Qualitative Case Review

Protocol for Review of Current Status of Children and Families and the Performance of Key System Functions

Produced for Use by

Utah Department of Human Services
Division of Child and Family Services

by Human Systems and Outcomes, Inc.

September 2017

Qualitative Case Review (QCR)

The QCR is a method used for appraising the current status of persons receiving child welfare and other publicly funded services on key indicators and for determining the adequacy of performance of key service system functions for these same persons. The QCR examines short-term results for children with special needs and their caregivers and the contribution made by a locally coordinated service system in producing those outcomes. Review results are used for understanding and improving the front-line practices of child-serving agencies.

These working papers, collectively referred to as the *QCR Protocol,* are used to support a professional appraisal of child status and service system performance for individual children and their caregivers in a specific service area at a given point in time. This protocol is not a measurement instrument designed with psychometric properties intended for research uses and should not be taken to be so. The Utah QCR Protocol is prepared for and licensed to the Utah Department of Human Services, Division of Child and Family Services. The QCR Protocol and use methodology are based on a body of work by Ray Foster, PhD and Ivor Groves, PhD of Human Systems and Outcomes, Inc. (HSO). These tools and methods follow a Service Testing ™ process developed and offered by HSO.

Proper use of the *QCR Protocol* requires reviewer training and supervision. Supplementary materials provided during training are necessary for reviewer use during case review activities. Persons interested in gaining further information about the QCR should contact an HSO representative at:

HSO Human Systems and Outcomes, Inc.

2107 Delta Way
Tallahassee, Florida 32303-4224

Phone: (850) 422-8900
Fax: (850) 422-8487

The QCR protocol is available online at: www.hsosr.utah.gov
or by contacting OSR (801)538-4277

Inquiry Areas & Examinations

For Testing Child Welfare Services

Areas of Inquiry Interest

- How well this child and family are doing now
- Quality of services as seen through their lives and status
- Service system integrity, continuity, and performance
- Consistency of decisions and actions with good practice
- Results and benefits achieved for this child and family

→

Review Objectives

- Determine the current status of the child and caregiver
- Appraise adequacy of services/practices being provided
- Examine transitions and progress made over time
- Compare practices and results with the principles of the Practice Model
- Build local capacity for quality management/ improvement

Determination of Child and Family Status

Fundamental Concerns

- Child doing well now and in the future
- Safe/stable living and learning settings
- Child healthy and making progress
- Consumer satisfaction with services/results

Status Reviews

1. Safety*
2. Stability
3. Prospects for Permanence
4. Health/Physical Well-being
5. Emotional/Behavioral Well-being
6. Learning or Developing Progress
7. Family Connections
8. Satisfaction

OVERALL CHILD/FAMILY STATUS

* Safety is a "trump" indicator meaning that Overall Child Status is ACCEPTABLE only when SAFETY is Acceptable.

↔

Linkage between child/ family status and service system performance

Appraisal of System Performance

Fundamental Concerns

- Service based on assessed strengths/needs
- Availability of services/use of supports
- Integration of supports and services
- Timeliness and intensity of services
- Effectiveness of supports and services

System Performance Reviews

1. Engagement
2. Teaming
3. Assessment
4. Long-Term View
5. Child and Family Plan
6. Intervention Adequacy
7. Tracking & Adapting

OVERALL SYSTEM PERFORMANCE

Status Review 1A: Child's Safety From Others

SAFETY: • Is the child safe from threats of harm in his/her daily living, learning, working, and recreational environments? • To what extent is the child vulnerable due to age, mental capacity, physical capacity, etc.? • Are the parents and caregivers capable of protecting the child from threats of harm?

Child safety is central to child well-being. The decision about whether a child is safe depends on the relationship between threats of harm, child vulnerability, and protective capacities.

> **Threat of Harm:** Threat is the condition where belief, opportunity, and potential action co-exist. Harm is the resulting effect.
> **Vulnerability:** The degree to which a child cannot avoid, negate, or modify the impact of a safety threat.
> **Protective Capacity:** Parent/caregiver strengths or resources that reduce, control and/or prevent threats of harm from arising or having an unsafe impact.

The capability and reliability of the parents and other responsible persons in recognizing threats of harm and their protective capacities in protecting the child from harm must be considered. This consideration extends to the effectiveness of any safety interventions (e.g., no contact orders, safety plans, after-school child supervision plans) put into place to protect the child. Factors for consideration include the continuum of time, chronicity of behavior and conditions, and severity.

Each child should be free from risks of harm in his/her daily environments. Safety from harm extends to freedom from unreasonable intimidations and fears that may be induced by family, neighbors, peers, etc. Safety applies to settings in the child's natural community as well as to any special care or treatment setting in which the child may be served on a temporary basis. All adult caregivers and professional interveners in the child's life bear a responsibility for maintaining safety for the child.

Child/Family Status Probes for Review Use

1. Is the child currently or has the child recently (30 days) been a victim of abuse, neglect, or exploitation in the home or other setting?
2. Is the child fearful, intimidated, or at high risk of harm in any current setting or activity?
3. Is the parent/caregiver meeting the child's needs for food, clothing, shelter, medical care and supervision?
4. Are physical living conditions hazardous or threatening to the safety of the child?
5. Did the parent/caregiver use excessive discipline or excessive physical force within the last 30 days? Does the parent/caregiver make plausible threats to cause physical harm to the child?
6. Does the parent/caregiver's violent behavior, abuse/addiction to drugs and/or alcohol, mental illness, emotional instability, criminal activity, developmental status, cognitive ability, or domestic violence impair his/her current ability to supervise, protect, or care for the child?
7. Does the parent/caregiver have the capacity and willingness to recognize the problems and situations placing the child in imminent danger and are they taking steps to protect the child from harm? Is at least one parent/caregiver in the home willing and able to take action to protect the child, including asking an offending caregiver to leave?
8. Does the caregiver have a capacity and willingness to accept safety interventions offered by the worker and/or other community agencies, including cooperation with continuing investigation/assessment?
9. What supports, resources, safety plans or strategies is the parent/caregiver using to keep the child free from harm?

Status Rating 1 A: Child's Safety From Others

Score	Environment	Threats of Harm	Vulnerability	Protective Capacities	Time Frame
6	There is optimal safety for the child. The child has a highly safe living situation at home with fully reliable and competent parents/caregivers who protect the child well at all times.	The child is free from harm in 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.	The child is not vulnerable to any specific threat of harm.	Any protective strategies used are fully operative and dependable in maintaining excellent conditions.	The child has not experienced harm within the past 30 days and the child has not been exposed to an elevated threat of harm within the past 30 days.
5	There is substantial safety for the child. The child has a generally and substantially safe living situation at home with reliable and competent parents/caregivers who protect the child well under usual daily conditions.	The child is generally free from harm in 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.	The child is generally not vulnerable to a threat of harm.	Any protective strategies used are generally operative and dependable in maintaining acceptable conditions.	
4	There is minimally acceptable safety for the child. The child has a minimally safe living arrangement with the present parents/caregivers.	The child is free from imminent danger of abuse or neglect. The child is at least minimally free from harm in daily settings, including at school and in the community. At home and/or in other settings, the child may have limited exposure to intimidation and fear of harm.	The child is minimally vulnerable to a threat of harm.	Any protective strategies used are at least minimally adequate in reducing threats of harm.	
3	There is partially unacceptable safety for the child. At home and/or in other settings, the child may be exposed to occasional intimidation and fear 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.	The child is somewhat vulnerable to a threat of harm.	Any protective strategies used may be somewhat limited or inconsistent in reducing threats of harm.	The child has experienced harm within the past 30 days or the child has been exposed to an elevated threat of harm within the past 30 days.
2	There are substantial and continuing safety problems for the child. At home and/or in other daily settings, the child may sometimes experience abuse, neglect, exploitation, or intimidation. At home or in other settings, the child may be exposed to frequent or serious intimidation and fears of harm.	The child is exposed to substantially elevated threats of harm in his/her home and/or in other daily settings, possibly at school and in the community.	The child is substantially vulnerable to a threat of harm.	Protective strategies used may not be implemented or effective in reducing the danger of harm.	
1	There are serious and worsening safety problems. The child may be exposed to continuing and increasingly serious intimidation, abuse, and/or neglect.	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.	The child is highly vulnerable to a threat of harm.	Any protective strategies used may not be implemented or effective when used, leaving the child in danger of continuing and worsening harm.	

Status Review 1B: Child's Risk to Self and/or Others

SAFETY: Does the child avoid self-endangerment and refrain from using behaviors that may put self and others at risk of harm? Are others in the child's daily environments safe from the child?

Throughout development, children and youth learn to follow rules, values, norms, and laws established in the home, school, and community, while learning to avoid behaviors that can put themselves or others at risk of harm. This indicator examines the target child/youth's choices, decisions, subsequent behaviors, and activities, and whether or not those choices engage him/her in potentially harmful activities. It addresses behavioral risks, including self-endangerment/suicidality and risk of harm to others. It considers the child/youth's engagement in lawful community behavior and socially appropriate activities and avoidance of potentially harmful or illegal activities. All adult caregivers and professional interveners in the child's life bear a responsibility for maintaining safety for the child and others who interact with the child. Consideration extends to the effectiveness of any safety interventions (e.g., no contact orders, safety plans, after-school child supervision plans) put into place to protect the child. Factors for consideration include the continuum of time, chronicity of behavior and conditions, and severity.

Examples of potentially harmful activities include:

- Running away or leaving supervision for extended periods
- Extreme tantrums that may result in harm to self or others
- Serious property destruction, including fire setting
- Bulimia and/or anorexia
- Use of weapons
- Gang affiliation and related activities
- Use or abuse of alcohol/addictive substances/illegal substances
- Suicidality, self-mutilation, or other forms of self-injurious behaviors
- Placing self in dangerous situations or neglecting exceptional self-care requirements
- Assault or physical attacks
- Predatory sexual activities such as grooming, coercion, or non-consensual sexual activities
- High risk sexual activities such as serial partners or indiscriminate sexual encounters

Child/Family Status Probes for Review Use

1. Does the child/youth present self-endangering behaviors or danger to others? If so, what are these behaviors and how are these behaviors being managed to keep people protected from such behaviors?
2. Is this child/youth presently making decisions and/or choosing to participate in activities that would cause harm to self or others?
3. Does this child/youth regularly associate with peers known for engaging in illegal or high risk activities?
4. Is there a history of the child/youth engaging in harmful, illegal, or dangerous activities?
5. Has the child's level of responsibility improved since the beginning of services? How is the youth modifying daily activities and peer relationships?
6. Is there a safety plan to keep others safe from the child?
7. Has any self-harm or harm to others occurred within the past 30 days? If so, what happened?
8. Is the child/youth presently placed in a specialized treatment or detention setting? Has seclusion or restraint been used to prevent harm to self or others? If so, how frequently and for what reasons?

Status Rating 1B: Child's Risk to Self and/or Others

Score	Threat of Harm	Risk Status	Protective Capacities	Timeframe
6	Optimal Safety. The child/youth is optimally and consistently avoiding behaviors that cause harm to self, others, or the community.	Behavioral risk status is excellent.	The child has demonstrated he/she has the internal capacity to avoid behaviors that could cause harm to self or others without external controls. (6 months or more)	The child's behavior has not resulted in harm to self or others in the past 30 days. The child's behavior in the past 30 days has not represented a threat of harm to self or others.
5	Substantially Acceptable Safety. The child/youth is generally and substantially avoiding behaviors that cause harm to self, others, or the community.	Behavioral risk status is good.	The child has demonstrated he/she has the internal capacity to avoid behaviors that could cause harm to self or others without external controls. (3-6 months)	
4	Minimally Acceptable Safety. The child is usually avoiding behaviors that cause harm to self, others or the community but rarely may present a behavior that has low or mild risk of harm.	Behavioral risk status is at least minimally acceptable.	The child's behavior constitutes a threat of harm to self or others but safety strategies and/or caregiver's protective capacities are sufficient to manage the threat. Protective strategies used are at least minimally adequate in reducing threats of harm.	
3	Partially Unacceptable Safety. The child is somewhat avoiding behaviors that cause harm to self, others or the community but sometimes presents a behavior that has a moderate risk of harm.	Behavioral risk status is limited, inconsistent or worrisome.	Protective strategies are in place but are insufficient or ineffective.	The child's behavior resulted in harm to self or others in the past 30 days. The child's behavior in the past 30 days represented a threat of harm to self or others and the safety strategies and protective strategies did not effectively manage the threat.
2	Substantial and Continuing Safety Problem(s). The child is presenting behaviors that may cause harm to self, others or the community. These possibly frequent behaviors have a moderate to high risk of harm.	Behavioral risk status is poor.	The child's behavior represents a continuing threat of harm to self and others and the caregiver's protective capacities are not effectively managing the threats. Protective strategies continue to be ineffective at protecting the child or others from the child's behaviors.	
1	Serious and Worsening Safety Problem(s). The child is presenting a pattern of increasing and/or worsening behaviors that may cause harm to self, others, or the community. These increasingly frequent or severe presentations of behavior have a high risk of harm. The potential for harm is substantial and increasing.	Behavioral risk status is poor and declining.	There is a need for protective strategies but none are in place.	

Status Review 2: Stability

STABILITY: • Has the child's placement setting been consistent and stable? Is the child's current placement setting stable and free from risk of disruption? If not, are appropriate services being provided to achieve stability and reduce the probability of disruption?

Stability in caring relationships and consistency of settings and routines are essential for a child's sense of identity, security, attachment, trust, and optimal social development. Building nurturing relationships depends on consistency of contact. For this reason, stability in the child's living arrangement and social support network is a foundation for child development. If, for reasons of child protection, psychiatric treatment, or juvenile justice services, this child is in a temporary setting or unstable situation, then prompt and active measures should be taken to restore the child to a stable situation.

Instructions:

- The indicator rating should reflect the likelihood that disruptions in the child's living situation may occur in the next year that would disrupt the child's placement, relationships and/or routines.
- Planned placement changes reflect agency efforts to achieve case goals such as a move from a foster home to an adoptive home, a move from a more restrictive to a less restrictive placement, a move from a foster home to kinship care, or a move that brings the child closer to family or community.
- Unplanned placement changes that do not reflect agency efforts to achieve case goals include moves due to unexpected and undesired placement disruptions, moves due to placing the child in an inappropriate placement (for example, one that was based on availability rather than appropriateness), moves to more restrictive placements when this is not essential to achieving a child's permanency goal, or temporary placements while awaiting a more appropriate placement.
- Stability is presumed to be unacceptable if the child's current placement is shelter, detention, etc.; or there is information indicating that the current substitute care provider may not be able to continue to care for the child, or there are problems in the current placement that threaten the stability of the placement that the agency is not addressing, or the child has run from the placement more than once.

Child/Family Status Probes for Review Use

1. How many placement changes did this child experience in the past year (or since the case opened, if less than a year)?
2. Have moves been planned toward achieving the permanency goal?
3. Are there risks of disruption? If yes, what are they?
4. What are the primary reasons for placement changes (safety concerns, run away, child's behavior, foster parent request, move to a relative, etc.)?

**** The timeframe for stability is one year or since the child began receiving DCFS services, whichever is shorter.***

Status Rating 2: Stability

Score	Degree of Stability	Expected Changes
6	The child has remained in the same placement for a year or since the case opened (if open less than a year)	There is no risk of disruption. No unplanned changes are expected in the next year.
5	The child has had no more than one unplanned change over the past 12 months with none in the past six months.	There is little to no risk of disruption. Only a move to an adoptive home is expected.
4	The child has had no more than one unplanned change within the past 12 months and none in the past 90 days.	The child is at risk of disruption with services in place to support the placement and prevent disruption, if needed.
3	The child has had two unplanned changes in the past 12 months or one unplanned change within the past 90 days.	There is information that the child's current caregiver may not be able to continue to care for the child. There are problems in the placement that the agency is not addressing.
2	The child had three or more unplanned changes within the past 12 months.	The child is at elevated risk of an imminent disruption.
1	The child has serious and worsening problems of stability with multiple unplanned changes within the past 12 months.	The child has run away from placement settings more than once in the past or is in AWOL status at the time of the review.

A planned transition that is the result of a placement disruption does not constitute a planned move.

Examples of Planned Moves

Move to less restrictive placement
Move from foster home to adoptive home
Move from foster home to kinship home
Move from foster home to return home
Move to unite child with siblings
Move from one kin to a better kin

Examples of Placement Disruptions

Foster parent requested a move
Foster parent moved out of state
Unsuccessful Trial Home Placement
Placement disrupts
Foster parent stops fostering
Move from kin to foster care

Status Review 3: Prospects for Permanence

PROSPECTS FOR PERMANENCE: • Is the child living with caregivers that the child, caregivers, and other stakeholders believe will endure until the child becomes independent? • If not, is a permanency plan presently being implemented on a timely basis that will ensure that the child will live in enduring relationships that provide a sense of family, stability, and belonging?

Every child is entitled to a safe, secure, appropriate, and permanent home. Families and children are entitled to a permanency plan in a timely manner. A child removed from his family home should be living in a safe, appropriate, and permanent home within 12 months of removal with only one interim placement. If the primary goal is reunification, a concurrent goal should be identified.

If it is anticipated that an older youth will remain in foster care until they are emancipated, the youth should be adequately prepared to make the transition from foster care to independent living, which includes stable relationships that endure into adulthood and can provide healthy supports when needed.

Evidence of permanency includes a committed and supported caregiver and the achievement of safety and 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 or youth. Permanency suggests not only a stable setting, but also stable caregivers and peers, continuous supportive relationships and some level of parental/caregiver commitment and affection. Because of the nature of congregate settings, with frequent turnover of caregivers, time limited stays, serial peer groups, conditional commitment and unreliable personal caring relationships; placements in congregate settings cannot be judged to achieve an acceptable permanency rating. An exception to this would be if a child is still placed in a congregate setting at the time of review, but everyone is ready to move the child to a safe, appropriate, and permanent family setting and the team agrees that the prospective placement will produce permanency (see scoring definition for 4).

Child/Family Status Probes for Review Use

1. Has there been timely progress towards achieving permanency? Are legal steps to achieve permanency being accomplished in a timely manner?
2. What are the child's primary and concurrent permanency goals? Are the identified permanency goals appropriate for the child's need for permanency and the circumstances of the case? Is there a clear permanency plan? Is it being implemented?
3. Is the child living with caregivers that the child, caregivers and caseworker believe will endure until the child becomes independent? Are the child and caregiver satisfied with the placement and permanency plan? Do they understand and commit to the responsibilities for rearing the child?
4. When a youth age 16 or older has a primary goal of Individualized Permanency, has the youth been adequately assessed for independent living skills? Are services being provided to prepare the youth to live independently?
5. If the youth is not living in a permanent home, does he/she have a strong connection to biological family or a trusting and enduring relationship to another significant adult (not a paid professional)?
6. Have there been ongoing efforts to locate and achieve a kinship placement?

Status Rating 3: Prospects for Permanence

	Endurance	Safety and Stability	Commitment	Goals
6	The child lives in a setting that the child, caregivers, and all team members have evidence will endure OR For a youth who is expected to eventually exit foster care to independence, the youth is successfully living in an independent living placement, and has enduring relationships that provide healthy supports when needed.	If the child lives at home with parents, identified risks have been eliminated and stability has been sustained over time.	The child has achieved or will imminently achieve legal permanency.	
5	The child lives in a setting that the child, caregivers, worker, and core team members have confidence will endure until the child reaches maturity. OR For a youth who is expected to eventually exit foster care to independence, the youth is successfully completing independent living skills development, is ready to move to an independent living placement imminently, and has enduring relationships that provide healthy supports when needed and the team has confidence the youth will be successful.	A plan is implemented that supports that confidence because safety and stability have been achieved.	The family will provide the child a "definitive legal status" separate from the child welfare system.	
4	The child lives in a setting that the child, caregivers, worker and core team members expect will endure until the child reaches maturity. OR The child is still living in a temporary placement, but child, caregivers, caseworker, and team members are ready to move the child to a safe and permanent family setting. Readiness for permanency is evident because a realistic and achievable child and family plan is being implemented, a permanent home has been identified, and the transition is being planned for. The team agrees that the prospective placement and plan will produce permanency. The youth is receiving what the youth needs for implementing the actual permanency goal and the parents or future permanent caregiver is receiving preparation for receiving the youth. OR for a youth who is expected to eventually exit foster care to independence, the youth's independent living skills have been assessed and the youth is receiving age appropriate independent living services. The youth has or is developing enduring relationships that can provide healthy supports when needed.	They are successfully implementing a well-crafted plan that supports that expectation because safety and stability are being achieved.	For children old enough to make responsible judgment, the child and caregiver verbalize commitment to the permanency plan. If in an adoptive family, adoption/guardian-ship issues are being resolved.	The permanency goals, including the concurrent goal, are well matched to the child's needs and are being achieved in a timely manner.
3	The child lives in a home that the child, caregivers, worker and some other team members are hopeful could endure until the child reaches maturity. –OR – The child is living on a temporary basis with a substitute caregiver, but likelihood of reunification or finding another permanent home remains uncertain. If in an adoptive family, adoption/guardianship issues are being assessed. OR For a youth who is expected to eventually exit foster care to independence, the youth has been assessed for independent living skills but is not receiving age appropriate independent living services.	They are working on crafting a plan that supports that hope by attempting to achieve safety and stability.	For children old enough to make responsible judgments, the child and caregiver are considering the plan.	The permanency goals are not well matched to the child's needs or are not being achieved in a timely manner.
2	The child is living in a home that the child, caregivers, and caseworker doubt could endure until the child becomes independent. –OR– The child remains living on a temporary basis (more than 9 months) with a substitute caregiver without a clear, realistic, or achievable permanency plan being implemented. OR For a youth who is expected to eventually exit foster care to independence, the youth has not been assessed for independent living skills.	There are safety and stability problems.	The current home is unacceptable to the child and the situation is not improving	
1	The child is moving from home to home. –OR–The child remains living on a temporary basis (more than 18 months) with a substitute caregiver without a clear, realistic, or achievable permanency plan being implemented.	There are safety and stability problems.	The situation is worsening.	

Status Review 4: Health/Physical Well-Being

HEALTH/PHYSICAL WELL-BEING: Is the child in good health? Are the child's basic physical needs being met? Does the child have health care services, as needed?

Children should achieve and maintain good health status consistent with their general physical condition. Healthy development of children requires that basic physical needs for proper nutrition, clothing, shelter, and hygiene are met on a daily basis. Proper medical and dental care (preventive, acute, chronic) is necessary for maintaining good health. Preventive health care should include immunizations, dental hygiene, and screening for possible physical or developmental problems. Physical well-being encompasses the child's physical health status, access to timely health services, and appropriate follow up on recommendations. Children who have chronic health conditions requiring special care or treatment should have a level of attention commensurate with that required to maintain and improve health status. Special care requirements may include nursing, physical therapy, adaptive equipment, therapeutic devices and treatments (e.g., medications, suctioning, etc.). Delivery of these services may be necessary in the child's daily settings including the school and home. The central concern here is that the child's physical needs are met and that follow up care and special care requirements are provided as necessary to achieve optimal health status. Adult caregivers and professional interveners in the child's life bear a responsibility for ensuring that basic physical needs are being met and that health risks, chronic health conditions, and acute illnesses are adequately addressed in a timely manner.

Child/Family Status Probes for Review Use

1. Is the child in good health with access to health care services?

    - Regular medical check-ups and screenings
    - Regular dental care
    - Vision care
    - Up-to-date immunizations
    - Prompt access to acute care, when needed
    - Continuous access to care and treatment of chronic conditions, if needed.

2. Were recommendations for follow up treatment addressed? Why or why not?

3. If the child has physical health problems, is he/she making progress with symptom reduction and improved condition?

    - The child receives consistent services.
    - Symptoms are diminishing and condition is improving.
    - The child is receiving appropriate follow-up treatment by qualified professionals.
    - The effectiveness of medication is monitored regularly by the prescribing physician.
    - A responsible adult is 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 prescribed by a physician.

4. Did the caregiver/foster parent/treatment center receive initial and ongoing medical information about the child?

Status Review 4: Health/Physical Well-Being

Score	Description	Routine Health Care	Follow Up Care	Acute or Chronic Needs
6	The child enjoys optimal health status.	Routine preventive medical and dental care (immunizations, check-ups, and developmental screenings) are consistently provided on a timely basis.	All appropriate and necessary follow up care is provided on a timely basis.	All acute or chronic health care needs are identified and met on a timely and adequate basis.
5	The child is in substantially good health. The child's health status is very good.	Routine health and dental care are substantially provided, but not always on schedule.	Follow up care has been substantially provided within reasonable time frames.	Acute or chronic health care is substantially adequate and usually timely.
4	The child has minimally acceptable health status. The child's health status is good.	Routine health and dental care are minimally provided, but not always on schedule. Some immunizations may not have occurred.	Follow up care may have been delayed for a month or two but provided.	Acute or chronic health care is generally adequate and timely.
3	The child's physical status is problematic.	Routine health and dental care is not always adequately provided. Some required immunizations have not occurred.	Follow up care has not been provided, or it has been delayed for more than a couple of months.	Acute or chronic health care is sometimes inadequate. Important treatments have been missed or delayed, but it is not immediately life threatening.
2	The child suffers from poor health status that is affecting the child's development and/or ability to perform in school.	Routine health and dental care have been seriously neglected.	There has not been follow up on important recommendations.	Health care needs are chronically or consistently unmet.
1	The child has serious and worsening physical or health care problems. The child suffers from poor and declining health status that is adversely affecting the child's development and/or ability to perform in school.	Routine health and dental care have been seriously neglected leading to serious physical deterioration, disability, or death.	Follow up care has been completely neglected.	Health care needs are unmet. Further neglect could lead to serious physical deterioration, disability, or death.

Status Review 5: Emotional/Behavioral Well-Being

EMOTIONAL/BEHAVIORAL WELL-BEING: • Is the child doing well emotionally and behaviorally? • If not, is the child making reasonable progress toward stable and adequate functioning, emotionally and behaviorally, at home and school?

To do well in life a child should:

- Have a sense of identity that connotes a feeling of personal worth.
- Have a sense of belonging and affiliation with others in his/her support networks.
- Feel capable of participating in major life activities and decisions that affect him/her.
- Feel that his/her life has meaning, purpose, and direction.
- Feel a part of his/her culture and its social supports.

For a child who requires special care, treatment, supervision, or support in order to make progress toward stable and adequate functioning in his/her home, school, and community, the child should be receiving necessary services and demonstrating progress toward adequate functioning in normal settings. Some children may require improved communication, social, and problem-solving skills to be successful. Other children may require special behavioral interventions or mental health treatment. Behavioral health needs include needs related to behavioral problems that are not always specified as mental health needs, including substance abuse. Reviewers should consider the mental/behavioral health needs that existed and the services that the agency provided to address those needs, including outpatient treatment, inpatient mental health treatment, treatment for substance abuse disorders, individual therapy, group therapy, family therapy, etc.

Child/Family Status Probes for Review Use

1. Is the child doing well emotionally and behaviorally at home and at school? (Stable circle of supporters, best friend, caring adult, appropriate peer activities, experience with success, etc.) If not, why not?
2. Has the child had a mental health assessment?
3. Does the child have a DSM diagnosis or school diagnosis?
3. Were recommendations for follow up treatment addressed? Why or why not?
4. If the child has emotional and/or behavioral problems, is he/she making progress with symptom reduction and improved functioning?

   Do the following statements below apply to this child?

   - The child receives consistent services.
   - Symptoms are diminishing and functioning is improving.
   - If any emotional/behavioral problems were identified, the child is receiving appropriate treatment by qualified professionals.
   - If the child is taking medication(s) for emotional/behavioral problems, the effectiveness of the medication is monitored regularly by the prescribing physician.

5. Is the youth demonstrating adequate personal responsibility in daily interactions, habits, and attitudes as appropriate to his/her age and ability? (e.g., communicates thoughts and feelings in acceptable ways, abstains from behaviors that cause harm and/or are illegal, etc.)
6. For a child age four months to five years, was the Ages and Stages Emotional screening tool used to assess the child's emotional level? If needs were identified, was a referral made?

Status Rating 5: Emotional/Behavioral Well-Being

Score	Description	Relationships	Stability/Functioning	Follow Up
6	Child shows optimal emotional/behavioral well-being in home and school settings.	Child has enduring circles of support with parents/ primary caregivers and friends.	Child has been emotionally and behaviorally stable and functioning well and responsibly for an extended length of time.	Any necessary supports and services for emotional or behavioral needs have been dependable and effective over time.
5	Child shows substantial emotional/behavioral well-being in home and school settings.	Child has generally positive circles of support with parents/primary caregiver and friends.	The child is presently emotionally and behaviorally stable and functioning adequately and responsibly in daily settings.	Child possibly has special supports and services that are working dependably for the child.
4	Child shows minimally acceptable emotional/behavioral well-being in home and school settings.	Child has developing or changing circles of support with parents/primary caregivers and friends.	The child is doing marginally well emotionally and behaviorally but has problems functioning consistently and responsibly.	Special supports and services are necessary and are minimally adequate OR The child is stable in a special treatment setting and making reasonable progress toward discharge and return home.
3	Child shows unacceptable emotional/behavioral well-being in home and school settings.	Child lacks adequate and appropriate circles of support with parents/primary caregivers and friends.	Child has mild to moderate emotional and behavioral problems that adversely affect functioning and responsibility in daily settings.	Special supports and services are necessary but are not provided or are inadequate OR the child is minimally stable in a special treatment setting but is making little progress.
2	Child has substantial and continuing problems of emotional/behavioral well-being in home and school settings.		The child has moderate to serious emotional and or behavioral problems that impair functioning and responsibility in daily settings.	Special supports and services are necessary but are inadequate or ineffective OR the child is unstable in a special treatment setting and not making progress.
1	Child has serious problems of emotional/behavioral well-being in home and school settings. The child's emotional/ behavioral condition is worsening.		The child has serious to life threatening emotional and/or behavioral problems that limit functioning and cause restriction in community or institutional settings.	Intensive supports and services are necessary and provided, but may be inadequate or ineffective.

Status Review 6a: Learning

(For children age 5 and older)

LEARNING PROGRESS: Is the child learning, progressing, and gaining essential functional capabilities commensurate with his/her age and ability?

Each child is expected to be a learner who is 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. Learning progress is concerned not only with academic progress as indicated by grades and achievement test scores, but also with the acquisition and demonstration of functional capabilities in major life areas that are consistent with age and abilities. Essential functional capabilities include: self-care, mobility, communications, literacy, self-direction, caring relationships, community orientation, citizenship participation, employability, and independent living. The ultimate concern is whether the child is learning and progressing at a rate that will enable him/her to become a responsible, competent, contributing citizen upon completion of public school.

Children with disabilities who are not functionally literate by age 14 *(Functionally literate = reads Reader's Digest fluently, follows a recipe, interprets a bus schedule, uses the Yellow Pages)* should be actively involved in vocational work programs that lead directly to work experience and job placement. Supports for living, learning, working, and socialization are required for some children who have major functional limitations due to disabilities, both during their public school experience and later in adult life. School-to-work is the goal for disabled children.

Child/Family Status Probes for Review Use

1. Is the child attending school on a regular basis? If NO, why not?

    - Health (child is out sick frequently, or has chronic health issues)
    - Truancy (child skips class or does not come to school)
    - Disciplinary action (child has been suspended or expelled)
    - Dropped out of school

2. Is this child at high risk of dropping out of school? If YES, what actions are being taken to reduce risks?
3. Is the child performing academic work at or above grade level? If NO, what is the problem and what is being done? Is the child making satisfactory progress?
4. Is the child receiving special education classes or other services to improve academic performance (e.g., tutoring, mentoring, extended school year, IEP, etc.)?
5. If the child is in DCFS custody and is 16 or older, does he/she have an independent living plan? If yes, has the youth started taking TAL classes? Is he/she making progress?
6. If disabled and 14 years old or older, does the child have a current IEP (Individual Education Plan) and transition plan? If YES, is it being implemented? If NO, why not?
7. Has the child had stability in his school setting? Have changes in the school setting affected academic progress or services?

Status Rating 6a: Learning

Score	Progress	Status and Functioning	TAL (16 and older)	ISFP or IEP or Disabled
6	Child is making optimal progress in all essential areas.	The child is working at or above grade level and has literacy skills appropriate to his/her age and ability.	The child is making excellent progress in the TAL program.	The child is making optimal progress on an IEP that will enable him to become literate if within the child's ability. If disabled, the child is making optimal progress in an appropriate alternative curriculum.
5	Child is making substantial progress in most essential academic and functional areas.	The child is working at grade level and has literacy skills.	The child is progressing in the TAL program.	The child is making substantial progress on an IEP that should enable the child to reach functional literacy if within the child's ability. If disabled, the child is making substantial progress in an appropriate alternative curriculum.
4	Child is making minimally acceptable progress in key academic and functional areas.	The child is no more than one grade level behind.	The child is making minimally acceptable progress in the TAL program.	The child is making partial progress on an IEP that should enable the child to reach functional literacy if within the child's ability. If disabled, the child is making progress in an appropriate alternative curriculum.
3	Child is making unacceptable progress in some key academic and functional areas.	The child is more than one year behind grade level but no more than two. Child may have an undiagnosed learning disability.	If the child is 16 or older and illiterate or disabled, he is not in a work-study program leading directly to employment.	The child is not making adequate progress on an IEP. If disabled, the child is not making acceptable progress in an alternative curriculum.
2	Child is not progressing in key academic, functional, or vocational areas. The child is not attending school regularly or is temporarily suspended.	The child is far behind or the child is illiterate and has no work skills or experience.		Few services are being provided.
1	The child is regressing or losing skills.	The child is far behind. The child is expelled or confined w/o appropriate instruction.		Needs have not been identified and services have not been provided.

Status Review 6b: Development

(For children under age 5)

DEVELOPING/LEARNING PROGRESS: Is the child developing, learning, progressing, and gaining skills at a rate commensurate with his/her age and ability?

Each child is expected to be actively engaged in developmental and educational processes that enable the child to develop the skills and functional capabilities at a rate and level consistent with his/her age and abilities. Essential functional capabilities include: walking/ mobility, talking/communicating, toileting, following simple and more complex directions, independent/parallel/ cooperative play, independent dressing, color recognition, etc. Developmental milestones include crawling at about age nine months, walking by 15 months, saying/signing a few words by about 18 months, having a vocabulary of about 50 words by two years, and following simple two-part commands at about three years. Children over age three should be developing readiness for beginning academic skills. Children who have developmental delays or physical limitations should be receiving the necessary supports to maximize their development.

Child/Family Status Probes for Review Use

1. Has the child reached appropriate developmental milestones consistent with age and ability?
2. Is the child developing behaviors (e.g., sharing, playing) appropriate to his/her age, keeping in mind the child's abilities, cultural background, and life experiences?
3. If the child has a documented developmental delay, does the child have a current IFSP (Individual Family Support Plan) or an IEP (Individual Education Plan)? Are the services listed on the IFSP/IEP being provided at an intensity/frequency necessary to support the development of essential skills?
4. If a need for early intervention services has been identified in the assessment, is the child receiving these services (enrolled in an early intervention program such as Head Start or preschool, or receiving services from individual therapists or qualified professionals) to support his/her development?
5. If the child requires special support, are these supports provided (such as sign language training, communication board, wheelchair) to support the child's development? (Sometimes foster parents are qualified to provide special supports and services.)

Status Rating 6b: Development

(for children under age five)

Score	Progress	Functioning Level	Supports	ISFP or IEP
6	Child is making optimal progress.	The child is developing the fundamental skills and competencies commensurate with his/her age and ability.	The child receives all necessary services to support his/her development.	If the child has an IFSP or and IEP, he/she is receiving all the services and supports listed in the plan.
5	Child is making substantial progress in most areas.	Child is functioning commensurate with age and ability.	Most necessary supports/services are being provided.	If the child has an IFSP or IEP, most necessary supports/services are being provided.
4	Child is making minimally acceptable progress in most areas.	Child's functioning is minimally acceptable considering age and ability.	Some necessary services are provided, but not all, or not at the frequency/intensity necessary.	If the child has an IFSP or IEP, some necessary services are provided, but not all, or not at the frequency/intensity necessary.
3	Child is making unacceptable progress in some key developmental/functional areas based upon his/her age and ability.	Child may have a learning impairment that hasn't been assessed yet that interferes with his/her development.	Necessary supports are not being provided.	If the child has an IFSP or IEP, necessary supports are not being provided.
2	Child is far behind and not progressing in key developmental, functional and learning areas based on age and ability.		The child is not receiving the necessary services or receives services at such a minimal level he cannot progress.	If the child has an IFSP or IEP, he is not receiving the necessary services or receives services at such a minimal level he cannot progress.
1	Child is far behind and regressing, losing skills once achieved.		Needs have not been identified and services have not been provided.	

Status Review 7: Family Connections

(For children in foster care)

FAMILY CONNECTIONS: While the child and family are living apart, are family relationships and connections being maintained through appropriate visits and other connecting strategies, unless compelling reasons exist for keeping them apart? To what degree are family relationships maintained through appropriate visits and other means when children and family members are temporarily living away from one another, unless compelling reasons exist for keeping them apart?

The continuity and preservation of family relationships and connections is essential for children. Family members should have frequent and appropriate opportunities to visit in order to maintain or develop family ties. Unless case circumstances suggest it is unsafe or inappropriate, visits and other forms of contact should be provided for family members, potentially including mothers, fathers, and siblings. All appropriate family attachments should be maintained regardless of the permanency goal. Children should be placed sufficiently close to the parents to allow frequent contact between the child and parents. (As a general rule, travel distance within the same county is considered close enough for face-to-face contact. If placement is not within the same county, reviewers should consider if the placement is sufficiently close to allow frequent contact.) If the parents live separately, priority would be given to the parent most involved in the case planning or who is most likely to be reunified with the child. Sometimes the child's needs require a placement that is not in close proximity to the parents (for example, to be with a relative, to be placed in a potential adoptive home, or to provide a highly specialized treatment setting). Facilitation of family connections should not only be supported by the agency and caseworker, but by care providers, service providers, therapists, etc.

Child/Family Status Probes for Review Use

1. Is the child's current placement close enough to the birth parents to facilitate frequent face-to-face contact between the child and parents? If not, why?
2. Are there any compelling therapeutic or legal reasons that family members should not visit with one another? If so, what are those reasons?
3. Are frequent and quality family visits occurring? Is the child visiting with the mother? Father? Siblings? If not, are there compelling reasons why visits are not occurring? Are visits conducive to "quality time" in relationship building?
4. Were concerted efforts made to ensure visitation of sufficient frequency to maintain or promote the child's relationship with mother? Father? Siblings?
5. Other than visitation, what efforts were made to promote, support, and otherwise maintain a positive and nurturing relationship between the child and the mother and father?

   For example, were the parents (Additional Connection Strategies):

   - ☐ Encouraged to participate in school activities and parent/teacher conferences?
   - ☐ Encouraged to participate in after school activities or sports activities?
   - ☐ Encouraged to attend the child's doctor and dentist appointments?
   - ☐ Provided opportunities to attend therapy with the child to strengthen relationships?
   - ☐ Provided or arranged for transportation or provided funds for transportation (as needed)?
   - ☐ Encouraged and facilitated contact with incarcerated parent and/or other where appropriate?

   Were the foster parents:

   - ☐ Encouraged to promote a relationship between the child and the parents?

Status Review 7: Family Connections

Score	Immediate Family Relationships	Visit Frequency	Additional Connecting Strategies
6 (6+ months)	The child's relationships with mother, father, siblings, or other permanent family attachments are being optimally maintained through quality visits **and** use of additional connecting strategies.	The child has regular and, where appropriate, increasingly frequent/extended visits with all appropriate family members.	Parents are fully participating in the child's activities including medical visits, health visits, school functions, etc.
5 (4-6 months)	The child's relationships with mother, father, and siblings are being substantially well maintained through appropriate visits **and** use of additional connecting strategies.	The child has regular visits with all appropriate family members.	Parents sometimes participate in the child's activities including medical visits, health visits, school functions, etc.
4 (90 days)	The child's relationships with mother, father, and siblings are being at least minimally maintained through appropriate visits and other connecting strategies OR the agency has *consistently* made *concerted* efforts to maintain the child's connections.	The child has periodic visits with all appropriate family members with parent visits scheduled or occurring at least weekly.	Parents are invited and encouraged to participate in the child's activities including medical visits, health visits, school functions, etc.
3	The child's relationships with mother, father, and siblings are being inconsistently maintained through visits and other connecting strategies. The child may have limited, inconsistent, or infrequent contact or connections.	The child has periodic visits with some appropriate family members. Visits may be scheduled, but occurring less than weekly.	Parents are informed after the fact or given insufficient notice to participate in the child's activities including medical visits, health visits, school functions, etc.
2	The child's relationships with mother, father, and siblings are being inadequately maintained through visits and other connecting strategies. Some members may have limited, inconsistent, or infrequent contact or connections. The child may be substantially disconnected from important family members.	The child has occasional visits with some appropriate family members. Some visits, if they are occurring, may be therapeutically inappropriate.	Parents are rarely informed about the child's activities.
1	The child's relationships with mother, father, and siblings are not maintained, declining in frequency or quality, or inappropriate for the child.	Appropriate and necessary visits are not occurring with sufficiency to maintain the child's connections. Visits, if occurring, are therapeutically inappropriate or unsafe for the child.	Parents are not informed about any of the child's activities.
N/A	Family Connection Indicator: the case type is not SCF or the target child lives at home or is in a trial home placement as of the day of the review.		
	TC: Contact is contraindicated for safety reasons or due to "best interests of the child" and documented by court order or therapeutic confirmation.		
	MO/FA/Other: • is unknown or location is unknown despite concerted efforts during the past 6 months • TPR occurred prior to review • is deceased • has explicitly declined/refused to participate in case activities or to be involved in the TC's life (Active Refusal)		
	Siblings: • Target Child has no siblings in care • All siblings in foster care are placed with Target Child		

The overall indicator is rated, and then the Mother, Father, Siblings and Other are each rated separately.

"Other" is an adult who is essential to the achievement of the LTV (enduring safety and permanency) such as a step-parent, parent's paramour, or relative who has or had caretaking responsibilities prior to DCFS involvement.

Status Review 8: Satisfaction

SATISFACTION: Are the child, parent/guardian, substitute caregiver, and other primary caregivers satisfied with the supports and services they are receiving?

Satisfaction is the degree to which the child and parents receiving services believe that those services are appropriate for their needs, respectful of their views and privacy, convenient to receive, tolerable (if imposed by court order), pleasing (if voluntarily chosen), and ultimately beneficial in effect.

Rating Statements to be used by Respondents

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I was treated with courtesy and respect.					
Child	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Substitute caregiver	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
2. The staff listened to my ideas and involved me in making decisions about plans and services.					
Child	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Substitute caregiver	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
3. Phone calls were quickly answered and my messages were returned by the caseworker.					
Child	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Substitute caregiver	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
4. I have good quality, dependable services that match my needs well.					
Child	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Substitute caregiver	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
5. If I had a complaint, it was handled quickly and to my satisfaction.					
Child	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Substitute caregiver	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
6. My family's circumstances are better now than before or they are getting better because of services.					
Child	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Substitute caregiver	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
7. What was the child/parent/caregiver satisfied or dissatisfied with?					

Status Review 8: Satisfaction

Score	Supports and Services	Meeting Expectations	Respondent's Feelings
6	Respondent reports optimal satisfaction with current supports and services.	The quality, fit, dependability, and results being achieved presently exceed a high level of consumer expectation.	The respondents "couldn't be more pleased" with the service situation and his/her recent experiences and interactions with service personnel.
5	Respondent reports substantial satisfaction with current supports and services.	The quality, fit, dependability, and results being achieved generally meet a moderate level of consumer expectation.	The respondent is "generally satisfied" with the service situation and his/her recent experiences and interactions with service personnel.
4	Respondent reports minimal satisfaction with current supports and services.	The quality, fit, dependability, and results being achieved minimally meet a low to moderate level of consumer expectation.	The respondent is "more satisfied than disappointed" with the service situation and his/her recent experiences and interactions with services personnel.
3	Respondent reports mild dissatisfaction with current supports and services.	The quality, fit, dependability, and results being achieved do not minimally meet a low to moderate level of consumer expectation.	The respondent is "more disappointed than satisfied" with the service situation and his/her recent experiences and interaction with service personnel.
2	Respondent reports moderate and continuing dissatisfaction with current supports and services.	The quality, fit, dependability, and results being achieved do not meet a low to moderate level of consumer expectation.	The respondent is "consistently disappointed" with the service situation and his/her recent experiences and interactions with services personnel.
1	Respondent reports substantial and growing dissatisfaction with current supports and services.	The quality, fit, dependability, and results being achieved fail to meet any reasonable level of consumer expectation.	The respondent is "greatly and increasingly disappointed" with the service situation and his/her recent experiences and interactions with service personnel.

NA	TC: • is under 12 years of age or is not developmentally capable of understanding the Satisfaction Survey
	MO/FA/Other: • is not interviewed • is unknown or location is unknown despite concerted efforts during the past 6 months • TPR occurred prior to review • is deceased • has explicitly declined/refused to participate in case activities or to be involved in the TC's life (Active Refusal)
	Caregiver: • is not interviewed • The child is placed in a congregate care setting (residential facility, group home, or similar placement)

The overall indicator is rated, and then the Child, Mother, Father, Caregiver and Other are each rated separately.

"Other" is an adult who is essential to the achievement of the LTV (enduring safety and permanency) such as a step-parent, parent's paramour, or relative who has or had caretaking responsibilities prior to DCFS involvement.

System Review 1: Engagement

CHILD/FAMILY ENGAGEMENT: Are those working with the child and family building a genuine, trusting, collaborative working relationship with the child and family? Are staff being receptive and willing to make adjustments in scheduling, meeting locations, and supports such as transportation and child care to accommodate family participation? Are the child and family "actively involved" in all aspects of the process? To what extent has the agency used rapport building strategies, including special accommodations, to engage the family?

The focus is on the diligence shown by the agency in taking actions to engage and build rapport with children and families, overcome barriers to participation, and actively involve children and families. To what extent have concerted, ongoing efforts been made to bring children and families in as full participants in assessment, planning interventions, choosing providers, monitoring results, making modifications, and evaluating progress?

- "Actively involved" *for a parent* means the agency involved the parent in identifying strengths and needs, identifying services and providers, establishing goals in case plans, evaluating progress toward goals, and discussing the case plan in team meetings.
- "Actively involved" *for a child* means the agency consulted with the child regarding the child's goals and services, explained the plan and terms used in the plan in language that the child could understand, and included the child in at least periodic team meetings.

The engagement process should demonstrate the core conditions of genuineness, empathy and respect. Engagement should build on the strengths of the child and family and value their strengths, culture, views, and preferences. The goal of engagement is that the child, family and agency develop a mutually beneficial, trust-based working partnership. Emphasis is placed on the agency making concerted efforts to obtain ongoing involvement by the family in all phases of service. Child and family satisfaction may be a useful indicator of engagement.

System Performance Probes for Review Use

1. To what degree has a mutually beneficial, trust-based working partnership been developed?
2. Do the child and family know their service providers and service objectives?
3. Are child and family strengths and preferences reflected in assessments, plans, and services?
4. Are special accommodations and convenient meeting times/places made to encourage and support participation and partnership?
5. Are the child and family kept fully informed about the current status of service plan implementation, barriers, and emerging issues?
6. Does the family feel that their cultural values were respected throughout the service process? If not, what are the reasons?
7. Did the worker use engagement strategies to actively involve the child/family?
8. Do the child and family have ongoing opportunities to participate in the assessment, planning, monitoring and modification of child and family plans, service arrangements, and evaluation of results?
9. Was the family involved in creating the plan?
10. What has the worker done to involve family members in the service process and build a working relationship?
11. Is the family encouraged to have a voice in the service process? To what extent does the family have control of or influence on the service process? Do the child and family have a sense of ownership in the plan and decision making process?

System Review 1: Engagement

Score	Relationship	Accommodations and Supports	Core Conditions of Engagement	Opportunities to Participate
6 (6+ months)	The agency and family have developed a strong, positive, and trusting relationship.	Meetings are always at times convenient for the family. Special accommodations or supports are always offered and available to support the child and family's participation.	The child and family were continuously treated with genuineness, empathy and respect and constantly reached out to by DCFS and providers.	The family has frequent, ongoing opportunities to participate in assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services.
5 (4-6 months)	The agency and family have developed a good, mutually beneficial, trusting relationship.	Meetings are scheduled at times convenient for the child and family. Supports to facilitate participation are routinely offered to the child and family.	The child and family were consistently treated with genuineness, empathy and respect and were frequently reached out to by DCFS and providers.	The family has regular opportunities to participate in assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services.
4 (90 days)	The agency and family have developed a minimally adequate working relationship with a minimal level of trust.	Special accommodations to facilitate participation are made on some occasions, if requested by the family or caregiver. Supports to facilitate participation are sometimes offered.	The family was usually treated with genuineness, empathy and respect and were usually reached out to by DCFS and providers.	The family has periodic opportunities to participate in assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services OR the agency has *consistently* made *concerted* efforts to engage the family.
3	The relationship between the agency and family is marginally inadequate.	Meetings are held at the convenience of DCFS or provider agencies. Supports to facilitate family participation are occasionally offered.	The child and family were sometimes not treated with genuineness, empathy and respect and were infrequently reached out to by DCFS and providers.	The family has occasional opportunities to participate in assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating
2	The relationship between the agency and family is poor.	Meetings are held at times or in places such that the parents cannot participate. Supports to facilitate participation are not offered.	The child and family were not treated with genuineness, empathy and respect nor reached out to by DCFS and providers.	The family has had at least one opportunity to participate in assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating. Some information has been withheld from the family.
1	The relationship between the family and agency is turbulent and impedes case progress.	The family is intentionally excluded from participation.	The child and family were treated rudely and were not reached out to by DCFS or providers.	The family has not had opportunities to participate in assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating. Decisions are made without the knowledge or consent of the family. Important information is withheld.
NA	TC is not old enough (age 5) or developmentally capable to participate in case planning activities.			
	MO/FA/Other: • is unknown or location is unknown despite concerted efforts during the past 6 months • TPR occurred prior to review • is deceased • has explicitly declined/refused to participate in case activities or to be involved in the TC's life (Active Refusal)			
	Caregiver: • CGs is ONLY rated when MO/FA/Other are all rated as NA or after all reunification services have been terminated for MO/ FA/Other • The child is placed in a congregate care setting (residential facility, group home, or similar placement)			

The overall indicator is rated, and then the Child, Mother, Father, Caregiver and Other are each rated separately.

"Other" is an adult who is essential to the achievement of the LTV (enduring safety & permanency) such as a step-parent, parent's paramour, or relative who has or had caretaking responsibilities prior to DCFS involvement.

Caregiver is rated ONLY when Mother, Father and Other are rated as Not Applicable OR after reunification services have terminated for Mother, Father and Other.

System Review 2: Teaming

CHILD AND FAMILY TEAM AND COORDINATION: Do the child, family and service providers function as a team? Do the actions of the team reflect a pattern of effective teamwork and collaboration that benefits the child and family? Is there effective coordination in the provision of services across all providers?

This indicator focuses on the structure and performance of the family team in collaborative problem solving, providing effective services, identifying the family's needs, and achieving positive results for the child and family. Child and family team members may include teacher, therapist, tracker, GAL, daycare provider, peer parent, health care provider, and other paid service providers. Parents and children are crucial team members. Collectively the team should have technical and cultural competence, family knowledge, authority to commit resources, and the ability to assemble supports and resources flexibly in response to specific needs. Members of the team should have the time available to fulfill commitments made to the child/ family. Team competence, authority, and performance are essential.

Team functioning and decision processes should be consistent with the practice model. Collaboration among team members from different agencies is essential. Evidence of team functioning lies in its performance over time and the results it achieves for the child and family. The focus and fit of services, authenticity of relationships and commitments, dependability of service system performance, and connectedness of the child and family to critical resources all derive from the child and family team.

System Performance Probes for Review Use

1. Are the important supporters and decision makers, including informal supports, on the team? Are the "right people" on the team? If not, what are the reasons? Do the family members agree with the composition of the child and family team? Do they feel somebody is missing who should be included?
2. Do the people involved in this case feel that they are part of a child and family team? Do they feel that they are involved in the decision making, their opinions are sought, and their input is being considered? Are they aware of how the case is progressing?
3. Do the actions of the team show a pattern of effective teamwork, commitment, and follow through? Do the family members think that the team works together effectively?
4. Is there effective coordination and continuity in the provision of services across all interveners? Are professionals from different agencies effectively collaborating together and coordinating their planning process? If problems have emerged with coordinating services, what has been done to resolve these problems?
5. Are critical decisions made by the team?
6. Does team coordination allow for continual assessment and acquisition of services?
7. Are face-to-face team meetings held regularly?
8. Has the team remained stable over the last 12 months (or since the case opened, if less than 12 months)?

System Review 2: Teaming

Score	Membership and Ownership	Common View and Effectiveness	Meetings and Participation
6 (6+ months)	The team contains all of the important supporters and decision makers, including informal supports. All team members report that they feel integral to the team and the family considers the team its own.	All team members share a common view of the issues affecting the child and family and have consensus on the case direction and goals. Services and supports are always coordinated. There is an optimal working team. The team is succeeding for the family.	Meetings are held frequently and at critical points to develop short-term and long-term plans. Face-to-face meetings are held.
5 (4-6 months)	The team contains most of the important supporters and decision makers, including some informal supports. Most team members report that they feel integral to the team and the family considers the team its own.	Most team members share a common view of the issues affecting the child and family and have consensus on the case direction and goals. Services and supports are frequently coordinated. There is a strong and dependable working team.	Meetings are held regularly and at critical points (i.e. transitions, service planning, crisis situations, etc.) The participation of all team members is encouraged, but if they could not attend the meeting, they provided input which was considered in making decisions.
4 (90 days)	The team contains some of the important supporters and decision makers, most importantly the family. Most team members report that they are members of the team and the family believes it has influence in the team.	Some team members share a common view of the issues affecting the child and family and agree on the case direction and goals. There is an adequate working team. The team has begun laying a foundation for moving the work of the child and family plan forward. Services and supports are mostly coordinated.	Some child and family team meetings have been held. The participation of all team members is encouraged, but if they could not attend, they were asked for input so their opinions could be considered in making decisions.
3	The team consists primarily of the worker and family, despite the existence of other important potential team members. More team development is needed to create a cohesive team. The family may not be included in the decision-making. The team was developed without the family's participation.	Team members do not share a common view of the family's issues. Some team members are not aware of important issues affecting the child and family. Services and supports are sometimes not coordinated. The assessment, plan and long term view were not created by the team.	Team meetings are rarely held. The main mode of information sharing and coordination is limited to phone conversations and e-mail. Team meetings resemble agency staffings. Some information is shared among team members, but there is not yet a pattern or process within the team to routinely share information.
2	There is not yet a complete team. The team was developed without attempts to elicit family participation. The family is given a to-do list.	Team members have different views of the issues affecting the child and family. Services and supports are confusing, misaligned, or lacking coordination. Some team members are functioning in isolation.	There are no face-to-face team meetings or they resemble agency staffings. There is limited coordination. .
1	There is no team yet.	There is no functioning team. Services and supports are not in place or are counterproductive.	No team meetings have been held in the past year. There is little or no coordination.

System Review 3: Assessment

CHILD AND FAMILY ASSESSMENT: Are the current, obvious, and substantial strengths and needs of the child, mother, father, and caregiver identified through existing assessments, both formal and informal, that all interveners collectively have a "big picture" understanding of the child and family? Does the team know what it needs to know to do what they need to do? Do the assessments help the team draw conclusions on how to provide effective services to meet the child's needs for enduring permanency, safety, and well-being? Are the critical underlying issues identified that must be resolved for the child to live safely with his/her family independent of agency supervision or to obtain an independent and enduring home?

Child and family assessment is the evolving process the team uses to determine what they need to know so that the family can be successful and independent from DCFS services. The team synthesizes this knowledge as they go through the assessment sequence of gathering information, analyzing information, drawing conclusions and acting on those conclusions. Mother, father, child, and the caregiver should be assessed. The focus is on the quality of the formal and informal assessment, and how they are being used. Members of the child and family team, working together, should synthesize their assessment knowledge to form a common "big picture" that provides a shared understanding of the child and family's situation. This provides a common core of team intelligence for drawing conclusions, unifying efforts, planning joint strategies, sharing resources, finding what works, and achieving a good mix and match of supports and services for the child and family. Developing and maintaining a useful big picture is a dynamic, ongoing process for the child and family team. Assessment techniques, both formal and informal, should be appropriate for the child's age, ability, culture, language or system of communication, and social support networks. Assessment should be performed promptly when child and family plan goals are met, when emergent needs or problems arise, or when changes are necessary. Assessment findings should stimulate and direct modifications in strategies, services, and supports for the child and family. Recent monitoring and evaluation results should be used to update the big picture of the child and family situation.

System Performance Probes for Review Use

1. What are the critical issues for the team to assess that will lead to the family's independence from DCFS and the child's enduring safety, permanence, and well-being?
2. Do initial and ongoing formal and informal assessments achieve an in-depth understanding of the strengths and needs of the child? Mother? Father? Caregiver? If not, what is missing?
3. Does the team know what they need to know to provide effective services to meet the child's needs for enduring permanency, safety, well-being, and independence from DCFS? ? Is the big picture being looked at?
4. How do the assessments help the team draw conclusions regarding what services are necessary to adequately address issues relevant to the agency's involvement with the family and achieve case goals?
5. Are the assessments evolving as a result of the work of the child and family team? Is there evidence of a continuous process?
6. If the child is an adolescent, are the child's needs for independent living skills development being assessed on an ongoing basis?
7. Have the assessments identified what the caregivers need to enhance their capacity to provide appropriate care and supervision of the child?

System Review 3: Assessment

Rating	Comprehensive	Big Picture	Team Understanding
6 (6+ months)	The current, obvious, and important strengths and needs, including the underlying needs, are identified through formal and informal assessments, monitoring results, and collective experiences of the child and family team.	An ongoing and accurate "big picture" is synthesized by the team. Assessment is a continuously integrated part of the practice model sequence and addresses all major events and decisions.	Members of the team share a common understanding of the child and family necessary for unifying efforts, drawing conclusions, sharing resources, and assembling a good mix and fit of supports and services that is formalized in an accurate, updated document.
5 (4-6 months)	A comprehensive set of strengths and needs, including major underlying needs, are identified through formal and informal assessments, monitoring results, and collective experiences of the child and family team.	An ongoing and accurate "big picture" is synthesized by the team. Assessment is generally integrated as a part of the practice model sequence and addresses most major events and decisions.	Members of the team share a common understanding of the child and family necessary for unifying service efforts, drawing conclusions, sharing resources, and assembling supports and services.
4 (90 days)	Selected strengths and needs, including key underlying needs, are identified through formal and informal assessments and from progress notes of the child and family team.	A periodic "big picture" is compiled by the team for planning purposes. Assessment is at least partially integrated with the practice model sequence and addresses critical events and decisions.	Most members of the team have a basic common understanding of the child and family necessary for drawing conclusions and collaborative planning.
3	Selected strengths and needs are identified through formal assessments, but some obvious and important needs, including underlying needs or preferences, are overlooked or excluded.	A periodic "snapshot" is compiled by the team, but is limited in scope and detail. This picture for planning is misfocused or incomplete. Assessment is only partially integrated into the practice model sequence and misses critical events or decisions.	Some members of the team have a basic common understanding of the child and family necessary for collaborative planning, others do not.
2	Few important strengths and needs are identified through assessments. Obvious and important underlying needs or preferences are overlooked or excluded.	This picture for planning is misfocused, incomplete, or obsolete. Assessment is isolated from the practice model sequence and is poorly connected to critical events or decisions.	The team's understanding of the child and family is limited in scope, detail, and usefulness. Few if any members of the team have an understanding of the child and family necessary for collaborative planning.
1	Important strengths have not been identified through assessments. Essential strengths, underlying needs, risks, or preferences are unknown or misunderstood.	No current picture of the child and family exists for meaningful use in planning. Assessment appears irrelevant to the practice model sequence and misses critical events and decisions.	Members of the team lack an understanding of the child and family necessary for collaborative planning.
NA	MO/FA/Other: • is unknown or location is unknown despite concerted efforts during the past 6 months • TPR occurred prior to review • is deceased • has explicitly declined/refused to participate in case activities or to be involved in the TC's life (Active Refusal)		
	Caregiver: • The child is placed in a congregate care setting (residential facility, group home, or similar placement)		

The overall indicator is rated, and then the Child, Mother, Father, Caregiver and Other are each rated separately.

Assessment of the caregiver pertains only to assessing needs regarding providing appropriate care and supervision of the child in their care to ensure safety, permanency, and well-being.

In a foster care case, only a substitute caregiver should be scored as Caregiver (not a residential treatment provider, stepparent, paramour, non-custodial parent, etc.) In all cases, a kinship caregiver should be scored as Caregiver.

"Other" is an adult who is essential to the achievement of the LTV (enduring safety and permanency) such as a step-parent, parent's paramour, or relative who has or had caretaking responsibilities prior to DCFS involvement.

System Review 4: Long-term View

LONG-TERM VIEW (LTV): Is there a clear understanding of how, with whom, and when the child will achieve safety and permanency? Are there steps, services, and supports identified that will lead the family and/or child toward achieving enduring safety and permanency independent of DCFS interventions? Does the team believe the permanency goal and steps to self-sufficiency from DCFS are realistic and achievable? Considering the proximity of case closure, how confident is the team that the child/family will be able to maintain safety and permanency without DCFS intervention?

The LTV is the path upon which a family moves towards enduring safety and permanency, and achieves and maintains independence from DCFS. The LTV provides a guiding strategic vision used to set the purpose and path of intervention and support. It provides a focus for the development of a coherent child and family plan. It may be expressed as strategic goals/objectives to focus and unify planning efforts, especially when multiple informal supports and service providers are involved. The LTV anticipates and defines what the child/family must have, know, and be able to do in order to be successful beyond case closure. To be acceptable, an exit strategy must "fit" the child/family situation, establish a common planning direction to be followed in the service process, and outline specific steps that will lead the child and family toward enduring safety and permanence and toward living independent of DCFS intervention. The LTV should answer the questions of where the case is headed and why.

Long-term View includes an understanding of where the family needs to be in order to close the case, move out of, and remain out of DCFS services. Where are we headed with the family? What are the steps that must be followed to get there?

Enduring safety means not only the achievement of safety for the child/family, but also maintaining an acceptable level of safety beyond case closure. Enduring permanency goes beyond the establishment of a permanency goal. Enduring permanency includes a clear understanding of how, with whom, and when a child will achieve permanency and how a child will maintain permanency after the case has closed. Achieving and sustaining independence from DCFS implies a level of confidence that the child and family will remain out of DCFS intervention due to establishing supports, completing service objectives, and internalizing skills learned from the services provided.

System Performance Probes for Review Use

1. **Where is the team headed with the case?**
   - Is there a clear, shared, supported understanding of how, with whom, and when the child will achieve safety and permanency?
   - Is there a strategy that will enable the child to live with caring adults who are willing and able to provide safety and lifelong family relationships?
   - To what degree do the child and family (birth parents, adoptive parents, guardian, kin, etc.) have an understanding of and commitment to the safety and permanency plans?
   - If the primary permanency goal does not appear to be achievable, is there a concurrent plan that is being implemented?
2. **What will it take to close the case?**
   - Is it clear to the team and the family what must be accomplished to achieve safety and permanency?
   - Are the steps and objectives clear, realistic, and achievable?
   - Is it clear what supports and services need to be in place to help the child and family achieve safety and permanency?
   - Are there steps addressing the major transition(s) toward achieving independence from DCFS?
3. **Will the family be able to maintain safety and permanency without DCFS intervention?**
   - How confident is the team that the family will be able to maintain safety and permanency without DCFS intervention?
   - Is it clear what durable supports and services need to be in place and working in order to sustain safety and permanency?
   - If case closure is imminent, have supports and services that need to be in place after case closure been identified and contacted?

System Review 4: Long-Term View

Rating	Shared Understanding and Common Planning Direction	Steps or Pathway	Sustaining Independence
6 (6+ months)	Team members (including the child and family) have a clear and consistently articulated understanding of where the case is headed that is shared, accepted, and used among team members.	The team has clearly identified the steps and supports needed to achieve enduring safety and permanency and sustain independence from DCFS and defined what the child and family must have, know and do to maintain safety and permanency, addressing all major transitions.	The team has strong confidence that the child/family will achieve enduring safety, permanency, and independence from DCFS.
5 (4-6 months)	Most team members (including the child and family) have an understanding of where the case is headed that is shared, accepted, and used among team members.	The team has identified the steps and supports needed to achieve enduring safety and permanency and sustain independence from DCFS and defines what the child must have, know, and do, to maintain safety and permanency, and addresses most major transitions.	The team has confidence the child/family will achieve enduring safety, permanency, and independence from DCFS.
4 (90 days)	Core team members (including the child and family) have an understanding of where the case is headed that is accepted and used for planning.	The team has identified most of the steps and supports needed to be successful and anticipates at least the next major transition.	The team expects the child/family to achieve enduring safety, permanency, and independence from DCFS.
3	There is an understanding that is shared between some team members but other team members have varied ideas of where the case is headed.	The team has identified some simple steps and supports that will increase the likelihood of a successful future transition.	The team is hopeful the child/family will achieve enduring safety, permanency, and independence from DCFS.
2	Team members have various understandings or desires about where the case is headed that are pulling the child/family into different planning directions.	There are a few simple steps identified that could increase the likelihood of a successful future transition.	The team is uncertain that the child/family will achieve enduring safety, permanency, and independence from DCFS.
1	Team members have not established any future planning direction for the child/family.	No steps have been identified to move the family toward achieving safety and permanency.	The team does not believe that the child/family will achieve enduring safety, permanency, and independence from DCFS.

System Review 5: Child and Family Plan

CHILD AND FAMILY PLAN: • Is the child and family plan individualized and relevant to the reasons the child came into care? Does the combination of supports and services fit the child and family's situation so as to maximize potential results?

Does the child/family have a single integrated plan that works as a comprehensive, dynamic service guide that is focused by the long-term view for the child and family? The written Child and Family Plan is a legal document. The written plan should be individualized and relevant to the needs and goals of the child and family. The child and family plan specifies the goals, roles, strategies, resources, and schedules for coordinated provision of assistance, supports, supervision, and services for the child, caregiver, and teacher. For the child to be successful at home and school, special supports may be necessary for the primary caregiver at home and for the teacher at school. Such supports should be addressed in the child and family plan, when indicated by the persons involved. If the youth is older, are the plan's goals, services, supports and educational trajectory consistent with achieving optimal self-sufficiency and independence given the capacities of the youth?

To be acceptable, a child and family plan should be based on the big picture assessments, clearly explain what clients need to do, reflect the views and preferences of the child and family, be directed toward the achievement of the permanency goal(s), be individualized to child and family needs, be culturally appropriate, and be modified frequently based on changing circumstances, experience gained, and progress made. The written child and family plan is the collective intentions of the child and family team that simply states the path and process to be followed.

System Performance Probes for Review Use

1. Does the written plan address the reasons the child came into care? If not, what is missing?
2. Does the written plan address the obvious and substantial needs of the child? Mother? Father? Caregiver? If not, what is missing?
3. Is the written plan sufficient to achieve enduring safety and permanency?
4. Does the Child and Family Plan build on the family's strengths and capabilities? Is the plan individualized and reflect the preferences, culture, and situation of the child and family? Does the plan clearly explain what each party is expected to do?
5. Is the written plan realistic? Does the combination and sequence of strategies, interventions, accommodations, supports, and services planned for the child and family make sense?
6. Does the written plan reflect the current situation of the family? Is the plan modified as a result of progress made and changes in the child and family situation?
7. Are the services individualized and assembled uniquely for this child and his/her parents? How well does the current mix of services match the child/family situation, cultural background, and expressed preferences?
8. Does the plan provide guidance to case planning and decision-making?

System Review 5: Child and Family Plan

Score	Connection to assessment and Long-term View	Service Mix and Fit	Family Preferences	Relevance
6 (6+ months)	The child and family plan builds upon the big picture assessment and long-term view for the child and family.	The plan includes all necessary supports and services in a sensible service process having an excellent fit between the child/family situation and the service mix.	The plan reflects child and family preferences in the assembly of supports and services.	The plan is continuously updated and reflects all changes in case circumstances.
5 (4-6 months)	The child and family plan reflects the big picture assessment and long-term view for the child and family.	The plan includes essential supports and services in a sensible service process having a workable fit between the child/family situation and the service mix.	The plan accommodates many child and family preferences in the assembly of supports and services.	The plan is frequently updated and reflects most changes in case circumstances.
4 (90 days)	The child and family plan minimally reflects the big picture assessment and long-term view for the child and family.	The plan includes basic supports and services that are assembled into a sensible service process having a minimally acceptable fit between the child/family situation and the service mix.	In the plan, some child and family preferences are considered in the assembly of supports and services.	The plan is regularly updated and reflects major changes in case circumstances.
3	The child and family plan does not reflect the big picture assessment and long-term view for the child and family.	In the plan, some, but not all, basic supports and services are assembled into a sensible service process. The fit between the child/family situation and the service mix is poor or services are insufficient.	Few child and family preferences are considered in the assembly of supports and services in the plan.	The plan is occasionally updated but does not always reflect major changes in case circumstances.
2	The child and family plan does not reflect the big picture assessment and long-term view for the child and family or works toward divergent or conflicting goals.	In the plan, basic supports and services are not assembled into a sensible service process. The fit between the child/family situation and the service mix is poor and services are inadequate to meet identified needs.	Child and family preferences have little if any influence in the selection of supports and services in the plan.	The plan has insufficient updates and is not reflective of most changes in case circumstances.
1	The Child and Family Plan works toward divergent and conflicting goals.	In the plan, basic supports and services are not provided. The fit between the child/family situation and the service mix is unacceptable and services are woefully inadequate to meet identified needs.	Child and family preferences did not influence the selection of supports and services in the plan.	The plan is outdated and irrelevant to the current status of the case.

System Review 6: Intervention Adequacy

INTERVENTION ADEQUACY: • To what degree are the planned interventions, services, and supports being provided to the child and family of sufficient power (precision, intensity, duration, fidelity, and consistency) and beneficial effect to produce results that would enable the child and family to live safely and independent from DCFS?

The purpose of intervention is facilitating necessary changes that meet a child's needs for safety, permanency, and well-being while stabilizing, supporting, and sustaining the family and/or caregiver. 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. Timeliness, competence, intensity, and consistency lead to dependability, consumer satisfaction, and positive results. A "smart" implementation process should be dynamic and interactive, offering ongoing adaptation of service arrangements in response to frequent feedback received about changing situations, emerging needs, and results being achieved. Positive change often requires a combination of informal supports and formal interventions. In determining the adequacy of the intervention, considerations should include:

- Appropriate Services- Services that are provided to the family with the goal of ensuring the child's safety and that meet the specific needs or circumstances of the family. For example, if a parent's substance abuse is associated with the neglect that brought the case to the attention of the agency, then substance abuse treatment would be an appropriate service. If, in this situation, all that is offered is parenting education, then that service by itself would not be appropriate to address the safety issues. Appropriate services would also include services for the non-custodial parent if the parent has contact with the child and there are safety concerns associated with that contact. Appropriate services for a caregiver may include services to enhance their capacity to provide appropriate care and supervision to the children in their home.
- 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 is consistent with the desired results.
- Beneficial Effects- Providing a pattern of changes that meets the family's needs and shows progress being made toward attainment of desired outcomes suggests planned strategies are the right strategies, strategies are being well delivered, and efforts are sufficiently powered.

Effective interventions include an assessment of the needs of the child, mother, father, and caregiver to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family, and then providing the appropriate services.

System Performance Probes for Review Use

1. Are appropriate services being provided to meet the identified needs of the child? Mother? Father? Caregiver?
2. What specific strategies are being used in the change process for this child and family? How well are the resources/services matched to the needs of the child and family?
3. Is the level of intensity, duration, coordination, and continuity commensurate with what is required for successful and sustained child and family change?
4. Are informal supports developed and used at home, at school, and in the community as part of the intervention? If not, why?
5. Are supports and services producing desired results and leading to attainment of important outcomes for the child?
6. Are noticeable changes occurring in the status of the child or family? If not, what is being done about it?
7. Are the services being provided addressing the reason for removal and the issues preventing the child from returning home?
8. Is there a pattern of change? Is the family attaining desired outcomes? If not, are the planned interventions the right interventions? Are services well delivered and sufficiently powered?

Intervention adequacy for the caregiver pertains to services needed to provide appropriate care and supervision of the child to ensure safety, permanency, and well-being. In a foster care case, only a substitute caregiver should be scored as Caregiver (not a residential treatment provider, step-parent, paramour, non-custodial parent, etc.) In all cases, a kinship caregiver should be scored as Caregiver.

"Other" is an adult who is essential to the achievement of the LTV (enduring safety and permanency) such as a step-parent, parent's paramour, or relative who has or had caretaking responsibilities prior to DCFS involvement

System Review 6: Intervention Adequacy

Score	Service Fit	Sufficient Power	Timeliness and Dependability
6 (6+ months)	An excellent combination of informal and, where necessary, formal supports and services is provided with excellent precision and optimal duration. An excellent array of supports and services provides a wide range of options that permits use of professional judgment about treatment interventions and family choice of providers. Services are fully convenient and accessible.	The power of the intervention is entirely sufficient to expediently and fully meet the needs and reach planned outcomes.	A highly dependable combination of informal and formal supports and services was promptly provided without delay.
5 (4-6 months)	A good combination of informal and, where necessary, formal supports and services is provided with good precision and a substantially commensurate level of duration. A substantial array of supports and services provides a narrow range of options that permits use of some professional judgment and family choice of providers. Services are generally convenient and accessible.	The power of the intervention is generally sufficient to expediently and fully meet the needs and reach planned outcomes.	A dependable combination of informal and formal supports was usually timely provided.
4 (90 days)	A minimally adequate combination of formal and informal supports and services is provided with some precision and a minimally adequate level of duration. A fair array of supports and services provides a few options, allowing limited use of professional judgment and family choice. Services are fairly convenient and accessible.	The power of the intervention is minimally sufficient to meet the needs and reach planned outcomes.	A somewhat dependable combination of supports and services is sometimes timely provided.
3	A marginally inadequate combination of supports and services is provided with little precision or an inadequate level of duration. A somewhat limited array of supports and services that may not be readily available provides few options, substantially limiting use of professional judgment and family choice in the selection of providers. Services are sometimes inconvenient or inaccessible.	The intervention is underpowered and not likely to meet important needs or reach planned outcomes. Service intensity limits the attainment of goals.	Provision of supports and services is often unreliable and/or delayed.
2	A poor or insufficient combination of supports and services is provided without adequate duration. A very limited array of supports and services may be inaccessible or inconsistently available and provide few options, preventing use of professional judgment and family choice. Services are often inconvenient or inaccessible.	The intervention is not capable of meeting important needs or reaching planned outcomes. Service intensity prevents the attainment of goals.	Provision of supports and services is usually unreliable and significantly delayed.
1	Planned supports and services have not been provided. Few, if any, necessary supports and services are provided. The team may be powerless to alter the service availability. No services are available.	Potentially successful interventions could be provided but are missing or not evident. Services are causing unintended problems or adverse effects.	Provision of supports and services is completely unreliable or intolerably delayed or no services were provided.
NA	MO/FA/Other: • is unknown or location is unknown despite concerted efforts during the past 6 months • TPR occurred prior to review • is deceased • has explicitly declined/refused to participate in case activities or to be involved in the TC's life (Active Refusal) • Reunification services have been terminated as of the day of the review OR services were never ordered AND are not indicated		
	Caregiver: • The child is placed in a congregate care setting (residential facility, group home, or similar placement)		

The overall indicator is rated, and then the Child, Mother, Father, Caregiver and Other are each rated separately.

System Review 7: Tracking and Adapting

TRACKING AND ADAPTATION: • Are the child and family status, service process, and progress routinely monitored and evaluated by the team? • Are services modified to respond to the changing needs of the child and family and to apply knowledge gained about service efforts and results to create a self-correcting service process?

Tracking and adaptation provide the "learning" and "change" processes that make the service process "smart" and, ultimately, effective for the child and family. An ongoing examination process should be used to track service implementation, check progress, identify emergent needs and problems, and modify services in a timely manner. How are the child and family doing? Has their situation changed? Have new needs emerged? Are supports and services being delivered as planned? How well are the mix, match, and sequence of supports and services working? How well do these arrangements fit the child and family? Are urgent response procedures working when needed? Are advance arrangements for transitions being accomplished? Are desired results being produced? What things need changing?

The strategic/working plan should be modified when objectives are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The service coordinator for the child and family should play a central role in monitoring and modifying planned strategies, services, supports, and results. Members of the child and family team (including the child and family) 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 continuing process.

System Performance Probes for Review Use

1. How often is the status of the child and family reviewed, particularly the safety, progress toward permanency, and well-being?
2. How are status and progress monitored (e.g., by the worker, by the team, face-to-face contacts, telephone contact, meetings with family, child, service providers; reviewing reports from providers, etc.)?
3. Are progress and implementation of the service process being tracked? Is there a pattern of successful adaptations that have been made?
4. Are detected problems being reported and addressed promptly? Are identified needs and problems being acted on?
5. Is the service process modified as goals are met? Is the service process modified if no progress is observed? If not, why not?

System Review 7: Tracking and Adapting

Score	Responsiveness	Monitoring, tracking, and communication	Adaptations
6 (6+ months)	Strategies, supports, and services being provided to the child and family are highly responsive and appropriate to changing conditions.	Continuous monitoring, tracking, and communication of child status and service results by the team are occurring.	Timely and smart 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.
5 (4-6 months)	Strategies, supports, and services being provided to the child and family are generally responsive to changing conditions.	Frequent monitoring, tracking and communication of child status and service results by the team are occurring.	Generally successful adaptations are based on a basic knowledge of what things are working and not working for the child and family.
4 (90 days)	Strategies, supports, and services being provided to the child and family are minimally responsive to changing conditions.	Periodic monitoring, tracking, and communication of child status and service results by the worker are occurring.	Usually successful adaptations to supports and services are being made.
3	Strategies, supports, and services being provided to the child and family are partially unresponsive to changing conditions.	Occasional monitoring and communication of child status and service results is occurring.	Partially successful adaptations are based on isolated facts of what is happening to the child and family.
2	Poor strategies, supports, and services are provided to the child and family and are not always responsive to changing conditions.	Limited monitoring, poor communication, and/or an inadequate child and family team is often unable to function effectively in planning, providing, monitoring, or adapting services.	Few sensible modifications are planned or implemented.
1	Strategies, supports, and services are limited, undependable, or conflicting for child and family.	Little or no monitoring or communication is 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 have become non-responsive to the current needs of the child and family. The service process appears to be “out of control.”

6-Point Rating Scales to Report Exam Findings

The following tables provide information for reviewers on scoring Child Status and System Performance indicators

6-Point Rating Scale Values for CHILD STATUS Indicators

Unacceptable Status Ratings (1-3)			Acceptable Status Ratings (4-6)		
Value 1: Poor and Worsening Status	**Value 2**: Poor and Un-changing Status	**Value 3**: Poor but Improving Status	**Value 4**: Minimally Acceptable Status	**Value 5**: Generally Favorable Status	**Value 6**: Optimal Status
The child's current status on the indicator is poor and the situation is becoming worse.	The child's current status on the indicator is poor and the situation is not improving.	The child's status on the indicator is a mixed pattern—predominantly unacceptable, but showing improvement.	Current status shows mixed indications—dominant pattern is minimally acceptable. "Groundhog Day" rule	Status on indicator is favorable with positive conditions for continued improvement in the area examined.	The child's status in the area examined is optimal with positive indicators for continued favor-able status and/ or improvement.

6-Point Rating Scale Values for SYSTEM PERFORMANCE Indicators

Unacceptable System Ratings (1-3)			Acceptable System Ratings (4-6)		
Value 1: Service Function Absent or Not Evident in Use	**Value 2**: Function Fragmented, Incoherent, Incomplete	**Value 3**: Function Under-Powered or Not Well-Matched to Need	**Value 4**: Function Minimally Adequate	**Value 5**: Function Generally Adequate	**Value 6**: Exemplary Service Function
The service function is missing or not evident in the service process for the child/ family.	Service functions evident but not fully present or operative on a consistent basis for the child/family.	Service function present but not working commensurate with presenting needs in case.	Function present and sufficiently dependable to be minimally adequate under present conditions. "Groundhog Day" rule	Function working well for child/ family under a variety of varying conditions over time.	Service function is optimal for child/ family over time and is indicative of exemplary practice.
			(90 days)	***(4-6 months)***	***(6+ months)***

Differences between Ratings 3 and 4

- A rating of 3 is close, but <u>not</u> presently acceptable
- A 3 is <u>not</u> adequate for the child to do well now or in the near term future
- A 3 may show some positive indications but now <u>falls short</u> of a desired result or adequate function
- Under favorable conditions a 3 could become a 4 later
- A rating of 4 is minimally acceptable <u>right now</u>
- 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 >> *Show me the evidence!*
- "Groundhog Day" Rule: If this case were frozen in time as it is today, would it be acceptable?

Utah DCFS Practice Model Principles

The Practice Model Development Team has worked hard to incorporate the wonderful suggestions that came from DCFS staff and from our community partners into the following set of principles.

"Protection" – Children's safety is paramount; children and adults have a right to live free from abuse.

"Development" – Children and families need consistent nurturing in a healthy environment to achieve their developmental potential.

"Permanency" – All children need and are entitled to enduring relationships that provide a family, stability and belonging, and a sense of self that connects children to their past, present and future.

"Cultural Responsiveness" – Children and families are to be understood within the context of their own family rules, traditions, history and culture.

"Partnership" - The entire community shares the responsibility to create an environment that helps families raise children to their fullest potential.

"Organizational Competence" - Committed, qualified, trained, and skilled staff, supported by an effectively structured organization, help ensure positive outcomes for children and families.

"Professional Competence" - Children and families need a relationship with an accepting, concerned, empathic worker who can confront difficult issues and effectively assist them in their process toward positive change.

Practice Model Skills Development

A set of key practice skills has been formulated from the Practice Principles to "Put Our Values Into Action." The training on the Practice Model will provide for the development of these practice skills. These basic skills are:

"Engaging" – The skill of effectively establishing a relationship with children, parents and essential individuals for the purpose of sustaining the work that is to be accomplished together.

"Teaming" – The skill of assembling a group to work with children and families, becoming a member of an established group, or leading a group may all be necessary for success in bringing needed resources to the critical issues of children and families. Child welfare is a community effort and requires a team.

"Assessing" – The skill of obtaining information about the salient events that brought the children and families into our services and the underlying causes bringing about their situation. This discovery process looks for the issues to be addressed and the strengths within the children and families to address these issues. Here we are determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being for the children.

"Planning" – The skill necessary to tailor the planning process uniquely to each child and family is crucial. Assessment will overlap into this area. This includes the design of incremental steps that move children and families from where they are to a better level of functioning. Service planning requires the planning cycle of assessing circumstances and resources, making decisions on directions to take, evaluating the effectiveness of the plan, reworking the plan as needed, celebrating successes, and facing consequences in response to lack of improvement.

"Intervening" – The skills to intercede with actions that will decrease risk, provide for safety, promote permanence, and establish well-being. These skills continue to be gathered throughout the life of the professional child welfare worker and may range from finding housing to changing a parent's pattern of thinking about their child.