Family Connection Grant:
Family Empowerment through Family Team Conferencing
Partnership for Strong Families
Grant #: 90CF0021
Final Report

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Section I: Executive Summary

This Executive Summary highlights the content of the final report for the Partnership for Strong Families' Family Team Conferencing project funded by the Children's Bureau.

Overview of the Community, Population and Needs

Established in 2003, Partnership for Strong Families (PSF) is the lead community-based care agency for Florida Judicial Circuits 3 and 8, and is contracted by the Florida Department of Children and Families (DCF) to deliver comprehensive child welfare services to children who are victims of abuse and neglect. PSF serves nearly 5,000 children in 13 Florida counties annually. Over 50 percent of referrals to DCF come from Alachua County, which is urban and suburban with some racial diversity. Most of the other counties within PSF's jurisdiction represent a homogeneous population of residents in rural communities that are predominantly white.

Given many changes to the Florida child welfare system, PSF saw a need for families to play a different role through a family engagement process that was genuine and meaningful. The grant allowed PSF to test new models of family engagement through Family Team Conferencing (FTC). The key components of the experimental FTC models were designed to align with the components of Family Group Decision Making (FGDM) and other types of family meetings that have shown the most promise or some evidence of success in specific jurisdictions. The primary population served by the project is families, including parents/caregivers and their children 18 years or younger. There have been no changes to the service recipients over the length of the project.

Overview of the Program Model

This project allowed for an evaluation of the current practice of FTCs (prior to the project) contrasted against two experimental FTC models. In the current practice model, referred to as "FTC-as-usual" (or Pathway 1), the FCC met with the family to conduct an FTC. There was no outside facilitator, no service providers were invited to the FTC, there was no family alone-time, and the family was minimally prepared prior to the meeting.

In the first experimental model, referred to as "FTC-new" (or Pathway 2), the FCC and an FTC Facilitator together met with the family. Service providers were invited to the FTC, and the family was prepared for the meeting (and was encouraged to invite their supports). The second experimental model, referred to as "FTC-new+family time" (Pathway 3), included all of the components in FTC-new, as well as alone time for the family.

There were no major modification to the FTC models made during project implementation; however, there were a number of procedural and practice/service modifications to FTC and study implementation tasks. The one major change to the system as a whole that had implications for the project was the start of Solutions Based Casework (SBC). SBC is a family-centered practice model of child welfare assessment, case planning, and ongoing casework, and was implemented into PSF's system of care for all clients.

Collaboration

To meet the needs of the families and children in these 13 counties, PSF has formal, contractual relationships with several Case Management Agencies (CMAs) to provide case management services. Also, PSF has partnered with more than 300 service providers and individual practitioners to provide a continuum of support and services to families who are involved with the child welfare system. To meet the needs associated with this project, PSF developed relationships with additional entities (e.g., nearly 120 locations were identified to provide safe, neutral and private environments to host FTCs within the catchment area).

Additionally, a strong collaboration between PSF, the Grant Operations team, the Grant Administrative team, and the local evaluators for the project was built to implement the project, study the FTC models, conduct trainings, troubleshoot, and disseminate information about the project. Through all these collaborations, PSF was able to complete the three year project successfully.

Sustainability

In discussions surrounding the sustainability of a new FTC model based on the project, it was clear that PSF's funding would not be able to support the six full-time positions that were funded by the grant. To prioritize needs, a team of FTC Facilitators would be retained to both plan and facilitate initial FTCs for new in-home supervision and shelter cases. Follow up FTCs would be completed by the FTC Facilitators if the family or another case participant felt it was appropriate. The responsibility of planning and coordinating these FTCs would be shifted to the FTC Facilitator position, as the FTC Coordinator position would be eliminated. In turn, the responsibility of making referrals for services recommended at the FTC would be shifted back to the case manager assigned to the case.

Evaluation

This study utilized an experimental design for the random assignment of families/study subjects into two experimental FTC model groups and one comparison group. A series of mixed-methods were utilized (using primary and secondary data sources) as part of a comprehensive process and outcome evaluation of the FTC models.

The main process evaluation results are highlighted below:

- Over the course of the project, a total of 1,894 FTCs (across all Pathways and time period) were conducted with 1,156 unique cases/families. Of these cases/families, 623 agreed to participate in the formal evaluation.
- The demographic characteristics of the families served were as expected. Overall, there were no statistically significant differences in these characteristics across the Pathways.
- A total of 3,410 service referrals were provided to those participating in FTCs across the Pathways over the course of the project.
- Study findings from the Questionnaire for Family Member and Professionals (QFMP) suggest that participation in FTCs is generally a positive experience for families and professionals.
- Independent observations of FTCs in the early implementation phase of the project indicated high fidelity of the FTC models with respect to facilitating the FTCs and engaging families in the decision-making process.

- Focus groups with families and service providers also indicated a generally positive experience by parents and service providers in the FTC process.
- The Community Partners Survey results showed that service providers support the FTC philosophy and approach; praise the FTC Facilitators for their skilled facilitation; believe families are respected during the FTCs; and support greater flexibility in the timeframes for FTCs.
- The project cost data suggest that the costs of service are equal across all Pathways in terms of average service costs (to the system) that result from case plans and service recommendations. The amount, type, and cost of service referrals did not change as a result of a family's participation in any FTC Pathway.

The main outcome evaluation results are highlighted below:

- It is important to note that there was an imbalance in the numbers of study subjects included in the samples due to lower participant response rates for Pathway 1. Therefore, the findings should be interpreted with caution.
- The Protective Factors Survey (PFS) was used to measure safety. For Pathway 2, the protective factor of family functioning increased over time; for all other scales of the PFS, there were no statistically significant changes over time. For Pathway 3, there were no significant changes over time to any protective factor.
- The outcomes of permanency and stability were analyzed using secondary data from the state SACWIS system. The results suggest that the re-entry rate for Pathway 3 cases (30.4%) was significantly higher than the rate observed for Pathway 2 (10.2%) cases but not necessarily for Pathway 1 cases (14.9%). The rate of re-entry for Pathway 1 cases did not differ statistically from the re-entry rate for Pathway 2 or Pathway 3 cases.
- Reunification within 12 months of entry into care was also analyzed. The reunification rate for Pathway 1 (58.8%) was significantly higher than the rate observed for Pathway 3 (36.6%) but not Pathway 2 cases (50.3%). The reunification rate for Pathway 2 cases did not differ significantly from Pathway 1 or Pathway 3 cases.
- When the actual number of placements was examined, there were no significant differences in the average number (and variance) of placements of children from Pathway 1 (Mean=1.56, SD=1.094, Range 1-9), Pathway 2 (Mean=1.63, SD=.893, Range=1-5), and Pathway 3 (Mean=1.57, SD=1.031, Range=1-8).
- Using panels of cases for available baseline and follow-up scores on the Strengths and Difficulties Questionnaire, Pathway 2 children were rated as having a significant reduction in Hyperactivity. The average Total Difficulties scores for Pathway 2 children showed a significant reduction from an average score within the "abnormal" range to an average score within the "borderline" range. With respect to Pathway 3 children there was a statistically significant reduction (a positive trend) in the average scores measuring Emotional Symptoms, Conduct Problems, Hyperactivity, and Total Difficulties.
- Findings from the Goal Attainment Scale suggest that Pathway 2 and Pathway 3 cases to have a more significant impact in moving families toward plan of care goals. These same effects were not manifested with Pathway 1 cases.

Conclusions

The design of our FTC models was intended to genuinely involve parents/caregivers, children, and their family and non-family supports in decision making around their service plans. This aim was undoubtedly achieved in the project, as evidenced by our extensive process evaluation that tracked the participation of parents/caregivers, children (as appropriate), and family and non-family supports, as well as directly solicit the experience of those involved in the experimental FTCs. In addition, results from the QFMP suggest that all three Pathways were implemented with fidelity, participants were adequately prepared and the family was clear on their role, the family members were active participants and empowered, participants (including family members) were satisfied with the process, and the outcomes (especially related to case plans) were appropriate, clear, and in keeping with the goals and objectives of FTC.

The most significant impact the project had on the partner organizations was the value placed on the FTC process. This project called to attention the importance and value of skilled and highly trained non-case carrying professional staff to plan and facilitate FTCs. FCC/Case Management staff began to prefer when families on their case load were assigned to FTC Pathways where a facilitator and coordinator would be involved. As a result of this project, Family Team Conferencing is now a core part of PSF's system of care.

The child welfare community would benefit tremendously from a process/practice that involves families and their supports in decision making. Although the outcomes do not indicate unquestionable support for FTCs in the way we designed them (that is, in terms of better outcomes in permanency, reunification, recidivism), it is a process that was supported by administrators, FCCs, families, service providers, and other community partners. This is beneficial, not only for the families but for the community as a whole. In order to support families and not punish them, FTCs that truly empower families are critical to the child welfare practice.

Recommendations

Recommendations to administrators of future, similar projects include:

- Use the dedicated facilitator model (Pathway 2) that separates the primary role of the FTC Facilitator from the role of the Family Care Counselor.
- Allow for quick/immediate engagement of families regarding the FTC process.
- Encourage but not require follow-up FTCs.
- Encourage family members to seek and involve family and other supports in the FTCs and as part of their broader service plan.
- Minimize the role of Family Care Counselors in data collection activities apart from that which is mandated by state statutes.
- Engage in regular and effective communication between FTC project and administrative staff and key service providers to help facilitate achievement of family and case goals.
- Encourage a culture change that embraces the philosophy of FTCs in the day-to-day practices of FCCs.

Recommendations to project funders include:

- Give more time to roll out the project, especially given the time and effort that is involved in gaining Institutional Review Board approval for evaluation activities and training efforts for new practice models to be tested.

- Include other outcome measures in addition to the CFSR standards. Set a minimum number of valid measures that supplement available secondary data from the state SACWIS system.
- Consider a standard measure or set of outcome measures that could be used by all grantees (to measure processes or outcomes) assuming that the nature of the work is similar.

Recommendations to the child welfare field:

- Consider a staggered introduction of major system or practice changes over time so that sufficient information regarding the impact of one intervention or system change can be assessed before another practice or system change is introduced.
- Have in place a well-structured and user-friendly Management Information System to monitor and evaluate any newly introduced practice or system change.
- Be prepared for a major time commitment to changing practice to involve families in decision making that is genuine and meaningful.

Section II: Community, Population and Needs

Grantee Organization

Established in 2003, Partnership for Strong Families (PSF) is the lead community-based care agency for Florida Judicial Circuits 3 (C3) and 8 (C8). PSF is contracted by the Florida Department of Children and Families (DCF) to deliver comprehensive child welfare services to children who are victims of abuse and neglect. PSF also works with at-risk families to prevent child abuse and to decrease the risk of children entering the out-of-home care system. To meet the needs of the families and children in 13 counties, PSF partners with several non-profit agencies to provide case management services. In addition, PSF partners with more than 600 service providers and individual practitioners in Circuit 3 Circuit 8 to provide a continuum of support and services to families who are involved with the child welfare system.

Community Contexts

PSF serves nearly 5,000 children in 13 Florida counties annually, including Alachua, Baker, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Madison, Suwannee, Taylor and Union Counties. Most of the referrals to DCF (over 50 percent) come from Alachua County. Based on the 2000 Census, 2005 Census estimates, and 2007 Bureau of Economic and Business Research[1] at the University of Florida estimates (U.S. Census Bureau, 2000; Bureau of Economic and Business Research, 2008)[2], Alachua is the largest county in C8, and is growing at a fast rate. The county, which has over 200,000 residents, has a younger population, is urban and suburban, and is

[1] Bureau of Economic and Business research (BEBR) produces Florida's official state and local population estimates and projections.

[2] U.S. Census Bureau (2000). *Census 2000 Data for the State of Florida.* Available on-line at: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml; and Bureau of Economic and Business Research (2008) *Florida estimates of population 2007: April 1, 2007.* Gainesville, FL: University of Florida.

moderately diverse with respect to race/ethnicity (e.g., African American residents represent about 20 percent of the county compared to 10 percent or less in some smaller counties, or 30 percent or more in others). The smaller proportion of families involved in DCF generally shares similar characteristics. There are outlying counties such as Madison, which has a comparatively smaller white population (i.e., African American residents represent 40 percent of the county). Most of these counties, however, represent a homogeneous population of residents in rural communities that are predominantly white, and have a population size of 30,000 residents or less.

Primary Issues Addressed by Demonstration Project

In 2007, Casey Family Programs (CFP) contacted the Secretary of DCF to determine how CFP could partner with Florida to help safely reduce the number of children in care by 50% by 2020. The Secretary referred CFP to the Regional Administrator for Northeast Florida to begin developing a plan for systems change. In 2008, CFP began contracting with the Secretary of DCF to provide technical assistance and grant funds to help support major system changes in the child welfare system in Northeast and North Central Florida. In April of 2008, DCF and PSF staff in C3 and C8 began meeting to develop a plan to implement major system changes in the child welfare system, to safely reduce the number of children in foster care by 50% by 2020. The change initiative was called the "Foster Care Redesign" (Redesign) and the action plan for C3 and C8 was finalized and began to be fully implemented in October of 2008.

As Phase 1 Redesign changes were beginning in 2008 the focus was on co-locating PSF staff with Child Protective Investigator staff to improve communication and coordination. In addition, new staff members were hired to access services for cases diverted from the formal child welfare system, as well as open in-home supervision and shelter cases. New staff were also hired to coordinate Multi-disciplinary Decision Team Staffings to ensure that a team of professionals was working together to help ensure that all children who remained in their homes were safe and that those who were removed were placed with relatives, if possible. While professional team decisions were becoming the norm for many high risk cases, an internal examination of practices suggested the family had limited, if any, involvement in decision making, case planning, or ongoing service provision. In addition, data showed that the re-referral rate for our service area was higher than the state average. After further analysis it became clear that families were being required to complete an array of services that was often overwhelming and there was limited, if any, family engagement in case plan development or service linkage. In turn, non-compliance with case plans was very high and many in-home supervision cases were being closed without engaging the family in the right services and supports that could have helped increase protective factors and reduce future risk of abuse and neglect.

As the system changes noted above were being made, it became clear that families needed to play a different role in the entire process. After reviewing the literature on promising and best practices for family engagement and after consultation with several national experts, the leaders and staff at DCF and PSF decided that it would be beneficial to develop more effective strategies for engaging families in decision making and case planning throughout the life of a case.

The first step was to conduct several expedited Family Team Conferences (FTC) with a few families with new in-home supervision or shelter cases within 5 days of the commencement of the investigation. A "small test of change" was conducted and several families participated in an expedited FTC that included their extended family and service providers. The goal was to determine if implementing expedited FTCs would be feasible with the existing staff and if it would be

beneficial for families. The small test of change showed that the FTC was a positive experience for the families involved and that service providers were willing to participate in an FTC to insure that services to the family could be expedited. Existing staff had received a series of trainings on Family Team Conferencing and had the skills to facilitate the FTC, but unfortunately, once the small test was completed it became clear that conducting a quality FTC was a labor and time intensive process. With existing resources and staff, PSF could not continue to conduct expedited FTCs for all new in-home supervision and shelter cases.

Population Served

The primary population served by the project was families, including parents/caregivers (typically the biological mother and/or father, but also includes guardians, adoptive parents and foster parents) and their children 18 years or younger.

The population that was served by the project is also described in the following ways:

- The project (i.e., providing FTCs) served all new in-home supervision and shelter cases unless there was a serious safety concern or the family was not available to participate (e.g., incarceration of parents and no extended family available).
- Family supports are other family members, friends, or family advocates who are invited by the family to participate in the FTC.
- Youth ages 10 and older were invited to participate in the FTC. Children younger than 10 years were given an opportunity to share their views prior to the FTC.
- Cases in which domestic violence was an issue included a Danger Assessment that was completed prior to the FTC by a counselor at the local domestic violence agency to conduct a thorough assessment of risk and safety concerns. In addition, a support person accompanied the victim to the FTC to protect her emotional and physical safety. If the victim did not have a support person, a counselor at the local domestic violence agency served in that role. If there were safety concerns that could not be addressed, a separate meeting was held with the batterer and if possible a staff person *from* a batterer's intervention program was invited to participate.

The service recipients did not change over the length of the project. Based on project reports, the service recipients were as expected, as indicated by service referrals/needs. For example, between May 2010 and March 2012, a total of 3,015 service referrals were provided for all caregivers/parents (1,926 referrals) and children (1,089 referrals) on caseloads at PSF. For parents and caregivers, 37.5% of all referrals were for parenting classes, followed by 36.9%, 15.8%, and 8% of referrals for mental health, domestic violence, and substance abuse services, respectively. For children, 50.9% of all referrals were for behavioral and parenting classes/services (that included children), followed by 45.8% for mental health services. A content analysis was conducted of the service plans and plans-of-care developed within the context of FTCs where study participant families were active contributors and prioritized and approved their service goals. This analysis revealed those issues of most prominence, including mental health needs (23.8% of all goals), case planning issues/needs (23.1%; i.e., caseworker and family members' tasks to help the family receive services, addressing care matters, etc.), substance abuse issues (12.8%), domestic violence issues (8.4%), and housing needs (8.3%). Other goals focused on employment (5.7%), education (4.6%), daycare (3.3%), visitation (3.3%), dental and medical needs (3.1%), and safety planning (2.8%). Service referrals and the expressed needs of families participating in the FTCs indicate the need for specialized mental

health services for caregivers and children often struggling with the effects of trauma of specific maltreatment events, family/parental dysfunction, and/or environmental conditions/stress that have had a detrimental effect on the development of children and the stability and protective factors within families.

Section III: Overview of Program Model

A. Project Goals and Objectives

There was one major goal and several objectives associated with this project.

Goal: To respectfully engage families in decision making and case planning through a strength based, family-centered, culturally appropriate system of care that includes initial and ongoing Family Team Conferences for every new VPS and shelter case.

Objectives:

1. Hire and train 4 full-time Family Service Facilitators (FSF) who will serve as the facilitators for all initial and ongoing FTC's for a random sample of new VPS and shelter cases. Hire 2 full-time Family Team Conference Coordinators to help coordinate all the planning and logistics for the FTC's.

2. Insure meaningful participation in case planning and decision making of families participating in an initial and ongoing FTC.

3. Increase participation of children and extended family members in initial and ongoing FTCs for families with new VPS or shelter cases.

4. Increase participation at initial and ongoing FTCs of the service providers who can meet the immediate and ongoing needs of families with new in home supervision or shelter cases.

5. Insure expedited services are provided to all of the families who participate in an initial FTC.

6. Improved "Goal Attainment Scale" score for the families who participate in an initial and ongoing FTC (measured by completing and monitoring the Goal Attainment Scale).

7. Increased protective factors for the families who participate in an initial and ongoing FTC (measured by administering the Protective Factors Survey).

8. Within 90 days of FTC reduce risk of the families engaged in an initial FTC, based on the SDM risk reassessment.

9. Reduce re-referral rates among families who have received an initial and ongoing FTC.

It was initially hoped that through the implementation of our new FTC models and our rigorous evaluation plan we would be able to measure the efficacy of three FTC models that and help inform

policy, practice and theory development. Toward this end, the lessons we hoped to learn from this project included:

i. The impact of having a non-case carrying, skilled facilitator for each initial and ongoing FTC
ii. The impact of having time for the family to prepare for the FTC
iii. The impact of including the extended family and support system in the FTC The impact of having service providers involved in the FTC
iv. The impact of immediately approving and connecting families to the services they need
v. The impact of having alone time for the family
vi. The impact of having a support person attend the FTC when there is a co-occurrence of domestic violence
vii. The impact of having two separate FTCs when domestic violence has occurred
viii. The impact of having ongoing FTCs within two weeks for all in home supervision cases
ix. The impact of having ongoing FTCs at critical junctures throughout the life of each case

With the new FTC models we expected to see an increase in child and family involvement in case planning and decision making. In turn, as family engagement improves we expected to see an increase in the number of children who are safely maintained in their homes. Through initial and ongoing FTC's we expected to see more families engaged quickly in the formal and informal services and supports they need to meet their needs and help protect their children in the home. In addition, we believed that when the right services and supports are in place, to meet the family's needs we will not only prevent removal, but we will reduce re-entry into foster care. In turn, when FTCs are successful and families are able to get the services and supports they need, we expected to see an increase in the number of families who have enhanced their capacity to provide for their children's needs. It was expected/hypothesized that these results/outcomes would be more pronounced with the experimental models that embodied some features (including the use of facilitators and the use of family alone time) recommended within the literature that were not utilized with the current practice (prior to the study) of FTCs at the Partnership for Strong Families.

B. Project's Logic Model

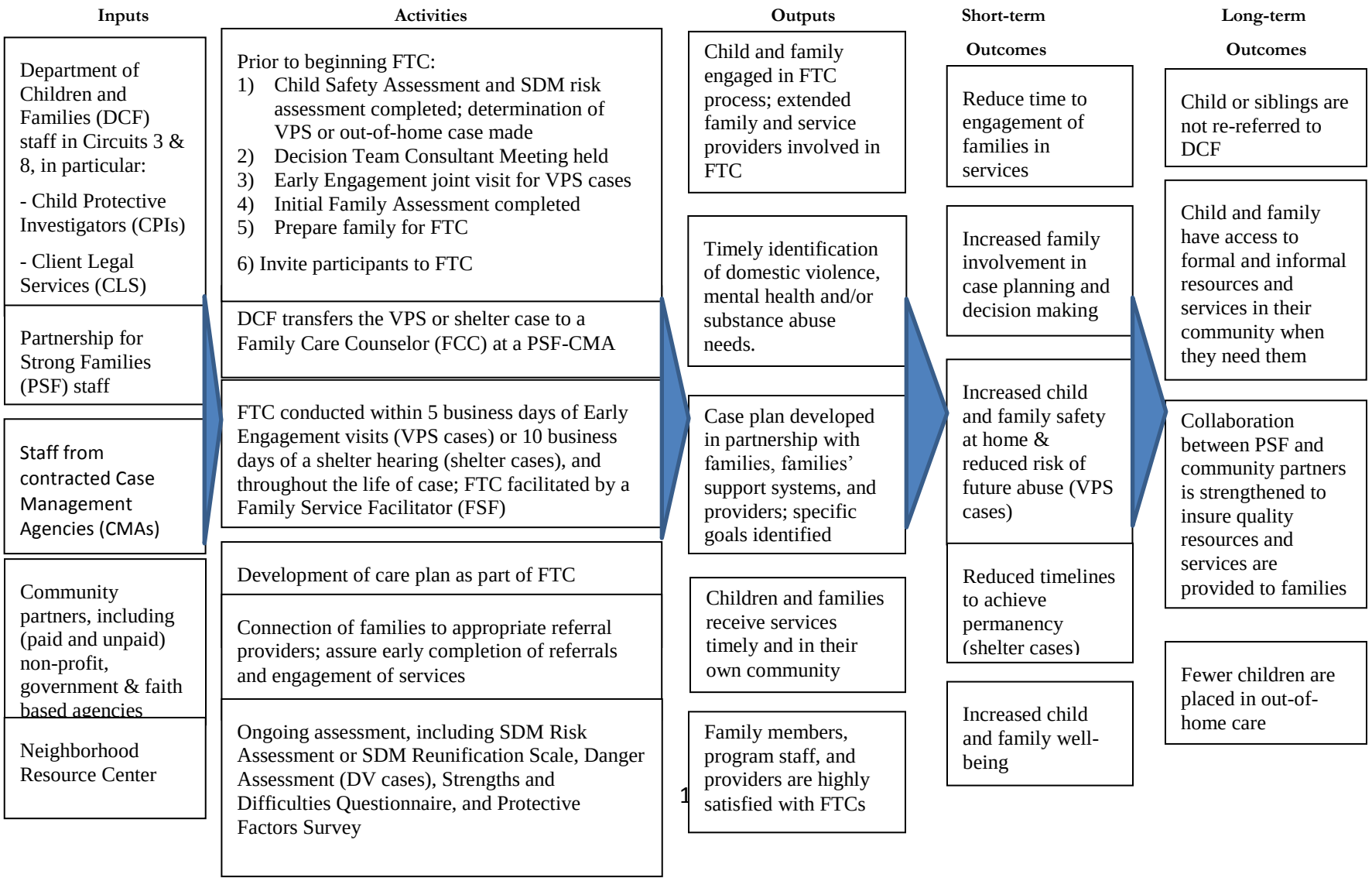
The Logic Model originally submitted for this project is denoted on the next page.

Partnership for Strong Families Family Team Conferencing

Logic Model

Target Population:

Children and families in Voluntary Protective Supervision (VPS) or out-of-home care/shelter care in 13 counties throughout Circuits 3 & 8



C. Program Model

i) Description of FTC Models

The integration of the Family Team Conference (FTC) into Partnership for Strong Families system of care stretched back several years prior to the start of this project. During the initial phases of this integration FTCs were conducted by all Family Care Counselors (FCC) on their respective cases and were mandated to occur within 14 days after the case was transferred from the Child Protective Investigator (CPI) to the FCC. For a short time this model was supplanted by specialized teams more highly trained in conducting these types of family network services. As these specialized teams were actively engaging families and bringing together a more natural network of supports, it became apparent that this previous model that had been implemented by the FCC's needed reinforcement in several key areas. During the FTCs, families had no time alone to discuss the suggestions and plans put forth by others attending the conference. In so doing, family specific ethnic and cultural decision making practices were not a priority. Complicating the provision of services was the lack of direct contact or knowledge with community providers. Often times, plans included services that were either not available in the area where the family lived or services were not targeted to the family. The final area in which the initial model faltered, FTCs were conducted early in a case, yet rarely were there routine follow-up FTCs or monitoring of the family goals and progress. As a constellation, the cultural ownership and sensitivity was lacking, direct connections to services were missing and follow-up and continued assistance through FTCs was not offered. Each of these areas, it was thought, significantly weaken the impact of FTCs. Due to high turnover of staff the specialized team concept was eliminated and FCC's continued to facilitate and plan FTC's for each family on their caseload; however, without any formal monitoring or evaluation of their success.

PSF has implemented a Utilization Management model since July 2007. This model was designed to shift services from a programmatic orientated system to a distinct unit based model which supports an individualized service plan for each client. This demonstration project employs the Family Team Conference model.

The new FTC model is one component of the Foster Care Redesign Initiative advanced by DCF and Casey Family Programs.

This project allowed for an evaluation of the current practice of FTCs (prior to study implementation) contrasted against two experimental FTC models guided, in part, by recommended or best-practice standards from FTCs. Please see the original proposal for an itemization of the literature supporting the form and structure of the experimental models. In total, this project intended to test the value and effectiveness of three FTC models.

The **first model** focused on conducting FTCs using the same model and process that was currently being implemented by Family Care Counselors (FCC) at the PSF case management agencies. This model was called **"FTC-as usual"** (or **Pathway 1**) and would occur within 14 days of the case transfer staffing. The FCC would meet with the family to conduct an FTC. There would be no outside facilitator, no service providers would be invited to the FTC, there would be no family alone time, and the family may be minimally prepared prior to the meeting.

In addition, there were two experimental models. The first one (as originally proposed) was called **"FTC-new"** (or **Pathway 2**) and included the following components:

FTCs will be mandatory for all "new" in home supervision and shelter cases unless there is a serious safety concern or the family is not available to participate- (i.e., incarceration of parents and no extended family available). Current PSF policy mandates FTCs for every family.

- During the first home visit with the family the FCC explains the purpose of the FTC and obtains consent from the family to plan the FTC.
- To help prepare families with open in home supervision cases for the FTC, the FCC will begin discussing the FTC process with the family during the in home supervision Early Engagement visit, which occurs within 48 hours of the commencement of the investigation. For shelter cases the FCC will begin discussing the FTC prior to the shelter hearing. The FCC continues to prepare the family for the FTC through phone calls and when possible, at least one in-person visit.
- If the father is not living in the same home as the mother the father will be contacted by phone, letter, or if possible through a personal visit and invited to participate in the FTC.
- Preparation time with the family will be approximately 4 days for in home supervision cases and 9 days for shelter cases.
- For all new in home supervision cases, the FTC will be conducted within 5 business days of the VPS Early Engagement visit and for all new shelter cases the FTC will be conducted within 10 business days of the shelter hearing.
- The family will be asked if they would like to include their biological and extended family members and support system in the FTC. Any requests to exclude an individual will be addressed on a case by case basis.
- The FCC and FTC Coordinator will work together with the family to invite all participants to the FTC. Invitations will be made through face-to-face visits, phone calls, or letters.
- If a family member cannot attend the FTC in person the FTC Coordinator will obtain their input in writing, on a DVD, etc. at least one day prior to the FTC. Teleconference options will be discussed with the family if requested.
- Providers who are presently working with the family or may be able to provide ongoing services will be invited to participate in the FTC.
- Youth ages 10 and older will be invited to participate in the FTC and those who are younger will have an opportunity to share their views prior to the FTC.
- If there are domestic violence issues the Danger Assessment will be completed prior to the FTC by a counselor at the local domestic violence agency to do a thorough assessment of risk and safety concerns.
- If there are domestic violence issues a support person will accompany the victim to the FTC to protect their emotional and physical safety. If the victim does not have a support person, a counselor at the local domestic violence agency will serve in that role. If there are safety concerns that cannot be addressed a separate meeting will be held with the batterer and if possible a staff person from a batterer's intervention program will be invited to participate. (The domestic violence agencies in our Circuits have agreed to partner with us on all FTC's with domestic violence issues).
- The FTC will be scheduled at a time that is convenient for the family, in a neutral location, that is family friendly (i.e.,: the Neighborhood Resource Center, family visitation center, etc.).
- All critical case facts will be shared with all the participants at the FTC.
- A non-case carrying Family Service Facilitator (FSF) will facilitate the FTC.
- There will be no family alone time in this model.

- Child care will be provided if needed.
- Transportation assistance will be provided if needed.
- Snacks and drinks will be served at the meeting if the family wants them.
- The meeting will last approximately 2 hours.
- The Goal Attainment Scale (GAS) will be completed with the family by the FSF at the FTC and will be incorporated into the final case plan. The plan will include timelines for activities, persons responsible for implementing plan components, services to be received, dates for reviewing progress, and how the FCC and the family will monitor successful completion of the plan. The final plan will be distributed to all participants.
- The final case plan will be developed by the family with input from the extended family, the family support system, the FCC and service providers, the FCC supervisor will approve the final plan if safety concerns have been adequately addressed.
- For in home supervision cases a 2 week follow-up FTC will be held and will be initiated by the FSF.
- For shelter cases a follow up FTC will be held at 4, 7 and/or 10 months and prior to an adoption staffing.

The second experimental model was called **"FTC-new+ family time"** (**Pathway 3**) and included all of the components listed above and alone time for the family. During the alone time the family will have the opportunity to develop a case plan that will be shared with the FSF and FCC and if it addresses all the safety concerns it will begin to be implemented immediately following the FTC. In this model the following differences exist:

- The family will have alone time to develop their plan.
- The final family plan will be approved by the FCC, the family and the child's attorneys as long as all safety concerns have been adequately addressed.
- The FTC may take 4-6 hours.

As outlined above, the two experimental FTC models include the components of practice that have shown to be most effective in engaging families in a strength based, culturally appropriate manner in decision making and case planning. Each model would be evaluated and compared against the control/comparison group of families who participate in the FTC process that was being implemented by PSF through the FCC's (FTC-as usual).

ii) Modification to the Model

There were no major modification to the FTC models; however, there were a number of procedural modifications in order to address unforeseen issues or problems that impacted implementation of the experimental FTCs (and their evaluation). Additionally, there were some modifications to agency practices and services (addressed in the next sub-section) that required some modification of FTC and study implementation tasks. The following represents modifications to the model and/or its implementation:

Follow-up FTC meetings scheduled for at 4 and 7 months moved to 3.5 and 6.5 months (two weeks earlier). After extensive and thoughtful discussion of this timeline with the project implementation team, and extensive feedback from administrative, project, and front-line staff, it became evident that a minor shift in the timeline for FTC meetings was necessary to accommodate various levels of service delivery. At the same time, it was critical to ensure that contact with families

via the FTC and other means was both timely and spaced out so that back-to-back meetings did not overwhelm families. Subsequent FTCs would remain the same with the exception of the 12-month FTC, which would now take place at 14 months in order to better space out the FTC's after the 10-month FTC.

Expanding child participants from those 10 and older to children of all ages (when appropriate).

Discontinued Use of SDM Risk Assessment. The State of Florida discontinued the use of the Structured Decision Making Risk Assessment tool.

Change in protocol for facilitating contact and family involvement in Initial FTCs. It was originally proposed that the In-Home Supervision case Initial FTCs would be completed within 5 business days of the Early Engagement home visit and the shelter cases would be completed within 10 days of the shelter hearing. Within the first few months of the project, the timelines were averaging (some modifications existed) approximately two days longer than designed. After close examination by grant staff and Case Management Agency staff, it was agreed that rather than waiting for the FTC Coordinator to call the family independently of the Early Engagement visit (the first joint visit with the family between the FCC and the PI), the FCC would call the FTC Coordinator from the home while meeting with the family for the Early Engagement Visit. Calling from the home serves to speed the time of contact between the Coordinator and the family and reduce the opportunity for delays due to a lack of family contact (follow up on phone messages to schedule the FTC).

Change in scheduling priorities. Within the summer of 2010, front-line staff (including FCCs) employed at member agencies had their pay changed from a salary to hourly rate. FCCs were no longer permitted to work overtime in any given week or allowed to "flex" time worked in one week to the next. Some FCCs reported to the Principal Investigator that should unexpected case demands be manifested (a common occurrence) during the week and an FTC (requiring 2-3 hours) is scheduled at the end of the week when 40 hours of work has already been logged, attempts were made on the FCC's part to re-schedule the FTC or it would be cancelled. Considerable effort was made to explore with all parties a resolution to these issues. A protocol was established to that included an availability request to the family, the FCC, and the FTC facilitator. The FTC Coordinator would then use these schedules to set up the FTC within the required 5 or 10 business days. The Coordinator would use the family's and the FTC Facilitator's schedules to set up the appointment, taking into account the FCCs schedule as best as possible. Should the designated appointment not fit the FCCs schedule, the CMA would bear the burden to find a suitable back up staff person. The proposed plan will serve to limit the number of FTCs delayed due to FCC scheduling issues and quicken the rate in which families can engage in services.

D. Describe the project's key interventions and activities.

i. As appropriate, specify which service recipient (e.g., parent, child, family, other) participated in each activity.

As noted in a description of the FTC models (and review of evaluation findings), parents, children, extended families, and family supports were all potential participants of FTCs, with parents, children, and other family members being the focus of services.

As part of PSF's initial proposal, it was the intention to include children, ages 10 and up in Family Team Conferences, as long as they were developmentally mature enough to meaningfully participate in the conference. Some FTC Facilitator staff had concerns with this part of the proposal, verbalizing the necessity to protect children who had been victims of abuse from further trauma. Consultation on this matter was obtained from the American Humane Association where it was suggested that that children of all ages be included in Family Team Conferencing, when appropriate. After receiving this information, PSF decided to engage children of all ages in Family Team Conferences, where appropriate. Although there are many instances where children's participation in the conferences may be appropriate, several barriers (related to child care issues, securing a neutral child friendly locations, and scheduling so as to not conflict with school hours) were encountered.

Key program interventions and activities.			
Services for Families	**Services for Parents**	**Services for Children**	**Other Key Services**
Decision Team Consultant meeting	Mobile Crisis Response Team members to help alleviate any immediate needs	Referrals to forensic/medical examinations with feedback loops and referral processing	
Early Engagement joint-visit for VPS cases	Community referrals to health and employment resources	High Risk staffings for cases meeting criteria such as very young children and previous shelter instances	
Initial family assessment	Parenting Competency and Behavioral Analysis to strengthen parenting skills	Daycare and educational resources considered for every child	
Preparation for Family Team Conferencing (FTC), which consists of: introductions, review of family history, discussion of strengths, needs, barriers to success, and case plan development.	All parents are considered for FTCs and contacted if available to ensure parent involvement.	Considered for FTC involvement based on maturity level. Involvement in some portions of the FTC is limited based on a determination of maturation.	
Facilitation of FTC within five business days of Early Engagement visit or 10 business days of shelter hearing, and throughout the life of			

the case.			

Key program services implemented.			
Service	**Who will implement the service?**	**On what timeline is this service implemented?**	**Where is this service implemented?**
Conduct Decision Team Consultant Meeting	The Child Protection Investigator (CPI), CPI supervisor, Decision Team Consultant, Operations Program Administrator, and Children's Legal Services	Once sufficient information is collected to assist in the determination of case progression – done prior to the closure of a CPI investigation	Alachua, Columbia and Suwannee Counties
Conduct an Early Engagement joint visit (in-home supervision cases) designed to expedite case assignment	Family Care Counselor (FCC) and CPI	No later than 2 business days from the commencement of the investigation	Entire catchment area
Complete an initial family assessment	FCC and CPI	During the Early Engagement Joint Visit	Entire catchment area
DCF transfers the in-home supervision or shelter case to a Family Care Counselor (FCC) at PSF-CMA	Child Protection Investigator and the Family Care Counselor	Within one business day after the Early Engagement Visit	Entire catchment area
Prepare the family for FTC and invite participants	Family Service Facilitator and FTC Coordinator	Begins once the decision has been made to involve case management staff and after assignment has been made to the Grant FTC staff members	Entire catchment area
Participate in Family Team Conferencing which includes: introductions, discussion of family history, strengths, needs, barriers to	Family Service Facilitator and FTC Coordinator	Within five business days of Early Engagement visit (In-Home supervision cases) or 10 business days of shelter hearing (shelter cases)	Entire catchment area

success, case plan			
Families are connected to appropriate referral providers	Family Service Facilitator	Referrals are required to be completed within 2 business of the FTC	Entire catchment area

ii. Note which interventions and activities were: a) evidence-based practices, or b) best / promising practices. Indicate which interventions and activities are culturally-based ("culturally based" refers to a practice developed for or rooted in a particular culture, and that was chosen by the grantee to be responsive to the service population).

The key components of the proposed experimental FTC models are aligned with the components of FGDM and other types of family meetings that have shown the most promise or some evidence of success in specific jurisdictions. The key components include:

- A non-case carrying facilitator who will facilitate each FTC
- The family will be prepared for the FTC
- The extended family and support system will be involved in the FTC
- Key service providers who can meet the family's needs will be involved in the FTC and provide expedited services
- The family will have alone time to develop their own case plan
- A support person will prepare the victim and attend the FTC when there is domestic violence involved
- Follow-up FTC's will be conducted at critical junctures throughout the life of each case.

Research has shown the benefits of having a non-case carrying, skilled, facilitator help organize and facilitate each family meeting (Connally, 2006; Duke University, Center for Child and Family Policy, Terry Sanford Institute of Public Policy, 2006). In addition, research has shown that preparing the family for the meeting and including older youth, as well as the extended family and the family's support system is very empowering and can have a positive impact on family outcomes (Edwards & Sagatun-Edwards, 2007; Holland, et al., 2005; Koch, et al., 2006; Horwitz, 2008; Pennell, 2006). Research has also shown that due to poor follow through and follow-up many families do not engage in services timely or at all (Edwards, et al. 2007; Marsh & Walsh, 2007; Pennell & Burford, 2000). Therefore, it is important to have providers participate in the FTC's so they can begin to develop rapport with families and be able to engage them in the right services quickly. Some studies have shown that alone time for the family is empowering and helps insure more commitment to the case plan and overall family goals (Connolly, 2006; Holland, et a1., 2004; Holland, et al., 2005; Pennell, 2006; Walton, et al. 2005). There have been mixed results regarding the impact of alone time for the family on outcomes but some suggest alone time for the family does increase family satisfaction and buy-in with case plan goals. There is also some research that has shown the importance and benefit of conducting follow-up family meetings to insure that families have the supports and services they need to succeed (Edwards, et al. 2007; Marsh & Walsh, 2007; Pennell & Burford, 2000).

Since there is such a high co-occurrence of domestic violence and child abuse and neglect our model of practice attempts to maximize a safe engagement of victims and their children in family meetings via a partnership with domestic violence agencies and use of a domestic violence advocate hat serve

as the victims support person during the family meeting. This helps insure the victim's emotional and physical safety. In addition, it is recommended that if it is not safe for the batterer to participate in the family meeting the facilitator should determine the best way to get the batterers input to address the safety and risk factors that exist (Salcido-Carter, 2003).

What best practices, evidence based models, or practice based evidence is the program implementing?				
Practice	**Why was the practice chosen?**	**Is this an established or developing practice?**	**Is this practice culturally based?**	**How will practices and models be adapted to fit the community context?**
Non-case carrying facilitator to facilitate each FTC.	Research has suggested that planning and facilitating an FTC is a labor intensive process, therefore it is beneficial to have a facilitator free from case management responsibilities.	Developing practice	Yes	Facilitators are specifically trained to deal with the cultural differences that are present in our catchment area.
Family will be prepared for the FTC.	Preparing the family for the FTC can potentially empower the family members as they work to determine the best interests of the children.	Developing practice	Yes	Preparation includes the calling of invited team members to better integrate the community and social supports into the process.
Extended family and support systems will be involved in the FTC.	Including other key family members in the FTC can empower the family as they work to determine the best interests of the children.	Established practice	Yes	
Key service providers will be included in FTC and will offer expedited services.	Service providers who participate will be positioned to provide families with services in a timely manner and establish good rapport.	Established practice	Yes	

Families will have alone time to develop case plans.	While there are mixed results regarding family alone time, research has shown that it can increase family satisfaction and buy-in with the case plan, and ultimately empower the families. Private family time allows families to incorporate their family knowledge based on their ethnic and cultural decision-making styles.	Developing practice	Yes	Based on the context, FTC facilitators will use their judgment on determining who should be involved in the 'alone time' as cultures may dictate that other 'Community elders' be represent along with the bio family members.
If there is domestic violence, a support person will prep the victim and attend the FTC.	In addition, involving a domestic violence advocate in FTC will support the emotional and physical safety of the victim and the children.	Established practice	Yes	
Follow-up FTC's will be held at other key junctures throughout the case.	Ongoing FTCs are important during the life of the case to make sure the family is progressing with their case plan goals, identifying areas for modification or improvement, and accessing any necessary services.	Established practice	Yes	

As denoted below in more detail, a Solution Based Casework model was added as a system-wide model of casework practice to be integrated with the model FTCs being tested as part of this grant. Solution Based Casework is evidenced based, and research revealed improved performance in studies involving child welfare federal outcomes where the SBC model was utilized and trained with high fidelity (Antle, Christensen, van Zyl, & Barbee, 2012; Antle, Sullivan, Barbee, & Christensen, 2010; Christensen, & Todahl, 1999).

iii. Note if there were there any key interventions that were added or removed during the three years of the project.

There was one major change within five months of the start of the study with respect to the service delivery system that impacted all clients. On September 20th, 2010 PSF rolled out a new casework

model to assist our Case Management Agencies' refocus efforts in a time of ever increasing burdens. This casework model was and has been applied to all families served by the Partnership for Strong Families and its member agencies, regardless of participation within the study or Pathway of FTC they were assigned to (if a study participant). Solutions Based Casework (SBC) was implemented into Partnership for Strong Families (PSF's) system of care. Solution Based Casework is a family-centered practice model of child welfare assessment, case planning, and ongoing casework. It integrates two approaches (relapse prevention and solution-focused models) to develop partnerships between family, caseworker, and service providers that account for basic needs and restores the family's pride in their own established strength. Solution Based Casework is a family centered practice model of child welfare assessment, case planning, and ongoing casework. The model targets specific everyday events in the life of a family that have caused the family difficulty. Solution Based Casework combines the best of problem focused relapse prevention approaches with solution-focused models. By integrating the two approaches, partnerships between family, caseworker, and service providers can be developed that account for basic needs and restore the family's pride in their own competence. This model dovetails with the FTC at a very pragmatic level. Family members and their support network are brought to the table and speak about the family's strengths, integrating these with tasks to accomplish goals and move the family to a setting of self-sufficiency. Solutions Based Casework provides a framework and language that can be used in the Family Team Conference to bring about a clear path to change. The practice model was developed through consultation with workers and supervisors who were attempting to remedy problems contributing to re-occurrence of abuse and neglect. However, it is applicable to a wide range of family problems such as mental health or work related issues. Solution Based Casework has three basic goals: (1) Develop a partnership with the family, (2) Focus on pragmatic everyday family life tasks, and (3) Promote specific prevention skills tied to the family's tasks. The integration of SBC and the Family Team Conference (FTC) family plans was thought to be an important step in enhancing the family plan and reinforcing the principles of family team conferencing. As the family plan is developed by the family in conjunction with the caseworker, not the caseworker solely, this model reinforces the strengths-based language and approach of SBC by helping the family, as well as their supports and professional partners, focus on a clear path to change.

Section IV: Collaboration

In 1998, Florida passed legislation to privatize child welfare services. Through privatization, The Florida Department of Children and Families (DCF) began changing their system of care and throughout Florida; non-profit Community Based Care (CBC) agencies began to contract with DCF to provide an array of child welfare services. Partnership for Strong Families (PSF) was awarded this contract in 2003 and now provides services to 13 counties spread throughout two Judicial Circuits (3 and 8). To meet the needs of the families and children in these 13 counties, PSF has formal, contractual relationships with several Case Management Agencies (CMAs) to provide case management services (Camelot Community Care, Children's Home Society, Community Development Services Family and Behavioral Health Services, Devereux Florida and Family Preservation Services). In addition, PSF has partnered with more than 300 service providers and individual practitioners to provide a continuum of support and services to families who are involved with the child welfare system. Many of these partnerships have been formalized through Memorandum of Understandings, vendor contracts and provider rate letter agreements and nearly all service providers are paid through a sophisticated Utilization Management system. PSF is able to measure service utilization to the client and individual service delivery level and can ensure that the service array provides a continuum of services and programs that provide families with access to the

individualized services they need to improve outcomes. All service providers are required to provide PSF with the results of their initial intake or assessment and the ongoing progress of the family in addressing their case plan goals.

In addition to the partnerships with DCF, the CMAs and array of service providers outlined above, PSF collaborates with the Guardian ad Litem program, Children's Legal Services (a department of DCF) and the 3rd and 8th Judicial Circuits, as part of our day-to-day operations. PSF operates two family resource centers in partnership with more than 40 community agencies that contribute to the array of neutral, family friendly locations in place to host FTCs for our families.

The partnerships mentioned thus far existed prior to our receipt of the Family Connection grant and continue to exist now that the project period is complete. All families that participated in the study were referred to PSF, for ongoing case management services, by DCF, with the CMAs being responsible for the day-to-day responsibilities of the case. The array of providers PSF works with offered services for these clients, to address needs identified at the Family Team Conference. These services were typically in areas related to mental health, substance abuse, domestic violence and parenting education. No relationships were dissolved during the course of the project period.

To meet the needs associated with this project, PSF developed relationships with additional entities. PSF contracted with Dr. Robin Perry of The Institute for Child and Family Services Research, as well as with Dr. Jane Yoo, of Clarus Research, to manage the responsibilities related to the evaluation of the project. Their role in the project was of great importance, and significant value. Dr. Perry was responsible for the outcome evaluation, working with analytical data provided to him by PSF's internal Pkids system, which housed information related to the number of FTCs completed, as well as results from the instruments (Strength and Difficulties Questionnaire, Protective Factors Survey, Goal Attainment Scale and Questionnaire for Family Members and Professionals) collected at the FTC. He also worked with data from FSFN and Florida's SACWIS system. Dr. Yoo headed up the process evaluation, which had survey, focus group, interview and observational components.

Additionally, nearly 120 locations were identified to provide safe, neutral and private environments to host FTCs within our catchment area. These locations include libraries, county and municipal offices, schools, community centers, and churches, as well as offices of other small groups and organizations. While our relationships with these organizations are informal, with space being reserved on an as needed basis, our access to these locations is critical in the FTC planning process and maintaining these relationships will be critical in the FTC model's sustainability.

It was seen as a critical component to this project that a sophisticated team of staff members oversee the day-to-day operations of the FTC model. In order to bring together the most talented members, three areas were examined: Operations within the Utilization Management model, Quality Assurance, and FTC experience. Following a cross-functional team approach, three staff members were chosen for their expertise in each of the three areas and worked as a steering committee. Initially, this team's function was to conduct weekly operations meetings on topics such as adherence to the protocol, sampling issues, data collection, policy compliance and any other pertinent issues. The existence of this team reflects PSF's strong quality assurance methodological processes and helped to strengthen our ability to detect, correct, and track any issues that posed barriers to the project's success. This team consisted of PSF employees.

This team, which was created in October 2009 eventually morphed into what became The Grant Operations team, which met regularly throughout the entire 3 year project period. Initially, the team met monthly and during the 3rd year of the project, meetings occurred every 6 weeks, to discuss a myriad of topics. Each meeting's agenda determined the key staff requested to attend and focused on areas such as, informed consent processes, data tracking issues, reporting standards, untimely FTCs, daycare for children's attendance, integration of other key innovative initiatives, travel of staff, FTC locations, staff roles at FTCs, and other program successes and challenges. The Grant Operations team was instrumental in successfully reducing the number of barriers that were present. Each area was targeted for specific concerns and PSF, DCF, and the CMAs each took responsibility for tasks they could directly affect. Additionally, staff from the Guardian ad Litem program and Children's Legal Services regularly participated in these meetings. Dr. Perry and Dr. Yoo also participated to provide insight to the evaluation of the project.

A smaller Grant Administrative team met periodically to address issues specific to the evaluation plan, funding responsibilities, and topics related to the Children's Bureau, Administration for Children and Families, and/or James Bell and Associates. The Administrative meeting topics did not typically filter down to the Operations team, as tasks were clearly delineated between the two. However, there were tasks that were unable to be handled at the Operations level, requiring senior staff member involvement. These issues were brought to senior staff outside of the Administrative meetings and handled independently of the full administrative team, which consisted of PSF staff members.

As part of the implementation process, trainings were held monthly with Family Care Counselors, Department of Children and Families, Children's Legal Services, Guardian ad Litem and Service Provider staff. Trainings were conducted to cover specific topics related to grant activities, including use of standardized instruments, informed consent, and making referrals. Training topics also covered the actual FTC process and what the roles and responsibilities of certain staff were to be during the meeting. These were important trainings to iron out key issues that impacted project implementation and continued to be held, as needed, throughout the entire project period.

An important lesson learned in this area was in the manner in which the trainings, specifically in the informed consent and research areas, were delivered. Early on, much information about the standardized instruments was presented to staff which seemed to confuse front line staff. Looking back, more practical trainings on how to administer the instruments and deliver the informed consent may have saved the time of additional trainings that were needed. It also may have reduced the confusion among CMA staff, which contributed to some initial dissatisfaction with the project.

During the third year of the project, the Grant Operations Team, described above, dedicated much time to discussing sustainability, as over the three year project period, it became evident that FTCs facilitated by neutral non- case carrying staff members was a valued part of PSF's system of care. CMA program directors, specifically, played an important role in these conversations, as they wanted to ensure that the Family Care Counselors would continue to have support from Facilitator staff during FTCs. Input was also received from DCF, GAL and CLS staff in regards to how PSF would be able to sustain the FTC model after the completion of the project period.

Through the collaborations outlined above, PSF was able to complete the three year project, successfully. Partnerships are at the center of the work we do at PSF and are embedded in our day-to-day practice of child welfare, including the FTC model. While many of these partnerships were formed as a result of the project, they will continue in an effort to ensure that the FTC model is sustained as a core value in PSF's system of care.

Section V: Sustainability

Partnership for Strong Families employs leading-edge, exhaustively-vetted programs and techniques designed to provide care and guidance to families and children at every level. PSF is an Innovation Site for Family Centered Practice, meaning we pioneer ways to improve the safety and overall outcomes for children that can be replicated statewide. Our staff-members have exceptional experience and a storied background of caring for at-risk children and providing coping skills to families. We rely on 3 core pillars of service to help us in this mission:

- Solution Based Casework – This heavily-researched practice provides step-by-step guidance through every aspect of the family experience, including safety planning, identifying and reaching family and individual level objectives, action plan development and progress monitoring.
- The Permanency Roundtable – This program provides support to the caseworker while taking an in-depth look at helping achieve permanency for every child in out-of-home care, particularly teenagers who have had a difficult time obtaining permanent placement solutions.
- Family Team Conferencing – This and other services help reinforce family values, resolve conflicts, improve communication and provide parents the tools to cope with daily challenges.

The Family Team Conferencing model existed in our system of care prior to be awarded the Family Connection Grant through the Children's Bureau. The funding we were awarded allowed us to test our original model as well as alternative approaches to Family Team Conferencing (FTC) to discover the most effective methods to promote child and family safety and well-being, permanent homes for children, family involvement and other vital goals. It was our intention, from the time we submitted our proposal to the Children's Bureau, that the FTC model would be sustained upon completion of the funded project period.

The funding we were awarded allowed us to hire 6 full time staff, dedicated to coordinating and facilitating Family Team Conferences. Prior to this, these positions did not exist and it was the case manager's responsibility to plan and facilitate FTCs for families on their own caseloads. Early in the project period, it became evident that PSF's system placed high value on the concept of a non- case carrying, specially trained individual to plan and facilitate both initial and follow up FTCs for new voluntary, in home supervision and court ordered shelter cases. While the system supported the FTC Coordinator and Facilitator positions, more value was placed on their roles in initial FTCs, rather than follow ups. Additionally, FTC Facilitators were responsible for generating and approving referrals for services that were recommended as a result of the FTC.

In discussions surrounding the sustainability of this new model, it was clear that PSF's funding would not be able to support the 6 full time positions that were funded by the Family Connection Grant. In prioritizing needs, it was determined that a team of FTC Facilitators would be retained to both plan and facilitate initial FTCs for new voluntary in home supervision and court ordered shelter cases. Follow up FTCs would be completed by the FTC Facilitators on an as needed basis, if the family or another case participant felt it was appropriate. The responsibility of planning and coordinating these FTCs was shifted to the FTC Facilitator position, as the FTC Coordinator position was eliminated. To compensate for this, the responsibility of making referrals for services recommended at the FTC was shifted back to the case manager assigned to the case.

Currently, PSF's FTC Department consists of 2 full time FTC Facilitators and 1 FTC Manager, who, in addition to managing the department, facilitates FTCs on a part time basis. These positions are funded by PSF. At this time, these three staff persons have been able to manage the load of facilitating initial FTCs for new voluntary in home supervision and court ordered shelter cases. They are also able to work on follow-up FTCs, as they are requested. Should one of these three staff persons not be able to take a new case, the assigned case manager would then become responsible for planning and facilitating the FTC. PSFs contractual agreement with all the case management agencies states that all case managers are responsible for becoming trained and certified in the FTC model.

Several products were created for the purposes of product replication. A brochure was created to introduce families to the concept of Family Team Conferencing, as well as provide an overview of the Grant. These brochures were distributed to families at the inception of their case, so that they had some understanding of what an FTC was, before being contacted to schedule the conference. A training binder was created and distributed to each case manager as part of the mandatory FTC training they participated in. The binder included information related to the FTC process as well as tips for administering the informed consent and research instruments. The case managers were encouraged to refer back to this binder to assist them in their work with FTCs. Finally, a replication manual was created to fully capture the project. The replication manual contains project overview information, including what our goals were and who we partnered with; implementation information, including staff roles and responsibilities, an implementation timeline and training strategies; procedural information; evaluation information and dissemination activities. Copies of these products may be found in the appendix section of this report.

Cost Data

Select cost data was itemized for services authorized and delivered to study participants. These data are also reported in Section VI of this report. Figure 1 provides an itemization of the average cost for delivered services for each service category across FTC Pathways. Please note that given the variation in number of units authorized per service type across individual cases and different rates of utilization of authorized services across individual families, there can be noteworthy variance (see standard deviations) in mean costs. A series of statistical tests (ANOVAs) were conducted in order to gauge if any observed mean score differences (across participant groups within each Pathway AND for each participant group across each Pathway) were statistically significant. Different tests were utilized based upon whether or not specific statistical assumptions were met (e.g. equality/homogeneity of variances, fixed versus random effects models, etc.) and for cross-validation purposes. For example, comparisons were made using a series ANOVA procedures with multiple group comparisons using the Bonferroni and Tukey-B tests (when equal variances existed) and Tamhane's T2 and Dunneutt's T3 test (when equal variances did not exist). These tests suggest there are no statistically significant differences in the average expenditures (valid cases used) across service categories for services delivered to cases across FTC Pathways. The greatest expenditures (and number of cases receiving services) are for mental health services. Average costs range (see Figure 1) from a low of $1,330.31 to a high of $1,808.54 for Pathway 1 and Pathway 3 cases (respectively). Although there is nearly a $500 difference in these averages, an imbalance in sample size (given the smaller number of Pathway 1 participants) and statistical assumption adjustments

(especially given observed variances) suggest these average expenditures are not significantly different. This is the case for all observed expenditures, where (generally) mental health services, followed by parenting classes and supports have the highest average costs, and substance abuse and other services have the lowest average costs per family. In total, $1,437,655.13 was spent on services for study participants across all three Pathways.

Figure 1 Average Costs for Services Across FTC Pathways

Pathway		Domestic Violence Services	Mental Health Services	Parenting Classes and Supports	Substance Abuse Services	Other Services	Total Costs of All Services
Pathway 1	Mean (N, Std. Deviation)	$306.71 (38, $362.14)	$1,330.31 (88, $1605.66)	$1,071.10 (67, $985.45)	$147.99 (53, $236.08)	$62.15 (48, $119.91)	$2,156.25 (98, $2106.18)
Pathway 2	Mean (N, Std. Deviation)	$364.32 (89, $453.41)	$1,765.43 (196, $2538.49)	$1,092.29 (166, $926.22)	$127.03 (131, $287.21)	$61.53 (127, $184.19)	$2,585.06 (226, $3,076.99)
Pathway 3	Mean (N, Std. Deviation)	$405.85 (91, $422.06)	$1,808.54 (204, $2092.87)	$1,301.66 (161, $1229.67)	$100.18 (122, $163.50)	$118.47 (122, $347.66)	$2,804.01 (229, $2972.97)
Total	Mean (N, Std. Deviation)	$371.61 (218, $425.28)	$1,704.99 (488, $2213.12)	$1,174.24 (394, $1072.47)	$119.96 (306, $235.76)	$85.02 (297, $258.68)	$2,599.74 (553, $2888.21)

These data (in conjunction with other service authorization and delivery findings—see section VI) suggest that the costs of service are equal across all Pathways (whether a FTC facilitator is used or not). There is equivalency across all Pathways in terms of average service costs (to the system) that result from case plans and service recommendations. The amount, type, and cost of service referrals did not change as a result of a family's participation in any FTC Pathway. This equivalency may be a function of the integration (system-wide) of Solution-Based Casework during the course of this study, for which FTCs have become/are an integral component. The only added cost of Pathway 1 and Pathway 2 FTCs are the personnel costs associated with hiring FTC Coordinators and FTC

facilitators (as there was no change in the amount of FCCs and other agency staff as a result of this project).

Section VI: Evaluation

A. Evaluation Methodology

This study utilized an experimental design for the random assignment of families/study subjects into two experimental FTC model groups and one comparison group. A series of mixed-methods were utilized (using primary and secondary data sources) as part of a comprehensive process and outcome evaluation of each of the FTC models. Please see Appendix A for more details regarding subject selection and assignment detail and overview of evaluation methods and procedures. All evaluation protocols, including data collection instruments and associated consent forms were approved by Western IRB.

Process Evaluation

Prior to and concurrent with any evaluation of outcomes, it is important to have a thorough understanding of the processes defining the service model and a valid gauge of the extent to which the model was implemented accurately in a manner that maximizes family involvement, commitment, and satisfaction with the process. It is extremely important to implement protocols that provide timely and honest feedback from all family members (and other participants) involved in family team conferencing regarding the strengths and limitations of the proposed service model. Toward this end, a composition of qualitative and quantitative data was collected, summarized, and analyzed to answer a series of questions deemed of value (within the professional literature) for conducting process evaluations of FGDM/FTC models. These questions are associated with model fidelity, the response of and coordination with community partners, family involvement and experience with the FTC, worker involvement and experiences, services utilized, and associated costs.

i. Process Evaluation Questions

Model Fidelity

Efforts were made to gauge the extent to which Family Team Conferences were implemented in a manner consistent with the proposed model and its practice principals. The main research questions associated with model fidelity included:

1. Was the FTC model implemented with fidelity?
2. What factors facilitated or hindered adherence to the FTC model?
3. What were the impediments to proper implementation of the FTC model?

Some issues of fidelity were captured in other sections that address family and worker involvement in the FTC. Regardless, the following sub-questions (and data sources for answering each question) listed below aided with testing model fidelity as encompassed by the broader questions denoted above.

a. Was there adequate and full preparation of FTC participants for the form and function of the proposed FTC meeting?
b. Was there successful completion of meetings?
c. Were appropriate and effective service plans and plans-of-care developed?
d. Was there a satisfactory match of services to child and family needs?
e. Were there high levels of relative placement?
f. Upon completion of the FTC and throughout the process, was there high confidence that the children would be safe?

Knowledge and Preparation

- What was the family's role in the FTC?

Family Participation

- What was the ratio of the number of family members to professionals that participated in family team conferences?
- Were family members involved in all aspects of the case plan and the development of evaluation criteria for success?
- Was the process dominated by professionals or family dialog?
- To what extent did the child or children participate in the family team conference?
- What was the extent or measurement of conflict between the family and the FCC or PSF?

Empowerment

- To what extent were family members involved in the FTC process; did families have a real voice in the process?
- To what extent did families feel empowered by the FTC?
- Did the process increase the likelihood of family leadership and self-autonomy?
- Did family members feel comfortable asking questions?
- To what extent did the family feel that the process was respectful or understanding of cultural issues (especially if there was not an ethnic match of FCC to family)?
- Was there respectful treatment of family participants?

- Did family members feel respected by the FTC facilitator and their CPS case manager (Family Care Counselor)?

Satisfaction

- What was the satisfaction of participation in FTC for different types of participants, including parents, children, and relatives?
- What were family members' levels of satisfaction with their involvement in the FTC?

Conference Outcomes

- What was the percentage of meetings that resulted in approved safety plans and plans of care?
- To what extent were resources highlighted within the plans of care for families provided?
- What was the distribution of the types of supports and services approved in safety plans and plans of care?
- To what extent were supports and services included in plans actually provided, and in a timely/recommended period?

ii) Process Evaluation Design

The process evaluation used a mixed-methods approach. A number of data sources (see section below of data sources) included the collection of information from all study subjects (e.g., the Questionnaire for Family Members and Professionals) that were randomly assigned to the two experimental and one comparison groups. Other qualitative methods (including independent observations, focus groups, key informant surveys, and interviews) utilized random samples of sub-groups of study participants, whether family members, program staff (including Family Care Counselors and Family Team Facilitators), and Community Service providers. Structured interviews with 20 percent of FCCs and all the FTC Facilitators were conducted in 2011 and 2012. For more details regarding methods associated with each, please see Appendix B *Evaluation Brief: Interviews with Family Care Counselors and FTC Facilitators* (dated May 12, 2011) and Appendix C *Evaluation Brief: Interviews with Family Care Counselors and FTC Facilitators – 2012*. An independent observation of 20 randomly selected FTCs (across all three FTC Pathways) was conducted between September 2010 and June 2011. For more details regarding methods associated with this method, please see Appendix D *Evaluation Brief: Lessons Learned from Observations of FTC Meetings*. Separate focus groups of parents/caregivers and service providers were conducted in 2011. Please see Appendix E *Evaluation Brief: Focus Groups with Families and Service Providers* for more details regarding the methods and conclusions associated with the focus groups. A web-based survey was sent in 2012 to all current service providers of study participants and community partners (N=98) across all three FTC

Pathways. A total of 33 (34%) responded to the survey. More details regarding the methods and data collection tool are denoted in Appendix F *Evaluation Brief: Community Partners Surveys*.

iii) Evaluation Participants (Process Evaluation)

There were a number of evaluation participants for the process evaluation. These included (with an itemization of the data source) the following:

- Individual family members and supports that participated in any FTC across all three Pathways (Questionnaire for Family Members and Professionals). Select parents/caregivers also participated in focus groups.

- Professionals that attended each FTC across all three Pathways (Questionnaire for Family Members and Professionals). Service providers also provided feedback via the Community Partners Survey and a select number participated in a focus group. These service providers represent various fields as clinical directors, therapists, parenting instructors, substance abuse counselors, domestic violence advocates, Guardian Ad Litem, case managers, and administrators. All but three of the survey respondents participated in at least one FTC, and most (88%) had worked with the Partnership for more than one year. Select service providers also participated in a focus group.

- Family Care Counselors and Family Team Facilitators (Structured Key Informant Interviews).

iv) Data Collection Procedures (Process Evaluation)

The Questionnaire for Family Members and Professionals (QFMP) was distributed to all FTC participants (family members, other professional and non-professional individuals) after the completion of each FTC (see Appendix G for a copy of the instrument). The standardized questions address all the process research questions (especially those associated with fidelity issues) denoted above and were drawn from the measurement tools and surveys utilized by Edwards, Tinworth, Burford, & Pennell, 2007, Brady (2006), Braumann, Tecci, Ritter, Sheets, & Wittenstrom (2005), and the Center for Child and Family Policy (2008).

Structured Key Informant Interviews with Family Care Counselors and FTC Facilitators took place in 2011 and 2012. The interview questions were adapted from a questionnaire developed for a study of FTC in Ireland (Brady, 2006). Five main topics were covered in the interviews with FCCs and FTC Facilitators. The first topic addresses pre-FTC procedures as well as procedures and experiences of the actual FTC. The second topic addresses post-FTC processes. In the third topic, operational issues, including resources for families and the role of service providers in executing the family plan, are discussed. The fourth topic covers general questions about the challenges and rewards of FTCs as experienced by the FCC and FTC Facilitator. The final topic asks questions

about the future development of FTC. More details regarding methods associated with this data collection procedure are denoted in Appendix B and C; a copy of the interview protocol can be found in Appendix H.

Independent Observations of FTCs across all three Pathways. The observation of FTC meetings was a process evaluation component that is intended to monitor program fidelity. It served several purposes, including: (1) measuring the degree to which the FTC Facilitator and Family Care Counselor (FCC) facilitate the meeting in keeping with established protocols; (2) assessing the extent to which family members speak/engage in the meeting and are given the opportunity to do so alongside professionals; and (3) gauging the extent to which all FTC participants are active in the establishment of the service plan. For more details regarding the observation methods and fidelity checklist used by the independent observer, please see Appendix D.

Focus Groups with Families and Service Providers. The focus groups were primarily intended to gather information about the FTC process in 2011 in order to inform program development and quality assurance. At the same time, the focus groups provided important contextual information that is critical for understanding outcomes of the FTC models. Details regarding the focus group methods are denoted in Appendix E; an itemization of focus group questions is denoted in Appendix I.

Community Partners Survey. The survey was web-based (using SurveyMonkey). The survey gathered the experience and perspective of service providers in the FTC process. This information can guide program development, quality assurance, and plans for sustainability of the FTC models. At the same time, findings from the survey provided important contextual information that is critical for understanding outcomes of the FTC models. Details regarding this survey and findings generated from it are denoted in Appendix F.

Service Utilization Database (referred to as P-Kids) maintained by the Partnership for Strong Families was used to track and monitor services delivered for all cases that participated in this study. A content analysis of these data (matched to specific cases) allows a determination of recommended and referred services (as a product of the FTC and denoted in service plans and the Goal Attainment Scale) were actually delivered/ utilized.

Outcome Evaluation

This study utilized an experimental design for the random assignment of families/study subjects into two experimental FTC model groups and one comparison group. The outcome evaluation focused on a number of measurements of safety, permanence, and well-being. Data from primary and available secondary data sources were utilized to gauge if there were any differences in outcomes across FTC Pathway groups.

i. Outcome Evaluation Questions

There were three broad research questions related for this study, which included:

1) Does immediate engagement with families and engagement throughout the life of the case lead to desired outcomes for children and families?
2) Does utilizing a separate entity to exclusively provide FTC's impact child and family outcomes?
3) Does a skilled approach using specially trained staff (i.e. Family Service Facilitators and Family Team Conference Coordinators) to connecting families to services impact child and family outcomes?

Child and family outcomes to be examined (using data from a variety of primary and secondary sources) included safety outcomes associated with: i) the likelihood that provided services protect child(ren) in the home and prevent removal or re-entry into foster care (using data from the Protective Factors Survey and the Florida Safe Family Network data, Florida's SACWIS data). Select well-being outcomes examined included: i) an examination of the effectiveness of services to meet the needs of children, parents, and foster parents (using data from Goal Attainment Scales, the Protective Factors Survey, and the Strengths and Difficulties Questionnaire), and ii) child and family involvement in case planning (Questionnaire for Family Members and Professionals). Outcomes associated with permanence examined: i) foster care re-entry rates of children served by the program, ii) number of foster care placements for children in care, and iii) rates of reunification, guardianship, or permanent placement with relatives (using FSFN/SACWIS data). With respect to select safety factors (using the Protective Factors Survey), there was an interest in measuring the level of desired change in family functioning/resiliency, emotional social support, concrete supports, parental knowledge of child development and parenting skills, and nurturing and attachment between parents and children. With respect to the Strengths and Difficulties Questionnaire, there was an interest in measuring (as a well-being indicator) level of desired change in the manifestation of emotional symptoms/problems conduct problems, hyperactivity/inattention, peer relationship problems, and pro-social behavior demonstrated by the children.

ii) Outcome Evaluation Design

As noted earlier in this report, the study utilized an experimental design for the random assignment of families/study subjects into two experimental FTC model groups and one comparison group. Select outcome measures relied upon the collection of data (via surveys and scales) directly from study participants. Other outcome measures utilized data from the state SACWIS system and quality assurance personnel at the Partnership for Strong Families. For more details associated with select methods and procedures for the evaluation, please see Appendix A.

iii) Outcome Evaluation Participants

The evaluation participants for the outcome evaluation included children and families. Information associated with protective factors and safety issues for children were collected from primary caregivers via the Protective Factors Survey (PFS). These data were collected at a baseline period prior to the first FTC and commencement of involvement with the agency and at follow-up FTCs or upon service completion. Each caregiver and youth (aged 11-17 self-reports) were provided the opportunity to complete a Strengths and Difficulty Questionnaire for child(ren) of focus for involvement or protective concerns at the same baseline period (for the PFS) and at follow-up FTCs or upon service completion. All family members (in consultation with professionals) were given the opportunity to complete Goal Attainment Scales as part of or upon completion of the first FTC, with follow-up measures of goal attainment at subsequent FTCs or upon service completion. Completion of all the above instruments was voluntary in accordance with approved IRB protocols. Data on select safety and permanence measures related to child and family participants was obtained for all study subjects from the state SACWIS system.

iv) Outcome Data Collection Procedures

The Protective Factors Survey (PFS) is a product of the FRIENDS National Resource Center in collaboration with the University of Kansas Institute for Educational Research and Public Service. It includes measures of family functioning/resiliency, emotional social support, concrete supports, parental knowledge of child development and parenting skills, and nurturing and attachment between parents and children, as measured by the PFS. The PFS was provided to the family prior to the first FTC as part of orientation to the FTC process (or within first two weeks if in the comparison group). It also was given to the family prior to each subsequent FTC or upon service completion. Scores were tabulated and analyses completed by the evaluators.

The Strengths and Difficulty Questionnaire (SDQ) is a brief behavioral screening questionnaire for children aged 3 to 16 year olds. Each version (based upon the child demographics and role of the assessor) of the instrument consists of 25 questions. An assessor can be the child's parent/caregiver (including foster parent), teacher, or youth aged 11-16, although information was only collected from the parent/caregiver/foster parent and youth). The SDQ (see Appendix J for a sample of the SDQ given to parents of children aged 4 to 10) was given to the primary caregiver(s) prior to or concurrent to the first FTC and at follow-up FTCs or upon service completion.

Goal Attainment Scales (GAS) were utilized as part of the initial FTCs in an effort to establish service and plan of care goals meaningful to family members. Movement toward established goals was measured (using established and agreed upon scoring mechanisms) at subsequent FTCs or upon service completion.

Florida Safe Families Network (FSFN Data [Florida SACWIS system]) included data for all cases (across all Pathways). Data specialists within Florida Department of Children and Families (DCF) extracted the population of cases that met select algorithm criteria for select performance/outcome measures related to safety, permanence, and well-being. These raw data were then sent to the Partnership for Strong Families several weeks after each yearly quarter. These data were examined and cleaned first by Quality Assurance personnel before being matched against case identifiers of participants for the FTC study (the data used for these analyses). Additional data checks and cleaning tasks were conducted by the evaluators. These data are then merged (by the evaluators) with other study databases.

v) Major Changes to the Evaluation Design

There were no **major** changes to the evaluation design; however, there were some changes that took place, in part, due to changes in select processes and protocols associated with the proposed models and timeline for FTCs. These changes were denoted in Section III of the report and related to:

- Follow-up FTC meetings scheduled for at 4 and 7 months moved to 3.5 and 6.5 months (two weeks earlier). This impacted only the timeframe when supplemental data was collected from primary sources in association with each FTC.
- Expanding child participants from those 10 and older to children of all ages (when appropriate). Although this potentially impacted the number of FTC participants, it had no impact on data collection as no primary data was collected from children younger than those approved by WIRB and select collection instruments (e.g. SDQ) were not validated for children under 10.
- Discontinued Use of SDM Risk Assessment by the State of Florida. This was no longer a data source for consideration for this study.
- Change in protocol for facilitating contact and family involvement in Initial FTCs.
- Change in scheduling priorities given workforce issues. These last two points were intended to maximize the timeliness to which FTCs were conducted (in accordance with the proposed model and evaluation design). However, changes in practice and administrative protocols limiting FCC work schedules may have contributed to a minimization of the participation of FCCs working with Pathway 1 cases (who were required to organize and facilitate FTCs) and subsequently the participation of Pathway 1 families and subsequent data collection.

Although not a change to the evaluation design, the formal evaluation was delayed for five months given issues (beyond the evaluators' control). State law and protocols in securing an IRB to review the proposal delayed our submission of an IRB application. Soon after confirmation of WIRB as an official IRB with Federal-Wide Assurance for the Florida Department of Children and Families, our IRB application was submitted and approved, with a study start date on May 24, 2010. Finally, the initial study design called for the collection of audio and/or visual data (and analyses of this content) as part of independent observations of FTC fidelity across Pathways. Following feedback and concerns by legal representatives (particularly of families), this was modified (and approved by WIRB) so no audio or visual data would be collected. Independent observations would still be made in person, but with the use of a fidelity checklist.

vi) Describe Training

The following represents key training activities associated with the project and evaluation:

- All project staff were required to participate and pass specific Human Subjects Training/Classes provided by the Collaborative IRB Training Initiative sponsored by the University of Miami and Western Institutional Review Board.
- Between November 2009 and February 2010, the evaluators engaged in information sessions and conducted training on the evaluation design, methods, and data collection measures for all project staff, including (but not limited to) FTC Coordinators, FTC Facilitators, Unit Supervisors, and all front-line FCCs (and other staff and administrators).
- The evaluators and all project staff participated in on-line training with representatives from FRIENDS regarding the use of the Protective Factors Survey. These trainings took place prior to the start of data collection; however, materials from these trainings were made available for continued reference and orientation to any new staff hired over the course of the study.
- Starting in April 2010 and continuing through the summer of 2012, trainings were held at least monthly with Family Care Counselors, Department of Children and Families, Children's Legal Services, and others on various topics. Trainings were conducted to cover specific topics related to grant activities, including use of standardized instruments, informed consent, and making referrals. These were important trainings to iron out key issues that impact project implementation, orientation/training of any new personnel hired over the course of the study, and as "Booster" trainings (i.e. follow-up trainings) for FCC and other staff.
- Between October, 2011 and April 2012, FTC Facilitators participated in coaching sessions with Case Management Agency (CMA) staff each month, to develop strategies to better implement the Solution Based Casework model into Family Team Conferences.
- Two formal trainings were presented to the Guardian ad Litem (GAL) Programs that are responsible for the two judicial circuits inside of PSF's catchment area.

B. PROCESS EVALUATION RESULTS

i) Number of Participants Served

Over the course of the project, a total of 1,894 FTCs (across all pathways and time periods) were conducted with 1,156 unique cases/families of which 623 families agreed to participate in the formal evaluation (i.e. be study subjects). With the 623 family participants, 1,252 FTCs were conducted, of which 47.2% were Initial FTCs, and 21.6%, 12.6%, 7.8% were Month 4, Month 7 and Month 10 FTCs (respectively). The remaining FTCs took place at Month 14, Month 18 and at "other" or "supplemental" times. Among the 623 unique families/study participants, 141 were Pathway 1 cases (the comparison group), 266 were Pathway 2 cases, and 270 were Pathway 3 cases. After cases were exempted from study participation, the study participation rate (at any point of time during the project period) was 42.5% (n=141 of 332) for Pathway 1 cases, 63.9% (n=265 of 415) for Pathway 2 cases, and 66.0% (270 of 409) for Pathway 3 cases. Pathway 1 cases had a significantly higher rate of

exemption for the Initial FTC and study participation than Pathway 2 and Pathway 3 cases. The observed participation rates (using the sampling frame) suggests (using tests of significance between independent proportions) that cases assigned to Pathway 1 FTCs have a statistically significant lower participation rate that those assigned to Pathway 2 and Pathway 3 cases. This raises some concern whether the comparison group (Pathway 1) is a legitimate comparison/control group for which results associated with those in the two experimental groups can be compared.

ii) Participant Demographics

The Table below provides an itemization of select demographics of study participants across each of the FTC Pathways.

Final Demographic Data (Non-Duplicate Count)			
Item	**Description**	**Defined as**	**Reported Output**
FGDM: Parent Level (Participant 1)			
Age	Age of Participant	Pathway 1 (n=75), Mean Age = 31.53 (SD=8.13) Pathway 2 (n=228), Mean Age = 32.24 (SD=8.15) Pathway 3 (n=241), Mean Age = 32.28 (SD=7.85)	
Gender	Gender of Participant	Pathway 1 (n=75), 80% Female, 20% Male Pathway 2 (n=228), 68.9% Female, 31.1% Male Pathway 3 (n=241), 72.2% Female, 27.8% Male	
Ethnicity	Race/Ethnicity of Participant	**Pathway 1** (n=75), 68% White, 20% African American, 8.0% Hispanic/Latino, 4% Other **Pathway 2** (n=228), 68% White, 20.6% African American, 3.9% Hispanic/Latino, 7.5% Other **Pathway 3** (n=241), 69.3% White, 25.3% African American, 3.3% Hispanic/Latino, 2.1% Other	

Final Demographic Data (Non-Duplicate Count)			
Item	**Description**	**Defined as**	**Reported Output**
Marital Status	Marital Status of Participant	**Pathway 1** (n=75), 45.3% Single Female, 17.3% Married Couple, 9.3% Single Male, 9.3% Unmarried Couple, 9.3% Separated, 9.5% Unable to Determine/Other **Pathway 2** (n=228), 42.5% Single Female, 22.4% Married Couple, 15.8% Single Male, 9.2% Unmarried Couple, 3.5% Separated, 3.6% Unable to Determine/Other **Pathway 3** (n=241), 40.2% Single Female, 20.7% Married Couple, 11.2% Single Male, 10.4% Unmarried Couple, 5.8% Separated, 11.7% Unable to Determine/Other	
History of Domestic Violence	Referral history in category of DV	Pathway 1: 32.0% (n=24) Pathway 2: 37.7% (n=86) Pathway 3: 36.9% (n=89)	
History of Substance Abuse	Referral history in category of SA	Pathway 1: 53.3% (n=40) Pathway 2: 51.8% (n=118) Pathway 3: 42.7% (n=103)	
FGDM: Child Level (Participant 2)			
Age	Age of Participant	Pathway 1 (n=44), Mean Age = 7.78 (SD=4.13) Pathway 2 (n=201), Mean Age = 7.35 (SD=4.57) Pathway 3 (n=220), Mean Age = 7.17 (SD=4.51)	
Gender	Gender of Participant	Pathway 1 (n=44), 52.3% Female, 47.7% Male Pathway 2 (n=201), 45.8% Female, 54.2% Male Pathway 3 (n=220), 45.5% Female, 54.5% Male	
Race/Ethnicity	Race/Ethnicity of Participant	**Pathway 1** (n=44), 61.4% White, 29.5% African American, 9.1% Hispanic/Latino, 0% Other	

Final Demographic Data (Non-Duplicate Count)			
Item	**Description**	**Defined as**	**Reported Output**
		Pathway 2 (n=201), 69.2% White, 24.4% African American, 3.5% Hispanic/Latino, 2.9% Other **Pathway 3** (n=220), 65.0% White, 27.3% African American, 5.0% Hispanic/Latino, 2.7% Other	
Previous involvement with System	Children with a history of System involvement (Previous Case or Re-opened During Study Period)	Pathway 1: 38.6% (n=17) Pathway 2: 25.9% (n=52) Pathway 3: 27.3% (n=60)	

iii) Service Received

As denoted in the final semi-annual report, a total 3,410 service referrals were provided to those participating in FTCs (across Pathways) over the course of the study (see Table 1 in Appendix K). These referrals have been for services classified as mental health, domestic violence, substance abuse, parenting classes, and "other." Each of these categories can have a variety of specific services or descriptions of these services. For an itemization/breakdown of the specific descriptions of services (provided by staff and captured within the P-Kids system) associated with each classification of service, see Table 2 in Appendix K. Although semi-annual reports provide summary data on the total number of service referrals made, these referrals can vary in type and magnitude, insofar as a different amount of service units can be authorized (along with associated costs for each service). The evaluators were able to obtain information regarding the specific authorizations for fee-based and other formal services and whether they were delivered. These data are from the Service Utilization Database within P-Kids. In addition to fee-based and formal services, clients can be referred to non-fee-based community services; these data are typically referred to as "pass throughs" among Partnership staff and administrators. The referrals denoted in past semi-annual reports do not involve "pass-throughs." Given such, efforts were made to examine the extent to which there was any variation in the type and magnitude of formal services authorized (i.e. referrals made) and delivered to families across each Pathways (in terms of service units across service classifications and with respect to costs).

With respect to formal referrals for service, a total of 6,522 service units were authorized for 533 unique (non-duplicate) study cases (see Table 3 in Appendix K). There does not appear to be any significant differences in the proportion of service units authorized across each Pathway for each classification of service. The proportion of total service units authorized within each Pathway is very similar and mirror the aggregate proportions for the entire study population. Here, mental health service (44.7%) represent the largest group of referrals, followed by referrals for parenting classes and supports (21.6%), substance abuse services (12.6%), other services (11.4%), and domestic violence services (9.8%).

These findings are corroborated with a series of separate ANOVA procedures that confirm there is no significant difference in the average number of units authorized (for applicable cases) for each service classification across the three Pathways. Further, when data on the number of units actually delivered is examined, there are no statistically significant differences in the average number of services delivered across Pathways for all service classifications. Please see Tables 4 &5 in Appendix K for the distribution of average number of units authorized and actually delivered for each service classification for cases across the three Pathways. Please note that there are noteworthy differences in the number of service units authorized versus delivered for each group of study subjects for each service classification. For example, although an average of 41.2, 43.0, and 45.8 mental health service units were authorized (for Pathway 1, Pathway 2, and Pathway 3 families respectfully) for each case, an average of 12.2, 14.3, and 15.1 mental health service units were delivered to Pathway 1 through Pathway 3 families (respectively).

iii) Other Key Process Results

Results from the Questionnaire for Family Members and Professionals

Following each FTC, all participants were provided with the opportunity to provide feedback (on a standardized scale) regarding their reaction and experiences as a participant (whether family member or support, professional, or program staff). A total of 1,202 QFMP surveys were completed by study participants (associated with 422 study cases) following the completion of each FTC. Although detailed information was collected regarding the relationship status (to the child/youth) of each participant, the modal participant was the mother. All other identified family members and supports were aggregated for comparisons. Table 6 (in Appendix K) highlights that 40.2% (n=483) of all QFMP surveys were completed by mothers, 44.4% (n=534) by all other family members and family supports combined, and 15.4% (n=185) by professionals. Concerns regarding the low participation rate of Pathway 1 cases is manifested as only 10% (n=120) of all QFMP surveys are associated with Pathway 1 cases, and 43.6% (n=524) and 46.4% (n=558) are associated with Pathway 2 and Pathway 3 cases (respectively). The majority (63.1%) of all completed QFMPs are associated with the Initial FTC (see Table 7 in Appendix [ ]), with 20.5% (n=246), 7.8% (n=94), and 5.6% (n=67) completed during Month 4, Month 7, and Other/Supplemental FTCs.

Details regarding the form and structure of the QFMP and an extensive review of analyses on these data are reported in Appendix K.

Table 9 in Appendix K provides a detailed summary of the mean scores for each item for each participant group (mothers, other family members and supports, and professionals) across each of the three FTC Pathways. A series of statistical tests (ANOVAs) were conducted in order to gauge if any observed mean score differences (across participant groups within each Pathway AND for each participant group across each Pathway) were statistically significant. Different tests were utilized based upon whether or not specific statistical assumptions were met (e.g. equality/homogeneity of variances, fixed versus random effects models, etc.) and for cross-validation purposes. For example, comparisons were made using a series ANOVA procedures with multiple group comparisons using the Bonferroni and Tukey-B tests (when equal variances existed) and Tamhane's T2 and Dunnett's T3 test (when equal variances did not exist). These results suggest that all study participants (family members, family supports, and professionals) following each FTC suggest that participation in FTCs

is generally a positive experience for families and professionals and that they were implemented with fidelity or in keeping with the intention and general goals of FTCs. Generally speaking (using average scores), study participants agreed (with positive directional measures and disagreed with inverse or habituation questions) that FTCs across all three Pathways were implemented with fidelity, participants were adequately prepared and the family was clear on their role, the family members were active participants and empowered, participants (including family members) were satisfied with the process, and the outcomes (especially related to case plans) were appropriate, clear, and in keeping with the goals and objectives of Family Team Conferencing. However, there are a few findings and significant differences in scores denoted in Appendix K worthy of highlight. These include:

- There was no statistically significant difference in the mean scores (on level of statement agreement) observed for mothers, other family members and supports, and professionals within **Pathway 1**.

- Mothers and/or family members had higher levels of agreement than professionals in **Pathway 2** or **Pathway 3** FTCs with the following statements:

    - *"Everyone at a meeting understands why it is being held"*
    - *"Families are prepared for taking part in the meetings (e.g., the purpose of the conference was clearly explained and reason for attending understood, etc.)"*
    - *"All the people that needed to be included attended the conference"*
    - *"The plans include ways that relatives, friends, or other close supports will help out"*
    - *"I understand what will happen if the plan is not followed"*
    - *"There are adequate resources to meet the goals/objectives of the family plan"*
    - *"The meetings are held in a place and at a time that was convenient for the family"*
    - *"I have a better understanding of how the family can ensure the safety of this/these child(ren)"*
    - *"I am confident that the plan ensures the child(ren)'s safety*"

- Professionals in Pathway 3 had a significantly higher level of agreement than mothers and other family members and supports with the following statement *"Facilitators run the meetings well*," even though the average level of agreement was very high across all groups.

- Professionals in Pathway 3 had a significantly lower level of agreement than mothers and other family members and supports with the following statement *"All the people that needed to be included attended the conference."*

Independent Observations

The main findings from the independent observations are as follows:

- The FTC Facilitators demonstrates high fidelity to the FTC models with respect to facilitating the FTCs and engaging families in the decision-making process.

- Some families were not aware of the purpose and goals of the FTC. Also, few families invited their supports to attend the FTC. There seemed to be inconsistent and at times insufficient communication about the FTC purpose and goals. As a result of this finding, the procedures for contacting families and providing more information to better prepare families for the FTC was revamped.
- Some FCCs were uncertain about their role in the FTC. They were unaware of the partnership between themselves and the FTC Facilitator in facilitating the FTC. As a result of this finding, this partnership was emphasized in trainings with FCCs on the FTC models and grant implementation.

Focus Groups with Families and Service Providers

The focus groups with parents and service providers yielded important findings that corroborated other findings from the process evaluation of the FTC models. The parents in the focus group responded positively to FTCs, as did the service providers from both Circuits, but identified glitches in how, when, and by whom FTCs are implemented suggest that a number of improvements could be made. For example, the interviews, observations, and focus groups all suggest that families are not inviting their family members and supports to participate in the FTCs. Therefore, there could be better communication with families about this goal, as well as a concerted effort to work with families in inviting their supports (including professionals) to the FTCs. A larger-scale and longer-term area of improvement is the idea of "culture change" that was raised in the focus groups. Despite promising features of the FTC models that have been identified from various sources, there is the bigger challenge of culture change (among FCCs and others to *put into practice* the philosophy and approach of FTCs) that is necessary for FTCs to be successful and sustainable. All in all, the information collected to provide insights into this challenge suggested that culture change is attainable and that current practices through FTCs and other means are evidence of culture change.

Community Partners Survey

The survey results for service providers yielded a number of key findings summarized here. To begin, service providers lent strong support for Family Team Conferencing with respect to its philosophy and approach; they praised the FTC Facilitators for their skilled work; they believed families are respected during the FTCs; and they unanimously supported greater flexibility in the timeframes of FTCs to accommodate each family's individual desires and needs. These positively perceived features, however, were counter-balanced with perceived challenges to implementation, impact, and sustainability of Family Team Conferencing from the perspective of survey respondents. With respect to implementation, survey respondents were challenged by the logistics of scheduling and participating in FTCs. As to the impact of FTCs, survey respondents were uncertain as to whether FTCs truly give decision-making power to families when they are typically outnumbered by professionals during the FTCs. Also, survey respondents perceived critical barriers to service linkages that potentially undermine the intended impact of FTCs to better connect families to services. Moreover, the ambivalence of survey respondents about the impact of FTCs on their own work and whether a cultural change has occurred to fully promote FTCs across the entire system presented a challenge to sustaining any new FTC model beyond the grant period. Yet despite the

uncertainties about Family Team Conferencing expressed in the survey, survey respondents believed in it and felt strongly that FTCs should continue. The results of this survey, along with results from previous studies for this project, show the expected mixed reactions to implementing a new practice model. However, overriding these mixed reactions has been a generally positive sentiment about FTCs and the potential of Family Team Conferencing to have a positive and meaningful impact on families.

Cost Data

Select cost data was itemized for services authorized and delivered (see above) to study participants. Figure 1 provides an itemization of the average cost for delivered services for each service category across FTC Pathways. Please note that given the variation in number of units authorized per service type across individual cases and different rates of utilization of authorized services across individual families, there can be noteworthy variance (see standard deviations) in mean costs. A series of statistical tests (ANOVAs) were conducted in order to gauge if any observed mean score differences (across participant groups within each Pathway AND for each participant group across each Pathway) were statistically significant. Different tests were utilized based upon whether or not specific statistical assumptions were met (e.g. equality/homogeneity of variances, fixed versus random effects models, etc.) and for cross-validation purposes. For example, comparisons were made using a series ANOVA procedures with multiple group comparisons using the Bonferroni and Tukey-B tests (when equal variances existed) and Tamhane's T2 and Dunneutt's T3 test (when equal variances did not exist). These tests suggest there are no statistically significant differences in the average expenditures (valid cases used) across service categories for services delivered to cases across FTC Pathways. The greatest expenditures (and number of cases receiving services) are for mental health services. Average costs range (see Figure 1) from a low of $1,330.31 to a high of $1,808.54 for Pathway 1 and Pathway 3 cases (respectively). Although there is nearly a $500 difference in these averages, an imbalance in sample size (given the smaller number of Pathway 1 participants) and statistical assumption adjustments (especially given observed variances) suggest these average expenditures are not significantly different. This is the case for all observed expenditures, where (generally) mental health services, followed by parenting classes and supports have the highest average costs, and substance abuse and other services have the lowest average costs per family.

Figure 1 Average Costs for Services Across FTC Pathways

Pathway		Domestic Violence Services	Mental Health Services	Parenting Classes and Supports	Substance Abuse Services	Other Services	Total Costs of All Services
Pathway 1	Mean (N, Std. Deviation)	$306.71 (38, $362.14)	$1,330.31 (88, $1605.66)	$1,071.10 (67, $985.45)	$147.99 (53, $236.08)	$62.15 (48, $119.91)	$2,156.25 (98, $2106.18)

Pathway 2	Mean (N, Std. Deviation)	$364.32 (89, $453.41)	$1,765.43 (196, $2538.49)	$1,092.29 (166, $926.22)	$127.03 (131, $287.21)	$61.53 (127, $184.19)	$2,585.06 (226, $3,076.99)
Pathway 3	Mean (N, Std. Deviation)	$405.85 (91, $422.06)	$1,808.54 (204, $2092.87)	$1,301.66 (161, $1229.67)	$100.18 (122, $163.50)	$118.47 (122, $347.66)	$2,804.01 (229, $2972.97)
Total	Mean (N, Std. Deviation)	$371.61 (218, $425.28)	$1,704.99 (488, $2213.12)	$1,174.24 (394, $1072.47)	$119.96 (306, $235.76)	$85.02 (297, $258.68)	$2,599.74 (553, $2888.21)

C. OUTCOME EVALUATION RESULTS

Safety

Protective Factors Survey Results

The Protective Factors Survey measures five protective factors with each family via a structured/standardized survey of parents/primary caregivers of children that are the focus of prevention and service initiatives. A brief summary of each factor and its definition is contained in Table 10 in Appendix K. All of the above factors (apart from Child Development / Knowledge of Parenting factor) are computed using composite scores that are standardized in accordance with structured measurement protocols issued by FRIENDS National Resource Center for Community-Based Child Abuse Prevention. Prior to the development of composite scores the raw scores of select items are reversed (given inverse directional score anchors). After the standardization of composite scores, the resulting protective factor score is on a scale from 1 to 7 (the same scale and associated anchors for individual items). Unlike the other composite protective factors, the knowledge of parenting and child development factor is composed of five unique items analyzed individually in accordance with measurement protocols.

A total of 653 Protective Factors Surveys completed over the course of the study with 124 (19.0%), 246 (37.7%) and 283 (43.3%) of the sample associated with Pathway 1, Pathway 2, and Pathway 3 (respectively). However, the vast majority (79.5% or n=519) of these were completed at the baseline (i.e. Initial FTC) with no follow-up measure. The willingness of study participants to complete this instrument at follow-up periods was low. When a panel of cases was examined (for which there was a baseline and follow-up measure(s), there were a total of only 10 Pathway 1 cases, 65 Pathway 2 cases, and 59 Pathway 3 cases for which change in Protective Factors could be measured over time. The very low response rate (especially for Pathway 1) does not allow valid comparisons across Pathways (especially between Pathway 1 with Pathway 2 or Pathway 3). Regardless, a series of analyses (independent sampled t-tests) revealed that there were no statistically significant differences

in the average baseline scores/ratings of those included versus excluded from the panel for all three Pathways. Therefore, those in the panel appear to be equivalent to those not included in the panel on all Protective Factors measures at baseline. When paired sampled t-tests were used for scaled scores (see Table 11 in Appendix K for more details re; analyses results) and the individual ratings represent child development knowledge, etc. for Pathway 2 cases (n=55-65 matched pairs), there were no statistically significant changes in scores over time apart from the measure on Family Functioning (a significant increase in scores). With respect to Pathway 3, there were no significant changes over time with respect to any Protective Factor. Subsequently, these findings suggest that there is limited improvement with respect to Protective Factors for a panel (sub-set) of families that participated in Pathway 2 and Pathway 3. The limited or low follow-up response rate raises questions regarding the representative nature of these findings. For example, at various points during the study, when response rates to follow-up measures were noticeably low, the evaluators scheduled meetings, had discussions, and solicited feedback from project staff, supervisors, family care counselors, and FTC Facilitators and Coordinators. Although efforts of encouragement were made to ensure data collection protocols were followed (they were, Pathway 1 concerns have already been noted), reports were made that many families declined to complete select supplemental measures for a variety of reasons, including possible respondent fatigue, termination of service involvement, and/or the perception that matters had improved and completion of study instruments was no longer needed (despite assurances to the contrary). Although study participants were encouraged to complete follow-up measures, no pressure to do so was exerted and their expressed desire not to participate in an element of the study (although they remained study participants) was respected in accordance with their voluntary consent agreement.

Permanency and Stability

Using data obtained from FSFN (the state SACWIS system) for all study cases, the evaluation examined the extent that among all the children who were discharged from foster care to reunification over the course of the study, the percentage of children that re-entered foster care in less than 12 months from the date of discharge. Here (as denoted in state data protocols), "out-of-home care" means care provided during a removal episode, regardless of placement type or custodian, including those in licensed board-paid foster care and kinship (relative and non-relative) care. A "removal episode" is the period that a child is removed from the child's home, beginning with a removal date and ending with a discharge date. "Removal date" means the date a child is removed from the home. "Discharge date" means the date a child leaves out-of-home care, either by achieving permanency or other reason. "Reunified" means the discharge of a child from out-of-home care with a discharge reason of either: (1) reunification with parent(s) or other primary caretaker(s), (2) living with other relatives or (3) Guardianship. "Re-enter" means a subsequent removal episode following reunification. There were a total of 47, 49, and 56 children that met the inclusion criteria for this algorithm for Pathway 1 through Pathway 3 participants (respectively). See Table 13 in Appendix K for a distribution of cases included for this measure. Please note that these data include all study participants.

The Pearson Chi-Square (chi-square=7.65, df =2, p=.02) and Likelihood Ratio Chi-Square (chi-square=7.55, df=2, p=.02) tests (using a two-sided asymptotic significance) confirm that there is a relationship between the likelihood that a child will re-enter care within 12 months of being

reunified and their Pathway status. Here the rate of re-entry was highest for Pathway 3 cases (30.4%), followed by those in Pathway 1 (14.9%) and then Pathway 2 (10.2%). A column proportions test (where each pair of columns are compared using a z test) that utilizes the Bonferroni correction was conducted. The results suggest that the re-entry rate for Pathway 3 cases (30.4%) was significantly higher (at $p < .05$) than the rate observed for Pathway 2 (10.2%) cases but not necessarily for Pathway 1 cases (14.9%). The rate of re-entry for Pathway 1 cases (14.9%) did not differ (with statistical significance) from the re-entry rate for Pathway 2 or Pathway 3 cases. When these rates of re-entry for study participates are compared against non-study participants included in algorithm (rates provided by Quality Assurance personnel), there was no statistically significant difference (using procedures denoted above) in the re-entry rate of non-study children (11.0%, n=58 of 529) contrasted against Pathway 1 and Pathway 2 rates. However, this percentage differed at a statistically significant level from the Pathway 3 re-entry rate.

Permanency and Continuity

Reunification Within 12 Months of Entry Into Care

One measure (using available FSFN data for all study cases) included the following: of all children who entered foster care for the first time, and who remained in foster care for 8 days or longer, the percentage that were discharged from foster care to reunification in less than 12 months from the date of latest removal from home. This measure corresponded with one of the performance measures utilized by DCF in accordance with CFSR standards. This measure is a percentage of those children that are reunified in less than 12 months where (in accordance with DCF data protocols) a "child" is any unmarried person under the age of 18 years who has not been emancipated by order of the court. "Reunified" means the discharge of a child from out-of-home care with a discharge reason of either: (1) reunification with parent(s) or other primary caretaker(s), or (2) living with other relatives. Children discharged with a reason of "legal guardianship" are excluded, even if the legal guardian to whom the child is discharged is a relative. The denominator includes all children who entered out-of-home care during the period ending one year prior to the reporting period and who remained in care eight days or longer, where the child's primary worker was an agent of the provider. The numerator is the subset of children in the denominator whose discharge date is less than twelve months from removal date of the most recent removal episode. Please note (given the structure of the algorithm) that this measure does not account for those cases that entered out-of-home care in the last year of the study.

There is an imbalance in the numbers of children included in the sample across all the Pathways (N=102, 145, and 153 for Pathways 1, 2, and 3 respectively) that reflects already stated concerns regarding the participant response rate for Pathway 1 (see Table 14 in Appendix K). The Pearson Chi-Square (chi-square=13.0, df =2, p=.002) and Likelihood Ratio Chi-Square (chi-square=13.1, df=2, p=.001) tests (using a two-sided asymptotic significance) confirm that there is a relationship between the likelihood that a child is reunified within 12 months and their Pathway status. Here the rate of reunification was highest for Pathway 1 cases (58.8%), followed by those in Pathway 2 (50.3%) and then Pathway 3 (36.6%). A column proportions test (where each pair of columns are compared using a z test) that utilizes the Bonferroni correction was conducted. The results that the reunification rate for Pathway 1 was significantly higher than the rate observed for Pathway 3 but not Pathway 2 cases. The reunification rate for Pathway 2 cases did not differ significantly from

Pathway 1 or Pathway 3 cases (at $p<.05$). When these rates of reunification for study participates were compared against non-study participants included in algorithm, there was no statistically significant difference in the reunification rate of non-study children (50.8%, n=732) contrasted against Pathway 1 and Pathway 2 rates. However, this percentage differed at a statistically significant level from the Pathway 3 rate.

Number of Placements

Data related to the number of placements of children in out-of-home care was examined for all study cases across all FTC pathways. The Pearson Chi-Square (chi-square=2.63, df =2, p=.27) and Likelihood Ratio Chi-Square (chi-square=2.57, df=2, p=.28) tests (using a two-sided asymptotic significance) indicated that there is no relationship between the likelihood that a child will have two of fewer placements while in care and their FTC Pathway status (see Table 15 in Appendix K). The percentage of two of children in out-of-home care with two or fewer placements was 88.5%, 88.2%, and 83.2% for children in Pathway 3, Pathway 1, and Pathway 2 (respectively). These percentages do not differ significantly from the percentage of non-study children (87.8%) that had two or fewer placements while in care. When the actual number of placements is examined, ANOVA models suggests that there are no significant differences in the average number (and variance) of placements of children from Pathway 1 (Mean=1.56, SD=1.094, Range 1-9), Pathway 2 (Mean=1.63, SD=.893, Range=1-5), and Pathway 3 (Mean=1.57, SD=1.031, Range=1-8).

Well-Being

Strengths and Difficulties Questionnaire Results

A total of 1,103 Strengths and Difficulties Questionnaires were completed over the course of the study. These apply to 617 individual children, whom may have been rated by one or more caregivers at any point in time. In total there were 503 unique/individual caregivers (within 293 unique study cases) that rated 617 unique children for a total combination of 855 unique child and rater cases. This number is reduced to 822 when 33 scores are excluded for select participants whose status as a study participant changed over the course of the study. The vast majority of these ratings were associated with Initial FTCs. When follow-up data are considered, there are 178 children with multiple measures over time. For these panel cases, any baseline measurement is contrasted against the latest rating of an individual child during follow-up FTCs or completion of service delivery. A distribution of responses (see Table 16 in Appendix K) suggests that the panel of Pathway 1 cases represents only 12% of those children measured on the SDQ at baseline. Follow-up measures are available for 28.5% of Pathway 2 cases and 21.7% of Pathway 3 children assessed at baseline have follow-up measures.

The Strengths and Difficulties Questionnaire is a standardized instrument normed on a representative population of children and youth based on parent, caregiver, youth self (if 11-17 years old), and teacher ratings. No teacher rating forms were utilized in this study. There is a structured

scoring protocol that differs based on the age range of the child and relationship of the rater to the child. Raw scores were utilized in the development of composite scores based upon established protocols and then these scores were contrasted against standardized thresholds for the classification of a child as within the "normal," "borderline," or "abnormal" range of behaviors/symptoms manifested as Emotional Symptoms Score, Conduct Problems Score, Hyperactivity Score, Peer Problems Score, ProSocial Behavior Score, and Total Difficulties Score. For this report, analyses will focus on the final classification structure of children and youth (as opposed to raw scores) based on interpretive guidelines provided in measurement protocols.

Given the low proportion of cases for which follow-up measures were available, a series of Independent Samples T-tests (whether equal variances are assumed or not using the results from the Levene's test for equality of variances) were conducted on average scores at baseline of those included versus excluded from the final panel of cases for each of the SDQ subscales (see Table 17 in Appendix K for more details). For Pathway 1 cases, average scores on all SDQ measures are equivalent for those included versus excluded from the panel apart from the ProSocial Behavior Scale where those excluded from the panel had significantly higher average ratings (Mean $_{\text{non-panel}}$ = 8.13, within the "normal range") of pro-social behaviors than those in the panel (Mean $_{\text{panel}}$ = 6.50, also within the "normal" range) (t=2.56, df=100 p=.012). With respect to Pathway 2 cases, there are no significant differences in the mean scores of those included versus excluded from the sample on the individual SDQ subscales and the Total Difficulties Scores. With respect to Pathway 3 cases there are no significant differences (at $p<.05$) in the mean scores of those included versus excluded from the sample on the individual SDQ subscales. However, significant differences exist in with respect to the Total Difficulties Scores. Here, those excluded from the panel (Mean $_{\text{non-panel}}$ = 17.76, within the "abnormal" range) had a statistically significant lower mean score than those included in the panel (Mean $_{\text{panel}}$ = 20.91, also within the "abnormal" range) (t=-2.64, df=397, p=.009). In addition to these comparisons, a series of ANOVA models were run to distinguish if there were any significant differences in average SDQ scale scores at baseline across all three panel groups. There were no significant differences between Pathway 2 and Pathway 3 scores on any SDQ measures. However, Pathway 1 cases had significantly higher average Conduct Problems scores (Mean=3.15; F=3.48, p=.031) and Total Difficulties Scores (Mean =18.93; F=3.70, p=.025) than those observed with Pathway 2 cases (Mean $_{\text{Conduct}}$ = 2.41; Mean $_{\text{Total}}$ = 16.86, respectively). With respect to Conduct Problems, the average score is within the "borderline" range for Pathway 1 children and within the "normal" range for Pathway 2 children. With respect to the Total Difficulties Score, both average scores (with rounding) are within the "abnormal" range of functioning.

Given the limited response/participation rate of Pathway 1 cases, the sample sizes are not balanced for ANOVA procedures. Although the harmonic means of group sizes are used (given this imbalance), protection against Type I errors (i.e. incorrect rejection of a true null hypothesis) for ANOVA tests are not guaranteed. Therefore the observed significance between average scores for Pathway 1 and Pathway 2 cases may be an error. Regardless, the above findings suggest that there is general equivalency on all measures of Strengths and Difficulties for children included versus excluded from the panel of cases for which change in these measures is assessed over time.

When data from a sub-sample for a sub-sample of panel cases is examined (see Table 17 in Appendix [ ]), children that were the subject of Pathway 2 FTCs (using Paired Samples T-tests) demonstrated a significant reduction in their average hyperactivity scores (t=2.91, df=89, p=.005); however the group average at both time periods was within the "normal" range. The average Prosocial Behavior score increased (a positive indicator for this measure) significantly (-3.31, df=88,

p=.001) but group averages at both time periods were also within the "normal" range. The average total difficulties score for Pathway 2 children showed a significant reduction (t=3.23, df=90, p=.002) from an average score within the "abnormal" range (Mean $_{baseline}$ = 17.84) to an average score within the "borderline" range (Mean $_{follow\text{-}up}$ = 15.62).

With respect to Pathway 3 panel cases, there was a statistically significant reduction (a positive trend) in the average scores measuring Emotional Symptoms (t=2.89, df=71, p=.005), Conduct Problems (t=2.03, df=72, p=.046), Hyperactivity (t=3.39, df=70, p=.001), and Total Difficulties (t=5.38, df=73, p<.001). Of particular note are the reductions in mean scores for Conduct Problems (whose average score moved from "borderline" to "normal" levels) and Total Difficulties (whose average score moved from "abnormal" to "borderline" levels). Changes in the average Emotional Symptoms and Conduct Problems scores were significant but within "normal" ranges.

In addition to measures of change of mean SDQ sub-scale scores, it is of value to gauge the movement of individual panel cases across levels (i.e., normal, borderline, abnormal) of symptomology given sub-scale scores. Table 18 and 19 in Appendix K summarize the distribution of a non-duplicate count of matched cases/children by level of symptomology across SDQ sub-scales (symptom/behavior constructs). Here, it is of value to observe the change in marginal totals for each level for these multinomial data. To gauge the significance of any change in marginal totals, a two marginal homogeneity test (a non-parametric test) was conducted for each distribution of cases over time associated with each sub-scale.

Table 18 and Table 19 summarize the distribution of children classified as "normal," "borderline," or "abnormal" on each of the individual symptom/behavior scales (including the Total Difficulties Scale) at the baseline and follow-up periods for Pathway 2 and Pathway 3 children respectively. Statistically significant changes in the distribution (marginal totals) of cases over time are noted for Pathway 2 children classified via the Hyperactivity Scale, ProSocial Scale, and Total Difficulties Scale. With Pathway 3 children, significant changes in the distribution of classification via the Conduct Problems Scale, Hyperactivity Scale, and Total Difficulties Scale were noted. Among Pathway 2 cases (see Table 18), the total number of children rated as demonstrating "abnormal" hyperactivity decreased by 36.4% (from 22 to 14). There was an increase (from 82% to 91%) in the proportion of children demonstrating normal pro-social behaviors and a significant decrease in the proportion of all Pathway 3 children classified as demonstrating "abnormal" social behaviors (from 11.2% to 4.5%). Finally, with respect to measures of Total Difficulties, only 23% of children at the start of the study scored within the "normal" range on Total Difficulties. This percentage increased to 42.8% by the end of the study. Although the majority of children were still scored at the "borderline" (the greatest decrease in distribution was with this group) and "abnormal" levels (combined), the almost doubling of children classified as "normal" was statistically significant and demonstrates some promise.

Among Pathway 3 cases (see Table 19), the number of children rated as "normal" with respect to conduct problems increased from 35 (47.9%) to 46 (63.0%), whereas the number rated as "abnormal decreased from 29 (39.7%) to 23 (31.5%). Those rated as "abnormal" with respect to Hyperactivity problems and Total Difficulties decreased (respectively) from 23 (32.4%) to 15 (21.1%) and from to 54 (72.8%) to 35 (47.3%). Both Pathway 2 and Pathway 3 FTCs are associated with significant improvement with respect to hyperactivity problems and a measure of total difficulties. Children from Pathway 2 FTCs additionally demonstrated an increase in the proportion of children rated as demonstrating "normal" social behaviors. Alternatively, children from Pathway 3 FTCs

demonstrated an increase in the proportion of children rated as "normal" with respect to conduct issues.

Goal Attainment Scales

There are a number of ways the impact of FTCs are being measured. For example, each family (as part of the FTC) develops their own Goal Attainment Scale (GAS) that is used to gauge the level to which specific service and personal goals (with meaningful measures) are obtained. Although the goals are individualized, the level of progress over time is measured via the standardization and comparison of scores. Taken together, the goals address a wide array of issues families are dealing with. Among the 1,667 goals established for 644 separate Goal Attainment Scales with 423 separate (non-duplicate) families (or 67.9% of all study cases), those issues of most prominence included mental health needs (23.2% of all goals), case planning issues/needs (24.8%), substance abuse issues (14.0%), domestic violence issues (8.2%), and housing needs (7.7%). Other goals focused on employment (5.4%), education (4.1%), daycare (2.9%), visitation (3.1%), dental and medical needs (3.4%), and safety planning (2.8%). Other miscellaneous goals (e.g., clothing, medical management, etc.) represented less than 1% of the total goals. Among the 423 families, 73 were assigned to Pathway 1 FTCs, 165 were assigned to Pathway 2 FTCs, and 185 were assigned to Pathway 3 FTCs. These figures represent 51.8%, 62%, and 68.5% of all Pathway 1, Pathway 2, and Pathway 3 study cases (respectively).

Individualized service goals and measurement anchors are structured within or as an outgrowth of the initial FTC with the family. Measurement of progress is made at subsequent FTCs or time periods deemed of value by the family and professionals for monitoring progress. There were 157 families (37.1% of 432) for which multiple measures using the GAS were available; 15, 66, and 76 families assigned to Pathway 1, 2, and 3 (respectively) are represented in this sub-sample.

Among the 157 families for which multiple measures are available (at least two follow-up measures following the establishment of agreed upon service goals), there was a statistically significant ($t = -6.17$, $df=135$, $p<.001$) rate of progress/improvement toward the accomplishment of all service and personal goals over time (using a standardized composite score) when all the data (across all Pathways) is aggregated for analyses.

When data from paired cases in each Pathway is examined (using a series of paired samples t-tests); there is no significant measured change in the rate of improvement for Pathway 1 ($t = -.715$, $df=12$, $p=.489$) cases; however, noteworthy and significant changes exist for families assigned to Pathway 2 FTCs ($t = -4.41$, $df=54$, $p<.001$), AND Pathway 3 FTCs ($t = -4.47$, $df=68$, $p<.001$). These findings (with available data seem to suggest that Pathway 2 and Pathway 3 FTC models have a more distinctive effect on moving the family (in a favorable direction) toward agreed upon service goals. However, given that the number of matched cases represents only 37.1% of all families completing a GAS, it is important to determine if matched cases differ from non-matched cases with respect to presenting issues and problems. One equivalency tests involves the comparison of initial standardized GAS scores of those in the matched panel (i.e. pair of cases) to those not in the panel, stratified by FTC Pathway. A series of independent t-tests conclude that there is no statistically significant difference in the Pathway 2 ($t=0.56$, $df=135$, $p=.579$) and Pathway 3 ($t=1.68$, $df=145$, $p=.10$) families included versus excluded from the panel with respect to the magnitude of change in accomplishing planned goals during the first measurement of the GAS. In addition, there was no significant difference ($t=1.29$, $df=63$, $p=.20$) in the difference observed among Pathway 1 cases. Taken together, these findings (qualifications noted) suggest that Pathway 2 and Pathway 3 cases to

have a more significant impact in moving families toward plan of care goals. These same effects are not manifested with Pathway 1 cases. Here, the use of a trained facilitator may be a key component in aiding families in the development of family goals and assisting in securing/facilitating the means (with other professionals) by which these goals can be achieved in a timely manner.

D. EVALUATION DISCUSSION

Overall, the comprehensive evaluation plan that was proposed for the project was executed with success, as virtually all components were completed. There were, however, challenges to the evaluation – some of which imposed limitations on the evaluation. Three challenges related to evaluation surfaced at the beginning of the project. The first challenge, which impacted project implementation, was the delay in the Institutional Review Board application submission due to the unavailability of approved IRBs. The second challenge was related to the process evaluation. The initial plan to conduct a review of tape or video recordings of FTC meetings to monitor program fidelity could not be executed due to the legal implications of recordings that may be accessed or used by legal counsel. In lieu of tape or video recordings, an independent observer to attend and rate the FTC meetings was used. The third challenge, which ultimately impacted the sample sizes for our experimental and comparison group analyses, was obtaining informed consent for Pathway 1 clients. Early in the evaluation, it was found that 47% of the families who declined participation in the research study were assigned to Pathway 1 (compared to approximately 25% for Pathways 2 and 3 each). Efforts were made throughout the project to boost participation in the research study, and there were noticeable improvements as a result of these efforts. In the end, the participation rates for Pathway 2 (63.9%) and Pathway 3 (66%) were at least 20% higher that the participation rates of Pathway 1 (42.5%) families. Regardless, exemption rates hovered around 20%; comparatively fewer families in Pathway 1 participated in the research study; and relatively large proportions (over 50%) of families in all three Pathways declined follow up FTCs. When efforts were made to ascertain the reasons influencing the decline of follow-up FTCs, anecdotal feedback from FCCs, project staff, and unit supervisors suggested there was reluctance on the part of families to participate in follow-up FTCs if "things were going good" or progress was being made on case plans. If this were true, then findings generated from a panel of cases with follow-up FTCs may be negatively biased or less likely to demonstrate desired change on a number of outcome measures/indicators. Efforts to contact a sample of families (n=100) without follow-up FTCs in order for them to complete the SDQ and PFS were unsuccessful with only a few willing to provide follow-up data.

As suggested earlier, the limited participation rates for Pathway 1 may have been facilitated by historical events; namely, the change in administrative protocols that prohibited the accumulation of overtime or flex time for FCCs from one week to the next. These events, coupled with the demands of being a study participant (i.e. responding to surveys, etc.) as well as facilitating FTCs may have prompted a reactive effect on the part of FCCs in Pathway 1 who needed to adapt to an increase in workload/work-related tasks within a more constrained work environment. In this situation, the use of facilitators heightened the participation rate of families and FCCs in Pathway 1 and Pathway 2. The different sample sizes across the three Pathways may have limited our interpretation of the study findings, which were mixed with respect to select outcomes measured. In addition, the high decline rates for follow-up FTCs resulted in small sample sizes for pre- and post-test analyses for the outcome evaluation. All in all, this limited the types and depth of statistical analyses proposed and desired for the evaluation. Regardless, efforts were made to gauge the level of equivalency across FTC Pathways at baseline periods with respect to key dependent variables and other indicators. Analyses suggest that despite the smaller sample of Pathway 1 cases, families across all three

Pathways were generally equivalent with respect to demographic characteristics, issues and problems demanding service, services authorized and delivered, and measures of key dependent variables/outcome indicators at baseline.

Section VII: Conclusions

A. Determine whether the project met its proposed goals and objectives. If the project did not meet goals and objectives, discuss why.

The primary goal of the project was to respectfully engage families in decision making and case planning through strength based, family centered, culturally appropriate system of care that included initial and ongoing Family Team Conferences for every new voluntary in-home supervision and shelter case entering PSF's system of care. To help with the successful implementation of the project and associated program, an implementation timeline was created. This timeline included tasks related to hiring staff, the designation of roles and responsibilities, the creation of protocols and processes and training and outreach to staff and community members.

The first objective was to hire and train 4 full-time Family Service Facilitators (FSF) who served as the facilitators for all initial and ongoing FTCs for the random sample of cases, as well as hire 2 full-time Family Team Conference Coordinators to help coordinate all the planning and logistics for the FTCs. The descriptions for these available positions were posted in October, 2009; and new staff were hired to begin working before the conclusion of 2009. These individuals were selected based on their strong communication and organizational skills, as well as for their extensive clinical and child welfare experience. The two coordinator positions were easily filled; however, several rounds of postings and interviews needed to take place to fill the 4 facilitator positions. Two of the facilitator positions were filled during the first round of the application and interview process; a third facilitator was hired during the second round and finally, the fourth facilitator was hired during a third round that took place in the spring of 2010.

Another objective related to implementation involved designating roles and responsibilities, which included the establishment of the FTC Implementation and Operations teams and finalizing the responsibilities that each position, including FTC Facilitators, FTC Coordinators, Family Care Counselors, Service Providers, PSF's IT department, Child Protective Investigators and Grant administration staff would have in their individual roles. This objective was finalized in writing by December 2009. Additionally, protocols and processes related to the intake and assignment of cases, administration of research material, budget and reporting, IT and data entry, data tracking and cleaning and model fidelity were established, in writing, by the completion of 2009.

The creation of an in-service training presentation related to the FTC process, research protocols and instruments, quality assurance and model fidelity was completed in November of 2009, and these trainings began to be presented in December 2009 and continued, as necessary, throughout the 3 year project period. Similarly, training for DCF, GAL, service provider and other community partner staff was initially created and presented in December of 2009 and continued, as necessary, throughout the 3 year project period. Outreach and education to community stakeholders and other potential partners also took place during this time period.

The application process for IRB approval began in October 2009 but faced delays due to DCF protocols. DCF granted permission to apply, and the application was immediately submitted to the Western Institutional Review Board in March 2010. IRB approval was obtained on May 6, 2010 and data formally began to be collected for research on May 24, 2010. Therefore, the evaluation rolled out immediately after approval to begin data collection. Outside of the data collection procedures for the FTCs, other process evaluation activities took place, starting with fidelity monitoring with an independent observer. All other process evaluation activities (i.e., initial and follow up interviews with FCCs and FTC Facilitators, focus groups with parents and service providers, and survey with community partners) were implemented and completed as planned. Importantly, these process evaluations were used to institute changes in order to adhere to model fidelity, and to improve project implementation and practice quality.

The outcome evaluation was implemented as planned, although the response rate to select supplemental instruments (e.g., the PFS, SDQ, and GAS) was impacted by the rate of participation of families in follow-up FTCs and the observed imbalance with respect to the sample size of Pathway 1 cases as baseline and throughout the study. Regardless, sufficient data was collected so as to allow for tests of equivalency of study participants across FTC Pathways and between those included versus excluded from panels of participants. Further, regardless of the occurrence of a follow-up FTC, complete data (over the course of the project) for all study participants was collected related to services utilized and delivered, costs of these services, and select safety and permanence data that could be retrieved from the FSFN (Florida SACWIS) system. Taken together, the outcome findings are mixed. Considering data available on all study cases/families, there are no variations in the types of service goals, service referrals, services delivered, and service costs to families across Pathways. Although there is equivalency in the demographic profile and types of cases assigned to each Pathway, children in Pathway 3 had a significantly lower rate of reunification than Pathway 1 cases and a higher rate (three times higher) of foster care reentry than Pathway 2 cases. These findings occur despite some positive evidence (with a sub-set of panel cases) that Pathway 2 and Pathway 3 cases have a significant impact upon movement and achievement of service and plan-of care goals (using the GAS), perceived value and utility of the FTCs (using the QFMP), family functioning and resiliency (for Pathway 2 cases only using the PFS), and social and behavioral symptomology of children (using the SDQ).

B. Describe any significant implementation facilitators and/or barriers (implementation drivers) and "lessons learned" related to project implementation.

The most significant facilitator to the implementation of this project was the strong partnership between the agency (PSF) and the evaluation team. Throughout the entire project period, the communication and relationship remained positive and consistent. This was critical in the implementation process, as well as for the success of the project, in general. This project was PSF's first federally funded project and the expertise and assistance provided by the evaluation team was invaluable.

While the implementation of the project was, overall, successful, there were some significant lessons learned that will assist in the implementation of future projects of this caliber. As mentioned in earlier sections of this report, the collaboration with the case management agencies, DCF, GAL and service providers was of tremendous importance to the project's success. With this, however, came some challenges related to the case management agency's Family Care Counselors (FCC) ability to deliver the informed consent and collect research instruments for families randomly assigned to Pathway 1. Although the FCCs bought into the FTC process and enjoyed the concept of FTC facilitators and coordinators being assigned to certain cases of theirs, buy-in on the importance of the research study lacked throughout the duration of the project period. Consequently, the population of families that consented to research and were assigned to FTC Pathway 1 was smaller than the population of two comparison pathways (2 and 3). For future projects, strong consideration would need to be given to place this responsibility, once again, on the FCCs. If the choice were made to give them this responsibility again, stronger, more intense training would need to be given, with respect to the informed consent and importance of model fidelity.

However, consideration of alternative arrangements should be made given noted workplace factors, including time constraints placed upon FCCs and other staff as a result of administrative protocols (e.g., restrictions related to overtime and flex time) and workplace culture and climate issues that impact responsiveness to the integration of new practices. Despite an abundance of training and responsiveness by project staff and evaluators to FCCs and other PSF staff, resistance of some staff and supervisors (anecdotal evidence suggests) to practice changes and attempts to monitor their practice can be manifested in non-participation rates and a negative reaction to testing/evaluation activities. Toward this end, some consideration may be given to a more parsimonious use of select data collection instruments. The ambitious nature of the evaluation model led to the collection of a variety of data. Although efforts were made to spread out the application of data collection instruments in an effort to minimize respondent fatigue, the data requirements from families or (more specifically) FCCs in Pathway 1 may have been perceived as a burden, promoting a negative reactive effect to the evaluation design. However, these fears are tempered by feedback (see comments earlier in the report) from select FCCs and unit supervisors that reported families' lack of interest in having a follow-up FTC (or completing select survey instruments upon service completion) resulted from a limited perceived need to do so as there had been desired progress with service plans. The significance, representativeness, and/or validity of these observations can only be conjectured. Regardless, they provide some food-for-thought regarding the potential need for alternative incentives for families to participate in the collection of follow-up data. Although incentives ($25 gift cards) were given to those that participated in qualitative data collection methods that aided elements of the process evaluation, perhaps a similar incentive could be given to families that participate in any collection of follow-up data, whether collected in accordance with FTC timelines or upon completion of involvement with PSF. For this study, the cost of such an endeavor (given the number of study subjects) was considered prohibitive and not feasible. For future studies, perhaps such incentives could be used with a more limited scope of potential study participants.

C. Describe and interpret the impact of the project on parents, children, and families. Include discussion of relevant process and outcome data to help interpret impact.

The design of our FTC models, which was based on the Family Group Decision Making literature, was intended to genuinely involve parents/caregivers, children, and their family and non-family supports in decision making around their service plans. This aim was undoubtedly achieved in the project, as evidenced by our extensive process evaluation that tracked the participation of parents/caregivers, children (as appropriate), and family and non-family supports, as well as directly solicit the experience of those involved in the experimental FTCs. The skill and respect with which FTC Facilitators co-led the FTCs left a positive impression on the parties involved. In addition, our high service referral rates to various community-based services, including mental health and domestic violence services, suggest that families were connected to services that they helped to determine through the FTC as important to their well-being.

These findings are reinforced when feedback from the QFMP is observed. As noted in Section VI, results from the QFMP suggest that all three Pathways were implemented with fidelity, participants were adequately prepared and the family was clear on their role, the family members were active participants and empowered, participants (including family members) were satisfied with the process, and the outcomes (especially related to case plans) were appropriate, clear, and in keeping with the goals and objectives of Family Team Conferencing. Although there were no significant differences between mothers (the modal response and family participant), other family members' and supports', and professionals' perspective on the value of FTCs in Pathway 1, mothers and family members in Pathway 2 and Pathway 3 scored higher on their agreement than professionals on several items that suggest FTCs were implemented with fidelity and maximized family participation and empowerment in developing service plans that spoke to child safety needs. There are a few findings and significant differences in scores denoted in Appendix K worthy of being highlighted. These include:

- There was no statistically significant difference in the mean scores (on level of statement agreement) observed for mothers, other family members and supports, and professionals within Pathway 1.

- Mothers and/or family members had higher levels of agreement than professionals in Pathway 2 or Pathway 3 FTCs with the following statements:

  - "Everyone at a meeting understands why it is being held"
  - "Families are prepared for taking part in the meetings (e.g., the purpose of the conference was clearly explained and reason for attending understood, etc.)"
  - "All the people that needed to be included attended the conference"
  - "The plans include ways that relatives, friends, or other close supports will help out"
  - "I understand what will happen if the plan is not followed"
  - "There are adequate resources to meet the goals/objectives of the family plan"
  - "The meetings are held in a place and at a time that was convenient for the family"
  - "I have a better understanding of how the family can ensure the safety of this/these child(ren)"
  - "I am confident that the plan ensures the child(ren)'s safety"

- Professionals in Pathway 3 had a significantly higher level of agreement than mothers and other family members and supports with the following statement "Facilitators run the meetings well," even though the average level of agreement was very high across all groups.

- Professionals in Pathway 3 had a significantly lower level of agreement than mothers and other family members and supports with the following statement "All the people that needed to be included attended the conference."

The variation in perspective—although all generally rated FTCs favorable on matters of fidelity, preparation, family participation, family empowerment, and outcomes—on the above items between family members and professionals (for Pathway 1 and Pathway 2 cases) suggests families value the role of a neutral facilitator in aiding the process of developing a service plan. This reinforces findings from the process evaluation that support the perceived value and utility of Pathway 2 and Pathway 3 FTCs among family members. The benefits of having a trained facilitator may be manifested in the enhancement of family functioning (measured by the PFS) for Pathway 2 cases, the improvement in the levels of hyperactivity and total difficulties for Pathway 2 and Pathway 3 children and youth (measured via the SDQ), improvements in the level of measured conduct problems (using the SDQ) for Pathway 3 children, the enhancement of pro-social behaviors demonstrated by Pathway 2 cases, and the significant movement (of Pathway 2 and Pathway 3 cases) toward the accomplishment of service goals (measured via the G.A.S.). Other measures of service utilization, placement stability, protective factors (e.g. social emotional support, concrete support, child development/knowledge of parenting, and nurturing and attachment) do not differ significantly across Pathways (earlier qualifications noted) over the course of the project. Taken together, these findings might suggest that the use of facilitators in FTCs (either with or without family alone time) have a definite benefit and potentially positive impact upon children, youth, and families.

Yet, noteworthy concern is raised regarding the potential benefit (or lack thereof) of Pathway 3 FTCs (that utilize family alone time) upon the rate of reunification of children (Pathway 3 rate was 22% lower than Pathway 1 but not statistically different from Pathway 2 rate) and the re-entry of children into foster care (Pathway 3 rate of re-entry was three times higher than Pathway 2 but not statistically higher than Pathway 1). Thus, Pathway 3 had a significantly lower rate of reunification than Pathway 1 cases but a similar rate of re-entry into foster care as Pathway 1 cases that was three times higher than the rate observed with Pathway 2 cases. This is interesting, especially given the level of equivalency of Pathway 3 cases with the other FTCs Pathways with respect to demographics, service needs and utilization patterns, and measures of principal dependent variables at baseline. Taken together, these results may suggest that Pathway 2 FTCs (without family alone time) have the greatest potential benefit for children, youth, and families. It was certainly the preferred model among FCCs (see interviews with FCCs). Since no professionals or project staff are present during family alone time, we can only conjecture as to what, if any, impact the discourse among family members during alone time might have had upon the responsiveness to developed service plans while professionals and a facilitator were present. Given feedback from the QFMP, focus groups, and information garnered from independent observations, the evaluators and project staff would not have imagined family alone time (by itself) would have had a detrimental impact upon these outcome measures. More time is needed to ascertain whether the significant differences in the foster-care reentry rates for Pathway 3 cases are sustained and meaningful. By way of

explanation, as noted in Section VI, the algorithm for this measure (a Florida and CFSR measure) "…all children who entered out-of-home care during the period ending one year prior to the reporting period and who remained in care eight days or longer." Therefore, a more valid measure of the impact of different Pathways upon foster-care re-entry rates (using this measure) would occur after data is obtained through September 30, 2013. There is a possibility that the observed differences (albeit significant) are an anomaly that would "regress" out after an extended period of time, in keeping with the time parameters (for the outcome measure) applicable to the time parameters of family participation in the study. However, if this finding is sustained over time (i.e., through September 30, 2013) then the value of requiring family alone time as part of an FTC model can seriously be called into question.

In addition, some consideration needs to be given to the impact of Solution-Based Casework as a neutralizing factor on a number of process and outcome measures as many of the tenets of the theories supporting the experimental FTC models are reinforced/mirrored within the SBC model integrated system-wide over the course of the study. Did SBC (as an interacting influence) provide benefits to Pathway 1 cases that in the absence of SBC may have been manifested only (or at greater levels) with Pathway 2 and/or Pathway 3 cases? Since SBC began to be integrated shortly after data for this project was collected, there is insufficient data (pre- post-SBC integration) that would allow the extraction or isolation of the SBC effect as a main effect or interactive effect upon select outcome measures.

D. Describe and interpret the impact of the project on the involved partner organizations. Include discussion of relevant process and outcome data to help interpret impact.

The most significant impact the project had on the partner organizations was the value placed on the FTC process. FTCs were completed as part of PSF's system of care prior to this project; however, they were not given adequate attention in terms of planning and facilitation. Family Care Counselors were responsible for these tasks for FTCs for families on their case loads. Due to other overwhelming responsibilities associated with case management, FTCs were often left on the back burner. This project called to attention the importance and value of skilled and highly trained non-case carrying professional staff to plan and facilitate FTCs. FCC/Case Management staff began to prefer when families on their case load were assigned to FTC pathways where a facilitator and coordinator would be involved. Similarly, DCF, GAL, service provider and other community partner staff also appreciated the concept of specially designated staff assigned to the FTC. These sentiments from multiple perspectives were evident in our process studies that sought to understand the experiences and perspectives of FCCs, service providers, and families with the FTCs. As a result of this project, Family Team Conferencing is now a core part of PSF's system of care.

E. Describe and interpret the impact of the project in the child welfare community. Include discussion of relevant process and outcome data to help interpret impact.

It is expected that the results of this project will contribute to a national report regarding Family Group Decision Making. A significant finding from this project is the value placed on having non

case-carrying staff plan and facilitate FTCs. The child welfare community would benefit tremendously from a process/practice that involves families and their supports in decision making. Although the outcomes do not indicate unquestionable support for FTCs in the way we designed them (that is, in terms of better outcomes in permanency, reunification, recidivism), it is a process that was supported by administrators, FCCs, families, service providers and other community partners. This is beneficial, not only for the families but for the community as a whole. In order to support families and not punish them, FTCs that truly empower families are critical to the child welfare practice. However, implementation of this comes with challenges that the field has to prepare for. These challenges include relative costs of extra staff balanced against workplace culture and climate issues that may impact the receptiveness of front-line staff to the experimental FTCs models examined in this project, especially if front-line staff members are responsible for arranging and facilitating FTCs. As suggested above, the influence of SBC shortly after this project began (beyond the evaluators' control) and potential diffusion effects (of FCCs participating in different FTC models) may have minimized any measurable differences in outcomes across Pathways (especially when Pathway 1 and Pathway 2 are compared) over time. Although the imbalance in the size of the sample of Pathway 1 cases (compared to Pathway 2 and 3) may have limited the meaningfulness of some comparative analyses, some select outcome findings (when combined with select process findings) may suggest that use of a non case-carrying staff to plan and facilitate FTCs is a promising practice (that requires more study). Less convincing is the value and utility of *requiring* family alone time as part of the structure of the FTC. After an additional year has passed and all potential study cases are included in the algorithm associated with foster care re-entry, more conclusive statements regarding the impact of Pathway 3 upon permanency and stability outcomes might be made. Regardless, it appears that FTCs benefit from the use of dedicated coordinators and facilitators; providing FTCs are structured to maximize family participation and empowerment, further or enhance existing practices (like SBC) that promote a systemic and community-based response to child and family needs, and allow flexibility) based on family desires) with respect to whether family alone time is used and follow-up FTCs are scheduled. In the end, more time and more study are needed.

Section VIII: Recommendations

Below are a series of recommendations extending from observations and study findings denoted in this report and referenced appendices.

A. Provide recommendations to administrators of future, similar projects.

It is recommended that consideration be given toward using the dedicated facilitator model (Pathway 2) that separates the primary role of FTC Facilitators from the role of FCCs. This model involves both the facilitator and FCC/caseworker in the FTC process; however, keeps the primary roles separate yet complimentary in that both are working together with families toward the achievement of family and case goals. If this model is used, considerable efforts should be made to continually monitor and evaluate the outcomes of families participating in FTCs versus those that opt out of these processes.

This project reinforced the perceived need among study participants for quick/immediate engagement of families regarding the FTC process. A shorter, rather than a longer, period of time to conduct the initial FTC is recommended because immediate contact with families through the FTC helps the engagement process. Although there was no consensus (among FCCs and Community Partners) on a specific timeline for the initial FTC, there was strong support for conducting the initial FTC as soon as possible upon case transfer to an FCC from DCF.

Consideration should be made regarding a possible redesign of the process by which follow-up FTCs are scheduled. Given the response rate and stated preferences of families and feedback from FCCs, it is recommended that any FTC model encourage but not require follow-up FTCs. It should be the family that decides whether or not – and when - they want or need a follow up FTC. If no follow-up FTC is scheduled, efforts should be made to develop or utilize a standardized mechanism for tracking and monitoring achievement of specific service plan and plan of care goals. These efforts will allow for a more detailed understanding of the perceived value and utility of FTCs in light of service progress (or lack thereof).

Continued efforts should be made (by FTC Coordinators and Facilitators) to encourage family members to seek and involve family and other supports in the FTCs and as part of their broader service plan. These efforts should be made in a manner that is respectful of the family's desires, preferences, and needs and represent empowerment not pressure. Letting families make the ultimate decision on who participates in the FTCs keeps to the FTC philosophy of self-determination and involvement in decision-making. At the same time, giving families options opens up the possibility for more immediate connections to be made to ensure that proper services are offered and received. Toward this end, administrators should continue to monitor who participates in FTCs.

Given the heavy workload of FCCs and workplace restrictions on overtime and flex time, efforts should be made in future projects to minimize the role of FCCs in data collection activities apart from that which is mandated by state statute. FCCs agreed that FTCs conducted with FTC Facilitators help them do their job better because FCCs receive important support to provide better case management services to their families. This reinforces the value of Pathway 2 FTCs. Should Pathway 2 FTCs be utilized, it is recommended that the Facilitators be the primary source for distribution and collection of any additional supplemental standardized data instruments (PFS and SDQ are recommended for future efforts) that will assist with monitoring protective factors and child and family well-being.

Regular and effective communication (prior to and following the Initial FTC and throughout the life of a case) between FTC project and administrative staff and key service providers is imperative if FTCs are successful in initiating services that help facilitate achievement of family and case goals. PSF has done much to develop a truly community-based perspective and reaction to the needs of the children and families they serve. These efforts should continue and should serve as a example/model for administrators in other child welfare systems regarding how collaborative networks and open communication (between partners and providers) that includes positive and negative feedback received from families, FCCs, FTC Facilitators, and others can improve services for families. In addition, it is important to involve service providers in training, regular meetings, and

special events as much as possible, and provide opportunities for service providers to meet each other.

Efforts should be made to encourage a culture change that embraces the philosophy of FTCs in the day-to-day practices of FCCs. The continuous engagement of FCCs (i.e. front-line staff) should continue through trainings, regular meetings, and special events to help them adapt to the culture change that is necessary to fully and consistently implement FTCs (or any major practice/system of care change). Because the success of FTCs and the success of family plans greatly hinges on the beliefs and skills of individual FCCs, ongoing engagement of competent and informed FCCs as potential practice leaders will be important in any effort to sustain these practices as valuable elements of any service delivery system. Front-line staff are an integral, if not primary, part of any service delivery system. Their feedback and involvement in the development and delivery of FTCs within any agency is crucial to its successful implementation.

B. Provide recommendations to project funders (Children's Bureau).

Although the project was prepared to implement the project within three months of receiving funding, unforeseen issues (beyond the control of the evaluators and PSF) impacted upon the project/study start date. It is recommended that future projects (that are similar in nature) be given more time to roll out the project, especially given the time and effort that is involved in gaining IRB approval for evaluation activities and the training efforts that must be engaged in, especially if the project involves the introduction of new practice models to be tested.

It is recommended that funders (Children's Bureau), include other outcome measures of safety, permanence, and well-being, especially from the perspective of families, in addition to the CFSR standards. A recommended minimum number of valid measures that supplement available secondary data (from state SACWIS systems) would be of value. This project utilized a variety of measures but found the Strengths and Difficulties Questionnaire and Protective Factors Survey to be of strong value given their ease to use, scoring mechanisms, established reliability and validity, their potential to provide immediate feedback, and their focus on safety and well-being indicators. An additional suggestion is to consider a standard measure (or set of outcomes measures) that could be used by all grantees (to measure processes or outcomes) assuming that the nature of the work is similar.

It is also recommended the Children's Bureau encourage and support process studies that inform practice throughout the project period. Process evaluations serve many important functions, including informing implementation and providing context and meaning to the outcomes. Furthermore, determining alternate means to grade projects other than the by CFSR standards or other outcome measures would be a solid value. In our study, the new models of FTCs did not necessarily demonstrate universally better outcomes for families. However, and importantly, the new models supported a process that was well received by multiple stakeholders. The experience may not always lead to better permanency outcomes, for example, but the experience itself is important for the families, workers, and field of child welfare.

C. Provide recommendations to the child welfare field.

Child welfare systems should consider a staggered introduction of major system or practice changes over time so that sufficient information regarding the impact of one intervention or system change can be gauged before the introduction of another practice or system change. For example, although the experimental FTC models (and FGDM) fit theoretically with the tenets of Solution-Based Casework, more time and data were needed prior to the introduction of SBC in order to isolate the main effects of each FTC from the interactive or compounded impact/effect of SBC across all three Pathways. Although it is noted that sometimes these events cannot be controlled for within select agencies impacted by broader State or system influences, continued dialog and collaboration between independent evaluators, agency administrators, and State authorities can help structure an evaluation agenda that can best inform practice regarding what works and make meaningful contributions to the professional knowledge base.

The development and utilization of a well-structured and user-friendly Management Information System is paramount for the successful monitoring and evaluation of any newly introduced practice or system change. Existing SACWIS systems, as informative as they are, need to be supplemented by alternative systems that link (or can potentially be linked to) supplemental case, service, and cost data that can aid with evaluation activities meant to inform practice and child welfare administration tasks. The Utilization Management System, P-Kids, and the "Surveyor" (developed for this study) databases developed by competent IT PSF IT staff are invaluable resources for practitioners, evaluators, and administrators. Any development or integration of data systems should (as this project did) involved a coordinated and collaborative process that networked IT personnel with administrators, project staff, potential users/practitioners, and evaluators.

Finally, it is recommended that the child welfare field understand that involving families in decision making is critical but the time commitment to do this is intense. Everyone knows that change is hard, so it is important to prepare for this in implementing any new practice that challenges workers' time and comfort with the "old ways". Child welfare systems need to enter into new projects understanding that newer workers will adjust faster to the changes and are more likely to get on the band wagon. Older staff will be more resistant; therefore, it is important to prepare for the time it will take to make the cultural shift, and to use champions, especially veteran staff, to promote the project or new practice.