

Acknowledgements

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Executive Summary: FTM Phase I Evaluation Report

Introduction

This report presents the initial work of the External Evaluation Team for the Family Team Meeting (FTM) Program at the District of Columbia Child and Family Services Agency (CFSA). The outcomes and progress of the process evaluation, the impact evaluation, and the fiscal impact statement form the content of this report. This external evaluation addresses requirements of the District of Columbia's Child in Need of Protection Act of 2004 for an "independent process and impact evaluation" of FTMs and the extension to 72-hours for holding the court proceedings regarding the removal of a child. Initial evaluation activities were qualitative in nature and conducted in the summer of 2005 and have described the implementation period and the views of a cross section of key informants. The evaluation is conducted by the Research and Evaluation unit of American Humane and a separate Advisory and Assistance Group of university-based and private-organization researchers.

Family Team Meetings

Description

The DC Child in Need of Protection Act of 2004 authorizes an extension from 24 hours to 72 hours as the period between removal of a child from the home and the court hearing regarding that removal. This extension allows CFSA, after removing children from their homes, to hold a FTM during the 72-hour period prior to the initial court hearing. CFSA describes FTMs as "structured planning and decision-making meetings that use skilled and trained facilitators to engage families, family supports, and professional partners in creating plans for children's safety and in laying the groundwork for permanency." In preparation for the FTMs, coordinators from the Healthy Families/Thriving Communities collaboratives invite family and service providers to the meetings. The initial goals of the FTM program are to address planning and decision making for new removals and for changes in child placements known as "re-placements." The District of Columbia Mayor, Anthony A. Williams strongly advocated this legislation through the CFSA Director Barbara Donald Walker. The FTM program was initiated in January 2005 for all Removal FTMs and in September 2005 for fully implemented Placement FTMs.

Uniqueness of FTM Legislation

The current report provides a review of highlighted literature around family engagement models and practice-based outcomes. Based on literature findings, it is clear that the Child and Family Services Agency FTM program utilizes a unique structure. The FTM legislation appears to be unique in North America to the extent to which it enables extended family members to be involved prior to court in the case of child removals and to the extent to which it mainstreams the use of a model of family involvement. Most



other efforts are driven by ‘good practice’ mandates instead of legislation. The most comparable legislation would seem to be New Zealand’s Children, Young Persons, and Their Families Act (1989). In this law, when a child or young person is compulsorily removed from their caregiver, the child must be brought before the Family Court within five days to consider the custodial status of that child. At the same time, the court must order that a family group conference (FGC) be convened. When ordered in these circumstances, the FGC must be convened within 30 days and completed within a further 30 days. Concerns have been raised in New Zealand that without a concerted attempt to engage family at the time of the removal crisis, the placement of the child with strangers may be prolonged. These concerns are well-placed given the substantial research evidence pointing to the decreasing likelihood over time of children returning to their family if they linger in foster care.

Crisis of Child Removal

The introduction of family inclusion at this early stage in the removal of a child raises questions about how families will respond in the midst of the removal crisis to these fast turnaround times. Concerns about the lack of time to thoughtfully plan for the longer range may be counterbalanced by the immediate effects of humanizing the legal process. Without this process, a plan may be set into motion dominated by legal and administrative procedures and creating obstacles to the family’s having a say afterwards. More than other approaches, the Washington, D. C. innovation holds the promise of bringing families, including the extended family and their supporters, to the table earlier and in greater numbers than other approaches. Attention should be paid to differences in responses of families to the early inclusion and in longer-range outcomes related to child safety and permanency. The levels of pre-existing crisis and trauma in the family, especially when that trauma has involved exposure to interpersonal violence, are likely to be important in explaining differences between families. Contrary to popular beliefs espoused by some advocates of post-traumatic stress, de-briefing an event can prolong trauma. Recovery, though, is associated with the availability of positive social supports. The question then is, “Will FTMs serve as a means to build social supports around children and their families at a time of crisis?”

Guiding Principles

The FTM program has eight guiding principles:

1. Family Inclusive Philosophy: Meaningful family participation in planning & decision-making.
2. Strength and Need Based Planning: Strengths-based assessment and plans are vitally important.
3. Ongoing Assessment and Planning: Plans are flexible for changing family needs.
4. Team Based Approach: Providing assistance to children & families requires a family inclusive team.
5. Multi-Systemic Intervention: Crucial to assessing, planning and providing suitable resources to children and their families.



6. Cultural and Community Responsiveness: Promote involvement of the community of origin in the planning with the families and children.
7. Brief Strategic Solution Focused Intervention: Use of flexible and easily accessible resources used to support those solutions.
8. Organizational Competence: Committed, qualified, trained and skilled staff, supported by an effectively structured organization.

Principles are a way to guide practice without rigidifying it into specific steps and provide a means of evaluating the accomplishments of a program. Accordingly, this study has utilized the eight CFT principles in designing the evaluation.

External Evaluation Activities

During this start-up phase of the external evaluation, four activities have been addressed:

- (1) process evaluation with key stakeholders,
- (2) assessment of an infrastructure and its development planning,
- (3) design of the impact data collection procedures, and
- (4) design of the cost assessment impact data collection procedures.

Process Evaluation with Key Stakeholders

In this first phase of the evaluation, interviews or focus groups were carried out with 36 key stakeholders with their informed consent. From within CFSA were representatives of program administrators, supervisors, front-line workers, FTM facilitators, and FTM coordinators. From the community were representatives of Family Court magistrates, assistant attorneys generals, guardians ad litem, and collaborative FTM coordinators. These interviews followed a consistent protocol.

In their statements, the participants identified an extensive number of helpful developments resulting from the institution of FTMs and a number of challenges in implementing the model. One positive development noted by many responses was the increased attendance by family members and their acquaintances at the hearings within 72 hours of the removal of a child. Below are listed some recurring themes and illustrative quotations.

- Overall, participants agreed that the extension from 24 to 72 hours did not affect the parents' right to be heard in court.

A magistrate: "The old way they had counsel as soon as the petition was filed. New way they have counsel as soon as the petition is filed."

- Families had a greater awareness of why CFSA had removed their children and was petitioning the court to keep them in care.



A social worker: “Parents . . . understand better why we had to intervene. Not just clueless when going into court.”

- With greater understanding of what was happening, tensions were reduced between CFSA and the parents and their communities.

A magistrate: “I’m seeing more parents coming to the initial hearing who are willing to work with the agency and . . . less defensive about what’s happening to them and their family.”

- As a result, parents arrived at court better able to present themselves, and the proceedings became less emotionally charged and more focused on the issues to be addressed.

A magistrate: Before FTMs, parents arrived in “shell shock,” but that now after a FTM parents appeared less “traumatized” and the hearings became “more productive.”

- Not only were the parents less confused and angry, but the FTM helped to keep the children and young people connected with their family: They might attend the meetings in person, their parents and relatives were informed about how they are doing, and the turn-out of relatives demonstrated and reinforced family ties.

A FTM coordinator: “Gives children hope that people want them to be with their family members.”

- The FTMs provided a forum in which the family had a greater say regarding placement decisions.

A FTM facilitator: Before FTMs, CFSA was seen as the “big, bad wolf” who “took kids never to return”; now “family are feeling empowered to say ‘no’ ” and the “family’s voice is being heard.”

- By meeting with the family and their extended support network almost immediately after the removal of the child from the home, CFSA more quickly identified kinship placements.

A social worker: “We look into family more intensely.”

- At the FTM, the group constructed plans that were clear and relevant, tapped community resources, and had the support of the participants.

A social worker: FTMs identify “different services and uses the community more as opposed to using federal dollars or using psychiatrists and psychologists to solve the family’s problems.”



- The FTM gathering led to the family network and CFSA firming up working relationships and expediting the work.

A magistrate: FTMs are working “because the families are running the show. They come in, they provide history of whatever the dysfunction is or the problem, they can provide information that I don’t think the agency would have been able to get ever, let alone in the short time frame that exists now under ASFA [Adoption and Safe Families Act].”

- Being present at the FTMs assisted guardians ad litem (GAL) to be better advocates for the children and adolescents.

A magistrate: The FTM “gives the guardian ad litem an opportunity to meet the children and to get a real sense of what’s going on and what they want.”

- While major strides were achieved on behalf of children and their families, substantial challenges remained in implementing a new model. An immediate problem was scheduling the meetings at times that worked for both the families and CFSA workers.

A coordinator: “Tough to coordinate when . . . forcing people [workers] to come to meetings on the weekends.”

- Tensions between coordinators and workers were exacerbated because the latter too often lacked an orientation to FTMs in general or to a specific family situation.

A FTM coordinator: FTM training should be “put in place at least once a month . . . because I know there are some social workers that don’t know the process.”

- At the meetings, intake workers who carried out the initial investigation were to transfer the case to the ongoing worker. Because of the 72-hour time frame before cases were heard in court, intake workers had limited time to carry out the investigation. As a result, the ongoing workers who assumed responsibility for the cases often felt at a disadvantage in understanding the family’s situation and knowing how to articulate clear goals and assess proposed action steps.

A supervisor: Whereas previously the “investigation was 30 days, now [it was] expected to be within 72 hours”; as a result the ongoing workers had to assume cases without “a clear picture of what’s going on.”

- Questions were raised about the plans resulting from the FTMs: inconsistency in presenting the plans in court, lack of creativity and clarity in the plans, and failures in following through on the plans.



A supervisor: The “creative voice of family is missing” because the family needed the “opportunity to express itself, free of the Agency and bureaucracy.”

- Concerns were raised that FTMs were diverging from family-centered forums because of an overemphasis on legal procedures.

A FTM facilitator: “Plans are drifting back to formula” and “legal [structures], bureaucracy are getting in the way”

- A lingering question was whether it was fair for the children’s lawyer to be present at the FTM when the parents did not have such counsel.

A supervisor: “Yes, [I] have seen [an] effect on parents’ due process. If going to have child’s attorney, should have parents’ attorneys too.”

- At the same time, most, who raised the concern about parents not having an attorney, also raised various concerns about the effect of including them at the FTM. Lawyers, in their view, could silence the parents, dominate the meetings, and generate a legalistic atmosphere.

A supervisor: “If the parents’ attorneys were there, . . . they wouldn’t want mom being honest and the whole point of the meeting is to be honest and open so that we can address the issues.”

In keeping with the eight FTM principles, key stakeholders commended FTMs for including family and like family at the meetings, they saw the plans as specifying concrete steps for the family system and service providers to help out in a manner responsive to the family’s needs, and they concluded that overall the meetings are a forum in which families voice their views. At the same time, their comments point to challenges in realizing the principles: questions about the extent to which families truly shape the plans, problems with meeting preparation and creating a cohesive team-based approach, the “professionalized” culture of the meetings and the resulting formulaic plans, and the lack of follow up on plans after the meetings. In the next phases of the evaluation, these preliminary findings will be checked against feedback on FTMs from family members, foster parents, and other professionals.

A principal evaluation question is the effect of the change in time from 24 to 72 hours for the initial hearing after the removal of a child. The extension of time from 24 to 72 hours appears to be seen as an acceptable and necessary change to the case process to enhance the engagement of families and the community. Respondents universally believed that that this was a change for the better. The expressed concern with the changes as a result of the legislation had less to do with the time when the hearing is to be held and had more to do with the roles of persons attending the hearing in protecting the rights of all.



Assessment of Infrastructure and Its Development Planning

The CFSA automated child welfare information system known as FACES is a valuable resource in conducting the external evaluation. The system is capable of producing information on child victimization, emergency removals and change of placement status, all of which are of central concern in assessing the impact of the legislation. Evidence of this capability is seen in the annual production of the Federal National Child Abuse and Neglect Data System (NCANDS) Child File. This file is used by the Children's Bureau with the Administration on Children, Youth and Families to assess child safety on state and national levels. The same procedures may be used to view child safety following a FTM. Other safety measures will also be implemented from these data. Further evidence of the capability of FACES is seen in its biannual production of the Federal Adoption and Foster Care Analysis and Reporting System (AFCARS) files for adoption and foster care. Those data are used to assess permanency on state and national levels. Such measures will also address the longer term impacts of the legislation. The FACES data will be used to profile the characteristics of families as well.

The FACES system is able to track a broad grouping of information specifically relevant to the FTM population. For example, the system has the capability to track demographic information, the services planned at an FTM and the actual delivery of those services following the FTM session, and the placement outcomes for children.

These will be key pieces of information in understanding the plans from FTMs and the implementation of those plans. It is intended that once the working database of the Internal FTM Evaluation Team has matured and stabilized, there will be joint planning to include its functionality into FACES.

Some information about FTMs is not contained in FACES. To obtain the required information, the Internal Evaluation Team has developed a working database to acquire information about meeting times, attendees, and their characteristics. Further, thirty-day follow-up telephone interviews measures have been incorporated into the facilitator responsibilities.

Design of the Impact Data Collection Procedures

The Internal FTE Evaluation Team has produced a valuable schematic known as a logic model. This diagram makes explicit the relationship of the components of the FTM program to the process results and longer term impacts of the FTMs and as a consequence the results of the 72 hour legislation. The reporting requirements of the legislation will be addressed as part of the results described in the data to support the logic model.

Currently, some client information and short-term outcomes tracking post-FTM exists in the Internal Evaluation database. Other information regarding client follow-up responses will be added to existing client information. In addition to the satisfaction items currently implemented, information about the degree to which clients felt they understood the



process, they felt included in planning, they thought plan events occurred, and they thought the plan events were crucial to success or needed to be altered given changes in the family's circumstances.

The fiscal impact of the 72 hour legislation and the FTMs will be described in aggregate and in terms of fixed costs to provide a level of services to families and the variable costs that are more directly tied to the number of families served and the degree to which they access program components.

Monthly reports will describe the development of necessary data elements and preliminary results obtained. These reports would begin in November 2005.

Recommendations for the External Evaluation

1. Continue monitoring utilization of FTM with greater attention to reporting of FTM participants.

The internal FTM Evaluation Team has a sound data collection system that is capable of producing needed data. FTM participant role, age, gender, race, and language are available and have been reported. Using these data to understand process and outcome results will provide a deeper understanding of the effects of the program. It is recommended that the FTM evaluation explore relationships between demographic characteristics and process and outcome results.

2. Develop reporting of service plan content and implementation.

The process surrounding the FTM is designed to provide effective services to families. The plan produced after the FTM and the Ongoing Service Plan are intended to have a close relationship. The Service Plan is intended to be implemented. Describing the correspondence between the FTM plan and the Ongoing Service Plan is recommended for the second year. Describing the services received by the family and the activities in which the members engage is another recommendation for the second year. Lastly, it is recommended to describe the degree to which planned services are provided and other services added as a measure of service plan implementation.

3. Develop safety and well-being report for children following the FTM.

Child safety is a principle mission of child protective services. The FACES information system holds data on child maltreatment allegations and the findings related to those allegations. Those data will be monitored for alleged maltreatment of children following an FTM and for substantiated maltreatment following an FTM. This measure of child safety following FTM has already been developed from FACES as part of the internal evaluation. Well-being indicators should be included in this report as a positive measure of child and family outcomes.



4. Develop a report on placement patterns of children before and after the implementation of FTM.

FACES data document the living arrangement of children. Description of the removal history of a child before an FTM may increase the understanding of FTM results. FACES data describe the living arrangements and duration of living arrangements for children. These results describe the degree and types of permanency results obtained. A measure of child permanency following FTM has been developed from FACES as part of the internal evaluation

5. Extend the follow-up questions with families beyond satisfaction to areas of participation in planning and assessment of services.

Family engagement services are intended to have the family and community members develop effective services to improve child safety and permanency and to enhance child and family well-being. The satisfaction follow-up data collection has the potential to assess the degree to which family members truly feel they are part of the service planning process, the degree they see their plans are implemented and the their perception of the effectiveness of those services. Plans may require revision because of changing conditions, policies, court decrees, and so forth. It is recommended that the processes for revision of plans be described and reasons for variations be analyzed. Not all possible questions can be asked during family follow-up interviews without the interview becoming burdensome to families. While maintaining a core set of questions to have consistency of results over time, it is recommended that some topical question to address specific issues be asked on a cyclical basis.

6. Develop description of families for whom FTM does not occur.

Not all families experiencing removal of a child have an FTM. It is recommended that the FACES demographic data and safety and permanency information for families not having an FTM be assembled and compared to the information for families that do.

7. Describe and assess the organizational structures within CFSA and inter-organizational collaboration between CFSA and its community partners and other public services for implementing FTM.

FTMs require collaboration within CFSA and between CFSA and its community partners and other public services for effective implementation of FTM. An external evaluation team can offer insights into the processes and structures facilitating and impeding FTM implementation. These may include availability of community services, funding sources, legislation, FTM training, and workload issues. Evaluation strategies include documentation review, surveys, observation, plan analysis, and focus groups.

8. Describe the fiscal impact of the 72-hour framework and of FTMs.



The fiscal impact of extending from 24 to 72 hours the period before the initial hearing is designed to be cost neutral. Funds for the FTM specific activities are drawn from sources intended for timely response, and funds for services have been available as CFSA resources. In the next phase of the evaluation, assessing actual costs is recommended. Beyond the impact of the 72-hour framework, the cost effectiveness of implementing FTMs and the resulting plans warrant evaluation.

9. Increase the planning with FACES for use of data and integration of reporting systems.

This recommendation is consistent with plans to develop infrastructure for FTM evaluation. Substantial work on requirements for FTM modules has been done with the development of the internal FTM evaluation. As the FTM becomes a more often used service technology, it will be more effective and efficient to embed its particular data elements into the Agency information system.



FTM Phase I Evaluation Report

Overview of this Report

The Year 1 External Evaluation Report describes the implementation of the FTM Program, the Evaluation Plan, the initial qualitative study of process measures, and recommendations for years two and three. The FTM program description addresses the purpose of the program, the goals and values, the design of the program, and its implementation as of the summer of 2005. The evaluation requirements from the legislation are described. The evaluation plan describes the separation of the FTM External Evaluation group at American Humane from the FTM Training group at American Humane. The evaluation plan will describe the purpose and design of the initial qualitative study of the FTM process and the quantitative capability resident at CFSA. The results of the preliminary qualitative study with supporting materials are presented as part of this report. Conclusions and discussion with accompanying recommendations for the second and third years of the project conclude this report.



Introduction

Overview of Family Team Meeting (FTM) Program

The FTM is designed to engage immediate family, extended family, and other support for the family in the planning for services related to the problems associated with the removal of a child from their home in Washington, D.C. by the Child and Family Services Agency (CFSA). The FTM program can be thought of as part of a larger approach to the inclusion of extended family and other supports called Family Group Decision Making. A unique feature of the program is its foundation in legislation rather than in practice decisions or advocacy efforts. The District of Columbia Mayor, Anthony A. Williams strongly advocated this legislation through the CFSA Director Barbara Donald Walker. The 2004 actions of the D.C. City Council (1) provided for the appointment of a guardian ad litem within 72 hours rather than the previous standard of 24 hours of a child being taken into custody due to a substantiated allegation of abuse or neglect, (2) required that a shelter care hearing commence within 72 hours after a child was taken into custody, (3) authorized the CFSA to convene a family team meeting within a 72-hour period to solicit the assistance of family members, relatives, social service workers, and the guardian ad litem in developing a safety plan for a child, and (4) required independent to assess the impact of the 72-hour time frame and the family team meetings.”

District of Columbia legislation had already provided for cooperation between the Agency and other public and private agencies for child and family services to have a neighborhood-based delivery approach aimed at meeting permanency and safety goals.

The FTM Program at CFSA addresses the need to change practice in the District of Columbia to engage families, communities, and public agency and private organization partners and to focus on improvement of child and family safety, permanency, and well-being outcomes. The timing and conduct of FTMs are important. The very rapid assembly of families, family supports, and professional partners for a meeting is a difficult task conducted by community agencies. The conduct of meetings by CFSA facilitators has the goal of plan development and decisions relating to children’s safety and eventual permanency. The initial goals of the FTM Program are to address service planning for new removals and address service planning for change of child placement setting known as “re-placements.” The service planning method may extend to other points in the life of a case at a later date.

The planning document for FTM is presented in Appendix I. The following items are the goals and purposes for all family team meetings:

1. To make placement decisions that keep children safe and promote permanency;
 - a) To create a continuum of care and develop support networks to reduce trauma for the child;



- b) To support a solution-focused approach to services, addressing behavioral changes; and
 - c) To develop relationships in an atmosphere of mutual respect to facilitate case planning, safety, and permanence.
2. Family Team Meetings addressing potential removals shall involve assessments of the safety and needs of both children and parents and shall focus on creating plans for safety and permanence.
 3. Family Team Meetings addressing potential placement changes shall focus on placement decisions that promote both safety and permanency for children.

The collaborative engagement of community organizations as partners has addressed a particularly difficult aspect of the FTM model. Identification and recruitment of family members to attend the meeting event is a necessary component for FTM success. From separate legislation in the District of Columbia, seven organizations known as “Collaboratives” were developed. Two of these organizations have played a necessary role in the identification and recruitment of family members, acquaintances, and local agencies to participate in FTMs. These organizations have had the relationships and the ability to locate and engage individuals in FTMs for the benefit of the family. Subcontracts with two “Collaboratives” have implemented this part of the program. The role of “Coordinator” designates staff members, who recruit participants and schedule the meetings.

An FTM event is conducted by a CFSA staff member in the role of “Facilitator.” This person conducts the meeting and transmits the plan produced at the meetings as agreed upon by the participants. The conduct of the meeting is a skilled activity that requires attention to family inclusion, brokering a service plan, and reaching decisions about participant actions after the meeting. The written plan is used at the court hearing and for referral to ongoing services.

It is expected that supervisors and social workers from CFSA ongoing services attend FTMs. The design of the meeting assumes that they are a vital part of the planning process. Referral of the family to ongoing services to implement the plan occurs at the end of the meeting. That referral is contingent upon the court agreeing to the plan.

The creation of positive working relationships with legal representatives and the judiciary are assumed to foster a climate that allows for non-adversarial meeting events. This allows planning to have a cooperative quality and to include many more family members in the hearing process. This inclusion of family members is believed to be a key component for services to be successful in keeping a child safe and in having a permanent living arrangement.

Why evaluation is being conducted

The legislation extending the period for a court hearing from 24 hours to 72 hours and enabling the FTMs also contained a requirement for an external evaluation. This was the



fourth point of the City Council actions described in the preceding section. The tables below present the requirements set forth in the legislation.

The evaluation requirements of the Act amending Prevention of Child abuse and Neglect Act of 1977 (Codification of District of Columbia Official Code, 2001 Edition, 2005 Spring Supplement, p.15) presented in the following table are the basis for the external evaluation plan, which is presented in a later section. The evaluation requirements have two parts. The first part identifies a set of process and outcome variables related to how FTMs are conducted and the results achieved for children and families. The second part is based in the overall legislative requirement for a fiscal impact statement. It relates to the costs of the program as implemented and projections of those costs.

Process and Outcome Variables:

- (1) Rates of participation in meetings for parents, children, relatives and others;
- (2) Demographics regarding child clients and families participating in FTM;
- (3) Percentage of FTMs resulting in approved safety plan;
- (4) Supports and services included in plan;
- (5) Supports and services included in plan and provided;
- (6) FTMs result in filing a removal petition in Family Court after FTM versus FTMs result in aversion of petition submission;
- (7) Placement outcomes of child clients with FTM (percent living with parent, percent living with relative, percent adopted, percent in traditional foster care, other);
- (8) Percent of children receiving permanent placement and cases closed;
- (9) Number of children with repeated reports of abuse and/or neglect following initial FTM date; and
- (10) The effect of the 72 hour time frame for the commencement of a Family Court hearing on families' legal protections and due process rights.

Fiscal Impact Statement as required by District of Columbia Home Rule Act of 1973 includes:

- (1) General Statement of the effects the measure will have on the operating and capital budgets for the current and next 4 fiscal years;
- (2) Quantitative estimate of the expenditures needed to implement the measure;
- (3) Identification of the revenues and funds currently available or likely available from existing revenue sources to implement the measure;
- (4) Extent to which current appropriations are available to finance implementation of the measure; and
- (5) Identification of the specific funding source to be recommended in the forthcoming fiscal years to implement the measure.

While fulfillment of legislative requirements is a primary reason to conduct the evaluation there are two other important reasons for the external evaluation, as well. Management of child welfare services is best accomplished based upon the results or outcomes of those services. The Federal approach to monitoring and assessment in the



Child and Family Services Review program is thoroughly based in the safety, permanency and well-being outcomes. Understanding the impact and results of FTM in terms of outcomes is expected to result in improved services to the children and families of the District. A second, larger reason is the national and international importance of the FTM program. The FTM innovation of the District is unique in its size and in its legislative foundation for early family engagement. These features make the practice an important event in the child welfare field. A well thought out and executed evaluation will have useable results. These results will provide important information about family engagement in service planning to the child welfare field both nationally and internationally.

External Evaluation Contractor

American Humane Association is a 128-year-old national nonprofit 501 (c) 3 organization tasked with the unique mission of protecting both children and animals from abuse, neglect and exploitation. As part of the mission, American Humane is dedicated to helping to create an aware and caring society, and to supporting the systems, agencies, communities, and individuals that care about vulnerable children and families. Headquartered in Denver, American Humane has two satellite offices: one in the Washington, DC area dedicated to government relations, and the other in Los Angeles that monitors the use of animals in film.

The Children's Services Division of American Humane has decades of recognized leadership in aspects of child welfare that have advanced and strengthened practice and policy nationally. American Humane's work is guided by four key objectives: 1) increasing the abilities, knowledge, and effectiveness of child protection professionals and child protective services agencies; 2) enhancing the community's capacity to respond effectively to the needs of vulnerable children and families; 3) improving the information and programmatic capacities of public and private child welfare agencies to enable them to respond effectively to child abuse and neglect; and 4) facilitating a concerted national response to the problem of child maltreatment.

American Humane staff maintain a working knowledge and depth of understanding about child protection and child welfare services, and their interface with community-based organizations, mental health systems, and court systems. Over the course of the last twenty years, American Humane has provided technical assistance domestically in all 50 states, and lent assistance internationally in numerous countries in areas related to child welfare policy and practice, strengths-based and culturally competent practice, training and staff development, research and evaluation, child welfare system advancements and organizational improvement.

The National Center on Family Group Decision Making (FGDM)

Since 1995, American Humane has been a national and international leader in promoting processes that formalize the integration of FGDM into child welfare systems and community-based and faith-based organizations. The National Center's mission is to



build community capacity to implement high quality, effective FGDM processes. Research increasingly demonstrates that FGDM is congruent with best social work practice, strengthens families, and achieves child safety, permanency, and well-being. The National Center's activities include: knowledge and material development and dissemination; training, technical assistance, evaluation, and consultation to communities implementing FGDM; and creating international linkages and networks through annual conferences and an FGDM-specific Web page and e-alerts. Specifically, since 2000, American Humane has provided training and technical assistance on family group decision making practices, implementation strategies and evaluation to multiple communities in 20 States, Washington, DC, Canada, and England. Since 2004, American Humane has delivered training, provided technical assistance, and evaluated the Family Team Meeting initiative in Washington, DC.

Outcome measures

American Humane is nationally recognized as a leader in the field of outcome measurement in child welfare services. From 1993-2002, American Humane, in conjunction with the National Association of Public Child Welfare Administrators (NAPCWA), cosponsored annual Roundtables on Outcome Measures in Child Welfare Services that served as an ongoing forum for hundreds of child welfare professionals, aiming to achieve meaningful client outcome-focused measures of service effectiveness. From these Roundtables, American Humane published proceedings, provided technical assistance to states, counties, and agencies, worked with the Federal Government, and conducted nationwide dissemination efforts to broaden interest in outcome measures. An example of these efforts is American Humane's ongoing contractual work in Philadelphia to develop and implement a child welfare outcome measurement system.

Program evaluation

American Humane has conducted comprehensive program evaluations of child welfare service systems for the states of NC, TX and MD, and of specific areas of focus in the child welfare systems in HI, IL, KY, NY, OH, PA, UT, and VA, as well as counties in CA, OH, and MN. These efforts have focused on analyzing service demands, case flows, and utilization of staff and agency performance measures, organizational structure, and resource needs. A unique approach is developed for each project.

Federal and state data system analyses

American Humane was responsible for the National Study on Child Neglect and Abuse Reporting, a project funded by the National Center on Child Abuse and Neglect from 1973 to 1987. Since the early pilot studies for the National Child Abuse and Neglect Data System (NCANDS), American Humane has been an active member of the Technical Team. American Humane has performed on-site technical assistance in CA, HI, KS, LA, MI, NE and NH, as well as in person and teleconference with about 20 other States. American Humane has contributed analytic work to all editions of *Child Maltreatment* since 1993. American Humane has used local versions of AFCARS for special projects,



including large city files from PA and CA as well as rural South Dakota for comparative and baseline purposes. American Humane has obtained local AFCARS files with unencrypted identifiers and then executed Children’s Bureau logic to assemble annual files. These files had results that were validated against outcomes published by the Children’s Bureau. These files were also combined with child and family well-being results to describe the relationship of child and family well-being and permanency.

Partners in External Evaluation Activities

Dr. Gale Burford is a Professor in the Department of Social Work at the University of Vermont and the Director for Child Welfare Training Partnership Staff Training and Development Programs. He has extensive experience in the delivery and research of family based services.

Dr. Joan Pennell is the Department Head for the Department of Social Work at North Carolina State University and the Principal Evaluator for the North Carolina Family-Centered Meetings Project. She also has extensive experience with the delivery and research of family based services.

Dr. John Fluke is the Director of Research for Walter R. McDonald and Associates, Incorporated. He is nationally known for his work in child protective services research.



Separation of Training and Evaluation Groups at American Humane

The evaluation will have two safeguards to provide “external evaluator” objectivity between all involved parties: the evaluation will be conducted by the Research and Evaluation unit of American Humane and there will be a separate Advisory and Assistance Group of university based and private organization researchers. The Research and Evaluation group of American Humane is separate from the unit performing training and program development activities related to FTM. Both units report to the Director of Children’s Services, Sonia Velazquez.

The Evaluation Group for the FTM project contains no individuals who perform FTM training. The lines of communication with the FTM project are from the Myles Edwards, Ph.D., American Humane Director of Research and Evaluation and then through Erin McDonald, FTM Evaluation Team Lead. These organizational structures are evidence of the separation of the Training and Evaluation groups at American Humane.

An Advisory and Assistance Group will be an active component of the external evaluation activities and subcontracted to American Humane. The group will include:

Gale Burford, MSW, Ph.D.
Professor, Department of Social Work
University of Vermont
Director, Child Welfare Training Partnership Staff Training & Development Programs

Joan Pennell, MSW, Ph.D.
Professor & Department Head, Department of Social Work
North Carolina State University

John D. Fluke, Ph. D.
Director of Research
Walter R. McDonald & Associates, Inc.

Advisory and Assistance Group members will have an active role not only in the planning and review of the evaluation but also in the on site data collection, data analysis and report writing. They will join in meeting with FTM staff and FTM Advisory Group on site. They will be actively involved in evaluation design, data collection, data analysis, findings, reporting and interactions with CFSA.



Family Team Meeting Program

History of Events

In 1989, efforts were initiated that led to the filing of a class action on behalf of abused children in the District of Columbia. This resulted in the child welfare services being taken into receivership. By 1994, the U.S. District Court for the District of Columbia modified a final order, which had been originally approved in 1991, and extended to over 100 the required the number of corrective actions ordered to be taken in the structure and practice of child welfare services in the District welfare system (US GAO, May, 2000). The following year, “the court removed the child welfare agency from the auspices of the District’s Department of Human Services and from local government control, putting a child welfare receivership in place to implement the MFO requirements (Ibid, p. 1)”. The Federal Court receivership of child welfare in the District ended with a Consent Order issued June 15, 2001. Responsibility for protecting abused and neglected children was transferred to a new, District government cabinet-level Child and Family Service Agency (CFSA).

Legislative Reform

Driven in large measure by these changes, but also moved along by federal service review program of the Children’s Bureau, the Child and Family Service Review (CFSR), amendments to the Prevention of Child Abuse and Neglect Act of 1977 were passed in 2004. The following amendments are crucial to the current evaluation in laying out its content and time frames:

to amend Title 16 of the District of Columbia Official Code to require the appointment of a guardian ad litem within 24 hours of a child being taken into custody due to a substantiated allegation of abuse or neglect, to require that a shelter care hearing commence within 72 hours after a child has been taken into custody, to authorize the Agency to convene a family team meeting within the 72-hour period to solicit the assistance of family members, relatives, social service workers, and the guardian ad litem in developing a safety plan for a child, and to require independent evaluations 6 months, 18 months, and 30 months after the effective date of this act to assess the impact of the 72-hour time frame and the family team meetings.

The legislation had already provided for cooperation between the Agency and other public and private agencies for child and family services to have a neighborhood-based delivery approach aimed at meeting permanency and safety goals set forth in the Adoption and Safe Families Amendment Act of 2000, effective June 27, 2000 (D.C. Law 13-136; 47 DCR 2850).



The authors of the legislation were particularly concerned that:

(A) A guardian ad litem shall be appointed to represent the child’s best interest within 24 hours (excluding Sundays) of the child having been taken into custody;

(B) A shelter care hearing shall be commenced not later than 72 hours (excluding Sundays) after the child has been taken into custody; and

(C) A petition shall be filed at or prior to the shelter care hearing.

(a-1)(1) During the 72-hour period authorized in the subsection (a)(1) of this section, the Agency may convene a family team meeting to solicit the input of family members, relatives and others concerned with the welfare of the child to develop a safety plan approved by the Agency. At a minimum, the Agency shall invite parents, relatives, caregivers, community representatives, service providers, and the guardian ad litem appointed to represent the child’s best interest to attend a family team meeting.

The FTM Program at CFSA addresses the need to change practice to engage families, communities, and public agency and private organization partners to improve child and family safety, permanency, and well-being outcomes. Concretely, “Family Team Meetings are structured planning and decision-making meetings that use skilled and trained facilitators to engage families, family supports, and professional partners in creating plans for children’s safety and in laying the groundwork for permanency.” (See Appendix I, page 1). The initial goals of the Program are to address service planning for new removals and address service planning for a change of child placement setting known as “re-placements.” The service planning method may extend to other points in the life of a case at a later date.

The planning document for FTM is presented in Appendix I. The following items are the goals and purposes for all family team meetings:

1. To make placement decisions that keep children safe and promote permanency;
 - a) To create a continuum of care and develop support networks to reduce trauma for the child;
 - b) To support a solution-focused approach to services, addressing behavioral changes; and
 - c) To develop relationships in an atmosphere of mutual respect to facilitate case planning, safety, and permanence.
2. Family Team Meetings addressing potential removals shall involve assessments of the safety and needs of both children and parents and shall focus on creating plans for safety and permanence.



3. Family Team Meetings addressing potential placement changes shall focus on placement decisions that promote both safety and permanency for children.

Collaborative engagement of community organizations as partners has addressed a particularly difficult aspect of the FTM model. Identification and recruitment of family members to attend the meeting event is a necessary component for FTM success. From separate legislation in the District of Columbia, seven organizations known as “Collaboratives” were developed. Two of these organizations have played a necessary role in the identification and recruitment of family members, acquaintances and local agencies to participate in FTMs. These organizations have had the relationships and ability to locate and engage individuals in FTMs for the benefit of the family. The positive functioning of these relationships is thought to be crucial to the development of family-centered child welfare reform. The community agencies, which are not part of the child protection investigative structure, are well positioned to accomplish this aspect. Subcontracts with two “Collaboratives” have implemented this part of the program. The role of “Coordinator” designates staff members, who recruit participants and schedule the meetings.

An FTM event is conducted by a CFSA staff member in the role of “Facilitator.” The facilitator conducts the meeting and records the plan agreed upon by the participants. The conduct of the meeting is a skilled activity that requires attention to family inclusion and brokering a service plan. Documentation of the plan is a product to be used at the court hearing and for referral to ongoing services.

Supervisors and social workers from CFSA ongoing services attend FTMs. The design of the meeting is that they be part of the planning process. Referral of the family to ongoing services to implement the plan occurs at the end of the meeting. That referral is contingent upon the court agreeing to the plan.

Working relationships with the legal representatives and the judiciary have allowed for non-adversarial meeting events and the inclusion of many more family members in the hearing process. The legislation provided for the minimal inclusion of a GAL at the FTM but no other legal representatives. This has been a controversial aspect of the program because the parents and social workers do not also have legal representation. Nevertheless, no charges have been filed at the time of the meeting, so there is no basis for representation. A non-adversarial planning and decision meeting is believed to result in plans and decisions that are in the best interests of the family. The belief is that in those conditions, the family and child are able to reach better safety and permanency outcomes in a faster time frame.

The FTM program has an Advisory Committee that includes a broad cross section of CFSA, community representatives and advocates. The use of an advisory committee structure to inform and discuss the program has allowed discussion of the program based upon goals and principles. The achievement of consensus in this group has provided the basis of program development. The Advisory Committee remains active in planning and monitoring the implementation of FTM.



The FTM program has an internal “FTM Evaluation Team.” This small staff has developed data acquisition procedures from the CFSA automated information system, called FACES, and has developed pertinent data collection procedures to fulfill the special needs of the FTM program. Development of an ongoing infrastructure for internal evaluation is a principle goal of the program. The evaluation efforts produce information both for external accountability to families, the community and the legislature and also produce information for internal practice management at CFSA.

Legislation from City Council has provided the foundation for developing the procedures by which FTM proceeds. The legislative motivation is discussed at length in the literature review. A part of the legislation requires this external evaluation. The evaluation requirements are detailed later in this report as part on the External Evaluation Implementation Plan.



Evaluation Plan

The guiding questions for the external evaluation are formed by the legislative requirements, the logic model and the FTM principles. The following sections show how these components may be implemented in Phase II.

The legislative requirements from the 2001 amendments to the Child Abuse and Neglect Act of 1977 (Codification of District of Columbia Official Code, 2001 Edition, 2005 Spring Supplement, p.15) state the items presented in the following table. Next to each item is the plan to address it.

Table 1
Implementation of Required Items for the External Evaluation

1. Rates of participation in meetings for parents, children, relatives and others	Counts of individuals, who attend the FTM meetings, by their family role will be obtained from the internal program documentation and compared to the number of child removals from families, which are documented in FACES, to obtain rates.
2. Demographics regarding child clients and families participating in FTM	Age, race, gender, and other descriptive statistics will be obtained on the FTM participants as part of the FTM meeting documentation.
3. Percentage of FTMs resulting in approved safety plan	FTM service plans will be compared to the court approved plans. Content analysis of FTM plans will be used to develop a service taxonomy, which will describe the items in the plan. Measures of degree of correspondence, based upon content analysis, will be developed to determine whether the final plan substantively represented the FTM plan. The number of court approved plans that substantively resemble the FTM plan divided by the number of FTM plans will provide a percentage of FTMs resulting in an approved safety plan.
4. Supports and services included in plan	Content analysis of FTM plans will be used to develop a service taxonomy to describe the items in the plan. Definitions of supports and services will be developed and used to code items in the FTM plans.
5. Supports and services included in plan and provided	Content analysis of services received by families using the same services taxonomy



	as applied to the plans will allow comparison of items included in the plan and provided.
6. FTMs result in filing a removal petition in Family Court after FTM versus FTMs result in aversion of petition submission	Follow-up of FTM families' legal status will document filing of removal petition or not. These results documented on the FTM internal evaluation database will be compared to the Agency documentation in FACES.
7. Placement outcomes of child clients with FTM (percent living with parent, percent living with relative, percent adopted, percent in traditional foster care, other);	Follow up of FTM families for type of child living arrangement will document placement outcomes. These results documented on the FTM internal evaluation database will be compared to the Agency documentation in FACES.
8. Percent of children receiving permanent placement and cases closed	Follow up of FTM families' permanency status and case closure will document these child outcomes. These results documented on the FTM internal evaluation database will be compared to the Agency documentation in FACES.
9. Number of children with repeated reports of abuse and/or neglect following initial FTM date.	Follow up of FTM families' safety status for will document these child outcomes. These results documented on the FTM internal evaluation database will be compared to the Agency documentation in FACES.
10. The effect of the 72 hour time frame for the commencement of a Family Court hearing on families' legal protections and due process rights	Legal case records will be reviewed to determine if any appeals, which were based upon lack of legal protection or due process rights, were successful.

The development of content analysis of FTM plans will be used to develop a “service taxonomy.” This should be a principal activity of evaluation Phase II. As noted above, this will allow comparison of service plans after FTM with Service plans after court decisions and with services actually provided.

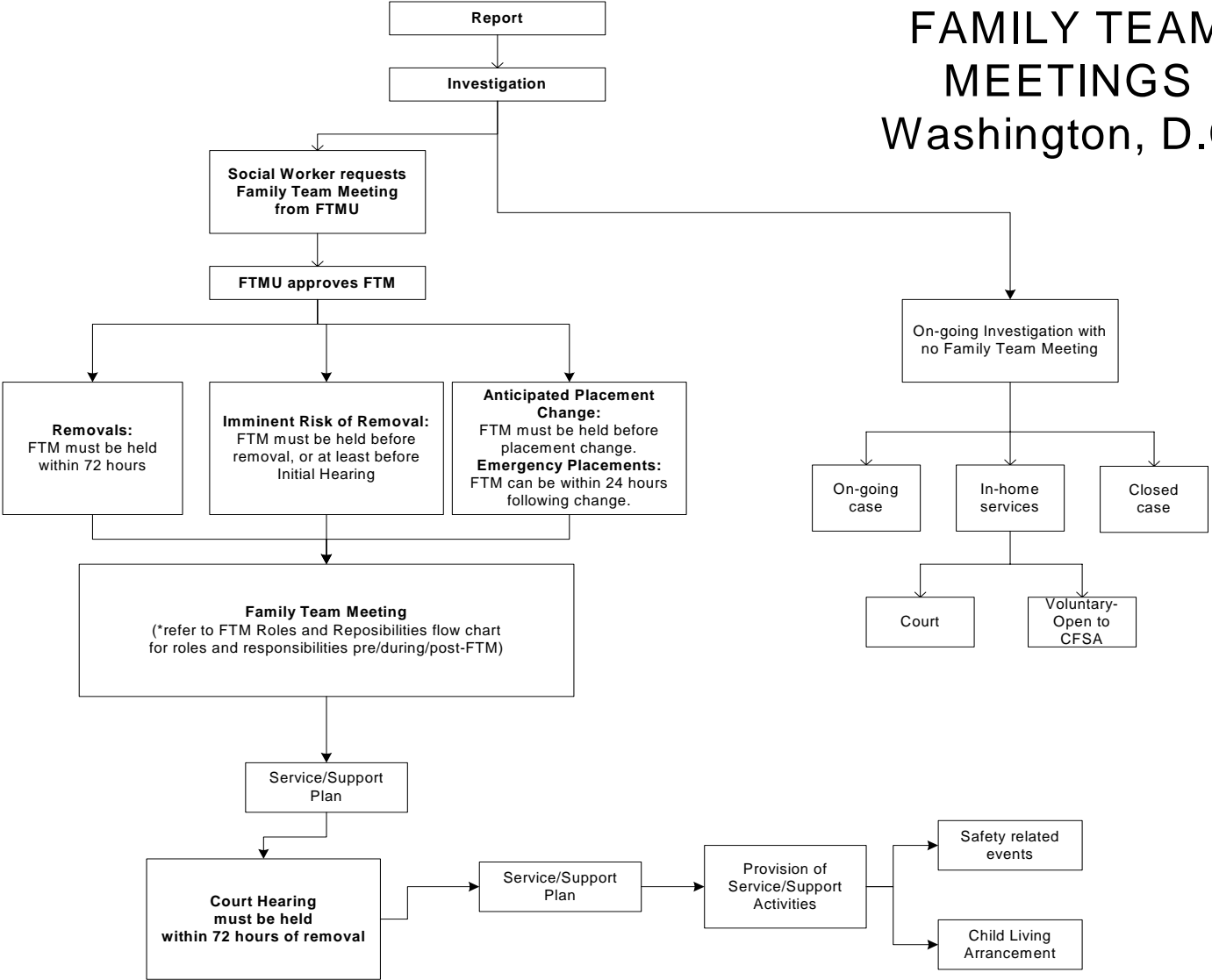
Logic Model

The items of the required evaluation correspond well to the case flow schematic as understood by the external evaluation team. This schematic is presented on the next page as Figure 1. It is helpful to relate the 10 items of the required evaluation to this schematic.



FAMILY TEAM MEETINGS

Washington, D.C.



Working Case
Flow Model of
External
Evaluation Team,
September 2005



The evaluation requirements of the legislation and the case flow model are consistent with the Logic Model developed by the Internal Evaluation Team.

The internal Logic Model is presented on the next page and it presents a more detailed view of the multiple roles involved in FTM. Both models will be used to guide the development of questions to be addressed.

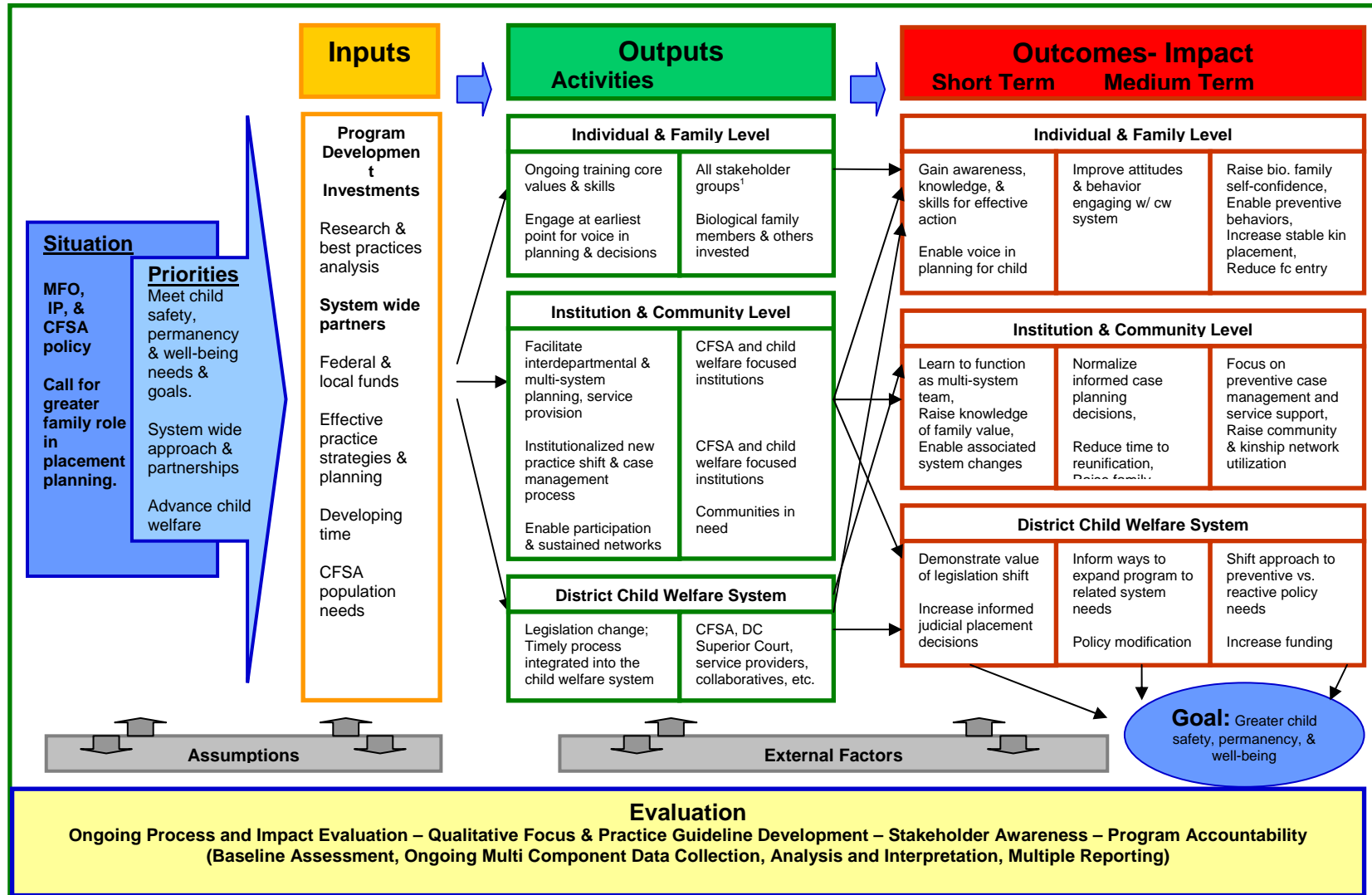
Following the schematic of the Internal Evaluation Team logic model, the preliminary qualitative evaluation of the FTM is presented. This qualitative evaluation is based upon the case flow logic model, the principles of FTM, and an Internal Logic Model (June 2005) and pays particular attention to the impact of the seventy-two hour requirements.

A literature review is included as part of the preliminary qualitative evaluation.

Initial quantitative findings are presented following the qualitative results.



Internal FTM Evaluation Team Logic Model, June, 2005



Qualitative Evaluation

Introduction

The qualitative evaluation analyzes and synthesizes perspectives from key stakeholders for Family Team Meetings (FTM) held by the District of Columbia Child and Family Services Agency (CFSA). These perspectives from a wide spectrum of stakeholders serve to identify (a) areas of common agreement and divergences in views; (b) dynamics of FTM preparation, meetings, and follow-up; and (c) the effect on FTM practice and outcomes of contextual factors, including organizational and inter-organizational issues, neighborhood culture, agency policy, and municipal and federal legislation. The qualitative evaluation offers a contextual framework in which to interpret the quantitative data. In addition, it serves as a source for examples of FTMs to illuminate the process and its outcomes and give a “story” of FTMs in the District. An integration of the quantitative and qualitative evaluation provides a foundation from which to make recommendations on enhancing FTM practice and outcomes.

The qualitative evaluation addresses three main questions:

1. From the perspective of key stakeholders, how are FTMs being implemented in the District of Columbia?
2. From the perspective of key stakeholders, what is the effect of FTMs on children and young persons, their families, human and health services, and legal systems?
3. On the basis of these perspectives, what are some suggestions on how to improve the organization and practice of FTMs?

FTM findings are assessed according to whether they are congruent with the eight guiding principles developed by CFSA for FTMs (CFSA, 2004, p. 2). These principles are as follows:

1. Family Inclusive Philosophy: Meaningful family participation in planning & decision-making.
2. Strength and Need Based Planning: Strengths-based assessment and plans are vitally important.
3. Ongoing Assessment and Planning: Plans are flexible for changing family needs.
4. Team Based Approach: Providing assistance to children & families requires a family inclusive team.
5. Multi-Systemic Intervention: Crucial to assessing, planning and providing suitable resources to children and their families.
6. Cultural and Community Responsiveness: Promote involvement of the community of origin in the planning with the families and children.
7. Brief Strategic Solution Focused Intervention: Use of flexible and easily accessible resources used to support those solutions.
8. Organizational Competence: Committed, qualified, trained and skilled staff, supported by an effectively structured organization. (Gerald, 2005)



Principles are a way to guide practice without rigidifying it into specific steps (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). This allows programs to develop different pathways to the same ends. Principles are also a means for evaluating fidelity to a model without setting unnecessarily restrictive criteria.

The qualitative evaluation is carried out by the external evaluation team in consultation with the CFSA internal evaluator, agency administrators, and the FTM Steering Committee. This report covers the qualitative evaluation for Phase I of the study conducted in July and August 2005.

The qualitative evaluation section of the report begins by reviewing theory and research findings regarding family meetings in child welfare, multisystemic interventions, and crisis management. Next the methodology for the qualitative evaluation is summarized, and future steps noted for the second and third phases of the external evaluation. Then the findings from the qualitative evaluation are presented, and their implications for practice discussed.

Literature Review

Introduction

In 1989, efforts were initiated that led to the filing of a class action on behalf of abused and neglected children in the District of Columbia. This resulted in the child welfare services being taken into receivership. By 1994, the U.S. District Court for the District of Columbia modified a final order originally approved in 1991, and extended to over 100 the required number of corrective actions ordered to be taken in the child welfare system (US GAO, 2000). The following year, “the court removed the child welfare agency from the auspices of the District’s Department of Human Services and from local government control, putting a child welfare receivership in place to implement the MFO requirements” (US GAO, 2000, p. 1). The Federal Court receivership of child welfare in the District ended with a Consent Order issued June 15, 2001. Responsibility for protecting abused and neglected children was transferred to a new, District government cabinet-level Child & Family Services Agency (CFSA).

Legislative Reform

Driven in large measure by these changes, but also moved along by federal service reviews, amendments to the Prevention of Child Abuse and Neglect Act of 1977 were passed in 2004. The following amendments direct the current evaluation:

To amend Title 16 of the District of Columbia Official Code to require the appointment of a guardian ad litem within 24 hours of a child being taken into custody due to a substantiated allegation of abuse or neglect, to require that a shelter care hearing commence within 72 hours after a child has been taken into custody, to authorize the Agency to convene a family team meeting within the 72-hour period to solicit the assistance of family members, relatives, social service workers, and the guardian ad litem in



developing a safety plan for a child, and to require independent evaluations 6 months, 18 months, and 30 months after the effective date of this act to assess the impact of the 72-hour time frame and the family team meetings. (p. 2)

The legislation had already provided for cooperation between the Agency and other public and private agencies for child and family services to have a neighborhood-based delivery approach aimed at meeting permanency and safety goals set forth in the Adoption and Safe Families Amendment Act of 2000, effective June 27, 2000 (D.C. Law 13-136; 47 DCR 2850).

The authors of the legislation were particularly concerned that:

- (A) A *guardian ad litem* shall be appointed to represent the child’s best interest within 24 hours (excluding Sundays) of the child having been taken into custody;
- (B) A shelter care hearing shall be commenced not later than 72 hours (excluding Sundays) after the child has been taken into custody; and
- (C) A petition shall be filed at or prior to the shelter care hearing. (p. 14)

The amendment also authorized the convening of a FTM during the 72-hour period prior to the court proceeding;

- (a-1)(1) During the 72-hour period authorized in the subsection (a)(1) of this section, the Agency may convene a family team meeting to solicit the input of family members, relatives and others concerned with the welfare of the child to develop a safety plan approved by the Agency. At a minimum, the Agency shall invite parents, relatives, caregivers, community representatives, service providers, and the guardian ad litem appointed to represent the child’s best interest to attend a family team meeting. (p. 15)

To the knowledge of the External Evaluation Team, this legislation is unique in North America to the extent to which it enables extended family members to be involved prior to the first hearing in court in the case of child removals and to the extent to which it mainstreams the use of a model of family involvement. Other family models have been implemented to bring family in early but have offered insufficient data on their practice to reveal the extent of family involvement. Anecdotal evidence suggests that the practice in the District of Columbia and its particular application of Family Team Meetings is considerably out in front in the numbers of extended family members getting to the meetings in this early phase of implementation. Most other efforts are driven by “good practice” mandates instead of legislation (Nixon, Burford, & Quinn, 2005).



The most comparable legislation would seem to be New Zealand's Children, Young Person's and Their Families Act (1989). In their law, when a child or young person is compulsorily removed from their caregiver by way of a Place of Safety warrant, the child must be brought before the Family Court within 5 days for the court to consider the custodial status of that child. At the same time, the court must order that a family group conference (FGC) be convened. When ordered in these circumstances, the FGC must be convened within 30 days and completed within a further 30 days. The law has provisions available if the timeframes cannot be met or if in the meantime the social worker determines that the matter does not warrant formal intervention or if parental cooperation is lacking. The law is seen as securing a child's immediate safety but also prevents any longer term care planning or intervention unless a FGC has been held. Concerns have been raised in New Zealand that without a concerted attempt to engage family at the time of the removal crisis, the placement of the child with strangers may be prolonged (Doolan, personal communication, August 7, 2005). These concerns are well-placed given the substantial research evidence pointing to the decreasing likelihood over time of children returning to their family if they linger in foster care. The literature review program of the External Evaluation Team will develop the references for this point. For these reasons in particular, the Washington, DC innovation will be of considerable interest those who advocate for family-centered, community-based approaches to child, youth and family work.

Family Team Meetings in the Crisis of Child Removal

The introduction of family inclusion at this early stage in the removal of a child raises questions about how families will respond in the midst of the removal crisis to these fast turnaround times. Concerns about the lack of time to thoughtfully plan for the longer range may be counterbalanced by the immediate effects of humanizing the legal process that otherwise would set in motion a plan dominated by legal and administrative procedures and creating obstacles to the family in having a say afterwards (Huntington, n.d.). More than other approaches, the Washington, D. C. innovation holds the promise of bringing families, including the extended family and their supporters, to the table earlier and in greater numbers than other approaches.

Research in the areas of crisis and trauma, and family dynamics, will be useful to fully understand the application. Attention should be paid to differences in responses in the aftermath of trauma of individuals (Riggs, Byrne, Weathers, & Litz, 1998) and families and in longer-range outcomes, according to levels of pre-existing conflict (Major, Richards, Cooper, Cozzarelli, & Zubek, 1998) and trauma in the family (King, King, Foy, Keane, & Fairbank, 1999; Stretch, Knudson, & Durand, 1998), especially when that trauma has involved exposure to interpersonal violence (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993; Breslau et al., 1998; Green et al., 2004; Nishith, Mechanic, & Resnick, 2000), the extent to which the removal can be understood in a context of discreet, acute, episodic and/or chronic stress, a by-product of planned or unplanned events, as an acute response to patterned behaviors, or a chronic condition. Additionally, the level of organization in the family versus the amount of chaos, the number of different helping systems the family is involved with that impinge directly on the removal and the responses that are required, and even the extent to which these services and



personnel are sensitive to the trauma in the family (Harris & Fallo, 2001) would all seem to figure in this early intervention and impinge on the safety of children and adults (Pennell & Burford, 2000).

Contrary to popular beliefs espoused by some advocates of post-traumatic stress debriefing, research shows that some affected persons benefit from a period of respite and may initially need to be allowed to avoid discussing their trauma (Charlton & Thompson, 1996; Tarrier, et al., 1999). In this connection, sustained criticism, supported by some research findings, of psychological debriefing (Bisson, McFarlane, & Rose, 2000; Gist & Woodall, 1999), is potentially offset by some findings that recovery is associated with the availability of positive social supports (Forbes & Roger, 1999; Foy, Sipperelle, Rueger, & Carroll, 1984; Harvey, Orbuch, Chwalisz, & Garwood, 1991; Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; King et al., 1999; Martin, Rosen, Durand, Knudson, & Stretch, 2000; Pennebaker & O'Heeron, 1984) including helping the affected individuals in anticipating problems in utilizing their social supports in the future. The FTMs focus on strengths, on the immediate tasks at hand, and helping the affected persons gain a measure of control rather than probing them to re-experience the pain may well hold some of the same benefits as other approaches that emphasize cognitive change and education with account taken of the complications that persons with major mental health challenges bring to any early intervention (Bryant, Sackville, Dang, Moulds, & Guthrie, 1999; Bryant & Harvey, 2000). Many questions remain about the extent to which family relations are in fact helpful or the conditions under which they are helpful for women with co-occurring substance abuse and mental health challenges who are also survivors of interpersonal abuse (Savage & Russell, 2005). Clearly this area of early intervention deserves careful study and special consideration paid to the development of safety measures consistent with this innovative involvement of wider family in this early response.

Family Team Meetings in a Family and Community Context

Philosophically, the Family Team Meetings have grown out of the same consumer and rights-based movements (Burford & Pennell, 2004) that spawned Systems of Care (Sproul & Friedman, 1994), Multisystemic Family Therapy (Cunningham & Henggeler, 1999; Henggeler et al., 1998), Patch (Adams, 2000), Wraparound (Burchard & Burchard, 2000), and other family- and community-based models (Center for the Study of Social Policy, 2002) that aim generally to engage families in partnerships that empower and build capacity in the parents and in extended family relations and local social support networks around the family, emphasize strength-based assessment of needs, and customize plans of intervention around families. While these models vary considerably in practice on the extent of family leadership that is invited and supported, range in goals from therapeutic outcomes through behavioral change to the promotion of civic and socially responsible activities, emphasize different levels of safety for all family members, and vary in the support for families to prepare for their meeting and carry out their plans (Nixon, Burford, & Quinn, 2005), the underlying tenets are comparable.

Too often the child welfare system in seeking to protect children fails to involve their families in finding creative and enduring solutions together (Berg & Kelly, 2000). Child



welfare systems today are seeking to move toward more family-centered approaches as a means of including the family and their community in planning and carrying out services (Parton, 1997; Pecora, Reed-Ashcraft, & Kirk, 2001; Walton, Sandau-Beckler, & Mannes, 2001). Family group decision making (FGDM) is an alternative aimed at facilitating the development of partnerships and planning among children, families, friends, communities, and public agencies and, thus, widening the circle of supports (Pennell & Anderson, 2005). FGDM provides families with a structure and a forum in which to utilize their own resources and strengths; build, rebuild, or strengthen support systems and community networks; and establish new partnerships and trust within formal systems that traditionally were unwilling to bridge these gaps.

The family group conference (FGC), one popular implementation of FGDM, was introduced as the formal decision-making process for New Zealand child protection, care and youth justice services in 1989 (Hassall, 1996). Since then, interest in the FGDM and FGC has ignited worldwide. According to Mike Doolan (2004), one of the founding fathers of FGC in New Zealand, “interest was initially generated by what appeared to be a fresh and unique approach in a field of professional endeavour [sic] where systemic and practice failures were high and results not encouraging.” In New Zealand, FGDM became part of legislation through the introduction of the *Children, Young Persons and Their Families Act* (1989). As the practice grew and positive feedback emerged, it was introduced elsewhere as “an alternative approach to mainstream decision-making constructs involving professionals” (Doolan, 2004) and was viewed as empowering families and young people to make decisions over their own affairs (Connolly & McKenzie, 1999; Gal, 2004; Lupton & Nixon, 1999; Marsh & Crow, 1998). Since then, Australia (South Australia, New South Wales, and Queensland), the Republic of Ireland, and Northern Ireland have all introduced legislative mandates in FGDM. Many other countries, including the United Kingdom, the United States, Israel, the Netherlands, and all of the Scandinavian countries, have adapted FGDM to use as a model within their own child welfare and justice systems (Burford & Hudson, 2000).

A number of factors have influenced many U.S. states and countries worldwide to embrace FGDM, including: the growing number of children, disproportionately children of color, living in out-of-home care; many children spending unreasonably long periods of time in out-of-home care settings; many children experiencing multiple out-of-home placements; and services delivered to children and their families perceived as racist (Crampton & Jackson, 2000; Merkel-Holguin, 2005; Roberts, 2005). These elements, among others, encouraged those in the child welfare field worldwide to research international practices in an attempt to discover new ways to work positively with children and their families.

Additionally, Merkel-Holguin (2005), the Director of the national Center on Family Group Decision Making, notes that FGDM “fits closely with some of the current philosophical changes in child welfare.” She cites “the increasing use of kinship care, capitalizing on family strengths, and creating a partnership and participatory decision-making process between the family and professional.” Moreover, the U.S. Children’s Bureau’s Child and Family Services Reviews have reported a positive association



between involving families in case planning and better outcomes for children in safety and permanency (US DHHS, 2004). FGC is viewed as one strategy for heightening the cultural competence of child welfare services by African American, Hispanic/Latino, and Cherokee community members (Waites, Macgowan, Pennell, Carlton-LaNey, & Weil, 2004). Given these developments, “it is not surprising that approximately 25 states in the United States are discussing or implementing some form of FGDM” (Merkel-Holguin, 2005).

“The emerging trend in many U.S. communities is to incorporate elements of the family unity model into the family group conferencing approach” (Merkel-Holguin, 2005). The family unity model includes structured time for a facilitated discussion of family strengths and concerns. “The differentiating element of the Family Group Conference is the provision of private time whereby only family consider the information presented, deliberate, and make decisions that are then presented back to the professionals and other Conference attendees for discussion and approval” (Merkel-Holguin, 2005).

In 2003, Merkel-Holguin, Nixon, and Burford (2003) compiled and reviewed FGDM research and evaluation in child welfare practice, citing U.S. and international implementations, variations, and explorations of FGDM. The authors divided the diverse methodologies and findings into three categories: implementation, process indicators, and outcome indicators.

In the area of implementation, both national and international studies reveal the importance of several key findings: initial implementation efforts require careful planning and time; strategic alliances and community partnerships support FGDM implementation; a minimal number of families get to have a conference; FGDM can be used safely and successfully with families that have multiple and high challenges; the coordinator plays a significant role in the FGC process; evaluations are adapting to practice variations; families are virtually invisible partners in early implementation efforts; and FGDM remains a marginalized practice (Merkel-Holguin et al., 2003).

Merkel-Holguin et al. (2003) also cite the following process indicators as consistent across national and international FGDM research and findings: preparation of participants is crucial to a successful conference; family members come when invited even though it can be stressful; balance in the number of family members and professionals is needed; families develop plans that are seen to be safe; FGC plans blend requests for formal services with family-delivered supports; family plans are rich, diverse, and original; private family time is embraced as an essential element of the FGC process; information sharing processes need critical review; family members are satisfied with the process; family members perceive they have considerable voice and decision-making authority in FGC; children’s involvement and participation vary considerably; FGCs increase the involvement of fathers and paternal relatives; social workers and service providers are satisfied with the process; social worker rates of referrals fluctuate; referral processes need further review; and family group conferencing provides cost neutrality or savings.

Finally, Merkel-Holguin et al. (2003) reference several key outcome indicators that they



have found to be consistent in their review of FGDM practice: for children who require out-of-home placement, a high percentage remain with extended family; FGC plans create stability for children; FGC increases family supports and helps family functioning; and FGC safeguards other family members. As is the case with child welfare research in general, long-term outcome research is lacking. Nevertheless, research findings to date support that FGC increases family participation (Pennell, in press), while enhancing the safety of children (e.g., Gunderson, Cahn, & Wirth, 2003) and their mothers (e.g., Pennell & Burford, 2000) or without a substantial adverse impact on children's safety (e.g., Berzin, 2004; Sundell & Vinnerljung, 2004). All of this is achieved without a significant variance in expenditures even when conferencing costs are included in the calculations (Andy Rowe Consultants, 1997; Berzin, 2004; Walter R. McDonald, 2000).

The external evaluation team is in the initial stages of data collection and analyses of these important outcome measures. While DC's FTM model is in its early stages, we can begin to assess and monitor whether or not this implementation of FGDM has a positive effect on children's safety and well-being, as well as providing enhanced and improved permanency for children and their families.

Inter-organizational and Cross-sector Collaboration

In response to the class action suit on behalf of abused and neglected children in the District of Columbia and in effort to reform child welfare in the mid-nineties, the Healthy Families/Thriving Communities Collaboratives were initiated. These Collaboratives were established in neighborhoods with elevated levels of reported child maltreatment. The intent was to create a community-based system of services and supports to assist families and, thus, to improve the neighborhoods' economic viability and the residents' quality of life. Today there are seven Collaboratives working with CFSA. Two of these Collaboratives—Columbia Heights/Shaw and Edgewood/Brookland—provide coordination of FTMs.

The introduction of family meetings at this early stage in the child protection process puts to the test the capacity of the system to organize around inter-organizational and cross-sector collaborations and utilize community collaborations (Chaskin, Brown, Venkatesh, & Vidal, 2001; Gray, 1989). Considerable research attention has been given especially in the United Kingdom to the significance of partnerships with parents and collaboration between professionals as they relate to outcomes in child welfare (DH, 1995). Two community approaches to child welfare services are multi-systemic family treatment and collaborations with community/judiciary. These have promise in addressing family needs at this early stage.

Logic Models in Program Evaluation

Given that models of intervention continue to evolve in this highly complex area of practice, careful consideration needs to go into the selection of evaluation approaches that foster accountability to vulnerable groups but maintain rigor and theoretical sensitivity at the same time. The purpose of a logic model is to identify the theory, principles, assumptions or hypotheses that answer questions about why a program is expected to



have a particular effect or why it will solve a particular problem (Alter & Eagan, 1997; McLaughlin & Jordan, 1999; Milstein & Wetterhall, 1999). As opposed to a plan of action or an intervention plan, an evaluation logic model explains the effect that a plan or an intervention is expected to have.

The Internal Evaluation Team has produced a preliminary logic model that fulfills these goals. It represents a starting point to address the organization of data collection, analysis and the presentation of results.

Qualitative Methodology

Approval of Design

The external evaluation team developed the design for the first phase of the qualitative evaluation study in consultation with the CFSA internal evaluator and agency administrators in a series of conference calls and meetings. The internal evaluator consulted with CFSA legal counsel on the confidentiality agreement and consent forms (see Appendix II: Letter from Legal Counsel on the FTM Evaluation). At the request of the Deputy Director, the internal and external evaluations are under review by the CFSA Institutional Review Board (Appendix III: Letter from Agency Administrator to CFSA Institutional Review Board).

Data Collection Methodology

The qualitative interviews and focus groups were conducted by Dr. Gale Burford of the University of Vermont, Dr. Myles Edwards of American Humane, Dr. Joan Pennell of North Carolina State University, and Ms. Kathleen Tinworth of American Humane. NCANDS and AFCARS data were received by the Internal Evaluation Team from FACES and analyzed by Ms. Tinworth and Dr. Edwards.

Data Sources

In Phase I of the study, the qualitative evaluation utilized three main data sources:

- Document Analysis – including the District of Columbia legislation mandating FTMs and their evaluation and descriptions of FTMs by CFSA;
- Individual and Focus Group Interviews – with key stakeholders; and
- FTM Steering Committee Observation – meeting of July 26, 2005.

Recruitment of Interview and Focus Group Participants

With agency administration and the internal evaluator, the external evaluation team developed a list of categories of key stakeholders to interview during Phase I of the study. The internal evaluator using this list selected the research participants (see Appendix IV: Interview and Focus Group Development Methodology). The protocol for inviting



participants can be found in Appendix V: Scheduling Protocol. This protocol includes the purpose of the interviews, the individual or focus group format for the interviews, and the tape recording of the interview with the participant's permission. The internal evaluator scheduled the times and places for the individual interviews and focus groups but was not present during the sessions. This meant that while the internal evaluator would know who was invited to participate, no one from CFSA would know who actually took part other than the participants.

Terms of Participation in the Evaluation

In addition to the internal evaluator not being present for the interviews and focus groups, confidentiality was affirmed through a series of measures. Before commencing data collection, the external evaluators signed an agreement on confidentiality (see Appendix VI: Confidentiality Agreement). The transcriber for the audio tapes also signed an agreement on confidentiality (see Appendix VII: Transcriber Agreement of Confidentiality). Prior to the start of the interviews or focus groups, the evaluators reviewed with the participants the consent form which gave the purpose of the interview, its authorization by the CFSA, the auspices of and members on the external evaluation team, the duration of the interview, the steps for maintaining confidentiality, and no offer of compensation or other personal benefit (see Appendix VIII: Consent Form). Participants could elect to have the interview recorded by both note-taking and audio taping or only by note-taking.

The terms for participation in Phase I of the qualitative evaluation were set forth in the letter from the Deputy Director to the Chair of the CFSA Institutional Review Board. This letter emphasized that participation would be voluntary and that confidentiality would be maintained:

I acknowledge that staff and external stakeholder engagement in the FTM focus groups and interviews is completely voluntary. All the information gathered during the focus groups and interview sessions will be collected and preserved in a fashion so as to ensure participant confidentiality. All individual and case identification will remain separate from individual responses in evaluation efforts and will be destroyed upon completion of the focus group or interview session. Information obtained in the individual focus groups and interviews will be utilized to inform the FTM process and future program development. Participants will not be exposed to risk which is beyond the acceptable level as identified by research standards. Information obtained in each session will be utilized solely as the participant has identified and consented.

Evaluation Protocol

The interviews and focus groups were scheduled over the course of five days in July 2005 and held on site in Washington, DC. The sessions were conducted either at CFSA or in the offices of professionals from outside of CFSA.



As outlined in Appendix IX: Interviewing and Focus Group Procedures, the sessions began with introductions of the evaluation team and participants and an overview of the purpose of the interviews. The evaluators reviewed the terms of research participation, answered any questions, and asked the participants to sign the consent form. The evaluators checked that all participants were in agreement on proceeding with the interview and with the audio taping. With their consent, the tape recorder was turned on. The sessions were usually co-facilitated with one facilitator leading the discussion and the other(s) taking notes and monitoring the tape recorder.

During the interviews and focus groups, the evaluators posed a series of 6 questions to which participants responded verbally (see Appendix X: Interview and Focus Group Protocol) and asked participants to complete a Likert-scale questionnaire with 19 items (see Appendix XI: Questionnaire). The questions asked the interviewees about their involvement in FTMs, their views on the effect of FTMs on services for children and their families, areas for improvement of FTMs, the effect of the 72-hour time frame on parents' rights and on children, and their feedback on the interview.

The questionnaire used a scale from 1 *strongly disagree* to 10 *strongly agree*. As a check on respondent's attentiveness to individual items, four of the items are in the reverse direction. These are items 3, 5, 6, and 19. The 19 items were developed in order to assess the extent to which FTM practice reflected the eight FTM principles (listed previously). Table 2 below shows the questionnaire items as originally conceived in relationship to the eight FTM principles. Each principle has at least one related questionnaire item; most have between two to five items. Because of interconnections among the principles, a case can be made for associating various questionnaire items with a number of FTM principles. In Phase II of the study the actual relationships among the items will be analyzed once data are available from families.

Table 2
Questionnaire Items Conceptually Related to FTM Principles

Principle	Questionnaire Item
1. Family Inclusive Philosophy: Meaningful family participation in planning & decision-making.	2. Families are prepared for taking part in the meeting. 5. <u>Only one</u> side of the children's family takes part in the planning. 12. Families have a real say in the planning.
2. Strength and Need Based Planning: Strengths-based assessment and plans are vitally important.	13. Plans build on family's strengths or good qualities.
3. Ongoing Assessment and Planning: Plans are flexible for changing family needs.	14. Plans can be revised when the family's needs change.



4. Team Based Approach: Providing assistance to children & families requires a family inclusive team.	1. Everyone at a meeting understands why it is being held. 3. Service providers are <u>not</u> well prepared taking part in the meetings.
5. Multi-Systemic Intervention: Crucial to assessing, planning and providing suitable resources to children and their families.	17. The plans include ways that CFSA and other public agencies will help out.
6. Cultural and Community Responsiveness: Promote involvement of the community of origin in the planning with the families and children.	4. People who are family or feel like family are at the meetings. 6. More service providers (“professionals”) are at the meetings than family and their close supports. 7. The meetings are held in a place that feels right to the family. 8. The meetings are held in a way that feels right to the family. 9. The meetings have enough supports and protections to make the participants feel safe and comfortable.
7. Brief Strategic Solution Focused Intervention: Use of flexible and easily accessible resources used to support those solutions.	15. The plans include ways that relatives, friends, or other close supports will help out. 16. The plans include ways that community or neighborhood organizations will help out. 18. The plans use local or neighborhood resources, such as group homes or counseling services.
8. Organizational Competence: Committed, qualified, trained and skilled staff, supported by an effectively structured organization.	10. Coordinators organize the meetings well. 11. Facilitators run the meetings well. 19. The facilitators do <u>not</u> consistently follow up to see if the plans are being carried out.

Interview and Focus Group Participants

In total, 36 individuals were interviewed: 9 individually and 27 in focus groups. The focus groups ranged in size from 2 to 8 participants. The average length was 60 minutes for the focus groups and 47 minutes for individual interviews. The categories of participants are indicated below. The number of interviewees per category is omitted in order to protect the identity of individuals in categories of small size. The roles of the interviewees were:

1. *Within* CFSA:



- a. Program Administrator and Supervisor – including intake and ongoing services.
 - b. Worker – including ongoing services.
 - c. FTM Facilitator.
 - d. FTM Coordinator.
2. Outside CFSA:
- a. Magistrate.
 - b. Assistant Attorney General.
 - c. Guardian ad Litem.
 - d. Collaborative FTM Coordinator.

In general, evaluation participants expressed satisfaction with the interview or focus groups and support for the implementation of the external evaluation. Typical feedback included “It was fun, debriefing” and “I’d be interested in knowing the results.” As one focus group participant commented, “Having mixed group was good. Good to bump heads into all these issues.”

Data Analysis and Validation

As a validity check, the findings from the interviews and focus groups were compared with the evaluators’ notes on the statements made by key stakeholders at the July 26th meeting of the CFSA FTM Steering Committee. Meeting attendees included representatives for CFSA administrators, supervisors, front-line workers, FTM facilitators, quality assurance unit, and internal evaluator; Healthy Families/Thriving Community Collaboratives; service providers from other agencies; the court-appointed monitor; legal community, including an assistant attorney general and guardians ad litem; children’s advocates from various community organizations; and the external evaluation team.

Future Steps for the Qualitative Evaluation

During Phase I of the qualitative evaluation, the number of interviews and focus groups were limited in number and categories of participants. This was because of time limitations and the need to use this period for testing the instrumentation. The FTM Steering Committee recommended that the interviewee group be expanded to include families (parents, children, young persons, relatives), parents’ attorneys, provider staff, foster parents, kinship providers, court monitors, and court staff. The external evaluation team likewise would like to see these groups included in the study. Modifications to the consent form and research protocol will be needed particularly prior to commencing interviews with families. In addition, qualitative analyses will be conducted on a sample of FTM plans and 2-5 FTMs will be observed with the permission of the participants.

Qualitative Evaluation Findings

Questionnaire



As noted previously, during the interviews and focus groups all 36 participants completed the 19-item Likert-scale questionnaire. Table 3 below provides the descriptive data for each of the 19 statements concerning FTMs. Because four items (3, 5, 6, and 19) were worded in reverse, these were recoded for the purpose of the analysis in order to facilitate comparison with the other items. The reversed item 3 would refer to service providers being well prepared for the taking part in the meetings; the reversed item 5 refers to both sides of the children’s family takes part in the planning; the reversed item 6 refers to more family and their close supports are at the meetings than service providers (“professionals”); the reversed item 19 refers to the facilitator consistently follows up to see if the plans are being carried out. Given the small number of respondents in many categories, the scores were not analyzed by the participants’ role in FTM.

In general, participants scored each item on a scale of 1 (*strongly disagree*) up to 10 (*strongly agree*) or circled *don’t know* or *not applicable*. For instance, respondents (e.g., magistrates) who were not present at FTMs tended to circle don’t know or not applicable for items such as number 7 on the location of the meetings. It should be noted that low response rate on the last item (#19) is the result of needing to reword it during this pre-test phase of the questionnaire. The responses prior to the change were omitted from the analysis.

The range in responses was quite wide with minimums often of 1 (strongly disagree) and maximums often of 10 (strongly agree). The standard deviations ranged from 1.457 to 2.828, with the majority around 2; this also shows a fairly extensive dispersion in scores, meaning that opinions differed among respondents. The measures of central tendency, the median and mean, were fairly close on all of the items, indicating that responses tended not to be skewed in a certain direction by extreme scores.

The items were reorganized in Table 3 from highest to lowest mean response. The six top responses have means above 7 and medians of 9 or 8. The remainder of the items’ means fall in the mid-range between 4 and 7, with their medians ranging from 5.00 to 7.50. Although the lowest mean (# 19) may be a function not the respondents’ views but instead of its low response rate, the findings discussed later indicate that respondents were concerned about the lack of follow up on plans. No item has a mean among the lowest possible scores of 1 to 3. These findings indicate that overall the respondents viewed the FTMs as performing solidly in 6 areas and more moderately in the other 13 areas.



Table 3
Responses to Questionnaire in July 2005 (N = 36)

Statement about Family Team Meetings	<i>n</i>	Range	Median	Mean	<i>SD</i>
4. People who are family or feel like family are at the meetings.	34	3 – 10	9.00	8.50	1.600
17. The plans include ways that CFSA and other public agencies will help out.	35	5 – 10	8.00	8.23	1.457
13. Plans build on family’s strengths or good qualities.	36	2 – 10	8.00	7.61	1.975
14. Plans can be revised when the family’s needs change.	27	4 – 10	8.00	7.56	1.805
15. The plans include ways that relatives, friends, or other close supports will help out.	36	1 – 10	8.00	7.53	2.372
9. The meetings have enough supports and protections to make the participants feel safe and comfortable.	31	1 – 10	8.00	7.39	2.044
10. Coordinators organize the meetings well.	32	3 – 10	7.50	6.91	1.692
11. Facilitators run the meetings well.	33	3 – 10	7.00	6.85	1.955
5. <u>Only one</u> side of the children’s family takes part in the planning. [Reversed]	34	2 – 10	6.50	6.56	2.501
2. Families are prepared for taking part in the meetings.	32	3 – 9	7.00	6.53	1.646
12. Families have a real say in the planning.	34	1 – 10	6.50	6.53	2.513
18. The plans use local or neighborhood resources, such as group homes or counseling services.	31	1 – 10	7.00	6.52	2.5152
6. More service providers (“professionals”) are at the meetings than family and their close supports. [Reversed]	30	3 – 10	6.00	6.43	1.942
16. The plans include ways that community or neighborhood organizations will help out.	33	1 – 10	7.00	6.39	2.828
8. The meetings are held in a way that feels right to the family.	31	3 – 10	6.00	6.16	2.146
3. Service providers are <u>not</u> well prepared for taking part in the meetings. [Reversed]	28	1 – 10	6.00	6.14	2.013
1. Everyone at a meeting understands why it is being held.	32	2 – 10	6.00	6.06	2.031
7. The meetings are held in a place that feels right to the family.	27	1 – 10	6.00	5.78	2.532
19. The facilitators do <u>not</u> consistently follow up to see if the plans are being carried out. [Reversed]	19	1 – 9	5.00	4.26	2.207

As discussed previously, the 19 items are intended to serve as indicators of the eight FTM principles developed by CFSA. Table 4 below replicates Table 2 with the insertion of a middle column in which the order of the items in terms of their mean response is shown going from 1 to 19. The top six items have their mean order highlighted. Three principles have only one indicator, and all of these have means of questionnaire items among the top six. According to the pattern of responses, the evaluation participants for the most part see FTMs as achieving the principles of strength and need based planning (2), ongoing assessment and planning (4), and multi-systemic intervention (5). The findings



on cultural and community responsiveness (6) and on brief strategic solution focused intervention (7) are mixed, with statements having higher and lower means. Two principles—a family inclusive philosophy (1) and organizational competence (8)—primarily have means in the middle. One principle—team based approach (4)—stands out as troubling because the means for its two indicators are both among the lowest.

Table 4
Questionnaire Items Conceptually Related to FTM Principles and Ordered by Mean Responses

Principle	Order by Mean	Questionnaire Item
1. Family Inclusive Philosophy: Meaningful family participation in planning & decision-making.	10	2. Families are prepared for taking part in the meeting. 5. <u>Only one</u> side of the children’s family takes part in the planning. [reversed] 12. Families have a real say in the planning.
	9	
	11	
2. Strength and Need Based Planning: Strengths-based assessment and plans are vitally important.	3	13. Plans build on family’s strengths or good qualities.
3. Ongoing Assessment and Planning: Plans are flexible for changing family needs.	4	14. Plans can be revised when the family’s needs change.
4. Team Based Approach: Providing assistance to children & families requires a family inclusive team.	17	1. Everyone at a meeting understands why it is being held. 3. Service providers are <u>not</u> well prepared for taking part in the meetings. [reversed]
	16	
5. Multi-Systemic Intervention: Crucial to assessing, planning and providing suitable resources to children and their families.	2	17. The plans include ways that CFSA and other public agencies will help out.
6. Cultural and Community Responsiveness: Promote involvement of the community of origin in the planning with the families and children.	1	4. People who are family or feel like family are at the meetings. 6. More service providers (“professionals”) are at the meetings than family and their close supports. [reversed] 7. The meetings are held in a place that feels right to the family. 8. The meetings are held in a way that feels right to the family. 9. The meetings have enough supports and protections to make the participants feel safe and comfortable.
	13	
	18	
	15	
	6	
7. Brief Strategic Solution Focused Intervention: Use of flexible and easily accessible resources used to support those solutions.	5	15. The plans include ways that relatives, friends, or other close supports will help out. 16. The plans include ways that community or neighborhood organizations will help out. 18. The plans use local or neighborhood resources, such as <u>group homes or counseling services</u> .
	14	
	12	
8. Organizational Competence: Committed, qualified, trained and skilled staff, supported by an effectively structured organization.	7	10. Coordinators organize the meetings well. 11. Facilitators run the meetings well. 19. The facilitators do <u>not</u> consistently follow up to see if the plans are being carried out. [reversed]
	8	
	19	



Interview Questions

In addition to the Likert-type questionnaire, questions were asked of those participating in interviews and focus groups in Phase I of the external evaluation (see Appendix X: Interview and Focus Group Protocol). This section summarizes their responses in regards to their impressions of how FTMs affect the way in which CFSA works with families, what makes FTMs work well for families, what ways FTMs can be improved, and what impact the 72-hour period has had on parents' rights and on children. The following analyses are based on transcripts of audio recordings and notes taken during the individual and group interviews. The findings are related back to those on the questionnaire.

FTMs and Services to Children and Families

In order to gain their perspectives on the effect of FTMs on services to children and families, the interviewers asked the evaluation participants, "Think back to your impressions of how CFSA worked with families before Family Team Meetings were started. In what ways, if any, are Family Team Meetings now making a difference?" After stating their views, participants were then asked, "Overall, would you say Family Team Meetings are making services for children and their families better, just the same, or worse?" To check out further their views on the benefits of applying FTMs, participants were then asked, "What is it about Family Team Meetings that make them work well for children and families? This question was followed by one to reach for challenges: "If you could change one thing about Family Team Meetings, what would it be?" The report begins with the ratings for the second question and then turns to the responses to the three open-ended questions in order to explain the pattern of ratings. Because the answers to the three open-ended questions interconnect, they are integrated together in this report.

As shown in Table 5 below, 25 of the 36 interviewees provided a rating. Among these, most (22) stated that FTMs were making services better for children and their families, a small minority (3) said services were left "just the same," and none said that services were "worse."

Table 5
Ratings of Effect of FTMs on Services to Children and Their Families (N = 36)

Overall, would you say Family Team Meetings are making services for children and their families:	<i>f</i>	Percentage
Better	22	88.0
Just the Same	3	12.0
Worse	0	0.0

Note. Among the 36 interviewees, 11 were undecided or did not give a rating.

In responding to the question of what ways FTMs were now making a difference, many interviewees expanded at length. These comments serve to clarify the reasons underlying



the ratings in Table 5 above. In their statements, the participants identified an extensive number of positive developments resulting from the institution of FTMs and a number of challenges in implementing the model.

- Families had a greater awareness of why CFSA had removed their children and was petitioning the court to keep them in care.

For instance, a social worker commented, “Parents . . . understand better why we had to intervene. Not just clueless when going into court.” Similarly, a supervisor, comparing agency interventions before and after the start of FTMs, reflected, “We didn’t deal with the issue of why the children were removed” and skirted around these matters “like the elephant in the room.”

- With greater understanding of what was happening, tensions were reduced between CFSA and the parents and their communities.

A respondent from outside of CFSA observed that the “community hated CFSA. Now, acceptance is easier for them. . . . Families know what happens next.” A magistrate stated, “I’m seeing more parents coming to the initial hearing who are willing to work with the agency and . . . less defensive about what’s happening to them and their family.” Similarly, a FTM coordinator asserted that FTM “lets the family see the other side of the Agency—that we’re not trying to destroy the family, that we are here as a support network, and . . . that we are willing to work with them instead of against them.”

- As a result, parents arrived at court better able to present themselves, and the proceedings became less emotionally charged and more focused on the issues to be addressed.

A magistrate noted that prior to FTMs, parents arrived in “shell shock,” but that now after a FTM parents appeared less “traumatized” and the hearings became “more productive.” Concurring, an attorney remarked, “Before FTM, maybe one parent [was] there, if anyone” and “often angry”; but “since FTM, a lot of people show up, both parents and relatives” and there is “far more identification of total issues not just the precipitating instance.” Another magistrate pointed out that “the parties are more prepared at the initial meeting” and “often times have a service plan that is already agreed to.”

- Not only were the parents less confused and angry, but the FTM helped to keep the children and young people connected with their family: They might attend the meetings in person, their parents and relatives were informed about how they are doing, and the turn-out of relatives demonstrated and reinforced family ties.

A CFSA administrator commented that FTM is a way for extended family to “stay connected to the child.” In a similar vein, a magistrate commended FTMs for ensuring that “kids linked with extended family.” A supervisor remarked that



the FTM “guarantees kids having initial visits after removal” and that “teens [are] almost always there” at the FTM and younger children are “often there” as well. All of this, a FTM coordinator pointed out, “Gives children hope that people want them to be with their family members.”

- The FTMs provided a forum in which the family had a greater say regarding placement decisions.

The FTM facilitators and coordinators, in particular, identified how the process helped the families to express their views and take charge of their affairs. One facilitator noted that before FTMs were instituted, “inner-city case workers with limited resources . . . didn’t have the time to include children and families in developing their own plans”; now “FTM. . . continues to create vehicle for families to be involved.” A second facilitator asserted that the “Agency has traditionally assumed an air of “we make all the decisions,” but now a “new philosophy to promote practice change involves seeing families in a different way.” Similarly a third facilitator reflected that before FTMs, the CFSA was seen as the “big, bad wolf” who “took kids never to return”; now “family are feeling empowered to say ‘no’ ” and the “family’s voice is being heard.” Going one step further, a coordinator pointed out that FTMs also demonstrate that families “can empower themselves rather than give the power to the government.”

- By meeting with the family and their extended support network almost immediately after the removal of the child from the home, CFSA more quickly identified kinship placements.

A conference coordinator explained that FTMs are “improving the identification of family members. . . really early in the process”; previously, the “aspirations of family members” were not included in the planning. Agreeing, a worker explained that since the start of FTMs, “We look into family more intensely.” At FTMs, a program manager noted, “Dads and paternal relatives” were included in the placement decisions. A magistrate observed that before there were “not as many relatives” and as a result, “placement issues took longer to resolve.”

- At the FTM, the group constructed plans that were clear and relevant, tapped community resources, and had the support of the participants.

A supervisor found because of FTMs, “People can digest the situation” and “every individual is contributing”; as a result, there are “clearer goals,” participants “feel better,” and a “collective effort” emerges. A worker noted that FTMs make the planning “more concrete” and get “everyone on board” with the service agreement. Another worker explained, that FTMs increase the “focus on behaviors rather than . . . just saying you need this therapy” and are “now forcing social workers to identify services and changes of behavior rather than just identifying services that the agency offers in general.” A third worker found that FTMs identify “different services and uses the community more as opposed to



using federal dollars or using psychiatrists and psychologists to solve the family's problems.”

- The FTM gathering led to the family network and CFSA firming up working relationships and expediting the work.

Front-line social workers were especially attuned to how FTMs facilitated their work with families. A social worker commended FTMs for offering a ready-made means of bringing together the family and workers: The FTM was a way to “set up meetings” that the worker would “like to have anyway.” The FTM, a second worker identified, made it possible for the family “to admit that there is an issue there” and accept “responsibility.” Continuing a third worker explained that the meeting brought together from the beginning “those who know the family and child best,” “generates ideas,” “rejuvenates” the group, and “creates team players.” Similarly, a fourth social worker observed a positive overall impact on work with families: The FTM “enriched” individual assessment and offered a “good medium for change” by fostering “buy-in early” of the intervention process. The better relationships and greater clarity on goals, according to a fifth worker, helped to move “the process a little faster and close the cases just a little bit faster.” A magistrate observing the impact of FTMs agreed with the workers’ perceptions and concluded that FTMs are working “because the families are running the show. They come in, they provide history of whatever the dysfunction is or the problem, they can provide information that I don’t think the agency would have been able to get ever, let alone in the short time frame that exists now under ASFA [Adoption and Safe Families Act].”

- Being present at the FTMs assisted guardians ad litem (GAL) to be better advocates for the children and adolescents.

A magistrate pointed out that the FTM “gives the guardian ad litem an opportunity to meet the children and to get a real sense of what’s going on and what they want.” This is in sharp contrast to before the institution of FTMs when the guardians ad litem “would be appointed the same day as the hearing, and most times could not speak with the child” in advance or find out from the “teenagers. . . where they might want to go” to live.

- While major strides were achieved on behalf of children and their families, substantial challenges remained in implementing a new model. An immediate problem was scheduling the meetings at times that worked for both families and the CFSA workers.

Difficulties in scheduling the meetings were highlighted by coordinators responsible for organizing the meetings and front-line workers expected to attend them. Meetings were often scheduled on evening and week-ends to accommodate the needs of families. When calling workers to attend FTMs during non-business hours, coordinators found that it was “tough to coordinate when . . . forcing



people [workers] to come to meetings on the weekends.” From the coordinators’ perspective, the workers were often unprepared for the call and “blow[ing] up” at coordinators. From the workers’ vantage point, there needed to be a “balance” between the “availability of the family and . . . the social worker.” Ongoing workers, in particular, felt that they got the “brunt of what goes on in agencies. Slammed with everything. Working late, working early.”

- Tensions between coordinators and workers were exacerbated because the latter too often lacked an orientation to FTMs in general or to a specific family situation.

Coordinators and workers proposed various ways of addressing these issues. A coordinator recommended that FTM training be “put in place at least once a month . . . because I know there are some social workers that don’t know the process and think that we are supposed to do case management. . . . for them.” Workers identified that they needed more support at the meetings. For supports, they suggested that the FTM facilitators “be knowledgeable” about the family and “take more ownership” if the intake worker is absent from the meeting. Another suggestion of the ongoing workers was that their supervisors make themselves “more available” to attend the meetings with the social workers.

- At the meetings, intake workers who carried out the initial investigation were to transfer the case to the ongoing worker. Because of the 72-hour time frame before cases were heard in court, intake workers had limited time to carry out the investigation. As a result, the ongoing workers who assumed responsibility for the cases often felt at a disadvantage in understanding the family’s situation and knowing how to articulate clear goals and assess proposed action steps.

Supervisors were particularly cognizant of the difficulties in the internal workflows and their impact on service. A supervisor pointed to how FTMs led to a “better incorporation of families” into the planning process but at the same time they added “one more burden” for the intake workers who needed to carry out the investigations under tight time constraints. Another supervisor pointed out that the ongoing workers to whom the cases were transferred at the time of the FTM had to pick up where the intake worker left off. Whereas previously the “investigation was 30 days, now [it was] expected to be within 72 hours,” as a result the ongoing workers had to assume cases without “a clear picture of what’s going on.”

- Questions were raised about the plans resulting from the FTMs: inconsistency in presenting the plans in court, lack of creativity and clarity in the plans, and failures in following through on the plans.

A magistrate, while remaining “a believer” of FTMs, recognized that “practical kinks in how to carry out the process” still needed ironing out. Magistrates do not “generally get the FTM plans” even though they are “supposed to get these” and need to hear a clear articulation of the children’s needs and what the services and



timeline should be. An intake supervisor was impressed that FTMs provided a “structure” for the planning process but was “not impressed” by the plans themselves. Continuing this supervisor explained that the “creative voice of family is missing” because the family needed the “opportunity to express itself, free of the Agency and bureaucracy.” Moreover, once plans were in place, a coordinator reported that the collaboratives heard the “complaints” of families who did not understand why “there’s no follow-up” of the plans.

- Concerns were raised that FTMs were diverging from family-centered forums because of an over emphasis on legal procedures.

A FTM facilitator identified that “plans are drifting back to formula” and that “legal [structures], bureaucracy are getting in the way”; FTM is “losing the core values of the process being family-driven.” Similarly a coordinator commented that “attorneys want to make it a courtroom [and] change to ‘cold’ legalized [procedures that] take away family’s voice.” A supervisor spoke at length about the negative impact of the guardians ad litem (GAL) at the meetings: “A lot of clinical pieces taken out because GAL is present. Gets legal. FTM gives people chance to understand things. Good, but having GAL there complicates. Room for improvement. GALs shouldn’t be invited. . . . Often GAL asks what recommendations will be in court—what are timeframes, etc. Those discussions shouldn’t happen in the FTM forum. Legal pieces create adversary in front of family. Negates purpose. Facilitators don’t do anything to stop GALs, sometimes joining them in asking about recommendations, etc. Workers feel pressure to make decisions because GALs are there.”

In summary, the interviewees elaborated at length on the benefits of FTMs and also acknowledged some serious shortcomings in implementing the model. In line with their ratings on the 19-item questionnaire (see Table 4 above), they commended FTMs for including family and other individuals with connections to the family at the meetings, they saw the plans as specifying concrete steps for the family system and service providers to help out in a manner responsive to the family’s needs, and they concluded that overall the meetings are a forum in which families voice their views. At the same time, their comments point to the same challenges as seen on the questionnaire responses: questions about the extent to which families truly shape the plans, problems with meeting preparation and creating a cohesive team based approach, the professionalized culture of the meetings and the resulting formulaic plans, and the lack of follow up on plans after the meetings.

FTM Steering Committee

The interview findings paralleled the feedback provided at the FTM Steering Committee meeting on July 26th, 2005 held at the CFSA. As noted previously, participants at the Steering Committee meeting included agency administrators, workers, facilitators, attorneys, collaborative representatives, providers from other services, child advocacy groups, court monitor, and internal evaluator. They identified both successes and



challenges in delivering FTMs. In a round on successes, they spoke of the following accomplishments:

- The greater involvement of family (including fathers) at the FTM and later at the initial hearings,
- Families having an opportunity to discuss what is happening and what should be included in the service plans,
- Faster identification of family resources (including kinship placements) and earlier provision of services (e.g., drug treatment),
- Using the collaboratives from outside of CFSA to coordinate the meetings,
- Social workers and guardians ad litem arriving at the initial hearing better informed about the children and their families,
- Reductions in adversarial interactions at the hearings, and
- Opening a discussion on whether to discontinue mediation as no longer necessary now that FTMs are in place.

In a second round on challenges, they pointed to a number of barriers to overcome:

- Differing viewpoints on whether to include children and young persons at the FTMs,
- Difficulties in scheduling meetings that accommodate family and workers' schedules,
- Lack of coordination between intake and ongoing social workers at the meetings,
- Slow down in placing children caused by lack of staffing to do assessments and requirements of interstate compacts, and
- Legal procedures taking precedence over engaging families in decision making,

Turning to next steps, the Steering Committee members proposed a number of measures:

- Establishing a subgroup to consider an infrastructure to align the different involved systems (e.g., around scheduling of meetings),
- Bringing together attorneys to discuss legal aspects of FTMs,
- Creating a structured format in which coordinators and facilitators can negotiate issues, and
- Continuing the external evaluation to provide an outside perspective on FTMs.

The convergences between the interview findings and the FTM Steering Committee discussion serve as a validity check of the qualitative evaluation. Further validity checks will occur in the next two phases of the external evaluation. These will include interviews with family members, observations of FTMs, analysis of plans, and comparing and contrasting quantitative and qualitative findings.



Impact of 72-Hour Framework

After eliciting the interviewees' views regarding the effect of FTMs on services to children and their families, the interviewers asked the evaluation participants a series of questions about the impact of the 72-hour framework. In order to orient the participants, they were read the following statement on the 72-hour period:

Before the change in legislation, the government had 24 hours after removing children from their home to have the case heard in court. Now, when the Child & Family Services Agency removes children from their home, the government has 72 hours before the case must be heard by a judge. The judge makes a decision on where the children will live. During those 72 hours, the children's family and/or support network are invited to take part in a Family Team Meeting in order to make a plan for the children.

Then they were asked two sets of questions. The first set concerned the parental legal rights: "What impact did holding court at 24 hours after placement have on parents' rights to be heard by the judge?" "What impact does extending this time period to 72 hours have on parents' rights to be heard by the judge?" The second set concerned the impact on the children. They were asked an open-ended question: "What impact does extending the period from 24 hours to 72 hours have on the children?" This was followed by a request that they rate the impact: "Overall, would you say that extending the period from 24 to the period from 24 to 72 hours in order to give time for the Family Team Meeting is making services for children and their family better, just the same, or worse?"

This report of findings begins with the last question in order to provide an overall profile of the pattern of responses. As seen in Table 6 below, one-quarter (9) of the 36 participants were either undecided or a rating was not available from them. Among the three-quarters who gave a rating, the large majority (21) affirmed that extending the period from 24 to 72 hours in order to allow the FTM to take place was making services for children and their families *better*. The remaining 6 all said services were *just the same*.

Table 6
Ratings of Impact of Extending the Period Prior to Court from 24 to 72 hours on Services for Children and Their Family (N = 36)

Overall, would you say that extending the period from 24 to 72 hours in order to give time for the Family Team Meetings is making services for children and their families:	<i>f</i>	Percentage
Better	21	77.8
Just the Same	6	22.2
Worse	0	0.0

Note. Among the 36 interviewees, 9 were undecided or a rating was not available.



In order to elucidate the reasons behind these ratings, the responses to the three open-ended questions are integrated into a series of points. These points are supported by material from various respondents.

- Overall, participants agreed that the extension from 24 to 72 hours did not affect the parents' right to be heard in court.

Summing up the issue succinctly, a magistrate stated, "Because your question is [about] the right to be "heard", the legislation has had absolutely no impact. . . . The old way they had counsel as soon as the petition was filed. New way they have counsel as soon as the petition is filed."

- Before the extension, the parents met the lawyer at court, and after the extension the same was true. With the extension, the parents' attorneys might have somewhat more information available by the time of the initial hearing.

A magistrate indicated that "the parents' attorneys aren't really any more prepared in coming to court. I mean they're appointed that day, the day of the hearing, and they may have a little more information because the agency has gotten more information. So that might help them."

- Nor was the 72-hour period unusual in the U.S. legal system.

According to a magistrate, "there are many jurisdictions where a three-day period is accepted and. . . . I don't believe there's a constitutional impediment to having that kind of time period."

- The main change having to do with the extension of time is that now the guardians ad litem (GAL) have the chance to meet the child and/or others before they walk into court and, thus, could better represent during the hearings. Previously they did not have this opportunity.

The same magistrate noted that "the only difference is that as soon as the removal happens, when a complaint is filed with the court, a GAL is appointed for the child."

- A lingering question, though, was whether it was fair for the children's lawyer to present at the FTM when the parents did not have such counsel. The presence of GALs signaled the possibility that the rights of parents could be exploited at the FTM if they were not represented by an attorney.

A supervisor reported, "Yes, [I] have seen [an] effect on parents' due process. If going to have child's attorney, should have parents' attorneys too." In agreement, a supervisor commented, "All parties at FTMs should have legal representation. Sometimes parents just in shock. Parents not having legal representation seems



odd. Having it seems appropriate.” Likewise a collaborative coordinator would have wanted to “see all [having] counsel at FTMs” but was “told just to invite GALs.” A magistrate pointed out that “if a case is being brought that shouldn’t be brought, or if the issues have been overblown by somebody who had a stake in trying to upset the family or something like that, then those concerns [about parents not having legal counsel at the FTM] . . . have some validity . . . [about] parents going into a session without any representation and possibly damaging their case when they really should take that case to trial and should fight it.”

- At the same time, most, who raised the concern about parents not having an attorney, also raised various concerns about the effect of including them at the FTM. Lawyers, in their view, could silence the parents, dominate the meetings, and generate a legalistic and chilling atmosphere.

A supervisor stated, “I’m thinking that if the parents’ attorneys were there, then all havoc would ensue because they wouldn’t want mom being honest and the whole point of the meeting is to be honest and open so that we can address the issues.” A FTM coordinator summarized the prevailing view: “I guess my issue would be surrounding the attorneys because when they come in they want to make it into a courtroom proceeding and we consistently have to fight with them, to explain to them this is not the courtroom. This is a family’s opportunity to strengthen themselves, to gain knowledge to be creative, to come up with ideas about what they feel should happen to their children. And for you to want to make it so cold and so legalized that takes away the family’s voice. Because then they’re not going to be heard, and they’re not going to feel like they’re going to be heard because basically you’re the law. . . . Some are better than others. . . . And some tend to improve as they come to more and more meetings. But then you’ve got some who just want to stick to their same guns and coming in with the same attitude of ‘okay mom, don’t say this, don’t say that, don’t say this, just sit back and listen’.”

- One proposed solution was making legal consultation available to parents during the 72 hour period.

Presenting such a proposal, an attorney elaborated, “What I would do is ask for the court to provide an on-call attorney, a consultant attorney, for the day if you will, so that parent could call in and say, ‘I’m in the 72 hour status, I have a question about stuff, could you let me see the attorney for the day to answer a question for me, or tell me if I should be doing this or that.’” But on further reflection, this same attorney questioned the solution, “But I think if you start to provide that, you’re going to have everybody trying to make use of it and that will overwhelm it.”

- In addition to the parents’ lacking legal counsel at the FTMs, social workers were also questioned their own lack of representation given the GALs’ participation.



A social worker commented, the “GAL sometimes works against us [social workers]. Don’t work together. GALs come up with grand ideas that can’t happen right away. Want AAG [assistant attorney general] there for balance.”

- Concerns about the presence of GALs at the FTMs was somewhat offset by the fact that the lawyers in the main were typically willing to counsel parents to get needed help.

A magistrate noted, “But the other side of it is . . . especially [with] . . . the more experienced attorneys, when they assess that there is a problem that needs addressing and you find that the sooner the parent starts getting the help [they need] the greater the chances the children will be returned home and so that does occur [parent’s attorneys encouraging parents to go into treatment].”

- Views differed on whether the 72 hours was appropriate for children and their families. From a legal perspective, the time length meant that children were held for a longer period in care before the parents had the opportunity to give their side in court.

Reflecting on the pros and cons of the 72 hours period, a magistrate elaborated, “I guess where there is a danger that rights have been diminished it’s in those cases where a parent is challenging the agencies’ allegations and these are especially . . . true in a case of what we call unexplained injuries. We have a statutory provision which allows the court to infer abuse where a child is found to have injuries which cannot be satisfactorily explained by the parent or whoever . . . had custody of the child. Those are really difficult cases anyway. Because you know there certainly can be circumstances where that happens but it is not any fault of the parent. And you’re talking about holding a child for an extra two days in a shelter care, not a shelter care but an agency placement.”

- At the same time, the 72 hours meant that parents were more prepared when arriving at court.

As evident in responses to earlier questions, the respondents noted the greater preparation of the parents for the court hearing. For instance, a FTM coordinator observed, “The 72 hours gives the family [the chance] to like meditate on what has happened. I think they’re in the middle of, obviously a chaotic situation . . . and . . . the 72 hours gives them a chance to really just look and think about what has happened and where they’re trying to move with it. I think . . . [at] the 24 hours you’re still in the midst of what is happening, you’re still in the shock and it’s all like ‘what’s going on?’ . . . You can’t possibly like make decisions and make good ones.”

- From a social work perspective, the extension from 24 to 72 hours improved services for children and their families.



A supervisor noted that the “24 hours was not enough time” and that the 72 hours provided “more time to assess issues and resources.” A FTM coordinator pointed out that the FTM “gives children an opportunity to go home or to family.”

- Additionally, the extension meant that sometimes a case did not need to go to court because the FTM had resolved the situation.

Affirming the benefits of the extension, a supervisor explained, “Sometimes you can get to work with the family and find a resolution. . . . find an alternative where you don’t end up having to go to court.”

- Some CFSA staff, though, had concerns that the 72 hours was still too fast because it did not permit the development of a comprehensive plan at the FTM.

The CFSA personnel who reflected the view that the 72 hours “still wasn’t long enough” differed in their views from others about the purpose of the initial hearing. The former believed the first hearing should focus on the longer range well-being issues of the child while the latter believed that the first hearing was predominantly for developing a safety plan.

- Another issue was that not all meetings were held within the 72 hour period because of delays in the referral process.

A social worker commented that the “72 hours works, but only if [the] referral is received in time.”

In summary, the prevailing view among those interviewed, with noted differences, was that any concern about the actual extension to 72 hours was mitigated by the evidence that the parents were able to come into court more prepared than before, with more relevant information available to them and to the professionals and that this created a better, less adversarial decision-making climate in the court. As for the rights of children, a few interviewees raised concerns about the rights of children but again these concerns were mitigated by the view that child removal is a serious matter and that the more thoughtful hearing in 72 hours better serves the children.

Themes

Similar to the identified process indicators consistent across national and international FGDM research and findings in Merkel-Holguin et al. (2003), many of the same process indicators came through in the interviews and focus groups.

Universal themes

- Family involvement on the front end creates a beginning collaborative team of players to work together in partnership with the family



- More relatives and more fathers are participating than they did in previous FGC approach
- More productive hearings, less trauma for parents, less conflict between family and child protection
- Earlier identification of family members
- Wide range of expectations about what FTMs should be able to accomplish
- Reduced conflict between families and the professionals at least in initial stage
- New work patterns for new categories of personnel (facilitators and coordinators) and changes in work patterns for some existing categories of personnel (intake workers, ongoing social workers, guardians ad litem)
- Uncertainty about legal status of the FTM (e.g., privileged information?, who should have lawyers – all parties or none?)
- 72 hours perceived as an insufficient time to accomplish what needs to be done with respect to the engagement of families and professionals and laying out of medium to create long-range plan

Sub themes

- Varying views of what family empowerment means and how to accomplish it (e.g., holding conferences in evenings)
- Enhancing parents' understanding of the child welfare role
- Promoting assessment of a wider context of family's life for professionals
- Challenges in identifying the family's ongoing social worker and their early entry into planning for the FTM
- Difficulties in sorting out some family issues whether the time frame is 24 or 72 hours
- Problems associated with the intake worker, on-going worker, coordinator, and facilitator not coordinating their work before the FTM
- Questions about the authorship of the plans: family endorses what agency has to say vs. family's plan
- No impact on legal rights because of the extension from 24 to 72 hours (i.e., cases were heard before, they are heard now; the parents had counsel at court and they have it now at first petition)
- Appointment of GALs earlier and meeting with child prior to the initial hearing
- Continuation of issues around planning to address mental health concerns

Summary

- FTM is an important practice expression of a larger shift in the mission and practice in the Washington, DC system of services
- Considerable variation is expressed in the expectations for FTM, hence, the need for carefully theorizing and evaluation
- The climate of decision making in court has in the view of most interviewees changed to less adversarial and more cooperative
- The philosophy of the practice is rippling into other areas of child and family service, e.g., child mental health and youth justice



- While there is more clarity about the potential benefits of moving from 24 to 72 hours, and some of these benefits are being demonstrated in practice, there is considerable lack of clarity about the actual concerns, especially about legal rights of parents, that extending the legislation from 24 to 72 hours could have
- There is considerable agreement about the philosophy of involving family, including extended family, early on in the process of a child removal
- There is less agreement about what systems changes and supports are needed to sustain this approach

When examining these overarching themes, it is of particular note that the DC Family Team Meeting (FTM) model and the external evaluation address many of these head-on. The District of Columbia's Child and Family Services Agency (DC CFSA) has embarked on the initial stages of implementing a FGDM model (FTM) that involves all families where a removal or replacement has occurred, not excluding families that may present multiple and high challenges. Consistent with the Merkel-Holguin et al. (2003) recommendations, the DC CFSA continues to build a coalition of support at multiple levels, as well as developing consultation processes, crafting protocols, and providing information and trainings to diverse stakeholders. Additionally evaluations are adapting, specifically through the role of the external evaluation, to the practice variations and specific needs of the DC CFSA. The DC CFSA and the external evaluators are working to ensure that families and youth are not silent or invisible partners in the development of successful child welfare practice. In fact, the family voice is being both sought and encouraged as the model continues to develop.

Recommendations Based on the Qualitative Evaluation

The findings from the qualitative evaluation support the action steps proposed at the July 26th FTM Steering Committee meeting. During their discussion, the Steering Committee members set forth a series of measures:

- Establishing a subgroup to consider an infrastructure to align the different involved systems (e.g., around scheduling of meetings),
- Bringing together attorneys to discuss legal aspects of FTMs,
- Creating a structured format in which coordinators and facilitators can negotiate issues, and
- Continuing the external evaluation to provide an outside perspective on FTMs.

All of these steps are helpful means for resolving the challenges presented in instituting FTMs.

The qualitative evaluation also points to areas for consideration in the quantitative evaluation:

1. When the FTM meetings are held (i.e., regular work hours, days, weekends) should be described quantitatively. That is, how many meetings happen when? This allows assessment of accessibility of meetings for families and as an estimate of the workload burden.



2. Different levels of effects or impact of FTM should be described as part of an overall logic model describing the FTM process from case identification to safety, permanency and well-being outcomes.
3. Particular attention should be paid to the assessment of planned services and delivered services. Procedures and activities around change of service plans should be described.

Preliminary Quantitative Findings

Patterns of Maltreatment for Children Removed from Home as a result of Investigation

The 2002 -2004 District of Columbia NCANDS Child Files were analyzed for the children removed during the course of the Investigation. Figure 2 on the next page shows that there were 760 removals in 2002, for an average of 63.3 per month, and 722 removals in 2003 for an average of 60.2 per month. The 2004 Child File had a reduced number of victims, but the number of removals was about the same, so the percentage went up. The 690 removals for 2004 was an average of 57.5 per month.

Particularly informative is the analysis of maltreatment types suffered by those victims removed from their homes as the result of the investigation. Neglect has a high occurrence as the only maltreatment for children removed as the result of the investigation. Figure 3, on the next page displays neglect as the maltreatment type for 70% of children.

Figure 2

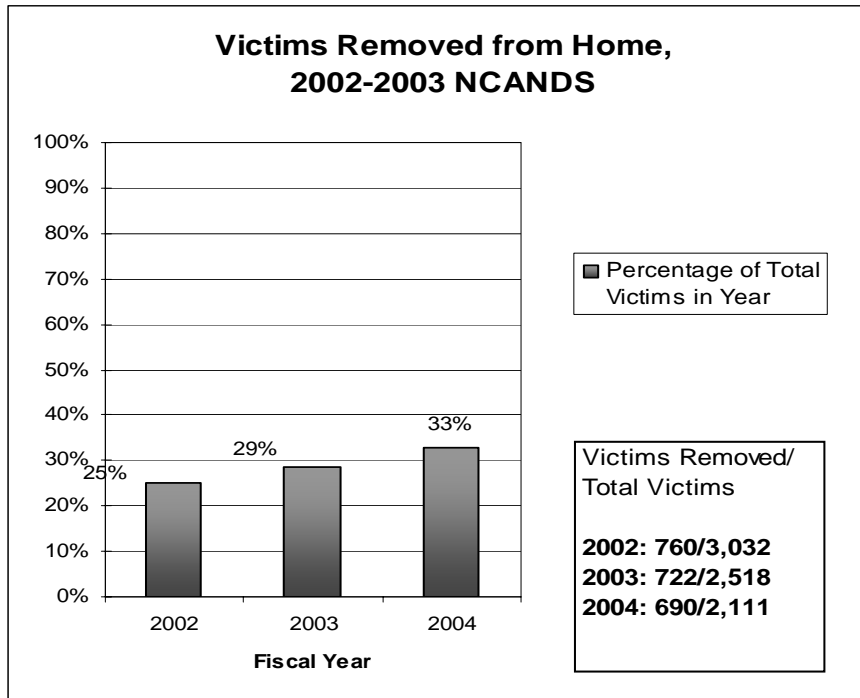
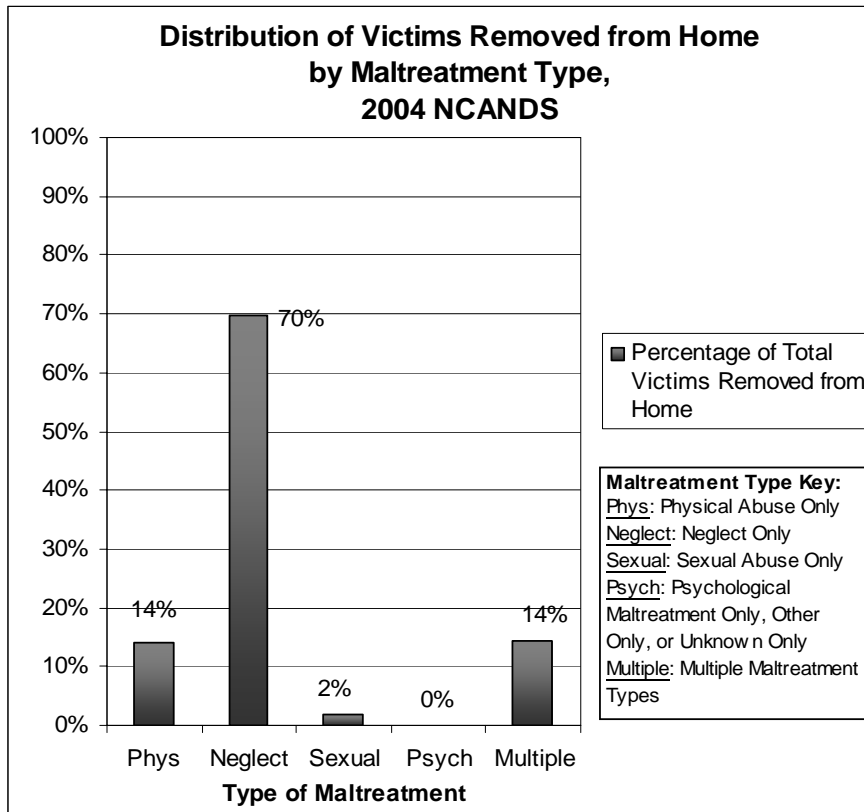


Figure 3



Analysis of the federal fiscal year placement data displays an average of 50.5 children per month as removed from their homes during Fiscal Year 2004. These data are taken from the 2004 AFCARS semester submissions. At this time the AFCARS and NCANDS files have not been reconciled as to the difference in the numbers which is an average of seven cases per month. Table 7 presents the monthly totals.

These NCANDS data are the same as those used by Children’s Bureau measures of safety outcomes. They will be also used for FTM. The occurrence of a subsequent substantiated maltreatment for a child who has been a victim of maltreatment is a measure of endangerment or lack of safety. This measure of lack of safety is what is used nationally as a safety measure. This will also be the safety measure for the FTM evaluation.

It is important to include well-being indicators when considering safety and permanency. Well-being indicators provide a positive view of how children and families are doing. Case planning occurs more at the well-being level than directly at the safety or permanency level. Changes in well-being are used to reach safety and permanency outcomes. There is practice evidence that shows that positive change in well-being is related to subsequent positive safety and permanency outcomes.



Table 7

Children Removed	
per Month	
Fiscal Year 2004	
October	53
November	37
December	21
January	39
February	51
March	74
April	54
May	81
June	56
July	46
August	45
September	48
Total	605

The NCANDS and AFCARS data sets will be merged with the FTM Internal Evaluation Team data set to provide the basis of reporting on child and family results.

Patterns of FTM Occurrence

From the qualitative results it was clear that the time of the FTM was an issue for staff. Benefits for family members of flexible scheduling were not disputed, but the issue of weekend and evening hours for the occurrence of FTM was occasion for feelings on the part of respondents.

The Internal Evaluation Team has analyzed the time of day of FTMs. The Internal Evaluation Team has analyzed the day of the week of FTMs. Both of these analyses are informative and present a pattern of about 20% of FTMs occurring during non-regular work hours. Full combination of these two analyses would describe if any FTMs occurred in the evening of weekend days.

Initial results on FTM occurrence indicate a substantial portion of FTMs occurring during non-regular hours. This pattern should be explicitly addressed in planning expected work times for staff.

Fiscal Impact of the FTM Program

CFSA expense budget reports for the periods before the startup of the FTM and for the period of FTM operation are not in a useful format for the Fiscal Impact assessment. They were not assessed in time for this report. They are being reviewed and recast into formats amenable to the Fiscal Impact assessment. It is intended to be shown from these reports that changes in the CFSA expense budget totals have not occurred due to FTM



and that funding for the FTM project has resulted in an expense neutral position. While data are not available at this point to verify this position, the assertion is based on the transfer of contract line item dollars to staff positions as the funding source for staff positions, absorption of operating expenses into the Agency indirect costs, and the use of early intervention funds to support direct costs of family involvement. In subsequent reports, these dollar items will be identified.

Over the course of the evaluation cost data will be used to help assess the cost effectiveness of the program and to develop cost projections based on trends over time. The remainder of this section addresses the methods that we anticipate using for the analysis of cost data.

The actual costs of the FTM program are of two types. Fixed costs are ones that are stable over time without regard for the number of families served. Variable costs are ones that change with the provision of services to families. Fixed costs are the costs of staff positions and contract services. The program is currently staffed by a Manager, four Facilitator positions, and an Evaluation Team Lead. Program oversight and support staff are included in the Office of Clinical Services. Those oversight and support costs are not directly assigned to the program. It is anticipated that this program structure, when fully staffed, would have the capacity to provide FTM services for an upper limit of 152 FTM events per month. That number would be decreased by leave time and other required non-case related time. Fixed costs, as conceptualized here, assume that the current staffing model is stable. Changes in the volume of meetings due to demand for services or changes in program scope will invalidate this assumption regarding fixed cost.

The variable costs are for resources used to support family participation in meetings. These are labeled “Federal Flex Funds” in the *Monthly Management Report* of the FTM Unit for the Office of Clinical Practice. Transportation, Child Care, Food, and Event Fee are categories of variable costs. These are costs supported by Federal resources intended for early intervention.

Program Utilization is discussed in the earlier section. The program design feature of a flexible, less than seventy-two hour response to a child placement, has resulted in a large proportion of services being provided after five o’clock in the afternoon or on weekends. It is estimated that about one third of all services occur in these “non-regular hours” time periods. This service pattern has been an expectation of the Facilitator job role. It does represent a change from previous Agency work patterns. This pattern of work may require a cost adjustment in the future. Current excess capacity appears sufficient to address service demands of flexible service delivery.

It is anticipated that cost ratios will be developed for assessing cost effectiveness. A methodology for determining the sum of fixed and variable costs per month will be developed. This will provide ongoing cost management in a timely manner. Several cost ratios are under consideration and include the following:

- Cost per family served,



- Cost per child served (taking into account the size of sibling groups),
- Cost per family meeting, and
- Separate ratios for “Removal FTM,” “Placement FTM,” and “At-risk FTM” may be developed.

Development of those ratios will require determination and documentation of a cost allocation methodology between the different service types. Another type of cost ratio would address the components of the meetings. For example, cost per FTM participant candidate would address the extent to which numbers of family members are recruited to attend the meetings. This cost ratio would specifically address the contribution of the community services performing outreach activities. Cost per meeting attendee is another ratio that appears feasible. This ratio would address the effectiveness of the contract services in recruiting family members for the FTMs. These results may be further analyzed by the addition of client characteristics. For example, immigrant families or families with relatives at a distance may change the cost structure. Immigrant families may be smaller but have the same level of fixed costs in staff time. This would lead to a larger cost per attendee. Families with distant relatives may require additional support for travel to the meeting but the incremental cost per attendee is small relative to the fixed costs of coordinator and facilitator resources to have a meeting. The increased number of attendees at relatively small incremental costs would lead to a smaller cost per attendee.

The use of fixed and variable costs are anticipated to allow for cost projections based upon anticipated services to clients. The ability to project costs based upon anticipated service utilization would be a significant planning tool. Current capacity is planned to allow for the increased utilization of placement FTM to address all placement changes for District children. These estimates are currently based upon expert opinion of the time it takes to perform FTM coordination and facilitation as well as what the utilization of the service will be. As the analysis of the NCANDS and AFCARS results has shown, monthly estimates of service utilization based upon past performance can be used to more accurately forecast need. To the extent that policy or practice changes give reason to expect differences in performance in the future, those estimates may be modified for future projections. This type of methodology will provide a model that is based in historical fact and be responsive to known changes in the future. These analyses will help CFSA in planning staffing needs as well FTM and service costs. It may be that original placement FTMs (vs. replacement FTMs) will take more staff member time and money to organize. It also may be that reunification FTMs may be on the higher cost end (e.g., for teens aging out of CFSA care).

Conclusions

The CFSA FTM program and its external evaluation are established in legislation. The legislation sets the parameters of the program and evaluation. Phase I of the external evaluation concerns the initial phase of the FTM program which started in January 2005 for all cases in which children were removed from their parents or caregivers. In keeping with the legislation and CFSA mission, the Agency ensured that the FTM program had



from the outset guiding principles advancing inclusion, strengths, responsiveness, competence, and collaboration.

Early reports from CFSA personnel and community partners point to accomplishments and challenges in fulfilling these principles. The most positive views concern the assessment and planning processes of a multi-systemic intervention and the least positive concern putting a team based approach in place. DC's FTM program appears to be unique in its timing of the meeting in the 72-hour period prior to the initial court hearing. This timing assists in having an early assessment and planning process involving multiple partners. At the same time, the time frame presents major challenges to team work. The uniqueness of the FTM design makes the legislatively mandated evaluation of the program's process, outcomes, and fiscal impact all the more crucial.

Process. The FTM process raises questions about participation: Who participates? Who does not participate? How satisfied are participants? How do they take part in the planning process? To what extent are parents' right to due process supported? What facilitates or hinders family, community, and agency participation?

Outcomes. The FTM program raises questions about immediate, intermediate, and long-term outcomes: Are plans created? Are these plans incorporated into the ongoing services plans? To what extent are plans implemented? Are they revised, and if so, by what procedures? What effect does the FTM process have on relationships within CFSA and between CFSA and its clientele, community partners, and other public services? What services are provided to children and their families with and without FTMs? What is the effect of FTMs on children's safety; placement stability; and connections to family, kin, and community? Assessment of child and family well-being will be recommended for exploration in Phase II. Well-being assessment is valuable for practice as well as impact analysis because the thorough view of a family from a comprehensive, multifaceted well-being assessment provides the basis for customized service plans. The well-being results are also valuable in explaining safety and permanency results.

Fiscal Impact. The 72-hour framework and the FTM program raise questions as well on fiscal impact: Is the extension from 24 to 72 hours cost neutral? As the FTM program comes on stream, what are its fixed and variable costs? Can these costs be predicted for different populations? How do these costs relate to outcomes for children, families, and service programs?

The following set of recommendations for next phases of the external evaluation address these questions. In addition, they propose means of strengthening the evaluation infrastructure of CFSA over the long term.

Recommendations for the External Evaluation

1. *Continue monitoring utilization of FTM with greater attention to reporting of FTM participants.*



The internal FTM Evaluation Team has a sound data collection system that is capable of producing needed data. FTM participant role, age, gender, race, and language are available and have been reported. Using these data to understand process and outcome results will provide a deeper understanding of the effects of the program. It is recommended that the FTM evaluation explore relationships between demographic characteristics and process and outcome results.

2. Develop reporting of service plan content and implementation.

The process surrounding the FTM is designed to provide effective services to families. The plan produced after the FTM and the Ongoing Service Plan are intended to have a close relationship. The Service Plan is intended to be implemented. Describing the correspondence between the FTM plan and the Ongoing Service Plan is recommended for the second year. Describing the services received by the family and the activities in which the members engage is another recommendation for the second year. Lastly, it is recommended to describe the degree to which planned services are provided and other services added as a measure of service plan implementation.

3. Develop safety and well-being report for children following the FTM.

Child safety is a principle mission of child protective services. The FACES information system holds data on child maltreatment allegations and the findings related to those allegations. Those data will be monitored for alleged maltreatment of children following an FTM and for substantiated maltreatment following an FTM. This measure of child safety following FTM has already been developed from FACES as part of the internal evaluation. Well-being indicators should be included in this report as a positive measure of child and family outcomes.

4. Develop a report on placement patterns of children before and after the implementation of FTM.

FACES data document the living arrangement of children. Description of the removal history of a child before an FTM may increase the understanding of FTM results. FACES data describe the living arrangements and duration of living arrangements for children. These results describe the degree and types of permanency results obtained. A measure of child permanency following FTM has been developed from FACES as part of the internal evaluation

5. Extend the follow-up questions with families beyond satisfaction to areas of participation in planning and assessment of services.

Family engagement services are intended to have the family and community members develop effective services to improve child safety and permanency and to enhance child and family well-being. The satisfaction follow-up data collection has the potential to



assess the degree to which family members truly feel they are part of the service planning process, the degree they see their plans are implemented and the their perception of the effectiveness of those services. Plans may require revision because of changing conditions, policies, court decrees, and so forth. It is recommended that the processes for revision of plans be described and reasons for variations be analyzed. Not all possible questions can be asked during family follow-up interviews without the interview becoming burdensome to families. While maintaining a core set of questions to have consistency of results over time, it is recommended that some topical question to address specific issues be asked on a cyclical basis.

6. Develop description of families for whom FTM does not occur.

Not all families experiencing removal of a child have an FTM. It is recommended that the FACES demographic data and safety and permanency information for families not having an FTM be assembled and compared to the information for families that do. Exploration of Family well-being assessment holds the potential of enhancing both service planning and impact assessment.

7. Describe and assess the organizational structures within CFSA and inter-organizational collaboration between CFSA and its community partners and other public services for implementing FTM.

FTMs require collaboration within CFSA and between CFSA and its community partners and other public services for effective implementation of FTM. An external evaluation team can offer insights into the processes and structures facilitating and impeding FTM implementation. These may include availability of community services, funding sources, legislation, FTM training, and workload issues. Evaluation strategies include documentation review, surveys, observation, plan analysis, and focus groups.

8. Describe the fiscal impact of the 72-hour framework and of FTMs.

The fiscal impact of extending from 24 to 72 hours the period before the initial hearing is designed to be cost neutral. Funds for the FTM specific activities are drawn from sources intended for timely response, and funds for services have been available as CFSA resources. In the next phase of the evaluation, assessing actual costs is recommended. Beyond the impact of the 72-hour framework, the cost effectiveness of implementing FTMs and the resulting plans warrant evaluation.

9. Increase the planning with FACES for use of data and integration of reporting systems.

This recommendation is consistent with plans to develop infrastructure for FTM evaluation. Substantial work on requirements for FTM modules has been done with the development of the internal FTM evaluation. As the FTM becomes a more often used



service technology, it will be more effective and efficient to embed its particular data elements into the Agency information system.

It is suggested that these recommendations be incorporated into the ongoing evaluation plans for the FTM. As outcome data become available, realistic assessments of these plans will suggest further change. Change may occur in some areas while preserving the initial evaluation objectives of the legislation. Feedback from the Advisory Group and other stakeholders in the community will be another important source of planning a responsive and pertinent evaluation of FTM that moves beyond initial legislative requirements and contributes to the lives of the children and families of the District of Columbia.



References

- Adams, P. (2000). Bringing the community back in: Patch and family group decision-making. In G. Burford & J. Hudson (Eds.), *Family group conferencing: New directions in community-centered child and family practice* (pp. 105-119). New York: Aldine de Gruyter.
- Alter, C., & Egan, M. (1997). Logic modelling: A tool for teaching critical thinking in social work practice. *Journal of Social Work Education, 33*, 85-102.
- Andy Rowe Consultants, Inc. (1997, November). *Comparative costs and cost-effectiveness of Family Group Decision Making Project: Technical report*. St. John's, Newfoundland: Author.
- Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services*. New York: W. W. Norton.
- Berzin, S. C. (2004, June). California's waiver demonstration project: Results from an experimental project. Workshop at *From Margin to Mainstream: 2004 Conference on Family Group Decision Making*, Harrisburg, PA.
- Bisson, J. I., McFarlane, A., & Rose, S. (2000). Psychological debriefing. In E. Foa, A. McFarlane, & M. Friedman (Eds.), *Effective treatments for PTSD* (pp. 39-59). New York: Guilford.
- Bremner, J.D., Southwick, S.M., Johnson, D.R., Yehuda, R. & Charney, D. (1993). Childhood physical abuse and combat related posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychiatry, 150*(2), 235- 239.
- Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit Area Survey of Trauma. *Archives of General Psychiatry, 55*, 626-632.
- Bryant, R. A., Sackville, T., Dang, S. T., Moulds, M., & Guthrie, R. (1999). Treating acute stress disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. *American Journal of Psychiatry, 156*(11), 1780-1786.
- Bryant, R. A., & Harvey, A. G. (2000). *Acute stress disorder: A handbook of theory, assessment, and treatment*. Washington, D.C.: American Psychological Association Press.
- Burchard, J. D. & Burchard, S. N. (2000). The wraparound process with children and families. In G. Burford & J. Hudson (Eds.), *Family group conferencing: New directions in community-centered child and family practice* (pp. 140-152). New York: Aldine de Gruyter.



Burford, G., & Hudson, J. (Eds.). (2000). *Family group conferencing: New directions in community-centered child and family practice*. New York: Aldine de Gruyter.

Burford, G., & Pennell, J. (2004). From agency client to community-based consumer: The family group conference as a consumer-led group in child welfare. In C. Garvin, L. Burford, G., & Pennell, J. (1998). *Family group decision making: After the conference —progress in resolving violence and promoting well-being: Outcome report* (Vol. I & II). St. John's, NF: Memorial University of Newfoundland, School of Social Work.

Center for the Study of Social Policy, Center for Community Partnerships in Child Welfare. (2002, March). *Bringing families to the table: A comparative guide to family meetings in child welfare*. Washington, DC: Author.

Charlton, P. F., & Thompson, J. A. (1996). Ways of coping with psychological distress after trauma. *British Journal of Clinical Psychology*, 35(Pt4), 517-530.

Chaskin, R. J., Brown, P., Venkatesh, S., & Vidal, A. (2001). *Building community capacity*. New York: Aldine de Gruyter.

Child and Family Services Agency [CFSA]. (2004, July 29). *Family team meetings (FTM)*. Author: Washington, DC.

Connolly, M. (in press). Fifteen years of family group conferencing: Coordinators talk about their experiences in Aotearoa New Zealand. *British Journal of Social Work*.

Connolly, M., & McKenzie, M. (1999). *Effective participatory practice: Family group conferencing in child protection*. New York: Aldine de Gruyter.

Courville, S., & Piper, N. (2004) Harnessing hope through NGO activism. *The Annals of the American Academy of Political and Social Science: Special issue on hope, power and governance*, 592, 39-61.

Crampton, D., & Jackson, W. L. (2000). Evaluating and implementing family group conferences: The family and community compact in Kent County, Michigan. In G. Burford & J. Hudson (Eds.), *Family group conferencing: New directions in community-centered child and family practice* (pp. 324–333). New York: Aldine de Gruyter.

Cunningham, P. B., & Henggeler, S. W. (1999, Fall). Engaging multiproblem families in treatment: Lessons learned throughout the development of multisystemic therapy. *Family Process*, 38(3), 281-6. Retrieved July 31, 2005 from http://www.findarticles.com/p/articles/mi_m0AZV/is_3_38/ai_56982162.



Department of Health [DH]. (1995). *Child protection: Messages from research*. London: HMSO.

Diclemente, C. C., & Prochaska, J. O. (1998). Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (2nd ed., pp. 3-24). New York: Plenum Press.

Doolan, M. (2004). *The family group conference: A mainstream approach in child welfare decision-making*. Keynote Speech from the 2004 National Conference on FGDM, Long Beach, CA. [Online] Retrieved from http://www.americanhumane.org/site/PageServer?pagename=pc_fgdm_ibrief

Forbes A., & Roger, D. (1999). Stress, social support and fear of disclosure. *British Journal of Health Psychology*, 4(2), 165-179.

Foy, D. W., Sippelle, R. C., Rueger, D.B., & Carroll, E. M. (1984). Etiology of posttraumatic stress disorder in Vietnam veterans: Analysis of premilitary, military and combat exposure influences. *Journal of Consulting Clinical Psychology*, 52, 79-87.

Gal, T. (2004, December). *Child victims and restorative justice: The appeal, the risks*. Presentation at New Frontiers in Restorative Justice, Massey University, Auckland, New Zealand.

Gerald, R. (2005, June). *Family team meetings: a model of family engagement*. Workshop presented at the annual conference of the American Humane on Family Group Decision Making, Long Beach, CA.

Gist, R., & Woodall, J. (1999) There are no simple solutions to complex problems: The rise and fall of critical incident stress debriefing as a response to occupational stress in the fire service. In R. Gist & B. Lubin (Eds.), *Response to disaster: Psychosocial, community, and ecological approaches*. Ann Arbor, MI: Braun-Brumfield.

Gray, B. (1989). *Collaborating: Finding common ground for multiparty problems*. San Francisco: Jossey-Bass.

Green, B. L., Goodman, L. A., Krupnick, J. L., Corcoran, C. B., Petty, R. M., Stockton, P., & Stern, N. M. (2004). Outcomes of single versus multiple trauma exposure in a screening sample. *Journal of Traumatic Stress*, 13(2), 271 – 286.

Gunderson, K., Cahn, K., & Wirth, J. (2003). The Washington State long-term outcome study. *Protecting Children*, 18(1–2), 42–47.

Gutierrez, & Galinsky, M. (Eds.), *Handbook of social work with groups* (pp. 415-431). New York: Guilford Publications.



- Harris, M., & Fallot, R. D. (Eds.) (2001, Spring). *New directions for mental health services: Using trauma theory to design service systems* (No. 89) (J-B MHS Single Issue Mental Health Services), San Francisco: Jossey-Bass/Pfeiffer.
- Harvey, J. H., Orbuch, T. L., Chwalisz, K. D. & Garwood, G. (1991). Coping with sexual assault: The roles of account-making and confiding. *Journal of Traumatic Stress, 4*, 515-531.
- Hassall, I. (1996). Origin and development of family group conferences. In J. Hudson, A. Morris, G. Maxwell, & B. Galaway (Eds.), *Family group conferences: Perspectives on policy and practice* (pp. 17–36). Monsey, NY: Willow Tree Press.
- Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment for antisocial behavior in children and adolescents*. New York: Guilford Press.
- Horwitz, M. (2003). *Building permanency with family group decision-making: The kinship connections project. Final report*. Northampton, MA: University of Massachusetts Medical School, Center for Mental Health Services Research.
- Huntington, C. (n.d.) *Rights myopia in child welfare*. (In preparation.). American Humane Association.
- Keane, T. M., Scott, W. O., Chavoya, G. A., Lamparski, D. M., & Fairbank, J. A. (1985). Social support in Vietnam veterans with Posttraumatic Stress Disorder: A comparative analysis. *Journal of Consulting and Clinical Psychology, 53*, 95-102.
- King, D. W., King, L. A., Foy, D. W., Keane, T. M., & Fairbank, J. A. (1999). Posttraumatic stress disorder in a national sample of female and male Vietnam veterans: Risk factors, war-zone stressors, and resilience-recovery variables. *Journal of Abnormal Psychology, 108*, 164-170.
- Lupton, C., & Nixon, P. (1999). *Empowering practice? A critical appraisal of the family group conference approach*. Bristol, England: Policy Press.
- Macgowan, M., & Pennell, J. (2002). Building social responsibility through family group conferencing. *Social Work with Groups, 24*(3/4), 67-87.
- Major, B., Richards, C., Cooper, M.L., Cozzarelli, C., & Zubek, J. (1998). Personal resilience, cognitive appraisals, and coping: An integrative model of adjustment to abortion. *Journal of Personality and Social Psychology, 74*(3), 735 - 752.
- Marsh, P., & Crow, G. (1998). *Family group conferences in child welfare*. Oxford, England: Blackwells.



- Martin, L., Rosen, L., Durand, D., Knudson, K., & Stretch, R. (2000). Psychological and physical health effects of sexual assaults and non sexual traumas among male and female united states army soldiers. *Behavioral Medicine*, 26(1), pp 23-33.
- McLaughlin, J. A., & Jordan, G. B. (1999). Logic models: A tool for telling your program's performance story. *Evaluation and Program Evaluation*, 22, 65-72.
- Merkel-Holguin, L. (2003). Promising results, potential new directions: International FGDM research and evaluation in child welfare. *Protecting Children*, 18(1-2), 1.
- Merkel-Holguin, L. (2005). Putting families back into the child protection partnership: Family group decision making. *National Center on Family Group Decision Making*. Retrieved July 14, 2005 from http://www.americanhumane.org/site/PageServer?pagename=pc_fgdm_what_is
- Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Learning with families: A synopsis of FGDM research and evaluation in child welfare. *Protecting Children*, 18(1-2), 2-11.
- Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Epilogue: Challenges and future directions in FGDM research and evaluation. *Protecting Children*, 18(1-2), 133-135.
- Milstein, R. L., & Wetterhall, S. F. (1999). Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report*, 48(RR11), 1-40. Retrieved December 2, 2003 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>
- Nishith, P., Mechanic, M. B., & Resnick, P. A. (2000). Prior interpersonal trauma: The contribution to current PTSD symptoms in female rape victims. *Journal of Abnormal Psychology*, 109, 20-25.
- New Zealand. (1989). *Children, Young Persons, and their Families Act 1989*. Wellington, New Zealand: Government Printer.
- Nixon, P., Burford, G., Quinn, A., with Edelbaum, J. (2005, May). *A survey of international practices, policy & research on family group conferences and related practices*. Retrieved July 31, 2005, from http://www.americanhumane.org/site/DocServer/FGDM_www_survey.pdf?docID=2841
- Parton, N. (1997). Child protection and family support: Current debates and future prospects. In N. Parton (Ed.), *Child protection and family support: Tensions, contradictions and possibilities* (pp. 1-24). London and New York: Routledge.
- Pecora, P. J., Reed-Ashcraft, K., & Kirk, R. S. (2001). Family-centered services: A typology, brief history, and overview of current program implementation and



- evaluation challenges. In E. Walton, P. Sandau-Beckler, & M. Mannes. (Eds.), *Balancing family-centered services and child well-being: Exploring issues in policy, practice, theory, and research* (pp. 1-33). New York: Columbia University Press.
- Pennebaker, J. W., & O'Heeron, R. C. (1984). Confiding in others and illness rate among spouses of suicide and accidental-death victims. *Journal of Abnormal Psychology, 93*, 473-476.
- Pennell, J. (2003). Are we following key FGC practice? Views of conference participants. *Protecting Children, 18*(1-2), 16-21.
- Pennell, J. (in press). Restorative practices and child welfare: Toward an inclusive civil society. In B. Morrison & E. Ahmed (Eds.), *Restorative justice and civil society*, special issue of *Journal of Social Issues, 62*(2).
- Pennell, J., & Anderson, G. (Eds.). (2005). *Widening the circle: The practice and evaluation of family group conferencing with children, youths, and their families*. Washington, DC: NASW Press.
- Pennell, J., & Burford, G. (2000). Family group decision making: Protecting children and women. *Child Welfare, 79*(2), 131-158.
- Pennell, J., & Francis, S. (2005). Safety conferencing: Toward a coordinated and inclusive response to safeguard women and children. In J. Ptacek (Ed.), special issue of *Violence Against Women, 11*(5), 666-692.
- Prevention of Child Abuse and Neglect Act of 1977. Codification of District of Columbia Official Code, 2001 Edition, 2005 Spring Supplement.
- Riggs, D. S., Byrne, C. A., Weathers, F. W., & Litz, B. T. (1998). The quality of intimate relationships of male Vietnam veterans: Problems associated with posttraumatic stress disorder. *Journal of Traumatic Stress, 11*, 87-102.
- Roberts, D. (2005, June). *Toward a community approach to child welfare theory, policy, and practice*. Keynote address presented at the annual conference of the American Humane on Family Group Decision Making, Long Beach, CA.
- Savage, A., & Russell, L. A. (2005). Tangled in a web of affiliation: Social support networks of dually diagnosed women who are trauma survivors. *Journal of Behavioral Health Services & Research, 32*(2), 199-214
- Sproul, B. A., & Friedman, R. M. (1994). *A system of care for children & youth with severe disturbance*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.



Stretch, R. H., Knudson, K., & Durand, D. (1998). Effects of pre-military and military trauma on the development of Post-traumatic Stress Disorder symptoms in female and male active duty soldiers. *Military Medicine*, 163, 466-470.

Sundell, K., & Vinnerljung, B. (2004). Outcomes of family group conferencing in Sweden: A 3-year follow-up. *Child Abuse & Neglect*, 28, 267-287.

Tarrier N., Pilgrim H., Sommerfield C., Faragher, B., Reynolds, M., Graham, E., & Barrowclough, C. (1999). A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. *Journal of Consulting Clinical Psychology* 67(1), 13-18.

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau [US DHHS]. (2004). *Findings from the initial child and family service reviews, 2001-2004*, Retrieved August 21, 2005, from <http://www.acf.hhs.gov/programs/cb/cwrp/results/statefindings/index.htm>

United States General Accounting Office. (2000, May 5). *Foster care: Status of the District of Columbia's child welfare reform efforts*. Statement of Cynthia M. Fagnoni last viewed on August 6th, 2005, <http://www.openminds.com/indres/fostercaregao.pdf>



Waites, C., Macgowan, M., Pennell, J., Carlton-LaNey, I., & Weil, M. (2004). Increasing the cultural responsiveness of family group conferencing. *Social Work*, 49(2), 291-300.

Walter R. McDonald & Associates, Inc. (2000, November). *The Santa Clara County family conference model outcome evaluation*. Sacramento, CA: Author.

Walton, E., Sandau-Beckler, P., & Mannes, M. (Eds.), *Family-centered services and child well-being: Exploring issues in policy, practice, theory and research*. New York: Columbia Press.



Appendix I: Family Team Meeting (FTM) Policy Document

POLICY TITLE: Family Team Meetings (FTM)		PAGE <u>1</u> OF 15
POLICY NUMBER:		
CHAPTER #:		
	CHILD AND FAMILY SERVICES AGENCY  Approved by: _____ Signature of Agency Director	PROFESSIONAL STANDARDS See Section VIII.
EFFECTIVE DATE:	LATEST REVISION: July 29, 2004	REVIEW BY LEGAL COUNSEL: Yes/No

I. AUTHORITY	The Director of the Child and Family Services Agency adopts this policy to be consistent with the Agency’s mission and applicable federal and District of Columbia laws, rules and regulations, including, but not limited to, provisions in Titles 4 and 16 of the D.C. Code and the Modified Final Order and Implementation Plan in LaShawn A. v. Williams.
II. APPLICABILITY	All Agency employees, contracted personnel, and contracted agency personnel.
III. RATIONALE	<p>The purpose of the Family Team Meetings policy is to specify how the Child and Family Services Agency (the Agency) is building on its commitment to engage families, communities, and public and private agency partners in supporting the safety, permanence, and well-being of children and families in the District of Columbia.</p> <p>Family Team Meetings are structured planning and decision-making meetings that use skilled and trained facilitators to engage families, family supports, and professional partners in creating plans for children’s safety and in laying the groundwork for permanency. The Child and Family Services Agency is using Family Team Meetings as a means of driving practice change. The Agency is beginning by implementing Family Team Meetings for removals and placement changes, but in the future, Family Team Meetings may be used at different stages throughout the life of a case.</p> <p>Implementing Family Team Meetings enhances the Agency’s focus on safety, permanency, and making carefully planned choices about placements. Critical decisions about safety are able to be made based on the best information available when families, family supports, and professional partners are involved. Family Team Meetings establish the foundation for strong permanency plans, regardless of the permanency goal, through encouraging relationships and facilitating the identification of permanency resources. When all participants take part in decision-making, all participants are encouraged to take ownership of decisions made</p>



	<p>concerning children’s safety, permanence, and well-being. Moreover, Family Team Meetings galvanize individuals to work as a team, even after an FTM is held.</p> <p>The Child and Family Services Agency aims to be explicit about the values that guide its practice. The Agency and its partners have embraced the following set of principles that should guide the practice of Family Team Meetings, as well as the broader changes in practice that result:</p> <p>Focus on Safety: Child safety is paramount. This includes ensuring the safety of children in the context of their families and addressing the safety issues of their family members.</p> <p>Focus on Permanence: Permanence for children is also paramount. Permanency planning from the start of the Agency’s involvement with children and families is crucial.</p> <p>Family Inclusive Philosophy: Meaningful family participation (from children, parents, kin, and resource parents) in planning and decision-making is essential.</p> <p>Strength and Need Based Planning: Strengths-based assessments and plans are vitally important. They should be produced with attention to:</p> <ul style="list-style-type: none"> The family’s underlying needs and conditions; Engaging the family in crafting effective interventions that address the family’s needs; Developing interventions with a family when there are family conflicts, or a family member’s behavioral or emotional needs are not being met; and Safety issues for all family members. <p>Ongoing Assessment and Planning: All children and family plans are developed and adapted to address ongoing and changing needs using a family team meeting approach.</p> <p>Team-Based Approach: The process of providing assistance to children and families requires a team that includes the family.</p> <p>Multi-Systemic Intervention: The use of multi-systemic participation and intervention is crucial to assessing, planning, and providing suitable resources to children and their families.</p> <p>Cultural and Community Responsiveness: Communities should be involved in planning with families and children, and when possible, meetings should be held in the community and language of each family. Children and families are to be understood within the context of their own family rules, traditions, history, and culture.</p> <p>Brief, Strategic Solution-Focused Intervention: The process is solution-focused with flexible and easily accessible resources used to support those solutions.</p> <p>Organizational Competence: Committed, qualified, trained, and skilled staff, supported by an effectively structured organization, help to ensure positive outcomes for children and their families. Family and community members are valued and included in the organizational change process.</p>
<p>IV. POLICY</p>	<p>It is the policy of the Child and Family Services Agency to hold Family Team Meetings before the initial court hearing for the removal of children from their homes and prior to making a placement change. For emergency placement changes, Family Team Meetings may be held within 24 hours following the placement change. Family Team Meetings shall be facilitated by a trained facilitator from the Child and Family Services Agency. These meetings should include families, family supports, resource parents, and professional partners and shall focus on making</p>



	decisions to support children’s safety, permanence, and well-being. This policy shall be fully implemented by January 2005.
V. CONTENTS	<ul style="list-style-type: none"> A. Criteria for Holding Family Team Meetings B. Goals and Purposes of Family Team Meetings C. Meeting Participants D. Preparation E. Confidentiality F. Meeting Structure and Content G. Decision-Making H. Meeting Follow-Up I. Role of the Facilitator J. Role of the Coordinator K. Role of the Social Worker L. Evaluation and Monitoring
VI. ATTACHMENTS	
VII. PROCEDURES	<p>Procedure A: Criteria for Holding Family Team Meetings</p> <p>Family Team Meetings shall be held according to specific criteria to generate practice change quickly and effectively and to support improved outcomes for children. While these meetings add additional requirements, they occur within the context of current case management practices and Agency and court processes.</p> <ol style="list-style-type: none"> 1. The Child and Family Services Agency shall hold Family Team Meetings for all removals, according to the following criteria: <ul style="list-style-type: none"> a. When the intake or ongoing social worker determines, based on his or her clinical judgment, that the child is at imminent risk of removal; (<i>See the Investigations Policy for information on assessing safety. Some cases that, in the past, may have been referred to other preventative services, such as EAP, now should be referred for a Family Team Meeting.</i>) and b. Prior to the removal of children from their homes, or at minimum, before the initial court hearing. 2. The Child and Family Services Agency shall hold Family Team Meetings for anticipated placement changes, according to the following criteria: <ul style="list-style-type: none"> a. With anticipated placement changes defined as when children may change caregivers; b. Including the following placement changes: <ol style="list-style-type: none"> i. Between resource homes of an individual family-based care provider agency; ii. Between facilities of an individual congregate care provider; iii. When a child is released from a detention facility; and iv. Emergency respite care; c. Excluding the following placement changes because of other meetings that should occur for these placement changes which embody the same principles as Family Team Meetings:



	<ul style="list-style-type: none"> i. A planned move to a pre-adoptive home; ii. Planned respite care occurring on an ongoing basis; iii. Entry into and discharge from residential treatment; and iv. Entry into and discharge from a hospital; <ul style="list-style-type: none"> d. When the ongoing social worker, the resource parent, the child, or another person involved with the child anticipates that a placement may need to change; and e. Prior to the placement change, but for emergency placement changes, Family Team Meetings may be held within 24 hours following the placement change. <ol style="list-style-type: none"> 3. For removals, a single meeting shall be held to include planning and decision-making for all of the children in the family, when appropriate. For placement changes, a single meeting shall be held for the child whose placement may change, as well as his or her siblings, when appropriate. 4. Intake and ongoing social workers shall initiate Family Team Meetings for removals and placement changes through requests to the Family Team Meeting Unit. 5. Removals and placement changes, as specified within this Procedure of this policy, shall not occur without holding or scheduling a Family Team Meeting. The Agency shall not petition on removals or change a child's placement without having scheduled an FTM.
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	<p>Procedure B: Goals and Purposes of Family Team Meetings</p> <p>Family Team Meetings are planning and decision-making meetings focused on whether a physical move is required to support a child's safety and permanency. Because these meetings include multiple participants and address potentially contentious issues, the goals of the meetings require clear delineation. All participants should work together to focus their attention on the goals and purposes of each Family Team Meeting.</p> <ol style="list-style-type: none"> 1. All Family Team Meetings have the following goals and purposes: <ul style="list-style-type: none"> a. To make placement decisions that keep children safe and promote permanency; b. To create a continuum of care and develop support networks to reduce trauma for the child; c. To support a solution-focused approach to services, addressing behavioral changes; and d. To develop relationships in an atmosphere of mutual respect to facilitate case planning, safety, and permanence. 2. Family Team Meetings addressing potential removals shall involve assessments of the safety and needs of both children and parents and shall focus on creating plans for safety and permanence. 3. Family Team Meetings addressing potential placement changes shall focus on placement decisions that promote both safety and permanency for children.
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Procedure C: Meeting Participants

The inclusion of families, including children when appropriate, is central to the concept of Family Team Meetings. As many people providing support to children and families as possible should also be included. With broadly defined family team membership, the best available information is on hand for critical decision-making about children's safety and permanence.

1. Families should be recognized as the experts on their families' needs and strengths and their presence and involvement is integral to Family Team Meetings. It is the expectation that families, including children ages twelve and older and younger children as age and developmentally appropriate, will attend Family Team Meetings and coordinators are responsible for making every reasonable effort, which may include being flexible with meeting times and locations, to secure the participation of family members in every FTM. In rare instances when the participation of family members is not secured, the coordinator shall document his or her efforts and discuss them with the facilitator. The facilitator shall elevate the issue to the Deputy Director for Clinical Practice, or his or her designee, to determine what additional steps, if any, should be taken. If the Deputy Director for Clinical Practice, or his or her designee, determines that every reasonable effort has been made, the absence of family members shall not preclude or postpone the FTM.
2. A facilitator and a coordinator shall attend each Family Team Meeting. The assigned social worker(s) and supervisor(s), or their designees, shall also attend. For Family Team Meetings on potential removals, both the investigative and ongoing social workers, as well as their supervisors, shall attend whenever possible to use the FTM as the basis of the case plan and as an opportunity to begin the case transfer.
3. Other individuals who can contribute to securing services or treatment and providing support to the family should be encouraged to participate in Family Team Meetings, as appropriate. The selection of individuals who may attend a particular FTM shall be based on maximizing family involvement in choosing supports to participate, respecting family privacy, and understanding the clinical expertise required for the particular meeting. The following individuals should be encouraged to attend whenever appropriate:
 - a. Non-relative supports that the child and/or the family may identify, such as neighbors or mentors;
 - b. Resource parents;
 - c. Service providers, including school representatives;
 - d. Community-based supports, which may include individuals from the Healthy Families/Thriving Communities Collaboratives;
 - e. Other Agency or contracted agency staff, such as placement workers, specialists from the Office of Clinical Practice or staff from the Office of Youth Development;
 - f. Representatives of the family's community, including communities defined by neighborhood, race/ethnicity, and religion; and
 - g. Attorneys. If an attorney is interested in attending, all other attorneys



	<p>connected to the case shall also be notified of the FTM. It shall be the obligation of the attorney participating in the FTM to contact all represented parties' attorneys as prescribed by the attorney's rules of ethics.</p> <p>4. In situations where the safety of meeting participants is at issue (e.g., with domestic violence), Agency staff shall use their clinical judgment to decide the appropriateness of the participation of specific individuals.</p>
	<p>Procedure D: Preparation</p> <p>Advance preparation is essential for successful Family Team Meetings. Participants are more effective in raising their concerns and proposing solutions when they have had time to prepare for meetings. Through preparation for meetings, facilitators learn more about families and potentially contentious issues.</p> <ol style="list-style-type: none"> 1. In contacts with parents prior to the FTM, social workers should identify family members and other potential participants for the FTM. 2. Coordinators should communicate with social workers and follow-up with family members and other potential participants for the FTM. 3. Coordinators shall invite participants in person or by telephone and encourage their participation in the FTM. 4. The coordinator's preparation of the family for the Family Team Meeting should involve: <ol style="list-style-type: none"> a. Gaining the family's perspective on what brought the family to the Agency's attention; b. Exploring the family's strengths and needs; c. Asking solution-focused questions to help the family determine its desired outcomes for the meeting; d. Discussing "non-negotiable issues" of the meeting (e.g., court orders); e. Communicating that if a decision is made for the child to be placed or change placements and kin volunteer, kin shall be licensed temporarily prior to the placement; (<i>See the Temporary Licensing of Foster Homes for Kin Policy.</i>) and f. Discussing confidentiality. 5. The coordinator's preparation of the other participants in the Family Team Meeting should involve: <ol style="list-style-type: none"> a. Clarifying the purpose and focus of the meeting; b. Explaining individual roles in the meeting, including each member's role in identifying the family's strengths and needs; and c. Discussing confidentiality. 6. The facilitator, coordinator, and social worker should communicate on an ongoing basis before each Family Team Meeting and address the following issues: <ol style="list-style-type: none"> a. The family's strengths and needs;



	<ul style="list-style-type: none"> b. The family’s desired outcomes for the meeting; c. Areas of potential conflict; and d. Issues for the family at the meeting such as the need for an interpreter, to include participants through a conference call, for transportation assistance, for child care during the meeting, or to exclude certain individuals from part or all of the meeting (for reasons including domestic violence). <p><i>See Procedures I, J, and K of this policy for specific roles with respect to preparation.</i></p>
	<p>Procedure E: Confidentiality</p> <p>Families have confidentiality rights that shall be protected in Family Team Meetings. While involving multiple participants in decision-making for children’s safety and permanency is valuable, it also adds requirements for ensuring that families’ rights are protected.</p> <ul style="list-style-type: none"> 1. In preparation for and during Family Team Meetings, parents’ and children’s privacy rights shall be respected. 2. Agency and contracted agency staff shall only share identifying client information for purposes related to addressing the needs of the particular child or other family member. 3. All participants in the FTM shall sign a confidentiality statement pledging not to divulge confidential information during or after the meeting for purposes unrelated to treatment, identification of individuals related to the case, or evaluation. The confidentiality statement shall not interfere with the obligations of mandated reporters. <p><i>See the forthcoming Confidentiality and HIV Policies for more information. See the Office of the General Counsel for further guidance.</i></p>
	<p>Procedure F: Meeting Structure and Content</p> <p>Family Team Meetings are decision-making and planning meetings. Because of this purpose, meetings shall be carefully structured to support decision-making. In this process, families and other participants are to be respected and valued. All participants shall be given the opportunity to discuss their needs and offer solutions.</p> <ul style="list-style-type: none"> 1. Each Family Team Meeting should last approximately one to two-and-a-half hours. 2. Key discussions, including of outcomes, ground rules, strengths, needs, brainstorming ideas, and plans, should be recorded on a white board, flip chart, or newsprint for all participants to view. 3. Family Team Meetings should have the following components: <ul style="list-style-type: none"> a. Introduction: The facilitator shall welcome participants. Beginning with the family, the facilitator should introduce family team members. The facilitator



shall review the purpose of the meeting and the family team shall establish guidelines to ensure safety and productivity;

- b. Confidentiality: The facilitator shall explain confidentiality requirements and obtain confidentiality statements; (*See Procedure E of this policy and the forthcoming Confidentiality Policy.*)
- c. Family story: The family should be encouraged to share information straightforwardly about itself, its needs, and its view of how it became involved with the Agency. The family should be encouraged to describe hoped for outcomes from the meeting and what it needs to achieve the outcomes. The family story establishes the meeting as the “family’s meeting” and assists the family team in developing empathy for the family;
- d. Update on the children: Parents should be placed in the role of experts on their children and should be encouraged to share information about the child’s needs, likes, dislikes, and daily habits or patterns. Resource parents should be encouraged to ask questions of parents about the children and may provide updates on the children’s experiences in their homes;
- e. Strength-assessment: Family team members should identify what is valued and working in the family;
- f. Information-sharing: The social worker shall directly and respectfully present the facts of the case to all participants. Family members, service providers, and other participants with significant involvement in the case should share related information and give their perspectives on the current situation;
- g. Options: The facilitator shall engage the family team and ask questions to identify and clarify potential outcomes of suggested plans and the specific roles of each family team member. The discussion shall focus on individualized support systems and services that match the family’s needs and builds upon its strengths. The FTM shall be facilitated toward consensus on whether removal is necessary or a placement change would be beneficial, and if so, what the child’s new placement may be;
- h. Decisions: Participants shall decide on a plan for safety, risk reduction, and permanence, and on corresponding recommendations to the Court, according to the following guidelines:
 - i. Action steps shall be developed that identify who is to do what and by when, maximizing involvement of informal supports;
 - ii. The initial steps in the plan should be readily achievable and support opportunities for early successes;
 - iii. The plan may include steps to ensure that expected changes in the family’s behavior are described in terms of behavior and not merely attendance or completion of activities;
 - iv. Steps should be measurable and within time limits;
 - v. The plan may include the provision of services through Agency, District or federal government, or community programs, as well as through flexible funds; (*See the forthcoming Flexible Funds Policy for information on the use of these funds and incentives for identifying services during the FTM.*)
 - vi. The plan may include arrangements for family visits, pursuant to Court order, and resolve practical family issues such as transportation and



	<p>appointments for doctor visits;</p> <ul style="list-style-type: none"> vii. The family team shall identify a lead worker and may identify a family member or family support person responsible for ensuring that the plan is followed; viii. The plan may include a recommendation that the Court hold a hearing so that Family Team Meeting recommendations on any changes of legal status, visitation, or other elements within a court order may be heard; and ix. If a decision is made for the child to be placed with or change placements to kin, kin shall be licensed temporarily prior to the placement. (<i>See the Temporary Licensing of Foster Homes for Kin Policy.</i>) If kin are not identified for the placement, placement workers may be contacted to describe any suitable placements available; i. Close: The facilitator shall thank the family team members for their efforts, advise them that the plan will be reviewed regularly and revised, as needed, and advise them that they may request follow-up meetings with the social worker and supervisor. The facilitator shall summarize the safety plan and action steps verbally, identifying who is responsible to do what by when. The plan from the meeting shall be given to participants upon closure of the meeting; and j. Meeting adjourned: All participants should leave together, unless the safety of meeting participants is a concern, to ensure and demonstrate that the family team’s plan and the corresponding recommendations to the Court are final.
	<p>Procedure G: Decision-Making</p> <p>As Family Team Meetings are decision-making and planning meetings, the process for arriving at decisions needs to be clear. The goal is for decisions on removals and placement changes to be made through shared decision-making.</p> <ol style="list-style-type: none"> 1. The facilitator shall guide the family team to develop a plan, agreed to by all participants, that promotes the child’s safety, permanence, and well-being. As part of the shared decision-making process, the facilitator shall help the family team discuss needs and problems that may arise with the plan. The facilitator has primary accountability for ensuring a plan is developed that promotes safety, permanence, and well-being. 2. Throughout Family Team Meetings, Agency and contracted agency social workers shall be open to a range of strategies to address their concerns and work toward consensus with the full family team. Social workers are obligated to raise any concerns they have during the meeting if they believe that the plan being developed does not promote children’s safety, permanency, and well-being adequately. 3. If members of the family team are reaching agreement on a plan but a social worker believes that the plan does not promote the child’s safety, permanency, and well-being adequately, the social worker is obligated to appeal to his or her program administrator or a person in a higher level position to make the removal or placement decision.



	<p>4. If members of the family team are reaching agreement on a plan but a team member other than a social worker believes that the plan does not promote the child’s safety, permanency, and well-being adequately, that team member may appeal to the program administrator or a person in a higher level position to make the removal or placement decision.</p>
	<p>Procedure H: Meeting Follow-Up</p> <p>After Family Team Meetings occur, it is crucial that the information shared and the decisions made are recorded and communicated to promote subsequent action. Follow-up is essential to ensuring that the productivity of the meetings leads to services and systems being put in place to support children and families involved with the Agency.</p> <ol style="list-style-type: none"> 1. The Family Team Meeting Unit shall enter the plan developed in the meeting into FACES within 24 hours of the meeting. 2. Decisions made in the meeting supercede decisions in existing case plans. Social workers shall update the case plan to reflect the plan developed in the meeting within 24 hours of the meeting. Any recommendations for changes to a court order shall not be implemented until the Court orders the recommended change. 3. For removals, the social worker shall share the plan with the Assistant Attorney General (AAG) assigned to the case before the initial court hearing. 4. For placement changes where a change of legal status is recommended, the social worker shall share the plan with the AAG assigned to the case immediately following the FTM and the AAG should request an Emergency Hearing from the assigned judge. 5. For placement changes where a change of legal status is not recommended, the social worker shall share the plan with the AAG assigned to the case and the AAG should distribute the plan to the assigned judge and all counsel within 48 hours of the FTM. 6. The coordinator shall follow-up on any actions intended to be taken immediately or within ten days of the FTM. 7. Social workers and their supervisors shall follow-up on all cases in their units that have had a Family Team Meeting on an ongoing basis, but at minimum, at the court mediation meeting, 60 days following mediation, and at administrative reviews, addressing: <ol style="list-style-type: none"> a. Whether each person with a role in the plan has followed through on agreed upon tasks; b. If services identified have been initiated and if initiated, whether they are leading to the desired results; and c. Whether an additional meeting with the family team is needed.
	<p>Procedure I: Role of the Facilitator</p> <p>Skilled and trained facilitators are central to Family Team Meetings. Facilitators</p>



	<p>have the role of ensuring a meeting environment that promotes respect and family engagement. Facilitators also have primary responsibility for guiding discussions toward decision-making.</p> <ol style="list-style-type: none"> 1. Prior to an FTM, the facilitator shall review the case information with the coordinator, identifying the family’s strengths and needs. The facilitator should plan for managing and transforming potential conflicts into productive partnerships during the FTM. 2. During an FTM, the facilitator should: <ol style="list-style-type: none"> a. Form cooperative relationships; b. Serve as a role model for solid casework practices and on how to engage families; c. Apply various strategies that help the family identify and use their strengths in the FTM; d. Conduct the meeting in ways that are respectful of the family’s attitudes, culture, and beliefs; e. Use solution-focused questions to lead the family team through a solution-focused process; f. Limit social workers and other team members from gathering information during the meeting that is not relevant for the meeting, such as asking for details about transferring the case; g. Employ strategies to engage all members in the FTM within the context of their roles; h. Facilitate toward consensus, employing strategies for managing group processes and breaking impasses; i. Guide the family team to develop a plan, agreed to by all participants, that promotes the child’s safety, permanence, and well-being. The facilitator has primary accountability for ensuring a plan is developed that promotes safety, permanence, and well-being; j. Employ strategies to assist all participants in assuming ownership of the plan; and k. Review, finalize, and distribute the plan to all participants upon closure of the meeting.
	<p>Procedure J: Role of the Coordinator</p> <p>Coordinators have primary responsibility for the logistics of Family Team Meetings. Coordinators invite and prepare families, family supports, resource parents, and professional partners for meetings. Before, during, and after meetings, coordinators play a central role in communicating issues and decisions to all participants.</p> <ol style="list-style-type: none"> 1. Prior to an FTM, the coordinator should: <ol style="list-style-type: none"> a. Identify family members and other potential participants for the FTM when meeting with the social worker and the parents. Identify, mobilize, and widen family’s support and resources network;



- b. Invite participants in person or by telephone and encourage their participation in the FTM;
 - c. Make the arrangements for the meeting, including scheduling the location and planning for special needs such as the need for an interpreter, to include participants through a conference call, for transportation assistance, or for child care during the meeting;
 - d. Form cooperative relationships with participants;
 - e. Clarify the purpose and focus of the meeting with participants;
 - f. Explain individual roles in the meeting, including each member's role in identifying the family's strengths and needs;
 - g. Discuss confidentiality requirements for the meeting;
 - h. Prepare participants to create positive expectations and to avoid conflicting agendas;
 - i. Gain the family's perspective on what brought the family to the Agency's attention;
 - j. Explore the family's strengths and needs;
 - k. Ask solution-focused questions to help the family determine its desired outcomes for the meeting;
 - l. Explore the family's concerns and assess what may go wrong during the meeting;
 - m. Discuss "non-negotiable issues" of the meeting (e.g., court orders);
 - n. Help participants to anticipate and manage their emotions during the meeting;
 - o. Help participants to understand the family's primary goal prior to the meeting;
 - p. Communicate that if a decision is made for the child to be placed or change placements and kin volunteer, kin shall be licensed temporarily prior to the placement; (*See the Temporary Licensing of Foster Homes for Kin Policy.*) and
 - q. Communicate on an ongoing basis with the facilitator before each Family Team Meeting to share the information learned.
2. During an FTM, the coordinator should:
- a. Provide assistance to the facilitator;
 - b. Record key discussions on a white board, flip chart, or newsprint for all participants to view;
 - c. Monitor the time and the meeting's progress; and
 - d. Record the plan developed in the meeting.
3. Following an FTM, the coordinator shall:
- a. Follow-up on any actions intended to be taken immediately but no later than ten days after the FTM; and
 - b. Provide feedback to the facilitator on observations of the meeting.



Procedure K: Role of the Social Worker

As the professionals responsible for families’ cases, social workers have extensive information to be shared in Family Team Meetings. Social workers are responsible for ensuring a decision is made that supports safety and permanency for children.

1. The social worker(s) assigned to a case shall initiate Family Team Meetings for removals and placement changes through requests to the Family Team Meeting Unit.
2. Prior to an FTM, the social worker should:
 - a. Provide the coordinator with the names and contact information of family members and community support persons that the parent(s) want to have present at the FTM;
 - b. Discuss with the coordinator any issues for the family at the meeting such as the need for an interpreter, to include participants through a conference call, for child care during the meeting, or to exclude certain individuals from part or all of the meeting (for reasons including domestic violence);
 - c. Explain the FTM process to the family, children ages twelve and older and younger children as age and developmentally appropriate, and the resource parents;
 - d. Provide the scheduling information for the FTM, if known, or inform the family that the coordinator will be in contact with them;
 - e. Review the case file, including all assessments;
 - f. Make a list of the critical questions to be addressed at the meeting;
 - g. Make a list of the family’s strengths and needs; and
 - h. Brainstorm options for the family.
3. During an FTM, the social worker should:
 - a. Directly and respectfully present the facts of the case to all participants;
 - b. Articulate his or her concerns, be open to a range of strategies, and work toward consensus with the full family team;
 - c. Raise any concerns he or she has during the meeting if he or she believes that the plan being developed does not promote children’s safety, permanency, and well-being adequately; and
 - d. Appeal to his or her program administrator or a person in a higher level position to make the removal or placement decision if members of the family team are reaching agreement on a plan but he or she believes that the plan does not promote children’s safety, permanency, and well-being adequately.
4. Following an FTM, the social worker shall:
 - a. Update the case plan to reflect the plan developed in the meeting within 24 hours of the meeting;
 - b. For removals, share the plan with the Assistant Attorney General (AAG) assigned to the case before the initial court hearing;
 - c. For placement changes where a change of legal status is recommended,



	<p>share the plan with the AAG assigned to the case immediately following the FTM and the AAG should request an Emergency Hearing from the assigned judge;</p> <ul style="list-style-type: none"> d. For placement changes where a change of legal status is not recommended, share the plan with the AAG assigned to the case and the AAG should distribute the plan to the assigned judge and all counsel within 48 hours of the FTM; and e. Follow-up on all cases that have had a Family Team Meeting on an ongoing basis, but at minimum, at the court mediation meeting, 60 days following mediation, and at administrative reviews, addressing: <ul style="list-style-type: none"> i. Whether each person with a role in the plan has followed through on agreed upon tasks; ii. If services identified have been initiated and if initiated, whether they are leading to the desired results; and iii. Whether an additional meeting with the family team is needed.
	<p>Procedure L: Evaluation and Monitoring</p> <p>Evaluation and monitoring is necessary for ensuring that Family Team Meetings support children’s safety and permanency. Individual cases shall be monitored to ensure that agreements reached are being followed.</p> <ul style="list-style-type: none"> 1. The coordinator shall follow-up on any actions intended to be taken immediately but no later than ten days after the FTM. 2. Social workers and their supervisors shall follow-up on all cases in their units that have had a Family Team Meeting on an ongoing basis, but at minimum, at the court mediation meeting, 60 days following mediation, and at administrative reviews, addressing: <ul style="list-style-type: none"> a. Whether each person with a role in the plan has followed through on agreed upon tasks; b. If services identified have been initiated and if initiated, whether they are leading to the desired results; and c. Whether an additional meeting with the family team is needed. 3. The Agency shall examine Family Team Meetings data on an ongoing basis to monitor the process and recommend improvements.
<p>VIII. Professional Standards</p>	



Appendix II: Letter from Legal Counsel on the FTM Evaluation

Child and Family Services Agency Office of General Counsel

MEMORANDUM

TO: Erin McDonald
FROM: Sarah R. Kaplan
DATE: July 11, 2005
RE: FTM Evaluation

As requested, I have reviewed the following documents related to the evaluation of the Child and Family Services Agency's (CFSA) implementation of family team meetings (FTMs): the evaluation introduction letter, the Consent to Participate in Interview or Focus Group, and the Researcher Confidentiality Agreement. With the changes indicated on the attached drafts, the documents are legally sufficient.

Pursuant to D.C. Official Code § 16-2312a, CFSA is required to "commission an independent process and impact evaluation" of the FTMs and 72-hour shelter period authorized by D.C. Official Code § 16-2312. An evaluation is required at least every six, 18 and 30 months after the effective date of the emergency act that first enacted the relevant law.¹

Each evaluation is required, "at a minimum, [to] assess the following processes and outcomes of the family team meetings:

- (1) Rates of participation in the meetings for different types of participants, including parents, children, and relatives;
- (2) Demographic information about children and families who participated in the meetings;
- (3) The percentage of meetings resulting in approved safety plans;
- (4) The supports and services included in approved safety plans;

¹ The Child in Need of Protection Emergency Act of 2004, D.C. 15-724, was effective January 19, 2005.



- (5) The extent to which supports and services included in approved safety plans actually were provided;
- (6) The percentage of meetings that resulted in the filing of a petition in the Family Court to remove a child from the home, and the percentage of meetings that resulted in a decision not to file a petition in Family Court;
- (7) The placement outcomes for children who were the subject of the meetings, including:
 - (A) The percentage of children living with parents;
 - (B) The percentage of children living with relatives;
 - (C) The percentage of children who have been adopted;
 - (D) The percentage of children living in foster care; and
 - (E) Other applicable placements;
- (8) The percentage of children who received a permanent placement and whose cases were closed;
- (9) The percentage of children who were the subject of subsequent reports to the Agency's abuse and neglect reporting line; and
- (10) The effect of the 72-hour time frame for the commencement of a Family Court hearing on families' legal protections and due-process rights.

The documents submitted for review are not inconsistent with the above requirements. The comments to the Consent to Participate in Interview or Focus Group note that the document does not mention the 72-hour provision. I suggest that such language be added.

The changes also clarify the legal requirements around maintaining confidentiality (including D.C. Official Code § 4-1303.06).

Please let me know if you have any questions.



Appendix III: Letter from Agency Administrator to CFSA Institutional Review Board

Dr. Roque Gerald
Deputy Director
Office of Clinical Practice
Child and Family Services Agency
400 6th Street, SW
Washington, DC

Ms. Virginia Monteiro
Chairwoman
CFSA Institutional Review Board
Child and Family Services Agency
955 L'Enfant Plaza, SW
Washington, DC

July 13, 2005

Dear Ms. Monteiro,

As Deputy Director of the Office of Clinical Practice of the District of Columbia's Child and Family Services Agency, I am writing to acknowledge and voice support for both internal and external program evaluation activities relevant to the Family Team Meeting (FTM) Initiative.

The Family Team Meeting Practice Initiative is a system-wide practice shift which is based in the Office of Clinical Practice at the District of Columbia Child and Family Services Agency. Family Team Meetings (FTMs) are a child welfare strengths-based, family conferencing model that was designed specifically to address the unique issues and best practice goals of the District of Columbia's child welfare system. FTMs are based on the ideals of family group conferencing or family group decision making and is one of the methods CFSA is utilizing to increase family and community involvement at critical decision-making points. More concretely, FTMs are structured planning and decision making sessions which engage the 'family' as they define it and other interested individuals at times of critical decision-making. Since the family is vital to the identification of family team members, a variation of team participants may emerge. In a neutral context, all identified stakeholders invested in the placement and well-being of the child(ren) in question are able to engage in strengths-based and solution-focused discussions to address child safety, permanency, and well-being.

The District of Columbia's Child in Need of Protection Amendment Act of 2004, Law 15-341, effective April 12, 2005 (Act), requires that an external or independent process and impact evaluation be conducted to determine the effectiveness of the FTM Initiative and related legislation. The scope of activities to be considered in the external evaluation



is defined by the afore mentioned legislation and may consider additional questions upon review and consent of the CFSA evaluation cottar. The external evaluation will be conducted concurrent with internal program evaluation activities. Internal program evaluation activities will include a quantitative component and a qualitative component which will engage participant groups in focus groups and interviews during all evaluation phases.

A group of nationally recognized researchers have been engaged in the FTM Program Evaluation through the American Humane Association (AHA). I acknowledge and consent to this evaluation. Further, I support the evaluation structure which includes individuals from both the internal AHA evaluation group, led by Dr. Myles Edwards and assisted by Kathleen Tinworth, and a group of independent experts whom will act as the evaluation advisory board. I agree that this group of advisory researchers will include Dr. Gale Burford, Dr. Joan Pennell, and Dr. John Fluke.

As a component of the internal and external evaluation activities, a series of focus groups and individual interviews will be utilized to secure qualitative data from several participant groups.

During Phase One of the evaluation, child welfare professionals both internal and external to the Agency will be engaged. I agree with these efforts. I acknowledge that staff and external stakeholder engagement in the FTM focus groups and interviews is completely voluntary. All the information gathered during the focus groups and interview sessions will be collected and preserved in a fashion so as to ensure participant confidentiality. All individual and case identification will remain separate from individual responses in evaluation efforts and will be destroyed upon completion of the focus group or interview session. Information obtained in the individual focus groups and interviews will be utilized to inform the FTM process and future program development. Participants will not be exposed to risk which is beyond the acceptable level as identified by research standards. Information obtained in each session will be utilized solely as the participant has identified and consented.

During Phases Two and Three of the Evaluation Initiative, individuals whom have been engaged in an FTM will be asked to participate in focus group and interview sessions. These populations may include Agency clients, family members, community members, child welfare staff, and other support network representatives. I agree with these efforts as an effective means to achieve the requirements set forth by the Act. I acknowledge that these groups will be solicited to participate in focus groups and interviews on a voluntary basis. No individuals will be forced to participate, penalized for their participation and comments, or have services delayed or withheld based on their participation. Further, all individual and case identification will remain separate from individual responses in evaluation efforts. No identifying information will be retained by the evaluation staff following participation in identified evaluation activities but will be destroyed upon completion of the focus group or interview session. Further, contact information utilized to engage the individuals will be retained by the CFSA evaluation team and will not be provided to the external evaluation group. In the event that



information is provide to engage family participants, the process will be reviewed by myself and the FTM Evaluation Team Lead and utilized by a separate and approved entity. The information will not be utilized for any other purpose than contact and scheduling and will be destroyed once the individual is contacted. Participants will not be exposed to risk which is beyond the acceptable level as identified by research standards. Information obtained in each session will be utilized solely as the participant has identified and consented.

A system has been established to ensure that participants are not endangered in the evaluation efforts. All precautions have been taken as evaluators will be required to supply information to participants regarding where they may go if they feel that their rights or safety have been violated. Individuals will be provided pertinent health and social support contact information and may contact the CFSA FTM Evaluation Team Lead, Erin McDonald, to report any concerns relevant to the FTM Evaluation. Participants may also direct concerns to their Agency supervisor. Participants may direct privacy concerns to CFSA's Interim Privacy Officer, Sarah Kaplan, Assistant General Counsel.

Please feel free to contact me for further questions and concerns regarding the FTM evaluation efforts.

Sincerely,

Dr. Roque Gerald
Deputy Director Office of Clinical Practice



Appendix IV: Interview and Focus Group Development Methodology

Qualitative focus groups and interviews with child welfare professionals were developed by Erin McDonald, Internal Evaluation Lead, during the weeks of June 13th through July 11th, 2005. The following groups were included in focus groups or interview sessions which ranged from one to five participants. Individuals participated in groups of peers with the same role or position versus a mix of participants with various roles. At least one focus group or interview session was conducted with:

- Ongoing social workers
- Ongoing supervisory social workers
- Intake and Investigation social workers
- Intake and Investigation supervisory social workers
- Family Team Meeting facilitators
- Family Team Meeting CFSA coordinators
- Family Team Meeting Community Collaborative coordinators
- Guardian at Litem
- CFSA program administrators
- Assistant Attorney Generals
- Magistrate judges

The most rigorous methodology possible for participant selection and inclusion in groups was utilized. First, the population size of groups was assessed and it was determined whether a focus group or individual interviews would be conducted. Second, a listing of all individuals in the populations targeted for focus groups was obtained from the appropriate location. All program administrators with social worker staff directly impacted by the FTM Program were asked for a listing of all current supervisors and social workers. For the Guardian at litem (GAL) population, a listing of all GALs was obtained from the CCAN Office which assigns GALs to FTM cases. A listing of each population was compiled and every fifth person on the listing was contacted via telephone. Once the individual was selected from the list, their name was removed such that a new individual would be selected in the repeat counts. If the person was unavailable to take the call, a message indicating the intention of the call, details regarding engagement in the focus group, and contact information was left. For those individuals who were available to take the telephone call, information regarding the intention of the focus group session, details regarding engagement, contact information, and any additional questions or discussion occurred. In order to ensure that a large enough sample of participants was contacted and engaged in the focus group, a total of 10 to 20 individuals from each population were contacted.

The telephone method of contact for these groups was effective as individuals either called back or were accessible by telephone. Approximately 90% to 95% of individuals contacted from each population responded to the call in some manner. It is important to note that all individuals contacted and invited to participate either (a) elected to



participate in the focus group, (b) identified that they would be on scheduled summer leave during that period but were interested in participating at some point in the future, (c) identified that they would not be able to participate as they would be in required Agency training during that period, or (d) stated that they had not been engaged in the FTM process to date and therefore would not have insight to share. This final response occurred with a small number of GALs.

Those populations with a small number, such as the Assistant Attorney Generals, were contacted through a group representative. An email was determined as the best means to solicit this group. Due to the very short notification time period prior to the scheduled focus group, only two individuals responded to the email and only one was able to participate. Therefore, an individual interview was conducted with the group versus a focus group session.

All individuals targeted for interview sessions were contacted either through telephone or by email. A date and time that was convenient for their schedule was selected and the researchers traveled to the designated office.



Appendix VI: Confidentiality Agreement



GOVERNMENT OF THE DISTRICT OF COLUMBIA Child and Family Services Agency Family Team Meeting Program Evaluation Researcher Confidentiality Agreement



I, _____, will be participating in the Child and Family Services Agency (CFSA), Family Team Meeting Program Evaluation (FTM Evaluation) as a lead researcher, member of the external evaluation team.

The purpose of the Family Team Meeting Program Evaluation is to assess the effectiveness of the District's family team meeting (FTM) legislation, the Child in Need of Protection Act of 2004, D.C. Law 15-341 (D.C. Official Code § 16-2312). Specifically, this evaluation seeks to assess whether the legislation has worked to impact the due process rights of parents and families engaged in the FTM process. In addition, the evaluation will consider the cost impact of the program and the process variables relevant to the meeting outcomes in regard to child safety, permanency, and well-being.

I understand that this phase of the evaluation will focus on staff based focus groups and interview sessions. I understand that in the course of this qualitative evaluation, I will receive information that is considered confidential pursuant to the D.C. Official Code, and in particular § 4-1303.06, including but not limited to, information which identifies individual children reported as or found to be abused or neglected or which identifies other members of their families or other persons or other individuals. I understand and agree that whoever willfully discloses, receives, makes use of or knowingly permits the use of confidential information concerning a child or individual in violation of D.C. Official Code § 4-1303.06, is guilty of a misdemeanor and upon conviction shall be fined not more than \$1,000.00.

I understand and agree that I will not use or disclose any information that I receive during the FTM evaluation except to duly authorized CFSA or FTM Program Evaluation staff and as part of the FTM evaluation process.

I understand and agree that if I have any questions concerning whether any use or disclosure of information would be consistent with this Agreement, I will not use or disclose the information addresses without permission for that use or disclosure from the CFSA Office of the General Counsel.

Signature

Witness Signature

Print Name

Print Name

Date

Date



Appendix VII: Transcriber Agreement of Confidentiality

AGREEMENT TO MAINTAIN CONFIDENTIALITY

The signature below indicates my agreement to maintain confidentiality pertaining to the work I am doing typing transcripts of tape-recorded interviews for the American Humane Association.

I will not discuss the content of the tapes with anyone except members of the evaluation team with whom I may need to seek clarification in order to type the transcripts. These persons include: Myles Edwards, Kathleen Tinworth, Gale Burford and Joan Pennell.

I will not release the identities of any of the people who are interviewed on the tape recordings.

I accept responsibility for keeping the tapes in a secure place until I return them with the typed transcripts.

Agreed and accepted:

Signature of Person Typing Transcripts

Name:
Title:
Date

Signature of Witness

Name:
Title:
Date:



Appendix VIII: Consent Form



CONSENT TO PARTICIPATE IN INTERVIEW OR FOCUS GROUP

Introduction to Study:

- You are invited to take part in an evaluation of the use of Family Team Meetings (FTM) in the District of Columbia.
- The evaluation is authorized by the District of Columbia Child and Family Services Agency to be carried out by the Internal Child and Family Services Family Team Meeting Evaluation group and the American Humane Association Child Welfare Service.
- Erin L. McDonald is the Internal FTM Evaluation Team Mead and Principal Investigator for this study. She can be reached at (202) 727-2845.
- Dr. Myles Edwards of the American Humane Association in Englewood, Colorado is the Principal Investigator for the external evaluation.
- Other researchers who may meet with you include Gale Burford, Joan Pennell, and Kathleen Tinworth.
- For the current study period, individual interviews and focus groups are being conducted as qualitative data collection sources.

Purpose of Family Team Meeting Evaluation Interviews and Focus Groups:

- The purpose of the FTM Interviews and Focus Groups is to find out and write down your thoughts on the use of Family Team Meetings. Broadly, you may be engaged in discussions regarding your role in the Family Team Meeting business process, your experiences the effects of the 72 hour time period between initial home removal and Initial Hearing on family and due process outcomes, and other relevant topic areas.
- The interviews and focus groups will be used in the evaluation of the use of Family Team Meetings as implemented through the District of Columbia Child and Family Services Agency and its partner agencies and collaborators.

What Will Happen During the Evaluation Interview or Focus Group:

- You are being invited to take part in either a single interview or a single focus group.
- You will not be asked to provide information concerning a particular FTM or to discuss a case with which you were involved.
- The interview or focus group will take about 1 to 1 ½ hours.
- You will be asked for permission to tape-record the interview/focus group. If you do not wish to be tape-recorded you can still have an individual interview. If you do not wish to be tape recorded please put your initials in the following space:
_____.
- The interview or focus group is taking place at _____.
- Your views will be aggregated with other participant's responses and/or anonymously included in reports related to the evaluation on the use of Family Team Meetings.



- Personal identification information used to contact you for participation will remain separate from the content of your responses and will be destroyed following completion of the session.
- Your participation is voluntary and you may withdraw from the focus group or interview session at any point which you do not feel comfortable. You do not need to respond to any question which makes you uncomfortable.
- Responses will not be utilized for job performance or evaluation purposes and will not be used against you in any manner.
- The data from these focus groups or interview sessions may be utilized to develop reports which are submitted to the District of Columbia City Council and other pertinent stakeholder groups.
- The data from these interviews and focus groups may be published upon review and consent of the CFSA Director and Deputy Director of Programs. No information will be published which identifies any person who participated in a focus group or interview session or which identifies any person who has received services from CFSA or a family member or who otherwise participated in an FTM.
- If you have any questions or concerns about the survey, you should contact Dr. Roque Gerald, the Deputy Director of the Office of Clinical Practice. He may be reached at (202) 727-7035.
- You will be provided an informational sheet which will contain names and contact information for you to call if you feel that you have further questions, you have been harmed, or would like to report any form of misconduct relevant to the focus group or interview session in which you participated.

Washington D.C Child and Family Services Institutional Review Board Approval:

- The Internal Review Board of the District of Columbia Family Services Agency has approved this study.
- The CFSA Office of the General Counsel has reviewed and approved the consent and confidentiality documents utilized for this study. If you have additional questions regarding privacy or confidentiality, you may call the Interim Privacy Officer, Assistant General Counsel Sarah Kaplan at 202 442-6154.

Agreement:

1. This is to state that I voluntarily agree to take part in an interview or focus group about my views on Family Team Meetings.
2. I understand that the purpose of the group is to find out and write down my thoughts about Family Team Meetings.
3. I understand that I will not be asked to provide information concerning a particular FTM or to discuss a case in which I was involved.
4. I understand that my views will be anonymously included in a report on the use of Family Team Meetings.



5. I understand that the data from this interview/focus group may be used in aggregated reports provided to the District of Columbia City Council and stakeholder groups.
6. I understand that the data from this interview/focus group may be published upon review and consent of the CFSA Director and Deputy Director of Programs.
7. I understand that I can refuse to answer any question and that I may withdraw my consent to participate in the evaluation at any time prior to the publication of the report that pertains to my interview/focus group without negative consequences to me.
8. I understand that the purpose of this interview/focus group is to evaluate the use of Family Team Meetings by the Child and Family Services Agency in the District of Columbia and the effect of the 72 hour period between initial home removal and initial court hearing.
9. I understand that no compensation or other personal benefit is being offered to me to participate.

I have had the chance to ask any questions I have about this interview or focus group, and they have been answered for me.

I have read the information in this Consent To Participate In Interview Or Focus Group, and I agree to be in the Focus Group or Interview (please circle which). I understand that I will get a copy of this Consent To Participate In Interview Or Focus Group, after I sign it.

Name (please print)

Witness Name (please print)

Signature

Witness Signature

Date

Date



Appendix IX: Interviewing and Focus Group Procedures

Family Team Meetings Interview and Focus Group Procedures

I. Preparation

A representative from the District of Columbia Children and Family Service will contact designated agency and partner personnel to ask if their names and contact information can be shared with members of an externally contracted evaluation team. A scheduler will then contact the persons who have given this initial verbal consent to set up a time and location for either an individual interview or a focus group. (See Scheduling Protocol.)

II. Interviews and Focus Groups

A. Introductions

A member of the evaluation team will introduce themselves and review the purpose of the interview or focus group.

B. Informed Consent

- The interviewer/facilitator will pass out the informed consent (see attached).
- The facilitators will review the forms and answer any questions.
- Participants will be asked to sign the forms.
- The interviews/group sessions will be audio taped with the permission of the participant(s). The tape recorder will be turned on once the consent form(s) has/have been read and opportunity for questions provided.

C. In the case of the focus groups, the facilitator will discuss group norms and review procedures for creating a environment in which everyone gets to speak. Copies of the questions for focus groups will be shown on flip chart paper to all members in the group.

D. One facilitator will lead the discussion while the others provide backup, observe interactions, take notes on a flip chart, and monitor the tape recorder.

III. Data Analysis

A. The audio tapes of all sessions will be transcribed and focus group flipchart notes will be recorded and summarized. The transcriber will sign an agreement of confidentiality (see the attached).

B. The transcriptions and notes will be analyzed qualitatively. The questionnaire will be quantitatively analyzed.

C. Results of the interviews or focus group will be shared with members of the American Humane Evaluation Team in planning further stages of the evaluation and in reporting on the findings of the evaluation.



Appendix X: Interview and Focus Group Protocol

Family Team Meetings
District of Columbia, Child & Family Services Agency
Questions for Interviews and Focus Groups

Date of Interview:

Individual Interview Focus Group

Interviewee(s) Code Number(s):

Interviewer:

Consent Form Signed yes no [do not proceed with interview]

Time of Start of Interview:

1. a. In what way have you been involved in Family Team Meetings with the Child & Family Services Agency? Sometimes people have been involved in more than one way; let us know about that too. [Inquire about when, how many, in what role(s).]

b. Am I correct in checking you as [check all that apply]:

- (1) Family for whom FTM held [circle relationship to chil(ren)/teen]
- | | |
|---------------------------|---|
| a) Mother | g) Extended family (Aunt, Uncle, Cousin, etc.) |
| b) Sister | h) Child or Teen for whom meeting is being held |
| c) Grandparent | i) Other |
| d) Father | |
| e) Brother | |
| f) Parent spouse/ partner | |
- (2) Close support for family for whom FTM held (e.g., relative, friend)
- (3) FTM coordinator, from Collaborative, from CFSA
- (4) FTM facilitator
- (5) CFSA in-take worker
- (6) CFSA continuing worker
- (7) CFSA Manager/Administration/Supervisor
- (8) GAL
- (9) Parents' lawyer
- (10) Assistant Attorney General
- (11) Magistrate
- (12) Judge
- (13) Service provider (other than CFSA) [specify] _____
- (14) Foster parent
- (15) FTM Training participant
- (16) Trainer
- (17) Policy maker
- (18) Evaluator
- (19) Other [specify] _____



2. Think back to your impressions of how CFSA worked with families before Family Team Meetings were started.

a. In what ways, if any, are Family Team Meetings now making a difference?

b. Overall, would you say Family Team Meetings are making services for children and their families:

Interviewee #1

___ better,
___ just the same, or
___ worse?

Interviewee #2

___ better,
___ just the same, or
___ worse?

Interviewee #3

___ better,
___ just the same, or
___ worse?

Interviewee #4

___ better,
___ just the same, or
___ worse?

Interviewee #5

___ better,
___ just the same, or
___ worse?

Interviewee #6

___ better,
___ just the same, or
___ worse?

3. What is it about Family Team Meetings that make them work well for children and families?

Values Inquiry:

4. If you could change one thing about Family Team Meetings, what would it be?



5. Before the change in legislation, the government had 24 hours after removing children from their home to have the case heard in court. Now, when the Child & Family Services Agency removes children from their home, the government has 72 hours before the case must be heard by a judge. The judge makes a decision on where the children will live. During those 72 hours, the children's family and/or support network is invited to take part in a Family Team Meeting in order to make a plan for the children.

a. What impact did holding court at 24 hours after placement have on parents' rights to be heard by the judge? What impact does extending this time period to 72 hours have on parents' rights to be heard by the judge? [Inquire as necessary, about advantages and disadvantages.]

b. What impact does extending the period from 24 hours to 72 hours have on the children? [Inquire as necessary, about advantages and disadvantages.]

c. Overall, would you say that extending the period from 24 to 72 hours in order to give time for the Family Team Meeting is making services for children and their family:

Interviewee #1
___ better,
___ just the same, or
___ worse?

Interviewee #2
___ better,
___ just the same, or
___ worse?

Interviewee #3
___ better,
___ just the same, or
___ worse?

Interviewee #4
___ better,
___ just the same, or
___ worse?

Interviewee #5
___ better,
___ just the same, or
___ worse?

Interviewee #6
___ better,
___ just the same, or
___ worse?



6. [For individual interviews, administer the following questionnaire either verbally or having the participant complete it on their own. For focus groups, usually have participants complete the questionnaire on their own.] We want to ask you about the extent to which you agree or disagree with the following statements about Family Team Meetings. Rate your level of agreement on a scale of 1 strongly disagree up to 10 strongly agree. If you don't know (DK) or the statement doesn't apply (NA), let us know that too.

Statement about Family Team Meetings	1	2	3	4	5	6	7	8	9	10	DK	NA
	strongly disagree										strongly agree	
1. Everyone at a meeting understands why it is being held.	1	2	3	4	5	6	7	8	9	10	DK	NA
2. Families are prepared for taking part in the meetings.	1	2	3	4	5	6	7	8	9	10	DK	NA
3. Service providers are <u>not</u> well prepared for taking part in the meetings.	1	2	3	4	5	6	7	8	9	10	DK	NA
4. People who are family or feel like family are at the meetings.	1	2	3	4	5	6	7	8	9	10	DK	NA
5. <u>Only one</u> side of the children's family takes part in the planning.	1	2	3	4	5	6	7	8	9	10	DK	NA
6. More service providers ("professionals") are at the meetings than family and their close supports.	1	2	3	4	5	6	7	8	9	10	DK	NA
7. The meetings are held in a place that feels right to the family.	1	2	3	4	5	6	7	8	9	10	DK	NA
8. The meetings are held in a way that feels right to the family.	1	2	3	4	5	6	7	8	9	10	DK	NA
9. The meetings have enough supports and protections to make the participants feel safe and comfortable.	1	2	3	4	5	6	7	8	9	10	DK	NA
10. Coordinators organize the meetings well.	1	2	3	4	5	6	7	8	9	10	DK	NA
11. Facilitators run the meetings well.	1	2	3	4	5	6	7	8	9	10	DK	NA
12. Families have a real say in the planning.	1	2	3	4	5	6	7	8	9	10	DK	NA
13. Plans build on family's strengths or good qualities.	1	2	3	4	5	6	7	8	9	10	DK	NA
14. Plans can be revised when the family's needs change.	1	2	3	4	5	6	7	8	9	10	DK	NA
15. The plans include ways that relatives, friends, or other close supports will help out.	1	2	3	4	5	6	7	8	9	10	DK	NA
16. The plans include ways that community or neighborhood organizations will help out.	1	2	3	4	5	6	7	8	9	10	DK	NA
17. The plans include ways that CFSA and other public agencies will help out.	1	2	3	4	5	6	7	8	9	10	DK	NA
18. The plans use local or neighborhood resources, such as group homes or counseling services.	1	2	3	4	5	6	7	8	9	10	DK	NA
19. The facilitators do <u>not</u> consistently follow up to see if the plans are being carried out.	1	2	3	4	5	6	7	8	9	10	DK	NA



7. What was this interview/focus group like for you?

Time of End of Interview:

Length of Interview _____ in minutes.



Appendix XI: Questionnaire

Date of focus group/interview: / /

Please indicate your role: _____

We want to ask you about the extent to which you agree or disagree with the following statements about Family Team Meetings. Rate your level of agreement on a scale of 1 strongly disagree up to 10 strongly agree. If you don't know (DK) or the statement doesn't apply (NA), let us know that too.

Statement about Family Team Meetings	1	2	3	4	5	6	7	8	9	10	DK	NA
	strongly disagree										strongly agree	
1. Everyone at a meeting understands why it is being held.	1	2	3	4	5	6	7	8	9	10	DK	NA
2. Families are prepared for taking part in the meetings.	1	2	3	4	5	6	7	8	9	10	DK	NA
3. Service providers are <u>not</u> well prepared for taking part in the meetings.	1	2	3	4	5	6	7	8	9	10	DK	NA
4. People who are family or feel like family are at the meetings.	1	2	3	4	5	6	7	8	9	10	DK	NA
5. <u>Only one</u> side of the children's family takes part in the planning.	1	2	3	4	5	6	7	8	9	10	DK	NA
6. More service providers ("professionals") are at the meetings than family and their close supports.	1	2	3	4	5	6	7	8	9	10	DK	NA
7. The meetings are held in a place that feels right to the family.	1	2	3	4	5	6	7	8	9	10	DK	NA
8. The meetings are held in a way that feels right to the family.	1	2	3	4	5	6	7	8	9	10	DK	NA
9. The meetings have enough supports and protections to make the participants feel safe and comfortable.	1	2	3	4	5	6	7	8	9	10	DK	NA
10. Coordinators organize the meetings well.	1	2	3	4	5	6	7	8	9	10	DK	NA
11. Facilitators run the meetings well.	1	2	3	4	5	6	7	8	9	10	DK	NA
12. Families have a real say in the planning.	1	2	3	4	5	6	7	8	9	10	DK	NA
13. Plans build on family's strengths or good qualities.	1	2	3	4	5	6	7	8	9	10	DK	NA
14. Plans can be revised when the family's needs change.	1	2	3	4	5	6	7	8	9	10	DK	NA
15. The plans include ways that relatives, friends, or other close supports will help out.	1	2	3	4	5	6	7	8	9	10	DK	NA
16. The plans include ways that community or neighborhood organizations will help out.	1	2	3	4	5	6	7	8	9	10	DK	NA
17. The plans include ways that CFSA and other public agencies will help out.	1	2	3	4	5	6	7	8	9	10	DK	NA
18. The plans use local or neighborhood resources, such as group homes or counseling services.	1	2	3	4	5	6	7	8	9	10	DK	NA

