QUALITY SERVICE REVIEW
FOR A CHILD AND FAMILY

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

PILOT TEST VERSION 2.1

DEVELOPED FOR THE

NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

BY

HUMAN SYSTEMS AND OUTCOMES, INC.

APRIL 2009
This protocol is designed for use in an in-depth case-based quality review process developed by Human Systems and Outcomes, Inc. (HSO). It is used for: (1) appraising the current status of a child identified with special needs (e.g., a child with a serious emotional disorder) in key life areas, (2) status of the parent/caregiver, (3) recent progress made by the child, and (4) performance of key system of care practices for the same child and family. The protocol examines recent results for children with special needs and their caregivers and the contribution made by local service providers and the system of care in producing those results. Review findings will be used by local agency leaders and practice managers in stimulating and supporting efforts to improve practices used for children and youth who are receiving services in a local system of care.

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

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

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Introduction to the Quality Service Review Protocol

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1. Copy of the “roll-up sheet”
Introduction to the Quality Service Review Protocol

A Focus on Practice and Results

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

Questions Explored via QSR

Questions about how children and families are doing include:

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

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

Questions about how well the service system is working include:

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

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

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

What’s Learned through the QSR

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

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

GENERAL INFORMATION

Persons using this protocol should have completed the classroom training program (12 hours). Candidate reviewers should be using the protocol in a shadowing/mentoring sequence involving two consecutive case review situations conducted in the field with an inter-rater agreement check made with the second case. The trainee’s first case analysis and ratings, feedback session with frontline staff, oral case presentation, and first case write-up should be coached by a qualified mentor. With the recommendation of the mentor, trainees who have successfully completed these steps will be granted review privileges on a review team under the supervision of the team leader and the case judge who approves written reports. Trainees may be certified after three successful reviews and successfully meeting the rating standards set by the expert review panel on the certification simulation. Any other users of this protocol should be certified reviewers. Users of this protocol should remember the following points:

◆ The case review made using this protocol is a professional appraisal of the: (1) status of a focus child and parent/caregiver on key indicators; (2) recent progress made on applicable change indicators; and (3) adequacy of performance of essential service functions for that child and parent/caregiver. Each focus child served is a unique and valid point-in-time “test” of frontline practice performance in a local system of care.

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

◆ Reviewers are to apply the following timeframes when making ratings for indicators: (1) child and parent/caregiver status ratings should reflect the dominant pattern found over the past 30 days; (2) progress pattern ratings on applicable items should reflect change occurring over the past 180 days (or since admission if less than 180 days); and (3) service system practice and performance item ratings should reflect the dominant pattern/flow over the past 90 days. [See display provided below.]

◆ Apply the 6-point rating scale for status, progress, and practice performance for each examination. Mark the appropriate ratings in the protocol, then transfer the ratings to the QSR Profile Sheet also referred to as the “roll-up sheet.” The rating scales are explained on pages 6-8.

◆ IT IS IMPERATIVE THAT REVIEWERS “CALL IT AS THEY SEE IT” and reflect their honest and informed appraisals in their ratings and report summary. When a reviewer mentions a concern about a participant in the oral...
INTRODUCTION TO THE QUALITY SERVICE REVIEW PROTOCOL

...
point or any essential aspect over that time. The situation may be dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed pattern may not endure or may have been less than minimally acceptable in the recent past, but not within the past 30 days.

- **Level 3 - Marginally Inadequate Status.** The child/youth or parent/caregiver status situation has been somewhat limited or inconsistent over the past 30 days, being inadequate at some moments in time or in some essential aspect(s) over this time period. The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have endured or may have been less than minimally acceptable in the recent past and somewhat inadequate.

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

- **Level 1 - Adverse or Poor and Worsening Status.** The child/youth or parent/caregiver status situation has been substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. The observed pattern may have endured or may have recently become unacceptable, substantially inadequate, and worsening.

**SERVICE SYSTEM PERFORMANCE INDICATOR RATINGS**

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

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

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

- **Level 4 - Minimally Adequate to Fair Performance.** The service system practice/system performance situation observed for the child/youth or parent has been at least minimally adequate at all times over the past 30 days, without being inadequate (level 3 or lower) at any moment or in any essential aspect over that time period. The observed performance pattern may have been less than minimally acceptable (level 3 or lower) in the recent past and somewhat inadequate. This level of performance may be regarded as falling below the range of acceptable performance spectrum that would have a reasonable prospect of helping achieve desired outcomes given that this performance level continues or improves. Some refinement efforts are indicated at this level of performance at this time.

- **Level 3 - Marginally Inadequate Performance.** The service system practice/system performance situation observed for the child/youth or parent has been somewhat limited or inconsistent, being inadequate at some moments in time or in some essential aspect(s) over this time period. The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have been less than minimally acceptable (level 5 or lower) in the recent past and somewhat inadequate. This level of performance may be regarded as falling below the range of acceptable performance and would not have a reasonable prospect of helping achieve desired outcomes. Substantial refinement efforts are indicated at this time.

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

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

**ORGANIZATION OF THIS PROTOCOL BOOKLET**
**QSR Interpretative Guide for Status Indicator Ratings**

**Maintenance Zone: 5-6**
Status is favorable. Efforts should be made to maintain and build upon a positive situation.

6 = OPTIMAL & ENDURING STATUS. The best or most favorable status presently attainable for this individual in this area (taking age and ability into account). The individual is continuing to do great in this area. Confidence is high that long-term needs or outcomes will be or are being met in this area.

5 = GOOD & CONTINUING STATUS. Substantially and dependably positive status for the individual in this area with an ongoing positive pattern. This status level is generally consistent with attainment of long-term needs or outcomes in area. Status is “looking good” and likely to continue.

**Improvement Zone: 1-2**
Status is problematic or risky. Quick action should be taken to improve the situation.

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

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

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

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

**Refinement Zone: 3-4**
Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.

**Acceptable Range: 4-6**

**Unacceptable Range: 1-3**

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**QSR Interpretative Guide for Practice Indicator Ratings**

**Maintenance Zone: 5-6**
Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.

6 = OPTIMAL & ENDURING PERFORMANCE. Excellent, consistent, effective practice for this individual in this function area. This level of performance is indicative of well-sustained exemplary practice and results for the individual.

5 = GOOD ONGOING PERFORMANCE. At this level, the system function is working dependably for this individual, under changing conditions and over time. Effectiveness level is consistent with meeting long-term needs and goals for the individual.

**Refinement Zone: 3-4**
Performance is minimal or marginal and maybe changing. Further efforts are necessary to refine the practice situation.

4 = FAIR PERFORMANCE. This level of performance is minimally or temporarily sufficient to meet short-term need or objectives. Performance in this area may be no less than minimally adequate at any time in the past 30 days, but may be short-term due to change circumstances, requiring change soon.

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

**Improvement Zone: 1-2**
Performance is inadequate. Quick action should be taken to improve practice now.

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

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

**Acceptable Range: 4-6**

**Unacceptable Range: 1-3**

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INTRODUCTION TO THE QUALITY SERVICE REVIEW PROTOCOL

This protocol booklet is organized into the following sections:

◆ **Introduction**: This first section of the protocol provides a basic explanation of the review process and protocol design.

◆ **Child Status Indicators**: The second section provides the eight child status indicators used in the review.

◆ **Parent/Caregiver Status Indicators**: The third section provides the four parent/caregiver indicators used in the review.

◆ **Child Progress Indicators**: The fourth section provides the five child progress indicators used in the review.

◆ **Practice Performance Indicators**: The fifth section provides the eight core practice function indicators and four specialized practice indicators used in the review.

◆ **Overall Patterns**: The sixth section provides the working papers that the reviewer uses to determine the overall patterns for the areas of child status, parent/caregiver status, progress, and practice performance domain. In addition, this section includes the instructions for making the six-month forecast.

◆ **Reporting Outlines**: The seventh section provides the outlines that reviewers are to use in developing and presenting the ten-minute oral summary of case findings and the written summary report to be submitted following the review.

◆ **QSR Profile**: This section provides a copy of the QSR Profile Sheet or "roll-up sheet" used by reviewers to submit information from the on-site review activity to the database manager for data entry, analysis, and reporting.
SECTION 2

CHILD STATUS INDICATORS

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**Focus Measure**

SAFETY - The degree to which: • The child is free of abuse, neglect, and exploitation by others in his/her place of residence, school, and other daily settings. • The parents and caregivers provide the attention, actions, and supports necessary to protect the child from known risks of harm in the home.

**Core Concepts**

Freedom from harm is a state of child well-being that exists in the balance of interactions between any known risks of harm and necessary protections put into place by parents and/or out-of-home caregivers, teachers, baby sitters, and others having immediate responsibility for the child. Thus, the capability and reliability of the parents (and other responsible persons) in recognizing risks of harm and protecting the child from those risks must be considered by reviewers. This consideration extends to the effectiveness of any protective strategies (e.g., no-contact orders, safety plans, after-school child supervision plans) put into place to keep a child free from known risks. This does not imply an absolute protection from all possible risks to life or physical well-being. The child should be free from known and manageable risks of harm in his/her daily settings. This means the child is free from abuse and neglect, including freedom from intimidation and unwarranted fears that may be intentionally induced by parents, caregivers, other children, or treatment staff for reasons of manipulation or control. The child should have food, shelter, and clothing adequate to meet basic physical needs as well as adequate care and supervision of parents/caregivers, as appropriate to the child’s age and developmental needs. A child who is at risk of harm or who lives in fear of assault, exploitation, humiliation, hostility, isolation, or deprivation may be at risk of suicide, disability, mental illness, co-dependent behavior patterns, learning problems, low self-esteem, and perpetrating similar harm on others. Freedom from harm is an essential condition for child well-being and development.

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

1. Is the child currently or has the child been a victim of abuse, neglect, or exploitation in the home or community?

2. Does the parent/caregiver present a pattern of abuse, neglect, or exploitation of the child? • How many reports have been made over the life of the case and/or in the past 18 months? • Were they substantiated? • What is the present status over the past 30 days?

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

4. Does the child have his or her immediate food, clothing, shelter, and medical/mental health needs met? • Are physical living conditions hazardous or threatening to the safety or well-being of the child? • Are the parent/caregiver’s methods of discipline appropriate for this child?

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

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

7. What informal supports and resources is the family now using to keep the children free from harm? • What recent family changes are now in place that help the family to better recognize risks of harm and to protect the child/children in the home from those risks?

8. How reliable are any protective strategies (e.g., no-contact order, safety plan) used to keep the child and/or family free from harm?
9. Are parents/caregivers aware of any risks to the child? • How reliable are parents/caregivers in recognizing risks of harm and taking steps to protect the child from those risks? • Are known risks being managed effectively for the child?

Description and Rating of the Focus Child’s Current Status

Description of the Status Situation Observed for the Child

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

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

◆ **Fair Safety.** Findings show a **minimally adequate to fair situation** in being free from imminent risk of abuse or neglect for the child. The child has a minimally safe living arrangement with the present parents/caregivers. Any protective strategies used are at least minimally adequate in reducing risks of harm. The child is at least minimally free from serious risks in other daily settings, including at school and in the community. At home and/or in other settings, the child may have very limited exposure to intimidation.

◆ **Marginal Safety.** Situation indicates **somewhat inadequate protection** of the child from abuse or neglect, which poses an elevated risk of harm for the child. Any protective strategies used may be somewhat limited or inconsistent in reducing risks of harm. The child may be exposed to somewhat elevated risks of harm in his/her home and/or in other daily settings, possibly at school and in the community. At home and/or in other settings, the child may be exposed to occasional intimidation and fear of harm.

◆ **Poor Safety.** Situation indicates **substantial and continuing risks of harm** for the child. At home and/or in other daily settings, the child may sometimes experience abuse, neglect, exploitation, or intimidation. Any protective strategies used may not be implemented or effective when used in reducing risks of harm. The child may be exposed to substantially elevated risks of harm in his/her home and/or in other daily settings, possibly at school and in the community. At home or in other settings, the child may be exposed to frequent or serious intimidation and fears of harm.

◆ **High Safety Risk.** Situation indicates **serious and worsening risks or harm** for the child. A pattern of abuse, neglect, exploitation, or intimidation by persons in the current daily life of the child may be undetected or unaddressed in the home and/or in other daily settings. Any protective strategies used may not be implemented or effective when used, leaving the child at risk of continuing and worsening harm. The child may be exposed to continuing and increasingly serious intimidation, abuse, and/or neglect.

◆ **Not Applicable.** This young child is under the age of five and not enrolled in a school program or any other early childhood education program.
Focus Measure

**BEHAVIORAL RISK - Degree to which the focus child:** • Avoids self-endangerment situations. • Refrains from using behaviors that may put him/herself or others at risk of harm.

Core Concepts

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

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

For older youth, examples of potentially harmful activities include:
- Running away (adolescents)
- Serious property destruction, including fire setting
- Gang affiliation and related activities
- Stealing
- Bulimia and/or anorexia
- Abuse of alcohol/addictive substances
- Suicidality, self-mutilation, or other forms of self-injurious behaviors (e.g., pica, head-hanging, eye-gouging)
- Placing him/herself in dangerous environments and situations or neglecting essential self-care requirements for maintaining well-being
- Neglecting dependent care requirements

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

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

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

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

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

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

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

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

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

7. Has the child/youth made suicidal gestures, threatened suicide, or had a suicide attempt? • Does the child need/have a SAFETY PLAN?
8. Does the child/youth cause harm to him/herself by biting, pulling hair, head-banging, having severe tantrums, self-mutilation, binging on alcohol, or inhaling toxic vapors to get high?

9. If the child/youth currently has a current GAF score less than 50, what behaviors does he/she present that may put him/herself or others at risk of harm? • Has any harm actually occurred within the past 30 days? If so, what happened? • Are steps being taken to prevent or reduce the probability of repeated injury?

10. Is the child/youth presently placed in a specialized treatment or detention setting? • Has seclusion or restraint been used within the past 90 days to prevent harm to self or others? • If so, how frequently has seclusion or restraint been used and for what reasons? • Has use of any emergency control techniques been reduced over the past 90 days? • Has 911 been called because of this child/youth’s behavior recently?

**Description and Rating of the Child’s Current Status**

**ALTERNATIVE TIME SCALE USED FOR RATINGS IN THIS INDICATOR.** This indicator is designed to look retrospectively over the past six months for a rating of 6 and over the past three months for ratings 4 and 5. This indicator is not applied to infants and toddlers or to young children under the age of 36 months.

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

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

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

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

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

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

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

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

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

**Core Concepts**  

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

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

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

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

1. **Is the child living in a permanent home?**  
   - If continued instability is present, is it caused by unresolved permanency issues?  
   - Is a concurrent permanency plan in place to minimize further disruption if efforts to achieve permanency fail?  
   - If so, what is the permanency plan?

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

3. **Are probable causes for disruption of home, school, or work present?**
   - Parent/caregiver's history of frequent moves
   - Change in adults living in the home
   - Behavioral problems and discipline issues between parent and child
   - Members of the household threatened by the child’s behavior
   - Parent/caregiver’s inability/unwillingness to provide appropriate level of care or supervision

4. **Has the child had a change in living, learning, or working environments in the past year resulting from:**
   - Removal from his/her home or from another out-of-home care setting for safety reasons?
   - Behavioral problems or emotional disorders?
   - Required out-of-home treatment for serious emotional disturbances?
   - Criminal involvement resulting in arrest, entry to custody, youth detention, or juvenile corrections?
   - Chronic health conditions requiring frequent or extended hospitalization?

5. **Has this child ever run away from home, school, or placement?**  
   - If so, is this likely to reoccur within the next six months?

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

**NOTE:**  

Track disruptions over the past 12 months and predict disruptions over the next 6 months.
## Description and Rating of the Child’s Current Status

**ALTERNATIVE TIME SCALE USED FOR RATINGS IN THIS INDICATOR:** This indicator looks retrospectively over the past 12 months and prospectively over the next six months to assess and project the relative stability of the child’s home settings and relationships. This is the only QSR indicator that uses a prospective dimension. A 12-month “opportunity window” is used to track recent life disruptions for the focus child in ratings 4, 5, and 6 to establish any movement pattern over that time period that has occurred. Prognosis for future disruption in the next six months is based on the pattern observed over the past 12 months (an ongoing movement pattern may be likely to continue in the near future) and on likely near-term events that would have high probability of causing a disruption.

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

<table>
<thead>
<tr>
<th>Rating Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6</strong></td>
<td><strong>Optimal Stability.</strong> The child has <strong>optimal stability</strong> in home settings and enjoys positive and enduring relationships with parents/primary caregivers, key adult supporters, and peers. There is no history of instability over the past 12 months and little likelihood of future disruption. Only age-appropriate changes are expected in school settings.</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td><strong>Good Stability.</strong> The child has <strong>substantial stability</strong> in home settings with no more than one disruptive change in either setting over the past 12 months with none in the past six months. The child has established positive relationships with parents/primary caregivers, key adult supporters, and peers in those settings. Only age-appropriate changes are expected within the next six months. Any known risks are now well-controlled.</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td><strong>Fair Stability.</strong> The child has <strong>minimally acceptable stability</strong> in home settings with no more than one disruption in settings within the past 12 months and none in the past three months. The child has established positive relationships with parents/primary caregivers, key adult supporters, and peers in those settings. Only age-appropriate school changes may be expected in the next six months. Future disruption (unplanned moves) appears unlikely (probability &lt; 50%) within the next six months.</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td><strong>Marginal Stability.</strong> The child has <strong>inadequate stability</strong> in home settings over the past 12 months with more than one disruption within the past six months and none in the past 30 days. The child may not feel secure in the living arrangement and disruptions may have resulted in changes of parents/primary caregivers, key adult supporters, and peers in those settings. Further disruptions may occur within the next six months (probability &gt; 50%). Causes of disruption are known.</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td><strong>Poor Stability.</strong> The child has <strong>substantial and continuing problems of instability</strong> in home settings with multiple changes in settings within the past 12 months and at least in the past 30 days. The child may feel insecure and concerned about his/her situation. Multiple, dynamic factors are in play, creating a “fluid pattern of uncertain conditions” in the child’s life, leading to ongoing instability. Intervention efforts to stabilize the situation may be limited or undermined by current system of care difficulties.</td>
</tr>
<tr>
<td><strong>1</strong></td>
<td><strong>Adverse Stability.</strong> The child has <strong>serious and worsening problems of instability</strong> in home settings with multiple changes in settings within the past 12 months. The child’s situation seems to be “spiraling out of control.” The child may be in temporary containment and control situations (e.g., detention or crisis stabilization) or a runaway. There is no foreseeable next placement with levels of supports and services expressed by service staff or providers. The child may be expelled from school.</td>
</tr>
</tbody>
</table>
Focus Measure

PERMANENCY - Degree of confidence held by those involved (child, parents, caregivers, others) that the child/youth is living with parents or other caregivers who will sustain in this role until the child reaches adulthood and will continue onward to provide enduring family connections and supports.

Core Concepts

Every child is entitled to a safe, secure, appropriate, and permanent home. Permanency is achieved when the child is living successfully in a family situation that the child, parents or out-of-home caregivers, and other stakeholders believe will endure lifelong. Permanency, commonly identified with the meaning of “family” or “home,” suggests not only a stable setting, but also stable out-of-home caregivers and peers, continuous supportive relationships, and a necessary level of parental/caregiver commitment and affection. Evidence of permanency includes resolution of guardianship, necessary supports for caregivers, and stability in the child’s home and school settings. Families and children are entitled to permanency in a timely manner. Ideally, a child removed from his/her family home should be living in a safe, appropriate, and permanent home within 12 months of removal with no more than a single interim placement.

Evidence of permanency includes resolution of guardianship, adequate provision of necessary supports for the out-of-home caregiver, and the achievement of stability in the child’s home and school settings. Thus, safety, stability, and adequate caregiver functioning are corequisite conditions of permanency for a child or youth. Because of the nature of congregate settings, with frequent turnover of out-of-home caregivers, time-limited stays, ever-changing peers, conditional commitment, and unreliable personal caring relationships, placements in congregate settings are rarely judged to achieve an acceptable permanency rating. Intensive services and timely family reunification should be provided, where indicated. Other permanency strategies should be implemented immediately when reunification is determined not to be possible. Such a determination should be made in a timely manner after appropriate intensive services and any planned reunification efforts have proven unsuccessful or inappropriate. Where appropriate, termination of parental rights and adoption should be accomplished expeditiously. An exception to this would be if a child is still placed in a congregate setting at the time of review, but everyone is ready to move the child to a safe, appropriate, and permanent family setting and the team agrees that the current placement and plan will produce permanency.

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

1. Is the child living with parents or out-of-home caregivers the child, parents/caregivers, and child welfare worker believe will endure lifelong?
   • Do the primary permanency and concurrent goals appear to be appropriate, given the circumstances?
   • What does the child say about permanency choices?
   • If this is an older youth free for adoption, is long-term foster care with independent living as the alternative path to permanency being followed?
   • If the youth is 17-19 years of age, within six months of system exit, and on the independent living path, are basic living needs, necessary supports, and social connections in place to ensure a smooth transition to and successful adjustment following transition into adult life?

2. If the child is residing with a parent, adoptive parent, or permanent out-of-home caregiver, for the identified home of the child:
   • Are legal steps to achieve permanency completed?
   • How much progress is being made in meeting conditions necessary for safe case closure?
   • Do they understand and commit to the responsibilities for rearing the child?
   • Are they incorporating the child’s family of origin, traditions, and culture into the new family’s arrangements?

3. If the child does not live with permanent out-of-home caregivers yet and the permanency goal is reunification, are the parents and child successfully resolving concerns to get the child safely home?
   • Is the parent acquiring, demonstrating, and sustaining required behavioral changes necessary to parent the child?
   • Is there a clear permanency plan?
   • Is it being implemented?
   • Does the child, family, and child welfare worker support the permanency plan?
   • What does the child say about permanency choices?

4. If the child does not live with permanent out-of-home caregivers yet and the permanency goal is adoption or guardianship, is preparation for adoption/guardianship timely and appropriate?
   • Is an alternative family identified or being actively recruited and developed?
   • Do the child, family, and child welfare worker support the permanency plan?
   • Have relatives, current out-of-home caregivers, and past out-of-home caregivers been approached about providing permanency?
   • Is the child aware of and becoming prepared for adoption/guardianship?
   • What does the child say about permanency choices?

5. Is the scope and pace of achieving permanency consistent with ASFA timelines?
   • If there have been delays, have adjustments been made to better address permanency?
   • What are the necessary conditions for safe case closure and what progress is being made in meeting these conditions?
Child Status Review 4: Permanency

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

Description and Rating of the Child’s Current Status

Description of the Status Situation Observed for the Child

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

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

◆ Minimal to Fair Status. Child has minimally acceptable to fair permanence. The child lives in a family setting that the child, out-of-home caregivers, caseworker, and core team members expect will endure until the child reaches maturity. They are successfully implementing a well-crafted plan that supports that expectation because safety and stability are being achieved. If in an adoptive family, adoption/guardianship issues are being resolved. • OR • The child is still living in a temporary placement, but the child, out-of-home caregivers, caseworker, and other team members are ready to move the child to a safe, appropriate, and permanent family setting. Readiness for permanency is evident, because a realistic and achievable child and family plan is being implemented, a permanent home has been identified, and the transition is being planned for. The team agrees that the prospective placement and plan will produce permanency, because the child is receiving what the child needs for implementing the actual permanency goal and the parents or future permanent out-of-home caregiver is becoming prepared for receiving the youth. For a child old enough to make a responsible judgment, the child and out-of-home caregiver (in all cases) are committed to the plan.

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

◆ Poor Status. Child has substantial and continuing problems of unresolved permanence. The child is living in a home that the child, out-of-home caregivers, and caseworker doubt could endure until the child becomes independent, due to safety and stability problems or failure to resolve adoption/guardianship issues, or because the current home is unacceptable to the child. • OR • The child remains living on a temporary basis with an out-of-home caregiver without a clear, realistic, or achievable permanency plan being implemented. Any concurrent pathways used may have stalled or failed.

◆ Adverse Status. Child has serious and worsening problems of unresolved permanence. The child is moving from home to home due to safety and stability problems or failure to resolve adoption/guardianship issues, or because the current home is unacceptable to the child. • OR • The child remains living on a temporary basis with an out-of-home caregiver without a clear, realistic, or achievable permanency plan being implemented.
Focus Measure

LIVING ARRANGEMENT - Degree to which: • The child is in the most appropriate/least restrictive living arrangement, consistent with needs for family relationships, social connections, age, ability, special needs, education, and positive peer group affiliation. • [If the child is in temporary out-of-home care] the living arrangement meets the child’s needs to be connected to his/her language and culture, community, faith, extended family, tribe, social activities, and peer group.

Core Concepts

The child’s home is the one that the child has lived in for an extended period of time. For a child who is not in out-of-home care, this home can be with the parents, relatives (informally arranged by family), adoptive parents, or a guardian. For a child in out-of-home care, the living arrangement can be in family foster care, therapeutic foster care, group home, or residential treatment. The child’s home community is generally the area in which the child has lived for a considerable amount of time and is usually the area in which the child was living prior to removal. A child’s home community is the least restrictive, most appropriate, inclusive setting in which the child spends his/her time on a daily basis. The community is a basis for a child’s identity, culture, sense of belonging, and connections with persons and things that provide meaning and purpose for the child. Whenever safe, the child should remain in the home with his/her family. If the child must be temporarily removed from the home, the child should live, whenever possible, with siblings and relatives or in his/her home community. Some children with special needs may require temporary services in therapeutic settings, which must be the least restrictive, most appropriate, and inclusive living arrangement necessary to meet the child’s needs and circumstances.

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

1. Is the child living in his or her family home? • If not, does the child’s current living arrangement facilitate the child’s connections to his/her culture, community, faith, extended family, and social relationships? • Are these connections meaningful to the child?
   • Is the child’s home an appropriate environment for the child?
   • Are the parents (or other out-of-home caregivers) able to meet the child’s daily needs for care and nurturing?
   • Does the child have any special needs (medical, behavioral, cognitive, etc.)? • If so, does the parent have the capacity and supports necessary to address the special needs?

2. If the child is in a temporary out-of-home living arrangement, the following points should be considered in determining the appropriateness of the setting. [Consider the appropriateness of the living arrangement with ICWA, MEPA, and ASFA, as applicable to the child.]
   • Is the child living in his/her home community (neighborhood and community close to friends, in his/her school district, and where he/she can continue extracurricular activities)? • Is this home consistent with the child’s language and culture?
   • Does the placement provide appropriate continuity in connection to home, school, faith-based organization, peer group, extended family, and culture?
   • Is the child placed with the non-custodial parent or relatives? • If not, are there clear reasons why not?
   • Is the child placed with siblings? • If not, are there clear reasons as to why this was not appropriate based upon the needs of the child?
   • Is the placement conducive to maintaining family connections and does the out-of-home caregiver support these activities?
   • Does the child feel safe and well cared for in this setting?
   • Should reunification not be possible, would the out-of-home caregiver be able and willing to provide for permanency? • Is this home consistent with ICWA?
   • Is the living arrangement able to meet the child’s developmental, emotional, behavioral, and physical needs and does it provide for appropriate levels of supervision and supports?
   • Do the out-of-home caregivers encourage the child to participate in activities that are appropriate to his/her age and abilities (sports, creative activities, etc.) and support socialization needs with peers and others?

3. If the child is living in a group care (more than five children) or residential care center, the reviewer should consider the following items.
   • Does the child feel safe and well cared for in this setting?
   • Is this the least restrictive and most inclusive setting that is able to meet the child’s needs?
   • Is the child placed with children in his/her same age group?
   • Does the placement provide for the appropriate level of supervision, supports, and therapeutic services?
   • Does the placement provide for family connections and linkages to the home community?

4. Does the child, parents, out-of-home caregivers, therapists, and child welfare worker believe that this is the best place for the child to be living?
Description and Rating of the Child’s Current Status

This indicator applies to the child’s current living situation, where the child or youth will sleep tonight.

<table>
<thead>
<tr>
<th>Description of the Status Situation Observed for the Child</th>
<th>Rating Level</th>
</tr>
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<tbody>
<tr>
<td>Optimal Living Arrangement. The child is living in the most appropriate setting to address his/her needs. The living arrangement is optimal to maintain family connections, including the child’s relationship with the siblings and extended family members. The setting is able to entirely provide for the child’s needs for emotional support, educational needs, family relationships, supervision, and socialization and addresses special and other basic needs. The setting is optimal for the child’s age, ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential care center, the child is in the least restrictive environment necessary to address his/her needs.</td>
<td>6</td>
</tr>
<tr>
<td>Good Living Arrangement. The child is living in a setting that substantially meets his/her needs. The living arrangement substantially provides the condition to maintain family connections, including the relationships with the siblings and extended family members. The setting provides the necessary educational needs, family relationships, supervision, supports, and services to provide substantially for the child’s emotional, social, special, and other basic needs. The setting is substantially consistent with the child’s age, ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential care center, the child is in the least restrictive environment necessary to address his/her needs.</td>
<td>5</td>
</tr>
<tr>
<td>Fair Living Arrangement. The child is living in a setting that is minimally consistent with his/her needs. The living arrangement minimally provides the conditions necessary to maintain family connections, including the relationship with the siblings and extended family members. The setting minimally provides the necessary educational needs, family relationships, supervision, supports, and services to address the child’s emotional, social, special, and other basic needs. The setting is minimally consistent with the child’s age ability, culture, language, and faith-based practices. Additionally, if the child is in a group home or residential care center, the child is in the least restrictive environment necessary to address his/her needs.</td>
<td>4</td>
</tr>
<tr>
<td>Marginal Living Arrangement. The child is living in a setting that only partially addresses his/her needs. The living arrangement is partially inconsistent with the conditions necessary to maintain family connections, including the relationship with the siblings and extended family members. The setting only partially provides for the necessary educational needs, family relationships, supervision, supports, and services to address the child’s emotional, social, special, and other basic needs. The setting is partially consistent with the child’s age, ability, culture, language, and faith-based practices. If the child is in a group home or residential care center, the child is not in the least restrictive setting. The level of care or degree of restrictiveness may be slightly higher or lower than necessary to address the child’s needs.</td>
<td>3</td>
</tr>
<tr>
<td>Poor Living Arrangement. The child is living in a substantially inadequate home or setting. The living arrangement inadequately addresses conditions necessary to maintain family connections. The necessary level of educational needs, family relationships, supervision, supports, and services to address the child’s needs are inadequate. The setting is inconsistent with the child’s age, ability, culture, language, and faith-based practices. If the child is in a group home or residential care center, the setting is not the least restrictive. The level of care or degree of restrictiveness is substantially more or less than necessary to meet the child’s needs.</td>
<td>2</td>
</tr>
<tr>
<td>Adverse Living Arrangement. The child is living in an inappropriate home or setting for his/her needs. The living arrangement does not provide for family and community connections. The necessary level of educational needs, family relationships, supervision, supports, and services to address the child’s needs is absent. If the child is in a group home, detention facility, or residential care center, the environment is much more restrictive than is necessary to meet the child’s needs while protecting others from the child/youth’s behavioral risks. Or, the child/youth may be on runaway status, homeless, residing in a homeless shelter, or in temporary shelter care for more than 30 days.</td>
<td>1</td>
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</table>
**CHILD STATUS REVIEW 6: HEALTH/PHYSICAL WELL-BEING**

**Focus Measure**

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

**Core Concepts**

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

A responsible adult should assure that the medications are taken as prescribed, that the effects of the medications (including side effects) are monitored, and that there is a mechanism to provide feedback with the physician on a regular basis. For children who are developmentally capable, the child should understand his/her condition, how to self-manage issues associated with the condition, the purpose of his/her medication, how to manage or report side effects of the medication, and how to self-administer. If the child requires any type of adaptive equipment or other special procedures, persons working with the child are provided instruction in the use of the equipment and special procedures. Should a child have a serious condition, possibly degenerative, the services and supports have been provided to allow the child to remain in the best attainable physical status given his/her diagnoses and prognoses. Children who are obese should be receiving dietary guidance and other appropriate supports.

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

1. Are the child’s **basic physical needs** being met adequately on a daily basis? • (If NOT, this may an indication of NEGLECT, a failure to provide critical care to the child. (See Child Status Review 1: Safety.)
   - Food, adequate nutrition, sleep, and daily exercise at a level necessary to balance the child’s height and weight within a healthy range?
   - Sanitary housing that is free of safety hazards?
   - Daily care, such as hygiene, dental care, grooming, and clean clothing?

2. Is the child achieving his/her optimal or best attainable health status? Does the child have a primary care physician/medical home?
   - Are the child’s immunizations complete and up to date?
   - Does the child miss school due to illness more than would be expected?
   - Does the child have any recurrent health problems, such as infections, sexually transmitted disease, colds, or injuries?
   - Does the child have recurrent health complaints, and if so, are they addressed (including dental, eyesight, hearing, etc.)?
   - Does the child appear to be underweight or overweight, and if so, has this been investigated?
   - Does the child use illegal substances?
   - If the child has had a need for acute care services, were they provided appropriately?

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

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

5. **OPTIONAL CONSIDERATION:** If the child is age ten or older, is the child/youth being provided reproductive health care education and services to prepare and protect (e.g., administration of the new HPV vaccine for girls to reduce the chances of cervical cancer) the child/youth from making poor life choices, exposure to sexually transmitted diseases, and teen pregnancy?
**CHILD STATUS REVIEW 6: HEALTH/PHYSICAL WELL-BEING**

**Description and Rating of the Child’s Current Status**

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</thead>
<tbody>
<tr>
<td>◆ <strong>Optimal Health Status.</strong> Child is demonstrating excellent health, or if he/she has a chronic condition, is attaining the best possible health status that can be expected given the health condition. The child’s growth and weight are well within age-appropriate expectations. Any previous or current health concerns have been met without any adverse or lasting impact, or there is no significant health history. Nutrition, exercise, sleep, and hygiene needs are fully met. This child appears to be in excellent physical health.</td>
<td>6</td>
</tr>
<tr>
<td>◆ <strong>Good Health Status.</strong> Child is demonstrating a good, steady health pattern, considering any chronic conditions. The child’s growth and weight are generally consistent with age-appropriate expectations. Any previous or current health concerns have been met in which there may be no lasting impact, or there is no significant health history for this child/youth. Nutrition, exercise, sleep, and hygiene needs are being substantially met. This child appears to be in good physical health.</td>
<td>5</td>
</tr>
<tr>
<td>◆ <strong>Fair Health Status.</strong> Child is demonstrating a minimally adequate to fair level of health status, considering any chronic conditions. The child/youth’s physical health is somewhat close to normal limits for age, growth, and weight range. If existing, any previous or current health concerns are not adversely affecting functioning. Nutrition, exercise, sleep, and hygiene needs are usually being met. The child appears to be in fair physical health.</td>
<td>4</td>
</tr>
<tr>
<td>◆ <strong>Marginal Health Status.</strong> Child is demonstrating a limited, inconsistent, or somewhat inadequate level of health status. Any chronic condition may be becoming more problematic than necessary. The child/youth’s physical health is outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be adversely affecting functioning. Nutrition, exercise, sleep, and hygiene needs may be inconsistently met. The child appears to be in marginal, or mixed, physical health.</td>
<td>3</td>
</tr>
<tr>
<td>◆ <strong>Poor Health Status.</strong> Child is demonstrating a consistently poor level of health status. Any chronic condition may be becoming more uncontrolled, possibly with presentation of acute episodes. The child/youth’s physical health is significantly outside normal limits for age, growth, and weight range. If existing, any previous or current health concerns may be significantly affecting functioning. Nutrition, exercise, sleep, and hygiene needs may not be being met, with significant impact on functioning. The child appears to be in poor physical health and physical health is not improving, rather, is remaining status quo.</td>
<td>2</td>
</tr>
<tr>
<td>◆ <strong>Worsening Health Status.</strong> Child is demonstrating a poor or worsening level of health status. Any chronic condition may be increasingly uncontrolled, with presentation of acute episodes that increase health care risks. The child/youth’s physical health is profoundly outside normal limits for age, growth, and weight ranges. If existing, any previous or current health conditions may be profoundly affecting functioning. Nutrition, exercise, sleep, and hygiene needs may not be being met, with profound impact. The child appears to be in poor physical health and his/her health status is declining.</td>
<td>1</td>
</tr>
</tbody>
</table>
**CHILD STATUS REVIEW 7: EMOTIONAL WELL-BEING**

**Focus Measure**

**EMOTIONAL WELL-BEING - Degree to which:** • Consistent with age and ability, the focus child is presenting adequate levels of emotional, cognitive, and behavioral development and adjustment, as evidenced by adequate adjustment, attachment, coping skills, and self-control. • The focus child is achieving an adequate level of functioning in daily settings and activities, consistent with age and ability. [For a child age 3 years and older]

**Core Concepts**

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

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

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

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

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

1. What is this child's level of emotional, cognitive and behavioral well-being and life adjustment? • Is it consistent with the child's age and ability? • As appropriate to age and ability, does the child report having a sense of identity, personal worth, purpose in life, and acceptance by and affiliation with others? • Is the child demonstrating personal responsibility for daily interactions, habits, and attitudes as appropriate to his/her age and ability?

2. How is the child adjusting to change and to any adverse life circumstances causing stress in his/her life? • Is the child currently engaging in positive emotional, cognitive, and constructive behavior at school, at home, and in the community?

3. Does the child have a diagnosed psychiatric disorder using the DSM? • If so, has the child received education about this diagnosis and how to better manage related signs and symptoms? • Is treatment resulting in both symptom reduction and improved positive functioning?
Child Status Review 7: Emotional Well-Being

4. What is the frequency of contact between the child and core members of his/her family and social network?

5. To what extent is the social network integrated in meeting the social/emotional needs of the child/youth? To what extent do members of the social network provide reliable positive relationships?

Scale for Rating the Child's Status

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

Description of the Status Situation Observed for the Child

◆ Optimal Well-being Status. Consistent with age and ability, the child is demonstrating excellent emotional development in all key areas of social/emotional development and life adjustment. The child may be demonstrating excellent daily functioning. The child may show excellent behavioral status in all key life areas.

◆ Good Well-being Status. Consistent with age and ability, the child is demonstrating a good and substantial level of emotional development in most areas of social/emotional development and life adjustment. The child may be demonstrating a good, steady level of daily behavioral functioning in most key functional life areas.

◆ Fair Well-being Status. Consistent with age/ability, the child is demonstrating a minimally/temporarily adequate level of emotional development. The child may be having problems adjusting in one area and is showing signs of distress in one area of emotional responsiveness or adaptations. The child's emotional development is minimally acceptable. The child may be demonstrating a minimally/temporarily adequate to fair level of daily behavioral functioning. The child may be functioning fairly well in his/her home and environment but may be having problems in one area of daily functioning. The child may have some disruptive behaviors or internalizing behaviors that are under minimally adequate control or may be showing rare, minor problems. The child’s behavioral functioning is at least minimally satisfactory to fair at the moment, but may be at some risk of decline.

◆ Marginal Well-being Status. Consistent with age and ability, the child is demonstrating a limited or inconsistent level of emotional development. The child may be having adjustment problems in several areas. The child may be showing distress in several areas of emotional responsiveness or adaptations. The child may be demonstrating a limited or inconsistent level of behavioral functioning in daily settings. The child is showing some emerging or continuing behavioral problems in the home, school, or community and may be exhibiting behaviors that interfere with several areas of daily functioning. The child may not be responding well to attempts to address disruptive behaviors or internalizing behaviors.

◆ Poor Well-being Status. Consistent with age and ability, the child is demonstrating a consistently poor level of emotional development. The child may show no progress or improvement in areas of social/emotional development and life adjustment. The child is demonstrating a consistently poor level of behavioral functioning in daily settings and may show no progress or improvement in functional status.

◆ Worsening Well-being Status. Consistent with age and ability, the child is demonstrating a poor and worsening level of emotional development. Rather than meeting adjustment expectations, the child's social/emotional development may be regressing. The child is demonstrating a poor and worsening level of behavioral functioning in daily settings and activities. The child’s functional behavioral status may be declining.

◆ Not Applicable. The child is under age three years; this indicator cannot be meaningfully applied at this time.
Focus Measure

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

Core Concepts

From birth, children progress through a series of stages of learning and development. The growth during this period is greater than any subsequent developmental stage. This offers great potential for accomplishments, but also creates vulnerabilities for the child if the child’s physical status, relationships, and environments do not support appropriate learning, development, and growth. These developmental years provide the foundation for later abilities and accomplishments. Significant differences in children’s abilities are associated with social and economic circumstances that may be impacting learning and development. The cumulative impact of multiple risk factors on development is well documented. Examples of risk factors are: having a parent who abuses substances, exposure to violence and trauma, inappropriate child care and nurturing, and living in a dangerous environment or community. Children served by child welfare systems are at very high risk for developmental delays and they often represent over 50% of the children under age five served through child welfare. Children with Fetal Alcohol Syndrome (FAS) may present significant developmental delays and learning problems. Since this developmental period is critical to the child’s future social, emotional, and cognitive development, every attempt should be made to provide these children with early intervention services both within the home and in child care settings. (Please see Indicators of Typical Developmental Ages 1-3 Years included in the packet).

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

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

2. If the child has had a developmental screening or assessment, does he/she show any developmental delays? • If so, to what degree and in what area? • Does this child present signs and symptoms of Fetal Alcohol Spectrum Disorder (FASD) or Developmental Trauma Disorder?

3. Does the child appear to be achieving the key development milestones at or above age-appropriate levels?
   • Social/emotional development
   • Cognitive development
   • Physical/motor development
   • Language development
   • Self-care skills
   • School readiness skills

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

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

6. If early intervention services are provided, do the child and parents seem to be responding to the interventions as shown in such areas as improved interaction, acceptance of attempts to nurture, more spontaneous play, emergence of language, etc.?
# Child Status Review 8A: Early Learning & Development (Under Age 5)

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

<table>
<thead>
<tr>
<th>Description of the Status Situation Observed for the Child, under age 5 years</th>
<th>Rating Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optimal Developmental Status.</strong> The child’s current developmental status is at or above age expectations in all domains, based upon normal developmental milestones. <em>(Sustained pattern for at least the last six months or since admission)</em></td>
<td>6</td>
</tr>
<tr>
<td><strong>Good Developmental Status.</strong> The child’s current developmental status is at age expectations in all domains, however, there may be one or two areas in which the child is not as strong and merits ongoing careful monitoring. <em>(Sustained pattern for at least the last three months or since admission if less)</em></td>
<td>5</td>
</tr>
<tr>
<td><strong>Minimally Adequate to Fair Developmental Status.</strong> The child’s current developmental status is near age expectations in most of the major domains and may be slightly below expectations in a few areas. If the child and caregiver is participating in early intervention programs either at home or in a child care environment, the child is making substantial gains and appears to be approaching age-appropriate expectations. <em>(Sustained pattern for at least the past 30 days)</em></td>
<td>4</td>
</tr>
<tr>
<td><strong>Marginally Inadequate Developmental Status.</strong> The child’s developmental status is mixed, somewhat near expectations in some domains, but showing significant delays in others. If the child and caregiver is participating in an early intervention program either at home or in a child care program, the child is making moderate to slow developmental gains and may not be improving in some domains. <em>(A mildly inadequate and possibly inconsistent pattern over the past 30 days)</em></td>
<td>3</td>
</tr>
<tr>
<td><strong>Poor Developmental Status.</strong> The child’s developmental status is showing significant delays in several areas as compared to age-appropriate expectations. If the child and caregiver are involved in an early intervention program, either at home or in a child care program, the child may be making gains but has such significant delays that it is not likely that the child will reach age-appropriate levels of functioning for some time. <em>(A present dynamic pattern of concern)</em></td>
<td>2</td>
</tr>
<tr>
<td><strong>Adverse Developmental Status.</strong> The child’s current developmental status is far below developmental milestones and there may be a decline in certain domains. The child and caregiver may be involved in early intervention programs, but the rate of improvement is no more than minimal and may be subject to periods of regression. <em>(A continuing dynamic pattern of growing concern)</em></td>
<td>1</td>
</tr>
</tbody>
</table>
Focus Measure

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

Core Concepts

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

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

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

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

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

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

3. Is the child assigned to the general education curriculum? • If not, is the child receiving special education and related services in an alternative curriculum directed via an IEP?

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

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

6. Is the child meeting curriculum requirements necessary for promotion, course completion, and IEP-directed transitions? • If not, why not?
Description and Rating of the Child’s Current Academic Status

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

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

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

◆ **Minimally Adequate to Fair Learning Status.** The child is enrolled in a minimally appropriate educational program, consistent with age and ability. The child has a fair rate of school attendance (e.g., ≥85 <90% attendance with no unexcused absences). The child’s fair level of participation and engagement in educational processes and activities is enabling the child to reach at least minimally acceptable educational expectations and requirements set within the child’s assigned curriculum and, where appropriate, the child’s IEP. The child may be reading near grade level or the level anticipated in an IEP. The child may be minimally meeting core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. [**Sustained pattern for at least the past 30 days**]

◆ **Marginally Inadequate Learning Status.** The child may be enrolled in a marginally appropriate educational or vocational program, or somewhat inconsistent with age and ability. The child may have a marginal rate of school attendance (e.g., ≥75 <85% attendance and may have tardy notes or unexcused absences). The child’s limited level of participation and engagement in educational processes and activities may be hindering the child from reaching at least minimally acceptable educational expectations and requirements set within the child’s assigned curriculum and, where appropriate, the child’s IEP. The child may be reading a year below grade level or somewhat below the level anticipated in an IEP. The child may not be meeting some core requirements for grade-level promotion, course completion, and successful transition to the next school or vocational program. [**A mildly inadequate and possibly inconsistent pattern over the past 30 days or longer**]

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

◆ **Adverse Learning Status.** The child may be chronically truant, suspended, or expelled from school. The child may be three or more years behind in key academic areas, may be losing existing skills and/or regressing in functional life areas, and/or may be confined in detention without appropriate instruction or hospitalized. [**A worsening dynamic pattern of growing concern**]
SECTION 3

CAREGIVER STATUS INDICATORS

Parent/Caregiver Status Indicators

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2. Special Parenting/Caregiving Challenges 36
3. Participation in Service Decisions 38
4. Satisfaction with Services/Results 40
CAREGIVER STATUS REVIEW 1A: CAREGIVER SUPPORT OF THE CHILD

Focus Measure

CAREGIVER SUPPORT OF THE CHILD - Degree to which: • The parents or foster caregivers with whom the focus child is currently residing are willing and able to provide the child with the assistance, supervision, protection, and support necessary for daily living. • Where necessary added supports are provided in the home to meet any special needs of the child and assist the caregivers, these required supports are reliably meeting the needs.

Core Concepts

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

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

1. Can the present caregiver perform necessary parenting functions reliably on a consistent daily basis and create a positive atmosphere and secure environment in the home?
   • If Yes, check statements that apply. • If No, explain the situation in the oral and written reports.
   • Does the caregiver perform parenting functions willingly, adequately, and consistently on a daily basis for this child and for other children at home?
   • Is the home free of hazards that might endanger the children?
   • Are all children in the home adequately supervised? Is the caregiver able to arrange for adequate child care?
   • Are the children attending school on a daily basis and doing their homework?
   • Are substitute caregivers attending parent-teacher conferences and special school events?
   • Does the caregiver use praise, affection, emotional support, and age-appropriate discipline?
   • Is the caregiver accessing and using necessary community resources?
   • Does the caregiver follow the service plan, attend required meetings, and transport the child to his/her appointments?
   • Does the caregiver/staff meet this child's parenting needs and/or special needs?

2. Is there anything that might impair the caregiver's functioning?
   • If Yes, determine and explain the reasons.
   • There are exceptional demands in the home (such as small children, high child/caregiver ratio, frail elderly, ill persons in the home, single parent family, social isolation).
   • The caregiver has problems of substance abuse.
   • The caregiver has a physical or mental disability.
   • The caregiver has a history of domestic violence.

3. If the caregiver's functioning is not adequate, are added supports being provided to meet the child's needs?
   • If Yes, what kind of supports have been provided?
Description and Rating of the Caregiver’s Support of the Child

Description of the Status Situation Observed for the Child and Current Caregiver

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

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

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

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

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

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

◆ **Not Applicable.** The child/youth lives in a congregate setting. Caregiver Status Review 1b was applied.
Focus Measure

GROUP CAREGIVER SUPPORT OF THE CHILD - Degree to which the focus child’s primary caregivers in the group home or facility are supporting the child’s education and development adequately on a consistent daily basis.

Core Concepts

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

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

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

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

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

14. Are supports and services being provided to assist caregivers in the group home? • If so, do these seem to be adequate in meeting the needs of the child and caregivers? • Do caregivers have access to sufficient and ongoing training?

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

<table>
<thead>
<tr>
<th>Description of the Status</th>
<th>Rating Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optimal Caregiving.</strong> The child always comes to school prepared and ready to learn; participates fully in the life of the school, including extracurricular activities; and is benefiting from his/her educational opportunities as shown through excellent academic achievement. The child’s basic and special needs are consistently met. Caregivers provide affection, discipline, logical consequences, and moral upbringing. Caregivers participate fully in teacher conferences, planning services, and special events. The child is assisted with homework, tutoring as needed, special assignments, and participation in extracurricular activities.</td>
<td>6</td>
</tr>
<tr>
<td><strong>Good Caregiving.</strong> The child usually comes to school prepared and ready to learn; participates occasionally in the life of the school, including extracurricular activities; and is benefiting from his/her educational opportunities as shown through satisfactory academic achievement. The child’s basic and special needs are generally met. Caregivers usually provide affection, discipline, logical consequences, and moral upbringing. Caregivers usually participate in teacher conferences and planning meetings. The child is usually assisted with homework and participation in extracurricular activities.</td>
<td>5</td>
</tr>
<tr>
<td><strong>Minimally Adequate to Fair Caregiving.</strong> The child comes to school minimally prepared and ready to learn, participates in a few extracurricular activities, and is benefiting from his/her educational opportunities as shown through fair academic achievement. The child’s basic and special needs are minimally met. Caregivers provide affection and discipline. Caregivers occasionally participate in teacher conferences and planning meetings. The child is minimally assisted with homework and extracurricular activities.</td>
<td>4</td>
</tr>
<tr>
<td><strong>Marginally Inadequate Caregiving.</strong> The child occasionally comes to school prepared and ready to learn, may participate in extracurricular activities, and is benefiting little from his/her educational opportunities as shown through poor academic achievement. The child’s basic and special needs are inconsistently met. Caregivers provide inconsistent affection and/or inadequate discipline. Caregivers seldom participate in teacher conferences and planning meetings. The child is inconsistently or inadequately assisted with homework or extracurricular activities. Follow-through with special interventions is limited. Minor support problems are present.</td>
<td>3</td>
</tr>
<tr>
<td><strong>Moderate and Continuing Problems in Caregiving.</strong> The child rarely comes to school prepared and ready to learn. Any benefit from his/her educational opportunities is questionable, as shown through poor academic achievement. The caregiver may be unable to meet the caregiving demands within the home for some period of time. Basic care of children, supervision, and assistance lapse for extended periods of time. The child is likely to be doing poorly in school, sick, absent, truant, suspended, or expelled. Discipline may be absent, inappropriate, or excessive. Moderate support problems and their consequences are present.</td>
<td>2</td>
</tr>
<tr>
<td><strong>Serious and Worsening Problems in Caregiving.</strong> The child does not come to school prepared and ready to learn and is not benefiting from his/her educational opportunities, as shown by failing academic performance. The caregiver may be frequently absent or unable to perform parenting responsibilities within the home for extended periods of time. There is serious concern regarding basic care, supervision, and assistance for the children. The child is most likely doing poorly in school, sick, absent, truant, suspended, or expelled. Discipline is absent, inappropriate, or excessive. Serious support problems and their consequences are present.</td>
<td>1</td>
</tr>
<tr>
<td><strong>Not Applicable.</strong> The child/youth lives in a small home setting. Caregiver Status Review 1a was applied.</td>
<td>NA</td>
</tr>
</tbody>
</table>
Focus Measure

**SPECIAL PARENTING CHALLENGES** - Degree to which: • The parent(s) with whom the focus child is currently residing or has a goal of reunification presents a pattern of significant, ongoing challenges that limit, disrupt, or adversely affect the parent’s capacity to function successfully as an adequate caregiver for this child. • The family has any special life challenges that interfere with or prevent them from living together safely and functioning successfully.

*This indicator applies to a focus child living with the birth parent or having a goal of reunification. If TPR has occurred, then apply to the child’s current home setting, including adoptive, foster, or kinship care. If the child is free for adoption but is living in a congregate care setting, then the indicator is NA.*

If domestic violence, substance abuse/addiction, and/or mental illness are limiting parental caregiving, then make sure that these areas are adequately addressed in the assessment/understanding and planning for change areas.

Core Concepts

When a family is involved with the child welfare system for reasons of child maltreatment, underlying reasons may be due to a combination of life challenges that limit and/or adversely affect the capacity of the parents to maintain safe and nurturing conditions for children in the home and the ability or willingness of the parent to provide essential requirements for effective child rearing. Factors may include one or a combination of the following challenges:

- Limited cognitive abilities (mental retardation, traumatic brain injury)
- Substance abuse impairment or addiction*
- Unlawful behavior pattern and incarceration
- Adverse effects of poverty (e.g., inadequate income; inadequate housing/homelessness; lack of child care; health care; transportation, etc.)
- Cultural or language barriers adversely affecting parenting abilities or doing child rearing inconsistent with normative expectations in the US
- Non-US citizen without required documentation and unable to meet basic needs of the child or family
- Extraordinary demands placed on the parent (e.g., multiple children under age 5; high child/caregiver ratio; frail elderly, mentally ill persons in the home; single caregiver attempting to meet an extraordinary care burden within the home)
- Immaturity of a young teen parent lacking skills and judgment for child care
- Life disruption and dislocation caused by natural disasters leading to homelessness and/or inability to meet child and family needs

The focus of this indicator is assessing the degree to which such factors currently pose serious challenges to the child’s parent(s), resulting in limited abilities, opportunities, and attitudes necessary for maintaining safe conditions in the home and consistently meeting requirements for effective child rearing.

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

1. **To what degree does the parent(s) with whom the child is living or has a goal of reunification present significant, ongoing challenges that limit parenting capacities?** Which, if any, of the following are underlying issues for this parent?
   - Limited cognitive abilities (mental retardation, traumatic brain injury)
   - Substance use impairment or addiction
   - Unlawful behavior patterns or current incarceration
   - Serious mental illness* (major depression, bi-polar disorder, schizophrenia)
   - Domestic violence* (repeated pattern, serious risk/injury)
   - Serious illness or physical disability (e.g., HIV, spinal cord injury, etc.)

2. **Are there any life circumstances that might limit, disrupt, or overwhelm the parent’s functioning?** If so, which of the following items apply?
   - Adverse effects of poverty (e.g., inadequate income; inadequate housing/homelessness; lack of child care; health care; transportation, etc.)
   - Cultural or language barriers adversely affecting parenting abilities or resulting in child rearing inconsistent with normative US expectations
   - Non-US citizen without required documentation and unable to meet basic needs of the child or family but not eligible for assistance
   - Extraordinary demands placed on the parent (e.g., multiple children under age 5; high child/caregiver ratio; frail elderly, mentally ill persons in the home; single caregiver attempting to meet an extraordinary care burden within the home)
   - Immaturity of a young teen parent lacking skills and judgment for adequate child care, reliable supervision, and family life management
   - Life disruption and dislocation caused by natural disasters leading to homelessness and/or inability to meet child and family needs

3. **To what degree do these challenges persist?** To what degree have these challenges been reduced via recent interventions?
Caregiver Status Review 2: Special Parenting Challenges

Description and Rating of the Parent/Caregiver’s Current Status

NOTE: This indicator may be rated for a birth family home where the child may live or have unsupervised visits and/or for a substitute home caregiver (e.g., foster, kinship, or adoptive home where the child may live). Thus, this safety indicator may be applied to either or both parent and caregiver homes.

Description of the Status Situation Observed for the Parents or Caregivers

◆ No Limitations. The parent of the child presently presents/experiences no challenging symptoms, behaviors, or life circumstances that would disrupt, disable, or limit consistent and adequate parenting capacities or opportunities. Parenting capacities are not limited at this time. [Sustained pattern for at least the last six months]

◆ Few, if any, Minor Limitations and with Good Supports. The parent/caregiver of the focus child presently presents/experiences few, very infrequent, and only mildly disruptive or limiting symptoms, behaviors, or life circumstances that could reduce or limit consistent, adequate parenting capacities or opportunities. Parenting capacities always remain good even when such factors are present. Any risk of harm is minimal and is well balanced with protective factors and other supports. [Sustained pattern for at least the last three months]

◆ Some Minor Limitations, but with Adequate Supports. The parent/caregiver of the focus child presently presents/experiences some, recurring, mildly to moderately disruptive or limiting symptoms, behaviors, or life circumstances that somewhat reduce or limit consistent, adequate parenting capacities or opportunities. Parenting capacities generally remain minimally adequate to fair when such factors are present. Any risk of harm is low and fairly balanced with protective factors and other supports. [Adequate, sustained pattern for at least the past 30 days]

◆ Limiting Circumstances - Inadequate Supports or Not Consistently Available. The parent/caregiver of the focus child presently presents/experiences some, recurring, mildly to moderately disruptive or limiting symptoms, behaviors, or life circumstances that reduce or limit consistent, adequate parenting capacities or opportunities. Parenting capacities may vary at moments in time from minimally adequate to occasionally inadequate when such factors are present, resulting in low to moderate risks of harm to children in the home, some of which may lack adequate protections or supports. [A mildly inadequate pattern over the past 30 days]

◆ Major Life Challenges - Supports Inadequate or Missing. The parent/caregiver of the focus child presently presents/experiences significant, recurring, moderately to serious disruptive or limiting symptoms, behaviors, or life circumstances that substantially reduce or limit parenting capacities or opportunities. Parenting capacities may be frequently inadequate when such factors are present, resulting in moderate to high risks of harm to children in the home. Such limited parenting capacities prevent children from safely remaining or returning to the home at the present time. [A present dynamic pattern of concern]

◆ Overwhelming Life Challenges. The parent/caregiver of the focus child presently presents/experiences significant and worsening disruptive or limiting symptoms, behaviors, or life circumstances that fully limit parenting capacities or opportunities. Continued disruption or limitations in parenting capacities at this adverse level prevent children from safely remaining in the home and could result in termination of parental rights. [An adverse, dynamic pattern of increasing concern]

◆ Not Applicable. Under any of the following conditions, this indicator may not apply to one or more of the persons being rated: • If the child is living in the birth home, then the substitute home caregiver would not be rated. • If the child is living in a substitute home and not returning to the family home, then the family home caregiver would not be rated. • If the older youth does not meet the four conditions listed above, then the youth would not be rated. • If the focus child has resided in a 24-hour staffed facility (e.g., hospital, residential treatment facility, detention center, nursing home, etc.) for the past 90 days and is not expected to return to the family home or to a known substitute home within the next 30 days, then neither family nor substitute home is rated.

◆ Not Applicable. Under any of the following conditions, this indicator may not apply to one or more of the persons being rated: • If the child is living in the birth home, then the substitute home caregiver would not be rated. • If the child is living in a substitute home and not returning to the family home, then the family home caregiver would not be rated. • If the older youth does not meet the four conditions listed above, then the youth would not be rated. • If the focus child has resided in a 24-hour staffed facility (e.g., hospital, residential treatment facility, detention center, nursing home, etc.) for the past 90 days and is not expected to return to the family home or to a known substitute home within the next 30 days, then neither family nor substitute home is rated.
**Focus Measure**

**CAREGIVER PARTICIPATION IN DECISIONS -** Degree to which the focus child’s caregivers are effective ongoing participants (e.g., having a significant role, voice, influence) in decisions being made about the child's life situation, educational, treatment, and support services. [As reported in the most recent planning meetings]

**Core Concepts**

As the child’s first and foremost teacher and as the child’s primary advocate, the caregiver (parents, relatives, foster and adoptive parents, or legal guardians) should be an able, active, and ongoing partner in the child’s education and/or treatment. Ideally, the caregiver should support the child by:

- Knowing and explaining the child’s/family’s strengths, needs, preferences, and challenges so that others may understand and assist.
- Attending team meetings and shaping key decisions about life goals, intervention strategies, special services, and essential supports.
- Fulfilling a lead role and providing the voice and views of the child and family when advocating for needs, supports, and services.
- Following through at home on educational or therapeutic interventions for a special needs child.
- Encouraging and supporting the child’s participation in extracurricular and recreational activities that build social supports.

To fulfill the role of child advocate and supporter, the caregiver should be engaged as a service partner in assessing needs, making plans, implementing and monitoring services, and evaluating results and outcomes. A caregiver’s/family’s strengths should be recognized by the team members and engaged. In some cases, caregivers may experience circumstances that reduce ability or opportunity to participate as a major partner. Working single caregivers may lose income if required to attend meetings during school hours. Caregivers with extraordinary demands in the home or other caregivers with special needs of their own may have difficulty participating without special accommodations or support. The service team has an obligation to engage the caregiver as a partner in decision making, to make accommodations and provide supports where necessary to facilitate caregiver participation, or to provide a capable and willing surrogate caregiver when parents are unable to fulfill this critical role. The surrogate should come prepared to participate in decisions made on behalf of the child. This means knowing the child, visiting with the teacher, and knowing the situation.

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

1. Where and with whom does the child live: biological parents, foster parents?
2. How often do the child’s caregivers attend teacher conferences, service team meetings, and other activities related to the needs and progress of the child?
3. How well does the child’s caregiver know and explain child and family strengths, needs, challenges, and preferences to others involved in the services processes?
4. How well is the parent fulfilling a lead role and providing the voice and views of the child and family when advocating for needs, supports, and services?
5. Is the child encouraged and supported in participating in extracurricular activities provided through the school or community organizations?
6. Are there any factors that substantially and repeatedly prevent or reduce the caregiver’s opportunity or ability to function as an advocate for the child in matters related to interventive services or to the child’s situation and performance at school or in the community? • If so, what are these factors?
7. If there are factors that substantially and repeatedly prevent or reduce the caregiver’s opportunity or ability to function effectively in matters related to the child’s service situation, has the service team offered special accommodations or supports to the caregiver to facilitate effective participation? • If so, have they been accepted by the caregiver and has this improved participation? If accommodations or supports have not been offered, why not?
8. If the caregiver is unable to function as an effective partner, has a surrogate caregiver been assigned by the service team? • If not, why not? • If so, is this person functioning as a knowledgeable and prepared advocate for the child?
Description and Rating of the Caregiver’s Current Status

Description of the Status of Caregiver Participation and Advocacy for the Child and Family

◆ **Optimal caregiver participation.** The child’s caregiver is a full and effective partner in all aspects of assessment, service planning, implementation and monitoring, and evaluation of results.

◆ **Substantially good caregiver participation.** The child’s caregiver is a substantial and contributing partner in most aspects of assessment, service planning, implementation and monitoring, and evaluation of results.

◆ **Minimally adequate to fair caregiver participation.** The child’s caregiver is a fair participant in some aspects of assessment, service planning, implementation and monitoring, and evaluation of results.

◆ **Marginally inadequate caregiver participation.** The child’s caregiver is a limited or inconsistent participant in a few aspects of assessment, service planning, implementation and monitoring, and evaluation of results. The caregiver may have limiting circumstances, may not have been offered accommodations or supports, or may not wish greater participation even with offered accommodations or assistance.

◆ **Substantially inadequate caregiver participation.** The child’s caregiver seldom participates in any aspects of assessment, service planning, implementation and monitoring, and evaluation of results. The caregiver may have limiting circumstances, may not have been offered acceptable accommodations or supports, or may not wish greater participation even with offered accommodations or assistance.

◆ **No caregiver participation or educational advocacy.** The child’s caregiver has not participated in any aspects of assessment, service planning, implementation and monitoring, and evaluation of results within the past 12 months. The child may be receiving services in a hospital, residential setting, detention center, or alternative educational placement situation and “lost” from the home school. The child may have been removed from the family home by child protective services and placed in a foster home, resulting in ambiguity surrounding parental responsibilities for educational advocacy. - OR - No surrogate caregiver has been identified and assigned to serve this child who otherwise lacks an educational or treatment advocate. The child presently lacks effective educational/treatment advocacy and may be adversely affected by a lack of needed services and loss of educational opportunities in his/her present situation.
Focus Measure

SATISFACTION - Degree to which the parent(s) or primary caregiver(s) is/are satisfied with the supports, services, and service results presently being experienced. [Satisfaction over the past 90 days or since the beginning of the current service/treatment plan]

Core Concepts

Satisfaction focuses the views of the caregiver(s) of the child who is the focus of the review. If the child lives with his/her parents, relative, foster parent, or group home parent, then that person’s views are solicited. If the child is being served temporarily in a residential treatment setting or hospital and will be returning home, then the views of the caregiver to whom the child will be returned is solicited. If the child is in a residential treatment setting and the future caregiver is unknown, then the caregiver part of the question should be noted as not applicable.

Caregiver satisfaction is concerned with the degree to which the child and caregiver 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. Satisfaction extends to:

- Participation in decisions and plans made for the benefit of the child and his/her caregiver.
- Feelings of respect for their views and preferences in the planning and delivery of services.
- Belief that a good mix and match of supports and services is offered that well fits their situation.
- Appreciation for the quality/dependability of assistance and support provided.
- Feelings that circumstances are better now than before or are getting better because of the supports and services.

Caregivers should be generally satisfied with services, taking into account that services may not always be voluntary.

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

1. How satisfied is the caregiver(s) with their role and impact (voice, views, influences, and choices) in shaping decisions made about intervention strategies, services, and supports being provided to the child and family?
2. Does the caregiver feel respected when sharing their views and preferences in the planning and delivery of services?
3. Does the caregiver believe they were offered reasonable alternatives from which to choose when selecting intervention strategies, services, supports, and providers?
4. To what degree does the caregiver(s) agree with and support the combination and sequence of strategies, supports, and services that are being offered and provided to the child and family?
5. Is the caregiver satisfied with the present mix and match of services being offered and provided? If not, what would they change?
6. How does the caregiver rate the quality and dependability of their current services and the providers of services?
7. How does the caregiver rate the effectiveness of current strategies, services, and supports in getting the results they were seeking?
8. To what degree does the caregiver believe they are benefiting from these services, even if some services were not voluntary in nature?
9. If the child lives in a foster or group home, does the caregiver feel adequately supported in serving this child?
10. If the child presently resides in a residential treatment setting, is the receiving caregiver back home satisfied with the nature, quality, and results of the residential services provider?
Description and Rating of the Caregiver’s Current Status

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

◆ The 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 respondent “couldn’t be more pleased” with the service situation and his/her recent experiences and interactions with service personnel.

◆ The 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. Any complaints and disappointments are minimal.

◆ The respondent reports **minimally adequate to fair 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 service personnel. Any complaints and disappointments are occasional and/or minor.

◆ The 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 “a little more disappointed than pleased” with the service situation and his/her recent experiences and interactions with service personnel. Any complaints and disappointments are recent and substantive.

◆ The 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 service personnel. Any complaints and disappointments are substantial and continuing over time.

◆ The 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. Complaints and disappointments may be longstanding, significant, and increasing in their scope and intensity.

◆ **This indicator does not apply or cannot be applied** to this person at this time.
SECTION 4

CHILD PROGRESS INDICATORS

1. Symptom/Substance Use Reduction
2. Improved Coping/Self-Management
3. School/Work Progress
4. Meaningful Relationship Progress
5. Well-Being/Quality of Life
PROGRESS REVIEW 1: REDUCTION OF PSYCHIATRIC SYMPTOMS/SUBSTANCE USE

Focus Measure

REDUCTION OF SYMPTOMS/SUBSTANCE USE - Extent to which targeted psychiatric symptoms and/or substance use patterns that have led to adverse life effects are being reduced/eliminated or maintained at a desired level by the focus child.

Core Concepts

A child receiving treatment for emotional/behavioral disorders has one or more diagnoses based on specific psychiatric symptoms (e.g., binge eating, panic attacks, or hallucinations), targeted maladaptive behaviors (e.g., pica, SIB, or hitting), or substance use that are to be reduced or eliminated via treatment intervention(s). As a result of treatment intervention and support, targeted symptoms and/or substance use patterns are expected to diminish as daily functioning is improved or restored. Often, the reduction of targeted symptoms or substance use behaviors is coupled with targeted increases in the development of coping skills to manage symptoms that cannot be fully eliminated via medications or to build functional replacement behaviors that remove the reinforcement value of maladaptive behaviors while increasing the child’s use of pro-social skills.

NOTE: The targeted increases in coping skills and/or functional replacement behaviors are addressed in Progress Review 2: Improved Coping/Self-Management. The reduction of targeted symptoms or drug use is addressed in this indicator, Progress Review 1.

Targeted symptoms, maladaptive behaviors, and/or substance use provide the basis for treatment interventions. Effective treatment response should be accompanied by reduction in targeted symptoms and, hopefully, restoration or improvement of the child to an adequate level of daily functioning at school and home. Children receiving appropriate treatment are expected to show reduction in symptoms, behavioral episodes, and/or substance use over the course of treatment. Application of this indicator to a child being reviewed requires that:

1. One or more psychiatric symptoms causing functional impairments and/or one or more maladaptive behaviors/substance use patterns causing adverse impact have been identified and targeted for reduction via planned treatment intervention(s).
2. Baseline information on the nature, frequency, and severity of the symptoms or maladaptive behaviors/substance use was taken and is being used for subsequent database comparisons to track frequencies and intensities over time.
3. Planned treatment interventions have been delivered for a period of 60 days or longer.
4. Current (within the past 30 days) tracking information (quantitative or anecdotal or both) is available for examination by the reviewer to use as a basis for rating this indicator. (Missing tracking information will be reflected in the rating process.)

The purpose of this review is to determine the child’s progress in the reduction of symptoms, maladaptive behaviors, and/or substance use associated with the disorder or condition being treated. The reviewer should use the scale provided to report the degree of progress made in symptom reduction reported by informants and records in this case. The reviewer should examine change over the past six months [or since the targeted treatment intervention began, if less than six months]. If multiple targets are being treated and tracked, the reviewer should focus on the targeted symptoms or maladaptive behaviors that were most troublesome to the child and others when rating this indicator. If treatment interventions (e.g., medications, psychotherapy, behavioral management techniques) are being used without data-driven tracking and adjustment, this practice deficit should be reflected, as appropriate to the case circumstances and impact, in the ratings made for assessment, service implementation, tracking and adjustment, medication management, and effective results. This indicator does not apply to a child for whom no psychiatric symptoms, maladaptive behaviors, or substance use are being or have been targeted for treatment intervention within the past six months.

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

1. Have one or more psychiatric and substance use symptoms or maladaptive/substance use behaviors been targeted and treated for this child within the past six months?
2. Was specific baseline data collected on each targeted symptom or behavior at the time it was selected for treatment intervention? • Is it available for review? • Have targeted and treated psychiatric and substance use symptoms or maladaptive behaviors been tracked via data collection over time for each targeted symptom or behavior?
3. To what degree have the targeted symptoms or behaviors been reduced via treatment intervention(s) over the past six months?
Description and Rating of the Focus Child’s Recent Progress

**Optimal Progress.** Tracking information on major symptoms/behaviors/substance use being treated reveals that **excellent progress** is being made in reducing targeted symptoms/behaviors/use patterns at a level **well above expectation.** - OR - The disorder is now in partial-to-full remission/sobriety and there are no longer any symptoms or signs of disorder or the adverse effect of any remaining symptoms/use are fully and effectively managed by the person using coping strategies and skills. Functioning has been restored to previous levels or has been advanced to a level necessary for adequate functioning in daily settings.

**Good Progress.** Tracking information on major symptoms/behaviors/substance use being treated reveals that the child is making **good progress** in reducing targeted symptoms/behaviors/use patterns at a level **somewhat above expectation.** - OR - The disorder is now at a mild level with few, if any, symptoms in excess of those required to make a diagnosis. Symptoms/use result in no more than rare, minor functional impairments in social, school, or work settings.

**Fair Progress.** Tracking information on major symptoms/behaviors/use patterns being treated reveals that the child is making **fair progress** in reducing targeted symptoms/behaviors/use at a level **somewhat near expectation.** - OR - The disorder is now at a mild to moderate level with some symptoms or functional impairments still present in social, school, or work settings.

**Marginal Progress.** The child is making **limited or inconsistent progress** in reducing targeted symptoms/behaviors, and/or use patterns at a level **somewhat below expectation.** - OR - The disorder is now at a moderate level with substantial symptoms or functional impairments present in social, school, or work settings. Tracking data available may be somewhat limited, inconsistent, or dependent on anecdotal statements with somewhat limited information based on tracked frequency and intensity of episodes.

**No Progress.** The child is making **little or no consistent progress** in reducing targeted symptoms/behaviors/use patterns. - OR - The disorder is now at a moderate to severe level with many symptoms and marked functional impairments present in social, school, or work settings. Risks of restriction, isolation, regression, addiction, or injury may be present and increasing. Tracking data available may be very limited, inconsistent, or totally dependent on anecdotal statements with little or no information based on tracked frequency and intensity of episodes.

**Decline.** The child’s symptoms, maladaptive behaviors, and/or use patterns are **increasing and intensifying.** Serious symptoms/substance use and increasing functional limitations may be present across settings. Risks of increased restriction, isolation, regression, addiction, or injury may be high. Quantitative tracking data on targeted symptoms/behaviors may be entirely missing with treating professionals relying only on sketchy anecdotal information, possibly obtained from persons who are unreliable or who have had very little contact with the child in the settings where troublesome symptoms/behaviors/use patterns are occurring.

**Not Applicable.** This child had not received treatment interventions for targeted psychiatric symptoms or serious maladaptive behaviors within the past six months. Therefore, this indicator does not apply to this child at this time.
IMPROVED COPING/SELF-MANAGEMENT - Extent to which the focus child has demonstrated adequate progress over the past six months, consistent with the child’s age and ability, in building appropriate coping skills that manage lingering psychiatric symptoms and prevent relapse from substance abuse recovery and/or in gaining functional behaviors and self-management skills.

Core Concepts

A child receiving treatment for emotional/behavioral/substance use disorders has one or more diagnoses based on specific psychiatric symptoms (e.g., binge eating, panic attacks, or hallucinations), targeted maladaptive behaviors (e.g., pica, SIB, or hitting), and/or substance use patterns that are to be reduced or eliminated via treatment intervention(s). As a result of treatment intervention and support, targeted symptoms of disorders are expected to diminish as daily functioning is improved or restored. The reduction of targeted symptoms, maladaptive behaviors, or substance use should be coupled or paired with targeted increases in the development of coping skills to manage symptoms that cannot be fully eliminated via medications or to build functional replacement behaviors that remove the reinforcement value of maladaptive behaviors/substance use while increasing the child’s use of pro-social and self-management skills to get needs met appropriately.

NOTE: The targeted increases in coping skills, functional replacement behaviors, and/or self-management is addressed in this indicator. Progress Review 2: The reduction of targeted symptoms, maladaptive behaviors, and/or substance use is addressed in Progress Review 1.

Increasing resiliency/drug abstinence in children who struggle with lingering psychiatric symptoms or drug use relapse tendencies, which may be reduced but not eliminated with treatment, requires that the child develop and use active coping strategies and skills to function effectively in daily settings. Similarly, good practice requires that targeted maladaptive behaviors/substance use patterns be paired with functional replacement behaviors that offer the child new strategies and pro-social skills to rely on in daily settings as maladaptive behaviors/substance use are being reduced and eliminated. The focus of this indicator is placed on the progress being made by the child in building and using coping skills and/or functional replacement behaviors in daily settings as troublesome symptoms, maladaptive behaviors, or substance use is being reduced via treatment intervention(s).

Effective treatment response should be accompanied by reduction in targeted symptoms/behaviors/drug use with concurrent improvement of the child to an adequate level of daily functioning at school and home. Concurrent with the reduction of symptoms/maladaptive behaviors/drug abstinence, the child is expected to demonstrate increasingly successful use of coping skills, functional replacement behaviors, and/or self-management strategies in the child’s daily settings. Baseline measures should be taken on targeted coping skills or targeted replacement behaviors to provide a basis for subsequent comparisons and tracking over time. Application of this indicator to a child being reviewed requires that:

1. One or more psychiatric symptoms/substance use issues causing functional impairments and/or one or more substance use behaviors causing adverse impact have been identified and targeted for reduction or elimination via planned treatment intervention(s). For each symptom or behavior, one or more targeted coping skills or replacement behaviors have been set for acquisition and demonstration.

2. Baseline information on the nature, frequency, and severity of the symptoms or maladaptive behaviors was taken and is being used for subsequent database comparisons to track frequencies and intensities over time. Baseline information on presentation and use of each targeted coping skill or replacement behavior was taken and is being used to track acquisition and use concurrently with the reduction of psychiatric symptoms or substance use behaviors.

3. Planned treatment interventions, including skill acquisition, have been delivered for a period of 60 days or longer.

4. Current (within the past 30 days) tracking information (quantitative or anecdotal or both) is available for examination by the reviewer to use as a basis for rating this indicator. [Missing tracking information will be reflected in the rating process.]

The purpose of this review is to determine the child’s progress in acquisition and use of coping skills and/or functional replacement behaviors associated with the treated disorder. The reviewer should use the scale provided to report the degree of progress made in daily coping and/or use of functional replacement behaviors reported by informants and records. The reviewer should examine change over the past six months [or since the targeted treatment intervention began, if less than six months]. If multiple targets are being treated and tracked, the reviewer should focus on the targeted coping skills or functional replacement behaviors that are most important and useful to the child and others when rating this indicator. If treatment interventions (e.g., medications, psychotherapy, behavioral management and training techniques) are being used without data-driven tracking and adjustment, this practice deficit should be reflected, as appropriate to the case circumstances and impact, in the ratings made for assessment, service implementation, tracking and adjustment, medication management, and effective results. This indicator does not apply to a child for whom no psychiatric symptoms or maladaptive behaviors are being or have been targeted for treatment intervention using acquisition of coping skills or functional replacement behaviors within the past six months.
**PROGRESS REVIEW 2: IMPROVED COPING/Self-MANAGEMENT**

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

1. Have one or more psychiatric symptoms or maladaptive behaviors been targeted for coping skill acquisition or functional replacement behaviors within the past six months?

2. Was specific baseline data collected on each coping skill or replacement behavior at the time it was selected for treatment intervention? Is it available for review? How has this data been used to track acquisition and use in this case?

3. Have targeted coping skills or replacement behaviors been tracked via data collection over time and linked to each targeted symptom or behavior?

4. To what degree have the targeted coping skills or replacement behaviors been gained and used via treatment intervention(s) over the past six months?

**Description and Rating of the Focus Child’s Recent Progress**

<table>
<thead>
<tr>
<th>Description of the Progress Observed for the Child</th>
<th>Rating Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optimal Progress.</strong> The child is demonstrating positive gains in coping skills, functional replacement behaviors, and/or self-management abilities in daily settings above expectation, based on the child’s daily functioning in home and school settings and activities, parent and teacher reports, tracking data collected on the frequency of skill use, and evidence of optimal progress toward achievement of planned intervention goals related to the targeted behaviors.</td>
<td>6</td>
</tr>
<tr>
<td><strong>Good Progress.</strong> The child is demonstrating positive gains in coping skills, functional replacement behaviors, and/or self-management abilities at expectation, based on the child’s daily functioning in home and school settings and activities, parent and teacher reports, tracking data collected on the frequency of skill use, and evidence of good progress toward achievement of planned intervention goals related to the targeted behaviors.</td>
<td>5</td>
</tr>
<tr>
<td><strong>Minimally Adequate to Fair Progress.</strong> The child is demonstrating positive gains in coping skills, functional replacement behaviors, and/or self-management abilities near expectation, based on the child’s daily functioning in home and school settings and activities, parent and teacher reports, tracking data collected on the frequency of skill use, and evidence of minimally adequate to fair progress toward achievement of planned intervention goals related to the targeted behaviors.</td>
<td>4</td>
</tr>
<tr>
<td><strong>Marginally Inadequate Progress.</strong> The child is demonstrating limited or inconsistent gains in coping skills, functional replacement behaviors, and/or self-management abilities below expectation, based on the child’s daily functioning in home and school settings and activities and evidence of somewhat inadequate progress toward achievement of planned intervention goals related to the targeted behaviors. Tracking data available may be somewhat limited, inconsistent, or dependent on anecdotal statements with somewhat limited information based on tracked skill acquisition.</td>
<td>3</td>
</tr>
<tr>
<td><strong>Poor Progress.</strong> The child is performing well below expectation in gaining coping skills, functional replacement behaviors, and/or self-management abilities. Tracking data available may be very limited, inconsistent, or totally dependent on anecdotal statements with little or no information based on tracked skill acquisition and use.</td>
<td>2</td>
</tr>
<tr>
<td><strong>Regression.</strong> The child is regressing in the areas targeted for skill acquisition or functional behavior replacement. Quantitative tracking data on skill acquisition and use may be entirely missing with treating professionals relying only on sketchy anecdotal information, possibly obtained from persons who are unreliable or who have had very little contact with the child in the settings where skills are to be used.</td>
<td>1</td>
</tr>
<tr>
<td><strong>Not Applicable.</strong> This child has not received treatment interventions for targeted coping skills or functional replacement behaviors within the past six months. Therefore, this indicator does not apply to this child at this time.</td>
<td>NA</td>
</tr>
</tbody>
</table>
Focus Measure

**SCHOOL/WORK PROGRESS** - Extent to which the focus child has demonstrated progress over the past six months, consistent with the child’s age and ability, in his/her assigned academic or vocational curriculum or work situation.

Core Concepts

The child is expected to be making progress in school or employment. Each child/youth is expected to be actively engaged in developmental, educational, and/or vocational processes that are enabling the child/youth to build skills and functional capabilities at a rate and level consistent with age and abilities. Each child/youth has an assigned curriculum (e.g., general education, with or without necessary accommodations and/or modifications, or an alternative curriculum with related assessments and instruction, special education alternative curriculum, vocational curriculum, work experience program, GED program curriculum, or post-secondary courses). If the child/youth has completed or dropped out of school and is working, then progress in satisfying expectations of the employer and making career advancement is the focus of rating progress in this review. If the child/youth is not in school and not working, then this review does not apply. Application of this indicator to a child being reviewed requires that:

1. The child/youth has been engaged in an educational or vocational curriculum or work situation over the past six months.
2. Information about the child/youth’s performance in the curriculum or work situation from six months ago is available for examination by the reviewer. Such information may include teacher reports, grades, and academic or vocational assessments.
3. Current information about the child/youth’s performance in the curriculum or work situation is available for examination by the reviewer. Such information may include teacher reports, grades, and academic or vocational assessments made within the past month.
4. The reviewer is able to determine the expected and actual pace and level of change that has occurred over the past six months. Teacher or employer reports gathered via interviews may be relied upon by the reviewer in making a determination and rating for this indicator. [Missing progress information will be reflected in the rating process.]

The purpose of this review is to determine the pace and extent of the child’s progress [relative to expectation] made in educational achievement, vocational skill progression, or improving work skills and competencies demonstrated on the job occurring over the past six months. The reviewer should gauge expectation levels for the child’s progress based on curriculum goals, content to be covered, and recent assessments and grades, taking into account any special accommodations made for the special needs of the student or alternative goals set in an IEP made for the child. The expectations of teachers or employers should be considered also when rating this indicator. The reviewer should use the scale provided to report the degree of progress made by this child over the past six months. The reviewer should examine change over the past six months. If instruction and training are being provided without progress assessment, reporting, and feedback, this practice deficit should be reflected, as appropriate to the case circumstances and impact, in the ratings made for assessment, service implementation, tracking and adjustment, and effective results.

This indicator does not apply to a child for whom no educational, vocational, or employment activities have been conducted over the past six months. Special circumstances that account for this learning opportunity deficit should be explained by the review in the oral and written case reports.

**NOTE:** *Child Status Review 8: Learning Status*, focuses on the current status at the time of review while *Progress Review 3: School/Work Progress*, focuses on progress made over the past six months. Consider the degree to which the child is meeting essential requirements for grade-level promotion, course completion, and/or IEP goal attainment. How well is the child’s progress over the past six months helping the child to meet curriculum-based or IEP-based performance expectations that are being applied to this child?

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

1. Has this child been engaged in an educational, vocational, or employment situation over the past six months? If not, why not?
2. What pace and level of educational, vocational, or employment progress was expected and accomplished over the past six months?
3. What information is available to support the degree of progress made? How confident are you in the accuracy of this information? How has this information been used by interveners involved with this child and family?
4. To what degree is the progress achieved consistent with expectations?
PROGRESS REVIEW 3: SCHOOL/WORK PROGRESS

Description and Rating of the Focus Child’s Recent Progress

Description of the Progress Observed for the Child

✶ **Optimal Progress.** The child/youth is making excellent rates and levels of progress in all or nearly all areas [as measured from an earlier performance baseline and/or from standardized academic assessments in the child’s curriculum]. This high level of progress is supported by teacher reports, routine assessments of progress, grades, grade-level promotions, and course completion. - OR - He/she is making excellent progress in satisfying expectations of an employer necessary for maintaining employment and making career advancement.

◆ **Good Progress.** The child/youth is making good and consistent rates and levels of progress in most areas [as measured from an earlier performance baseline and/or from standardized academic assessments in the child’s curriculum]. This favorable level of progress is supported by teacher reports, routine assessments of progress, grades, grade-level promotions, and course completion. - OR - He/she is making good and substantial progress in satisfying expectations of an employer necessary for maintaining employment and making career advancement.

◆ **Fair Progress.** The child/youth is making minimally adequate to fair rates and levels of progress in key areas [as measured from an earlier performance baseline and/or from standardized academic assessment in the child’s curriculum]. This basic level of progress is supported by teacher reports, routine assessments of progress, grades, grade-level promotions, and course completion. - OR - He/she is making minimally adequate to fair progress in satisfying expectations of an employer.

◆ **Marginally Inadequate Progress.** The child/youth is making limited or inconsistent rates and levels of progress in some key areas [as measured from an earlier performance baseline and/or from standardized academic assessment in the child’s curriculum]. This marginal level of progress is supported by teacher reports, routine assessments of progress, grades, grade-level promotions, and course completion. - OR - He/she is making limited or inconsistent progress in satisfying expectations of an employer.

◆ **No Progress.** The child/youth is making little or no progress in many important areas [as measured from an earlier performance baseline and/or from standardized academic assessment in the child’s curriculum]. - OR - He/she is not making progress in satisfying expectations of an employer necessary for maintaining employment and making career advancement.

◆ **Regression.** The child/youth is regressing in some key areas [as measured from an earlier performance baseline and/or from standardized academic assessment in the child’s curriculum]. - OR - He/she is having significant problems in satisfying expectations of an employer necessary for maintaining employment.

◆ **Not Applicable.** EITHER: This child is in a highly restrictive or highly specialized treatment setting where school/work progress cannot be appropriately delivered or assessed. - OR - The child has not participated in an educational, vocational, or employment situation at a level necessary to expect progress to occur over the past six months.
Focus Measure

MEANINGFUL RELATIONSHIPS - Extent to which the focus child has made progress in developing and maintaining meaningful relationships with family members/caregivers, age peers, and other adult supporters [at home, at school, and in the community] over the past six months.

Core Concepts

A child/youth who has special needs (e.g., a serious emotional disability) and/or who may have experienced damaging or disruptive life circumstances (e.g., maltreatment in a birth home resulting in multiple placements in foster homes or treatment facilities) often faces serious difficulties in developing and maintaining meaningful relationships. For this reason, the service team for such a child may target specific goals, interventions, supports, and activities for helping the child to develop positive, enduring relationships with family members, age peers, and other supportive adults (e.g., teacher, coach, mentor, scout leader, tutor, foster parent). To make progress in social integration and relationship development, the child/youth should have access to the same social and extra-curricular activities as his/her non-disabled age peers who may be attending the neighborhood school. Such activities include school-sponsored events and other organized activities for recreational or enrichment purposes. A child having greater social challenges may require a mentor, life coach, "big brother," or more intensive or specialized support person for a period of time.

The focus of this review is on recent progress made by the child in forming and maintaining meaningful relationships in increasingly socially integrated settings and groups. This review applies to a child/youth for whom treatment goals have been aimed at developing positive and enduring relationships. If the child/youth is not working toward such goals, then this review indicator does not apply. Application of this indicator to a child being reviewed requires that:

1. The child/youth has been engaged in goal-directed efforts to develop and maintain meaningful relationships over the past six months.
2. Information about the child/youth’s relationship patterns from six months ago is available for examination by the reviewer. Such information may include self-report of the child as well as statements made by teachers, therapists, court counselors, or parents.
3. Current information about the child/youth’s current relationship patterns and social activities is available for examination by the reviewer. Such information may include self-report of the child as well as statements made by others who know the child well.
4. The reviewer is able to determine the expected and actual pace and level of change that has occurred over the past six months. Informant reports gathered via interviews may be relied upon by the reviewer in making a determination and rating for this indicator. [Missing progress information will be reflected in the rating process.]

The purpose of this review is to determine the pace and extent of the child’s progress [relative to expectation] made in developing and maintaining meaningful relationships demonstrated in daily settings and social groups over the past six months. The reviewer should gauge expectation levels for the child’s progress based on planned goals and on the perspectives offered by the child and others who know the child and his/her situation well. The reviewer should use the scale provided to report the degree of progress made by this child over the past six months. The reviewer should examine and rate the change in the child’s relationships over the past six months.

NOTE: Child Status Review 7: Emotional Well-Being, includes quality of relationships at the time of the review while Progress Review 4: Progress Toward Meaningful Relationships, focuses on progress made in relationship building made over the past six months.

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

1. Has this child been engaged in a goal-directed relationship development and maintenance effort over the past six months? • If not, why not?
2. What pace and level of relationship development and maintenance progress was expected and accomplished over the past six months?
3. What information is available to support the degree of progress made? • How confident are you in the accuracy of this information? • How has this information been used by interveners involved with this child and family?
4. To what degree is the progress achieved consistent with expectations?
Progress Review 4: Progress Toward Meaningful Relationships

Description and Rating of the Focus Child’s Recent Progress

Description of the Progress Observed for the Focus Child with Others

◆ **Optimal Progress.** The child/youth has made excellent progress over the past six months in developing and maintaining positive relationships with various family members (or substitute caregivers), non-disabled age peers, and other adults in the child’s daily settings and activities. For a child with a history of serious emotional/behavioral challenges and/or disruptive life circumstances, this represents excellent progress. All of these relationships are being made and experienced in increasingly socially integrated settings and social activities.

◆ **Good Progress.** The child/youth has made good and substantial progress over the past six months in developing and maintaining positive relationships with various family members (or substitute caregivers), non-disabled age peers, and other adults in the child’s daily settings and activities. For a child with a history of serious emotional/behavioral challenges and/or disruptive life circumstances, this represents good progress. Many of these relationships are being made and experienced in increasingly socially integrated settings and activities.

◆ **Fair Progress.** The child/youth has made minimally adequate to fair progress over the past six months in developing and maintaining positive relationships with some family members (or substitute caregivers), non-disabled age peers, and other adults in the child’s daily settings and activities. For a child with a history of serious emotional/behavioral challenges and/or disruptive life circumstances, this represents minimally adequate to fair progress. Some of these relationships are being made and experienced in increasingly socially integrated settings and social activities.

◆ **Marginally Inadequate Progress.** The child/youth has made limited or inconsistent progress over the past six months in developing and maintaining positive relationships with few family members (or substitute caregivers), non-disabled age peers, and other adults in the child’s daily settings and activities. For a child with a history of serious emotional/behavioral challenges and/or disruptive life circumstances, this represents limited, inadequate progress. Few of these relationships are being made and experienced in increasingly socially integrated settings and social activities.

◆ **Poor or No Progress.** The child/youth has made little or no progress over the past six months in developing and maintaining positive relationships with any family members (or substitute caregivers), non-disabled age peers, and other adults in the child’s daily settings and activities. For a child with a history of serious emotional/behavioral challenges and/or disruptive life circumstances, this represents a disappointing lack of progress. Possibly, none of these relationships are being made and experienced in increasingly socially integrated settings and social activities.

◆ **Regression.** The child/youth has lost positive relationships over the past six months with family members (or substitute caregivers), non-disabled age peers, and other adults in the child’s daily settings and activities.

◆ **Not Applicable.** EITHER: The child/youth does not have a goal to develop and maintain meaningful relationships in his/her ISP or IEP; therefore, this review is deemed not applicable. OR: The child may be recently and temporarily hospitalized, placed in residential treatment or detention, served through a home-bound arrangement, or assigned to an alternative educational setting for periods greater than 45 days.
Focus Measure

IMPROVED WELL-BEING & QUALITY OF LIFE (QOL) - Extent to which interventions provided:
• Have not just removed deficits but actually have improved the overall well-being and life quality of the focus child and family.
• Have increased the positive strengths and general well-being of the child and family in key areas (i.e., physical, cognitive, spiritual, and social).

NOTE: Reviewers should consider a variety of factors when evaluating improved well-being because it is a subjective interpretation. QOL can include commonly accepted expectations, community/cultural differences, and a variety of personal factors. What might constitute a good QOL often varies by age and level of ability, as well as gender, cultural, and personal preferences.

Core Concepts

Some of the generally accepted principles of overall well-being are:

• Basic needs for food, shelter, and belonging are met
• Meaningful social relationships
• Opportunities to grow, develop, and learn
• Good physical and emotional health
• Control over one’s environment
• Ability to contribute to the community

The reviewer should identify aspects of life that have changed for the positive in the child/family’s daily functioning, relationships, living arrangements, educational environment, and goals/vision for the future. For progress to have been made, the focus child/family should perceive that their life situation has improved over the past six months. NOTE: The targeted positive increases in coping skills, identifying and using personal strengths, functional replacement behaviors, and/or self-management addressed in Progress Review 2 are essential to improving overall well-being. Progress Review 5 addresses whether the overall well-being and circumstances for a child and family have improved over the past six months. The goal of assisting a focus child/family is to build the capacities necessary to live safely and to function successfully and independently, thereby achieving improved well-being and a more satisfying quality of life following services. When these capacities are demonstrated and sustained over time, the need for outside support and supervision have ended or diminished significantly. Indicators that a child/family is building necessary capacities may include:

• Knowing and using key life skills in solving basic problems related to daily living.
• Knowing and using the strengths of the child and other family members to create a more positive, supportive, and optimistic environment.
• Taking control of one’s needs, issues, and assets and having clear life plans for the future.
• Linking with informal supports and resources in the extended family, neighborhood, and community.
• Reducing social isolation and building social networks that create supports, linkages, and opportunities.
• Setting and achieving important life goals (e.g., vocational training, high school graduation, GED, post-secondary education).
• Finding ways to meet fundamental needs (e.g., income, housing, transportation, health care, food, child care).
• Establishing and maintaining trusting and supportive relationships among family members and supporters.
• Forming and relying on a sustainable support network independent of agency funding or supervision.
• Knowledge of services generically available in the community that can be used to support the child and other members of the family.

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

1. Is the child/family gaining competence in learning, navigating, and relying upon community resources, his/her own social networks of people, his/her own problem-solving abilities, and knowledge of his/her living environment?

2. Is the family linking with informal supports and resources in the extended family, neighborhood, spiritual community, and/or larger community?

3. Is the child and family developing and maintaining sustainable, positive, long-term relationships with others?

4. Is the child/family finding acceptable ways to meet fundamental living needs (e.g., income, housing, transportation, health care, food, child care)? • Is the youth forming and relying on sustainable support networks that are independent of public agencies
Progress Review 5: Overall Well-Being & Quality of Life

providing supervision and support?

5. Is the family or older youth seeking and sustaining affordable housing? • Does the youth have transition plans for supported housing/living services, if needed?

6. Is progress towards independence at a level where supervision can be reduced? • Supports faded? • Case closed?

7. Does the child/family/youth perceive that their overall well-being/quality of life has improved over the past six months?

Description and Rating of the Focus Child’s Recent Progress

Description of the Progress Observed for the Focus Child and Family

◆ Optimal Progress. The child/family or youth has been making excellent progress over the past six months in: (1) developing and using personal strengths in building life skills and problem solving, (2) developing long-term supportive relationships, (3) gaining core independent living/life skills, (4) developing community supports and networks, (5) advancing education and employment opportunities, and (6) developing meaningful and achievable future plans. As appropriate, the family or the youth is making excellent progress in: (1) garnering a living wage, (2) acquiring affordable housing, and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.

◆ Good Progress. The child/family or youth has been making good and substantial progress in: (1) developing and using personal strengths in building life skills and problem solving, (2) developing long-term supportive relationships, (3) gaining core independent living/life skills, (4) developing community supports and networks, (5) advancing education and employment opportunities, and (6) developing meaningful and achievable future plans. As appropriate, the family or the youth is making good progress in: (1) garnering a living wage, (2) acquiring affordable housing, and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.

◆ Fair Progress. The child/family youth has been making minimally adequate to fair progress in: (1) developing and using personal strengths in building life skills and problem solving, (2) developing long-term supportive relationships, (3) gaining core independent living/life skills, (4) developing community supports and networks, (5) advancing education and employment opportunities, and (6) developing meaningful and achievable future plans. As appropriate, the family or the youth is making minimally adequate progress in: (1) garnering a living wage, (2) acquiring affordable housing, and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.

◆ Marginally Inadequate Progress. The child/family or youth has been making limited or inconsistent progress in: (1) developing and using personal strengths in building life skills and problem solving, (2) developing long-term supportive relationships, (3) gaining core independent living/life skills, (4) developing community supports and networks, (5) advancing education and employment opportunities, and (6) developing meaningful and achievable future plans. As appropriate, the family or the youth is making limited progress in: (1) garnering a living wage, (2) acquiring affordable housing, and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.

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

◆ No Progress. The child/family or youth has been making no progress in: (1) developing long-term supportive relationships, (2) gaining core independent living/life skills, (3) developing community supports and networks, (4) advancing education and employment opportunities, and (5) developing meaningful and achievable future plans. As appropriate, the family or the youth is making no progress in: (1) garnering a living wage, (2) acquiring affordable housing, and (3) finding ways to meet fundamental needs; e.g., income, housing, transportation, health care, food, and child care, if necessary.
**SECTION 5A**

**PRACTICE PERFORMANCE INDICATORS**

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Focus Measure

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

Core Concepts

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

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

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

NOTE: Caregiver Status Review 3: Participation in Decisions and Caregiver Status Review 4: Satisfaction with Services/Results may provide useful information to consider when rating Practice Review 1: Engagement of the Child & Family. Remember that engagement focuses on the practice activities that lead to and support an active and effective partnership with the child and family. When these engagement activities are effective, parent participation and satisfaction should be positive.

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

1. What outreach and engagement strategies are service providers using to build a working partnership with the child and family? • Are special accommodations made as necessary to encourage and support participation and partnership?
2. Can all members of the team identify, acknowledge, and support the use of family strengths?
3. How well engaged are the child and family in the service process at this time?
4. Do the child and family demonstrate enthusiasm about their interactions with service providers? • Do they report being treated with dignity and respect? • Do they have a trust-based working relationship with those providing services?
5. How are the child and family involved in the ongoing assessment of their needs, circumstances, and progress? • Do the child and family routinely participate in the monitoring/modification of the service arrangements?
6. Is the planning and implementation process child/family-centered and responsive to this family’s particular cultural values? • Do the child and family routinely participate in the evaluation of the progress of the service process?
**Practice Review 1: Engagement of the Child & Family**

**Description and Rating of Practice Performance**

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

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

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

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

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

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**Poor Engagement Efforts.** Some persons involved report that few family members and/or the child’s substitute caregiver(s) ever participate even to a limited degree in service planning and annual evaluation activities. The child and family may report having a poor or possibly conflicted relationship with service providers. - OR - No efforts have been made by the team to increase the engagement and participation of the family, though a team member may report that they have made efforts to establish rapport with at least some members of the family.

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**No Engagement Efforts.** Service planning and decision-making activities are conducted at times and places or in ways that prevent or severely limit effective child and family participation. Decisions are made without the knowledge or consent of the parents, the caregivers, or the child. Services may be denied because of failure to show or comply. Appropriate and attractive alternative strategies, supports, and services are not offered. Important information may not be provided to parents or caregivers. Procedural or legal safeguards may be violated.
**Practice Review 2: Teamwork**

**Focus Measure**

- **TEAM FORMATION** - Degree to which: (1) The “right people” for this child and family have formed a working team that meets, talks, and plans together. (2) The team has the skills, family knowledge, and abilities necessary to organize effective services for this child and family, given their level of complexity and their cultural background.

- **TEAM FUNCTIONING** - Degree to which: (1) Members of the child and family’s team collectively function as a unified team in planning services and evaluating results. (2) The decisions and actions of the team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the child and family as revealed in present results.

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

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

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

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

1. Are parents/caregivers partners along with professionals, funders, and others in planning and guiding services?  
   • Are persons with similar backgrounds to the family members of the team?  
   • Which members did the family invite to participate?  
   • Does the family believe that these are the “right people” for them?

2. Is the family satisfied with the functioning of the team?  
   • Can the child or family request a team meeting at any time?  
   • Is a trained team facilitator used, if indicated?  
   • Do all parties believe that they are fully aware of how the child and family are progressing (including the child, if age appropriate)?

3. Does the team have a common conceptualization of the needs of the family?  
   • Do the goals and objectives set by the team reflect the values of the family?

4. Do team members commit and ensure dependable delivery of services and resources for the child/family?  
   • Are all members of the team kept fully informed of the status of the child and family and the implementation of planned services?

5. Are team decisions coherent in design with efforts unified across all service agencies involved with the child and family?  
   • Does the team have and use flexible funding, informal resources, and generic services as appropriate to planned goals and case closure requirements, strategies, and activities?

6. Do team actions and decisions reveal a pattern of consistent and effective problem solving for this child and family?  
   • What are the present results?
Practice Review 2: Teamwork

Description and Rating of Practice Performance

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

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

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

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

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

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

◆ **Absent or Adverse Teamwork.** EITHER: There is no evidence of a functional team for this child and family with all intereners working independently and in isolation from one another. • AND/OR • The actions and decisions made by the group are inappropriate, adverse, and/or antithetical to the guiding principles of family-centered practice and system of care integration and coordination of services across agencies for the child and family.
Practice Review 3: Assessment & Understanding

Focus Measure

ASSESSMENT & UNDERSTANDING - Degree to which those involved with the child and family understand: (1) Their strengths, needs, risks, preferences, and underlying issues. (2) What must change for the child to function effectively in daily settings and activities and for the family to support the child effectively. (3) What must change for the child/family to have better overall well-being and improved Quality of Life. (4) The "big picture" situation and dynamic factors that impact the child and family sufficiently to guide intervention. (5) The outcomes desired by the child and family from their involvement with the system. (6) The path and pace by which permanency will be achieved for a child who is not living with nor returning to the family of origin.

Core Concepts

Effective assessments supporting team-based reasoning lead to essential understandings in an ongoing process that informs the choice of intervention strategies and supports used to help the child and family make changes that lead to desired outcomes. As appropriate to the situation, a combination of clinical, functional, educational, and informal assessment techniques should be used to determine the strengths, needs, risks, underlying issues, and future goals of the child and family. Once gathered, the information should be analyzed and synthesized to form a functional assessment or “big picture understanding” of the child and family. Assessment techniques, both formal and informal, should be appropriate for the child's age, ability, culture, embraced faith, language or system of communication, and social ecology. New assessments should be performed promptly when planned goals are met or are not being met, when emergent needs or problems arise, or when changes are necessary. Continuing assessments and understandings direct modifications in strategies, services, and supports for the child and family as conditions change. Maintaining a useful big picture understanding is a dynamic, ongoing process. The focus here is placed on finding what works.

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

1. How well does the case manager and/or team understand this child and family? • Does the case manager and team know why this child and family are open to services? • Does the team know what it will take to reach independence and successful outcome(s)? • What is working or not working now or in the recent past for this child and family?
   - How well are the strengths, needs, risks, and preferences of the child and caregiver known and understood by those involved (team)?
   - How well does the team understand what may be required for: (1) situational stability, (2) safety, (3) skills and behaviors for daily functioning in essential life activities and roles, (4) concurrent alternatives to permanency, (5) sustainable supports, (6) resiliency/coping for children, (7) recovery/relapse prevention for older youth and adults, (8) independence from system involvement, (9) successful transitions and life adjustments, (10) permanency, and (11) achieving clearly specified outcomes?

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

3. What observations, data, formal assessments, or evaluations have been obtained? • Are assessments appropriate for this child and family? • Are assessments conducted in natural settings and during everyday activities? • Have assessment facts been interpreted to form a useful understanding? • Is there evidence that assessment is a dynamic, continuous learning process? • How has team understanding evolved over the life of the case?

4. Are child and family strengths, needs, risks, and issues understood in a useful manner to support decisions about what works and what to do next?

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

6. Do the assessments include the consideration of the youth’s history of abuse (physical and/or sexual) and use of any special procedures, such as seclusion and restraints?

7. Has the youth received an assessment for suicide risk, especially for the following:
   - Youth’s diagnosis with depression?
   - Bipolar disorder?
   - Impulse control disorder?
   - History of suicidal ideations, plans, or attempts?
   - Substance/alcohol abuse?
   - During commencement or termination of antidepressants, new admissions, discharges, or change in clinical status?
**Practice Review 3: Assessment & Understanding**

**Description and Rating of Practice Performance**

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

- **Optimal Assessment and Understanding.** The child and parent’s functioning and support systems are comprehensively understood. Knowledge necessary to understand the child and family’s strengths, needs, and context is continuously updated and used to keep the big picture understanding current and comprehensive. Present strengths, risks, and underlying needs requiring intervention or supports are fully recognized and understood. Necessary conditions for improved functioning and independence from the system are fully understood and used to select effective change strategies.

- **Good Assessment and Understanding.** The child and parent’s functioning and support systems are generally understood. Information necessary to understand the child and family’s strengths, needs, and context is frequently updated and used to keep the big picture understanding fresh and useful. Present strengths, risks, and underlying needs requiring intervention or supports are substantially recognized and well understood. Necessary conditions for improved functioning and independence from the system are generally understood and used to select promising change strategies.

- **Fair Assessment and Understanding.** The child and parent’s functioning and support system are minimally understood. Information necessary to understand the child and family’s strengths, needs, and context is periodically updated and used to keep the big picture understanding fairly useful. Some strengths, risks, and underlying needs requiring intervention or supports are minimally recognized and understood. Necessary conditions for improved functioning and independence from the system are somewhat understood and used for some possible change strategies.

- **Marginally Inadequate Assessment and Understanding.** The child and parent’s functioning and support system are marginally understood. Information necessary to understand the child and family’s strengths, needs, and context is limited and occasionally updated. Present strengths, risks, and underlying needs requiring intervention or supports are partly understood on a limited or inconsistent basis. Necessary changes in behavior or conditions are somewhat interpreted and expressed.

- **Poor, Incomplete, or Inconsistent Assessment and Understanding.** Knowledge of the child and parent’s functioning and support system may be obsolete, erroneous, or inadequate. Information necessary to understand the child and family’s strengths, needs, and context is poorly or inconsistently updated. Uncertainties exist about present conditions, risks, and underlying needs requiring intervention or support. Necessary changes in behavior or conditions may be confused or contradictory. Dynamic conditions may be present that could require a fundamental reassessment of the child and family’s situation.

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

- **Not Applicable.** The birth parents are no longer involved due to divorce, termination of parental rights, death of parent, incarceration, deportation, or other case circumstances. There is no kinship, foster, or adoptive family involved or the child is placed or presently resides in a congregate care setting with no plan for reunification or adoption.
Practice Review 4: Outcomes & Goals

Focus Measure

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

Core Concepts

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

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

This review focuses on the specification and use of the outcomes and goals that must be attained by the child and family (birth, adoptive, or guardianship) to achieve stability, adequate functioning, permanency, and other outcomes necessary for the child and family to achieve their desired improvements and goals.

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

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

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

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

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

5. If the youth is age 14 years or older, is there a planned trajectory that guides his/her transition for getting from school to work, to independent/supported living, and to any necessary adult services? • What are the conditions necessary for independence from supports and services that have been set for this youth and used in planning services? • Will the youth's current trajectory likely lead to greater independence, social integration, and community participation?
Practice Review 4: Outcomes & Goals

Description and Rating of Practice Performance

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

Rating Level

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

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

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

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

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

◆ Absent, Ambiguous, or Adverse Specification of Outcomes & Goals. There is no common direction, outcome, or requirement to guide services that is accepted and used by those involved in intervention and change processes. The future trajectory is obscure or ambiguous and interveners may be working in isolation with divergent or conflicting intentions. Goals may not address key outcomes or other requirements that would apply to determine readiness for closure. Conflicting goals and tacit expectations, if implemented, could lead to poor results or possible adverse consequences for the child or family.
Practice Review 5: Intervention Planning

Focus Measure

PLANNING - Degree to which child/family-centered, strength-based, culturally competent, safety conscious, evidence-based, well-reasoned, ongoing planning is being used in selecting and managing intervention strategies, actions, resources, and schedules that facilitate child/family progress to attainment of functional outcomes and improved well-being. [Planning efforts revealed in plans and interviews over the past 90 days]

Core Concepts

This review focuses on how well child/family interventions, supports, and change processes are planned and managed by those involved in partnering with the parent and child to manage symptoms, acquire and use more functional behavior and skills, and improve the overall well-being of the child and family. As necessary for the child and family to achieve adequate functioning and independence, a specifically arranged combination and sequence of interventions leads to: (1) situational stability; (2) safety; (3) skills and behaviors for daily functioning in essential life activities and roles; (4) sustainable supports; (5) resiliency/coping for children; (6) recovery/relapse prevention for older youth and adults; (7) independence from system involvement; (8) successful transitions and life adjustments; (9) resolution of legal issues, including permanency; and (10) successful outcomes and improved well-being. The outcomes and goals used for planning defines the destination points for the journey of change by framing the end-states or outcomes necessary for the child/family to function successfully independently. For each change to be made by the parent and/or child, one or more intervention strategies are selected to achieve family changes linked to conditions for improved functioning and greater self-sufficiency. Persons involved specify the strategies, actions, resources, timelines, and persons who are accountable for helping in the change process in certain written agreements or plans made by participating agencies working with the parent and child. Various agencies participating in and supporting a change process have their respective agreements or plans. [Child welfare may have a family change plan aimed at safety, permanency, and well-being. The school may have a plan for special education services. Behavioral health may provide child treatment and adult recovery plans. A given child and family may have multiple written agreements used to provide change strategies for achieving a variety of important outcomes.] The expectation here is that representatives of participating agencies are actively and collaboratively supporting change efforts for the parent or child in coordination with each other. The focus of review is placed on vitality and intelligence of the planning process, not any single plan document.

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

1. What are the specific planned change strategies with and for the parent and child? • Which agencies are/should be involved with each of these strategies? Are they evidence-based practices? • Is the provider competent in evidence-based practices, e.g., fidelity assurance, knowledge of contraindications, measurable objectives?

2. Which of the following child/family change areas have strategies for:
   - Providing safety/stability at home?
   - Reducing symptoms of psychiatric disorders and improving functioning?
   - Staging successful transitions and life adjustments?
   - When needed, addressing strategies for achieving permanency?
   - Supporting recovery and relapse prevention and improved well-being?
   - Facilitating behavior change?
   - Meeting requirements or constraints imposed by court order?

3. Do planning details offer the following for each change strategy:
   - The service actions to be provided to execute the change strategy?
   - The timelines to be followed in implementation and progress reporting?
   - A way of knowing whether the strategy is working or not working?
   - The agency and persons who will be responsible for these service actions?
   - The authorization of services and resources necessary for implementation?

4. Has the responsible person for representing each participating agency prepared/executed the necessary service agreement/plan with the family? • Are goals/strategies aligned across agencies and plans for this child and parent?

5. How well are strategies linked to specific actions for change? • How well is coherence and consistency being achieved in the planning process? • Do the combination and sequence of strategies, services, and actions fit the child and family situation, including their language and culture?

6. To what degree is daily practice actually driven by the planned change strategies? • Does the planning process have a sense of urgency in working toward successful family independence and timely case closure?

7. Is a treatment/care plan complete and available to all who need to know, including the family? • Was the necessary plan/authorizing document developed by each funding agency? • Does the treatment/care plan coordinate with the strengths and needs assessment?

8. Have special procedure assessments been completed, e.g., level of supervision, suicide risk assessment, critical transition points (admission, discharge, change in status, anti-depressant medications), abuse history considered, and restraint/seclusion?
Description and Rating of Practice Performance

NOTE: The reviewer applies rating scale criteria to each area in which intervention strategies are planned to achieve outcomes for this child. Areas for rating are: (a) reduction of psychiatric symptoms or substance use; (b) functional behavior changes; (c) sustainable family supports; (d) crisis response/safety-supports; (e) recovery and relapse prevention; and/or (f) successful transitions and independence. Each applicable intervention area is rated.

Optimal Planning. An excellent, well-reasoned, continuous planning process is being fully used to design intervention specifications for the applicable intervention area. Planning provides for precise use of intervention strategies, actions, timelines, and an accountable person for each change strategy used in the change process for achieving desired outcomes, stability, sustainability, and case closure. Where necessary, strategies may be fully aligned and actions well-integrated across providers and funding sources. Daily practice is being fully driven by the planning process, bringing a great sense of clarity, direction, and urgency to actions to achieve outcomes and goals.

Good Planning. A generally well-reasoned, ongoing planning process is being substantially used to design intervention specifications for the applicable intervention area. Planning provides for substantial use of intervention strategies, actions, timelines, and an accountable person for each change strategy used in the change process for achieving desired outcomes, stability, sustainability, and case closure. Where necessary, strategies may be substantially aligned and actions generally integrated across providers and funding sources. Daily practice is being substantially driven by the planning process, bringing a good sense of clarity, direction, and urgency to actions to achieve outcomes and goals.

Fair Planning. A somewhat reasoned, periodic planning process is being at least minimally used to design intervention specifications for the applicable intervention area. Planning provides for minimal adequacy to fair use of intervention strategies, actions, timelines, and an accountable person for each change strategy used in the change process for achieving desired outcomes, stability, sustainability, and case closure. Where necessary, strategies may be somewhat aligned and actions fairly integrated across providers and funding sources. Daily practice is being somewhat driven by the planning process, bringing a fair sense of clarity, direction, and urgency to actions to achieve outcomes and goals.

Marginally Inadequate Planning. A marginally reasoned, somewhat inadequate planning process is being used inconsistently to design intervention specifications for the applicable intervention area. Planning provides for somewhat inadequate use of intervention strategies, actions, timelines, and an accountable person for each change strategy used in the change process for achieving desired outcomes, stability, sustainability, and case closure. Where necessary, strategies may be inconsistently aligned and actions inadequately integrated across providers and funding sources. Daily practice is limited or inconsistent in driving the planning process, bringing a muddled sense of clarity and lack of urgency to actions to achieve outcomes and goals.

Poor Planning. A poorly reasoned, inadequate planning process is generally failing to provide or design intervention specifications for the applicable intervention area. Planning provides for poor use of intervention strategies, actions, timelines, and an accountable person for each change strategy used in the change process for achieving desired outcomes, stability, sustainability, and case closure. Strategies may not be aligned and actions not integrated across providers and funding sources. Daily practice is not driving the planning process, bringing no sense of clarity or urgency to actions to achieve outcomes and goals.

Absent or Misdirected Planning. EITHER: No clear planning process is operative at this time. - OR - Planning activities are substantially misdirected, conflicting, or insufficient in thought or detail to drive an effective intervention and change process.

Not Applicable. One or more planning areas do not apply at this time.
Practice Review 6: Resources

Focus Measure

RESOURCES - Degree to which: • Supports, services, and resources (both informal and formal) necessary to implement change strategies are available when needed for by the child and family. • Any flexible supports and unique service arrangements (both informal and formal) necessary to meet individual needs in the child's plans are available for use by the child and family on a timely, adequate, and convenient local basis. • Any unit-based and placement-based resources necessary to meet goals in the child's plans are available for use by the child and family on a timely and adequate basis.

Core Concepts

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

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

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

1. Are all important needs matched with appropriate supports and services for this family? • Will supports shift from formal to informal over time?
2. Are resources matched to intervention and support strategies addressed in plans? • Is each intervention strategy and related resources for implementation therapeutically appropriate for the child and family? • Is each service and support readily accessible when needed? • Were any of the supports and services tailored or assembled uniquely for this child or family? • Are they sustainable as needed over time? • If not, what is missing?
3. Have informal supports been developed or uncovered and used at home and in the community as a part of the service process? • Is the combination of informal and formal supports and services used for this family sufficient for the child and family members to do well? • Is the combination of supports and services used for by this family dependable and satisfactory from their point of view?
4. To what extent are informal resources of the family, extended family, neighborhood, civic clubs, churches, charitable organizations, local businesses, and general public services (e.g., recreation, public library, or transportation) used in providing supports for this family?
5. Is the team taking steps to locate or develop or advocate for previously unknown or undeveloped resources? • Is the child on a waiting list for services?
6. Did practitioners on the child/family's team have appropriate service options from which to choose when selecting recommended professional services? • Did the family have appropriate and preferred options from which to choose when selecting supports and services? Has the child or family been denied services?
7. Has the service team taken steps to identify resource gaps and notify the community?
**Description and Rating of Practice Performance**

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

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

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

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

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

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

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

- **Absent or Adverse Resources.** Few, if any, necessary supports and services are provided at this time. They may not fit the actual needs of the family well and may not be dependable over time. Because informal supports may not be well developed and because local services or funding is limited, any services may be offered on a “take it or leave it” basis. The family may be dissatisfied with or refuse services, and results may present a potential safety risk to family members. The service team may be powerless to alter the service availability situation or the child and family may lack a functioning service team.
Practice Review 7: Adequacy of Intervention

Focus Measure

INTERVENTION ADEQUACY - Degree to which change-related interventions, actions, and resources being provided to the child and family have sufficient power (precision, intensity, duration, fidelity, and consistency) to produce results necessary to achieve and maintain desired functional goals and well-being outcomes set for this child and family.

Core Concepts

The purpose of intervention is to facilitate successful change collaboratively with a child and family. As necessary for the child and family, a specifically arranged combination and sequence of interventions may lead to: (1) situational stability, (2) reduction of symptoms or substance use, (3) planned behavioral outcomes including adequate daily functioning in normal settings and life activities, (4) sustainable supports, (5) resiliency/coping for children, (6) recovery/relapse prevention for older youth and adults, (7) independence, (8) successful transitions, and (9) improved functioning and well-being. The outcomes and goals used for planning defines the destination points of the journey of change by framing desired end-states. It is essential that these be developed collaboratively with the child and family.

The central principle and moral imperative of practice is to find what works. The purpose of this review is to determine the extent to which the combination of change strategies/interventions being used with the child and family demonstrates that the planned interventions and supports are commensurate with the changes to be made for child and family success. The reviewer should consider the following elements as they combine to form the change process for the child and family:

- What is required includes use of evidence-based practice strategies and related fidelity criteria or measures applied to ensure adequate implementation for the desired effect.
  - Level of intensity, duration, coordination, and continuity necessary to produce the changes necessary for the child and family.
  - Demonstration of progress toward attainment of desired outcomes and goals. Lack of expected progress suggests that planned strategies are either the wrong strategies or that the right strategies are being delivered poorly or less frequently than necessary.

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

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

1. What specific strategies are being used in the change process for this child and family? • What is required for precise delivery (for desired effect) for each strategy?

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

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

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

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

6. To what degree is daily practice actually driven by the intervention planning process?
Practice Review 7: Adequacy of Intervention

Description and Rating of Practice Performance

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

◆ Optimal Intervention. An excellent combination, sequence, and power of current interventions is helping the child and family reach optimal levels of functioning necessary for them to make progress and improve functioning and well-being. An excellent combination of informal and, where necessary, formal supports and interventions is provided with excellent precision and with fully commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is fully sufficient to quickly and fully reach or exceed all of the outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

◆ Good and Substantial Intervention. A good combination, sequence, and power of current interventions is helping the child and family reach good and substantial levels of functioning necessary for them to make progress and improve functioning and well-being. A dependable combination of informal and, where necessary, formal supports and interventions is provided with good precision and with substantially commensurate levels of intensity, duration, continuity, and coordination. The power of intervention is generally sufficient to generally reach most of the outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

◆ Minimally Adequate Intervention. A fair combination, sequence, and power of current interventions is somewhat helping the child and family reach minimally adequate to fair levels of functioning necessary for them to make progress and improve functioning and well-being. A minimally adequate combination of informal and, where necessary, formal supports and interventions is provided with some precision and with at least minimally adequate levels of intensity, duration, continuity, and coordination. The power of intervention is minimally adequate to reach some of the outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

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

◆ Poor Intervention. A very limited combination, sequence, and power of current interventions is not helping the child and family reach levels of functioning necessary for them to make progress and improve functioning and well-being. A poor and insufficient combination of informal or formal supports and interventions is provided without precision and without adequate levels of intensity, duration, continuity, and coordination. The power of intervention is not adequate to reach many of the outcomes and identified goals necessary for this child and family to achieve functional independence, successful transitions, and improved functioning, self-sufficiency, and well-being.

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

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

Core Concepts

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

Intervention strategies, supports, and/or services should be modified when objectives are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The service coordinator, along with the team for the child and family as well as the child and family, should play a central role in tracking and adjusting intervention strategies, services, and supports. Members of the team (including the child and caregiver) should apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services.

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

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

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

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

- **Optimal Tracking and Adjustment Process.** Intervention strategies, supports, and services being provided to the child and family are highly responsive and appropriate to changing conditions. Continuous or frequent monitoring, tracking, and communication of child status and service results to the team are occurring. Timely and smart adjustments are being made. Highly successful modifications are based on a rich knowledge of what things are working and not working for the child and family.

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

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

- **Marginally Inadequate Tracking and Adjustment Process.** Intervention strategies, supports, and services being provided to the child and family are partially responsive to changing conditions. Occasional monitoring and communication of child status and service results are occurring. Limited or inconsistent adaptations are based on isolated facts of what is happening to the child and family. Their status may be adequate in some areas but unacceptable in others. Mild to moderate problems are present.

- **Fragmented or Shallow Tracking and Adjustment Process.** Poor intervention strategies, supports, and services may be provided to the child and family and may not be responsive to changing conditions. Rare or shallow monitoring, poor communications, and/or an inadequate service team may be unable to function effectively in planning, providing, monitoring, or adapting services. Few sensible modifications may be planned or implemented. Child and family status may be poor in several areas. Serious ongoing problems continue unresolved.

- **Absent, Nonoperative, or Misdirected Tracking and Adjustment Process.** Intervention strategies, supports, and services may be limited, undependable, or conflicting for the child and family. No monitoring or communications may occur and/or an inadequate team (inadequate structure or functioning) may be unable to function effectively in planning, providing, monitoring, or adapting services. Current supports and services may have become non-responsive to the current needs of the child and family. The service process may be “out of control.” Child and family status may be generally poor or worsening. Serious and worsening problems persist without adequate attention or effective resolution.
## Section 5B

### Practice Review

Specialized Practices (Past 90 Days, may not always apply)  

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SPECIAL PRACTICE REVIEW 1: CULTURAL COMPETENCE

Focus Measure

CULTURAL COMPETENCE - For the focus child and family, the degree to which: • Any significant cultural issues are being identified and addressed effectively by service providers. • Any behavioral health services are provided in a culturally appropriate manner consistent with the family’s cultural and linguistic background.

Core Concepts

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

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

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

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

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

1. Are the child and family’s cultural and linguistic needs identified?
2. Are assessments performed appropriate for the child’s background?
3. Do the service providers know and respect the child’s beliefs and customs?
4. Do the service provider and individual share the same cultural and/or linguistic background or does the service provider have adequate knowledge of cultural issues relevant to service delivery for this child and his/her informal supporters?
5. If the child and family has a primary language that is other than English, are bilingual or interpreter services provided?
6. Has the service team explored natural, cultural, or community supports appropriate for this child and family?
7. Has the family expressed any cultural preferences and desires for culturally adapted services? • Specific cultural issues identified and addressed are:
   - None identified after careful assessments
   - Racial
   - Ethnic
   - Religious
   - Gender
   - Disability
   - Sexual orientation
   - Other
8. Are cultural differences impeding working relationships or service results with this child and his/her informal supporters? • What do they say?
9. If necessary, is the agency or facility able to decide when the rights and preferences of an individual will be limited by the rights and preferences of other individuals in the setting?
Description and Rating of Practice Performance

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

◆ **Optimal Cultural Competency.** The child's cultural and linguistic identity is recognized, fully understood, and services are culturally adapted as necessary. Cultural beliefs and customs are fully respected and well integrated into all aspects of service provision. All assessments are culturally appropriate and the service provider's potential cultural biases are identified and acknowledged. Service providers are fully knowledgeable about issues related to the individual's identified culture and shape treatment planning and delivery appropriately. Service providers show evidence of considering all those who may be important to the individual's culture (e.g., family members, traditional healers) and attempts are made to include these individuals in service planning and delivery, at the request and invitation of the individual. As needed, interpreter services are provided in a culturally and linguistically appropriate manner.

◆ **Good Cultural Competency.** The child's cultural and linguistic identity is recognized and services are generally culturally adapted as necessary. Cultural beliefs and customs are generally respected and taken into consideration for planning services. Assessments are generally conducted in a culturally appropriate manner and the service provider's potential cultural biases are identified and acknowledged. Service providers document attempts to advance their understanding of the individual's identified culture and there is evidence that the service provider has utilized resources relevant to the individual's cultural and linguistic identity in order to assist with treatment planning and service delivery. Those important to the individual's culture are acknowledged and information is obtained from them with the agreement of the individual. If needed, interpreter services are accessed.

◆ **Fair Competency.** The child's cultural and linguistic identity is recognized and the provider acknowledges this in the assessment, treatment planning, and service delivery process. Cultural beliefs and customs are usually acknowledged and services are planned in an effort to be supportive. For example, the provider might acknowledge other natural community helpers important to the individual's culture and works with the individual to integrate those supports. If needed, interpreter services are usually available.

◆ **Marginal Cultural Competency.** The child's cultural and linguistic identity is recognized and the provider acknowledges that while assessment, treatment planning, or services are not a good fit, they are seeking to improve these processes for just this individual. There may be evidence that the behavioral health provider/agency has attempted to integrate culturally adapted practices into their services, although it is limited or inconsistent for this individual. Cultural beliefs and customs are not viewed as relevant by the service provider to the assessment, treatment planning, or service delivery process. If needed, interpreter services are only sporadically available.

◆ **Poor Cultural Competency.** The child's cultural and linguistic identity is not recognized in the service process by the service provider. Inappropriate assessment, treatment planning, or service delivery processes ignore the individual's cultural beliefs and customs. If needed, interpreter services may be limited or difficult to secure through the behavioral health system. Few, if any, provisions are made for understanding and incorporating the person's cultural beliefs and values.

◆ **Adverse Cultural Competency.** There is no evidence of cultural or linguistic recognition or the integration of culturally appropriate practices by behavioral health service providers in this case. The individual's cultural and linguistic identity may be treated with disrespect and his/her customs and beliefs may be ignored or treated as irrelevant. Inappropriate assessment, treatment planning, or service delivery processes ignore or violate the individual's cultural beliefs and customs. If needed, interpreter services are not provided by the behavioral health system.

◆ **Not Applicable.** The child does not identify any cultural or linguistic needs relevant for service system performance when asked by a service provider.
**Focus Measure**

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

**Core Concepts**

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

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

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

1. Is the child anticipating a major transition within the next few months? • Has the case manager or service coordinator identified the person’s next critical transition? If so, what transition plans are being made to accomplish a smooth adjustment? • How are the transitional activities and events being carefully staged and arranged across settings, time, providers, and funding sources?

2. Do permanency plans for this child indicate that the child protection agency is using or is considering using trial home visits to facilitate transition from out-of-home care for family reunification? • If so, how are the child’s mental health and/or addiction treatment staff coordinating efforts to ensure a safe, smooth, and successful reunification?

3. If this child has a history of difficult transitions following discharge from hospitalization or incarceration, how is this knowledge being used to improve transitions for this child?

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

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

6. For what period of time, such as 60-90 days, is the child closely monitored following a transition in home or school to track the person and those supporting the person through the life change and adjustment process, including the predictable “honeymoon” and near-term “crises” of adjustment that often attend the movement and life adjustment process for a child or youth?
**Special Practice Review 2: Transitions & Life Adjustments**

**Description and Rating of Practice Performance**

Description of the System Performance Situation Observed for the Child

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

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

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

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

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

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

◆ **Not Applicable.** Identification efforts reveal no evidence of needs to be addressed for transition services for this child at this time. This review indicator is deemed **not applicable** to this child.
SPECIAL PRACTICE REVIEW 3: MEDICATION MANAGEMENT

Focus Measure

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

Core Concepts

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

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

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

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

Description and Rating of Practice Performance

Description of the Practice Performance Situation Observed for the Child

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

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

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

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

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

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

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

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

Core Concepts

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

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

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

Note: Suicidality and self-endangerment for children with depression and bipolar disorders requires higher surveillance:
- For the first six weeks of medication trials of SSRIs and other antidepressants
- For the first 30 days of new treatment
- During the discharge phase of treatment
- When there is a significant change in clinical status or sudden emotional loss

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

1. Does the child have a recent history (past six months) of behavioral, health, or safety crises? • If not, this indicator may not apply. If so:
   - Did the episode involve harm caused to the focus child by another? If so, Status Indicator 1. Safety should be rated also.
   - Did the episode involve self-endangerment or harm to others? If so, Status Indicator 2. Behavioral Risk should be rated also.

2. Does this child have a crisis prevention/intervention plan? • If so, how was it designed? • What is the monitoring or surveillance plan? • Is there an alert procedure and crisis response plan for this child specified in the treatment plan or other relevant service documents? • Who is to respond to what cues using what strategies? • Does the plan include any advance directives set by the child? • Are the people who would send the alert and implement the crisis response plan aware of and ready to fulfill their assigned responsibilities?

3. Are crisis management services available when and as needed? • Have crisis services ever been denied? • If so, why?

4. Have the alert and crisis management processes been used in the past six months for this child or caregiver? • If yes, did they work effectively? • Were such services timely given the urgency of the situation? • Was any relevant advance care directive followed?

5. Does the crisis management plan address transitions? • Is it linked to any transition plan the child may have?
Description and Rating of Practice Performance

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

Description of the Special Practice Situation Observed for the Child

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

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

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

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

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

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

◆ **Not Applicable.** The focus child has no history of psychiatric or medical crises or safety breakdowns within the child’s daily settings over the past six months. Therefore, this indicator does not apply at this time.
SECTION 6

OVERALL PATTERNS

1. Overall Child/Youth Status 84
2. Overall Caregiver Status 84
3. Overall Child/Youth Progress Pattern 85
4. Overall Practice Performance 86
5. Six-Month Prognosis 87
## Overall Child and Family Domain

### Overall Child/youth Status & Caregiver Status Scoring Procedure

There are eight child/youth indicators and four parent/caregiver indicators to be rated in the areas of Child/Youth Status and Parent/Caregiver Status. Each review produces a finding reported on a 6-point rating scale. An “overall rating” for each section is based on the reviewer’s holistic impression of the applicable indicators. This overall ratings answer these questions:

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

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

### Child/youth Status Indicators [30-day pattern]

<table>
<thead>
<tr>
<th>Status Indicators</th>
<th>Improve</th>
<th>Refine</th>
<th>Maint</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>a. School</td>
<td></td>
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<tr>
<td>b. Home</td>
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<tr>
<td>Behavioral risk</td>
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</tr>
<tr>
<td>a. Risk to self</td>
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<tr>
<td>b. Risk to others</td>
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<tr>
<td>Stability</td>
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<tr>
<td>Permanency</td>
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<tr>
<td>Living arrangement</td>
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<tr>
<td>Health/Phys. well-being</td>
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<tr>
<td>Emotional well-being</td>
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<tr>
<td>Learning &amp; develop.</td>
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</table>

**Overall CY Status**

### Caregiver Status Indicators [30-day pattern]

<table>
<thead>
<tr>
<th>Status Indicators</th>
<th>Improve</th>
<th>Refine</th>
<th>Maint</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Support of child</td>
<td></td>
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</tr>
<tr>
<td>a. Small home set.</td>
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<tr>
<td>b. Congregate set.</td>
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<tr>
<td>Challenges</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Family parent</td>
<td></td>
<td></td>
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<tr>
<td>b. Sub. caregiver</td>
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<tr>
<td>Part. in decisions</td>
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<tr>
<td>Satisfaction</td>
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<td></td>
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<tr>
<td>a. Family parent</td>
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<tr>
<td>b. Sub. caregiver</td>
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</tbody>
</table>

**Overall Caregiver Status**

a. Family parent
b. Sub. caregiver
OVERALL CHILD/YOUTH PROGRESS SCORING PROCEDURE

There are five indicators to be conducted in the area of Child/Youth Progress. Each review produces a finding reported on a 6-point rating scale. An “overall rating” of Child/Youth Progress is based on THE REVIEWER’S HOLISTIC IMPRESSION OF THE CHILD’S RECENT CHANGES ON APPLICABLE INDICATORS. Each child’s situation is unique and, to assess the overall progress, a reviewer must consider where the child began to where the child is now. The reviewer should recognize that consistently high performance in a domain may not show much change over time but is still a good outcome. (1) Begin by transferring the rating value for each progress indicator from the protocol pages to the roll-up sheet having the display presented below. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) Give weight to those items judged to be most important at this time for this child. (4) Focusing on those applicable indicators having the greatest importance to the child at this time, determine an “overall rating” based on your general impression of the child’s recent progress. (5) Mark the box indicating your overall rating on item #6 on the roll-up sheet. Report this rating value on the oral and written reports prepared for this child/youth.

The reviewer should remember that an overall rating cannot be higher than the highest rated indicator nor lower than the lowest rated indicator. It should be reflective of the trend or pattern observed among indicators with added weight to those of greater importance to the child and parent/caregiver at the time of review. The added weight given in this overall formulation must be explained by the reviewer in the oral and written reports provided for this child/youth.
OVERALL SYSTEM PERFORMANCE DOMAIN

OVERALL PRACTICE PERFORMANCE SCORING PROCEDURE

There are eight core practice function indicators (1–8) and four possible specialized practices (1–4) in the area of Practice Performance. Each review produces a finding reported on a 6-point rating scale. An “overall rating” of practice performance is based on THE REVIEWER’S HOLISTIC IMPRESSION OF THE APPROPRIATE EXECUTION OF PRACTICE FUNCTIONS AND THE DILIGENCE IT SHOWS IN RESPONSE TO THIS CHILD AND FAMILY. Consider the fidelity with which each practice function is carried out and whether the intent of the function is being achieved. Overall, is the system taking the necessary actions to appropriately address the individual factors for this child and family that must be addressed if this child and family are to make progress toward positive outcomes? (1) Begin by transferring the rating value for each progress review item from the protocol exam pages to the portion of the roll-up sheet containing the display presented below. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) Give weight to those practice performance indicators judged to be most important at this time for this child and family. (4) Focusing on those applicable indicators having the greatest importance to the child and family at this time, determine an “overall rating” based on your general impression of the practice performance. (5) Mark the box indicating your overall rating on the roll-up sheet. The reviewer should remember that an overall rating cannot be higher than the highest rated indicator nor lower than the lowest rated indicator. It should be reflective of the trend or pattern observed among indicators with added weight to those of greater importance to the child and parent/caregiver at the time of review. The added weight given in this overall formulation must be explained by the reviewer in the oral and written reports provided for this child/youth.

<table>
<thead>
<tr>
<th>SYSTEM/PRactice PERFORMANCE [90-DAY PATTERN]</th>
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<tbody>
<tr>
<td><strong>Indicator Zones</strong></td>
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<tr>
<td>Core Practice Functions</td>
</tr>
<tr>
<td>1. Engagement</td>
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<tr>
<td>2. Teamwork:</td>
</tr>
<tr>
<td>a. Formation</td>
</tr>
<tr>
<td>b. Functioning</td>
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<tr>
<td>3. Assessment &amp; understanding:</td>
</tr>
<tr>
<td>a. Child</td>
</tr>
<tr>
<td>b. Family</td>
</tr>
<tr>
<td>4. Outcomes &amp; goals</td>
</tr>
<tr>
<td>5. Intervention planning:</td>
</tr>
<tr>
<td>a. Symptom/SA reduction</td>
</tr>
<tr>
<td>b. Behavior changes</td>
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<tr>
<td>c. Sustainable supports</td>
</tr>
<tr>
<td>d. Crisis response</td>
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<tr>
<td>e. Recovery/relapse</td>
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<tr>
<td>f. Transitions/independ.</td>
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<tr>
<td>6. Resources</td>
</tr>
<tr>
<td>7. Adequacy of intervention</td>
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<tr>
<td>8. Tracking &amp; adjustment</td>
</tr>
</tbody>
</table>
ESTIMATING THE TRAJECTORY OF THIS CHILD’S EXPECTED COURSE OF CHANGE

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

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

Based on what is known about this case and what is likely to occur in the near-term future, make an informed prediction of the forecast in this case. Mark the appropriate alternative future statement in the space provided below. The facts that lead the reviewer to this view of case trajectory should be reflected in the reviewer’s recommendations. Insert your determination in the appropriate space on the roll-up sheet.

**Six-Month Prognosis**

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

- □ MAINTAIN at a CURRENTLY HIGH STATUS LEVEL (5-6 range)
- □ IMPROVE to a level HIGHER than the current overall status
- □ CONTINUE at the SAME STATUS LEVEL — status quo
- □ DECLINE to a level LOWER than the current overall status
SECTION 7

REPORTING OUTLINES

Oral Case Presentation Outline 90
Written Case Summary Outline 91
# Reviewer’s Outline for a 10-Minute Oral Case Presentation

<table>
<thead>
<tr>
<th>Outline Elements</th>
<th>Reviewer’s Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Core Story of the Child and Family (3 minutes)</td>
<td></td>
</tr>
<tr>
<td>• Reason for services (Why are we involved with this child/youth and family?)</td>
<td></td>
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<tr>
<td>• Goals that focus interventions provided (What are we trying to achieve in the case?)</td>
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<tr>
<td>• Strengths and needs of the child and family</td>
<td></td>
</tr>
<tr>
<td>• Services provided and by which agencies</td>
<td></td>
</tr>
<tr>
<td>2. Child and Caregiver Status (3 minutes)</td>
<td></td>
</tr>
<tr>
<td>• Overall child/youth and caregiver status finding</td>
<td></td>
</tr>
<tr>
<td>• Status rating patterns by “color/action zones”</td>
<td></td>
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<tr>
<td>• Progress made over the past six months</td>
<td></td>
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<tr>
<td>• Problems</td>
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<tr>
<td>3. System Practice and Performance (3 minutes)</td>
<td></td>
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<tr>
<td>• Overall system performance finding</td>
<td></td>
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<tr>
<td>• Performance rating patterns by “color/action zones”</td>
<td></td>
</tr>
<tr>
<td>• What’s working now in this case</td>
<td></td>
</tr>
<tr>
<td>• What’s not working and why</td>
<td></td>
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<tr>
<td>• Six-month forecast</td>
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<td>4. Next Steps (1 minute)</td>
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<tr>
<td>• Important and doable “next steps”</td>
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<tr>
<td>• Any special concerns or follow-up indicated</td>
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**Total Presentation Time (10 minutes)**

**Group Questioning of Presenter (3-5 minutes)**
**Written Case Review Summary**

**Child/Caregiver Status Summary**

**Facts about the Child and Family Reviewed**

- Agency or Office
- Child’s Initials
- Reviewer’s Name
- Review Date
- Date of Report
- Child’s Placement

**Persons Interviewed during this Review**

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

**Facts About the Child and Family** [About 100 words]

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

**Child’s Current Status** [About 250 words]

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

**Caregiver’s Status** [About 100 words]

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

**Factors Contributing to Favorable Status**

[About 100 words]

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

**Factors Contributing to Unfavorable Status**

[About 100 words]

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

**System Performance Appraisal Summary**

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

**What’s Working Now**

[About 250 words]

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

**What’s Not Working Now and Why**

[About 150 words]

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

**Six-Month Forecast/Stability of Findings**

[About 75 words]

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

**Practical Steps to Sustain Success and Overcome Current Problems**

[About 75 words]

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

**Report Length**

The summary should not exceed two-to-four typed pages, depending on the complexity of the case and the extent of supports and services being provided by various agencies.
SECTION 8

APPENDIX

Copy of the CSR Profile or “Roll-up Sheet” 94
### New Mexico QSR Profile - Child/Youth

#### 1. General Review Information

| 0. Record Number: |  |
| 1. Child's Name: |  |
| 2. County: |  |
| Provider: |  |
| 3. Counselor/Caseworker: |  |
| 4. Review Date: |  |
| 5. Reviewer: |  |
| Shadow: |  |
| 6. Number of persons interviewed: |  |

#### 2. Current Placement

| 7. Child's placement (check only one item): |
| Family bio/adopt. home |
| Kinship:relative home |
| Foster home |
| Therapeutic foster home |
| Youth care |
| Group home |
| Independent living |
| Detention |
| Hospital/MHI |
| Residential treatment facility |
| Juvenile institution |
| Adult correction facility |
| Other: |

#### 3. Co-Occurring Conditions

| Identify the co-occurring conditions (check all that apply): |
| 8. Mood Disorder |
| 9. Anxiety Disorder |
| 10. PTSD/Developmental Trauma Disorder |
| 11. Thought Disorder/Psychosis |
| 12. ADD/ADHD |
| 13. Anger/Impulse Control |
| 14. Substance Abuse/Dependence |
| 15. Learning Disorder |
| 16. Communication Disorder |
| 17. Autism/Autism Spectrum Disorder |
| 18. Disruptive Behavior Disorder (CD, ODD) |
| 19. Mental Retardation: mild |
| severe |
| moderate |
| profound |
| 20. Medical Problem: |
| 21a. Other Disability/Disorder: |
| 21b. Other: |

#### 4. Demographic and Service Information

| 22. Child's Age |
| 0 - 4 yrs |
| 5 - 9 yrs |
| 10 - 13 yrs |
| 14+ yrs |
| 23. Child's Gender |
| Male |
| Female |

#### 5. Program and Intervention Information

| 24. Child's Ethnicity |
| Euro-American |
| African-American |
| Latino-American |
| American Indian |
| Pacific Islander |

| 25. Case Open |
| 0 - 3 mos. |
| 3 - 6 mos. |
| 6 - 9 mos. |
| 9 - 12 mos. |
| 12 - 15 mos. |
| 15 - 18 mos. |
| 18 - 21 mos. |
| 21 - 24 mos. |
| 24 - 30 mos. |


| 51. Placement in past 30 days, if different from current placement (check only one): |
| Family/adoptive home |
| Kinship:relative home |
| Foster home (regular or therapeutic) |
| Private residential facility |
| Group home |
| Other: |

### Special Procedures Used in Past 30 Days (check all that apply)

| 37. Voluntary time out |
| 38. Loss of privileges via a point & level system |
| 39. Disciplinary consequences for rule violation |
| 40. Room restriction |
| 41. Exclusionary time out |
| 42. Seclusion/locked room |
| 43. Take-down procedure |
| 44. Physical restraint (hold, 4-point, cuffs) |
| 45. Emergency medications |
| 46. Medical restraints |
| 47. 911 emergency call: police |
| 48. 911 emergency call: EMS |
| 49. 911 emergency call: police |
| 50. Other: |

### Medical Problem: (check all that apply)

| 29a. Do current services received match Level of Care? |
| Yes |
| No |

### Level of Care: Date:  |
| 29b. Level of Care: |
| 1. Outpatient |
| 2. Supportive Community Based |
| 3. Intensive Community Based, CM, Day TX, Intensive Outpatient, Hospital Based Services |
| 4. Intensive Community Based, Wraparound |
| 5. Community Alternative to Psych, residential Treatment, Wraparound Team |
| 6. Psych, Residential Treatment or SOP |

### Other Agencies Involved (check all that apply)

| Child Welfare |
| Dev. Disabilities |
| Substance Abuse |
| Mental Health |
| Juvenile Justice |
| Other: |

### Special Ed |

| 34. Number of Psychotropic Medications Prescribed (check only one item): |
| No psych meds |
| 1 psych med |
| 2 psych meds |
| 3 psych meds |
| 4 psych meds |
| 5 psych meds |

### Other: |

### Who received a copy of the mental health assessment (check all that apply)

| Parent |
| Welfare |
| DOC |
| Court |
| Other: |

### Other: |

### Educational Placement or Life Situation (check all that apply)

| Self-cont. sp. ed. |
| Part-time sp. ed. |
| Full inclusion |
| Alternative ed. |
| Work |

| Parenting team |
| Expelled/suspen. |
| Dropped out |

### Recent Placement Changes (check only one)

| 26. Placement Changes (past 12 months): |
| None |
| 1-2 placements |
| 3-5 placements |
| 6-9 placements |
| 10+ placement |

### Other: (check only one)

| Group home |
| Foster home (regular or therapeutic) |
| Private residential facility |
| Group home |
| Residential treatment center |
| Youth services facility |
| Foster home (regular or therapeutic) |
| Hospital/institution |

### Level of Care (check only one)

| Court |
| CYFD |
| School |
| Self-referral |
| Primary care physician |
| Other: |

### System of Care Participation (check only one)

| Yes |
| No |

### Program and Intervention Information

| 51a. Placement in past 30 days, if different from current placement (check only one): |
| Family/adoptive home |
| Kinship:relative home |
| Foster home (regular or therapeutic) |
| Group home |
| Other: |

### Medical Problem: (check all that apply)

| 29a. Do current services received match Level of Care? |
| Yes |
| No |

### Level of Care: Date:  |

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FAX to HSO for processing 850/422-8487
7. BIRTH FAMILY OR ADOPTIVE FAMILY CHALLENGES

53. Caregiving Challenges in the Child’s Birth Family or Adoptive Family: (check all that apply)
- Caregiver has limited cognitive abilities (mental retardation, traumatic brain injury)
- Caregiver has serious mental illness (depression, bi-polar, schizophrenia)
- Caregiver has substance abuse impairment or serious addiction with relapses
- Caregiver experiences domestic violence (repeated pattern, serious injuries)
- Caregiver has a serious physical illness or disabling physical condition
- Caregiver has a pattern of unlawful behavior or is incarcerated
- Caregiver experiences adverse effects of poverty (unemployment, homelessness, etc.)
- Caregiver experiences extraordinary care burdens in the home/can’t meet needs
- Caregiver experiences cultural/language barriers/barriers to acceptable child-rearing behaviors
- Caregiver is undocumented and unable to meet family needs due to legal barriers
- Caregiver is/was a teen parent lacking necessary skills and judgment for child rearing
- Caregiver experiences life/home disruption/homelessness due to natural disaster
- Other: _____________________________________________

9. CASE MANAGER/CARE COORDINATOR INFORMATION

This section is either completed by the child’s case manager or care coordinator or completed by another person who is describing the child’s case manager or care coordinator.

55. Person’s Job Title or Functional Description: (check only one item)
- Case manager
- Care coordinator
- Therapist
- Nurse
- Mentor
- Other: _____________________________________________

56. Length of Time the Case Manager or Care Coordinator has been Employed by Current Agency: (check only one item)
- < 1 month
- 1-3 months
- 4-6 months
- 7-12 months
- 13-24 months
- 25-36 months
- > 60 months

57. Length of Time the Case Manager or Care Coordinator has been Assigned to This Position: (check only one item)
- < 1 month
- 1-3 months
- 4-6 months
- 7-12 months
- 13-24 months
- 25-36 months
- > 60 months

58. Length of Time the Case Manager or Care Coordinator has been Assigned to This Child or Youth: (check only one item)
- < 1 month
- 1-3 months
- 4-6 months
- 7-12 months
- 13-24 months
- 25-36 months
- > 60 months

59. Current Caseload Size of Current Case Manager or Care Coordinator: (check only one item)
- < 10 cases
- 10-15 cases
- 16-20 cases
- 21-30 cases
- 31-40 cases
- > 40 cases

60. Barriers Affecting Case Management or Services: (check all that apply)
- Caseload size
- Billing requirements
- Eligibility/access denial
- Case complexity
- Adeq. parent support
- Treatment compliance
- Adeq. team participation
- Family instability/moves
- Family disruptions
- Other: _____________________________________________
- Case management
- Billing
- Driving time to services
- Case complexity
- Cultural/language barriers
- Child refusal of treatment
- Child refusal of treatment
- Team member follow-thru
- Family instability/moves
- Arrest/detention of child
- Other: _____________________________________________

8. CHILD’S GLOBAL ASSESSMENT OF FUNCTIONING

54. Child’s General Level of Functioning

Level (check the one level that best describes the child’s global level of functioning today)
- Superior functioning in all areas (at home, at school, with peers, in the community), involved in a wide range of activities and has many interests (e.g., has hobbies, participates in extracurricular activities, belongs to an organized group such as the Scouts); likely, confident, “everyday” worries never get out of hand; doing well in school, getting along with others; behaving appropriately; no symptoms.
- Good functioning in all areas: secure in family, in school, and with peers; there may be transient difficulties but “everyday” worries never get out of hand (e.g., mild anxiety about an important exam, occasional “blow-ups” with siblings, parents, or peers).
- No more than slight impairment in functioning; at home, at school, with peers, and in the community; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separation, death, birth of a sibling); these are brief and interfere with functioning is transient; such youth are only minimally disturbing to others and are not considered deviant by those who know them.
- Some difficulty in a single area, but generally functioning pretty well (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or committing petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties that do not lead to gross avoidance behavior, self-doubts); has some meaningful interpersonal relationships; most people who do not know the youth well would not consider him/her deviant but those who know him/her well might express concern.
- Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the youth in other settings.
- Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.
- Major impairment in functioning in several areas and unable to function in one of these areas, i.e., disturbed at home, at school, with peers, or in society at large; e.g., persistent aggression without clear instigation, markedly withdrawn and isolated behavior due to either thought or mood disturbance, suicidal attempts with clear lethal intent; such youth are likely to require special schooling and/or hospitalization (but this alone is not a sufficient criterion for inclusion in this category).
- Unable to function in almost all areas; e.g., stays at home, in a ward, or in a bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate speech).
- Needs considerable supervision to prevent hurting self or others (e.g., frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication (e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor).
- Needs constant supervision (24 hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.
- Not available or not applicable due to young age of the child.
10. Child/Youth Status Indicators

<table>
<thead>
<tr>
<th>Status Indicators</th>
<th>Improve</th>
<th>Refine</th>
<th>Maintain</th>
<th>NA</th>
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<tbody>
<tr>
<td>Child/Youth</td>
<td>1</td>
<td>2</td>
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<tr>
<td>1. Safety:</td>
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<tr>
<td>a. School</td>
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<td>b. Home</td>
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<td>2. Behavioral risk:</td>
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<tr>
<td>a. Risk to self</td>
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<td>b. Risk to others</td>
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<td>3. Stability</td>
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<td>4. Permanency</td>
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<td>5. Living arrangement</td>
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<td>6. Health/Physical well-being</td>
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<td>7. Emotional well-being</td>
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<td>8. Learning &amp; development</td>
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<td>OVERALL CY STATUS</td>
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11. Caregiver Status Indicators

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<th>Status Indicators</th>
<th>Improve</th>
<th>Refine</th>
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<td>Caregiver</td>
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<td>1. Support of child:</td>
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<tr>
<td>a. Small home setting</td>
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<td>b. Congregate setting</td>
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<td>2. Parenting Challenges:</td>
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<td>a. Family parent</td>
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<td>b. Sub. caregiver</td>
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<td>3. Participation in decisions</td>
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<td>4. Satisfaction:</td>
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<td>b. Sub. caregiver</td>
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<td>OVERALL CAREGIVER STATUS</td>
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12. Six-Month Forecast (next 180 days)

Based on review findings, over the next six months the child's situation is likely to:

- [ ] MAINTAIN at a HIGH STATUS LEVEL (5-6 range)
- [ ] IMPROVE to HIGHER than the current overall status
- [ ] CONTINUE at the SAME STATUS LEVEL — status quo
- [ ] DECLINE to a level LOWER than the current overall status

13. Child/Youth Progress Indicators

<table>
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<tr>
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<th>Refine</th>
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<td>1. Reduction of problems:</td>
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<tr>
<td>a. Psych./beh. symptoms</td>
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<td>b. Substance use</td>
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<tr>
<td>2. Improved coping/self-mgt.</td>
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<td>3. School/work progress</td>
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<td>4. Improved relationships:</td>
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<tr>
<td>a. Family/caregiver</td>
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<td>b. Peers</td>
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<tr>
<td>c. Other adults</td>
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<tr>
<td>5. Well-being/Quality of life</td>
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<td>6. OVERALL PROGRESS</td>
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14. System/Practice Performance

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<td>a. Formation</td>
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<td>b. Functioning</td>
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<td>3. Assessment &amp; understanding:</td>
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<td>a. Child</td>
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<td>b. Family</td>
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<td>4. Outcomes &amp; goals</td>
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<td>5. Intervention planning:</td>
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<td>a. Symptom/SA reduction</td>
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<td>b. Behavior changes</td>
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<td>c. Sustainable supports</td>
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<tr>
<td>d. Crisis response</td>
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<tr>
<td>e. Recovery/relapse</td>
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<td>f. Transitions/independ.</td>
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<td>6. Resources</td>
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<td>7. Adequacy of intervention</td>
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<td>8. Tracking &amp; adjustment</td>
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<tr>
<td>Specialized Practice</td>
<td>1</td>
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<tr>
<td>1. Cultural competence</td>
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<td>2. Transitions &amp; life adj.</td>
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<td>3. Medication management</td>
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<td>4. Crisis management</td>
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<td>OVERALL PRACTICE</td>
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