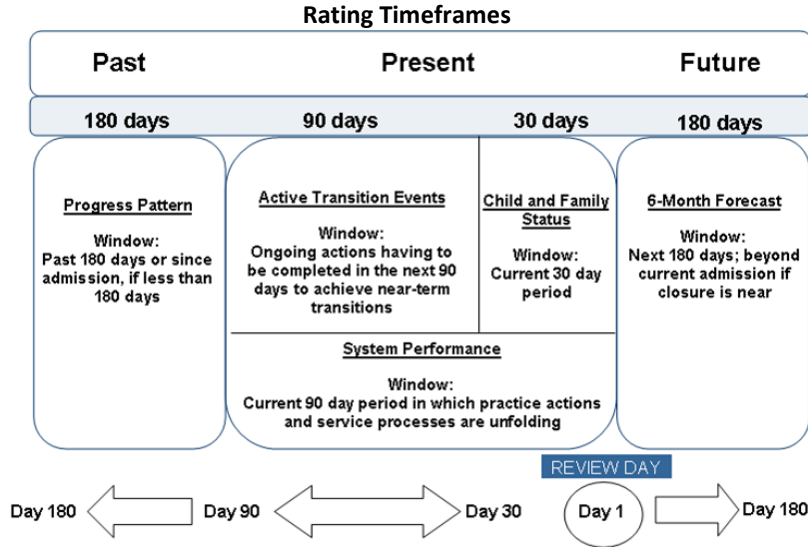
If possible, interviews should be conducted where the persons to be interviewed are located, e.g., in the foster home or in the family's home. Where travel arrangements, time needed to travel to a location or preference of the persons to be interviewed does not permit interviews to be conducted outside the office, the review team leader may arrange an alternate location. Telephone interviews may be arranged for individuals who are located outside of the local review site. Review team leads should limit the interviews to one hour per interview and allow for time between interviews for any necessary travel to the appointments. Maps or other written directions to the interview sites should be prepared in advance and be provided to the reviewer.

Overall Ratings for the Status & Practice Indicators

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

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

The general timeframes for rating indicators is 4 = when sustained for 30 days, 5 = when sustained for 90 days, and 6 = when sustained for 180 days to reflect the durability of status conditions or practice performance over time. [Three status indicators have alternative rating times that differ from the 30-90-180 day pattern.] These time parameters help reviewers clearly and consistently define conditions necessary for a particular rating value. Greater clarity in rating values increases inter-rater reliability.



Rating the Child & Family Status

General guidance is provided to assist reviewers when selecting one of six possible rating categories for reporting the Overall Rating for the Status Section for the child being reviewed. This rating provides an answer to the question: *Overall, how well is the child and family/caregiver doing at the time of the review?* Selecting the Overall Status Rating category is based on the aggregate pattern found for the applicable status indicators in a case. The aggregate pattern is taken into account by the reviewer after assuring that the child is **SAFE** -- that is, having ratings of 4 or higher for all applicable settings on Status Indicator 1: Safety from Exposure to Threats of Harm to Self and Others and Status Indicator 2: Child Vulnerability.

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

- **6 - Optimal Status.** At level 6, the child is SAFE. The preponderance of applicable indicator ratings in the status domain are rated 6. All status ratings for the child are in the 4-6 range.
- **5 - Good Status.** At level 5, the child is SAFE. The preponderance of applicable indicator ratings in the status domain is rated in the 5-6 range. No status indicator is rated lower than 3.
- **4 - Fair Status.** At level 4, the child is SAFE. The preponderance of applicable indicator ratings in the status domain is rated in the 4-5 range. No status indicator is rated lower than 2.
- **3 - Marginal Status.** At level 3, the child may have some occasional safety concerns of a mild nature and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 3-4 range.
- **2 - Poor Status.** At level 2, the child may have some significant safety concerns and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 2-3 range.
- **1 - Adverse and Worsening Status.** At level 1, the child and/or family situation may pose serious and worsening safety threats and/or the preponderance of applicable indicator ratings in the status domain may be rated in the 1-2 range.

The reviewer uses the rating patterns to determine the rating category above that best describes the overall status situation observed at the time of review.

Rating Practice

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

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

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

- **6 - Optimal Practice.** At level 6, the preponderance of applicable indicator ratings in the practice domain are rated 6. All practice ratings for the child are in the 4-6 range.
- **5 - Good Practice.** At level 5, the preponderance of applicable indicator ratings in the practice domain are rated in the 5-6 range. No practice indicator is rated lower than 3.
- **4 - Fair Practice.** At level 4, the preponderance of applicable indicator ratings in the practice domain are rated in the 4-5 range. No practice indicator for the child is rated lower than 2.
- **3 - Marginal Practice.** At level 3, the preponderance of applicable indicator ratings in the practice domain may be rated in the 3-4 range for the child. Some indicators may be rated in the 1-2 range.
- **2 - Poor Practice.** At level 2, the preponderance of applicable indicator ratings in the practice domain may be rated in the 2-3 range for the child. Many indicators may be rated in the 1-2 range.
- **1 - Absent or Adverse Practice.** At level 1, the preponderance of applicable indicator ratings in the practice domain may be rated in the 1-2 range for the child with many falling into the 1 rating.

Interpretive Guide Rating Key

The following graphic provides guidance for Indicator rating domains. A rating of 5-6 means status is favorable and efforts should be made to maintain and build upon a positive situation. A rating of 3-4 means the status is minimal or marginal and further efforts are needed to refine the situation. A rating of 1-2 means the performance is poor and quick action is needed to improve the situation. The blue line denotes the range where practice is unacceptable. The green zone is acceptable, the yellow zone is cautionary with refinements needed, and the red zone means improvement is needed.

Interpretative Guide for Status Indicator Ratings		
<p>Maintenance Zone: 5 - 6</p> <p>Status is favorable. Efforts should be made to maintain and build upon a positive situation.</p>	<p>6 = OPTIMAL STATUS. The best or most favorable status presently attainable for this person in this area (taking age and ability into account). The person doing great! Confidence is high that <u>long-term needs or outcomes will be or are being met</u> in this area. (6 month sustained pattern or since admission if < 6 months)</p> <p>5 = GOOD STATUS. Substantially and dependably positive status for the person in this area with an <u>on-going positive pattern</u>. This status level is <u>consistent with attainment of long-term needs or outcomes</u> in area. Status is "looking good" and likely to continue. (3 month sustained pattern or since admission if < 3 months)</p>	<p>Acceptable Range: 4 - 6</p>
<p>Refinement Zone: 3 - 4</p> <p>Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.</p>	<p>4 = FAIR STATUS. Status is minimally or <u>temporarily sufficient</u> for the person to <u>meet short-term needs or objectives</u> in this area. Status has been no less than <u>minimally adequate</u> at any time in the past 30 days, but may be short-term due to changing circumstances, requiring change soon. (30 days adequate status)</p> <p>3 = MARGINAL STATUS. Status is <u>mixed, limited or inconsistent</u> and <u>not quite sufficient to meet the person's short-term needs or objectives</u> 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.</p>	
<p>Improvement Zone: 1 - 2</p> <p>Status is problematic or risky. Quick action should be taken to improve the situation.</p>	<p>2 = POOR STATUS. Status is and may continue to be <u>poor and unacceptable</u>. The person may seem to be "stuck" or "lost" with <u>status not improving</u>. Any risks may be mild to serious.</p> <p>1 = ADVERSE STATUS. The person's status in this area is <u>poor and worsening</u>. <u>Any risks of harm</u>, restriction, separation, regression and/or other poor outcomes <u>may be substantial and increasing</u>.</p>	<p>Unacceptable Range: 1 - 3</p>
Interpretative Guide for Practice Indicator Ratings		
<p>Maintenance Zone: 5 - 6</p> <p>Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.</p>	<p>6 = OPTIMAL PERFORMANCE. <u>Excellent consistent effective practice</u> for this function area. This level of performance is indicative of <u>exemplary practice and results</u> for the person. (6 month pattern or since admission if less)</p> <p>5 = GOOD PERFORMANCE. At this level, the system function is <u>working dependably</u> for this person, under changing conditions and over time. Effectiveness level is <u>consistent with meeting long-term needs and goals</u> for the person. (3 month sustained pattern or since admission if less than 3 months)</p>	<p>Acceptable Range: 4 - 6</p>
<p>Refinement Zone: 3 - 4</p> <p>Performance is minimal or marginal and maybe changing. Further efforts are necessary to refine the situation.</p>	<p>4 = FAIR PERFORMANCE. This level of performance is <u>minimally or temporarily sufficient to meet short-term need or objectives</u>. Performance may be time-limited, somewhat variable, or require adjustment soon due to changing circumstances. (30+ day continuing pattern. Some refinement is indicated).</p> <p>3 = MARGINAL PERFORMANCE. Practice at this level may be <u>under-powered, inconsistent or not well-maintained to need</u>. Performance is <u>insufficient for the person to meet short-term needs or objectives</u>. (With refinement, this could become acceptable in the near future).</p>	
<p>Improvement Zone: 1 - 2</p> <p>Performance is inadequate. Quick action should be taken to improve practice now.</p>	<p>2 = POOR PERFORMANCE. Practice at this level is <u>fragmented, inconsistent, lacking necessary intensity, or off-target</u>. Elements of practice may be noted, but it is <u>incomplete/not operative on a consistent basis</u>.</p> <p>1 = ADVERSE PERFORMANCE. Practice may be <u>absent or not operative</u>. Performance may be <u>missing (not done)</u> - OR - practice strategies, if occurring in this area, may be <u>contra-indicated</u> or <u>may be performed inappropriately or harmfully</u>.</p>	<p>Unacceptable Range: 1 - 3</p>

The reviewer uses the rating patterns and ranges noted on the complete Roll-Up Sheet for the child to determine the rating category above that best describes the overall case practice situation observed.

Compelling Reasons for Giving an Alternative Section Rating

The patterns of aggregate ratings suggested to guide a reviewer to overall status and practice ratings are meant to be used under general conditions. If, in the course of a review, the reviewer finds a rare and complex situation that, by its unusual nature, strongly points to a different rating interpretation, the reviewer should present the evidence and compelling reasons that a higher or lower domain rating should be given. The presentation of evidence and compelling reasons should be made to the review team and team leader. If the team concurs with the reviewer's recommendation and if the leader so directs, the reviewer may report a rating that fairly fits the situation found although it departs from the rating guidance offered above.

Rating Rationale

At the end of each indicator there are additional data points that will be captured as a "Strength", "Gap", or "NA". This information should be used to help guide decisions on the overall rating of the indicator. In addition, it will provide information to help direct system improvements.

Differences between Ratings 3 and 4

- A rating of 3 is close, but not presently acceptable
- A rating of 4 is minimally acceptable right now
- A 3 is not adequate for the child to do well now or in the near term future
- A 3 may show some positive indications but now falls short of a desired result or adequate function
- Under favorable conditions a 3 could become a 4 later
- A 4 is just enough for the child to do OK now and in the near term future
- A 4 requires evidence of acceptance status/results or of adequate functioning related to acceptable present results
- "Groundhog Day" Rule: If this case were frozen in time as it is today, would it be acceptable?

QSR Web Tool

The QSR web-based tool is built on case work processes that impact the child and family status and practice. Some indicators have sub-parts termed "rating rationales" that are "counted" as a means to identify discrete areas of performance. The status or practice indicator receives the numerical rating. Ratings are achieved through reflective, qualitative, and critical thinking, including the reviewer's professional judgment.

Six-Month Forecast

Forecasting the Trajectory of the Child's Expected Future Course

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

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

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

Six-Month Forecast
Based on the child's current overall status , recent progress, the current level of overall practice performance , and events expected to occur over the next six months , is this child's overall status expected to maintain at a high level, improve to a higher level, remain about the same, decline over the next six months, or remain at low level six months from now? (check only one)
<input type="checkbox"/> MAINTAIN at a CURRENTLY HIGH STATUS LEVEL (5-6 range)
<input type="checkbox"/> IMPROVE to a level HIGHER than the current overall status
<input type="checkbox"/> CONTINUE at the SAME STATUS LEVEL — status quo
<input type="checkbox"/> DECLINE to a level LOWER than the current overall status
<input type="checkbox"/> REMAIN at a CURRENTLY LOW STATUS LEVEL (1-2 range)

Requests for Action

During the course of a case review a CBC QA reviewer may find reasons for concern related to child safety or well-being. If so, the reviewer must immediately complete a Request for Action (RFA) clearly articulating the reasons for concern and provide the document to either the team lead or the liaison of the agency under review. CBC QA managers of staff generating the RFA must track the RFA progress to its satisfactory conclusion. This may involve several iterations if the initially reported resolution is not deemed sufficient or other issues have surfaced. In addition, the RFA must be documented in FSFN.

Case Manager/Supervisor Debriefing (Chapter 6)

Once the review has been completed the team will conduct a debriefing with the case manager, supervisor and others as deemed appropriate. The debriefing is intended to tell-the-story about the child and family as learned from the file review and all of the interviews; and to discuss or clarify any gaps or address any additional questions. The debriefing also includes an opportunity to discuss what may be the most appropriate next steps to take in

working with the family from the family's perspective, the case manager's perspective, and from the reviewers' perspectives. The debriefing, at a minimum, should include information as to the strengths of the child and family and practice as well as the challenges. A template for a "debriefing" is included in Chapter 6. This template provides suggested content and discussion timeframes.

Written Case Review Summary (Chapter 6)

The final step in completing the QSR is writing the case review summary. The summary includes some basic demographics and facts about the child and family. The core of the summary describes the child's and caregiver's status, factors contributing to favorable or unfavorable statuses, to include some analysis of what's working now and why as well as some practical steps to sustain success or overcome problems. The summary should be 2-4 pages in length and read like an assessment document. A template is included in Chapter 6.

Chapter 3

Family Centered Practice and Summary of Indicators Measured in the QSR Process

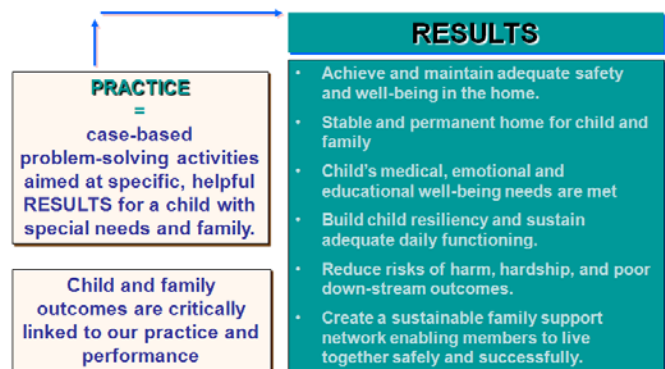
Family-centered practice is a way of working with families in Florida's child welfare system across service systems to enhance their capacity to care for and protect their children. It focuses on the needs and welfare of children within the context of their families and communities. Family-centered practice recognizes the strengths of family relationships and builds on these strengths to achieve optimal outcomes.

- Family centered practices focuses on the family as a whole, and not just the individual child, and sees the family in the context of their own culture, networks and community. Families are seen as partners in the change process, helping to define problems and identifying solutions through the strengths in their own stories.
- Children and their families are actively engaged and involved in the assessment, planning, delivery and coordination of services when it is safe and in the best interest of the child for his/her family to do so.

The Quality Service Review (QSR) Protocol provides reviewers with a specific set of qualitative 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 Florida's

child welfare practice model. The indicators are divided into two distinct domains: *status indicators* and *practice performance indicators*. A basic assumption in the protocol is that services should be family centered, individually determined, strengths-based, and focused on behavior changes and team delivery.

Reflecting on the link between practice and performance...



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Child & Caregiver Status Indicators

This version of the QSR Protocol provides nine possible qualitative indicators for measuring the current status of a child and the child's parent and/or caregiver. Status is determined for a recent time period. A status measure represents 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. Listed below are the primary areas of focus for each of the QSR indicators.

1. **SAFETY - From Exposure to Threats of Harm:** Degree to which:
 - The child is free of abuse, neglect, and exploitation by others in his/her place of residence, school, and other daily settings.
 - The child's parents and/or caregivers provide the attention, actions, and supports necessary to protect the child from known threats of harm in the home and in other settings.
2. **SAFETY - Child Vulnerability:** Degree to which the child:
 - The child does not have inherent factors of vulnerability
 - Is able to avoid self-endangerment.
 - Is able to refrain from using behaviors that may put others at risk of harm.
3. **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]*

4. **LIVING ARRANGEMENT:** Degree to which: • Consistent with age and ability, the child is living in the most appropriate/least restrictive living arrangement, consistent with needs of the child for family relationships, assistance with any special needs, social connections, education, and positive peer group affiliation. • [If the child is in temporary out-of-home care] the living arrangement meets the child's needs to be connected to his/her language and culture, community, faith, extended family, tribe, social activities, and peer group.
5. **PERMANENCY:** Degree to which: • Those involved (child, parents, caregivers, others) have confidence that the child is living with parents or other caregivers who will remain in this role until the child reaches adulthood and will continue onward to provide enduring family connections and supports in adulthood.
6. **PHYSICAL & DENTAL HEALTH:** Degree to which: • The child is achieving and maintaining positive health and dental status. • And, if the child has a serious or chronic physical condition, the child is achieving his/her best attainable health status given the diagnosis and prognosis.
7. **EMOTIONAL WELL-BEING:** Degree to which: • Consistent with age and ability, the child is displaying an adequate pattern of: • Attachment and positive social relationships, • Coping and adapting skills, • Appropriate self-management of emotions and behaviors.
8. **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 the age of 6 years]*
9. **ACADEMIC STATUS:** Degree to which: • The child [according to age and ability] is: • regularly attending school, • placed in a grade level consistent with age or developmental level, actively engaged in instructional activities, reading at grade level or IEP expectation level, and • meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent. *[For a child age 6 years or older]*
10. **PATHWAY TO INDEPENDENCE:** Degree to which the child [according to age and ability] is: • Gaining skills, education, work experience, connections, relationships, income, housing, and necessary capacities for living safely and functioning successfully independent of agency services, as appropriate to age and ability. • Developing long-term connections and informal supports that will support him/her into adulthood. *[For a child age 13 years or older and in foster care]*
11. **PARENT & CAREGIVER FUNCTIONING:** Degree to which: • The parent or caregiver, with whom the child is currently residing and/or has a goal of permanency, is able to provide the child with the assistance, protection, supervision, and support necessary for healing from trauma and/or achieving emotional well-being. • If added supports are required in the home to meet the needs of the child and assist the parent or caregiver, the added supports are meeting the needs.

Practice Performance Indicators

This version of the QSR Protocol provides qualitative indicators for measuring certain core practice functions being provided with and for the child and the child's parents and/or caregivers. Practice performance is determined for a recent time period.

20. **ENGAGEMENT:** Degree to which those working with the child and family (parents or other caregivers) are: • Developing and maintaining a culturally competent, mutually beneficial trust-based working relationship with the child and family. • Focusing on the child and family's strengths and needs. • Sensitive and responsive to traumas experienced by the child and family. • Engaging children in a developmentally appropriate manner. • Being receptive, dynamic, and willing to make adjustments in scheduling and meeting locations to accommodate family participation in the service process, including case planning. • Offering transportation and child care supports, where necessary, to increase family participation in planning and support efforts.

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21. **VOICE & CHOICE:** Degree to which:
 - The child, parents, 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.
22. **TEAMING:** Degree to which:
 - Appropriate family members and providers have been identified and formed into a working team that shares a common “big picture” understanding and long-term view of the child and family.
 - Team members have sufficient craft knowledge, skills, and cultural awareness to work effectively with this child and family.
 - Members of the family team have a pattern of working effectively together to share information, plan, provide, and evaluate services for the child and family.
23. **ASSESSMENT & UNDERSTANDING:** Degree to which those involved with the child and family understand:
 - Their strengths, needs, preferences, and underlying issues.
 - 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?
 - What must change in order for the child and family to achieve timely permanence and improve the child/family’s well-being and functioning?
 - The “big picture” situation and dynamic factors impacting the child and family sufficiently to guide intervention.
 - The outcomes desired by the child and family from their involvement with the system.
 - 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.
24. **PLANNING FOR SAFE CASE CLOSURE:** Degree to which the planning process:
 - Is individualized and matched to the child and family’s present situation, preferences, near-term needs, and long-term view for safe case closure.
 - Provides a combination and sequence of strategies, interventions, and supports that are organized into a holistic and coherent service process, providing a mix of services that fits the child and family’s evolving situation so as to maximize potential results and minimize conflicts and inconveniences.
25. **TRANSITION PLANNING:** Degree to which:
 - The current or next life change transition for the child and family is being planned, staged, and implemented to assure a timely, smooth, and successful adjustment for the child and family after the change occurs.
 - Plans and arrangements are being made to assure a successful transition and life adjustment in daily settings.
 - There are well-planned follow-along supports provided during the adjustment period occurring after a major change is made in a child’s life to ensure success in the home or school situation.
26. **IMPLEMENTATION:** Degree to which:
 - Planned and accessible intervention strategies, services, and supports being provided to the child and family have sufficient power (precision, intensity, duration, fidelity, and consistency) and beneficial effect to produce results necessary to meet near-term needs and achieve outcomes that fulfill the long-term view for safe case closure.
 - An adequate array of home, school, and community resources is available to implement planned strategies.
27. **MAINTAINING QUALITY CONNECTIONS:** When a child is placed out of the home, the degree to which the child’s important family connections are maintained through appropriate and good quality visits and other means -- unless compelling reasons exist for keeping certain family members apart.
28. **TRACKING & ADJUSTMENT:** Degree to which:
 - The team routinely monitors the child and family’s status and progress, interventions, and results and makes necessary adjustments.
 - Strategies and services are evaluated and modified to respond to changing needs of the child and family.
 - Constant efforts are made to gather and assess information and apply knowledge gained to update planned strategies to create a self-correcting service process that leads to finding what works for the child and family.
29. **PSYCHOTROPIC MEDICATION MANAGEMENT:** Degree to which:
 - Any use of psychotropic medications for this child is necessary, safe, properly authorized, and effective.
 - The child and parents/caregivers understand the benefits and risks of each medication.
 - The child and parents have a voice in medication decisions and management.
 - The child is routinely screened for medication side effects and treated when side effects are detected.
 - 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).

Chapter 4

Child & Family Status Indicators

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12-19 Reserved for future use.	

Reminders for Reviewers

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

- 1. Focus on the central construct measured in each indicator.** While two constructs may be logically related (e.g., stability and permanency), the reviewer is to focus on the central matters related to each specific indicator and follow the probe and rating guidance provided for each indicator.
- 2. Stay within the time-based observation windows associated with each indicator.** For most indicators, status is measured over the past 30-90-180 day time periods unless stated differently for particular indicators. *Status Indicator 2: Child Vulnerability* and *Status Indicator 3: Stability*, *Status Indicator 10: Pathway to Independence* and *Practice Indicator 12: Teamwork* have observation windows that differ from the 30-90-180 day rules.
- 3. Rate indicators based on events that have occurred or conditions that were present within the time-based observation window.** Theorizing about events that might have occurred but did not is not a factual basis for rating. With the exception of *Status Indicator 3 - Stability*, future possibilities about events that may occur are not considered in rating current status. The Six-Month Forecast or prognosis is used to reflect expectations or concerns about future prospects.
- 4. Determine if each of the discrete “Rating Rationales” are a Strength, Gap, or Not Applicable**

Status Review 1: Safety from Exposure to Threats of Harm

REVIEW QUESTION

Focus Measure

SAFETY FROM EXPOSURE TO THREATS OF HARM: Degree to which:

- The child is free of abuse, neglect, and exploitation by others in his/her place of residence, school, and other daily settings.
- The child's parents and/or caregivers provide the attention, actions, and supports necessary to protect the child from known threats of harm in the home and in other settings.

Response - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status

RESPONSE GUIDE

Description of the Status Observed for the child – Consider protective capacities of caregiver

6 - Optimal Safety. Findings show an excellent safety situation for the child. The child has a threat-free living situation at home with fully reliable and competent parents/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. Optimal pattern - sustained for 6 months or longer.

5 - Good Safety. Findings show a good situation for the child. The child has a generally threat-free living situation at home with reliable and competent parents/caregivers who protect the child well under daily conditions. Any protective strategies used are generally operative and dependable in maintaining acceptable conditions. The child is generally free from threats in other daily settings, including at school and in the community. At home and/or in other settings, the child is free from abuse, neglect, exploitation, and/or intimidation. Good pattern - Sustained for 3 months or longer.

4 - Fair Safety. Findings show an acceptable situation that is free from imminent threat of abuse or neglect for the child. The child has a fairly safe living arrangement with the present parents/caregivers. The child is at least fairly free from serious threats in other daily settings including at school and in the community. At home and/or in other settings the child may have very limited exposure to intimidation. Any protective strategies have been recognized and utilized in reducing threats of harm. Minimally adequate to fair pattern - past 30 days or longer.

3 - Marginal Safety. Situation indicates somewhat inadequate protection of the child from abuse or neglect, which poses an elevated threat of harm for the child. Any protective strategies used may have been recognized but not utilized in reducing threats of harm. The child may be exposed to somewhat elevated threats of harm in his/her home and/or in other daily settings possibly at school and in the community. At home and/or in other settings the child may be exposed to occasional intimidation and fear of harm. **2 –Poor Safety.** Situation indicates substantial and continuing threats of harm for the child. At home and/or in other daily settings the child may sometimes experience abuse, neglect, exploitation, or intimidation. Any protective strategies used may not have been recognized or utilized in reducing threats of harm. The child may be exposed to substantially elevated threats of

harm in his/her home and/or in other daily settings possibly at school and in the community. At home or in other settings the child may be exposed to frequent or serious intimidation and fears of harm.

1 - Adverse. Situation indicates serious and worsening threats or harm for the child. A pattern of abuse, neglect, exploitation, or intimidation by persons in the current daily life of the child may be undetected or unaddressed in the home and/or in other daily settings. Any protective strategies used may not be implemented or effective when used, leaving the child at threat of continuing any worsening harm. Caregivers refuse to protect the child. The child may be exposed to continuing and increasingly serious intimidation abuse and/or neglect. If it meets state criteria, a call to the Abuse Hotline may be needed.

GUIDING LANGUAGE

Core Concepts

Safety is central to child well-being. The focus is on identifying safety factors, present and/or impending danger, protective capacities, and working with caregivers to supplement protective capacities through safety interventions. A child is considered safe when there is a balance between known safety factors and the identification of protections that are put into place by all responsible persons. This includes the capability and reliability of parents and/or out-of-home caregivers, school personnel, child care providers, and others having immediate responsibility for the child in recognizing safety factors.

Reviewers should also take into account the effectiveness of any safety intervention (e.g., no-contact orders, safety plans, after-school child supervision plans) put into place to protect the child. This does not imply an absolute protection from all possible risks to life or physical well-being. The child should be free from safety issues 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 presently in danger of or who lives in fear of assault, exploitation, humiliation, hostility, isolation, or deprivation may be in danger of suicide, disability, mental illness, co-dependent behavior patterns, learning problems, low self-esteem, and perpetrating similar harm on others. Freedom from harm is an essential condition for child well-being and development.

NOTE: *Self-endangerment, as a risk of harm, is addressed in Indicator 2: Child Vulnerability.*

Considerations

- Does the child have his or her immediate food, clothing, shelter, and medical/mental health needs met? Are physical living conditions hazardous or threatening to the safety or well-being of the child? Did the caregiver use excessive discipline or excessive physical force? Are the parent/caregiver's methods of discipline appropriate for this child?
- Does the child receive an appropriate level of care and supervision from parents/caregivers and other adults, relative to age and special needs?
- 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?

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- Is the child’s care or supervision currently compromised by the denial of abuse allegations or safety concerns or issues? Is the caregiver in denial of the issues relating to abuse/neglect?
- What informal supports and resources is the family now using to keep the children safe? What recent protective capacities are now in place that helps the family to better recognize risks of harm and to protect the children in the home from those risks?
- How reliable are any protective strategies (e.g., no-contact order, safety plan) used to keep the child and/or family free from harm? Is the caregiver willing to accept temporary interventions offered by the caseworker and/or other community agencies, including cooperation with continuing investigation/assessment? Is there evidence of a healthy relationship between the caregiver and child?
- Is the child fearful, intimidated, or in present or impending danger in any of his/her current daily settings and activities?
 - Family home (Including in-home living/visitation with a non-custodial parent and/or 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) and after school (e.g., an informal neighbor child-sitting arrangement or an after-school program at the Boys & Girls Club)
 - Work (including a work experience program, apprenticeship placement, part-time job, supported employment)
 - Weekend (including the use of a child’s “free time” in and around the home while away from organized activities)
 - Play (including informal neighborhood play activities and organized activities, such as sports, clubs, church activities)
 - Treatment for mental illness or addiction (including any setting in which seclusion or restraint may be used)
 - Detention (including locked detention)

Rating Rationale – NA should never be applied to the following subparts.

- 1.1 Home environment (The home is free from dangerous environmental hazards. The child’s food, clothing and shelter needs are being met consistently.)
 Strength Gap NA
- 1.2 Other environments (The child remains safe while in other daily settings such as child care, school, after school programs, in the work place, and when participating in weekend visits/events and during play times.)
 Strength Gap NA
- 1.3 Child-specific characteristics (The relationship between the child and caregiver(s) appears normal and healthy with the child’s behaviors or statements indicating no fear while in any of the environments described above. The prior history has been appropriately addressed and the child’s medical and emotional well being needs are met.)
 Strength Gap NA
- 1.4 Caregiver capacity/behavior (The caregivers demonstrate protective capacities and are free from domestic violence, addiction and criminal activities. The caregivers have appropriate perceptions and expectations of the child and respond accordingly to ensure the child remains safely in their care.)
 Strength Gap NA

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- 1.5 Services and efforts (Concerted efforts were made to provide or arrange for appropriate services for the family to protect the child and prevent the child's entry into out-of-home care.)
 Strength Gap NA

- 1.6 Safety concerns (All immediate and emerging safety concerns were addressed and additional needed interventions were provided to protect the child.)
 Strength Gap NA

Status Review 2: Child Vulnerability

REVIEW QUESTION

Focus Measure

CHILD VULNERABILITY: Degree to which the child: • Lacks capacity for self protection. • Is able to avoid self-endangerment. • Is able to refrain from behaviors that may put others at risk of harm.

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status

RESPONSE GUIDE

Description of Vulnerability Risk Observed in this Case

6 - Optimal Status. The child consistently avoids behaviors that cause harm to self, others, or the community. This child may have no history, diagnosis, or behavior presentations that are consistent with behavioral risk and is continuing this pattern. Or, the child may have had related history, diagnoses, or behavior presentations in the past but has not presented risk behaviors at any time over the **past 6 months**. Behavioral risk status is excellent.

5 - Good Status. The child generally and substantially avoids behaviors that cause harm to self, others, or the community. This child may have a very limited history, diagnosis, or behavior presentations that are not significant now. Or, the child may have had significant history, diagnoses, or behavior presentations in the past but has not presented the risk behaviors at any time over the **past 3 months**. Behavioral risk status is good.

4 - Fair Status. The child usually avoids behaviors that cause harm to self, others, or the community but may present a behavior that has low or mild risk of harm. The child may have had related history, diagnoses, or behavior presentations in the past but may have presented risk behaviors at a declining or much reduced level over the **past 3 months**. Behavioral risk status is minimally adequate to fair.

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

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

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

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. **ALTERNATIVE TIME SCALE USED FOR RATINGS IN THIS INDICATOR.**

GUIDING LANGUAGE

Core Concepts

Child Vulnerability. Refers to a child's capacity for self-protection. It is the degree to which a child can avoid, negate or modify safety threats, or compensate for the caregiver's missing or insufficient protective capacities. Child vulnerability encompasses child attributes such as age; developmental level and mental disability; physical disability and illness; whether a child acts provocatively or passively; whether a child seems powerless or defenseless; the visibility of a child to others; a child's ability to communicate; a child's ability to meet basic needs; and, whether the child is seen as a scapegoat. Other factors that affect vulnerability are a perpetrator's access to a child and the perpetrator's relationship to the child, such as the ability to exert power and control in the relationship. Siblings within a family setting may have varying levels of vulnerability and each child must be assessed independently on all of the attributes.

- *Age.* Children from birth to six years of age are especially vulnerable. They have limited speech capacity and are totally or primarily dependent on others to meet their nutritional, physical and emotional needs. Young children lack the ability to protect themselves from abuse or neglect. In addition, important social, cognitive and physical skills are developed in early childhood and failure to meet a child's needs may have a significant impact on later growth and development.
- *Developmental level and mental disabilities.* Regardless of age, a child who is cognitively limited is vulnerable because of possible limitations, such as recognizing danger, knowing who can be trusted, meeting basic needs, having the ability to communicate concerns and seeking protection. It should be clear that this elaboration of protective capacities does not place the concept within general family functioning.
- *Physical disability and illness.* Regardless of age, children who are physically limited and therefore unable to remove themselves from danger are vulnerable. Children who, because of physical limitations, are highly dependent on others to meet basic needs are vulnerable as are children who have continuing or acute medical problems and needs.
- *Provocative, irritating or non-assertive behaviors.* Children's emotional or mental health or behavioral problems can be such that they irritate and provoke others to act out toward these children or to avoid them. Regardless of age, children who are passive or withdrawn and not able to make basic needs known, or who cannot or will not seek help and protection from others are vulnerable. Children who exhibit significant behavioral challenges may be more vulnerable because of increased stress levels associated with supervising and controlling negative behavior. Children exhibiting problems with toilet training, inconsolable crying and delinquent or defiant behavior may be vulnerable because these conditions can be highly distressing to many caregivers.
- *Powerless and defenseless.* Regardless of age, intellect and physical capacity, children who are highly dependent and susceptible to others are vulnerable. Such children are typically so influenced by emotional and psychological attachment that they are subject to the whims of those who have power over them. Children who are unable to defend themselves against aggression are vulnerable. This can include those children who are unaware of danger. (The reference here is to dysfunctional attachments and the misuse of power. It is noted that all children need to have relationships on which they can rely and have psychological attachment.)

- *Visibility.* Children that no one sees (who are hidden or hide) are vulnerable regardless of age. Children who do not attend day care, school, community or social activities may have increased vulnerability when compared to children with contacts outside of the family. This includes children who may be hidden from the public child welfare agency. If children are very isolated, abuse may go undetected or unreported, which may increase the likelihood of future abuse.
- *Ability to communicate.* Children's inability to transmit information, thoughts, needs and feelings so that they are clearly understood may make them vulnerable. While communication ability is influenced by age and developmental level, it is also related to physical and mental disabilities and other individual characteristics.
- *Ability to meet basic needs.* Children vary in their ability to meet their own basic needs for nutrition and physical care and this affects vulnerability.
- *Scapegoat.* One or more children in a family may be a scapegoat — i.e., consistently the target of maltreatment while other children are not. For instance, one child may resemble a birth parent, which leads to that child being targeted for abuse by the other birth parent or a paramour. Increased vulnerability may be a consequence of animosity toward the individual whom the child resembles.
- *Accessibility by perpetrator.* Unsupervised access to a child by a perpetrator may present an obvious vulnerability for that child. This may be lessened by the presence of another adult who is capable and takes responsibility for their protection. The key component involves providing safeguards to ensure that a perpetrator does not have access to a child or the opportunity to compromise the safety of a child.
- *Perpetrator's relationship to the child.* The ability of the perpetrator to exert power and control in the relationship can create situations of compliance and/or fear.

Above section on child vulnerability extracted from American Public Human Services Association, National Association of Public Child Welfare Administrators A Framework for Safety in Child Welfare (2009). Used by permission.

Throughout development, children learn to follow rules, values, norms, and laws established in the home, school, and community, while learning to avoid behaviors that can put themselves or others at risk of harm. Children who have experienced trauma may behave in ways related to their early survival that are difficult for caregivers, teachers, and peers to understand. To assess self endangerment and risky behaviors consider the following:

- Suicidality, self-mutilation, or other forms of self-injurious behaviors (e.g., self-cutting, pica, head-banging, huffing chemicals, overdosing);
- Placing him/herself in dangerous environments and situations or neglecting essential self-care requirements for maintaining well-being, e.g., 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, running away (adolescents), serious property destruction, including fire setting, gang affiliation and related activities, neglecting critical care requirements (e.g., insulin injections), stealing, eating disorders, abuse of alcohol/addictive substances, provoking behaviors related to poor social judgment that result in harm, dangerous thrill-seeking activities, use of weapons, and sexual promiscuity.

Considerations

1. What is the child's capacity for self-protection? Can the child avoid, negate or modify safety threats, or compensate for the caregiver's missing or insufficient protective capacities? Is the child very young or does the child have developmental, mental, or physical disabilities? Is the child visible to others?

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2. Is the child able to communicate?
3. What is perpetrator's access to a child? What is the perpetrator's relationship to the child?
4. Does the child present a pattern of self-endangering behaviors or danger to others? If so, what are these behaviors and how are these behaviors being managed to keep themselves and others protected from such behaviors?
5. Has the child made suicidal gestures, threatened suicide, or had a suicide attempt?
6. Is this child participating in activities (including illegal gang activities) that would cause harm to him/her or others? Are the child's behaviors in the community likely to lead to arrest and/or detention or adult incarceration?
7. Is the child behaving responsibly and appropriately to avoid behaviors that would cause harm to him/her or others?
8. Does this child regularly associate with peers known for engaging in illegal or high risk activities? Does this child engage in any high risk behaviors, including running away, robbery, car theft, drug use/sale, having unprotected sex, or prostitution?
9. Is the child involved with the juvenile justice system? If the child is involved with the juvenile justice system, is he/she actively participating with the court's plans and avoiding reoffending? How is the child modifying daily activities and peer members to avoid reoffending and to become a "good citizen"?
10. Is the child presently placed in a detention setting or other DJJ program? Has redirection or de-escalation been used, as appropriate?
11. Does the child cause harm to him/herself by biting, pulling hair, head-banging, having severe tantrums, self-mutilation, binging on alcohol, or inhaling toxic vapors to get high?
 - Has any harm actually occurred within the past six months? If so, what happened?
 - Are steps being taken to prevent or reduce the probability of repeated injury?
 - If there has been a multi-disciplinary staffing, has it resulted in an adequate plan to manage and reduce risks?
12. Is the child presently in a group care setting? Has redirection or de-escalation been used, as appropriate?
13. Based on the potential impact of trauma or children in care, in any setting, has seclusion or restraint been used within the past 90 days to prevent harm to self or others?
 - Has use of any emergency control techniques been reduced over the past 90 days?
 - Have crisis services or 911 been called because of this child's behavior recently?
14. Has a safety plan been developed to mitigate harmful behavior to self or others?

Rating Rationale - NA should never be applied to the following subparts

- 2.1 Child characteristics (The child is on-target developmentally or if needed, appropriate services are in place to move the child forward. The child follows rules, has established personal values and self-respect, and generally conforms to societal expectations.)
 - Strength Gap NA

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- 2.2 Child behavior: self-endangerment (The child is free from suicidal gestures or threats. The child behaves responsibly by not committing crimes that result in being placed in jail or detention, running away, or demonstrating self-injurious behaviors to include misusing substances. The child demonstrates appropriate self-protective behaviors.)
Strength Gap NA

- 2.3 Child behavior: risk to others (The child does not intentionally provoke others, is not violent to other people or towards animals, and generally avoids high-risk situations that could negatively affect others.)
Strength Gap NA

- 2.4 Mitigation of vulnerability (When there are child vulnerability issues, appropriate, effective and active mechanisms are in place to mitigate the risks to child vulnerability, i.e., the child is learning how to manage behaviors, and/or informal or formal supports are in place specific to the needs identified.)
Strength Gap NA

Status Review 3: Stability

REVIEW QUESTION

Focus Measure

STABILITY: Degree to which the child's daily living, learning, and work arrangements are stable and free from disruptions as evidenced by:

- **Stability in living arrangement (past 12 months & next 6 months);**
- **Stability in the school (other than natural changes);**
- **Stability in service provider;**
- **Stability in case manager;**
- **Low risk of disruption (future – near or next year);**
- **Common concern for case participants interviewed; and**
- **Number of moves.**

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status

RESPONSE GUIDE

Description of the Status Situation Observed for the Child

6 - Optimal Stability. The child has optimal stability in living arrangement 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.

5 - Good Stability. The child has substantial stability in living arrangement and school settings with only planned changes and no more than one disruption in either setting over the past 12 months with none in the past 6 months. The child has established positive relationships with parents/primary caregivers, key adult supporters, and peers in those settings. Only age-appropriate changes in school settings are expected within the next 6 months. Any known risks are now well-controlled.

4 - Fair Stability. The child has minimally acceptable stability in living arrangement and school settings with only planned changes and no more than one disruption in settings within the past 12 months and none in the past 90 days. The child has established positive relationships with parents/primary caregivers, key adult supporters, and peers in those settings. Only age-appropriate school changes may be expected in the next 6 months. Future disruption (unplanned moves) appears unlikely (probability <50%) within the next 6 months.

3 - Marginally Inadequate Stability. The child has inadequate stability in living arrangement and/or school settings over the past 12 months with more than one disruption within the past 6 months and none in the past 60 days. The child may not feel secure in the living arrangement and disruptions may have resulted in changes of parents/primary caregivers, key adult supporters, and peers in those settings. Further disruptions may occur within the next 6 months (probability >50%). Causes of disruption are known.

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

1 - Adverse Stability. The child has serious and worsening problems of instability in living arrangement and/or school settings with multiple disruptions in settings within the past 12 months and at least one change in the past 30 days. The child's situation

seems to be “spiraling out of control.” The child may be in temporary containment and control situations (e.g., detention or crisis stabilization) or a runaway. There is no foreseeable next placement with levels of supports and services expressed by service staff or providers. The child may be expelled from school.

GUIDING LANGUAGE

Core Concepts:

STABILITY = CONTINUITY & NORMAL LIFE-STAGE CHANGES • INSTABILITY = DISRUPTIVE CHANGES IN CHILD’S LIFE

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

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

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

Considerations

1. How long has the child been in the current living arrangement and attended the current school or daytime activity?
2. How many out-of-home placements has this child had in the past 12 months?
 - For what reasons?
 - Of the placement changes, how many have been planned?
 - How many have been made to unite the child with siblings/relatives, move to a less restrictive level of care, or make progress toward the planned permanency outcome (e.g., reunification or TPR/adoption)?
3. Is the child’s living arrangement a permanent home?
 - If continued instability is present, what are the factors?

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4. Are there probable causes for disruption of placement or school?
 - Parent/caregiver's history of frequent moves, relapses, hospitalizations, or possible incarceration
 - Change of adults in child's living arrangement
 - Behavioral problems and discipline issues at school or in the placement
 - Parent/caregiver's inability to provide the appropriate level of care or supervision
5. Are any known changes in the child's home or school expected to occur in the next six months? Such a change could involve a discharge from residential treatment or detention to a new home or school. Did the child change school placements in the past 12 months due to child welfare involvement?
6. Are there present indications that the child may run away from home, school, or treatment placement?
7. What steps are being taken, if necessary, to prevent future disruptions and/or to achieve stable living and learning environments and settings for this child?
8. Changes in case managers and the impact on the child's stability in their placement.
9. Changes in service providers and the impact on the child.

Rating Rationale - NA should never be applied to the following subparts with the exception of 3.6.

- 3.1 Stability in living arrangement (The child has thrived while living in the same home for a significant period of time without having to experience changes in caregivers or environmental settings.)
Strength Gap NA
- 3.2 Stability in school setting (The child has attended the same school for a significant period of time and was free from experiencing major changes in teachers, principals, school or counselors. The child was able to maintain connections with peers and the academic community.)
Strength Gap NA
- 3.3 Stability in case management (The same primary case manager worker has been assigned to the child's case for a significant period of time.)
Strength Gap NA
- 3.4 Stability in service provider (The same providers, counselors, therapists, doctors, or other professionals involved in the child's case have remained consistent over time.)
Strength Gap NA
- 3.5 Risk of disruption to living arrangement (The child's current placement is stable and appropriate to meet the child's needs with no apparent or significant risks or projections of disruption.)
Strength Gap NA
- 3.6 Risk of disruption to school setting (The child's current school setting is stable and appropriate to meet the child's educational needs with no apparent or significant risks or projections that the school system intends to remove the child from that environment.)
Strength Gap NA
- 3.7 Management of risks to stability (Continuous, concerted efforts were made to ensure stability in each of the above elements to include: planning for placement or school setting changes, or considering transitional issues ahead of time and taking the necessary steps toward preventing potential disruption of living and school settings.)
Strength Gap NA

Status Review 4: Living Arrangement

REVIEW QUESTION

Focus Measure

LIVING ARRANGEMENT: Degree to which: Consistent with age and ability, the child is living in the most appropriate/least restrictive living arrangement.

- Fits child's needs, age, culture and peer group;
- Most appropriate educational placement;
- In accordance with Indian Child Welfare Act if applicable (Bio family first, Tribe next, American Indian family outside the tribe, then with others);
- Current placement supports permanency planning; and
- Provides the most appropriate level of care

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status

RESPONSE GUIDE

6 - Optimal Status. The child is living in the most appropriate setting to address his/her needs. The living arrangement is optimal to maintain family connections, including the child's relationship with the siblings and extended family members. The setting is able to entirely provide for the child's needs for emotional support, educational needs, family relationships, supervision, and socialization and addresses special and other basic needs. The setting is optimal for the child's age, ability, culture, language, and faith-based practices. If the child is in a group home or residential facility, the child is in the least restrictive environment necessary to address his/her needs and there is an active plan to transition the child to a lower level of care or home of parent. Been in placement for 6 months.

5 - Good Status. The child is living in a setting that substantially meets his/her needs. The living arrangement substantially provides the conditions to maintain family connections, including the relationships with the siblings and extended family members. The setting provides the necessary educational needs, family relationships, supervision, supports, and services to provide substantially for the child's emotional, social, special, and other basic needs. The setting is substantially consistent with the child's age, ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential facility, the child is in the least restrictive environment necessary to address his/her needs and there is an active plan to transition the child to a lower level of care or home of parent. Good pattern – Been in placement for 3 months.

4 - Fair Status. The child is living in a setting that is minimally consistent with his/her needs. The living arrangement minimally provides the conditions necessary to maintain family connections, including the relationship with the siblings and extended family members. The setting minimally provides the necessary educational needs, family relationships, supervision, supports, and services to address the child's emotional, social, special, and other basic needs. The setting is minimally consistent with the child's age ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential facility, the child is in the least restrictive environment necessary to address his/her needs and there is an active plan to transition the child to a lower level of care or home of parent. Minimally adequate to fair pattern – Been in placement 30 days or longer.

3 - Marginal Status. The child is living in a setting that only partially addresses his/her needs. The living arrangement is partially inconsistent with the conditions necessary to maintain family connections, including

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

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

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

GUIDING LANGUAGE

Core Concepts

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

Considerations

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

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2. If the child is in out-of-home placement, the following points should be considered in determining the appropriateness of the setting: *[Consider appropriateness of the living arrangement with the Indian Child Welfare Act, Multi-Ethnic Placement Act, and Adoptions and Safe Family Act.]*
 - Is the child living in his/her community (neighborhood and community close to home of parent, in his/her school district, and where he/she can continue extracurricular activities)?
3. 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?
4. Does the team believe this is the best place for this child at this time?
 - Should reunification not be possible, would the out-of-home caregiver be able and willing to provide for permanency?
 - Is the living arrangement able to meet the child's developmental, emotional, behavioral, and physical needs and does it provide for appropriate levels of supervision and supports?
 - Do the out-of-home 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?
5. Is a group care setting the least restrictive and most inclusive setting that can meet the child's needs? Consider the following matters:
 - Does the child feel safe and well cared for in this setting?
 - Is the child placed with children in his/her same age group?
 - Is this the least restrictive and most inclusive setting that is able to meet the child's needs?
 - Is the placement working on a goal to transition the child to a less restrictive setting?
 - If the child is 16+ years and reunification services have ended, is the placement providing transitional living skills to prepare the child for independent living?
 - Does the placement provide for the appropriate level of supervision, supports, and therapeutic services?
 - Does the placement provide for family connections and linkages to the community?
 - Is the placement providing services and resources to support a transition back to the home of parent?

Rating Rationale - *NA should never be applied to the following subparts with the exception of 4.4, 4.5, and 4.6*

- 4.1 Appropriateness of living arrangement (Concerted efforts were made to identify, locate, and evaluate potential relatives to care for the child prior to placing in licensed care. Or, if no relatives were identified, the child was placed in licensed care with the least restrictive and most inclusive environment.)
Strength Gap NA
- 4.2 Matching with caregivers (Concerted efforts were made to match the child with the most appropriate caregiver, considering: the caregiver's skill set, the population the caregiver chooses to care for, the caregiver's locale, the caregiver's ability to nurture and work with this specific child, meeting the child's needs and supporting the child's culture.)
Strength Gap NA

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- 4.3 Caregiver capacity (The child is living with caregivers who provide for the child’s individual needs to include: supporting emotional well being, addressing developmental issues, managing behavioral concerns, meeting physical needs, providing the appropriate level of supervision, and supporting normalcy for age appropriate activities such as sports and other social activities.)
Strength Gap NA

- 4.4 Appropriateness of educational placement (The school setting provides appropriate educational opportunities that meet the child’s specific educational needs.)
Strength Gap NA

- 4.5 Maintains connections (Unless the child’s specific needs could only be met outside of the home community, the current living arrangement is in close proximity to the parents in order to maintain connections and encourage face-to-face contact between the child and parents while the child remains in the out-of-home placement.)
Strength Gap NA

- 4.6 Consistent with Indian Child Welfare Act (Concerted efforts were made to place the child in a living arrangement in accordance with the Indian Child Welfare Act.)
Strength Gap NA

- 4.7 Permanency support (The current living arrangement supports permanency planning and achieving the desired outcome in a timely manner.)
Strength Gap NA

Status Review 5: Permanency

REVIEW QUESTION

Focus Measure

PERMANENCY: Degree to which: Those involved (child, parents, caregivers, others) have confidence that the child is living with caregivers who will remain in this role until the child reaches adulthood and will continue onward to provide enduring family connections and supports in adulthood.

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status

RESPONSE GUIDE

6 - Optimal Status. The child has optimal/certain permanence. The child has achieved legal permanency and/or lives in a family setting about which the child, out-of-home caregivers, and all team members have confidence will endure lifelong. Optimal pattern - Sustained for 6 months or longer.

5 - Good Status. The child has substantial/promising permanence. The child lives in a family setting (his/her own or that of a caregiver) that the child, parents, caregivers, and team members have confidence will endure lifelong. A plan is implemented that is expected to achieve safety, stability, and legal permanence. If in a resource family, there is agreement that adoption/kinship care issues will be imminently resolved. For children old enough to make a responsible judgment, the child and caregiver (in all cases) are committed to the plan. Primary and concurrent goals have been developed and implemented and team members are aware of the steps necessary to achieve each plan. Good pattern - Sustained for 3 months or longer.

4 - Fair Status. The child has minimally acceptable to fair permanence. The child lives in a family setting that the child, parents, caregivers, caseworker, and team members expect, with short-term agency support, will endure until the child reaches maturity. They are successfully implementing a well-crafted plan that supports that expectation because safety and stability are being achieved. If in an adoptive family, adoption issues are being resolved. - OR - The child is still living in a temporary placement, but the child, parents, caregivers, and team members are ready to move the child to a safe, appropriate, and permanent family setting. Readiness for permanency is evident, because a realistic and achievable child and family plan is being implemented, a permanent home has been identified, and the transition is being planned. The team agrees that the prospective placement and plan will produce permanency, because the child is receiving what the child needs for implementing the actual permanency goal and the parents or future permanent caregivers are becoming prepared for receiving the child. For children old enough to make a responsible judgment, the child and parent and/or caregiver (in all cases) are committed to the plan. Primary and concurrent goals have been developed and implemented and team members are aware of the steps necessary to achieve each plan. Minimally adequate to fair pattern - 30 days or longer.

3 - Marginal Status. The 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/kinship care issues are being assessed. Any concurrent pathways used may be somewhat slower or more troublesome than foreseen. For a child old enough to make a responsible judgment, the child and out-of-home caregiver (in all cases) may be considering the plan. Concerted action is needed in this area.

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

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

GUIDING LANGUAGE

Core Concepts

Every child is entitled to a safe, secure, appropriate, and permanent home. Permanency is achieved when the child is living successfully in a family situation that the child, parents, 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 caregivers and peers, continuous supportive relationships, and a necessary level of parental/caregiver commitment and affection. Evidence of permanency includes resolution of custody, adequate provision of necessary supports for the caregiver, and the achievement of stability in the child's home and school settings. Thus, safety, stability, and adequate caregiver functioning are co-requisite conditions of permanency for a child. The case should have identifiable steps that will move the child to stability and permanency. Because of the nature of group care settings, with frequent turnover of out-of-home caregivers, time-limited stays, ever-changing peers, conditional commitment, and unreliable personal caring relationships, placements in group care settings are rarely judged to achieve an acceptable permanency rating. An exception to this would be if a child is still placed in a group setting at the time of review, but everyone is ready to move the child to a safe, appropriate, and permanent family setting and the team agrees that the new placement and plan will produce permanency.

Considerations

1. Is the child living with caregivers that the child, caregivers, and caseworker believe will endure until the child reaches maturity and beyond?
 - Is the parent involved in the development of a back-up plan?
 - Is the back-up plan in place if any concerns surround the placement?
 - Is the child satisfied with this home?
 - Is the caseworker satisfied with this home?
 - Are all legal barriers to achieving permanency resolved (e.g., child is legally free for adoption)?
 - Are caregivers capable, supported, and satisfied?
 - Does the caregiver accept/understand the legal responsibilities of caring for this child?
 - Likelihood of caregivers raising the child to the age of majority.

2. If the child does not yet live with permanent caregivers and the permanency goal is reunification, are reunification services being provided?
 - Is the parent acquiring, demonstrating, and sustaining required behavioral changes necessary to parent the child?
 - Is there a clear permanency plan? Is it being implemented?
 - Do the child, family, and team support the permanency plan?
 - Is there concurrent planning (formal or informal)?
 - How is the child engaged in reunification planning efforts?
 - How is the child being prepared for permanency?
 - Is the child engaged in the concurrent planning efforts?
 - What is the likelihood that of reunification in the near future?

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3. If the child does not yet live with permanent caregivers and the permanency goal is adoption, is the permanency plan being implemented?
- Is an adoptive/kinship placement being actively sought?
 - Were there reasonable efforts to localize a possible kinship placement?
 - Are fit and willing kin available as a permanency resource?
 - Are any current or past caregivers available as a permanency resource?
 - What does the child say about the permanency choices? Does the child agree with the permanency choices? Was the child involved in making the permanency choices?

Rating Rationale - *NA should never be applied to the following subparts with the exceptions of 5.2.*

- 5.1 Life-long home and family (The child is placed with capable and supportive caregivers who are committed to a long-term relationship with the child. The child and case manager are in agreement with the permanent placement and it is likely that the caregivers will raise child to the age of majority and remain connected.)
Strength Gap NA
- 5.2 Progress toward reunification (When the permanency goal is to reunify the child with the parent, appropriate case work activities are in place that will help ensure the reunification is successful, e.g., regular visits are occurring between the child and parents, there is a solid plan for transitioning from the current placement back home, all participants agree reunification is the best permanency option, and it is likely that the return home will be permanent.)
Strength Gap NA
- 5.3 Progress toward adoption (When the permanency goal is adoption, reasonable efforts are underway to locate, match, recruit and approve prospective adoptive parents for the child.)
Strength Gap NA

Status Review 6: Overall Physical Health

REVIEW QUESTION

Focus Measure

OVERALL PHYSICAL HEALTH: Degree to which the child is achieving and maintaining positive health status to include, dental, audio and visual assessments and services; if the child has a serious or chronic health condition, the child is achieving his/her best attainable health status given the diagnosis and prognosis.

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status

RESPONSE GUIDE

6 - Optimal Status. The child is demonstrating excellent overall physical 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. Optimal pattern - Sustained for 6 months or longer. The child receives routine, age appropriate attention to physical, dental, audio and visual status, to include identified follow-up.

5 - Good Status. The child is demonstrating a good, steady overall physical 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 without any lasting impact, or there is no significant health history for this child. Nutrition, exercise, sleep, and hygiene needs are being substantially met. This child appears to be in good physical health. Good pattern - Sustained for 3 months or longer. The child receives routine, age appropriate attention to physical, dental, audio and visual status that includes consistent follow-up.

4 - Fair Status. The child is demonstrating an adequate to fair level of overall physical health status, considering any chronic conditions. The child's physical health is somewhat close to normal limits for age, growth, and weight range. If existing, any previous or current health concerns are not adversely affecting functioning. Nutrition, exercise, sleep, and hygiene needs are usually being met. The child appears to be in fair physical health. Minimally adequate to fair pattern - 30 days or longer. The child receives routine, age appropriate attention to physical, dental, audio and visual status, with minimal follow-up.

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

2 - Poor Status. The child is demonstrating a consistently poor level of overall physical health status. Any chronic condition may be becoming more uncontrolled, possibly with presentation of acute episodes. The child's physical health is significantly outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be significantly affecting functioning. Nutrition, exercise, sleep, and hygiene needs may not

be being met, with significant impact on functioning. The child appears to be in poor physical health and physical health is not improving, rather, is remaining status quo. Concerted action is needed in this area. The child receives inconsistent to minimal attention to physical, dental, audio and visual status.

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

GUIDING LANGUAGE

Core Concepts

Children should achieve and maintain their best attainable health status, including dental, audio and visual care consistent with their general physical condition when taking medical diagnoses, prognoses, and history into account. Healthy development requires that the child's basic needs for proper nutrition, clothing, shelter, and hygiene be met on a daily basis. Proper medical care (preventive, acute, and chronic) is necessary for maintaining good health. Preventive health care should follow EPSDT (Early, Periodic, Screening, Diagnosis, and Treatment) and Early Intervention Program (0-3) guidelines, as appropriate. This extends to reproductive health care education and services for older children to prepare and protect them from exposure to sexually transmitted diseases, and teen pregnancy, as appropriate.

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

Considerations

1. Are the child's basic physical needs being met adequately on a daily basis?
 - Food, adequate nutrition, sleep, and daily exercise?
 - Sanitary housing that is free of safety hazards (considered for infants, toddlers, and young children)?
 - Daily care, such as hygiene, dental care, grooming, and clean clothing?
 - Based upon the child's age and developmental level, access to sex education and family planning services?
2. Is the child achieving his/her optimal or best attainable health status? Is the child as healthy as he/she can be at this time?
 - Is appropriate preventive health care being provided as appropriate to the child's age (e.g., immunizations, dental, audio and visual screenings, etc.)?
 - Does the child miss school due to illness more than would be expected? (What is a reasonable expectation?)
 - Does the child have any recurrent health problems such as infections, sexually transmitted diseases, colds, or injuries?
 - Does the child have recurrent health complaints, and if so, are they addressed (including eye sight, hearing, etc.)?
 - Does the child appear to be underweight or overweight, and if so, has this been investigated?
 - Does the child use illegal substances or abuse prescription medication?

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- If the child has had a need for acute care services, were they provided appropriately?

- 3. Has the child maintained his/her best attainable health status, given any physical health diagnoses?
 - Receives appropriate follow-up, adaptive equipment, treatment, and/or services as appropriate to meet their special needs.

- 4. If the child takes medication for health maintenance on a long-term basis, is the medication properly managed for the child's benefit?
 - A responsible adult should be monitoring the use of the medication, ensuring that it is taken properly, watching for signs of effectiveness or side effects, providing feedback to the physician, and making changes as warranted.
 - The child, at the level that she/he is capable, has been taught about his/her condition, understands how to self-manage the condition, understands the purpose and impact of the medication, and is able to self-administer his/her medication with supervision as appropriate.

- 5. Has the child maintained his/her best dental status, given any dental diagnoses?
 - Child sees dentist in accordance with dental guidelines.
 - Child receives appropriate follow-up for any identified dental needs.

Rating Rationale - *NA should never be applied to the following subparts with the exception of 6.4.*

- 6.1 Physical (includes dental, audio and visual) needs met (The child's basic physical needs are met on a daily basis, to include being provided adequate nutrition, getting enough sleep, maintaining good hygiene, and having opportunities for daily exercise.)
Strength Gap NA

- 6.2 Achievement of optimal physical (includes dental, audio and visual) health (The child receives appropriate preventive health services and any recurrent health issues are addressed on an ongoing basis.)
Strength Gap NA

- 6.3 Maintenance of optimal physical (includes dental, audio and visual) health (Appropriate follow up occurs when necessary to treat any physical health diagnoses to include providing additional and necessary services.)
Strength Gap NA

- 6.4 Medication management (A responsible adult monitors and manages the child's medication on a regular basis.)
Strength Gap NA

Status Review 7: Emotional Well-Being

REVIEW QUESTION

Focus Measure

EMOTIONAL WELL-BEING: Degree to which, consistent with age, ability, and developmental level, the child is displaying an adequate pattern of:

- Attachment and positive social relationships,
- Coping and adapting skills,
- Appropriate self-management of emotions and behaviors.

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status

RESPONSE GUIDE

6 - Optimal Status. The child is demonstrating an excellent and sustained pattern of emotional well-being. As appropriate to age and developmental stage, the child is generally exceeding expectations for forming attachments and positive social relationships, coping and adapting skills, and appropriate self-management of emotions and behaviors. An optimal pattern is evident from multiple sources. Optimal pattern - Sustained for 6 months or longer.

5 - Good Status. The child is demonstrating a good and steady pattern of emotional well-being. As appropriate to age and developmental stage, the child is consistently meeting expectations for forming attachments and positive social relationships, coping and adapting skills, and appropriate self-management of emotions and behaviors. Most expectations in these areas are generally well met and no expectation is found to be unacceptable in recent times. Good pattern - Sustained for 3 months or longer.

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

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

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

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

GUIDING LANGUAGE

Core Concepts

Emotional well-being is achieved when a child's essential human and developmental needs are met in a consistent and nurturing manner in a relationship with a caregiver. When these needs are met, children are able to successfully attach to caregivers, establish positive interpersonal relationships, cope with difficulties, and adapt to change. They develop a positive self-image and a sense of optimism. Conversely, problem behaviors, difficulties in adjustment, emotional disturbance, and poor achievement are the result of unmet needs. Abuse, neglect, loss, and other trauma affect children's needs for safety, attachment, positive self-regard, and self-regulation. With a stable and nurturing caregiver, these children can be helped to develop a sense of safety, self-control, self-satisfaction, mastery, and hopefulness.

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

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

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

Considerations

1. Does the child have a history of significant unmet needs? Look at placement stability & planned placement changes. Is there a history of abuse, neglect, other trauma, multiple living arrangements, lack of a consistent caregiver, severe poverty, caregiver emotionally unavailable due to drug/alcohol abuse or psychiatric disorder?

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2. If any mental health screening or other assessments, Comprehensive Behavioral Health Assessment (CBHA) for out-of-home care, formal in-home assessments such as Early Steps (children under 5), or observations from daycare providers have been conducted, what were the concerns?
3. Has the child been diagnosed with a mental or developmental disorder?
 - Does the child have a history of psychiatric hospitalization or has he/she been prescribed psychotropic medication in the last 90 days?
 - Is there a history of suicidal ideation, gesture, or attempt or self-mutilation (e.g., cutting)? Recently released from Baker Act?
4. If served in child care, does the child's provider have any concerns about the child's social, emotional, or behavioral development? Does this child present parentified behaviors?
5. Has the child exhibited any behaviors that have resulted in suspension/expulsion from school, extracurricular activity or community setting/group? Has the child been suspended or expelled from school within the last 6 months due to behavior?
6. Does the child have age-appropriate positive peer relationships?
7. For older children, are they making appropriate planning and preparation for transitions from dependence to independence? Is there a history of substance misuse, arrests, and running away? Is the child emotionally prepared to become independent?

Rating Rationale - NA should never be applied to the following subparts.

- 7.1 Attachment and social relationships (The child's essential human and developmental needs are being met in a consistent and nurturing manner by the caregiver. The child has the ability to offer and accept nurturing positive relationships.)
Strength Gap NA
- 7.2 Coping and adapting skills (The child has the ability to self-regulate emotions and understands personal strengths, attributes, accomplishments and potential personal limitations.)
Strength Gap NA
- 7.3 Behavioral or developmental status (Assessments and/or evaluations from professionals reflect the child is currently demonstrating appropriate self management of emotions and behaviors.)
Strength Gap NA
- 7.4 Behavior or developmental status (Status is assessed when needed and appropriate interventions are implemented.)
Strength Gap NA

Status Review 8: Early Learning Status

REVIEW QUESTION

Focus Measure

EARLY LEARNING STATUS: Degree to which:

- **The child is achieving developmental milestones based on age and developmental capacities.**
- **The child's developmental status in key domains is consistent with age- and ability-appropriate expectations.** *This Indicator Applies to a Child Under the Age of 6 Years. Because mandatory school attendance begins at age 6, Status Indicator 8 is applied to a child who is under age 6 and who is not yet attending a formal school program.*

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status NA

RESPONSE GUIDE

6 - Optimal Status. The child's current developmental status is at or above age expectations in all domains, based upon normal developmental milestones. Optimal pattern over the past 6 months or since birth if less than 6 months old.

5 - Good Status. The child's current developmental status is at age expectations in all domains; however, there may be one or two areas in which the child is not as strong and merits ongoing careful monitoring. Good pattern over the past Sustained for 3 months or longer.

4 - Substantial Status. The child's current developmental status is near age expectations in most of the major domains and may be slightly below expectations in a few areas. If the child and caregiver are 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. Minimally adequate to fair pattern over the past 30 days or longer.

3 - Marginal Status. The child's developmental status is mixed, somewhat near expectations in some domains, but showing significant delays in others. If the child and caregiver are participating in an early intervention program either at home or in a child care program, the child is making moderate to slow developmental gains (determined by reviewing providers/assessors developmental evaluation or progress report) and may not be improving in some domains. Concerted action is needed in this area.

2 - Poor Status. 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 (determined by reviewing providers/assessors developmental evaluation or progress report). Concerted action is needed in this area.

1 - Adverse Status. The child's current developmental status is far below developmental milestones and there may be a decline in certain domains. The child and 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. Concerted action is needed in this area.

NA – Not Applicable. If child is six years of age or older.

GUIDING LANGUAGE

Core Concepts

Early Steps is Florida's early intervention system that offers services to eligible infants and toddlers (birth to thirty-six months) with significant delays or a condition likely to result in a developmental delay. Early Intervention is provided to support families and caregivers in developing the competence and confidence to help their child learn and develop. To be enrolled in Early Steps, the child must first be found eligible. Through the screening processes, the Early Steps staff will be able to find out if the child has significant delays or an established medical condition that will likely result in a delay. To determine if the child is eligible, he or she will be evaluated in the following areas:

Physical: *health, hearing, vision*

Cognitive: *thinking, learning, problem solving*

Gross & fine motor skills: *moving, walking, grasping, and coordination*

Communication: *babbling, languages, speech, conversation*

Social/emotional: *playing and interacting with others*

Adaptive development: *self-help skills, (i.e. feeding, toileting, dressing)*

Once the child is determined eligible, Early Steps will put together a team of service providers to address the child's needs. This team will develop the Individualized Family Support Plan (IFSP) based on family/caregivers outcomes and goals. A child age 3-5 who exhibits a delay may receive services through the local school board and have an Individualized Education Plan (IEP) instead of an IFSP.

In regard to developmental capacity, a child may be diagnosed with a genetic or metabolic condition that impacts his/her developmental capacity, but does not prevent them from reaching appropriate developmental milestones given level of functioning.

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 children with some delays often represent over 50% of the children under age five served through child welfare.

Some things to consider are: substance and/or alcohol exposure in utero, failure to thrive, and serious physical abuse/neglect resulting in brain injury (shaken baby, drowning, and heat exposure). Because this developmental period is critical to the child's future social, emotional, and cognitive development, every attempt should be made to provide these children with early intervention services both within the home and in child care settings.

Considerations

1. If this child is in the first 36 months of life and not meeting developmental milestones, 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?

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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?
 - Based on the screening/assessment does the child present with signs or symptoms associated with exposure to any forms of abuse or neglect by the parent/caregiver?

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. If the child does not appear within appropriate range of development:
 - Has the child been screened and evaluated for developmental delays or disabilities?
 - If so, what are the significant findings regarding the child's development path, pace, and potential?

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

6. If early intervention services are provided, do the child and caregiver seem to be responding to the interventions? Examples may be: improved interaction, acceptance of attempts to nurture, more spontaneous play, emergence of language, etc.?

7. Data to consider includes: Were formal developmental assessments done? Were informal assessments done through well child checks? If formally evaluated, do they have an IFSP or IEP?

Rating Rationale - NA only applied if the child is age 6 and older.

- 8.1 Achievement of developmental milestones (The child is developmentally on target, or if not, has been referred for screening of developmental delay or disability in order to initiate early interventions.)
Strength Gap NA

- 8.2 Developmental status consistent with expectations (The child is at or above age-appropriate levels in the areas of social interactions, cognitive thinking, physical development, use of language, and self-care.)
Strength Gap NA

- 8.3 Supports for early learning and development (The child receives necessary screenings and assessments to include, well-child checkups, early intervention services , and other supports as necessary to meet early learning and development needs.)
Strength Gap NA

Status Review 9: Academic Status

REVIEW QUESTION

Focus Measure

ACADEMIC STATUS: Degree to which the child [according to age and ability] is:

- 1) regularly attending school and placed in a grade level consistent with age or developmental level,
- 2) actively engaged in instructional activities,
- 3) reading at grade level or Individual Education Program (IEP) expectation level, and
- 4) meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent, or vocational program.

This Indicator Applies to a Child 6 Years or Older

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status NA

RESPONSE GUIDE

6 - Optimal Status. The child is enrolled in an educational program that is highly appropriate, consistent with age and ability. The child has an excellent rate of school attendance (>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. Optimal pattern - Sustained for 6 months or longer.

5 - Good Status. The child is enrolled in an educational program that is generally appropriate, consistent with age and ability. The child has a substantial rate of school attendance (e.g., 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. Good pattern - Sustained for 3 months or longer.

4 - Fair Status. The child is enrolled in an educational program that is minimally appropriate, consistent with age and ability. The child has a fair rate of school attendance (e.g., 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. Minimally adequate to fair pattern - 30 days or longer.

3 - Marginal Status. The child may be enrolled in an educational or vocational program that is marginally appropriate, or somewhat inconsistent with age and ability. The child may have an inconsistent rate of school attendance (e.g., 75-85% attendance and may have tardy notes or unexcused absences). The child's limited level of

participation and engagement in educational processes and activities may be hindering the child from reaching at least minimally acceptable educational expectations and requirements set within the child's assigned curriculum and, where appropriate, the child's IEP. The child may be reading a year below grade level or somewhat below the level anticipated in an IEP. The child may not be meeting some core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. Concerted actions needed in this area.

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

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

NA – Not Applicable. The child is under six years of age.

GUIDING LANGUAGE

Core Concepts

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, or at level anticipated at based on IEP instructional expectations and placement are altered via an Individual Educational Plan (IEP) to an alternative curriculum.
- 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.

For children in foster care who have reached 13 years of age, the department or community-based provider shall ensure that the child's case plan includes an educational and career path based upon both the abilities and interests of each child. The child, the foster parents, and a teacher or other school staff member shall be included to the fullest extent possible in developing the path. The path shall be reviewed at each judicial hearing as part of the case plan and shall accommodate the needs of children served in exceptional education programs to the

extent appropriate for each individual. Such children may continue to follow the courses outlined in the district school board student progression plan.

The Florida Department of Education requires students to complete one course in career and education planning in 7th or 8th grade. The course may be taught by any member of the instructional staff; must include career exploration using Florida CHOICES or a comparable cost-effective program; must include educational planning using the online student advising system known as Florida Academic Counseling and Tracking for Students at the Internet website FACTS.org; and shall result in the completion of a personalized academic and career plan. Each student shall complete an electronic personal education plan (ePIP) that must be signed by the student; the student's instructor, guidance counselor, or academic advisor; and the student's parent.

- The ePIP is part of a required class for 7th or 8th grade, supposed to be required prior to promotion to 9th grade.
- It is created and maintained by the individual student through an account on the FACTS.org website. Teachers can access and comment to the students, but can NOT change any of the information.
- The plan must be signed by the student, instructor or guidance counselor/advisor, and parent.

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

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

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.

Considerations

1. Is this child enrolled in an educational program consistent with age and ability? If not, why not?
2. Does the child's grade level match the child's age? If not, why not?
3. Is the child assigned to the general education curriculum leading to a high school diploma? If not, is the child receiving special education and related services in an alternative curriculum directed via an IEP? If the child is placed in an alternative curriculum, what is the expected educational outcome?
4. Is the child actively and consistently engaged in the instructional processes and related activities necessary for acquisition of expected skills, competencies, and performances associated with curricular goals and objectives?
5. Is the child reading on grade level or at a level anticipated in an IEP?
6. Is the child meeting curriculum requirements necessary for promotion, course completion, and IEP-directed transitions? If not, why not?
7. If child is in middle school, high school or above do they have an ePIP?

Rating Rationale – Apply NA if the child is age five and under.

- 9.1 Child’s educational achievement (The child is enrolled in an educational program consistent with age and ability to meet requirements for annual promotion and course completion.)
Strength Gap NA

- 9.2 Child engagement in school activities (The child attends school regularly, participates in class activities/discussions, and is involved with extra-curricular activities.)
Strength Gap NA

- 9.3 Educational supports for child (Appropriate and formalized plans are in place such as the IEP or ePEP to ensure the child receives individualized educational and related services, i.e., alternative curriculum, specially assigned instructors, etc.)
Strength Gap NA

Status Review 10: Pathway to Independence

REVIEW QUESTION

Focus Measure

PATHWAY TO INDEPENDENCE: Degree to which the child [according to age and ability] is:

- Gaining skills, education, work experience, connections, relationships, income, housing, and necessary capacities for living safely and functioning successfully independent of agency services, as appropriate to age and ability.
- Developing long-term connections and informal supports that will support him/her into adulthood.
- Experiencing involvement in extracurricular activities as age and developmentally appropriate, as desired.

This Indicator Applies to a Child 13 Years or Older and in Foster Care

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status NA

RESPONSE GUIDE

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

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

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

3 - Marginal Safety. The child has been making limited or inconsistent progress over the past 30 days: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate for older children, the child is making limited progress in: (1) developing a realistic budget; (2) acquiring affordable, quality housing; and (3) finding ways to meet

fundamental needs; e.g., income, housing, transportation, health care, food, and child care if necessary. Concerted action is needed in this area.

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

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

Not Applicable. The child is under 13 years or is part of an in-home case. Therefore, this indicator does not apply at this time.

GUIDING LANGUAGE

Core Concepts

NOTE: *This indicator is looking for outcomes beyond formal independent living services. An alternative time scale is used for this indicator.*

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

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

Building these capacities requires a high standard of practice to ensure that the child has what is necessary to achieve and maintain adequate levels of well-being, functioning, fulfillment of adult roles, and social integration as a citizen in the community.

Considerations

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

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2. If the child is 16 years or older, does the child have an identified transitional living plan? If not, when will this plan be developed?
3. If applicable, does the child have a realistic budget that includes income and expenses that are projected after transition to adulthood?
4. Does the child practice skills related to daily living (e.g., food preparation, laundry, cleaning, nutrition, time management, etc.)?
5. Has the child had a voice in deciding current educational needs, such as study skills, tutoring, and IEP development (if appropriate)?
6. Does the child have plans for any post-secondary education or vocational training related to potential career goals? If so, has he/she taken steps toward planning and support related to these goals?
7. Has the child been an active participant in planning for his/her current physical, behavioral health, and engagement with other community resources related to his/her overall well-being?
8. Does the child have a plan for health care after discharge, including physical and behavioral health and other community resources related to the child's overall well-being?
9. Is the child establishing positive and permanent connections with informal supports and resources in the extended family, neighborhood, spiritual community, and/or larger community?
10. Does the child have in his/her possession, or have access to, key documents, such as social security card, birth certificate, photo identification, insurance cards, IEP, etc.?
11. Has the child gained knowledge of appropriate prevention skills related to alcohol and drugs, smoking, and consequences of sexual behavior?
12. Has the child identified and become involved in extracurricular activities?
13. Has the child/youth identified and/or engaged in employment opportunities in line with their career plan?

Rating Rationale – Apply NA if the child is age 12 and under.

- 10.1 Child's ability to function successfully independent of services (The child is in the process of building the necessary skills to take care of oneself on a daily basis upon reaching the age of majority.)
Strength Gap NA
- 10.2 Long term connections and supports (The child has a social network of peers, mentors, coaches, or other informal support systems that will be available to assist the child in future.)
Strength Gap NA
- 10.3 Preparing the child for independence (When the child is over 16 years of age, the transition plan includes the child's perspective of the future; it identifies chosen educational and career paths, needed services, the plan to turn over key documents, and assists in planning for future health care.)
Strength Gap NA

Status Review 11: Parent & Caregiver Functioning/Resourcefulness

REVIEW QUESTION

Focus Measure

PARENT & CAREGIVER FUNCTIONING: Degree to which the parent or caregiver, with whom the child is currently residing and/or has a permanency plan, is able to provide the child with the assistance, protection, supervision, and support necessary for healing from trauma and/or achieving emotional well-being. If added supports are required in the home to meet the needs of the child and assist the parent or caregiver, the added supports are meeting the child's needs.

RESPONSE - Status Rating:

6 Optimal Status 5 Good Status 4 Fair Status 3 Marginal Status 2 Poor Status 1 Adverse Status

RESPONSE GUIDE

6 - Optimal Status. The parent/caregiver demonstrates excellent and enduring parenting capacities on a reliable daily basis at or above that required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the parent/caregiver demonstrates optimal knowledge and excellent use of specialized skills and supports that may be required to meet the needs of the child. Sustained for 6 months.

5 - Good Status. The parent/caregiver demonstrates good and consistent parenting capacities on a reliable daily basis at or above that required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the parent/caregiver demonstrates good working knowledge and proficient use of specialized skills and supports that may be required to meet the needs of the child. Past Sustained for 3 months.

4 - Fair Status. The parent/caregiver demonstrates adequate to fair parenting capacities on a reliable daily basis at a level required to provide the child with appropriate nurturance, guidance, support, protection, discipline, education, medical care, and supervision. If the child has special needs, the parent/caregiver demonstrates at least adequate working knowledge and use of specialized skills and supports that may be required to meet the needs of the child. Past 30+ days.

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

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

1 - Adverse Status. The parent/caregiver demonstrates a seriously inadequate pattern of parenting capacities most of the time, offering much less than the level required to provide the child with appropriate nurturance, guidance,

support, protection, discipline, education, medical care, and supervision. If the child has special needs, the parent/caregiver lacks working knowledge and ineffectively uses specialized skills and supports that may be required to meet the needs of the child. Immediate action is needed in this area.

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

GUIDING LANGUAGE

Core Concepts

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

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

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

Considerations

NOTE: *When applying this indicator, parents and/or any caregiver(s) should be rated. When scoring a mother/father, the reviewers should take the parents' capacities into consideration and rate each individually.*

1. Do the child's parent(s) and/or caregiver(s) have sufficient income and resources to provide basic necessities adequately, reliably, and consistently on a daily basis, such as food, safe shelter, clothing, transportation, health care, and child care?
2. Do the parent(s) and/or caregiver(s) demonstrate that they have and actively use knowledge, skills, and emotional capacity to take care of the child and provide the child with physical and psychological safety? Do they make decisions and act in ways that are protective? Are they emotionally connected to the child, sensitive to the child's needs, and able to respond in positive and nurturing ways that appropriately meet the child's needs?
3. Do the parent(s) and/or caregiver(s) provide adequate supervision, nurturance, guidance, and emotional support, such as age-appropriate praise, affection, structure, discipline, and moral guidance as the child moves through his/her life stages?

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4. If the parent(s) or caregiver(s) have life challenges (e.g., trauma history, substance use disorder, mental illness, developmental disability, victimization from domestic violence), are they making progress in symptom management and use of recovery skills and supports?
5. Do the parent(s) and/or caregiver(s) adequately access the necessary services to meet the age-appropriate physical, dental, and mental health needs of the child? Are there any risk factors that impair the parent(s)' and/or caregiver(s)' ability to parent, such as substance abuse, mental disability, domestic violence?
6. Do the parent(s) and/or caregiver(s) have the ability, understanding, and willingness to engage with an informal support system to assist them with essential care giving responsibilities, such as family members, close friends, helpful neighbors, informal social service organizations, faith-based organizations, social clubs, and charitable organizations?
7. Do the parent(s) and/or caregiver(s) have the ability, understanding, and willingness to engage with a formal support system to assist them with essential care giving responsibilities, such as social service agencies, schools, medical providers, transportation, housing, law enforcement, and/or vocational training?
8. Are the parent(s) and/or caregiver(s) meeting the child's special and/or regular educational needs by assuring school attendance, homework completion, and parent/teacher conference attendance; attending school events; and participating in extracurricular activities?
9. Are there extraordinary demands placed on the parent(s) and/or caregiver(s) of this family that impact their ability to parent? (such as a small child, high child/caregiver ratio, frail elderly, ill persons in the home, single parent family, social isolation, a child with special health or medical conditions, a disability or behavioral issues)
10. If the child is older, are the parent(s) and/or caregiver(s) able to assist with critical life decisions, such as education, vocation, employment, sexuality, reproductive health care, religion, morality, or the use of addictive substances?
11. If the child is older or in substitute care, do the parent(s) and/or caregiver(s) have the willingness and ability to maintain contact and a relationship while the child is out of the home? Do the parents attend planned visitations with their child?
12. Are necessary supports and services being made culturally appropriate via special accommodations in the engagement and service delivery process being used with this child and family?

Rating Rationale

- 11.1 Caregiver resources (The caregiver has sufficient income and other resources to meet the daily needs of caring for the child, that includes, maintaining appropriate housing, providing transportation, health care, food and clothing.)
Strength Gap NA
- 11.2. Mother capacity/behavior (The caregiver demonstrates appropriate degree of knowledge, skills and abilities to include, emotional and protective capacities to adequately care for the child, as well as, how to manage the after affects of trauma, overcoming behavioral issues and willingness to actively support and participate in service interventions.)
Strength Gap NA

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- 11.3. Father capacity/behavior (The caregiver demonstrates appropriate degree of knowledge, skills and abilities to include, emotional and protective capacities to adequately care for the child, as well as, how to manage the after affects of trauma, overcoming behavioral issues and willingness to actively support and participate in service interventions.)
Strength Gap NA
- 11.4. Caregiver capacity/behavior (The caregiver demonstrates appropriate degree of knowledge, skills and abilities to include, emotional and protective capacities to adequately care for the child, as well as, how to manage the after affects of trauma, overcoming behavioral issues and willingness to actively support and participate in service interventions.)
Strength Gap NA
- 11.5. Supports and services for caregivers (The necessary supports and services are in place to include family members, close friends, helpful neighbors, informal or formal social service organizations, faith-based organizations, social clubs, and/or charitable organizations.)
Strength Gap NA

NOTE: Status Review Indicators 12-19 reserved for later use.

Chapter 5

Practice Performance Indicators

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Reminders for Reviewers

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

- 1. Focus on the central construct measured in each indicator.** While two constructs may be logically related (e.g., engagement and teamwork or assessment and planning), the reviewer is to focus on the central matters related to each specific indicator and follow the probe and rating guidance provided for each indicator. For example, if a reviewer discovered that strong recent assessments were present but that planning did not reflect the most recent assessments, then the reviewer would rate the assessments as being strong and rate the planning as less than acceptable for not reflecting the most recent and important information. Assessment would not be rated lower because assessment findings were not reflected in the planning of appropriate strategies, supports, and services. Planning would not be rated higher because of the strong assessments.
- 2. Stay within the time-based observation windows associated with each indicator.** Follow the 30-90-180 day time rules when applying practice indicators.
- 3. Rate indicators based on events that have occurred or conditions that were present within the time-based observation window.** Theorizing about events that might have occurred but did not is not a factual basis for rating. The Six-Month Forecast or prognosis is used to reflect expectations or concerns about future prospects or the suspected future effects of any present insufficiencies in core practice functions.
- 4. Follow the guidance provided in rating statements when selecting a rating value for measuring an indicator having multiple components or conditions to be met.**

Practice Review 20: Engagement Efforts

REVIEW QUESTION

Focus Measure

ENGAGEMENT: Degree to which those working with the child and family (parents or other caregivers) and support systems are:

- Developing and maintaining a culturally competent, mutually beneficial trust-based working relationship with the child and family.
- Focusing on the child and family's strengths and needs.
- Sensitive and responsive to traumas experienced by the child and family.
- Engaging children in a developmentally appropriate manner.
- Being receptive and willing to make adjustments in scheduling and meeting locations to accommodate family participation in the service process, including case planning.
- Offering transportation and child care supports, where necessary, to increase family participation in planning and support efforts.

NOTE: Practice Indicator 21: Voice and Choice of family members in shaping decisions may provide useful information to consider when rating **Practice Indicator 20: Engagement Efforts**. Remember that engagement focuses on practice activities that lead to and support an active and effective partnership with the child and family. When these engagement activities are effective, parent participation and satisfaction should be positive.

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice

RESPONSE GUIDE

6 - Optimal Practice. Excellent, culturally competent outreach efforts are being used as necessary to find and engage the child, parents, all family members, and caregivers. Excellent accommodations provide for scheduling times and locations based on family convenience, support with transportation and child care, individualized problem solving, and time spent in whatever setting necessary to build the necessary relationship and rapport. Family engagement efforts are made consistently and persistently over time. Strong, positive working relationships between team members are evident in this case or high quality efforts have been made to engage key family members. Excellent pattern - sustained for 6 months.

5 - Good Practice. Good, consistent, culturally competent outreach efforts are being used as necessary to find and engage the child, parents, most family members, and caregivers. Team members report specific, useful accommodations being used to provide scheduling times and places based on family convenience, support with transportation and child care, individualized problem solving, and the time necessary to build relationship and rapport. Good working relationships between team members are evident in this case, or reasonable efforts have been made to engage key family members. Substantially good pattern - Sustained for 3 months.

4 - Fair Practice. Minimally adequate to fair outreach efforts are being used as necessary to find and engage the child, parents, some family members, and caregivers. Team members report some accommodations being offered to provide scheduling times and places based on family convenience, support with transportation and child care, individualized problem solving, and time spent in settings necessary to build the necessary relationship and rapport. Efforts are made at least once a month. Fair working relationships between team members are evident in

this case, or minimally adequate efforts have been made to engage the key people. Minimally adequate to fair past 30 days or longer.

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

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

1 - Absent or Adverse Practice. There were no efforts made to engage the family. Service planning and decision-making activities are conducted at times and places or in ways that prevent or severely limit effective child and family participation. Decisions are made without the knowledge or consent of the parents, the 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. Immediate action is needed in this area.

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

GUIDING LANGUAGE

Core Concepts

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

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

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

- Approach the family from a position of respect and cooperation.
- Engage the family around strengths and utilize those strengths to address concerns for the health, safety, education, and well-being of the child.

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- Engage the child and family in case planning, including setting goals in case plans and evaluating the service process.
- Help the family define what it can do for itself and where the child and family need help.
- Engage the child and family in decision making about the choice of interventions and the reasons why a particular intervention might be effective. This includes discussion of the logistics of getting to and participating in interventions in a manner that is practicable and feasible for the family.

Considerations

1. What outreach and engagement strategies are team members using to build a working partnership with the child and family? Has the team offered special accommodations to the family as necessary to encourage and support engagement, participation, and partnership? Are diligent efforts continuing to look for and find family members who can provide support and permanency for the child over the life of the case?
2. Have efforts been made to help the child understand the parents' special challenges (e.g., mental illness, substance use disorder, victimization)?
3. Are necessary supports and services being made culturally appropriate via special accommodations in the engagement and service delivery processes being used with this child and family?
4. If the child or parent/caregiver has a primary language that is other than English, are translator services provided, and how is reliability of translator ensured?
5. Does the team understand possible triggers and develop sensitive ways of responding to the child and family so that re-victimization does not occur?
6. Do family members report being treated with dignity and respect? Do they have a trust-based working relationship with those providing services?
7. 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 adjustment of the service arrangements?
8. 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 their progress?

Rating Rationale

- 20.1 Strategies for effective working relationships (Outreach and engagement strategies to build and maintain a productive working partnership with the child and family are in place.)
Strength Gap NA
- 20.2 Ongoing efforts to engage (Case work practices include ongoing efforts to build a trust-based relationship that is culturally sensitive, dynamic and effective.)
Strength Gap NA
- 20.3 Trauma sensitivity (The parent/caregiver understands the child's or parent's past trauma, their special challenges, likely triggers and the means by which to avoid re-victimization.)
Strength Gap NA
- 20.4 Engaging the child (As age and developmentally appropriate, child was involved in some (or all) aspects of case planning and setting individual goals specific to his/her needs.)
Strength Gap NA
- 20.5 Engaging the mother (Through formal or in-formal support systems, the mother was engaged in the overall process of case planning and setting goals.)
Strength Gap NA

- 20.6 Engaging the father (Through formal or in-formal support systems, the father was engaged in the overall process of case planning and setting goals.)
Strength Gap NA
- 20.7 Engaging the caregiver (Through formal or in-formal support systems, the caregiver was engaged in the overall process of case planning and setting goals.)
Strength Gap NA

Practice Review 21: Voice and Choice

REVIEW QUESTION

Focus Measure

VOICE & CHOICE: Degree to which the child, parents, family members, and caregivers are active ongoing participants (e.g., having a significant role, voice, choice, and influence) in shaping decisions pertaining to child and family strengths and needs, goals, supports, and services.

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice

RESPONSE GUIDE

6 - Optimal Practice. Key family members fully participate in all aspects of assessment, service planning, implementation, monitoring, and evaluation of results for the child and family. The child, parent, and/or caregiver (as appropriate) have a central and directive role, providing a voice that shapes the decisions made by the team on behalf of the child and family. Visits are of sufficient quality to move the case forward. Excellent pattern - Sustained for months.

5 - Good Practice. Key family members are substantial and contributing partners on the team, generally participating in most aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The child, parent and/or caregiver (as appropriate) have a present and effective role, providing a voice that influences the decisions made by the team on behalf of the child and family. Visits are of sufficient quality to move the case forward. Good pattern - Sustained for 3 months.

4 - Fair Practice. Key family members are fair participant(s) in some aspects of team decision making, minimally participating in some assessment, service planning, implementation and monitoring, and evaluation of results. The child and parent and/or caregiver (as appropriate) have a minimally effective role, providing a voice that suggests and affirms the decisions made by the team on behalf of the child and family. Visits are of adequate quality to move the case forward. Pattern - 30 days or longer.

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

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

1 - Absent or Adverse Practice. Key family members have not participated in any aspects of assessment, service planning, implementation, monitoring, and evaluation of results. The parent/caregiver may be experiencing

overwhelming life circumstances, without the benefit of special accommodations for support or participation. The child may be receiving services in a placement setting or alternative educational placement situation and is detached from all previously established connections. Immediate action is needed in this area.

GUIDING LANGUAGE

Core Concepts

Evidence shows that the child and family who have a sense of personal ownership in the plan and decision process are those most likely to succeed in making and sustaining necessary life changes. Supports and services should benefit children and families by helping to create conditions under which the child can succeed in school and life. Interventions should build on the strengths of the child and family and should reflect their solutions, views, and preferences. The parent and/or caregiver (as appropriate) have a central and directive role, providing a voice that shapes decisions made by the team on behalf of the child and family. Emphasis is placed on direct and ongoing involvement in all phases of service: assessment, planning interventions, provider choice, monitoring, modification, and evaluation.

The child and family should have an active role and voice in developing goals and objectives, as well as in the development and implementation of plans. This includes, but is not limited to:

- Knowing and explaining his/her strengths, needs, preferences, and challenges so that others may understand and assist.
- Understanding, accepting, and working toward any non-negotiable conditions that are essential for safety and well-being.
- Attending team meetings and shaping key decisions about goals, intervention strategies, special services, and essential supports.
- Advocating for needs, supports, and services.
- Parents are provided opportunities for input and participation in education, health, and extra-curricular activities.
- Follow through on identified interventions.
- Providing quality and frequent visits between the agency worker and the child, mother, and father.
- When ICWA (Indian Child Welfare Act) applies, active efforts are required to assure a role and voice for the tribe.

Child and family satisfaction may be a useful indicator of participation and ownership of the case plan.

Considerations

1. To what degree does the family influence all phases of service planning and implementation, including court hearings?
2. Do the child, family and primary caregiver routinely participate in the assessment, planning, monitoring/modification of child and family plans, arrangements, and evaluation of results?
3. How involved are the child's parent(s)/caregiver(s) in the child's medical, educational and behavioral health meetings/appointments?
4. Are worker visits with the child and family purposeful to ensure safety, permanence, and well-being and promote achievement of the case goals?
5. If in care, how does the child feel about the current situation and caregivers? How does the child feel about the frequency and quality of visits with family members?

6. Are parents/caregivers included as partners in planning and implementing transitions that a child in care may experience?

Rating Rationale

- 21.1 Child participation in assessment and setting goals (The child participated in assessment activities that included his/her personal perspectives related to strengths, needs and goals.) NA if not age and developmentally appropriate.
Strength Gap NA
- 21.2 Child participation in service selection and delivery (The child participated in selecting intervention strategies, identifying supports, and evaluating effectiveness of services and supports.)
Strength Gap NA
- 21.3. Mother participation in assessment and setting goals. (The family participated in assessment activities that included his/her personal perspectives related to strengths, needs and goals.)
Strength Gap NA
- 21.4. Father participation in assessment and setting goals. (The family participated in assessment activities that included his/her personal perspectives related to strengths, needs and goals.)
Strength Gap NA
- 21.5. Caregiver participation in assessment and setting goals. (The family participated in assessment activities that included his/her personal perspectives related to strengths, needs and goals.)
Strength Gap NA
- 21.6 Family participation in service selection and delivery. (The family participated in selecting intervention strategies, identifying supports, and evaluating effectiveness of services and supports.)
Strength Gap NA
- 21.7 Frequency and quality of visits. Visits with the child and parent/family member/caregiver were purposeful and of sufficient frequency and quality to encourage ongoing communication and feedback. The intention is to gage the quality of interaction between the case manager and the family/caregiver.
Strength Gap NA

Practice Review 22: Teamwork

REVIEW QUESTION

Focus Measure

TEAMING: Degree to which appropriate family members and providers have been identified and formed into a working team that shares a common “big picture” understanding and long-term view of the child and family.

- Team members have sufficient knowledge, skills, and cultural awareness to work effectively with this child and family.
Members of the family and involved professionals have a pattern of working effectively together to share information, plan, provide, and evaluate services for the child and family.

UNITY OF EFFORT, COMMONALITY OF PURPOSE, AND EFFECTIVENESS IN PROBLEM-SOLVING = SUCCESSFUL TEAMWORK

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice NA

RESPONSE GUIDE

6 - Optimal Practice. Formation: All of the people who provide support and services for this child and family were identified and formed an excellent working team. The team has excellent skills, family knowledge, cultural awareness, and abilities necessary to organize effective services for the child and family. All of the family team members are optimally organized and able to shift leadership roles as needed, remain in timely, ongoing communication, and are accountable for ensuring a common purpose. Functioning: The team has an excellent pattern of having a unified and comprehensive strength-based understanding that is clearly working toward common goals and objectives leading towards safe case closure for the child/family. The team has shown a consistency in their ability to assess, plan, implement, and prepare for safe case closure. Excellent pattern over the past 3 months.

5 - Good Practice. Formation: Most of the people who provide support and services for this child and family have been identified and formed a good and substantial working team. The team has good skills, family knowledge, cultural awareness, and abilities necessary to organize effective services for the child and family. All of the family team members are substantially organized and generally able to shift leadership roles as needed, remain in timely, ongoing communication, and are accountable for ensuring a common purpose. Functioning: The team has a good and dependable pattern of having a unified and comprehensive strength-based understanding that is working toward common goals and objectives leading towards safe case closure for the child/family. The team has shown a general consistency in their ability to assess, plan, implement, and prepare for safe case closure. Good pattern over the past 3 months.

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

to assess, plan, implement, and prepare for safe case closure. Minimally adequate to fair pattern over the past 3 months.

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

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

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

GUIDING LANGUAGE

Core Concepts

This review focuses on the formation and functional performance of the family team in conducting ongoing collaborative problem solving, providing effective services, and achieving positive results with the child and family. The team shall have the authority to act and ability to assemble supports and resources on behalf of the child and family. Team functioning and decision-making processes should be consistent with principles of family-centered practice. Unity in effort and commonality of purpose apply to team functioning. Present child status, family participation and perceptions, and achievement of effective results are important indicators about the functionality of the team.

Formation - Team members should include all available family members, the child welfare caseworker and supervisor, any contracted service provider, health care providers, educational partners, and child and parent advocates. When applicable, team members should also include mental health professionals, spiritual leaders, caregivers, Guardians ad Litem, volunteers, and others as identified throughout the life of the case. Collaboration among team members from different agencies is essential. Team members should have knowledge of the family, technical skills, cultural awareness, authority to act, flexibility to respond to specific needs, and time necessary to fulfill the commitment to the family.

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

Considerations

1. Do available family members, informal supports, child welfare professionals, caregivers, and outside stakeholders feel they are a part of the team?
2. Do family team members participate in information sharing, planning, decision making, and evaluating results?
3. Did the protective investigator and case manager work together in partnership during the transition of this case from intake to ongoing services?
4. Is the family satisfied with the functioning of the team? Can the caregiver or older child request a team meeting at anytime?
5. Has the family team explored natural, cultural, or community supports appropriate for this child and family?
6. Does the family team have a unified understanding and common goals for achieving safe case closure?
7. Does the family team have the necessary skills to work effectively with the child and family?
8. Are all members of the team responsible for initiating contact to share information?
9. Has the family team worked together to create and implement a comprehensive and individualized service plan for the child and family?
10. Are family team meetings conducted at crucial points throughout the life of the case (e.g., upon determination of high or very high risk, after removal from the home, prior to change in placement, prior to change in goal, and at the request of a parent/caseworker/child)?

Rating Rationale - NA should never be applied to the following subparts.

- 22.1 Team formation, knowledge, and skill (Available family members' informal supports, child welfare professionals, caregivers, and stakeholders with appropriate capacity were identified and formed into the child and family team).
Strength Gap NA
- 22.2 Team functioning and effectiveness (The team is unified and effective, sharing responsibility for contact and communication, planning, decision-making, evaluating and collaborative problem-solving.)
Strength Gap NA
- 22.3 The child protective investigator and case manager demonstrated shared responsibility for contact and communication, planning, decision-making, evaluating and collaborative problem-solving.
Strength Gap NA
- 22.4 Team meetings (The family team meetings are conducted at crucial points throughout the life of the case.)
Strength Gap NA

Practice Review 23: Assessment & Understanding

REVIEW QUESTION

Focus Measure

ASSESSMENT & UNDERSTANDING: Degree to which those involved with the child and family understand:

- The "big picture" situation and dynamic factors impacting the child and family sufficiently to guide intervention.
- The child and family's strengths, needs, preferences, and underlying issues.
- 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?
- What must change in order for the child and family to achieve timely permanence and improve the child/family's well-being and functioning?
- The outcomes desired by the child and family from their involvement with the system.
- 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.

Note: Rate for current caregiver (parent, adoptive parent, substitute caregiver)

.RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice

RESPONSE GUIDE

6 - Optimal Practice. Assessment of child/family functioning, life circumstances, underlying issues, and support systems are comprehensively and progressively understood by the team. Knowledge necessary to understand the child and family's strengths, needs, and choices is continuously updated and used to keep the big picture understanding current and comprehensive. Present strengths, risks, and underlying needs requiring intervention or supports are fully recognized and understood. Necessary conditions for improved functioning and independence from the system are fully understood and used to select effective change strategies. Optimal pattern - Sustained for 6 months or longer. It is evident the family's input has been considered and incorporated on an ongoing basis.

5 - Good Practice. Assessment of child/family functioning, life circumstances, most underlying issues, and support systems are generally and progressively understood by the team. Information necessary to understand the child and family's strengths, needs, and choices is frequently updated and used to keep the big picture understanding fresh and useful. Present strengths, risks, and underlying needs requiring intervention or supports are substantially recognized and well understood. Necessary conditions for improved functioning and independence from the system are generally understood and used to select promising change strategies. Good pattern - Sustained for 3 months or longer. It is evident the family's input has been considered and incorporated most of the time.

4 - Fair Practice. Assessment of child/family functioning, life circumstances and support systems are at least adequately identified and periodically understood by some participants of the team. Information necessary to understand the child and family's strengths, needs, and choices is periodically updated and used to keep the big picture understanding fairly useful. Some strengths, risks, and underlying needs requiring intervention or supports are minimally recognized and understood. Necessary conditions for improved functioning and independence from the system are at least minimally understood and used for some possible change strategies. Minimally adequate to fair pattern - 30 days or longer. There is evidence in some of the situations that the family's input has been considered & incorporated.

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

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

1 - Absent or Adverse Practice. Current assessments are absent or incorrect and miss critical events and decisions. Some adverse associations between the current situation, the child's bio/psycho/social/educational functioning, and the parent's functioning and support system may have been made. Glaring uncertainties and conflicting opinions exist about things that must be changed for needs and risks to be reduced and the child to function adequately in normal daily settings. A new and complete assessment should be made and used now for this case to move forward. There is no evidence of any assessments

GUIDING LANGUAGE

Core Concepts

Maintaining a useful big picture understanding is a dynamic, ongoing process. The focus here is placed on understanding the family's situation well enough to help the family make positive life changes. Effective assessments supporting team-based reasoning lead to essential understandings in an ongoing process that informs the choice of intervention strategies, services and supports that are used to help the child and family make changes that lead to positive behavior changes. As appropriate to the situation, a combination of clinical, functional, educational, and informal assessment techniques should be used to determine the strengths, needs, underlying issues, and future goals of the child and family. Once gathered, the information should be analyzed and used 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 and parent's age, ability, culture, embraced faith, language or system of communication, and educational level. 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.

Considerations

1. What are the critical issues (i.e., strengths, needs, safety threats/factors, risk factors, caregiver capacities, behaviors, underlying issues, etc.) that exist for the child and family?
2. What has been the child and family's input on their assessment & analysis of their strengths needs & critical issues
3. Has there been a thorough review of past investigations and services provided to this child and family?

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4. Does the assessment identify any significant language, cultural issues, family beliefs and customs of the child and family? If identified, have the issues been addressed?
5. How well does the social worker and team know and understand the strengths and needs of this child and family?
6. How well are child and family stressors recognized? How are these understood within the context and culture of this child and family?
 - Earlier life traumas, losses, disruptions
 - Ability to meet family financial needs
 - Risks of harm, abuse, or neglect
 - Recent tragedy, loss, victimization
 - Problems of attachment and bonding
 - Extraordinary caregiver burdens
 - Learning problems affecting school or job performance
 - Developmental delays or disabilities
 - Physical and/or behavioral health concerns
 - Court-ordered requirements/constraints
 - Co-occurring disabling conditions
 - Recent life transitions and adjustments to new conditions
 - Impacts of criminal issues, substance, mental health & domestic violence
7. What observations, formal assessments, or evaluations have been obtained? Are assessments appropriate for this child and family? Is there evidence that assessment is a dynamic, continuous learning process? Is there evidence that the child/family assessment evolved over the course of the life of the case and impacted decision making and planning?
8. How well does the assessment and understanding process reveal the big picture situation for any substitute caregivers and permanency resources (e.g., relatives and foster parents who may become the permanency caregiver for the child)? If there are different views of the child, family, and/or substitute caregivers/permanency resources, what would it take for them to form a common vision and understanding?
9. Does the assessment support a long-term view of the child and family leading to independence from service system involvement and supports?

Rating Rationale - NA should never be applied to the following subparts.

- 23.1 Initial understanding of the child (Critical issues were identified by reviewing past child welfare involvement, conducting an initial assessment of family strengths, needs, and preferences, including the family's perspective with a recognition of family stressors and cultural context.)
Strength Gap NA
- 23.2 Initial understanding of the mother (Critical issues were identified by reviewing past child welfare involvement, conducting an initial assessment of family strengths, needs, and preferences, including the family's perspective with a recognition of family stressors and cultural context.)
Strength Gap NA
- 23.3 Initial understanding of the father (Critical issues were identified by reviewing past child welfare involvement, conducting an initial assessment of family strengths, needs, and preferences, including the family's perspective with a recognition of family stressors and cultural context.)
Strength Gap NA

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- 23.4 Initial understanding of the caregiver (Critical issues were identified by reviewing past child welfare involvement, conducting an initial assessment of family strengths, needs, and preferences, including the family's perspective with a recognition of family stressors and cultural context.)
Strength Gap NA
- 23.5 Update and apply understanding of the family (Ongoing assessments were conducted throughout the life of the case and at critical junctures that dynamically impacted planning and decision-making processes; new or ongoing issues were addressed with supports in place to promote successful outcomes.)
Strength Gap NA

Practice Review 24: Planning for Safe Case Closure

REVIEW QUESTION

Focus Measure

PLANNING PROCESS: Degree to which the planning process:

- Is individualized and matched to the child and family's present situation, preferences, and long-term view for safe case closure.
- Provides a combination and sequence of strategies, interventions, and supports that are organized into a coherent service process providing a mix of services that fits the child and family's evolving situation.

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice

RESPONSE GUIDE

6 - Optimal Practice. An excellent planning process is used that is fully individualized and relevant to child and family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning is well-reasoned, building on accurate understandings from recent assessments and fully reflecting the long-term view. Change strategies, interventions, and supports are optimally organized into a holistic and coherent service process providing a sensible combination and sequence of strategies, interventions, and supports uniquely matched to the child/family's situation and preferences. Strategies and services are based on need rather than availability. Planned strategies, interventions, and supports optimally fit the family's situation and change requirements to maximize potential results and prevent conflicts and inconveniences. Planning adapts immediately to changes in life circumstances and includes a viable concurrent plan. To be optimal, plans have an individualized, current safety plan with present capacities for effective implementation, if applicable. Optimal - Sustained for 6 months.

5 - Good Practice. A good and consistent planning process is used that is generally individualized and relevant to child and family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning is thoughtful, building on accurate understandings from recent assessments and substantially reflecting the long-term view. Change strategies, interventions, and supports are well-organized into a holistic and coherent service process providing a useful combination and sequence of strategies, interventions, and supports well matched to the child/family's situation and preferences. Planned strategies, interventions, and supports substantially fit the family's situation and change requirements so as to enhance potential results and minimize conflicts and inconveniences. Planning adapts quickly to changes in life circumstances and includes an identifiable concurrent plan. To be determined substantial, plans have a generally individualized and current safety plan with developed capacities for effective implementation, if applicable. Good pattern - Sustained for 3 months.

4 - Fair Practice. An adequate to fair planning process is used that is somewhat individualized and relevant to child and family needs and to family changes that must be made to achieve independence and sustainable, safe case closure. Planning somewhat builds on basic understandings from assessments and adequately reflects the long-term view. Change strategies, interventions, and supports are somewhat organized into a useful service process providing a combination and sequence of strategies, interventions, and supports somewhat matched to the child/family's situation and preferences. Planned strategies, interventions, and supports adequately fit the family's situation and change requirements to support potential results and reduce conflicts and inconveniences. Planning adapts periodically to changes in life circumstances and includes a potential concurrent plan. The plan has a somewhat individualized and current safety plan, if applicable. Minimally adequate to fair - 30 days.

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

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

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

GUIDING LANGUAGE

Core Concepts

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

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

Considerations

1. Does the case plan have a sense of urgency in working toward resolution & closure?
2. How well are the child and family engaged and participating in planning? Are strategies and services tailor-made and assembled uniquely for this child and his/her parents? How well does the current mix of strategies and services match the child/family situation, cultural background, and expressed preferences? Are strategies and services based on need rather than on availability?
3. If the child presents developmental delays or disabilities, is the child receiving early intervention services? If not, why? Has consideration been given to other developed plans (e.g., I.E.P, DJJ plans)? If not, why not? Are the appropriate early intervention services accessible and available to meet the child's identified needs?
4. How well are change strategies, interventions, and supports matched to the family changes necessary for achieving family independence and for sustaining family functioning and well-being following safe case closure?
5. When applicable, are the concurrent plans individualized to the child/family and do they maximize potential results and minimize conflicts?
6. Are all members of the family team involved in the planning process and contributing to plan revisions? Do team members share a common understanding and big picture view of this child and family and what it will take to achieve successful results and outcomes?
7. Are the roles, assigned responsibilities, commitments, and timelines clear and agreed upon by the key parties for this child and family? Are there dependable working relationships among the key parties? Are the time frames for the task sequential and/or staggered when appropriate?
8. To what degree is daily practice actually driven by the service planning process?

Rating Rationale - NA should never be applied to the following subparts.

- 24.1 Individualized planning (The planning process that included input from the child and the family was individualized and specific to the family's current situation and their goals for the future.)
Strength Gap NA
- 24.2 Effective planning (Planning efforts were effective; there was a sense of urgency by all parties to access and participate in intervention services quickly in order to maximize the chance for positive results and achievements.)
Strength Gap NA
- 24.3 Dynamic planning (The planning process occurred over the life of the case and considered the family's continuously evolving situation.)
Strength Gap NA

Practice Review 25: Supporting Transitions & Life Adjustments

REVIEW QUESTION

Focus Measure

TRANSITION PLANNING: Degree to which:

- The current or next life change transition for the child and family is being planned, staged, and implemented to assure a timely, smooth, and successful adjustment for the child and family after the change occurs.
- Plans and arrangements are being made to assure a successful transition and life adjustment in daily settings.
- There are well-planned follow-along supports provided during the adjustment period occurring after a major change is made in a child's life to ensure success in the home or school situation. Unpredicted/emergency changes are assessed and follow-up supports are engaged to ensure child's adjustment.

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

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice NA

RESPONSE GUIDE

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

5 - Good Planning. The child/family's next transition has been identified and discussed. What the child/family should know, be able to do, and have as supports to be successful are planned and being addressed. If a transition to another setting (or return to home and school) is imminent, substantial arrangements for supports and services are being made to assist the child during and after the move. If the child has made a transition within the past 3 months, the child is generally stable and successful in his/her daily settings. Good pattern - Sustained for 3 months or longer.

4 - Fair Planning. The child/family's next transition has been identified. What the child/family should know, be able to do, and have as supports to be successful are known and being used for planning. If a transition to another setting (or return to home and school) is imminent, basic arrangements for supports and services are in place to adequately assist the child during and after the move. If the child has made a transition within the past 30 days,

the child is adequately stable in his/her daily settings and is not at risk of disruption due to transition and life adjustment problems. Minimally adequate to fair - 30 days or longer.

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

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

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

Not Applicable. Findings reveal no evidence of transition to be addressed for this child/family at this time. This review indicator is deemed not applicable to this child/family.

GUIDING LANGUAGE

Core Concepts

A child/family moves through several critical transitions over the course of childhood and adolescence (e.g., from preschool to kindergarten; from school to school; or from high school to college, work, or adult services). Some children may experience removal from their birth family for child protection or treatment reasons. Some may be reunified with the birth family, placed with kin, or adopted by a family. For children who already may have experienced multiple traumas, a change in caregivers can be extremely difficult and re-traumatizing. Well-coordinated efforts in assisting the child through significant transitions are essential for success. Follow-along tracking may be required for an adjustment period (beyond the honeymoon period in placement changes). Special coordination efforts may be necessary to prevent breakdowns in services and to prevent any adverse effects transition activities may have on the child and family. To be effective, transition plans and arrangements have to produce successful transitions as determined after the change in settings actually occurs. The reviewer should remember that transition planning is an ongoing team-based process for designing and organizing transitions, for life changes, and for adjusting strategies and directing resources toward the accomplishment of defined outcomes set forth in the long-term view for the child and family.

Considerations

1. Is the child moving through a current transition and life adjustment phase? Is the child/family anticipating a major transition within the next three months? If so, is there a well planned and supported transition and life adjustment process provided to ensure success?
2. Has the child/family team identified the child's next critical transition? If so, what transition plans are being made to accomplish a smooth transition? Are necessary transitional and follow-along adjustment plans being

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individually tailored to meet the identified need(s)? Are timely sequencing and supports used appropriately to provide follow-along support for successful life adjustments in the child's normal daily settings (home and school) and life activities?

3. Do permanency plans for this child indicate that the agency has used or considered using trial home visits to facilitate transition and return from out-of-home care? How is the family involved in implementing important aspects of the child's life change and adjustment and any necessary changes needed in the home and care giving arrangements to achieve successful reintegration of the child into the life of the family?
4. If this child has a history of difficult transitions or placement changes, how is this knowledge being used to improve transitions?
5. If a transition is imminent, is a well-staged transition plan or articulation process currently being implemented for this child/family?
6. Is this child/family currently experiencing adverse consequences of a recent transition or change in placement? If so, what are the reasons, and what is being done about it?
7. For what period of time is the child being closely monitored following a transition in home or school? How well are follow-along supports being used to track the child and those supporting the child through the life change and adjustment process?
8. Is the transition support plan comprehensive enough to cover the full scope of the child's life change effects and adjustment needs?
9. Where appropriate, are timely and necessary transition steps being planned and implemented for the older child moving to needed adult services?
10. If a transition was emergent and unplanned, were follow-up supports engaged to assist during the child's adjustment period?

Rating Rationale - NA should never be applied to the following subparts.

- 25.1 Transition identification and planning (The family was included in planning for imminent and future events in an effort to support a seamless transition from one setting to another.)
Strength Gap NA
- 25.2 Transition implementation and support (Upon transitioning from one setting to another, appropriate supports and services were in place to make the transition successful, e.g., adequate monitoring of the situation, involving connected caregivers, frequent and quality visits, etc.)
Strength Gap NA

Practice Review 26: Implementation

REVIEW QUESTION

Focus Measure

IMPLEMENTATION: Degree to which:

- **Planned and accessible intervention strategies, services, and supports being provided to the child and family have sufficient power (precision, intensity, duration, fidelity, and consistency) and beneficial effect to produce results necessary to meet needs and achieve outcomes that fulfill the long-term view for safe case closure.**
- **An adequate array of home, school, and community resources is available to implement planned strategies.**

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice

RESPONSE GUIDE

6 - Optimally Powered Intervention & Resources. An excellent combination, sequence, and power of current interventions is helping the child and family reach optimal levels of functioning necessary for them to make progress and improve functioning and well-being. An excellent combination of informal and, where necessary, formal supports and interventions is provided with excellent precision and with fully commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is entirely sufficient to quickly and fully meet near-term needs and reach planned outcomes. Optimal pattern - Sustained for 6 months or longer.

5 - Good Intervention & Resources. A good combination, sequence, and power of current interventions is helping the child and family reach good and substantial levels of functioning necessary for them to make progress and improve functioning and well-being. A dependable combination of informal and, where necessary, formal supports and interventions is provided with good precision and with substantially commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is generally sufficient to quickly and fully meet near-term needs and reach planned outcomes. Good pattern - Sustained for 3 months or longer.

4 - Minimally Adequate to Fair Intervention & Resources. A fair combination, sequence, and power of current interventions is somewhat helping the child and family reach at least minimally adequate to fair levels of functioning necessary for them to make progress and improve functioning and well-being. A minimally adequate combination of informal and, where necessary, formal supports and interventions is provided with some precision and with at least minimally adequate levels of intensity, duration, continuity, and coordination. The power of intervention is minimally sufficient to meet important near-term needs and eventually reach planned outcomes. Minimally adequate to fair pattern - 30 days or longer.

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

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

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

GUIDING LANGUAGE

Core Concepts

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

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

- **Sufficient Power** -- Providing interventions at necessary levels of intensity, duration, coordination, consistency, and continuity to produce the changes necessary for the child and family that are consistent with the desired results.
- **Beneficial Effects** -- Providing a pattern of changes that shows satisfaction of identified needs and progress being made toward attainment of desired outcomes as evidence that interventions are producing *beneficial effects*. Lack of expected progress suggests that planned strategies/services are either inappropriately matched to need or that the right strategies/services are being poorly delivered or that efforts may be underpowered.
- **Adequate Resources** -- Necessary supports and services are available as needed on a convenient local basis to the child and family.

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

Considerations

1. What specific strategies are being used in the change process for this child and family? What is required for precise delivery (for desired effect) for each strategy? How well are resources matched to the strategies that are to meet needs and achieve planned outcomes? Are resources available on a timely, adequate, and convenient local basis to deliver the planned strategies, supports, and services planned in this case? If not, what resources or services are missing or inadequate to meet the outcomes planned for the child and family in the long-term view?
2. Is the level of intensity, duration, coordination, and continuity commensurate with what is required for successful and sustained child/family change? If not, are current service authorization rules or limitations leading to discontinuity or inadequacy of effect? Do the strategies match the changes to be made? If not, what is missing?
3. Are services that are being provided to child and family working well? If not, why not?
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? Are there any identified needs for changing service providers to better meet a need? If so, can the change be made timely so there's continuity of service? If change was needed, why, and was new service engaged timely?
5. Are there any change strategies for this child/family that cannot be adequately implemented with precision, resourced, coordinated, or delivered with continuity? If yes, what and why?

Rating Rationale - *NA should never be applied to the following subparts.*

- 26.1 Effective strategies and services (The intervention strategies, services and supports are of sufficient intensity and duration to promote achievement of desired outcomes.)
Strength Gap NA
- 26.2 Adequate array of resources (An array of appropriate resources is in place to support successful implementation of intervention strategies.)
Strength Gap NA

Practice Review 27: Maintaining Quality Connections

REVIEW QUESTION

Focus Measure

MAINTAINING QUALITY CONNECTIONS: When a child is placed out of the home, the degree to which the child's family connections and other important people are maintained through appropriate and good quality visits and other means -- unless compelling reasons exist for keeping certain family members apart.

NOTE: If the child is residing with a parent, this indicator will not be applicable.

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice NA

RESPONSE GUIDE

6 - Optimal Practice. Fully effective family and other important connections are being excellently maintained through appropriate visits and other connecting strategies. All appropriate parties have regular and, where appropriate, increasingly frequent visits and interactions. Excellent strategies are in place to effectively build and maintain positive interactions, provide emotional support between the child and his/her family and important people. Optimal pattern - Sustained for 6 months or longer.

5 - Good Practice. Family and other important connections are being substantially well maintained for all family members through appropriate visits and other connecting strategies. All appropriate parties have regular visits and interactions. Good strategies are effective in building and maintaining positive interactions and providing emotional support between the child and his/her family and important people. Good pattern - Sustained for 3 months or longer.

4 - Fair Practice. Family and other important connections are being at least adequately maintained for all family members through appropriate visits and other connecting strategies. All appropriate family members have periodic visits and interactions (every other week). Minimal adequate strategies are in place to support building and maintaining positive interactions and providing emotional support between the child and his/her family and important people. Minimally adequate to fair pattern - 30 days or longer.

3 - Marginal Practice. Family and other important connections are being at least marginally maintained for most family members through visits and other connecting strategies. Some appropriate family members have periodic visits and interactions (occurring less than every other week). Inconsistent and/or somewhat inadequate strategies are limiting building and maintaining positive interactions and providing emotional support between the child and his/her family and important people. There may be some evidence that visits may have been withheld as a punishment or used as an incentive at least once in the past 3 months. Immediate action is needed in this area.

2 - Poor Practice. Family connections are being inconsistently maintained for some family members through visits and other connecting strategies. Some appropriate family members have occasional visits/interactions. Some members may have very limited, inconsistent, or no contact or connections. Substantially inadequate strategies are limiting building and maintaining positive interactions and providing emotional support between the child and his/her family and important people. There may be some evidence that visits may have been withheld as a punishment or used as an incentive more than once in the past 3 months. Immediate action is needed in this area.

1 - Absent or Adverse Practice. Family connections are fragmented, declining in frequency or quality, or inappropriate for family members. Appropriate and necessary visits are not occurring with sufficiency to maintain family connections (or visits are withheld as punishment or used as an incentive). Some visits may be therapeutically inappropriate or unsafe for one or more family members. There may be some evidence that visits may have been withheld as a punishment or used as an incentive more than once in the past 3 months. Immediate action is needed in this area.

Not Applicable. The child is residing with a parent; therefore, this indicator does not apply.

GUIDING LANGUAGE

Core Concepts

This indicator measures the quality of relationships between the child and his/her family members and other important people in the child's life. Quality relationships depend on opportunities for positive interactions which are emotionally supportive, mutually beneficial connections; and engaging in nurturing exchanges with one another. Quality relationships promote the preservation of families and the successful reunification of the child and his/her parents or their natural support. Fostering relationships between biological parents and out of home caregivers is critical to improving parental capacity.

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

Visits should be conducted in locations conducive to family activities and offer 'quality time' for advancing or maintaining relationships among family members. Visits and/or other techniques, such as phone calls, letters, and/or exchange of photos, should be used when safe and appropriate to do so to enable both parents, siblings, relatives, and other important people in the child's life to maintain family ties. Infants and young children may need support from their current caregiver to feel secure during visits with parents or other family members with whom they do not have a strong relationship.

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

Considerations

1. Are initial and ongoing efforts to identify and locate family members and other important people in the child's life being made?
2. Are visits and appropriate interactions occurring now? If so, are visits:
 - Frequently occurring?
 - Therapeutically appropriate?
 - Conducive to relationship building?
 - Located in a convenient and least restrictive setting?
 - Rescheduled in a timely manner?
 - Increasing in frequency and duration and decreasing in supervision, if appropriate?
 - Being used to assess reunification appropriateness?
 - Providing mentoring opportunities for caregivers to mentor parents?

3. Are other forms of family contact, interactions, or connecting strategies being used (e.g., phone calls, letters, family photos), tapes, Skype, recordable book, life books) when appropriate?
4. What supports are being provided to parents, beneficial connections, out of home caregivers (e.g., transportation), and case managers (e.g., flexible schedules to meet family's needs.) to facilitate and assist visits?
5. What steps are being provided to encourage contact between children and incarcerated parents?
6. Is there an effort to integrate the parents or beneficial connections into the child's life (e.g., participation in doctor's appointments, teacher conferences at school, sporting events, etc.)?
7. Do the parents or beneficial connections and the child describe one another in positive terms and identify ways in which they have been able to enhance the quality of their relationship with one another?
8. Is there any evidence that visits have been withheld as a punishment or used as an incentive for compliance or "good behavior" at any time within the past 90 days in this case?

Rating Rationale - *NA should never be applied to the following subparts.*

- 27.1 Identifying family connections (Initial and ongoing efforts were made to locate family members and other important people in the child's life.)
Strength Gap NA
- 27.2 Maintaining family connections (Concerted efforts were made to maintain family connections through the choice of placement locales [in proximity to home community], frequent visitation among case participants and other interactions that are conducive to building and maintaining positive relationships.)
Strength Gap NA

Practice Review 28: Evaluating & Adjusting

REVIEW QUESTION

Focus Measure

MONITORING & ADJUSTMENT: Degree to which:

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

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice

RESPONSE GUIDE

6 - Optimal Practice. The strategies, supports, and services being provided to the child and family are highly responsive and fully appropriate to changing conditions. Child/family status and service results are occurring and shared among all team members through continuous monitoring, evaluating and effective communication. Timely and appropriate adaptations are being made. Highly successful modifications are based on a rich knowledge of what things are working and not working for the child and family. Optimal pattern - Sustained for 6 months or longer.

5 - Good Practice. The strategies, supports, and services being provided to the child and family are substantially responsive to changing conditions. Frequent monitoring, evaluating, and communication of child/family status and service results are occurring and are shared among most team members. Generally successful adaptations are based on a basic knowledge of what things are working and not working for the child and family. Good pattern - Sustained for 3 months or longer.

4 - Fair Practice. The strategies, supports, and services being provided to the child and family are adequately responsive to changing conditions. Periodic monitoring, tracking, and communication of child/family status and service results are occurring and are shared among some team members. Adaptations to supports and services are being made. Minimally adequate to fair pattern - 30 days or longer.

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

2 - Poor Practice. Poor strategies, supports, and services are provided to the child and family and are not always responsive to changing conditions. Limited monitoring or poor communications exists, and/or an inadequate child and family team is often unable to function effectively in planning, providing, monitoring, or adapting services. Few sensible modifications may be planned or implemented. Child and family status may be marginal or poor in several

areas. Limited tracking and adjusting has the potential to lead to poor child/family outcomes. Immediate action is needed in this area.

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

GUIDING LANGUAGE

Core Concepts

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

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

Considerations

1. How well is the family team really finding what works for this child and family?
2. How is the child/family progress monitored by the team (e.g., face-to-face contacts, telephone contact, and meetings with family, child, service providers, reviewing reports from providers, etc.)?
3. How well are the status and progress of the child/family being evaluated and adjusted by the team in the following areas? Consider how well:
 - Ongoing assessment is used to determine if present and impending threats to child safety have emerged/reemerged.
 - Parent/caregiver protective capacities are evaluated.
 - Enhancement of protective capacities is mitigating the safety threats/factor.
 - Development and demonstration of required child and/or parent behavior changes are occurring.
 - Adequate and sustainable supports necessary for child/family functioning are secured.

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- Concurrent planning and active efforts are occurring to attain child permanency.
 - Any special needs that were identified.
 - Successful transitions and life adjustments are achieved.
 - Any outstanding issues necessary for sustainable, safe case closure are resolved as needs arise and/or goals met.
4. Is the implementation of planned supports and services being evaluated? Are detected problems or breakdowns in service design or delivery being reported and addressed promptly? Is progress or lack of progress being identified and noted? If not, why not?
5. How well are transitions anticipated, planned, evaluated, adjusted and sustained?
6. Is the court advised of permanency progress in a timely fashion? Are any requests to revise court orders pursued in a timely manner?

Rating Rationale - NA should never be applied to the following subparts.

- 28.1 Monitoring of child and family progress (The team routinely and regularly monitored and assessed the child's and family's situation gauging case progress, or the lack thereof)
Strength Gap NA
- 28.2 Apply and adjust for progress (Strategies and services were adjusted to respond to the child's and family's changing needs, to include but not limited to, changes in parental protective capacities, changes due to transitioning from one setting to another, or changes in service providers based on past successes that should be replicated.)
Strength Gap NA

Practice Review 29: Psychotropic Medication Management

REVIEW QUESTION

Focus Measure

PSYCHOTROPIC MEDICATION MANAGEMENT: Degree to which:

- Any use of psychotropic medications for this child is necessary, safe, and effective.
- The child and parents/caregivers understand the benefits and risks of each medication.
- The child and parents and/or caregivers have a voice in medication decisions and management.
- The child is routinely screened for medication side effects and treated when side effects are detected.
- 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, addiction, HIV).

NOTE: This applies to any child who has taken psychotropic medications whether it is for a psychotherapeutic, medical or other reason. This Indicator Applies to a Child Who Has Taken Psychotropic Medications in the Past 90 Days

RESPONSE - Practice Rating:

6 Optimal Practice 5 Good Practice 4 Fair Practice 3 Marginal Practice 2 Poor Practice 1 Adverse Practice NA

RESPONSE GUIDE

6 - Optimal Medication Management. The child presents symptoms or behaviors that are responding optimally to current generation medications with no report of bothersome side effects. The child and caregiver report full compliance with the prescribed medications and are not requesting any changes at this time. Use of medications is fully 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. Optimal pattern -sustained for 6 months or longer.

5 - 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. Good pattern evident for 6 months or longer.

4 - 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 report some at non-compliance but medication log is not reviewed. 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. Minimally adequate to fair pattern evident for 30 days or longer.

3 - Marginally Inadequate Medication Management. The child presents symptoms or behaviors that may be responding somewhat to medications. Medication use may be inconsistent either due to child's refusal or caregiver's inconsistent disbursement. Appropriate consent or court orders have not 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. Concerted action is indicated in this area.

2 - 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. Appropriate consents or court orders have not been obtained. 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. Concerted action is indicated in this area.

1 - 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. Appropriate consent or court orders have not been obtained. 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. Concerted action is indicated in this area.

Not Applicable. The child does not now take psychotropic medications, nor has the child used such medications within the past 90 days. Therefore, this indicator does not apply.

GUIDING LANGUAGE

Core Concepts

Use of psychotropic/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, trauma-informed care, 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, obesity). **The purpose of this indicator is to determine whether the child receives and benefits from safe medication practices.**

When a child in out-of-home is prescribed psychotropic medication(s), FSFN must accurately reflect the process that is involved in the consent for, and administration of these drugs. As the official system of record for all case management activities, the data maintained in FSFN regarding all psychotropic medications prescribed must be accurate, current and modified as necessary, to include adding new medications when prescribed and terminating prior medications as deemed appropriate by the prescribing physician. If parental rights have not been terminated, parents (birth or adoptive) and/or a legal guardian are authorized to provide informed consent that the child receive psychotropic medication(s). If a child does not have a birth or adoptive parent, or a legal guardian, authorization to treat with psychotropic medications must be pursued through a court order. The child, if age appropriate, also has a right to be advised about the prescribed medication and to agree to take the medication. For children in foster care whose parents' rights have not been terminated, case management and the prescribing physician must attempt to obtain written express and informed consent from the child's parent or legal guardian.

Case management must take necessary steps to facilitate the inclusion of the parent in the child's consultation with the prescribing physician.

"Express and informed consent" means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

Considerations

1. Does the child take a psychotropic/addiction control medication at this time or at any time in the past 90 days? Prior to use of psychotropic medication was there an attempt to use other interventions (e.g., behavior modification)?
2. Is the prescribing physician a psychiatrist or primary care physician? 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?
3. Is educational information about the medications, effect/side effects, and self-medication available to the child, parents and caregivers? Are the child/parents and the caregivers trained on the use of these medications (e.g., purpose of the medication, administration, effects, side effects, risks)? How well do the child, parents and caregivers understand the purpose, safe use, expected benefits, and what to watch for and report if medication-related problem occur? Is written express and informed consent or court order obtained for the use of each psychotropic medication? If parental rights have been terminated, has the court authorized the use of psychotropic medications? Does the caregiver have a copy of the court order? If the psychotropic medication is prescribed for a non-psychotropic reason (e.g., seizure), is the child, parents and caregivers aware of the reason for the medication?
4. Is there a DSM-IV-R I diagnosis to support each psychotropic medication prescribed to this child? Is the purpose for each medication documented and tracked to target identified mental health/behavioral needs? Is each medication consistent with intended use? Is medication use consistent with current treatment protocols with respect to the age of the child?
5. Is psychotropic medication use coordinated with other treatment modalities? Is all use of prescribed medications coordinated by prescribers to prevent any medication contraindications or adverse effects?
6. Is each prescribed psychotropic medication being taken consistently by the child in the manner recommended by the prescriber? Has the child or caregiver requested medication adjustments? What were the reasons? • What changes were made?
7. Is there periodic evaluation of the child's response to treatment using data to track target symptoms or behaviors? 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? Is there quarterly screening of the child for adverse effects of medications? If adverse effects have been found, have appropriate countermeasures been implemented?
8. 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?
8. For child age 10 or under, has paper work been submitted for additional review?

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9. Has the Pre-Consent Review for psychotropic medication treatment plans for children under eleven (11) years of age in out-of-home care who are prescribed two (2) or more psychotropic medications been completed
10. Is there clear documentation that when a prescribing physician recommended the child be placed on psychotropic medications, case management facilitated communication between the parents, the child and the physician to obtain their express and informed consent? If express and informed consent by the parents or legal guardian was not obtained or their whereabouts were unknown, was the case immediately referred to Children's Legal Services to obtain a court order?

Rating Rationale – Apply NA if the child is not prescribed psychotropic medications.

- 29.1 Medication use is safe and necessary (If the child in care is prescribed psychotropic medications, the prescribing physician explained why the medication was necessary, how it is consistent with treatment protocols for age, and any adverse effects that might be involved.)
Strength Gap NA
- 29.2 Child and parent/caregiver participation (The case management organization involved the child and the parents/legal guardian in the decision making process by facilitating contacts with physicians for treatment planning. The child and family were fully informed of the prescribing physician's recommendation and each had a voice in making medication decisions.)
Strength Gap NA
- 29.3 Express and Informed Consent or court order (The parents were fully informed of the physician's recommendations and formally agreed the medications be administered. Or, if the parents disagreed or were not available or their rights had been terminated, the court authorized administering these medications.)
Strength Gap NA
- 29.4 Monitoring of use (Routine monitoring to ensure the caregiver was administering the medication correctly and quarterly screenings occurred in order to make any necessary adjustments.)
Strength Gap NA
- 29.5 Coordination with other treatments (As available and appropriate, other behavioral and non-psychotropic medical interventions were consulted and accessed.)
Strength Gap NA
- 29.6 Prior to seeking a medical evaluation to determine the need to initiate or continue a psychotropic medication, the case manager provided the prescribing physician all pertinent medical information known to the agency at the time.
Strength Gap NA
- 29.7 When express and informed consent could not be obtained from the child's parents, the case management organization submitted a request for court authorization to Children's Legal Services.
Strength Gap NA
- 29.8 All data fields in the Florida Safe Families Network related to psychotropic medications appropriately and accurately documented the child's prescribed medications. (*applies to out-of-home cases*)
Strength Gap NA

Chapter 6

Case Specific Rating Profile Worksheet

Florida Quality Services Review Rating Profile

Child's Name: _____ Reviewer: _____ Date: _____

Child and Family Status Indicators

Status Indicators	Improve		Refine		Maint		NA
	1	2	3	4	5	6	
1. Safety from Exposure to Threats of Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Child Vulnerability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Living Arrangement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Permanency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Overall Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Emotional Well-Being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Early Learning & Development (0-5 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Academic Status (6-18+ years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Pathway to Independence (14+ years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Parent & Caregiver Functioning & Resourcefulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Child Status Indicators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Child and Family Status Indicators

Status Indicators	Improve		Refine		Maint		NA
	1	2	3	4	5	6	
1. Engagement Efforts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Voice and Choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Teamwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Formation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Assessment and Understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Planning for Safe Case Closure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Supporting Transitions and Life Adjustments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Implementation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Maintaining Quality Connections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Evaluation and Adjusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Psychotropic Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Practice Performance Indicators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Chapter 7

Case Debriefing and Reporting Outlines

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

- 1. Core Story of the Child and Family (2 minutes)**
 - Reason for services (Why are we involved with this child and family?)
 - Goals that focus interventions provided (What are we trying to achieve in the case?)
 - Strengths and needs of the child and family
 - Services provided and by which agencies

- 2. Child and Caregiver Status (3 minutes)**
 - Overall child and caregiver status finding
 - Status rating patterns
 - Progress made over the past six months
 - Problems

- 3. System Practice and Performance – focus on the Practice Wheel (3 minutes)**
 - Overall system performance finding
 - Performance rating patterns
 - What's working now in this case?
 - What's not working and why
 - Six-month forecast

- 4. Next Steps (1 minute)**
 - Important and doable "next steps"
 - Any special concerns or follow-up indicated

- 5. Reflection Question (1 minute)**
 - *What does this Story Teach Us about Practice?*

Group Questioning of Presenter (3-5 minutes)

Reviewer's Outline for Case Manager/Supervisor Debriefing

1. Discuss story as learned from family and team members about the child and family and clarify any gaps/questions.

- Reason for services (Why are we involved with this child and family and what is known about child/family history?)

 - Goals that focus interventions provided (What are we trying to achieve in the case?)

 - Team member perspectives on strengths and needs of the child and family

 - Team member concerns and ideas for getting better results
-

2. Discussion of Next Steps

- Ideas of Case Manager and Supervisor

 - Feedback on suggestions gathered from family and team members interviewed

 - Some reviewer ideas that may be an option
-

3. If case manager and supervisor could make any system changes that would help to get better results for this child and family, what would they be?

Written Case Review Summary

The final step in completing the QSR is writing the case review summary. The summary includes some basic demographics and facts about the child and family. The core of the summary describes the child's and caregiver's status, factors contributing to favorable or unfavorable statuses, to include some analysis of what's working now and why as well as some practical steps to sustain success or overcome problems.

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, teacher, caseworker, therapist, etc.) of the persons interviewed.

Facts About the Child and Family [About 150 words]

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

Child's Current Status [About 250 words]

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

Caregiver's Status [About 150 words]

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

Factors Contributing to Favorable Status [About 100 words]

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

Factors Contributing to Unfavorable Status [About 100 words]

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

System Performance Appraisal Summary

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

What's Working Now [About 250 words]

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

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

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

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

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

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

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

Report Length

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

Definitions

The assessment and management of threats to child safety are based on concepts that should be fully understood and applied. The foundation for what child welfare workers do throughout safety intervention is grounded on these concepts. The proficient use of the ideas that are expressed through these definitions is fully dependent on a versatile working knowledge of what these concepts are and how they have relevance, give meaning and apply to safety intervention from receiving a referral to closing a case. (Source: National Resource Center for Child Protective Services An adaptation of copyrighted material of ACTION for Child Protection. May be reprinted and distributed with accompanying citation.)

1. **Safety Intervention** refers to all the actions and decisions required throughout the life of a case to a) assure that an unsafe child is protected; b) expend sufficient efforts necessary to support and facilitate a child's caregivers taking responsibility for the child's protection; and c) achieve the establishment of a safe, permanent home for the unsafe child. Safety intervention consists of identifying and assessing threats to child safety; planning and establishing safety plans that assure child safety; managing safety plans that assure child safety; and creating and implementing remedial case plans that enhance the capacity of caregivers to provide protection for their children. Safety intervention represents an overarching term that includes all safety assessment and safety management activities occurring during intake, initial assessment and ongoing CPS.
2. **Safe Home** refers to the required safety intervention outcome that must be achieved in order for a case that involves an unsafe child to be successfully closed. A safe home is a qualified environment and living circumstance that once established can be judged to assure a child's safety and provide a permanent living arrangement. A safe home is qualified by the absence or reduction of threats of severe harm; the presence of sufficient parent or caregiver protective capacities; the existence of refuge experienced by a child; perceived and felt security by a child; and confidence in consistency and endurance of the conditions that produced the safe home. The term "safe home" is used in the Adoption and Safe Families Act (ASFA) as the objective of CPS intervention.
3. **Safety** refers to the absence of present or impending danger to a child or sufficient parent or caregiver protective capacities to assure that a child is protected from danger.
4. **Unsafe** refers to the presence of present or impending danger to a child and insufficient parent or caregiver protective capacities to assure that a child is protected.
5. **Safety Threat** refers to specific conditions, behavior, emotion, perceptions, attitudes, intent, actions or situations within a family that represent the potential for severe harm to a child. A threat to child safety may be classified as present danger, impending danger or a safety threat. However, the term *safety threat* identifies impending danger.
6. **Safety Threats** refers to standardized impending danger contained as criteria on a safety assessment instrument for assessing, determining and recording the presence of impending danger. The list of safety threats is the safety assessment criteria used by CPS to indicate a conclusion about whether impending danger exists.
7. **Parent or Caregiver Protective Capacities** refers to personal and parenting behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person being protective of his or her child. A protective capacity is a specific quality that can be observed, understood and demonstrated as a part of the way a parent thinks, feels, and acts that makes her or him protective.

8. **Present Danger** refers to an immediate, significant and clearly observable severe harm or threat of severe harm occurring to a child in the present requiring immediate CPS protective response. The protective response is called a *protective action*.
9. **Impending danger** refers to a state of danger in which family conditions, behaviors, attitudes, motives, emotions and/or situations are out of control and while the danger may not be currently active it can be anticipated to have severe effects on a child at any time. Commonly impending danger threats to child safety are not obvious or occurring at the onset of CPS intervention or in a present context but which are identified and understood upon more fully evaluating and understanding individual and family conditions and functioning and without safety intervention reasonably could lead to severe harm. Impending danger refers to a family situation in which a child is not in immediate or present danger but exists in a general state of danger because of what is understood to be happening within his or her family.
10. **Harm** refers to detrimental effects on a child of any degree from mild to severe. Harm is consistent with the negative results of child abuse or neglect on a child of any degree including jeopardizing general well being.
11. **Severe Harm** refers to detrimental effects consistent with serious or significant injury; disablement; grave/debilitating physical health or physical conditions; acute/grievous suffering; terror; impairment; even death.
12. **Safety Threshold** refers to the point at which family behaviors, conditions or situations become directly threatening the safety of a child. The safety threshold is crossed when family behaviors, conditions or situations occur in such a way that they are beyond being just problems or risk influences and have become directly threatening to child safety. These family behaviors, conditions or situations are active at a heightened degree and a greater level of intensity; have moved passed being in control; and have implications for dangerousness. Therefore, the safety threshold includes only those family behaviors, conditions or situations that are judged to be out of the parent/caregiver or family's control. Family behaviors, conditions or situations can no longer be considered just problematic or contributing to the risk of maltreatment but have become alarming in so far as they are indicative of sure danger.

The safety threshold is the means by which a family condition can be judged or measured to determine if a safety threat exists. The safety threshold criteria includes: family behaviors, conditions or situations that are out of control; are extreme in nature; likely to produce severe harm; occurring in the presence of a vulnerable child; are imminent; and are observable, specific and justifiable.

- a. **Out-of-Control** refers to family behavior, conditions or situations which are unrestrained resulting in an unpredictable and possibly chaotic family environment. These family conditions which can affect a child are unrestrained; unmanaged; without limits or monitoring; not subject to the influence, manipulation or internal power within the family's control. This includes family members who cannot prohibit themselves from behaving in such a way that a child's safety is threatened. Such out-of-control family conditions pose a danger and are not being managed by anybody or anything internal to the family system.
- b. **Severity** refers to the effects of maltreatment that have already occurred and/or the potential for harsh effects based on the vulnerability of a child and the family behavior, condition or situation that is out of control. Severity is consistent with severe harm.
- c. **Vulnerable Child** refers to a child who is unable to protect him/herself; it includes a child who is dependent on others for protection. This definition includes all young children from 0 — 6 and older children who, for whatever reason, are not able to protect themselves or seek help from protective others. A vulnerable child is dependent on others for sustenance and protection; essentially defenseless; exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to age; physical and emotional development; ability to communicate needs; mobility; size and robustness and dependence and susceptibility.

d. Imminence refers to the belief that family behaviors, conditions or situations will remain active or become active without delay resulting in or contributing to an event or circumstances that reasonably could result in severe harm to a vulnerable child within the near future. Now or near future are consistent with *the immediate present to within the next several days up to a couple of weeks*. Imminence is consistent with a degree of certainty or inevitability that danger resulting in severe harm is possible, even probable without intervention.

e. Observable refers to family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen and understood and are subject to being reported and justified. The connection of these family behaviors, conditions or situations to posing a danger to a child is evidenced in explicit, unambiguous ways. The criterion "observable" does not include suspicion, intuitive or gut feeling, difficulties in worker-family interaction, lack of cooperation, difficulties in obtaining information, or isolated, even provocative information considered exclusive of family behaviors, conditions or situations.

13. Risk of maltreatment refers to the likelihood that parenting behavior will be harmful and destructive to a child's cognitive, social, emotional and/or physical development and those with parenting responsibility are unwilling or unable to behave differently. The time that negative effects on children might occur is not specified; the seriousness of negative effects on children is not specified.

14. Protective Action refers to an immediate - same day, short term and sufficient approach or strategy to protect a child from present danger in order to allow completion of the initial assessment. A protective action usually occurs during the initial contact with a family. A protective action occurring the same day that present danger is encountered provides a child with responsible adult supervision and care and compensates for immediate physical and situational danger. Typically a protective action will include a straightforward, immediately achievable protective arrangement such as relying on a non-maltreating caregiver to protect the child; arranging and confirming that the maltreating parent will leave and remain away from the home; arranging for the non-maltreating caregiver to leave home with the child; using people and resources available to the family to immediately protect the child; and placing the child in kin care, foster care or appropriate temporary shelter facilities. Criteria for a protective action are:

a. Immediate requires that the protective action must be capable of being in operation the same day it is created. Before CPS leaves the home the protective action must be in motion and confirmed.

b. Short Term requires that the protective action is specifically focused on and tied to particular family behaviors, conditions or situations representing present danger and must control those threats from the present until sufficient information can be gathered and analyzed to determine the need for a more formal continuing safety plan. Protective actions should be sufficient to manage safety until the initial assessment is complete. The time frame for the protective action is determined by the amount of time it will take CPS to gather all the information necessary to understand the issues/conditions that affect safety.

c. Sufficient requires that protective actions are pertinent and adequate to manage present danger; people participating are suitable and parent/caregiver ability, willingness and cooperation have all been confirmed.

15. Safety Intervention Information refers to relevant knowledge and facts necessary to assess, analyze, create continuing safety plans and manage threats to child safety. Relevant knowledge and facts are obtained through the collection of information associated with six assessment areas:

- a. What is the extent of the maltreatment?
- b. What surrounding circumstances accompany the maltreatment?
- c. How does the child function on a daily basis?

- d. What are the disciplinary approaches used by the parent?
- e. What are the overall, typical pervasive parenting practices used by the parent (excluding discipline)?
- f. How does the adult function in respect to daily life management and general adaptation including mental health and substance use?

16. Safety Assessment refers to a focused evaluation that documents determines and documents the presence of impending danger. Present danger is observed and assessed to exist while an initial assessment worker is in the field and must be recorded within 24 hours of the first contact. Documenting present danger can occur in case notes, narrative, a specific form for that purpose or in other ways. A more robust safety assessment (including sufficient information gathering to judge impending danger) is conducted as part of the entire initial assessment and is officially completed on a safety assessment instrument at the conclusion of the initial assessment. A safety assessment applies criteria comprised of standardized safety threats. Safety intervention information collected during the initial assessment and added to during continuing involvement with a family provides the content for the safety assessment occurring at the conclusion of the initial assessment.

17. Safety Analysis refers to an examination of safety intervention information; safety threats (concerned with impending danger threats) as identified by the safety assessment; and parent/caregiver protective capacities. The purpose of a safety analysis is to fully examine how safety threats are occurring within a family and to determine the necessary level of intrusion and level of effort required to assure child safety. The safety analysis is conducted to determine what is required within a continuing safety plan in order to effectively control and manage impending danger threats to child safety. The objective of a safety analysis is to support the development of a sufficient continuing safety plan. Safety analysis consists of the examination of four variables: manifestation of safety threats (how impending danger is occurring); potential for an in home continuing safety plan; need for an out of home continuing safety plan (or a continuing safety plan that combines in home and out of home options); and the necessary level of effort required in the continuing safety plan to manage how safety threats are occurring.

18. Can/Will Protect refers to the extent to which a non-maltreating parent or caregiver can control and manage safety threats (impending danger threats.) The extent to which a parent or caregiver can/will protect a child from impending danger threats is evaluated by considering the nature and intensity of present or impending danger and the presence of enhanced and sufficient of parent/caregiver protective capacities. The judgment about whether a caregiver "can/will protect" occurs as part of the safety assessment.

19. Continuing Safety Plan refers to a written arrangement between parents/caregivers and CPS that establishes how safety threats (impending danger threats) will be managed. The continuing safety plan is implemented and active *as long as* impending danger threats exist and caregiver protective capacities are insufficient to assure a child is protected. The continuing safety plan specifies what impending danger exists, how impending danger will be managed using what safety actions, tasks or safety services; who will participate in those actions, tasks or safety services; under what circumstances and agreements and in accordance with specification of time requirements, availability, accessibility and suitability of those involved. The continuing safety plan is designed along a continuum of least to most intrusive intervention: in home continuing safety plans; a combination of in home and out of home continuing safety plans; and out of home continuing safety plans.

- a. In home Continuing Safety Plan** refers to safety management so that safety services, actions and responses assure a child can be protected in his own home. In home continuing safety plans include activities and services that may occur within the home or outside the home but contribute to the child remaining home. People participating in in-home continuing safety plans may be

responsible for what they do inside or outside the child's home. An in-home continuing safety plan primarily involves the home setting and the child's location within the home as central to the safety plan, however, in-home safety plans can also include periods of separation of the child from the home (e.g., protective day care) and may even contain an out of home placement option such as on weekends.

b. Out of Home Continuing Safety Plan refers to safety management that primarily depends on separation of a child from his home, separation from the safety threats and separation from caregivers who lack sufficient protective capacities to assure the child will be protected. Out of home continuing safety plans can include safety services and actions in addition to separation or out of home placement. Out of home continuing safety plans always should contain a caregiver-child visitation plan based on the unique circumstances of each case. Out of home continuing safety plans can contain some in home safety management dimension to them. Out of home continuing safety plans can include safety service providers and others concerned with safety management besides the out of home care providers.

20. Safety Services refers to actions; things provided, supervision identified as part of a continuing safety plan occurring specifically for controlling or managing impending danger threats. Safety services are required to sufficiently address the identified impending danger threat to child safety. Safety services must control safety threats (the impending danger threat) immediately upon being put in place: safety services must have an immediate effect whenever they are delivered; safety services must do immediately what they are intended to do. Safety services are categorized according to the objective they seek to address within a continuing safety plan:

- *Behavior Management* is concerned with applying action (activities, arrangements, services, etc.) that controls caregiver behavior that is a threat to a child's safety.
- *Crisis Management* is specifically concerned with intervening to bring a halt to a crisis and to mobilize problem solving to return a family to a state of calm.
- *Social Connection* is an action that reduces social isolation and seeks to provide social support.
- *Resource Support* refers to safety action that is directed at a shortage of family resources and resource utilization, the absence of which directly threatens child safety.
- *Separation* refers to safety action that removes a child from the impending danger threat and/or the home for brief to extended periods of time to provide relief to caregivers or to the child and to assure protection at specific times.

21. Safety Service Providers refers to anyone who participates as one responsible for safety management within a protective action or a continuing safety plan. Safety service providers can be professionals, para-professionals, lay persons, volunteers, neighbors or relatives.

22. Accessibility of Safety Service Providers refers to the extent to which those responsible for safety management are close enough with respect to time and proximity for timely involvement in a protective action or a continuing safety plan.

23. Accessibility of Threatening Person refers to the extent to which a person who is a danger to a child has access to a child under unsupervised circumstances.

24. Availability of Safety Service Providers refers to whether those responsible for safety management within a protective action or a continuing safety plan exist in sufficient quantities under the circumstances prescribed by the protective action or the continuing safety plan.

25. Reasonable Efforts refers to activities and attempts to assess and analyze safety threats and to seek people, resources and alternative methods for in home continuing safety plans that prevent child placement or allow

for a child to be reunified with his or her family. The reasonable efforts standard is not required when responding to present danger.

- 26. Conditions for Return** refers to a statement of the specific behavior and circumstances that must exist within a child's home for a child who is placed to return to his or her home. Conditions for return can be included within a court order. Conditions for return must be clearly communicated to caregivers.
- 27. Reunification** refers to a safety decision to modify an out of home continuing safety plan to an in home continuing safety plan based on an analysis that a) safety threats (impending danger threats) have been eliminated or reduced; b) caregiver protective capacities have been sufficiently enhanced; c) caregivers are willing and able to accept an in home continuing safety plan; and d) conditions for return have been met.
- 28. Safety Management** refers to assessing safety threats; involving caregivers and others; organizing ideas and efforts related to protection; planning how protection will be achieved; creating protective action *and* continuing safety plans; modifying continuing safety plans; arranging for safety services and safety providers; evaluating safety providers; evaluating the sufficiency of continuing safety plans; communicating with all concerned with continuing safety plans; overseeing daily and weekly implementation of continuing safety plans; handling breakdown, lapses, underperformance or shortfall related to the continuing safety plan; and controlling or governing all activity, practice, communication and decision making concerned with continuing safety plans.
- 29. Provisional Safety Management** refers to the philosophical base upon which safety management occurs. The belief is that the best, most fair, most equitable and most family centered safety management is that which is dynamic, vigorous and amenable to alteration. It is temporary in that it is constantly subject to adjustment and modification based on what is happening within a family and changes that are occurring concerning safety threats and caregiver protective capacities. Provisional safety management is not short term necessarily since continuing safety plans remain in effect until such time as a child can be judged to be safe. Provisional safety management emphasizes the least intrusive methods for assuring child protection. This kind of safety management results in CPS routinely assessing safety threats and caregiver protective capacities in order to determine the sufficiency of continuing safety plans and stepping up or stepping down the level of effort and activities appropriately and as necessary to assure a child is protected.
- 30. Case Management**, as applied to safety intervention, refers to engaging caregivers in a process for change; conducting protective capacity assessments; identifying diminished caregiver protective capacities that must change; identifying enhanced caregiver protective capacities that can be used to support change; integrating caregiver protective capacities into case plans as the center piece for change; arranging and implementing remedial services focused on enhancing diminished caregiver protective capacities; communicating routinely with caregivers and service providers concerning effective implementation of the case plan; identifying and removing barriers and conflict that can jeopardize the successful implementation of the safety plan; evaluating caregiver progress; and closing cases when outcomes are achieved.
- 31. Protective Capacity Assessment** refers to the worker-caregiver interpersonal and decision making process that examines; selects; and integrates safety concerns into a case plan. The protective capacity assessment reveals enhanced caregiver protective capacities that can be employed within change efforts to reinforce change. The protective capacity assessment considers diminished caregiver protective capacities that must change in order for caregivers to be restored to their role and responsibility for protecting their children. The protective capacity assessment involves a process that includes engaging caregivers in a collaborative partnership for change; evaluating caregiver readiness for change; facilitating

communication and interaction with caregivers in order to identify caregiver and family member needs; facilitating awareness and agreement with caregivers regarding protective capacities that must change and other changes needed in a family in order to create a safe home; involving caregivers in the development and implementation of case plans that are individualized; employing enhanced caregiver protective capacities; and addressing diminished caregiver protective capacities that must change to assure that children are not maltreated and are safe.

32. Case Plan, in reference to safety intervention, refers to the approach that an ongoing CPS worker and caregivers agree will most effectively support and enable the enhancement of diminished caregiver protective capacities. The protective capacity assessment and case planning process involve a collaboration with caregivers in reaching an agreement about enhanced protective capacities that can support change; diminished caregiver protective capacities that must be enhanced; safety factors that should be reduced or eliminated. The case plan is the document which confirms the agreement reached between an ongoing CPS worker and a caregiver

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