



**District of Columbia Government
CHILD AND FAMILY SERVICES AGENCY**

2013 Annual Report of Quality Service Reviews (QSRs)

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2013 QSR Report

Overview

This annual report on findings from the 2013 Quality Service Reviews (QSRs) identifies themes and patterns in practice that have been shared with Child and Family Services Agency (CFSA) leadership and stakeholders. It is just one mechanism for sharing information about the QSRs. There is also the QSR follow-up process that engages staff during and immediately after the review and includes an initial debriefing. Additional follow-up meetings with the social worker and supervisor provide opportunities to discuss individual cases while other meetings allow management staff to discuss all cases reviewed within a program area or private agency. The entire process ensures implementation of findings and subsequent recommendations and next-step actions have the desired impact on practice.

While the annual report presents collective findings, QSR results are consistently presented throughout the year to management and senior leadership in order to identify any practice areas where performance is exceeding targets, remaining the same, or declining. Findings are presented in terms of change from the previous calendar year so as to provide a bigger picture on whether or not the current performance is an anomaly or to be expected.

The following themes emerged from the 2013 QSRs:

- Ratings for *Safety (Child)* continue to demonstrate high performance from previous years.
- Social workers are demonstrating improved practice with fathers, by involving them more frequently in case planning and in service provision.
- The health status of children and their access to needed health care has been consistently high over the past three years.
- *Team Formation*, which measures if the system is involving all the necessary people to work with a family, remains high and is improving compared to 2012.
- *Team Functioning*, the ability of the team to work together, has not exhibited cohesive planning to meet families' needs.
- In cases jointly served by CFSA and the Department of Behavioral Health, communication has often been crisis-driven rather than focused on assessment and planning.

As described later in this document, there have been a number of practice changes that have been implemented over the past year. These have directly impacted how QSR findings are shared and utilized to strengthen overall performance. While there are indicators that require improvement, the foundation for strong case practice is evident.

Structure of the Report

This report first provides an overview of performance as measured by the QSR¹ from 2010 to-date and then focuses on the specific findings from 2013. As part of the discussion of the 2013

¹ See Appendix 1 for a detailed description of the QSR process.

QSRs, we include a detailed look at the cases that were reviewed as part of the *Shared Practice Protocol*² developed between CFSA and the Department of Behavioral Health (DBH), formerly the Department of Mental Health. Finally, we note the key changes that occurred to the QSR process, including the revised protocol³ and the increased sample size, along with expected next steps as the Agency begins a new year of reviews.

QSR Scores over Time

Previous QSRs are not completely analogous to the 2013 QSRs. For example, the number of cases included has increased; in 2011, 67 cases were reviewed compared to 100 in 2013. Still, it is worthwhile to look at the overall status of trends over the past three years. Table 1 (below) highlights a comparison of specific indicators from 2011 to 2013.

Table 1: Comparison of Acceptable Indicator Ratings 2011-2013			
<i>Indicators</i>	<i>2011 (67 reviews)</i>	<i>2012 (66 reviews)</i>	<i>2013 (100 reviews)</i>
<i>Child Status Indicators</i>			
Safety: Home	96%	92%	93%
Stability: Home	79%	67%	69%
Physical Status	99%	94%	93%
Emotional Functioning	88%	83%	80%
<i>System Performance Indicators</i>			
Engagement: Child	99%	88%	91%
Assessment and Understanding: Child	99%	85%	86%
Implementation of Supports and Services: Child	94%	86%	86%
Coordination and Leadership (NB: <i>This was replaced with Team Functioning and Coordination.</i>)	85%	80%	
Case Planning Process (NB: <i>This was replaced with Planning Interventions.</i>)	81%	74%	72% ⁴
Pathway to Case Closure	70%	56%	64%

The *Safety* indicator measures the degree to which the child is safe from injury caused by the child him/herself or others in his/her daily living environment. This indicator has remained consistently high over the last 3 years. The *Stability* indicator measures the degree to which a child’s home living arrangement is stable and free from risk of disruption. This particular indicator measures the number of changes in settings within the past year (a change from 2 years

² This shared protocol combines CFSA’s QSRs with DBH’s Community Service Reviews (CSRs) such that it can be used independently by each agency or shared when cases involve service delivery overlapping.

³ See Appendix 2 – QSR Protocol.

⁴ This figure is arrived at by determining the pattern of ratings for the individual planning indicators, with the exception that for any case where planning for safety was scored as unacceptable, the overall planning rating must also be unacceptable regardless of the other ratings.

with the new protocol) and the probability of an unplanned move within the next year. There has been a slight fluctuation in the ratings for this indicator over the past 3 years.

The *Physical Status* indicator shows that our children and youth are in good health. It is measuring the degree to which the child’s physical needs are being met. While *Emotional Functioning* (changed from *Emotional Well-being*) has remained above 80 percent for the past 3 years, there was a decline in 2012 and again in 2013. This indicator measures the degree to which, consistent with age and ability, children are displaying adequate patterns of emotional functioning, including self-management of behaviors and emotions. This increase in the percentage of children with emotional difficulties may explain the drop in acceptable ratings in some of the practice indicators since these are children and youth who present with more complex problems and may require more intensive and creative coordination and follow-up. This population is discussed in greater detail below under *Challenges*.

Under *System* indicators, we note the following:

Engagement and Assessment and Implementation: Child were amongst the highest rated indicators for the system performance at 91, 86 and 86 percent respectively. Although the ratings for these indicators remained high in 2013, they represent a decrease from 2011 and 2012, when the percentages were consistently in the 90s. These indicators evaluate (1) efforts made to engage and build quality relationships with the child, (2) the assessment and understanding used to guide interventions and the quality, and (3) level of services being provided to meet intervention goals.

Coordination and Leadership and *Case Planning Process* were not rated as individual indicators in 2013 (see Table 2 below).

Pathway to Case Closure, which decreased in 2012, exhibited an increase in ratings in 2013, ending the year at 64 percent of the cases being rated acceptable. This indicator looks specifically at the permanency goal and the level of progress made towards its achievement.

Table 2: Acceptable Indicator Ratings 2013	
Indicators	2013
Teamwork and Coordination	
Formation	85%
Functioning	70%
Coordination	66%
Planning Interventions	
Safety	84%
Permanency	90%
Well-being	81%
Functioning Role Fulfillment	72%
Transition Life Adjustment	63%

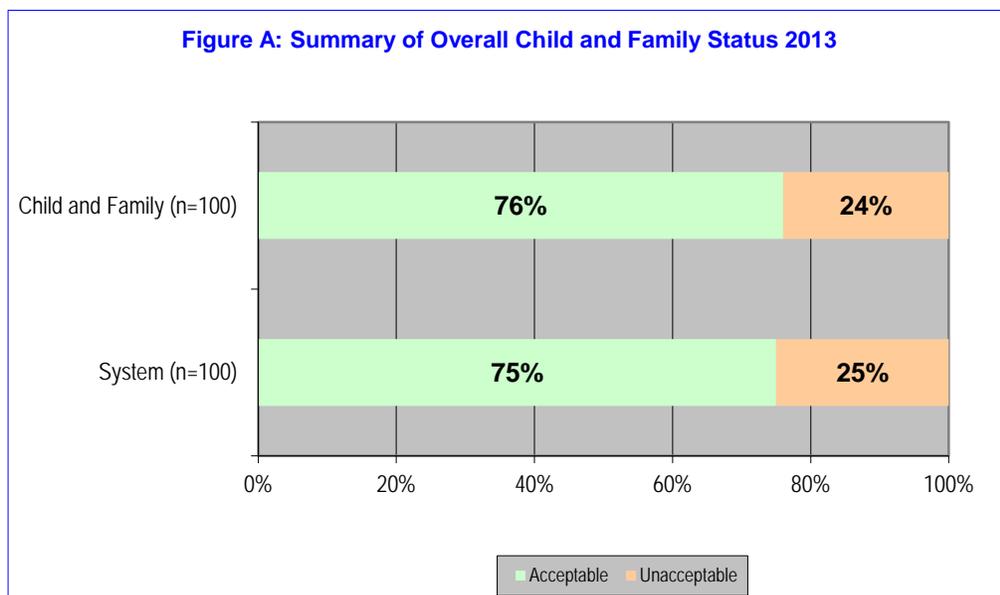
Teamwork and Coordination is broken out into 3 categories (*Formation, Functioning, and Coordination*). Where *Coordination and Leadership* only focused on the social worker’s ability to lead and coordinate, this new indicator focuses on the team as a unified body and their ability to collaboratively problem solve and to provide effective services to achieve positive results for the child and family. *Formation* was rated the highest at 85 percent with *Coordination* rating the lowest at 66 percent. This implies that in most cases the right people with the appropriate skills and knowledge have formed a working team. Findings indicate, however, that the team often did not work as a unified and cohesive team. Leadership (that is, responsibility for guiding the team) was not always clear and coordination of services was lacking.

Planning Interventions measures the degree by which planning is meaningful, measurable, and achievable in the areas of safety, permanency, well-being, daily functioning in fulfilling life roles, and transition and life adjustment. *Planning for Permanency* was rated the highest at 90 percent, followed by *Safety and Well-being*. Planning in the areas of *Functioning Role Fulfillment* and *Transition Life Adjustment* were the two lowest rated indicators at 72 and 63 percent respectively.

In the next section, we will discuss in more depth the significant 2013 findings and provide case examples for illustration. In the section *Moving Forward* we discuss some of the interventions being taken in response to the findings.

Summary of 2013 QSR Results

In 2013, CFSA reviewed a total of 100 cases throughout the year using the QSR process. In consultation with the Child Welfare Policy and Practice Group (CWPPG), the sample was stratified in an attempt to make sure the cases reflect as closely as possible the actual population of children in out-of-home care (see Appendix 3, for a breakdown of the sample). Figure A below summarizes overall findings of the *Child, Family, and System Status* indicators.



As Figure A indicates, overall *Child Status* (drawn from individual child status scores) was rated acceptable in 76 percent of the 100 cases. The highest-rated indicators were *Health/Physical Status* at 93 percent acceptable, *Health/Receipt of Care* at 96 percent acceptable, *Safety at Home* at 93 percent acceptable, and *Safety at School* at 95 percent acceptable. These findings demonstrate that CFSA is indeed maintaining safety for children in their homes and at school in the majority of cases. It is also an indication that the majority of children reviewed were in good health and receiving good health care services.

On the other end of the spectrum, *Permanency/Legal Custody* was rated as the lowest of these indicators with 47 percent acceptable. This indicator was applicable to 78 of the 100 cases reviewed where legal custody was not resolved. *Stability at Home* was rated at 69 percent acceptable. The latter rating indicates that a number of children and youth in care have had several placement disruptions during the year preceding the review.

Another significantly low-rated indicator was *Preparation for Adulthood*, which is rated for youth from age 15 up until age 21. This indicator was rated acceptable in 54 percent of cases. Low ratings in this indicator are typically associated with youth lacking sufficient skills for a successful transition out of foster care. These areas warrant further discussion, which will be explained in depth in the *Challenges* section of this report.

Caregivers (i.e., birth parents, foster parents, kinship parents, and congregate care staff) received a high rating of 90 percent. This suggests that the majority of the children and youth are receiving good care in their current placement.

The *Overall System Status* indicator, which provides an aggregate of the scores for specific system functions, was rated at 75 percent acceptable, a reduction of 8 percent from 2012. *Cultural Identity of the Child* was rated at 97 percent, *Engagement of the Child* at 91 percent and *Assessment and Understanding of the Child* at 86 percent were amongst the highest rating indicators in the practice performance. *Engagement of Substitute Caregiver* at 90 percent and *Planning for Permanency* at 90 percent were the other two highest rated indicators. System indicators for *Engagement and Assessment of Fathers* have historically revealed low ratings for performance and while they were the lowest rated indicators in 2013 at 58 and 43 percent respectively, this was an increase from 2012. This is an indication that practice is improving in the work with fathers. *Long-Term View* was the third lowest rated indicator at 56 percent and is one of the new indicators being rated in 2013. This indicator is applicable only to mental health cases and was rated in 47 of the 100 cases.

Findings

Excerpts from case summaries have been included as examples of various trends. As noted earlier, ratings for many of the indicators described in this section give us an opportunity to look closely at how the core principles of the *Practice Model* and the *In-Home* and *Out-of-Home Practice Guides*⁵ are infused into everyday practice as well as the impact these principles, when applied, have on individual cases. We have highlighted excerpts from the QSR protocol

⁵ All three documents can be found at http://cfsa.dc.gov/publications-list?keys=PRTGDE&type=77&sort_by=field_date_value&sort_order=ASC

throughout this section to demonstrate the relationship between the Agency’s’ overarching *Practice Model* tenets and the QSR indicators.

Selected highly-rated indicators are described in more detail in the *Strengths* section; similarly, a sample of low-rated indicators is described in the *Challenges* section. Areas identified below as strengths are not necessarily those with the highest ratings or with the most ratings in the maintenance zone, nor were they rated as acceptable in 100 percent of the cases. Similarly, areas identified as challenges were not rated as unacceptable in every case, or even in a majority of cases. In fact, the areas described as challenges were rated “acceptable” overall in most cases, but the percentage of acceptable ratings was lower than other indicators. We have selected these issues because the QSR identified them as illustrative of growth or success in particular practice areas or as specific areas in need of further examination and practice change.

This section provides an in-depth discussion of the following areas of strength:

- Safety
- Physical Health
- Living Arrangement

- Cultural Identity of the Child/Youth
- Engagement of the Child/Youth
- Assessment and Understanding Child/Youth
- Supports and Services Child/Youth

- Cultural Identity of the Caregiver
- Engagement of Substitute Caregiver
- Assessment and Understanding Caregiver
- Team Formation

The following challenges are also explored:

- Team Functioning and Coordination
- Pathway to Case Closure
- Long-Term View

Strengths

Safety of the Child: (Home)

Acceptable
93%

The *Safety* indicator measures the degree to which the child is free from injury caused by him/herself or by others in his/her daily living environment. It also measures whether the child is being protected against physical, social, spiritual, psychological, or educational factors that could be considered non-desirable or harmful. Safety also recognizes potential hazards that impact an acceptable level of risk. As well, safety is the condition of a steady and positive state. Safety is of utmost importance regarding the well-being of children and heavily contributes to their progress.

QSRs now measure safety in three areas (home, school and community), the scores of which have remained consistently at or above 88 percent acceptable over the past three years. The results of this indicator are a reflection of quality practice. Safety was planned for in the majority of the cases reviewed. Caregivers implemented safety precautions and ensured that the children in their care were free from known manageable risks of harm.

Safety for children also improves considerably when the children are placed in a home environment where they feel content, loved, and supported. In case #38, the youth and her two siblings had an optimal level of safety. In case #68, strategic planning occurred to ensure the youth’s safety.

The youth has a nearly risk-free living situation. She is free from harm, abuse, exploitation, intimidation, and neglect in her daily settings to include her home and the community. Although she resides in an ILP program, she is fully supported by dependable and competent program staff. She follows established rules within the ILP program and community. She presents no safety risk to herself or others. The youth has no history of behavior presentations that warrant concern. She behaves responsibly and appropriately, and avoids engaging in risky or dangerous situations. (Case #38)

The youth has been in an adult acute forensic psychiatric unit since August 9, 2013. Although the unit is inappropriate in that it primarily serves patients who have pending charges or have already been convicted and sentenced of violent offenses, staff have devised a plan to ensure his full protection and safety. He is provided 1:1 safety monitoring/supervision during all waking hours. (Case #68)

Physical Health

Physical Status	Receipt of Care
Acceptable	Acceptable
93%	96%

The *Physical Health* indicator measures the degree to which the child is sustaining their best attainable health status, has access to appropriate healthcare services, has health needs being met adequately on a daily basis, and has medication properly monitored for the benefit of health maintenance purposes.

Physical health is measured in two areas: physical status and receipt of physical care, and preventative and primary health care. The latter includes periodic examinations, dental hygiene, immunizations, and screenings for possible developmental or physical problems. The child’s physical care needs include exercise, nutrition, sleep, and hygiene. In addition, children and youth need to have an established relationship with a primary care or specialty physician.

The health status of children in care has been consistently high over the past years 3 years. This is a clear demonstration that children in care are receiving optimal health care and maintaining good health status. Receiving proper and consistent levels of health care appropriate to the child/youth’s age and personal needs is important.

In situations where a child is dealing with a chronic health concern, consistent health care is necessary and paramount to the child's overall well-being. In cases #8 and #12, both children had chronic medical concerns that required specialty visits and surgical intervention.

Everyone was aware of the concerns for the focus child regarding her epileptic seizure and the team collaborated to ensure that all the supports and services were in place to meet her needs. (Case #8)

The focus child is diagnosed with congenital hydrocephalus at birth which causes chronic increased intracranial pressure if left untreated. This medical condition requires the placement of a valve (shunt) in his brain. The cerebral shunt is a one-way valve used to drain excess cerebrospinal fluid from his brain and carry it to other parts of his body. The team ensures that the focus child is routinely monitored by his neurosurgeon. (Case #12)

Living Arrangements

Acceptable	The <i>Living Arrangement</i> indicator looks at the appropriateness of the placement given the child's particular needs. The living arrangements must be able to meet the child or youth's developmental, medical, emotional, and behavioral needs; in addition to providing appropriate levels of supervision. The child should be residing in the most appropriate and least restrictive living arrangement. The current placement should provide appropriate continuity in connection to his/her culture, community, faith, extended family, and social relationships.
89%	

There was only one child who was placed in a psychiatric residential treatment facility (PRTC) out of 100 children reviewed. Our findings demonstrated that children were living in an environment that closely matched their identified needs; the majority of children were in a family-like setting. In case #67, the child was returned to the care of her birth mother and to a home where the child felt loved and had a supportive network.

The focus youth is currently thriving in the care of her mother. She is safe, stable and healthy. The birth mother is highly motivated and has taken control of the situation to ensure that her daughter's safety and well-being needs are met. Furthermore, the mother has an extensive support network, which also includes the former foster parents, whom she reaches out to when she needs or anticipates needing assistance. (Case #67)

Foster parents play an important role in helping to create the most family-like setting for the children in their care, and many of foster parents maintain close connections with the child's birth family. In case #13, the focus child has competing adoption petitions, one with his current foster mother and the other with his maternal aunt. The family and the foster mother and birth father have been able to have a healthy relationship and the focus child and his sister have maintained close connections with everyone.

He has been living with his pre-adoptive mother and his sister since they came in to care. He also has a very close connection with his birth father and his maternal relatives. The caregiver is willing to continue to care for the focus child even if the permanency goal is changed to adoption with his maternal aunt. Although it is unknown whose adoption petition will be granted, the caregiver and the maternal aunt have an amicable relationship with one another and the focus child is benefiting from being able to spend time with his entire family. (Case #13)

We note that the 11 children whose living situation was not rated as acceptable were in a variety of placement types; all but three were in family-based settings, and four were placed with kin.

Engagement, Assessment/Understanding, and Implementation of Supports and Services: Child

Engagement	Assessment/Understanding	Implementation
Acceptable	Acceptable	Acceptable
91%	86%	86%

Engagement, Assessment and Understanding, and Implementation Services (for the child) received some of the highest ratings for system indicators. It was evident that team members had established a trust-based working relationship with most of the children and youth and there was meaningful engagement in all aspects of the service process.

Responsiveness to Cultural Identity is one of the new indicators added to the *Shared Practice Protocol*.⁶ This indicator for the child received the highest rating under *System* - 97 percent. How a system responds to a child’s identity contributes significantly to the success of the work with that child. Culture can be the deciding factor in having a good assessment and the identification of the right supports and services. This was clearly being demonstrated along the 100 cases that were reviewed.

Social workers and other team members were using formal and informal assessments to identify needs and were implementing appropriate services or making appropriate adjustments to case plans. Many children and youth were connected to and receiving the appropriate services to address their individual needs to yield positive life outcomes as is illustrated in the two cases below:

The service team recognized that the focus child was experiencing severe behavioral problems during school as he was impulsive and had difficulty forming positive relationships with his peers. Therefore, a team meeting was held to determine if supportive services would benefit the child at school. A behavioral support teacher was then assigned to the child to provide redirection and to help enhance his socialization skills. The IEP

⁶ As noted earlier, this is a QSR protocol shared between CFSA and the Department of Behavioral Health for cases where both agencies have involvement.

[individual education plan] was amended to reflect the change in his treatment goals. Additionally, the child was exhibiting signs of mood fluctuation, extreme difficulty listening, and [difficulty] complying with the grandmother's requests. A referral for integrated family therapy was submitted and he was reevaluated for psychotropic medications. (Case #66)

The team recognized that the focus child's grades have declined in core subject areas in addition to his continued struggles with math and reading skills. Therefore, an in-home tutoring service was provided. The team recognized the focus child's progress in therapy and his ability to utilize his coping skills. (Case #12)

Working with older youth can be very challenging and can make the engagement process very difficult. In the case of an 18-year-old African American male, the social worker adjusted her approach in order to build a supportive and trust-based relationship with the youth.

The social worker described the focus youth and his siblings as very good at keeping things private. She understood the family dynamics and has been able to use this knowledge to effectively engage them and understand her limitations. She knows how to carefully ask questions to get information, but also knows that the family will share more information if and when they build more trust with people outside of the family. (Case #57)

Worker understanding of the trauma that many youth in care have experienced contributed to the good work demonstrated in their assessment and understanding of the child/youth. This knowledge is helpful with guiding the process of implementing supports and services.

Those assisting the child maintained a broad and deep understanding of her circumstances necessary to provide effective interventions. The child was referred to individual therapy to help her cope with her transition to foster care, self-affirmation, and her struggles with asserting her needs appropriately with loved ones. (Case #28)

The youth has experienced traumatic events in her life such as entering foster care due to her mother's inability to keep her safe and provide for her and having a child at age 13. The team and the youth discussed the benefit of the youth speaking with a trained professional to help her continue to process her feelings properly. The youth welcomed the idea of help and the team submitted a referral for individual therapy to help her manage stresses of daily life as a teen mom as well as the strained relationship she presently has with her own mother. (Case #38)

Responsiveness to Cultural Identity, Engagement, and Assessment & Understanding: Caregiver

Cultural Identity	Engagement	Assessment/Understanding
Acceptable	Acceptable	Acceptable
95%	90%	88%

The *Cultural Identity* indicator, while broadly defined, examines how the team has recognized, assessed, understood and accounted for the child or family’s culturally-specific identity or needs. In 95 percent of the cases, the cultural identity of caregivers (i.e., foster parents, birth parents, or kinship caregivers) was recognized and was used to set the foundation for the work between the caregivers and the team. Social workers were utilizing caregivers’ strong religious beliefs for optimal engagement, as seen in the following example.

The team’s understanding and support of the focus youth and the foster parents’ strong spiritual practices have been evident in service provision. As a result, the social worker has been able to actively engage them in services that suit their needs. The team has arranged visits and spent time learning how [the foster parents’] beliefs shape their values and actions. The social worker has gone to the foster father’s faith-based crisis center where the focus youth currently volunteers. (Case #57)

The *Engagement* indicator measures the diligence of outreach efforts demonstrated by the team to locate, build rapport, and engage the caregiver, as well as overcome barriers to participation. Good quality engagement efforts have been reflected in 90 percent of the cases reviewed with team members, demonstrating strong and positive working relationships with caregivers and including them in the case planning process. Team members were flexible as needed in order to be accommodating to caregivers and to maintain their active participation.

The team understood the challenges and limitations that the foster mother faced with having a newborn in the home. The team was respectful in planning sessions and visits to suit the family’s needs. (Case #81)

The *Assessment & Understanding* indicator measures the team’s knowledge and understanding of the caregiver’s strengths and needs. In the majority (88 percent) of cases reviewed, it was evident that team members were assisting and supporting the caregivers as well as developing and maintaining a broad and comprehensive understanding of the child and caregiver’s situation. In this manner, they could support effective strategies for positive and healthy life changes. Data has shown that when team members have a good assessment and understanding of caregivers, it is inextricably linked to good supports and services.

The team has now gained a better perspective of the great-grandmother’s strengths, needs and challenges, which will allow them to adequately plan and incorporate culturally appropriate services and supports. The team implemented respite care (day time and overnight) services to preserve the

child’s placement as well as to support the foster mother. This was a result of the repeated out-of-school suspensions due to the child’s inappropriate behavior. Reportedly, the foster mother was unable to take additional leaves of absence from her employer and the child needed to be monitored at all times. (Case #83)

Team Formation

Acceptable
85%

The *Team Formation* indicator looks at the group of people that support the child and includes the child/youth/family and any informal supporters or professionals who offer a supportive role. The team should be culturally competent, have knowledge of the child/youth/family, have the ability to fulfill commitments made, and have a working relationship with the child/youth/family. *Team Formation* is one of three indicators to assess teamwork. Of the three, it was rated the highest.

The majority of cases reviewed had the right people involved with the child and family. These individuals had the appropriate skills and were knowledgeable about what needed to happen in order to achieve positive outcomes for the child and family. This included the different internal and external stakeholders who participated in, and contributed to, decision-making and case planning.

The composition of the team was optimal, which included the focus child, birth parents, child welfare and mental health experts. The team consisted of diverse, motivated, and highly qualified people. Members of the team had a strong commitment to the child and family. (Case #24)

The team was composed of all the necessary people. Members of the team had a strong commitment to the child and his family. The team demonstrated the ability to collectively plan and organize effective services. (Case #76)

Challenges

Team Functioning and Coordination

Team Functioning
Acceptable
70%

Coordination
Acceptable
66%

The *Team Functioning* indicator looks at how the team members collectively participate in planning and organizing. It also examines the team’s ability to problem-solve and work together with the child and the family. Working together, the team supports the child and family in identifying needs, setting goals, and planning intervention strategies and services that will enable the child and family to meet their needs. The team also defines conditions for case closure.

The *Team Coordination* indicator measures the effectiveness of team leadership in facilitating teamwork activities, preparing team members for meetings, maintaining contact with and between service providers, and guiding the team with planning and intervention strategies.

Leadership and coordination are necessary to 1) engage the team in a life changing process for the child and family; 2) form a family-centered team and facilitate team work; 3) plan, implement, monitor and evaluate essential service functions; 5) alter strategies that do not work; and 6) determine progress toward readiness for transitions or case closure.

Although *Team Formation* is improving compared to previous years,⁷ the ability of those teams to function and to fulfill their missions has not improved compared to prior years. *Team Functioning* over the past year has not exhibited cohesive planning to meet families' needs. Many teams have worked in isolation of one another, and reviews found many instances of duplication of services which overwhelmed and frustrated families and other team members.

Similarly, in cases where *Team Coordination* was scored as unacceptable, the team lacked a clear point of leadership. Many teams reviewed did not have direction to monitor or manage service functions, and there was a clear lack of accountability to ensure that plans were implemented. While coordination and function are evaluated separately during the reviews, the two concepts are closely linked. The following examples illustrate how poor coordination can lead to adverse functioning.

From review of the case file and conversations with M.P. [focal youth], it is clear that the case worker has had limited contact with M.P. M.P. reports not seeing the worker in 2 years and that the worker was inconsistent before then in engaging with the youth. Since January 2013, the worker has one telephone contact with the youth before the May 2013 court hearing. M.P. has no recollection of this conversation. The worker coded that contact as a preparation meeting for a youth transition plan. (Case # 60)

Teaming, functioning and coordination are in the unacceptable range. Although there are many of the right people involved with this family there is not a functioning team or coordination of services. The birth mother has been very resourceful on her own. She is primarily responsible for navigating through a system that she is figuring out as she goes along. It was described that often times when resources are recommended to the birth mother, she has already sought the service on her own. This seems to have added to the lack of teaming and coordination as she is seen as driving her team without much direction. (Case #54)

Pathway to Case Closure

Acceptable
64%

While the system has improved over the past year, there are still challenges in the *Pathway to Case Closure* indicator. This indicator measures the degree to which the system has established a clear and achievable case goal. Further, it examines team members' understanding and agreement of the established goal and the

⁷ *Team Formation* was rated acceptable in 82 percent of cases reviewed in 2011, 80 percent in 2012, and 85 percent in 2013. *Team Functioning* was rated at 73 percent in 2011 and 68 percent in 2012, and 2013's rating is midway between the two.

strides made toward achieving that goal. The reviews showed that in several cases, team members did not agree on the permanency goal and this lack of consensus hindered the case from moving towards timely and appropriate closure. Reviewers noted how such a discrepancy can impact cases.

For example a child's permanency goal was adoption with either the foster mother or the competing adoption petitioners. This case was plagued with many factors that affected practice performance: lack of engagement, poor assessment and understanding, and adverse teamwork and coordination.

Although some team members agree not to recommend the current foster mother for adoption, they have not agreed on how to implement strategies and functionally perform to achieve permanence. (Case #78)

The legal process can also have a negative effect on achieving permanence, as was the case in #78. In this particular situation the legal team was primarily guiding the progress (or lack thereof) on the case. This stalled case planning, which had a negative effect on the case progress and the timeline for achieving permanence. Although the adoption trial is fast approaching, it is unlikely that exit to permanence will occur in the near future.

Likewise in the case of an 8-year-old child with the goal of adoption:

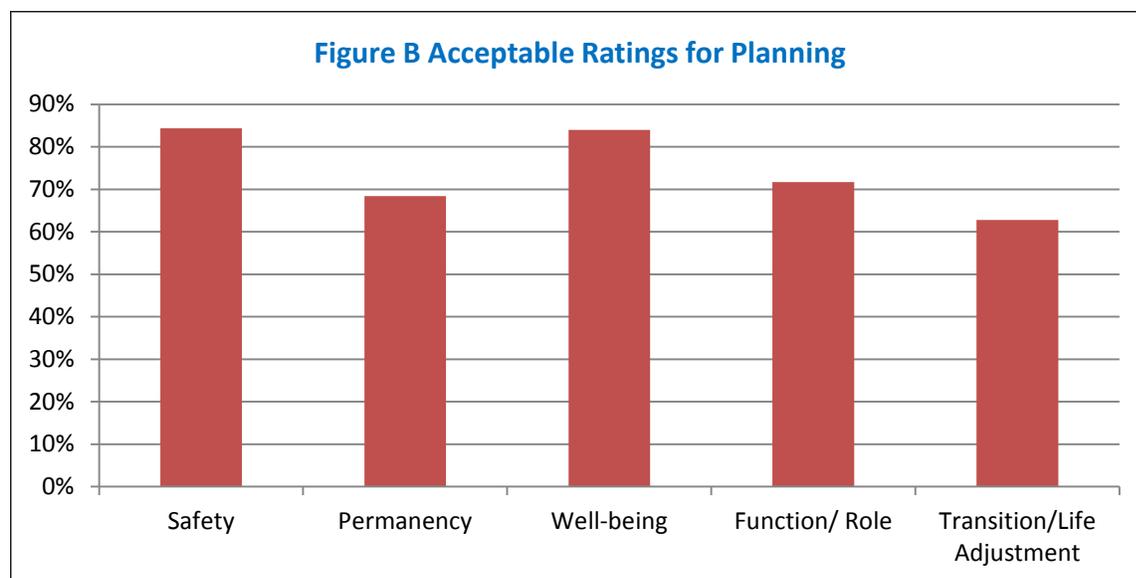
The planning on this case had a negative effect on permanency and case closure, which remains uncertain. Although the focus child is in a pre-adoptive home, the team is faced with several issues regarding the child's safety, protection, overall well-being, daily functioning and role fulfillment and transition. Most team members reported that the focus child will need to be removed from her current home and placed in another home if the foster parents remain non-compliant with the ICPC process. All team members have not come together to address the issues regarding the child's current living status and the effect it is having on her achieving permanence.(Case #18)

The decline in the *Pathway to Case Closure* indicator is also impacted by cases where there was an apparent lack of urgency around establishing clear timelines.

The focus child has had a guardianship goal since June 2007. There is no clear guideline or timeframe provided for the attainment of this goal. (Case #35)

A similar finding from the QSR scores can be seen in the scores related to *Planning*. Of the five *Planning* domains, *Permanency* and *Transition & Life Adjustment* consistently rated⁸ had the lowest ratings, as Figure B below shows:

⁸ Ratings for the sixth domain, *Other*, were only given in five cases in 2013.



Moving Forward: More Strategic Case Planning

The 2013 QSR findings confirm that social workers are effectively planning for safety. Areas for improvement include initiation of permanency planning meetings at earlier points in the case, and consistent contact with team members to assess the appropriateness of the permanency goal throughout the life of the case. These factors have the potential to decrease delays in implementing services and developing appropriate steps towards closing cases safely and expeditiously. As families continue to experience changes in their lives, a consistent assessment and planning meeting with all team members’ participation gives the opportunity to gain a clear understanding of the family’s current status. This gives members an increased opportunity to strategize and develop specific steps needed to achieve permanency.

Additionally, in 2013 CFSA began implementation of the Consultation and Information Sharing Framework and the RED⁹ Team Process, which are designed to respond to the needs of children and families at risk of experience abuse and neglect from prevention to permanency. There are a variety of types of RED teams held throughout the agency, and in 2014 the agency began utilizing QSR Big RED teams to respond to specific areas of concern raised in these reviews.

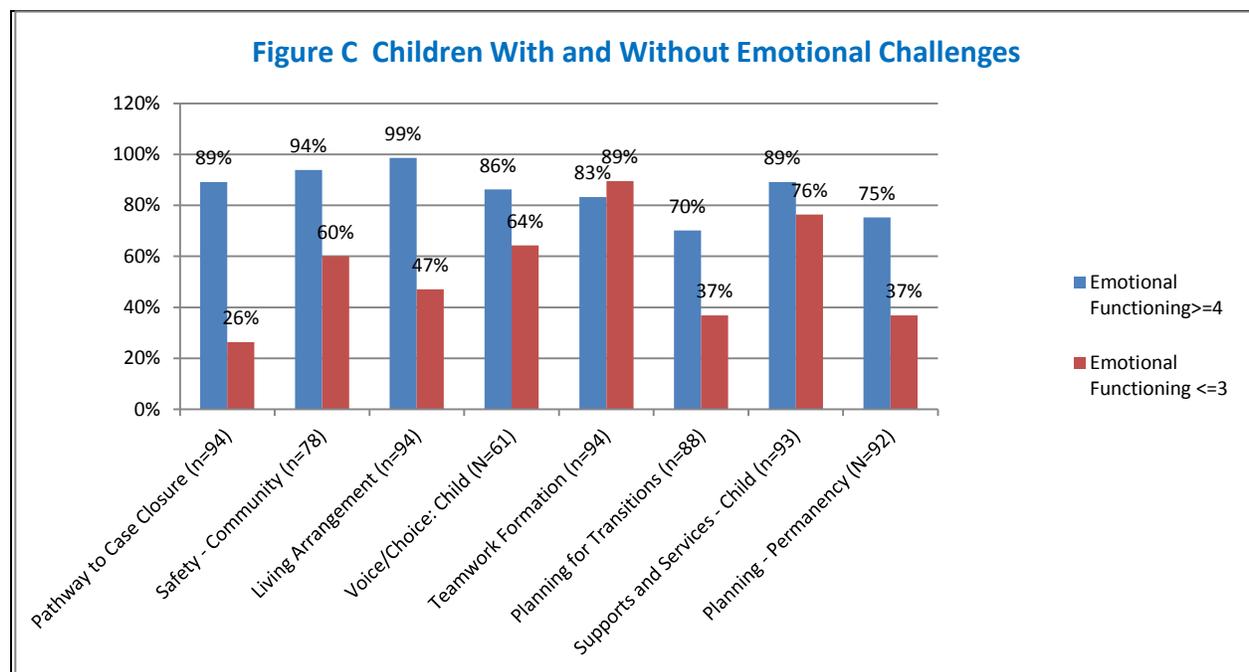
Children with Emotional Challenges

One of the status indicators in the new *Shared Practice Protocol* (Appendix 2) is a rating for *Emotional Functioning* of the child. This rating, which corresponds largely to the GAF score, rates the degree to which a child is displaying an adequate pattern of relationships, coping skills, and self-management. Of the 100 children reviewed in 2013, all but six were rated for this indicator; those who were not rated were under the age of 3 and thus ineligible for rating.

More than three-quarters of the children rated for this indicator scored in the acceptable range, which equates to a score of 6 or above (out of 10), based on the protocol’s guidelines for

⁹ RED stands for Review, Evaluate and Direct.

*Estimating a Child’s Level of Emotional Functioning.*¹⁰ Those who were rated unacceptable, though, were far more likely to have other important scores in the unacceptable range as well. This included both status indicators and practice indicators, as the figure below indicates.



The red bars indicate the percentage of children who rated 5¹¹ and below, according to the protocol, and were rated unacceptable in *Pathway to Case Closure*, *Safety in the Community*, and other factors. This is despite the fact that scores for assessment for children and parents were not significantly different for the two groups. These data suggest that children with diminished emotional functioning are particularly challenging for our staff and that additional supports in the form of training, coaching, or resource identification may be needed. These needs are likely to become more pronounced as CFSA seeks to shift its resources to working with families in their own homes and communities.

Additional Analysis

This section will focus on the analysis of two specific areas: preparing youth for independence and working with fathers.

Preparation for Adulthood

Working with youth continues to be an area of challenge and has historically rated low. The 2013 rating of 56 percent is an increase from 2012 (43 percent) and mirrors the same rating as 2011. Prior to 2013, this rating was based on two indicators: *Responsible Behavior* and *Life Skills Development*. In the Shared Protocol implemented in 2013, the criteria for these two indicators have been combined under the new indicator *Preparation for Adulthood*.

¹⁰ A score of 6 is rated as variable functioning.

¹¹ A score of 5 is rated as a moderate degree of interference in emotional functioning.

Preparation for Adulthood focuses on youth ages 15 to 21. It assesses the degree to which the youth is gaining life skills, developing meaningful relationships and fostering lifelong connections, as well as building the capacities to live and function safely, independent of the child welfare system. *Preparation for Adulthood* also examines the youth's capacity to take control over his/her needs and issues, and have a clear life plan for early adulthood. For teen mothers and fathers, this indicator looks at whether the teen parent is gaining the skills, knowledge, and support necessary to care for their own children.

There were 41 youth reviewed in 2013, including 15 youth who were case managed by CFSA's Office of Youth Empowerment (OYE), four of which were teen parents. According to the data, youth who were case managed by OYE did not rate significantly higher than the general population of youth. Seven out of the fifteen youth were rated acceptable for *Preparation for Adulthood*.

In the few cases where the youth were parents, reviewers found mixed results. One mother of a three-year-old child was functioning well with support from her family:

The youth graduated high school and received her diploma. Reportedly, she has enrolled in the fall semester at a local university... The youth is a nurturing and caring mother. She protects and ensures her child's needs are met. She is pursuing her postsecondary education and is currently working. She is saving and managing her money appropriately. She has adjusted well to the ILP program. She is very close to her older sister and maintains contact with her younger sisters and birth mother. (Case #53)

In the case of a 19-year-old pregnant teen whose first child was removed from her care, she openly acknowledged that she outwardly defied authority and refused to participate in any aspect of planning. Her actions were preventing her from gaining and developing core independent living skills to be able to live on her own successfully.

She continues to need to build life skills around such areas as money management and maintaining a healthy living environment to ensure that she can maintain a household. Also, the youth is preparing to deliver her second child without a high school diploma or gainful employment. (Case #50)

In case #42, another 19-year-old female has made inconsistent progress in preparing for adulthood in the area of gaining independent living skills.

The youth has been making limited progress towards preparation for adulthood. Most of the youth's teenage years were spent in a residential facility or group home, which limited her ability and exposure to gaining core independent living skills. (Case #42)

In approximately half of the cases (21) reviewed, youth had a diagnosis of mood, depressive, or bipolar disorder, or a combination of the three. Although youth exhibited mental health

challenges, this in itself was not a contributing factor for the number of youth who were not successful in achieving independence. There were youth in this category who were able to successfully develop core life skills that would improve their quality of life upon exiting foster care. Factors which contributed to the success of youth were teamwork coordination and facilitation of the youth transition planning.

The formation of the team seemed to occur naturally; all team members appear dedicated to seeing the success of the family and joined on that fact. The functioning and coordination also was quite positive. There also seemed to be a natural lead from the mental health team members which was appropriate as this case should transition out of the child welfare system in the upcoming months. (Case #27)

In five cases, the overall system performance was rated in the maintenance zone, including engagement, teamwork, assessment, planning, and implementing support and services. However, the youth in these five cases were all rated unacceptable. For example, in the case of an 18-year-old female who was involved with the legal system in two jurisdictions as well as the mental health system, she was resistant to services and would abscond from her placement when she knew that her probation officer and other team members would come for visits. The team strategically planned to supervise her whereabouts and worked together to include her in case planning; however the youth was absent in decision-making.

In cases where the youth were actively involved in the case planning process and considered themselves a part of the decision-making, they had better outcomes.

The youth actively participates in all aspects of his service plan and members of the team explain the plan to him in a way that he can understand. During the review, the youth shared with reviewers his understanding of the plans for him. He is aware that he is about to age out of the child welfare system and will be transitioned to adult services. The youth has an effective role and voice that influences the decisions made by the team that benefits him. He informs reviewers that he attends team meetings and his team shapes key decisions about goals, interventions, and essential supports. (Case #79)

Implications for Practice

Youth preparing for adulthood from foster care are faced with many challenges. In many of the cases reviewed, we find that they do not begin to embrace the preparation process until the final months of being in care. “Suddenly” they find that they are unprepared and overwhelmed for the future. In some instances, youth lack the motivation or foresight to be able to appreciate the need for planning and preparing for adulthood. Moreover, some youth in foster care do not have lifelong adult connections identified and may even be more at risk for poor choices due to a lack of stable, loving, adult guidance. While most youth in care try to be responsible with their behavior and planning for the future, it is often their limited judgment in decisions regarding personal relationships that jeopardize their safety, raising the concern of team members.

Findings from the reviews support the importance of team members working with a sense of urgency. This includes involving the youth in the process of identifying a reliable network that can serve as lifelong connections. Case planning and transition planning with the use of the Foster Club Toolkit serve as a mechanism to foster those connections by including identified individuals in the planning and decision-making process. As noted, oftentimes, youth are overwhelmed with the task of planning for the future. An integrated approach to transition planning can provide the youth with a roadmap to consider what is needed before exiting care. While the expectation is that this would be enforced through the independent living programs or in foster homes, this is often not the case due to a youth's resistance and non-compliance. Many times youth could visualize and even conceptualize their basic needs but had no plan for sustaining themselves absent the foster care system. The youth in the example below was offered numerous supports and services but refused to attend or to participate in meetings:

Several team members have spoken to the focus youth regarding his future plans and goals... the focus youth has not utilized any services, avoids meeting with team members, and does not have a concrete plan for aging out of the system... The focus youth has been making slow progress in advancing employment opportunities as well as developing meaningful and achievable future plans. The youth will emancipate from care in 6 months and he has no source of steady income, no concrete plan for housing and no identified means of meeting his fundamental needs. (Case #70)¹²

Responsiveness to the youth's cultural identity will continue to be a significant component in working with youth. At times, reviewers found that professionals were providing the youth with resources for employment, housing, and transportation without considering the youth's cultural needs. In contrast, when there was clear evidence of youth's cultural identity being acknowledged and supported, reviewers saw more positive outcomes and better preparation for adulthood.

Working with Birth Fathers

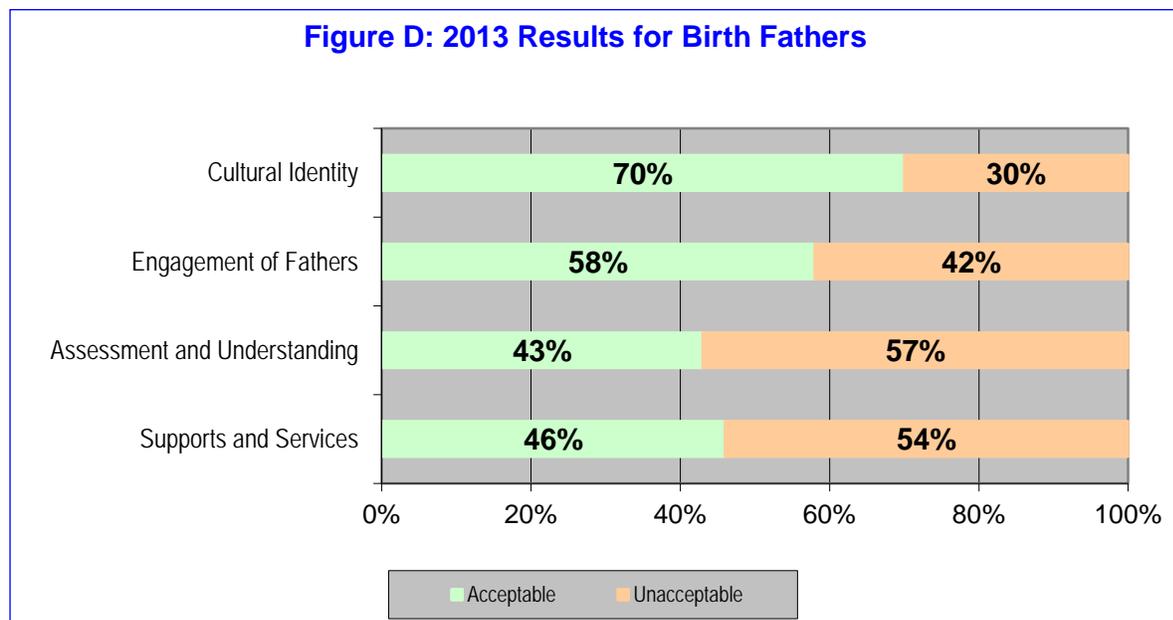
Figure D (following) shows the results of the 2013 QSRs related to fathers. The *Engagement* indicator measures the diligence of outreach efforts demonstrated by the team to locate, build rapport, and engage the birth father and overcome barriers to participation. Strong and positive working relationships between the father and team are evident. Good quality engagement efforts were reflected in 58 percent of the cases reviewed. Between 2011 and 2013 there has been improvement in our work with fathers. Some of the trends we found:

- The team demonstrated good efforts to include birth fathers in the case planning process.
- In cases where birth fathers are involved, they are dedicated and committed to achieving permanence for their child.
- QSR interviews have shown that social workers and other team members have vastly improved their efforts at involving and working with fathers.

¹² When the youth in this case aged out of care, he was refusing to return his worker's calls or be available for visits, but had a steady job and at least two housing options.

- Fathers are being referred to the Connecting Dads program, which links fathers to community-based services, particularly the Fatherhood Empowerment and Education Program (FEED) through the Healthy Families/Thriving Communities Collaboratives.

Figure D: 2013 Results for Birth Fathers



The following examples highlight how working with fathers has positively impacted case progress. In case #11, the step-father was the one working with the Agency on behalf of the youth. He was extremely active in the case planning process for the focus youth.

Although the father on this case was the focus youth’s step-father, the team did an outstanding job in engaging him in the youth’s case and including him in the decision-making process. (Case #11)

In this case, the youth’s step-father was linked with needed supports and services, which included the Agency’s Connecting Dads program. By linking the step-father to a support service, the team was able to guide the family toward obtaining positive outcomes beyond case closure.

In another case, the focus youth’s goal was reunification with the birth mother but the case was not progressing. Once the birth father was located, the team immediately included him in the case planning process.

Although the birth father was just notified in Jan. 2013 that the youth came into care, the team has [made] consistent efforts to maintain a positive working relationship with the birth father and is currently assessing the birth father’s needs if any so that he can be considered as a permanent placement resource. (Case #14)

While the QSRs show improvement in fathers’ involvement, social workers continue to struggle with identifying or locating birth fathers. The significance of engaging birth fathers is understood

by most, but knowing the fathers identity and his whereabouts are dependent on information provided by mothers and extended family members. In one case the birth mother was uncooperative with providing information on the birth father; this did not prevent the team from attempting to locate him.

The team has been unsuccessful in identifying and locating the birth father due to not having his date of birth, his known name is very common, and the birth mother is reluctant to share any information regarding his whereabouts. However, the team made enormous efforts to engage and find the birth father. The team not only conducted diligent searches; they also reached out to local detention facilities and followed through with updates and additional information provided in order to make contact with the birth father. (Case #56)

It is known that most youth who emancipate from the child welfare system return to their family of origin. Often times this is the birth mother or birth father. In the case of a 20-year-old female who did not have a good relationship with her father and was preparing to age out of foster care, the team was working with the father to develop the relationship such that he could become a life-long connection for the youth. The youth was in agreement with working on their relationship.

Implications for Practice

It is becoming more evident that following the mandate of making attempts to engage birth fathers can have positive outcomes. Over the past 5 years, the QSRs have shown evidence of timely case closure, positive changes in youth behaviors, and an increase in family participation.

QSRs have also shown the challenges for social workers struggling to locate birth fathers despite diligent search efforts. In many cases, family members are reluctant to provide information or assist social workers in locating birth fathers. To support increased engagement efforts, the Agency has continued to provide training and guidance on the importance of a father's involvement with his children and the direct impact that involvement can have on children's overall well-being. Although there are still improvements needed, the Agency's efforts to comply with federal guidelines reveal measured success in engaging parents, particularly fathers and paternal relatives. For example, in case #71 a diligent search for the birth father produced positive life-long connections with multiple paternal relatives and the development of a relationship between father and son.

Reviews of Cases with CFSA and DBH Involvement

In 2013, CFSA and the Department of Behavioral Health (DBH) not only partnered in their annual joint QSR and Community Service Review (CSR) but there was collaboration throughout the year on all cases with both CFSA and DBH involvement. The *Shared Practice Protocol* (Appendix 2) is designed to be used independently by each agency and for shared cases. The joint reviews conducted in 2013 were the beginning of a partnership between CFSA and DBH in evaluating practice and service delivery to a population that most often interfaces with both systems. With the development of a shared QSR/CSR protocol for partnering on reviews, both

CFSA and DBH are also strengthening their continuous quality improvement (CQI) approach to sustaining best practices in conjunction with a high-performing service delivery system.

Review Sample

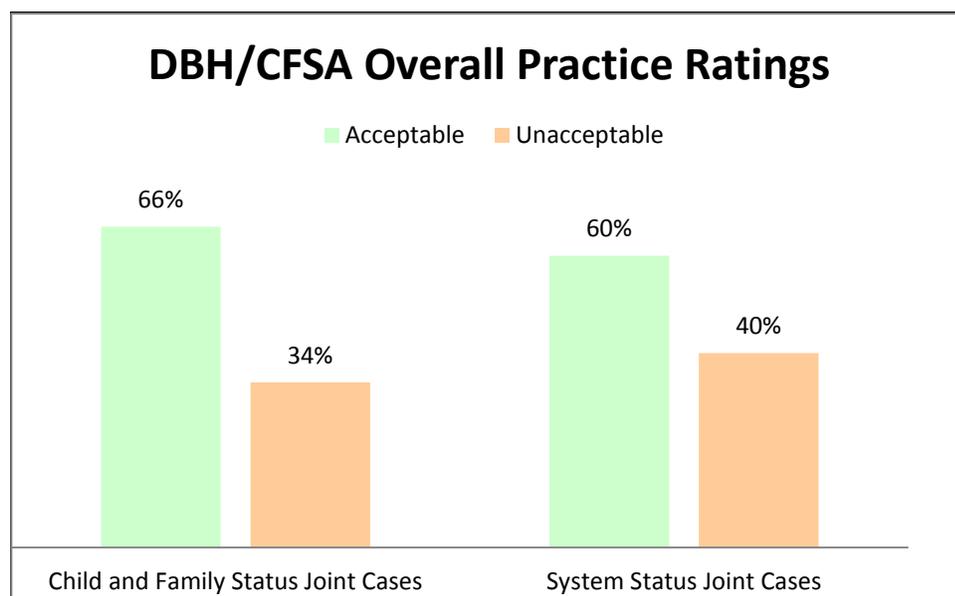
In 2013, CFSA reviewed 47 cases where children and youth had an open child welfare case and were receiving mental health services through DBH. Twenty-six of these cases were randomly selected by DBH in May 2013 as part of the DBH review. This random sample of children under the age of 18 was also stratified to reflect the percentage of cases active with each DBH Core Service Agency.

Although the results from the sample of 47 cases cannot be generalized to all cases where children are receiving services from both agencies, they do illustrate themes regarding the general state of practice throughout the District’s child welfare and mental health system.

Findings

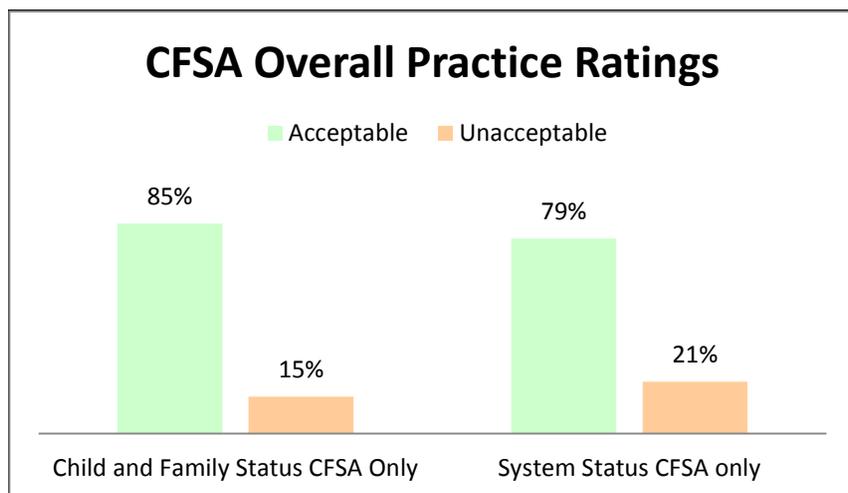
In Figure E (below), the overall performance of the *Child and Family Status* indicator was rated acceptable at 66 percent and the *System Performance* acceptable at 60 percent on the joint cases.

Figure E: Overall Ratings for Joint Cases



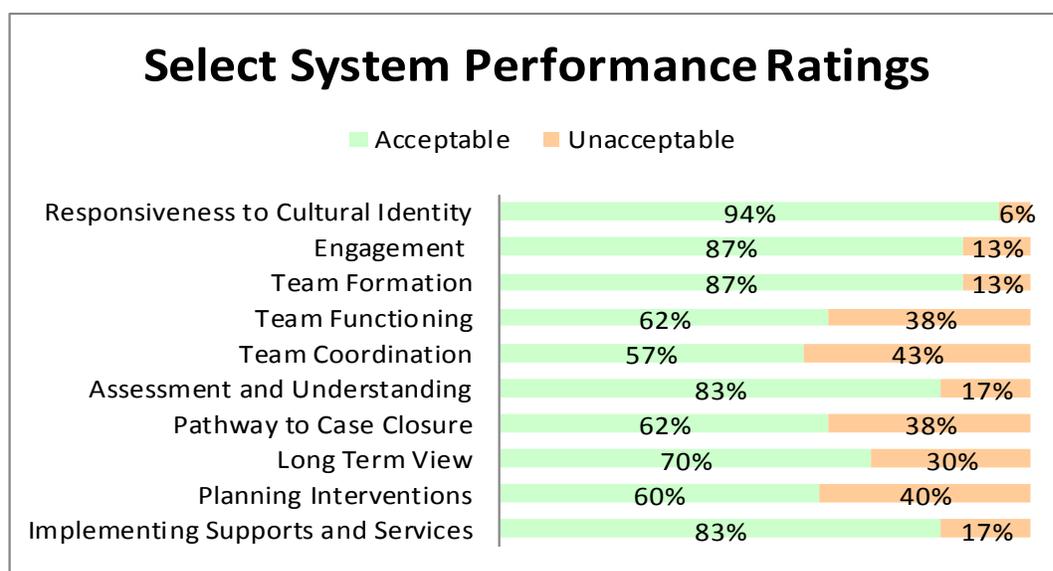
In contrast to the joint cases above, the overall performance for the CFSA-only cases scored higher. As noted in Figure F below, *Child and Family Status* was rated at 85 percent and *System Status* at 79 percent acceptable. The cases where there was no identified mental health (DBH) involvement received higher ratings for both the child and family, and the system status.

Figure F: Overall Ratings for CFSA-only Cases



Although the joint review looked at all the indicators for the *Child and Family Status* and the *System Performance*, only specific indicators are highlighted. These indicators are considered the foundation to quality practice and underlie the successful intervention strategies that are essential to achieving positive results. They include *Responsiveness to Cultural Identity*, *Engagement*, *Assessment and Understanding*, and *Implementation of Supports and Services* (for the child). These provide the necessary information to coordinate appropriate interventions for addressing the underlying issues. *Teamwork and Coordination* (formation, functioning and coordination), *Planning Interventions* (safety, permanency, well-being, role fulfillment and transition planning), *Pathway to Case Closure*, and *Long-Term View* speak to the collaboration between the two agencies to ensure one common goal and outcome for the family.

Figure G



Responsiveness to Cultural Identity, Engagement, Assessment & Understanding, and Supports and Services: Child

The *Responsiveness to Cultural Identity* was rated 94 percent, *Engagement of the Child* was rated at 87 percent while *Assessment & Understanding*, and *Implementation of Supports and Services* were both 83 percent. These results were also similar to the overall QSR scores for 2013, which were at 97 percent, 91 percent, 86 percent, and 86 percent (respectively). There was evidence that the professionals were developing and maintaining quality and trust-based relationships with the children. Team members, including mental health providers, were cognizant of the fact that each child/youth has their own unique identity and world views that shape their ambitions and life choices. Having this deeper level of assessment contributed positively to the engagement of the child and family in the change process. It also provided for a more comprehensive assessment and understanding of the child and his or her family situation. Team members were able to make a positive difference in the child's life, prevent harm, and work in collaboration with each other. As the examples below illustrate, most supports and services were of the right fit (i.e., clinically appropriate) and delivery of services was timely, competent, and consistent with needs identified.

In case #6, the focus youth is an 18-year-old male diagnosed with depressive disorder, pervasive development disorder, r/o ADHD (attention deficit hyperactivity disorder), and mild mental retardation. His goal is independent living but due to his developmental delays, the plan is to transfer him to a facility that provides care to adults with disability. Both systems worked collaboratively to ensure that the services being provided to the youth were appropriate and were meeting his needs.

The team demonstrated good efforts to assess and understand the youth and mother's cultural identity and community supports. The team recognizes the youth's cognitive delays and has engaged and connected the youth to supportive services based on his intellectual ability. The team has linked the youth with providers who understand developmentally-delayed youth. (Case #6)

In case #28, the supports and services provided to the 7-year-old child diagnosed with adjustment disorder with mixed anxiety and depressed mood were beneficial to her emotional stability and daily functioning.

She is developing healthier coping skills and is able to self-manage her emotions and behaviors. Per reports, the child experienced extreme crying spells when first removed from her birth mother's care. The emotional episodes have declined over the past 3 months. She utilizes writing poetry and spirituality as means to appropriately channel and express her feelings. (Case #28)

The data demonstrates a clear correlation between assessments that are individualized and identify specific needs, and providing the most appropriate supports and services for children receiving services from both systems. At least 80 percent of youth reviewed were receiving the most appropriate services. More than 50 percent were also maintaining good emotional

functioning. It was evident that team members' assessments of children receiving services were based on their responsiveness to the child/youth's cultural identity which contributes to their overall well-being.

Teamwork and Coordination, Planning Interventions, Pathway to Case Closure and Long-term View

Teamwork is a vital element in the collaboration of services between agencies servicing the same family. Looking at the children who interface with both the child welfare and mental health systems allows for a closer examination of how the systems are functioning collectively in unity, and how both are planning services and evaluating results. Based on the QSR findings, *Teamwork and Coordination (formation, functioning and coordination)* is an area in need of improvement. *Team Formation* was rated at 87 percent, *Team Functioning* was rated at 62 percent and *Team Coordination* was rated at 57 percent.

In most cases, there was a team of motivated and qualified individuals with the right skills and knowledge appropriate to the needs of the child (team formation). However, the individuals on the team in most cases were not working effectively and cohesively to problem solve (team coordination). In many cases, no one was identified as the team leader to ensure a unified process with a shared decision-making approach. This had a negative effect on *Planning Interventions* which was at the lower scale of the acceptable rating at 60 percent. *Pathway to Case Closure* and *Long-term View* were rated at 62 and 70 percent respectively. *Long-term View* and *Pathway to Case Closure* are very similar in terms of practice. While *Long-term View* is rated only on cases with mental health involvement and *Pathway to Case Closure* is rated on all cases, the expectation is that team members, including mental health providers, have a strategic vision/plan that is used to set the purpose and path to achieve closure. The protocol measures the extent to which mental health providers have a guiding view for service planning that includes strategic goals for the child. Those goals should lead to the child functioning successfully in their daily life. This was not present on all the cases where children were receiving mental health services.

Common trends that were observed in the joint cases included lack of a long-term plan for the child or youth. Services were implemented to address immediate needs and there was no consistent demonstration of team members looking beyond the end of the intervention. Additionally, the mental health agency's treatment plan did not always accurately reflect the child/youth's needs. This was demonstrated in case #31 where the focus child was dealing with grief and loss as the result of her birth father murdering her birth mother.

While the team has been dedicated to permanence for the focus child, the mental health and child welfare teams worked in isolation. The reviewers learned that there were duplicate interventions between the mental health therapist and the grief and loss therapist. Additionally, there was no cohesive treatment meeting, no consistent contact and no information sharing among the team. One team member stated that she received updates on case progress from the focus child and her sister. (Case #31)

Similarly, in case #26, a 13-year-old was receiving community support services and individual therapy.

Although the Individualized Recovery Plan is current, the plan was created without the presence of the focus youth or his family. The plan was renewed from the previous plan, and the paramour had already complained that the previous plan was inaccurate and did not reflect the youth's needs or his perception of his needs. (Case #26)

Based on the data reviewed, there was no evidence from the sample that indicated a correlation between cases with DBH involvement and the rating for safe case closure. Cases with DBH involvement were rated at 62 percent while those without DBH involvement were rated at 64 percent. Ratings were based on team members' actions and decisions that did not reveal a pattern of consistent and effective problem-solving and communication.

Trends in Practice: Joint Cases

- In most cases the “big picture” situation and dynamic factors that impact the child were understood by the professionals.
- Diligence by team members to engage with the child increased the child's participation in case planning, specifically for older youth.
- Supports and services were being coordinated across agencies.
- CFSA and DBH team members responded positively to the cultural identity of children and families.
- The long-term guiding view for mental health providers was often absent or not clear.
- Although team members were identified, oftentimes roles were not clear and many did not serve a significant role in the case planning process.
- Communication was often driven by crisis versus assessment, planning, or the effort to create common goals at the onset of the partnership.
- Team members were often working in silos and did not consistently collaborate on the development of treatment or case plans to identify common goals and objectives for achieving measurable outcomes.

Improving Practice: Joint Cases

The practice models of both CFSA and DBH emphasize teamwork, collaboration, respect for families, and a common desire for the agencies to provide interventions which strengthen rather than marginalize families and children. Building on this common ground, the purpose of the joint review is to identify key areas of strength and areas in need of improvement. The goal is to provide quality practices and a high performing service delivery system across child welfare and mental health. Both systems seek to design their interventions based on thorough assessments and solid clinical judgment. The mutual hope is for the interventions to be as unobtrusive and as brief as possible while also being consistent with the goals outlined for protecting the child. Although these goals are shared and findings to-date show evidence of positive practice, there remains work to be done in terms of stronger and more informed collaboration between the child welfare and mental health systems.

Teaming between CFSA and DBH was identified as an area in need of improvement, including the need for initiating consistent collaboration on joint cases. While it is evident that the right people are forming teams for children and families, as indicated by the ratings, the teams'

functioning and coordination is lacking. The overall ratings for the 2013 joint child welfare and mental health cases demonstrate that team members were performing at an acceptable standard, but at a rate that needs improvement. Moving forward, it will be important for both agencies to reach out to their staff, service providers, and contractors to impress upon them the significance and the benefits of cross-system collaboration. Technical assistance may also be required to change people's perception of what the collaborative team should look like, as well as the roles and responsibility of its members.

Moving Forward

The most significant change to the Agency's QSR process in 2013 was the implementation of a revised protocol that combines the qualitative measurement indicators from both the child welfare and the mental health systems. This effort was undertaken in 2012 as a joint organizational development process and included representatives from CFSA, DBH, and the Center for the Study of Social Policy. The resulting protocol design was technically reviewed, revised, pilot tested, refined, and used for measurement of practice performance. Effective January 2013, CFSA and DBH have implemented the use of the *Shared Practice Protocol*.

Also in 2013, the QSR unit partnered with stakeholders to strengthen the communication process for disseminating QSR findings. As described earlier, findings are disseminated throughout the process to allow for timely information-sharing and feedback. In 2013, the Agency enhanced this process to align the QSR feedback with the RED¹³ team framework. For example, the Office of Program Operations will convene a Permanency Big RED team meeting to discuss the findings and progress made on the QSR 60 days following the initial debriefing. Then, throughout the year, themes from the Permanency Big RED teams will be compared to those identified through the QSR to inform strategies for overall systemic improvements. The flow chart in Appendix 5 outlines the flow for sharing QSR findings from the initial case review through the publication of the annual report. Throughout 2014, changes to the communication process will be made as needed, based on the ongoing feedback from stakeholders.

The Agency continues to build on the great strides made over the past 2 years in terms of practice and organizational changes – the findings from the QSRs reflect these positive improvements and provide the Agency with the information it needs to continue to move forward to address challenges.

Appendices

- Appendix 1 - The QSR Process
- Appendix 2 - QSR Protocol
- Appendix 3 - Sample
- Appendix 4 – Reviewers
- Appendix 5 – QSR Communication

¹³ The RED (review, evaluate, and direct) teams are comprised of individuals representing various administrations within the Agency, depending on the case being reviewed. For example, RED team members may be staffed from CFSA's Child Protective Services (CPS) administration, the In-Home and Permanency administrations, mental health and kinship services, and/or CFSA's contracted community partners, the Healthy Families/Thriving Communities Collaboratives. Each RED team has a unique focus depending on the program area. Big RED teams are comprised of staff at the supervisory level and provide more comprehensive reviews for the benefit of the front-line social workers or other staff as applicable.

Appendix 1 - The QSR Process

To enhance case practice and system performance, CFSA has instituted the QSR process to gather data and provide feedback about individual child welfare cases and the system as a whole. In partnership with the Center for the Study of Social Policy (CSSP), CFSA began using this best practice in October 2003, particularly to supplement the ongoing collection and assessment of quantitative data. In addition, CFSA partners with the District's Department of Behavioral Health on shared child welfare - mental health cases to promote District-wide consistency for assessing the quality of mental health services and measurements of improvement.

The QSR process examines case practice, system performance, and outcomes for individual children and families in order to identify strengths and areas that need improvement. Findings from the QSRs are shared with a broad audience of internal and external stakeholders. Together, quantitative and qualitative data provide a deeper understanding of family dynamics, needs, and service delivery system performance, helping to inform practice and system improvements.

The QSR process is an essential component of CFSA's commitment to providing quality care to our clients, in addition to the Agency's Continuous Quality Improvement (CQI) approach to sustaining best practices and a high-performing service delivery system. Further, in alignment with the foundational tenets of the Agency's *Practice Model*, QSR indicators have been purposefully incorporated into the development of CFSA's *In-Home* and *Out-of-Home Practice Guides*. Both models were developed in collaboration with community partners to outline values and guiding principles for effective practice and service delivery.

Appendix 2 - QSR Protocol

CFSA’s original QSR protocol was developed in 2004 by national experts from Human Systems and Outcomes, Inc. (HSO), a management consulting and performance measurement organization. The HSO consultants facilitated meetings to tailor a QSR protocol specifically for the District’s child welfare system. Representatives from CFSA’s community partners participated in the development process, including the Healthy Families/Thriving Communities Collaboratives, the Consortium for Child Welfare, the Foster and Adoptive Parent Advocacy Center, and the Children’s National Medical Center. Since then, CFSA has further refined the protocol to conduct population-focused QSRs, e.g., cases involving teens, or in-home cases where the children are living with their family of origin and receiving services. As noted earlier in the document, the *Shared Practice Protocol* was implemented in January 2013.

Structure of the Shared Practice Protocol

The revised protocol has two sections: **Child and Family Status** and **System Status**. The table below lists indicators for each section. For *Child and Family Status*, reviewers examine the situation of the child and their family within the past 30 days, using up to 12 indicators, as shown. These areas are rated to help identify the baseline from which the child and family are operating and to indicate the level of service needs.

QSR Indicators by Section	
<i>Child/Family Status Indicators</i>	
<ul style="list-style-type: none"> • Safety • Behavioral Risk • Stability • Permanency • Living Arrangement • Physical Health 	<ul style="list-style-type: none"> • Emotional Functioning • Academic status • Preparation for Adulthood • Caregiver Functioning • Family Functioning & Resourcefulness • Voice and Choice
<i>System Status Indicators</i>	
<i>Practice Performance Indicators</i>	
<ul style="list-style-type: none"> • Cultural Identity • Engagement • Teamwork & Coordination • Assessment and understanding • Pathway to Case Closure • Long-Term Guiding View 	<ul style="list-style-type: none"> • Planning Interventions • Implementing Supports and Services • Medication Management • Managing Chronic Health Concerns • Tracking & Adjustment

The indicators of the *System Status* assess not only the child welfare system’s overall performance within the past 90 days, but also the practice between child welfare and mental health. The system’s performance is based on the framework of a specific practice that is the basis for CFSA’s *In-Home* and *Out-of-Home Practice Guides*. The system includes all people working with the child and family, such as child welfare staff, school staff, service providers, and legal personnel.

Collectively, these two sets of indicators allow reviewers to thoroughly assess functioning of the child welfare system (as represented by the cases reviewed) and to identify what areas are working well, and what areas are in need of improvement for serving children and their parents and caregivers.

Scoring Protocol

Reviewers score indicators based on a 6-point scale. Table 2 below presents an example, the “QSR Interpretive Guide for Child Status”, with a scale that runs from **1 - adverse** status to **6 - optimal** status. After scoring, the protocol provides either of two options for viewing findings:

- By zones—Improvement, Refinement, or Maintenance
- By status—Acceptable or Unacceptable

While we used “status” as the basis for analyzing data from QSRs in 2013, the table below provides charts for each indicator according to zones and to status.

Score Reliability

In addition to requiring that all reviewers undergo training and are paired with another reviewer, CFSA has taken additional steps to guarantee the reliability of the scores and findings from the QSRs. In the spring of 2012, a case presentation process was implemented whereby cases are presented to the QSR management team and to a mentor reviewer. Prior to the finalization of the ratings given, reviewers present their case and provide justification for ratings given. Beginning in January 2013, this process was bolstered to include a panel review of representatives from CFSA, DBH, and CSSP. This diversity in the panel allows for greater reliability based on the expertise of the panel reviewers.

In addition to the case presentation process, each case story is reviewed by a minimum of two management staff. This is done to provide feedback on the readability of the story, to ensure that the narrative covers all important aspects of the case, and to ensure that the numerical ratings are consistent with the information in the story. This process works well with the time structure of the QSRs and allows the ratings to be reconciled with a standardized written document.

Example of QSR Scoring Protocol			
QSR Interpretive Guide for Child Status			
<i>Zones</i>	<i>Scoring</i>		<i>Status</i>
MAINTENANCE Status is favorable. Maintain and build on a positive situation.	6 = OPTIMAL Best or most favorable status for this child in this area (taking age and ability into account). Child is doing great! Confidence is high that long-term goals or expectations will be met.	ACCEPTABLE	
	5 = GOOD Substantially and dependably positive status for the child in this area with an ongoing positive pattern. This status level is consistent with attainment of goals in this area. Situation is “looking good” and likely to continue.		
REFINEMENT Status is minimal or marginal, possibly unstable. Make efforts to refine situation.	4 = FAIR Status is minimally or temporarily sufficient for child to meet short-term goals in this area. Status is minimally acceptable at this time but this status may be short term due to changes in circumstances, requiring adjustments soon.		
	3 = MARGINAL Status is marginal/mixed, not quite sufficient to meet the child’s short-term objectives now in this area. Not quite enough for the child to be successful. Risks may be uncertain.		UNACCEPTABLE
2 = POOR Status has been and continues to be poor and unacceptable. Child seems to be “stuck” or “lost” and is not improving. Risks may be mild to moderate.			
1 = ADVERSE Child status in this area is poor and getting worse. Risks of harm, restrictions, exclusion, regression, and/or other adverse outcomes are substantial and increasing.			

Appendix 3 - Sample

Each year CFSA randomly selects a carefully calculated number of cases for the QSR. This number takes into account both time and staff resources available for a dedicated, thorough, and detailed review process. The table below provides specific aspects of the 2013 sample, showing the percentage of cases reviewed by gender, age, permanency goal, and placement type. Reviewers completed over 382 interviews, with a median of eight interviews per case.

2013 QSR Sample Compared to Foster Care Population		
<i>Gender</i>	<i>% in QSR sample population</i>	<i>% in CFSA foster care population</i>
Male	53	52
Female	47	48
<i>Age Group</i>		
0-5	22	24
6-12	28	24
13-17	37	26
18-29	13	26
0-5	22	24
<i>Placement Type</i>		
Kinship Home	37	19
Traditional foster home	20	32
Therapeutic Foster	15	24
Group home	4	4
RTC	2	2
Independent Living Program	2	5
Pre-adoptive home	17	5
Other (hospital, corrections, abscondence, etc.)	2	7
<i>Permanency Goal</i>		
Reunification	37	28
Guardianship	24	29
Adoption	28	21
APPLA	9	19
Other (legal custody, no goal entered)	2	3
<i>Case Management</i>		
CFSA	48	43
Private Agency	52	57

Also noted earlier in the document, the QSR draws from a stratified random sample that covers a diverse population of cases from across the Agency. The sample size is designed to be large enough to provide a snapshot of what is working well and where improvement is needed on individual cases and to indicate what is occurring in the system as a whole. Because the review deals with qualitative data, however, there is no firm formula for determining statistical validity. Nevertheless, the sample is large enough to be representative of CFSA’s client population, as

well as CFSA's general case practice. In 2013, reviews were done on almost 6 percent of the children in out-of-home care. To facilitate the process, CFSA has a unit of trained QSR reviewers to coordinate, conduct, and report on QSRs. In addition, CFSA trains and maintains a pool of internal staff and external stakeholders who serve as reviewers.

Once the sample is selected, the QSR unit meets with social workers to identify the essential participants in the child's case. Pairs of reviewers go through each case record for background, which allows them to assess how social workers use written assessments and evaluative information in case planning and decision-making. Reviewers then interview as many stakeholders as possible, beginning with the social worker and including the age-appropriate child, birth parents, resource parents, guardian *ad litem*, family members and their legal representatives, school staff, service providers, and others. Reviewers then rate a series of indicators that assess the status of the child, parent or caregiver, and the system. Next, reviewers conduct a debriefing with the ongoing social worker and supervisor to share strengths, challenges, and recommended next steps regarding the case. For each case in the sample, reviewers write a narrative or "case summary" that highlights effective case practices and areas in need of improvement. For purposes of tracking, these summaries are stored in a special QSR database. The findings from all of these case stories, which are the primary source for identifying areas of strength and challenges, offer concrete insights into ways to improve practice.

Appendix 4 - Reviewers

QSR review teams consist of a pair of reviewers, one of whom serves as the *lead* or *mentor* reviewer and one who is the *partner* or *shadow* reviewer. CFSA first began certifying lead reviewers in 2010, based on successful participation in a 2-day certification training process and at least four reviews that reflect reviewers' skills and knowledge of QSRs. In 2013, CFSA held three two-day training sessions for those interested in becoming reviewers or in learning about the QSR process. Also in 2013, CFSA established a one-day QSR management training to provide managers with an overview of the QSR process. Reviewers were also invited to this one-day training where the new QSR protocol was introduced and new indicators discussed. This provided an opportunity for reviewers to update their knowledge of the instrument and the expectations of the new process. During 2013, CFSA and the Department of Behavioral Health (DBH) worked to develop a consistent process for training and certifying lead reviewers, a process which will be fully implemented in 2014 and will include training in both the child welfare and mental health systems.

CFSA draws these qualified and trained reviewers from CFSA's unit of QSR specialists, as well as various program areas, e.g., Child Protective Services; Permanency Administration; Office of Youth Empowerment, the Office of Policy, Planning and Program Support (OPPPS); and contracted private agencies. In addition, the 2013 reviews included trained reviewers from other disciplines, such as mental health and education.

Prior to participating in a QSR, all reviewers must complete 2 days of rigorous training on the QSR protocol, focusing on critical thinking, interviewing, and impartial assessment skills. The reviewers also learn to conduct independent and objective assessments, based on information they gain from the case review and practice giving feedback to the program staff involved.

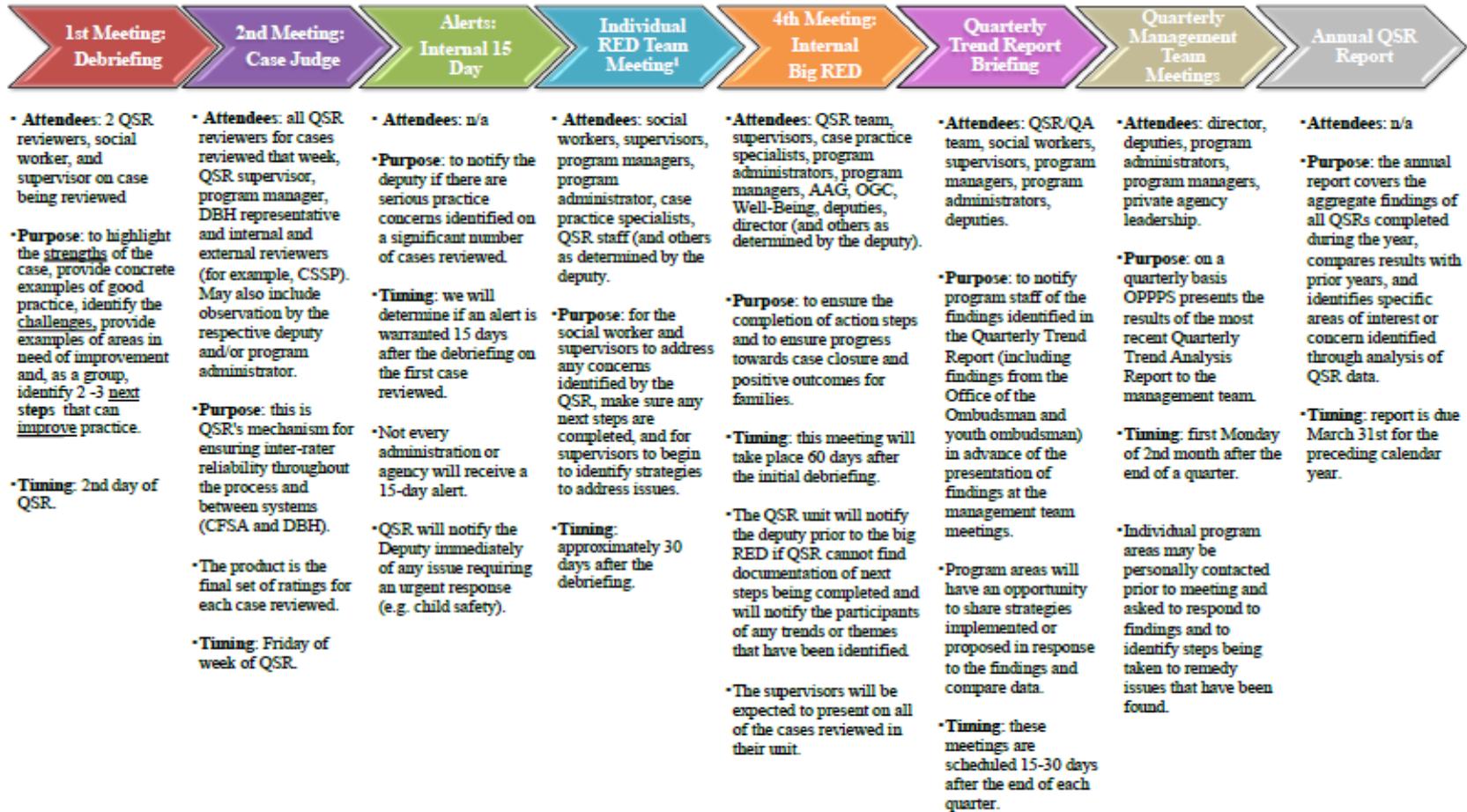
After completing classroom training, reviewers have the opportunity to "shadow" or pair with an experienced lead/mentor reviewer to conduct a QSR. The lead/mentor reviewer guides the case review while the first-time reviewer observes. A shadow reviewer has the opportunity to become a lead reviewer after successfully reviewing four or more cases. Mentors evaluate the shadow reviewers' skills in interviewing, assessing, and analyzing information. For example, engaging individuals is an important component of a reviewer's interviewing skills while exercising discernment is necessary during assessment and analysis.

To gather as much qualitative data as possible, QSR reviewers employ their interviewing skills to ensure the interviewees are comfortable and at ease. As a result, new information may often come to light, some of which may not have been shared previously among all the team members. While reviewers are responsible for protecting confidentiality, they are also required to inform all interviewees of their responsibilities as mandated reporters.

The lead/mentor reviewer conducts the interviews and takes the lead in a debriefing session with the social worker and supervisor. During the debriefing, the lead/coach reviewer outlines the strengths and challenges within the case and provides detailed feedback to social workers and supervisors. The lead/mentor reviewer also ensures that next steps for case and system improvement are developed in collaboration with the social worker and supervisor. During the collaborative process, it is imperative that the reviewers provide social workers and supervisors

with strength-based feedback to establish a trusting work relationship and for the social workers to genuinely commit to the process of developing next steps. Lastly, in concert with the partner/shadow reviewer, the lead reviewer prepares a comprehensive and concise written case summary that documents findings and recommendations for each case.

Appendix 5 – Communication of QSR Findings



¹ The 30 day RED team was proposed by In-Home as part of the strategy to integrate the QSR findings into the RED team framework (February 2014).