

## EXECUTIVE SUMMARY

The Mississippi Department of Human Services (MDHS) is in the second year of implementing the terms of a settlement agreement, approved by the court in January 2008 pursuant to the *Olivia Y. vs. Barbour* class action lawsuit. The settlement agreement requires that MDHS change its practice of child welfare in many significant ways and also requires that MDHS implement or strengthen a number of systemic improvements to support improved practice in the field. It also calls for MDHS to contract with an independent consultant to make recommendations about the design of a Continuous Quality Improvement (CQI) process that will monitor performance in serving children and families over time. As part of the settlement agreement, MDHS is also seeking to become accredited through the Council on Accreditation (COA). COA accreditation includes a set of multiple requirements that the State must meet for compliance with accreditation standards, many of which relate to or overlap with some of the settlement agreement requirements regarding child welfare practice in the field or the agency/systemic supports needed to sustain practice requirements. MDHS is also preparing for its second Federal Child and Family Service Review (CFSR), which is scheduled to occur in May 2010. Many of the Federal requirements reviewed in the CFSR correspond to requirements and standards within the *Olivia Y* settlement agreement and COA criteria.

In preparing to make the major changes to the child welfare system in Mississippi needed to comply with its various mandates, MDHS chose to frame the requirements within a child welfare practice model that would provide an integrated context for implementing the changes in the field and reflect the mission and goals of the Department in serving children and families. The Center for the Support of Families, Inc. (CSF) was awarded a contract to develop the practice model in February 2009 and this report describes the model we are recommending for MDHS, along with our recommendations for the CQI process.

In developing the practice model, we first conducted an assessment of policy, training, monitoring activities, resources and practice, gathering information from the following sources:

- ◆ An electronic survey administered to MDHS child welfare staff;
- ◆ A series of focus groups and individual interviews that included social workers, supervisors, Regional Directors, parents, service providers, youth in foster care, resource families, and central office staff;
- ◆ The court monitor's report for the *Olivia Y* settlement agreement;
- ◆ Reports from the Council on Accreditation; and
- ◆ A review of MDHS child welfare policy, training curricula, and Foster Care Review (FCR) findings.

We approached the development of the practice model in a principle-based and outcome-oriented manner. First and foremost, the practice model is grounded in the mission statement and values of the MDHS Division of Family and Children's Services, which include the following:

**Mission Statement:**

*Our mission is to lead Mississippi in protecting children and youth from abuse, neglect and exploitation by providing services to promote safe and stable families.*

The values underlying the mission statement are:

◆ Competence	◆ Respect
◆ Integrity	◆ Personal Courage
◆ Responsibility	◆ Collaboration

Second, we understand clearly that family-centered practice is a very important concept within MDHS and among its staff and stakeholders. In the focus groups and interviews, the concept of family-centered practice was always raised as the ideal that the system was striving for. Therefore, we attempted to frame the practice model within a family-centered approach in order to help MDHS bring its ideals and vision closer to reality.

Finally, we also attempted to conform the practice model to the requirements and underlying principles of the *Olivia Y* settlement agreement. In the report, we have cross-referenced these requirements with the components of the practice model. By framing the practice model within a set of guiding principles, it provides a common basis for staff and stakeholders to understand MDHS' approach to serving children and families; for guiding decisions regarding policy, planning, and resources; and for integrating the various programs and services that MDHS offers. The framework that we have developed includes some key features, as noted below:

***The practice model is a clinical intervention model, not a case management model.***

The model focuses on the substance of casework activities that MDHS and its providers perform, and emphasizes the importance of particular interventions, such as performing substantive strengths and needs assessments that address presenting issues and their underlying causes; involving children and parents in case planning activities and decision making; and tailoring case plans and interventions to the individual needs of children and families.

***The model emphasizes clinical supervision as a key element in improving practice, as opposed to administrative supervision.*** We acknowledge the importance of supervision in strengthening child welfare practice with children and families. In each component of the model, we identify the appropriate roles for supervisors in terms of reviewing, guiding, coaching, and mentoring with regard to assuring qualitative casework practices and strengthening staff capacity.

***All of the components of the practice model are interconnected.*** The components are not designed as stand-alone modules but, rather, as part of a comprehensive approach to serving children and families. Implementing one component independent of the others is not likely to lead to improvements in overall practice or outcomes.

***The practice model is integrated with key functions within MDHS.*** The framework that we have provided integrates training, policy, resources and service array, and monitoring around similar concepts in order to provide a holistic approach to serving children and families, and to

ensure that the principles and values upon which we have based the practice model are integrated throughout all of the support functions of the agency.

By grouping together the major requirements of the settlement agreement, considering recognized best practices in child welfare, and operationalizing the Mission Statement and values above, we were able to identify six broad categories of activities in working with children and families that comprise the practice model. They are as follow:

### ***Mobilizing Appropriate Services Timely***

In defining appropriate and timely services, we are referring to a process whereby services are designed and delivered pursuant to a careful assessment of children's and parents' needs. This concept emphasizes the need for a broad array of services and supports that are individualized to meet the specific needs of the children and families, provided in the least restrictive setting appropriate for the child and accessible to all jurisdictions within the State.

### ***Safety Assurance and Risk Management***

Safety and risk-related interventions are designed to help children remain safely at home whenever possible and appropriate. Assuring child safety begins with the first report to MDHS that someone believes a child is being maltreated and continues through initiating investigations of maltreatment; initial safety and risk assessment; ongoing safety and risk assessment; developing a case plan; assuring safety during placement; reunification; and case closure. Safety and risk interventions are applicable for all children within a home, not only for a child for whom a report of maltreatment has been received.

### ***Involving Children and Families in Case Planning and Decision Making***

This component includes active involvement of age-appropriate children, families, and youth in identifying their unique strengths, needs, and service requests, and in developing plans that address their needs, establish and attain their goals, and support safe and appropriate relationships within families while children are in foster care. It includes all relevant family members, whether in the household or not, preparing them for and supporting their participation in meetings, reviews, and other processes that affect them.

### ***Strengths and Needs Assessments of Children and Families***

Comprehensive family assessment is the ongoing and continuous process of gathering, organizing, and analyzing information for the purpose of informed decision making and service planning concerning the safety, permanency, and well-being of children, youth, and families. Beyond an assessment of risks, safety and the circumstances leading to agency involvement, the assessment includes a broader focus of the strengths and needs of all individual family members along with underlying conditions affecting the family.

### ***Preserving Connections and Relationships***

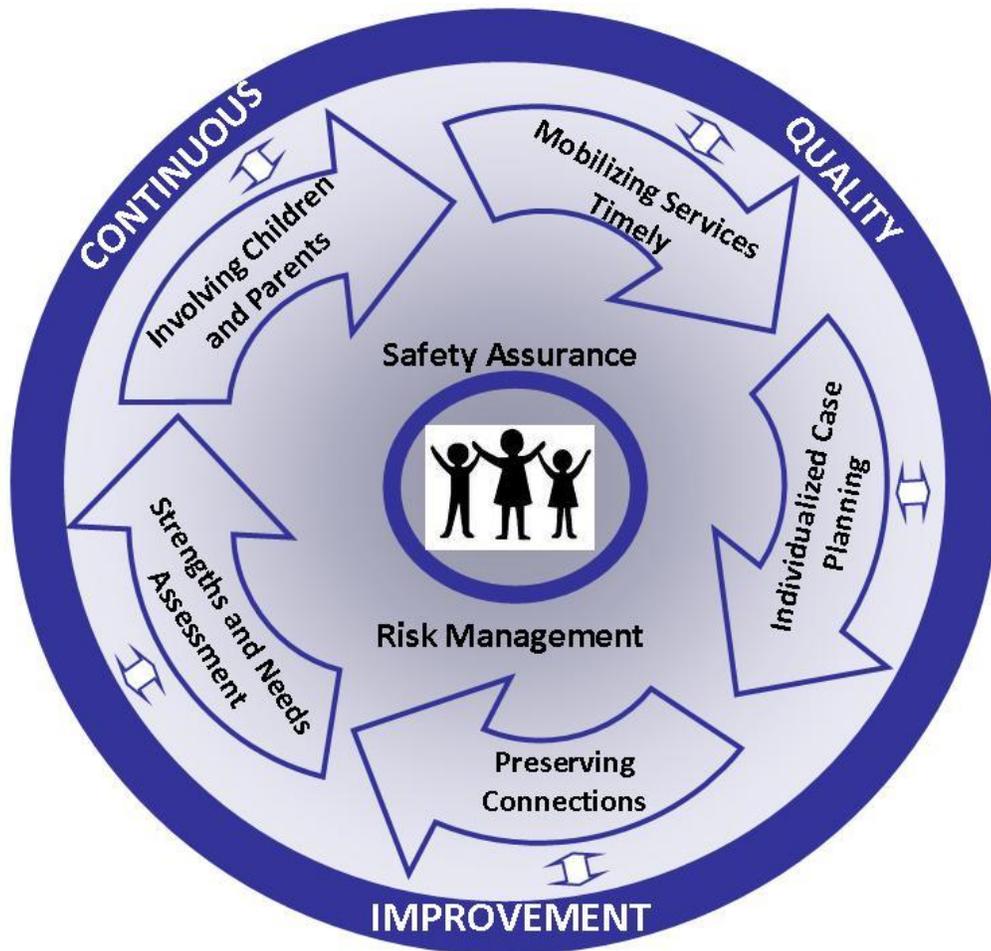
This component of the practice model emphasizes the normalizing of connections and relationships for children in foster care to the extent that it is safe and appropriate to do so. The

focus is on keeping children safe and stable within placement settings that permit them to retain important relationships with family members, retain normalized sibling relationships and friendships, important traditions and connections that define them culturally, and continue being a part of the social institutions that nurture them, such as school, religion, and so forth.

### ***Individualized and Timely Case Planning***

An individualized case plan should start with information from the comprehensive family assessment and should continue to be informed by the assessment throughout the life of the case. Individualized case plans should be developed *with* the family not *for* the family; occur early in the casework process, address underlying issues that contribute to the presenting needs; include the safety plan; demonstrate the family’s culture and level of functioning; be flexible and change as the family’s needs and progress toward achieving the identified goals change; include independent living goals and specific plans and tasks for age appropriate youth; and be reviewed and updated regularly with the family.

The six components of the practice model are tied together and support each other in providing a comprehensive family-centered approach to child welfare interventions with children and families, as depicted in the graphic below:



As illustrated in the graphic, all the agency's interventions revolve around the family, which is at the core of the practice model. At its most fundamental level, the practice model is concerned with assuring child safety and managing the risk of harm. The activities that comprise the other components are designed to protect the child and support the family's capacity to care for the child safely and appropriately, while also meeting the child's needs for permanency, stability, and well being. At any point in time, each of the components of the practice model may be at play and as the model is defined, it is important that the agency emphasize and support all components simultaneously. While each of the practice model components includes unique skills and activities and requires particular systemic supports to function, they are also highly interrelated and should be implemented in an integrated manner in order to be effective in improving outcomes for children and families. Further, the Continuous Quality Improvement (CQI) process supports the practice model by monitoring for the practices within the model. It reinforces the model by providing feedback on how the agency's interventions with children and families contribute to improved outcomes.

The components of the practice model are more than ideals and concepts. They comprise specific activities, roles, and responsibilities that will affect the work of caseworkers, supervisors, Regional Directors, service providers, resource parents, and Central Office staff in various ways.

### ***What Does it Mean to Caseworkers?***

Implementing the practice model in Mississippi will mean that all MDHS caseworkers will strengthen their skills and begin to intervene with all children and families in a family-centered way that reflects the components of the practice model. The chart that follows provides an overview of the major casework activities associated with each component of the practice model.

**Mississippi Practice Model**

<b>Mississippi Practice Model Components and Key Activities</b>					
<b>Mobilizing Appropriate Services Timely</b>	<b>Safety Assurance &amp; Risk Management</b>	<b>Involving Family Members in Decision Making &amp; Case Activities</b>	<b>Strengths and Needs Assessments</b>	<b>Preserving Connections and Relationships</b>	<b>Individualized and Timely Case Planning</b>
Link services to individualized needs in case plans	Conduct initial safety and risk assessments	Involve in strengths and needs assessments	Assess strengths and needs before developing case plans	Use assessment information to identify relationships/connections	Link services to the individual strengths and needs of each family member
Engage service providers	Initiate investigations of maltreatment	Involve in developing the case plan	Involve all family members and foster caregivers in assessment	Identify and locate relevant family members	Address individual strengths & needs in case plans
Caseworker visits	Caseworker visits	Caseworker visits	Caseworker visits	Caseworker visits	Caseworker visits
Clarify service needs when referring for and monitoring services	Initiate services to address safety and risk	Involve in family team meetings	Conduct ongoing specialized assessments	Family meetings	Engage service providers
Provide services promptly and early in interventions to address safety and risk	Conduct ongoing safety and risk assessment	During foster care placements	Conduct initial physical, dental, mental health, development and education screenings	Support family involvement with children in care	Conduct individualized case planning activities outside of a FTM when indicated
Provide ongoing services needed to attain permanency goals	Address safety and risk in case plans		Update assessment at key intervals	Address relationships and connections issues in initial and updated case plans	Link ongoing case planning to individual strengths and needs
Provide services to children in placement	Address in reviewing case plans		Use assessment to make decisions on case closure	Identify/support tribal and other cultural backgrounds	Monitor case plans and revise as needed
Provide services at the time of discharge or case closure	Ensure children are safe while in placement			Advocate for school consistency	
Monitor and evaluate the effectiveness of services	Ensure safety at reunification			Place children in settings that support connections.	
	Ensure safety at case closure			Identify and evaluate relative resources early	

### ***What Does it Mean to Supervisors?***

In each component of the practice model, we describe the roles and responsibilities of supervisors in implementing the model. Among the cross-cutting responsibilities are the following:

- ◆ Reviewing caseworkers' work for the quality and substance of the work, rather than only reviewing to see if tasks have been completed;
- ◆ Providing direct and constructive feedback to staff on the quality of their work in order to identify strengths and needs of practice and facilitate professional development;
- ◆ Monitoring for activities that comprise the practice model, such as involving all appropriate family members in decision making, ensuring that case plans are individualized, and that appropriate services are put into place timely;
- ◆ Coaching staff in effective approaches and methods that are consistent with the practice model;
- ◆ Identifying systemic needs, such as training, services, and policy that are essential to maintaining the practice model and advocating for those needs; and
- ◆ Serving as part of the broader continuous quality improvement process.

### ***What Does it Mean to Regional Directors?***

- ◆ Implementing the practice model means that Regional Directors will also need to tailor their roles and responsibilities to support practice in the following ways:
- ◆ Serving as a visible spokesperson and advocate within their regions for improved casework practice through implementation of the practice model;
- ◆ Managing to the outcomes associated with the Olivia Y settlement, COA standards, and the CFSR that are included in the practice model, by monitoring data related to outcomes and practices that are consistent with the model;
- ◆ Identifying the strengths and needs of the region's capacity to implement and maintain the practice model, and advocating with communities and others within MDHS for needed resources and supports;
- ◆ Working closely with service providers and placement resources to help ensure consistency of approach and common principles in intervening with children and families, in part by ensuring their ongoing involvement in implementation and maintenance of the model;
- ◆ Leading the design and implementation of program improvement efforts where the need is identified; and
- ◆ Holding staff and providers within the region accountable for consistently engaging in family-centered practice and for the outcomes indicated by the child welfare reforms underway in Mississippi.

### *What Does it Mean for Continuous Quality Improvement Staff?*

As MDHS implements a CQI process simultaneously with the practice model, there are implications for the roles and responsibilities of CQI staff as follows:

- ◆ The CQI process should serve as a reinforcement for practice that is consistent with the model and a support to staff in the field;
- ◆ CQI staff should regularly monitor the quality of work associated with the practice model and the outcomes for children and families that result from MDHS interventions;
- ◆ CQI should provide case-level and broader level feedback that helps staff at various levels identify the strengths and needs of their work with children and families and understand better how their interventions affect outcomes;
- ◆ CQI should provide periodic comprehensive reports that address counties, regions, and statewide effectiveness in implementing the model and improving outcomes;
- ◆ CQI should monitor for the capacity of the child welfare system to support improved practice in the field, for example through the service array, training, information system capacity, and so forth;
- ◆ CQI should monitor services provided both by MDHS and other providers in order to reinforce consistency in approach;
- ◆ CQI should include stakeholders outside of MDHS in order to facilitate broad community ownership in service to children and families and facilitate coordination among stakeholders;
- ◆ CQI should coordinate with other monitoring and oversight functions, such as supervision and the FCR in order to provide for an integrated, consistent approach to reinforcing work in the field; and
- ◆ CQI should identify needs for improvement in practice and systemic capacity and support counties, regions, and the Central Office in designing and implementing improvement strategies.

### *What Does it Mean to Others?*

There are other responsibilities associated with practice model that are essential to successful implementation and improved outcomes. The following is just a few of the key roles:

- ◆ State Office leadership will carry a large responsibility for communicating the messages of child welfare reform in the State to MDHS staff and stakeholders and for encouraging the active support of key stakeholders, such as the provider community, the courts, and others;
- ◆ Resource families and placement facility staff will need to support efforts to include parents in the lives of their children while in placement and to involve them in decision-making and planning activities;
- ◆ Service providers will need to develop their capacity to respond flexibly to the individual needs of children and families rather than offering a pre-set menu of services and programs that may or may not be matched to individual needs;

- ◆ State Office resource development staff will need to examine funding and contracting procedures in ways that solicit the services needed by children and families and to allow providers to develop their capacity to respond flexibly;
- ◆ Training staff will need to revise and develop training that is skills-based and supports the needs of staff for intervening with children and families in family-centered ways; and
- ◆ Policy staff will need to revise and develop policies that similarly encourage and guide staff in family-centered practice consistent with the practice model.

### ***How Will the Practice Model be Implemented?***

*In developing the practice model, we used a logic model approach that identifies the following:*

- ◆ The inputs needed in order to implement the practice model, including existing policy, training, monitoring, and resources and new or revised policy, training, monitoring, and resources;
- ◆ The outputs that will be produced through implementing the model, including work products related to training, policy, monitoring, and resources; roles and responsibilities of key participants, and the casework activities associated with each component of the practice model; and
- ◆ The outcomes and indicators associated with each component, including benchmarks of progress, stages of implementation, and performance indicators to be used in monitoring implementation.

The implementation plan recommendations that are included in Section IV of this report provides a plan for addressing and developing the inputs and outputs, and a schedule for working toward the outcomes and indicators. We have recommended a staged approach to implementing the practice model region-by-region within the State in order to bring up the entire integrated practice model regionally rather than attempting to implement it piecemeal statewide. There are several key features to our recommended implementation strategy, including the following:

- ◆ Each region would have a six to eight month planning phase to develop implementation plans, engage stakeholders, and prepare to implement the model;
- ◆ The planning phases will be followed by an initial 12-month implementation period that includes intense technical assistance and coaching to adopt the practices in the model;
- ◆ Each region will begin implementation with a baseline CQI review to establish a base for evaluating progress over time, followed by a follow-up CQI review approximately a year after the initial implementation process begins in order to evaluate progress and adjust implementation plans as needed; and
- ◆ Regions will continue to receive technical assistance beyond the initial implementation period in order to completely adopt the practice model and adapt its practices and systemic capacity.

We have recommended criteria for identifying the order of implementation and for staff the implementation process, including hiring an implementation manager and liaisons to the field, who will provide ongoing support to counties and regions in shaping practice and improving

outcomes. We have also provided a projected time line for implementation activities that will ensure that all regions are engaged in implementing the practice model within four years. It is important to recognize that the practice model, because it is shaped by the requirements of an encompassing settlement agreement, represents major systemic reform of child welfare in Mississippi and will take time to change practice in ways that can be sustained over time.

### ***Continuous Quality Improvement Recommendations***

In supporting the implementation of the practice model, this report also includes a section of recommendations on developing the CQI process required by the Olivia Y settlement agreement. As noted, we have recommended a CQI process that reinforces and supports practice rather than a strict compliance-based process. It should be an inclusive process that includes stakeholders outside of MDHS, and provides feedback at the individual case level at regional and statewide levels through reports that identify the strengths and needs of practice and the status of outcomes. In order to ensure that MDHS adopts a CQI process that is consistent with the principles and requirements of COA and the Olivia Y settlement agreement, we have cross-referenced those requirements to the proposed CQI process in Section V of this report.

The CQI process that we propose will review both qualitative and quantitative information. It will examine individual cases periodically and solicit input from the children, families, caseworkers, service providers, and foster caretakers in individual cases. We recommend a review instrument that mirrors the components of the practice model. We also recommend that CQI identify needed aggregate data reports and review those for outcomes. A part of the CQI process also should be the periodic review of systemic capacity within regions needed to support improved practice and outcomes.

The proposed process includes a State Office unit that will lead CQI activities statewide. We have recommended a State CQI director and liaisons for each region in the State to staff the unit, along with a data analyst and report writer. We have proposed that the State implementation team and regional/county implementation teams for the practice model double as State and local CQI coordinating bodies so that the practice model and CQI remain integrated and consistent.

The proposed plan calls for CQI to be implemented statewide concurrently with the practice model. In each region beginning to implement the practice model, CQI would conduct a baseline review and a subsequent review approximately a year later. In order not to exclude regions in the State from CQI activities until they begin implementing the practice model, however, we have also recommended interim CQI activities that can be implemented statewide early on and remain in place between regularly scheduled CQI reviews. These interim activities may take the form of either peer reviews or reviews by county CQI teams, with either option following the protocols of the CQI process.

In order to ensure that accountability is built into the CQI process, we recommend that counties/regions develop and implement program improvement plans that address the strengths and needs of practice and systemic factors identified in CQI reviews. The State Office should adopt accountability measures to ensure completion of needed program improvement plans, and Regional Directors and CQI staff should be charged with responsibilities pertaining to monitoring the completion of the plans.