

ACF-OGM SF-PPR

Final Report

Funding Recipient: The Village Family Service Center
Grant#: 90CF003301

Program Name: Family Engagement for Native American Youth
City and State: Fargo, ND

Reporting Period: September 30, 2011 – September 29, 2014

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I. Executive Summary

Native American children are overrepresented in the foster care population in North Dakota. Native children are also overrepresented in the child victim population in North Dakota, significant to child welfare as children are often removed from their homes based on child abuse and neglect activity/reports.

Through the Family Engagement for Native American Youth project, The Village and North Dakota Department of Human Services focused on preventing Native American youth in North Dakota living in Burleigh, Cass, Morton, Ramsey, Rolette and Ward Counties from entering or re-entering state foster care and increasing the number of youth in kinship care, which would reduce the time these children are involved with the child welfare system. The Village used a combination of Family Team Decision Making and Family Group Decision Making meetings to engage families in capacity building. The intention was to meet children's needs by strengthening the family's protective factors such as safety planning, linking families with resources and services, and broadening social connections. Additionally, the meetings strive to reduce risk factors and address domestic violence, mental health and substance abuse concerns through family-specific action plans.

Over the course of three years, 146 family meetings were held serving 313 children. Most meetings served families in which a child was just removed or where placement was imminent. In 81% of cases presented, the children were already placed out of home when the meeting was held. However, by the end of the meeting, the plan was for the child/ren to be at home in 29% of cases. Six months after the meeting, the child/ren were placed at home in 32% of cases. The families involved in this project were mostly in poverty, mostly single parents, and had significant service barriers including housing problems, substance abuse, and lack of familial

support at meetings. These proved as barriers to full family engagement. However, family support was identified in most meetings.

Lessons Learned:

- Working with the Native American population will require more extensive preparatory work by facilitators and service providers in the exploration of informal supports, including both tribal and non-tribal resources.
- Our experience with this project leads us to believe that urban Native families can greatly benefit from an urban Native American Center that can offer them more community support.
- Prior to submitting a future grant it would be beneficial have more collaboration between the Department of Human Services and the counties in establishing realistic outcomes.
- Prior to a future grant submission, data system issues be discussed and resolved. Grant funds might need to be allocated for personnel in data management.
- A 72 hour FTDM model may not fit all families. As with all models, flexibility is a strength. Consideration may need to be made that the FGDM model is a better fit than FTDM for Native American families.
- Technology was a very important piece in implementing FGDM/FTDM in a rural state.

This report summarizes the data collected, including process and outcome findings, cost analysis, and lessons learned. Recommendations are offered regarding future research and services.

II. Overview of the Community, Population and Needs

A. Describe the grantee organization

The Village Family Service Center has a long history of serving children and families. Founded in 1891 as the North Dakota Children’s Home Society, an auxiliary agency of the Children’s Home Society of Minnesota, The Village was mandated to “act as friend and protector to homeless, neglected and destitute children.” Societal needs changed and the organization grew to meet those needs. Today, The Village is a private, nonprofit, non-denominational, multi-service agency operating in 21 communities across North Dakota and Minnesota. Programs and services available from The Village include:

- Family Group Decision Making
- Family Team Decision Making
- Financial Resource Center
- The Village Business Institute
- Adoption Services
- Big Brothers Big Sisters Program
- Family Based Services
- Counseling
- The Village Family Magazine
- Pregnancy Counseling
- Nokomis Child Care Centers
- Truancy Intervention Program
- First Step Recovery Program

At the time of the original proposal, the Village served more than 77,000 people in North Dakota and Minnesota. In 2013, the Village served 86,929 people fulfilling its mission *to improve the quality of life through services designed to strengthen individuals, families and organizations.*

The Village has demonstrated the ability to respond to the needs of children, adolescents and families, as well as shifts in national, state and community policy, and to develop and provide services that meet those needs in a professional, ethical and resource-responsible manner. This ability is demonstrated through agency history which includes working with the

state in the late 1980s to implement Family-Based services; rallying the legislature and ND DHS to fund Family Group Decision Making, with the financial support of the Archibald Bush Foundation, in 2006; and creating a school-based mental health program in conjunction with the Robert Wood Johnson Foundation in 2007.

Eleven active board members oversee The Village Family Service Center’s operations, which are managed day-to-day by a President/CEO and three additional leadership team members. The Village has 175 full-time paid staff and 68 part-time paid staff. Volunteers are utilized on a regular basis for clerical projects and other special events.

B. Describe the community in which the project takes place.

Counties served: Cass, Burleigh, Morton, Ramsey, Rolette, Ward, and Mountrail

(Mountrail County was invited to participate, but declined to be part of the project)

Six counties comprise the four target sites; counties were paired in three instances, based



on service delivery areas. This group of urban and rural counties comprises the most significant service population of Native American youth in the state, with the exception of Native American children living on North Dakota Indian Reservations. It should be

noted that children served with this grant were in the state and county foster care system and typically did not live on any of the North Dakota Indian Reservations. However many of the children served had family living on the Native American Indian Reservations.

The graph below depicts the number of Native American children in county/state foster care. Contextual factors impacting the numbers listed below can be found on Page 5, Section C.

County	Total # of Children in Foster Care 2010	Total # of Children in Foster Care 2013	# of Native American Children in Foster Care 2010	# of Native American Children in Foster Care 2013	% of Native American Children in Foster Care 2010	% of Native American Children in Foster Care 2013	% Change Of Native American Children in Foster Care
Cass	414	388	43	84	10.4	21.6	+11.2
Burleigh	251	259	91	135	36.3	52.1	+15.8
Morton	32	15	6	6	18.8	40.0	+21.2
Ramsey	52	75	30	49	57.7	65.3	+7.6
Rolette	73	80	64	69	87.7	86.3	-1.4
Ward	137	141	32	38	23.4	27.0	+3.6

Source: North Dakota KIDS COUNT, 2010 & 2013

In Cass County (the largest populated county in the state) which serves an urban Native American population, of the 414 children in foster care in 2010, 43 (or 10.4%) were Native American. In 2013, that number rose to 84 Native American children (or 21.6%). Burleigh County (the next largest county) serves two nearby reservations, Standing Rock and Three Affiliated Tribes. Of the 251 children in foster care in this county in 2010, 91(or 36.3%) were Native American. In 2013, that number rose to 135 Native American children (or 52.1%). Ward County, the fourth largest county in the state, serves a nearby reservation (Three Affiliated Tribes). Of the 137 children in foster care in this county in 2010, 32 (or 23.4%) were Native American. In 2013, that number rose to 38 Native American children (or 27%).

Ramsey, Rolette and Morton counties were chosen because of their significant Native American populations and their proximity to reservation lands. Ramsey is close to Turtle Mountain and adjacent to Spirit Lake, Rolette is adjacent to Turtle Mountain, and Morton is near Standing Rock. 2010 statistics show, of the 52 children in state foster care in Ramsey County, 30

(or 57.7%) were Native American. 2013 statistics show for Ramsey County, of the 75 children in state foster care, 49 (or 65.3%) were Native American. In Rolette County, of the 73 children in foster care in 2010, 64 (or 87.7%) were Native American. In 2013, Rolette County had 80 children in foster care, 69 (or 86.3%) were Native American children.

C. Describe the primary issues the demonstration project addresses. Describe significant contextual conditions, events, and/or community changes and how they figure into these problems.

The primary issue addressed in this grant is that Native American children are overrepresented in the foster care population in North Dakota. Native children are also overrepresented in the child victim population in North Dakota, significant to child welfare as children are often removed from their homes based on child abuse and neglect activity/reports.

Through our project, The Village focused on preventing Native American youth in North Dakota from entering or re-entering state foster care and increasing the number of youth in kinship care, which would reduce the time these children are involved with the child welfare system. The Village used a combination of Family Team Decision Making and Family Group Decision Making meetings to engage families in capacity building. The intention was to meet children's needs by strengthening the family's protective factors such as safety planning, linking families with resources and services, and broadening family and community connections. Additionally, the meetings strive to reduce risk factors and address domestic violence, mental health and substance abuse concerns through family-specific action plans.

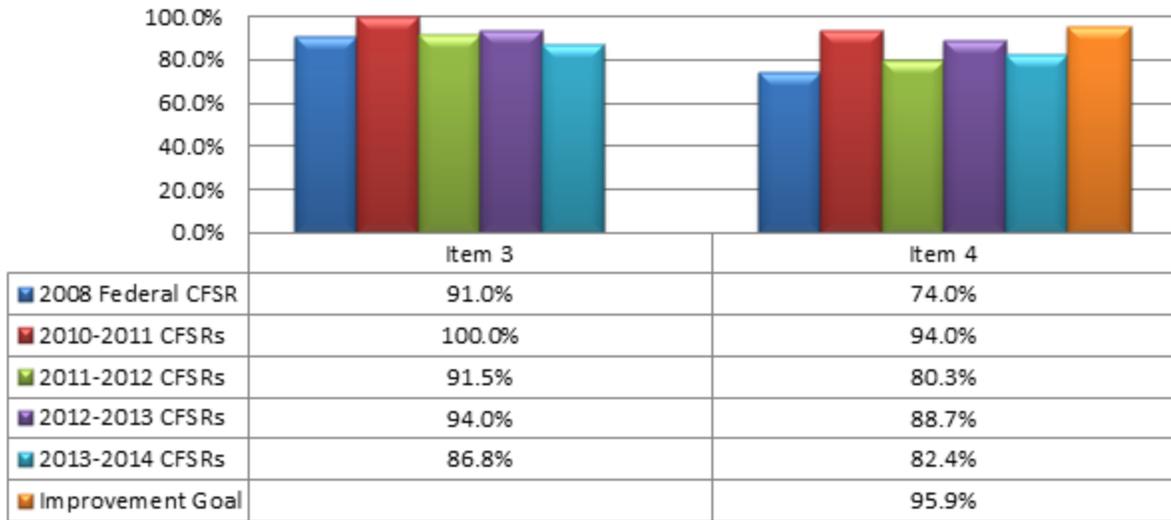
With this grant project, the intent was to further address two outcomes related to the North Dakota Child Welfare CFSR outcomes for Safety and Well-Being. The utilization of FGDM and FTDM interventions would help strengthen those two outcomes.

Village staff has participated in North Dakota's Children and Family Services Review (CFSR) for the last several years. Though North Dakota did well overall in its initial review in 2001, one area of concern was the number of foster care re-entries. According to the review, 16.3% of the children entering foster care in ND during fiscal year 1999 were re-entering care within 12 months of discharge from a prior foster care episode. The national number was 8.6%. This grant project, Family Engagement for Native American Youth, is in direct response to the CFSR results. It proposes to assist ND DHS in improving CFSR ratings on services to families to maintain the child or youth safely in the home, to prevent entry or re-entry into foster care, with an emphasis on serving Native American youth, to include:

- Assessment of risks and safety management (defined by CFSR Safety Outcome 2
“Children are safely maintained in their homes whenever possible and appropriate”)
 - Item 3: “Services to family to protect child(ren) in the home and prevent removal or re-entry into foster care,” determines whether, during the period under review, the agency made concerted efforts to provide services to the family to prevent children’s entry into foster care or re-entry after reunification.
 - Item 4: “Risk assessment and safety management,” determines whether, during the period under review, the agency made concerted efforts to assess and address the risk and safety concerns relating to the child(ren) in their own homes or while in foster care.

The chart on the next page (p. 8) shows the results of Safety Outcome 2 from 2008 to 2013. Even though improvements vary each year, Items 3 & 4 show improvement in the 3 years of this grant.

Safety Outcome 2 - Percentage of Cases Rated Strength



Source: Child and Family Services Review (CFSR) Data, November 2014

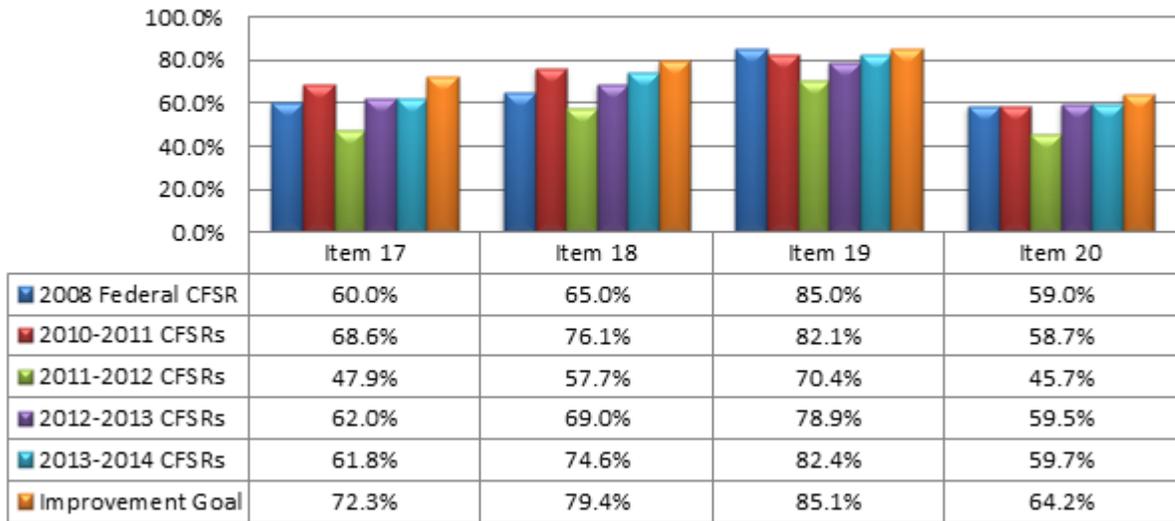
**Data represents all children included in the CFSR. No specific data available related to Native American children in the CFSR.

The second CFSR Rating, Well-Being Outcome 1, intended to work on the following:

- Assessment of needs and provision of services to Native American children, parents and foster parents (defined by CFSR Well-Being Outcome 1 “Families have enhanced capacity to provide for their children’s needs”)
 - Item 17: “Needs and services of child, parents and foster parents,” determines whether, during the period under review, the agency makes concerted efforts to assess the needs of children, parents, and foster parents to identify services necessary to achieve case goals and adequately addresses issues relevant to the agency’s involvement with the family, and provides the appropriate services.
- Improve the level of engagement of children, youth and family members in case planning to enhance family capacity to provide for the children’s needs including educational, physical and mental health needs (defined by Well-Being Outcome 1, Item 18).

- Item 18, “Child and family involvement in case planning,” determines whether, during the period under review, concerted efforts are made to involve parents and children (if developmentally appropriate) in the case planning process on an ongoing basis.

Well-Being Outcome 1 - Percentage of Cases Rated Strength



Source: Child and Family Services Review (CFSR) Data, November 2014
 **Data represents all children included in the CFSR. No specific data available related to Native American children in the CFSR.

The data indicates North Dakota has improved in the Safety Outcome Number 2, Items 3 & 4 and Well Being Outcome 1, Items 17 & 18 from 2008 to 2014. (See above charts.) The results would indicate that ND Child Welfare Services continues to work very hard in meeting the Safety and Well-being Outcomes.

In regard to contextual conditions and community changes, at the time of the proposal, every region suffered devastating floods. All of the Human Service agencies and Child Welfare agencies had increased workloads and their own personal disaster experiences. Those communities have since rebuilt and the population has either recovered with the community or

relocated to other areas of the state. The western portion of the state has now been impacted by another significant change i.e. the Oil Boom of North Dakota. In the last three years, the discovery of oil in western North Dakota has impacted all human services and statewide infrastructure including: law enforcement, medical services, county social services, workforce shortages, inflationary cost, housing, food, transportation, schools, roads and highways.

While the discovery of oil has a significant positive effect on the prosperity of the state and some citizens, the Department of Human Services has been mandated to manage a hold-even budget for the last eight years. The population numbers of North Dakota as well as the counties served by this grant continue to increase as do the wages, inflationary costs of living expenses, and social problems such as the increase of drug addictions, sex trafficking, and other violent crimes associated with the oil boom.

Oil prosperity has touched the lives of some Native American families living on North Dakota Indian reservations, but there is no evidence yet that poverty rates are decreasing for Native American peoples. Poverty among the Native Americans served in this grant is evidenced by 85.7% of all families making less than \$20,000 per year, 62.3% fall under the \$10,000 income per year. According to the Department of Health and Human Services, for a family of four, below \$23,050 is the poverty guideline (<http://aspe.hhs.gov/poverty/12poverty.shtml>, 2012).

Another contextual condition facilitators observed was many of the Native American families felt isolated from their families and alienated from their tribal culture. This was an unsuspected finding, difficult to overcome, and possibly led to the decrease in extended family involvement in meetings. Other risk factors such as: 35.6% substance abuse, 50% child abuse/neglect, 24% adult law violations/incarcerations, 21.2% family discord, 15.1% joblessness/financial/housing made it difficult for families to address issues in a timely manner.

Across the state and especially in the regions served, we have experienced workforce challenges. Throughout the public and private sectors providing child welfare and social services, supervisory positions and direct line positions have been difficult to fill. This was especially evident in Ward County Social Services where we were unable to start the project for 1 ½ years after it began. Because of this contextual condition, facilitators have been continuously training the new county social workers regarding the importance of the FGDM/FTDM processes.

A final note concerning contextual conditions effecting North Dakota families, including our Native American families, can be found in the recent executive summary of North Dakota Behavioral Health Planning Final Report, July 22, 2014. This report finds the ND mental health and substance abuse system in a state of crisis and lays out a concise implementation plan to fix it. (www.TheSchulteTeam.com)

All of the contextual issues noted very likely contributed to the successes and challenges of this project, as well as the overrepresentation of Native American children in the state and county foster care system.

.D. Describe the population to be served. Differentiate between parents, children, families, and other service recipients as appropriate. Include other notable characteristics of the population, including cultural issues, as appropriate.

The intent of this project was to serve Native American youth (0-18 years of age) from the six counties previously identified in the report in the state and county foster care system. All counties signed MOUs with a commitment to refer Native American youth to the project. Our goal was to serve all Native American youth and their families with either FGDM or FTDM intervention. FGDM and FTDM are voluntary services offered to the families by service providers. Consequently, it is hard to determine if all children and their families were referred to

the interventions. It should be further clarified that the Native American families that chose not to participate in the project were still given the option of the intervention, just not included in the results of this research project.

Native American youth referred to this project were self-identified as Native American from different tribes across the United States. Youth from North Dakota tribes were affiliated with the Turtle Mountain Band of Chippewa, Three Affiliated Tribes, Standing Rock Sioux, Spirit Lake Sioux and Sisseton-Wahpeton Oyate.

It was difficult to ascertain how cultural influences within the family systems worked within the project. Some families clearly had strong ties with their tribal culture; some parents did not want ICWA workers notified or present; some parents refused to provide the names of relatives that could be invited to the FTDM/FGDM meeting. It is believed that family generational mistrust along with mistrust of governmental services and community services contributes to the sense of isolation and alienation so many Native American parents experience.

The families served typically were single-headed households living significantly below the poverty line. Employment, housing and transportation were significant needs expressed from parents. Homelessness, parental incarceration, father disengagement and substance abuse issues further compounded issues of participation.

These factors significantly impacted facilitators' ability to engage parents and family members. Even though stipends for transportation, phone conferencing, food/lodging were available to attend conferences, locating and ensuring the presence of family members continued to be problematic.

This being said, Native American parents and family members who participated showed incredible resilience and commitment to their children. Every Native American child had a

parent or family member present either by phone or face to face for FGDM/FTDM meeting. Given the poverty issues faced by Native American families and the short time frame of 72 hours for FTDM meetings, incredible efforts were made by family members to participate in a very difficult situation. Having children removed from home and placed in foster care is a crisis for any parent. FTDM continues to be an innovative practice that allows families and service providers to come together and discuss the safety issues, needs and resources available to the families.

III. Overview of the Program Model

A. Describe the project's goals. For each goal, describe the associated objectives or desired outcomes.

The intent of this project was the implementation of the Family Engagement for Native American Youth project in the five counties in North Dakota. The target population was Native American children, 0-18 years of age, who are at imminent risk of out-of-home placement or currently in out-of-home placement. The project goal was to serve 100 children annually with a focus on seeing that children are safely maintained in their homes whenever possible and families have enhanced capacity to provide for their children.

This was implemented with two interventions FTDM (immediate response) and FGDM (long term planning).

The logic model long term evaluation goals and outcomes include:

Goal #1 To generate new knowledge about the implementation and outcomes of FTDM/FGDM with Native American populations.

Objective 1: Measure and collect data associated with outcomes for the 100 Native American families who participate in FTDM/FGDM each year.

Results: This project served a total of 313 children in three years.

Goal #2 To determine the extent to which the proposed intervention is successful at decreasing disproportionality and/or increasing kinship placements in North Dakota.

Result: On the last day of the Federal Fiscal Year (September 30, 2013) 1,297 children remained in foster care (includes tribal IV E cases, DOCR-Division of Juvenile Services youth placed in foster care and pre-adoptive placements). 29.6% (n=384) of these children were Native American.

AFCARS data show the percentage of Native American children in the total annual foster care population as 27% in 2006, 26.5% in 2007, 24.7% in 2008, 25.4% in 2009, and on September 30, 2013 showed 29.6%. Based on this data, we were not successful in decreasing the disproportionality of Native American children in foster care.

Objective 1: The program will collect comparison group data about Native American children in non-intervention counties vs. 100 families served through FTDM/FGDM.

Result: Our evaluation model was changed in year one and comparison data was not collected.

Objective 2: Parents will identify their needs and strengths.

Objective 3: Parents will be provided a community resource list, assistance in making referrals to services to best meet their needs, and the means to engage in services.

Objective 4: Families/kinship will be invited to the FTDM/FGDM meeting and be active participants in plan development.

Results:

Our project successes include:

- At least one biological parent was present for every FGDM or FTDM. On average 1.86 parents participated in each meeting.

- The average number of family members participating in FGDM/FTDM was 3.82 and 2.59 respectively.
- Facilitators brought family members to the table for engaging kinship, community and support for the kids.
- Safety issues and family needs were addressed at every meeting.
- Family plans were developed utilizing resources necessary to meet family needs.
- Caseworkers and service providers were included in the meeting and the strengthening of the family plan.
- ICWA workers were invited to the FTDM/FGDM meeting when the child was an enrolled member or in the process of enrollment in their particular tribe.
- Family circles were widened to increase the number of family members participating.
- Native American families were offered a Native American community member to be an advocate and support during meetings.
- Other community resources of specialized services were included in meetings as it relates to the purpose or family needs. (Adoption, domestic violence, and addiction services.)
- Children's voices are at the table whenever possible.

Goal #3 To determine the extent to which children served by FTDM/FGDM experience reoccurrence of neglect or abuse.

Objective 1: The evaluator will analyze the link between the intervention and outcomes (time in care and rate of family placements).

Objective 2: Children will have no further child protection reports.

Objective 3: Cases with domestic violence will receive support and services and facilitators will follow established domestic violence protocol.

Objective 4: Safety and risk issues are facilitated and plans developed to address these concerns at each meeting.

Results: See evaluation report for Objective 1, 2, 3. All cases were screened for domestic violence issues. Protocols were followed concerning no contact orders, restraining orders, and individuals' sense of safety. We follow the protocols established in the Guidelines for Family Group Decision Making in Child Welfare, developed by American Humane Association in 2010 and the FGDM Guidelines Committee and In the Moment Strategies for Facilitators of Team Decision-making Meetings: When Domestic Violence is Present or Suspected, developed by the Annie E. Casey Foundation, May 2004.

Where safety issues were present, a safety plan was developed. In a majority of the cases a FTDM meeting follows the immediate placement of their children. A majority of the children stay in foster care until the ongoing the social worker does home study and background check of potential placement option(s) before placement occurs. Consequently, safety plans are not done in the cases where foster care is the only placement option because foster homes have already been studied and determined a safe environment. When the child or teenager returns home, safety plans are developed for both the child team and the parents.

Goal #4 To inform future family-centered child welfare practices.

Objective 1: Understand the basic costs and resources associated with FTDM/FGDM implementation.

Objective 2: Document program fidelity (adherence with the proposed intervention).

Objective 3: Document, understand and resolve implementation barriers.

Result: Please see evaluation report for these results.

B. Include a copy of the project's logic model.

See complete logic model in Appendix Attachment A – Logic Model

C. Describe the project's service model and evidence based practice

Family Group Conferencing models are family-driven processes that combine community support with family strengths to keep children well cared for and safe. North Dakota began using the New Zealand Family Group Decision Making (FGDM) model in 2006. We credit the American Humane Association for contributing a vast body of research studies in establishing this model as evidence based and culturally responsive. This model has four stages: 1.) referral to create the conference, 2.) planning, and engaging formal and informal supports 3.) conference/meeting including private family time and plan development and 4.) follow-up meetings.

In the Village's current FGDM model, family members have private time in which to talk about "family business" without the intrusion of outside providers. It is an empowerment strategy that assists families and children in speaking, being heard and in making decisions. This model is used for families whose children have already been removed or are struggling with either their own needs or the special needs of the child.

North Dakota began using the Family to Family Initiative: Family Team Decision Making model in June 2010. We credit The Annie E. Casey Foundation for this evidence based model that is also culturally responsive. Family Team Decision Making (FTDM) uses a Family Team Meeting and differs from FGDM in that it approaches child placement as a crisis and the meeting takes place as soon as possible and always within 72 hours of the child's immediate removal from the home. FTDM has similarities to FGDM, but it is a faster "call to action." FTDM also differs from FGDM in that it does not have private family time. Because an

immediate placement has occurred, a majority of children are in the care of the county social service system at the time of the FTDM meeting. North Dakota began using this process in 2010 in Cass, Burleigh and Morton Counties in an effort to front-load engagement services to families at the onset of child placement. This grant project expanded FTDM into Ward, Ramsey and Rolette Counties. The State further expanded FTDM in Grand Forks County in 2013 using State funds. This family engagement process is embraced by the counties who utilize the intervention. The Department of Human Services is actively pursuing funding for the implementation of FTDM statewide. This objective is evidence in the DHS IV-B Child Welfare Plan 2014-2019.

The FTDM phases include: 1.) Engagement of the family and formal and informal support systems, where the family's opinions are respectfully considered. 2.) A family/service provider meeting is held where the family's strengths, needs, child risks, safety issues and underlying factors that contributed to child placement are assessed. A thorough assessment is critical in identifying the underlying issues to be addressed so the child can return home safely. All meeting participants understand the family needs as well as the resources needed for the child to return home. 3.) Development of an Action Plan with the necessary action steps and timelines. 4.) Distribution of the plan to the ongoing child welfare worker/team members.

ii. If applicable, discuss modifications to the model that occurred over the course of program funding.

Fidelity checklists were developed and followed true to the fidelity measures of the FGDM and FTDM processes. A modification was made in the logic model presented in the proposal. The modification was facilitators did not complete the DHS family assessment tool: Family Assessment Instrument (FAI), a safety/strength/risk assessment. Child welfare workers complete the FAI tool. Safety/risk issues along with strengths were facilitated at all FTDM/FGDM meetings.

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

Many of the activities that were done during this project are ones that we may do with all of our clients, though we found that these activities had to be done with much more intensity due to the situations the Native American families were facing. We had to work much harder at finding and engaging fathers; working with jails and prisons on allowing the participation of parents in their child(ren)'s meeting, assigning family members to monitor the plan for accountability, stipends for participation (gas, food and hotel vouchers), and finding appropriate community representatives.

The facilitators had been previously trained in the finding and engaging of fathers for both family engagement strategies. When working with the Native American population, it was discovered that fathers were even more disengaged with their children. It was not uncommon for the father's location to be unknown to the case manager. Facilitators took an active role in searching out these fathers by calling on extended family members to find a way to contact the fathers. Once contacted, the facilitator had to find a way to bring the father back into a decision making role. Through webinars hosted by The Kempe Center, past publications by The American Humane Association, and other publications, facilitators have learned how to help fathers become an integral part of their child(ren)'s lives and help in making long term plans. This information was organized and posted on the online Facilitator Manual for future reference.

It was not uncommon for a parent or both parents to be incarcerated during the preparation phase and/or the family conference. Early on in the project this became a regular circumstance for the families we were working with. Barriers to having the parent(s) incarcerated are that it can be very difficult to get them to agree to be part of the research, complete the research materials, and participate in the conference. Communication between

facilitator and the incarcerated individual is difficult and limited. Facilitators built relationships with jail and prison staff and learned what language to use to get the best results. See Appendix Attachment B – Jails and Prisons

The family monitor is an informal support person assigned by the family during the conference. This person's duty is to ensure the family plan is being carried out by those who volunteered to do various tasks. Family members are more likely to be honest and have greater accountability to other family members. If there is concern the family plan is not being followed, the family monitor contacts the facilitator and a follow-up meeting is scheduled to address the concerns. See Appendix Attachment C – Family Monitor

Facilitators have worked hard to locate individuals who would be willing to fill the role of community representative. The role of community representatives is to attend a Family Decision Making meeting when the family requests their presence. They may represent specific cultures, religions, or areas of professional expertise (e.g. addiction or mental health). Their main role is to provide information and resources to the family. Specific tasks at the meeting will depend on the needs of the family and the Community Representative's area of expertise, but may include: providing information to the family on services, supports and activities in the community from their area of expertise that best fit the needs of the child(ren) and parent(s); advocating for the family to address their needs and support as it relates to the Community Representative's area of expertise; and/or help coordinating cultural and/or spiritual customs to be carried out at the meeting. See Appendix Attachment D – Community Representative

Unique to this project was engaging ICWA workers; engaging tribal healers; finding Native American representation on our focus teams; and both attending and presenting cultural

trainings (ICWA conference) to make our staff more culturally responsive to the community we are serving.

We found we became very reliant on the technology we use to connect with one another and the families for the conferencing process and assisting each other as facilitators. Our researcher developed a blog which contains explanations of all of the research forms, how to process the forms, and the scripts that would help facilitators explain the research component of this grant. The Village developed brochures, flyers, referral packets and data fact sheets to disseminate to families, service providers, ICWA staff, community representatives, schools and tribal workers. We developed job ads, including specific job ads to attract Native American applicants. We also developed interviewing strategies for job applicants.

Meetings are held in locations that are most comfortable and safe for the family and service providers. It is important for the participants to feel they are in a safe space to share difficult information and make plans for their children. Facilitators seek out various locations that will fit the needs of the family. Dependent on the family's needs, this location may need to be handicap accessible, have security staff close at hand, be large enough to accommodate the number of people attending, and/or a neutral place where no has 'home court advantage.'

A key activity was to train all facilitators, county social service supervisors and direct line staff in the FGDM and FTDM processes. In partnership with the Department of Human Services, trainers in FTDM were brought in from Washington State with the purpose of insuring fidelity to the FTDM model across the project counties. In addition to the initial FTDM training, a select number of Village facilitators were trained as trainers on the FTDM process so they would have the ability to train statewide social service staff on an ongoing basis. Village staff

was previously trained in FGDM. Facilitators train county social service staff and supervisors through either focus team meetings or county social service in-service trainings.

A major activity is the continuous training and partnership with all of the social service providers within our pilot counties and throughout North Dakota. FGDM is offered in all 52 counties in ND.

IV. Collaboration

A. Describe key partners critical to providing: a) referrals, b) program services, c) evaluation services, and d) other services and that have a collaboration mechanism such as a contract or MOU. If grantee organization is a private or non-project, include the public child welfare agency as applicable.

The partners in the three year Family Engagement for Native American Youth project for which MOUs were obtained The Village Family Service Center, the North Dakota Department of Human Services, Children and Family Services Division, the evaluation is being done by the University of North Dakota, Department of Social Work team, and the five county social service agencies.

The **ND Department of Human Services (DHS)** is the state governmental administrative agency that provides services that help vulnerable North Dakotans of all ages to maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional crises, disabling conditions, or an inability to protect themselves. The Department administers comprehensive human services and economic assistance on behalf of individuals and families in North Dakota. It is an umbrella agency headed by an executive director appointed by the Governor. Comprised of over 2,000 employees, the Department of Human Services has six major organizational components overseen by the DHS Cabinet: Medical Services; Economic Assistance; Program and Policy; Human Service Centers; Institutions; and Fiscal.

Delivering human services involves a partnership between the DHS, counties, tribes, and service providers. The Division of Children and Family Services (CFS) is a part of the Program and Policy component of the Department of Human Services.

The CFS Division administers the interstate compact on the placement of children (ICPC); intensive in-home services; early childhood services; child protection services (CPS); North Dakota Child Fatality Review Panel (NDCFRP); State Child Protection Team (SCPT); Wraparound services; foster care services; independent living services; special needs adoption services; subsidized guardianships; services to pregnant teens; parent aide services; prime time child care services; background checks; Safety/Permanency funds; the Children's Trust Fund (CTF); child abuse and neglect prevention; refugee resettlement services; and other children and family services. CFS includes twenty full and part-time staff at the Central Office- State Capitol in Bismarck, with some staff out-stationed in other locations in ND.

Melanie Sage, LICSW, PhD, Assistant Professor of Social Work at The University of North Dakota, is the Primary Investigator in the evaluation of this intervention plan. Dr. Sage is responsible for all aspects of evaluation and will coordinate with stakeholders in order to manage data security, create or identify appropriate evaluation instruments, collaborate with stakeholders at DHS, The Village, and with FTDM/FGDM participants to access appropriate data, secure any necessary IRB permissions and approvals, develop methodology plans and execute statistical analysis, attend quarterly evaluation meetings, supervise the work of a research assistant, and provide evaluation reports and project briefs.

Dr. Sage is a Tenure Track faculty member at UND. For the last four years, she has conducted research with University of North Dakota. She brings 9 years of child welfare

research experience. Her other experience derives in part from years of experience as a public child welfare social worker and trainer.

A Research Manager, Winonah Monette, manages data collection and entry, and supports analysis and report writing. She is an enrolled member of the Turtle Mountain Band of Chippewa. She works with the evaluator, Dr. Sage, at the University of North Dakota.

B. Note if key partner relationships: a) existed prior to the Family Connections grant, or b) were developed to respond to Family Connection grant activities. Indicate any partnerships that were dissolved over the course of grand funding and the reason why.

The Village Family Service Center has partnered with the State of North Dakota for more than 20 years to provide services to families with children at risk of placement outside the home through our intensive in-home services, including Family Group Decision Making and most recently, with Family Team Decision Making.

The Village has a strong history of working in partnership with DHS to implement grant-funded family conferencing meetings for families in the child welfare system. Following the CFSR in 2001, The Village and North Dakota DHS partnered to submit a grant to the Archibald Bush Foundation. This \$1.1 million grant proposal was funded and The Village used Family Group Decision Making as a specific intervention to address issues such as family involvement, building family connections for children at imminent risk of placement, and for those currently placed outside the home. The Bush funded FGDM model, implemented statewide in 2006, conformed to the guidelines found in the 2008 Fostering Connections legislation referencing meetings that *enable families to make decisions and develop plans that nurture children and protect them from abuse and neglect.*

The Village continues to partner with the Department of Human Service Administrators in the guidance and direction of the development of FGDM and FTDM. This is accomplished through quarterly conference calls, IV-B strategic planning process, CFSR stake holders meetings and two to three face to face meetings per year between Village Staff and DHS Administrators.

The Village routinely meets with County Directors, supervisors and social service staff to discuss the needs and services in each of their communities. See Appendix Attachment H – Informational Meetings

The research partnership between The Village and the UND Department of Social Work was a first endeavor. There was a previously established relationship between The Village and the UND Department of Social Work because The Village has provided both Bachelor and Graduate levels internships within the agency. In fact, the Village Fargo office is currently providing an internship for a UND Department of Social Work Graduate student in the FGDM/FTDM department.

C. Grantee may include, at their discretion, organizations they work with as a matter of daily operations but where a formal arrangement does not exist or is needed.

Our outreach to the Native American service providers in each of the local communities was extensive. Facilitators made regular visits to school social workers, school counselors, mentors, Native American Coalition in Fargo, Spirit Lake Suicide Prevention Committee, and hold referral breakfast meetings in Ramsey and Rolette Counties.

Facilitators specifically met with all of the Native American child welfare workers representing each of the ND tribes and gave them information on the two interventions.

Other agencies that participated in meetings and conferences include: mental health case managers, therapists, psychiatrists, PATH Family Support and Foster Care, Guardians ad litem, foster parents from each county, juvenile justice staff, Federation of Families, Human Service Center Regional Directors, County Social Service Supervisor, Parent Aides, Village Intensive In-home Therapists, Adults Adopting Special Kids Case Managers, and Youthworks (regional agency offering programming to adolescents and their families).

Organizations that we work with as a matter of daily operations mainly center on staff recruitment. Ads are often placed with Job Services of ND, with our state college career centers, local newspapers and the National Association of Social Workers.

Collaboration with domestic violence community agencies has strengthened The Village's family conferencing service model. The Village has included staff from various Rape and Abuse Crisis Centers, women's shelters, and victim advocacy services on its FGDM Focus Team to assist in developing service protocols to be used in domestic violence cases.

D. Describe any advisory groups or steering committees associated with the project, including group or committee participants. Indicate if this was an existing group repurposed to advise Family Connection-funded activities or a new group formed to provide input into the project.

In 2006, The Village established regional focus teams to create FGDM partnerships. The focus teams have strengthened statewide collaboration. The regional focus teams meet quarterly for 1 ½ to 2 hours to discuss program development and implementation, evaluate program effectiveness, and explore options for sustainability. Members of the focus teams include service providers, community members, parents/family members, and FGDM staff. Additional effort was made to approach and invite tribal members to join the focus teams.

The Board of Directors of The Village Family Service Center has a membership of 11-13 community members and meets a minimum of nine times per year. Members serve on various board committees including Program, Budget & Finance, and Human Resources. The responsibility of a board member is governance, consultancy, fundraising, leadership, and ambassador.

E. Describe how you collaborated with these participants in implementation and sustainability planning. Describe your lessons learned.

The Village's regional program supervisors and facilitators regularly meet with county social services, juvenile courts, tribal governments, and the North Dakota State Legislators to keep these relationships strong. Maintaining these vital community partnerships and relationships will help support the continuation of the great work done through the Family Engagement for Native American Youth project.

North Dakota is experiencing a population explosion. Currently, the state's modest approach to the funding of Child and Family Services is not keeping pace with growth. An interim legislative study conducted in 2014 regarding the delivery of human services noted that access, availability and work force were all significant issues. Sustainability under such restrictions will require agencies like ours to find creative ways to provide needed services while still being as fiscally responsible as possible.

V. Sustainability

A. Describe what portions of your program – program services as well as partnership activities – you plan to sustain. Describe how you will sustain them through resources, partnerships, etc.

The Village will continue to provide FGDM services to the entire state currently through our contract with Department of Human Services. Outreach will continue to be done in all of our regions to ensure we are serving all of the Native American youth that are in need of our service.

The partnerships we have built through this project have become strong and stable to ensure this will continue to happen.

The Village will continue to provide FTDM services to the piloted sites (Cass, Burleigh, Morton and Grand Forks) through state contract funding. The Department of Human Services is actively pursuing funding for the implementation of FTDM statewide. This objective is evidence in the DHS IV-B Child Welfare Plan 2014-2019.

Ultimately, the sustainability of the FGDM/FTDM interventions depends on a partnership effort among all of the agencies in this project to secure future funding. The next legislative session begins January 2015 and it is hoped that new monies will be appropriated for the continuation of FGDM and FTDM.

It is our further hope that new monies will be offered through The Children's Bureau for a new round of funding for 2015 and/or 2016.

We will continue to foster all of the relationships we have built throughout this process. This includes continuing to reach out to our Native American leaders for support in our work with their children.

B. Describe key products that were developed as part of the project or for replication purposes.

Village Employee Website

An online manual for family engagement programs was created to contain a comprehensive list of documents and resources needed by facilitators. While the main purpose of this manual is to provide all the appropriate paperwork and resources for facilitators to use for family conferences, there is also information on paperwork regarding the Family Connections grant, and a link to the FGDM Evaluation Blog where all the paperwork, resources, and other information is kept regarding the *Family Engagement for Native American Youth* project. Only Village facilitators

utilize this site, and the main objective is to streamline paperwork across the regions so all facilitators are using the same, most recent documents and have instant access to various resources and information regarding the programs and grant project. *Note: Dissemination contact for the manual is Sandi Zaleski, szaleski@thevillagefamily.org.*

FGDM Evaluation Blog

The Lead Evaluator for the Family Engagement for Native American Youth project created a blog to disseminate research paperwork, post relevant resources, and communicate project updates. All project facilitators and supervisors have access to this blog.

Please visit <http://fgdm.blogspot.com/> to view the updated blog. *Note: Dissemination contact for the blog is Melanie Sage, melanie.sage@email.und.edu.*

Other Dissemination Materials

See Appendix Attachment E – Other Dissemination Materials

- Melanie Sage’s Presentations and Articles
 - Presented at FGDM Conference 2014: “Fidelity and Findings”
 - Article Use of Web 2.0 to train facilitators in fidelity: A case study
 - Workshop presentation at SSWR, *Using Technology to Support Research Fidelity*
 - Presented at FGDM Conference 2012: “FGDM with Diverse Communities” & “The Proof is NOT Just in the Pudding: Tools for Measuring and Demonstrating the Effectiveness of an FGDM Program”
- Grantee Site Visit CBX Article written by Penny Putnam-Collins, “Technology Promotes Project Knowledge, Implementation”.

C. Cost Study findings included in the following Evaluation report.

VI. Evaluation (written by Lead Evaluator, Dr. Melanie Sage)

This evaluation reports on a Family Team Decision Making and Family Group Decision Making project, in which The Village Family Services Center held 146 family meetings in North Dakota between the years 2011-2014. All meetings were held on behalf of a child member who the family self-identified as American Indian. All families resided in one of six target counties in North Dakota, off of tribal reservation land. Families were primarily referred by the county child welfare system because they were at risk of, or currently involved in, out-of-home services. This report summarizes the data collected, including process and outcome findings, cost analysis, and lessons learned. Recommendations are offered regarding future research and services.

Intervention Description

The intervention utilized in this project consisted of two processes: Family Team Decision Making and Family Group Decision Making. Both processes follow protocol described by American Humane/Kempe Center (American Humane Association, 2010), including use of an outside meeting coordinator, meeting preparation, documenting family strengths and concerns, wide family involvement in planning, and utilization of the family's plan for child safety whenever it addresses safety needs.

Family Team Decision Meeting (FTDM)

This process is utilized when the child/ren is identified at risk of coming in to foster care or has come in to care in the last three business days. A referral is generated by the child welfare county agency, and a Village facilitator contacts the family to request a meeting. Family members are contacted using referral information and by eliciting additional contacts during phone calls to the family members listed on the initial referral. The caseworkers and other service providers involved in the family are invited to this meeting. The meeting is designed to

identify safety concerns and support the family in developing a family plan. These meetings do not regularly incorporate private family time.

Family Group Decision Meeting (FGDM)

This process is utilized when a child is involved in a system (most often child welfare) and is at a critical case point, including a placement change, return home, or has recently come in to care. This meeting may occur as a follow-up to the FTDM, or a direct referral from child welfare or another agency. The meeting has an extended preparation time which may last several weeks in order for the Village facilitator to engage an extended group of supports. Participants are recruited through telephone calls and letters, and include family members and service providers. These meetings include private family time so that the family can talk about and plan for child safety.

A. Methodology

The primary author of this report, an Assistant Professor at the Department of Social Work, University of North Dakota (UND), worked with The Village Family Service Center, the cross-site evaluation team at James Bell and Associates, the Children's Bureau, and North Dakota Department of Human Services to identify and develop a set of data collection instruments and research procedures, described below. This evaluation methodology was reviewed and determined exempt from approval each year by the University of North Dakota Institutional Review Board. It was additionally classified as exempt for review by the North Dakota Department of Human Services.

Data Management

De-identified data was stored in locked filing cabinets and password-protected computers at the University of North Dakota. Client ID numbers assigned by The Village and Department

of Human Services are used to identify cases. Data was entered in to SPSS, a statistical software package, by a project data manager employed by UND.

Process Evaluation

i. Evaluation Questions

Our primary process evaluation questions are as follows: (a) was the intervention carried out as planned? (b) what adjustments were made during the intervention process? (c) what were the strengths and challenges of this intervention?

Specifically, we sought benchmarks associated with the intervention delivery (Village Project Narrative, 2011, p 40): (1) serve 100 children per year across intervention sites, (2) conduct quarterly meetings with DHS child welfare workers in intervention sites, (3) serve 100% of Native American children who are taken in to protective custody with FTDM within 72 hours, (4) Serve 100% of Native American children each intervention year who are already in foster care through FGDM, (5) Document demographic information of FGDM participants, (6) Document culturally specific training for facilitators, and (7) document implementation issues that impact fidelity.

ii. Research Design

The evaluation of this project offered a mixed-methods quasi-experimental approach to answer questions about the process of, and fidelity to, the research design, as well as outcomes related to the FTDM/FGDM interventions. Quantitative data included surveys administered prior to the family meetings, surveys administered to meeting participants and facilitators at the end of each meeting, and 6-month outcome data reported by North Dakota Department of Human resources. Qualitative data included interviews with facilitators administered in the middle and

end of the grant project, feedback collected from meeting participants and facilitators on end-of-meeting forms, and stakeholder feedback offered through the life of the project. Fidelity research addressed conformity to the chosen model and agency collaboration, and also explored barriers to fidelity. Outcome research addressed post-meeting placement, rates or post-meeting child welfare contact, costs and savings associated with placements and meetings. Demographic information is reported, including family characteristics such as age and family size, meeting participant relationships, tribal affiliations, needs, depressive symptoms in caretakers, protective factors, and time in placement.

iii. Evaluation Participants

Meeting facilitators. Data was collected on an ongoing basis from meeting facilitators employed by the Village to carry out the intervention. This includes completion of a fidelity form at the end of each family meeting, as well as group and individual interviews.

Referring workers. Referring workers, typically county child welfare employees, provided referral forms as described in the instrumentation section below.

Meeting attendees. Data was collected from each meeting attendee, as described in the instrumentation section below. Data was primarily collected from primary caregivers, most typically mothers. However, all meeting participants, including service providers, were asked to complete a fidelity/satisfaction survey tool at the end of the meeting.

Prior to the grant application, and again at the beginning of the grant award in 2011, The Village Family Services program staff met with county directors and workers in each target county where the intervention would be offered in order to explain the program. County employees were asked to refer all families that involved a child who the family identifies as American Indian who is at risk of, or has entered, foster care, or who is facing a transition in

which a family meeting might be helpful. Similar outreach was provided in schools and juvenile justice systems in the target communities, as well as other child-serving agencies who work with families where children may be placed out of home, including youth homeless shelters. Village facilitators continued outreach and training with these agencies through the life of the grant to support ongoing referrals.

iv. Data Collection Procedures

Instruments used include normed instruments, instruments created exclusively for this project, and untested measures used in other projects, as described below. Unless otherwise indicated, one primary caregiver, typically a mother, is asked to provide the data for the forms. The data is primarily collected on-site by the Village facilitator either on a day before or the day of the family meeting. Forms are used at both the FTDM and FGDM meetings unless otherwise indicated. Paper forms that are collected by The Village are sent in hard or electronic copy directly to the project evaluator after identifying information is removed. No incentives were provided to participants.

Referral form. This form is created by The Village, and includes information about the reason for meeting, the concerns, and strengths. This form is filled out by the referring agency, and varies slightly for an FTDM vs FGDM meeting. See Appendix Attachment F

Intake/Closure form. This form is created by The Village to track demographic case information. See Appendix Attachment G

Assent/Consent form. The research for this project was explained to every meeting participant referred. Children are asked to fill out an assent form, and adults fill out a consent form. The parent form is modified for parental consent, and parents can provide follow-up contact information on the form. See Appendix Attachment H

Facilitator and observer fidelity forms. These 21-22 item forms (dependent on meeting type) were created by The Village and evaluator, and are a modified version of a survey (Rauktis, Bishop-Fitzpatrick, Jung, & Pennell, 2013) used to assess fidelity in other family team meeting research projects. The survey asks questions that align with the guidelines provided by American Humane (2010) for best practices in family meetings, and are filled out at the end of each meeting by the meeting facilitator or non-participant meeting observer (typically a trainee or supervisor). The surveys were modified to match language and procedures used by The Village for meetings. Answers are reported on a 4-point Likert-type scale from Strongly Agree to Strongly Disagree, and include statements such as, *I clearly explained the purpose of the meeting to all participants* and *I was able to prepare attendees adequately for the meeting*. Additional options include Unsure and Not Applicable. Four open-ended questions at the end ask for additional information about the meeting process, including the question, *what factors were barriers to making full fidelity possible?* While the original survey on which this survey is based supports a three-factor model of content validity, we can only claim face validity on the modified survey. The FTDM survey is slightly modified for relevant content from the FGDM version of the survey. See Appendix Attachment I

Satisfaction survey. This survey matches the facilitator fidelity form, but is framed as a satisfaction survey for meeting participants. Participants identify their role in the meeting, and report the extent to which the meeting accomplished specific tasks, such as family input, identification of strengths, and inclusion of family members (See Appendix Attachment J). The survey is anonymous and filled out immediately after the meeting. The FTDM survey is slightly modified for relevant content from the FGDM version of the survey. Answers are reported on a

4-point Likert-type scale from Strongly Agree to Strongly Disagree. Additional options include Unsure and Not Applicable. See Appendix Attachment J

PHQ-9. The Patient Health Questionnaire 9 is a nine-item inventory that screens for depression. This survey asks respondents whether they have been bothered by depressive symptoms in the last two weeks. An adult and adolescent version of this survey was self-administered to primary caretakers and adolescents who attended meetings at time of intake. The facilitators who collected these surveys referred families if scores were high and follow-up was indicated. The purpose of delivering this survey was to screen for mental health related needs in the sample population. This survey has strong reliability and validity for the screening of depression severity (Kroenke, Spitzer, & Williams, 2001). See Appendix Attachment K

Family Needs Scale. This 41-item Likert-type scale asks questions about needs for assistance. The primary caregiver self-administers this scale at intake, and scaled responses range from *almost never have this need* (1) to *almost always have this need* (5). *Does not apply to me* (0) is also an option. Items range from *have clean water to drink* to *find child care for my child in the future*. The reliability and validity of this measure has been assessed using a sample of pre-school children with disabilities in an early-intervention program (Shonkoff & Meisels, 2000). See Appendix Attachment L

Protective Factors (FRIENDS) Survey. This survey, self-administered by the primary caregiver at intake, includes 10 demographic questions related to marital status, education, household, and public services received (food stamps, Earned Income, etc.), as well as 20 questions related to family protective factors (*I have people who will listen when I need to talk, in my family we take time to listen to each other, I praise my child when he/she behaves well*). These questions are rated on 7-point Likert-type scales based on frequency of agreement. Some

questions are reverse-scaled. An exploratory factor analysis (n=249), tested across multiple sites with families involved in public services programs, revealed a 4-factor solution in the categories of family functioning, emotional support, concrete support, and nurturing/attachment. In the population used for testing of this scale, less than 1% of the group identified as Native American. The survey was found reliable and valid based on sample population data (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010). See Appendix Attachment M

Team Plan. This form, created and filled out by The Village facilitator, documents the plan created by the facilitator at the family meeting. It includes documentation of family strengths and needs, safety concerns, and other information recorded during the meeting. The meeting participants sign and receive copies of the plan. See Appendix Attachment N

Non-participation form. This form was created by the lead evaluator, and facilitator from The Village provides this documentation. If a family is referred to the research project and declines participation in the research, they are still able to engage in the family meeting but no other data is collected. In this case, the meeting facilitator identifies a brief reason for non-participation, which includes cases where the caregiver participated by phone or jail (and thus could not easily fill out self-administered research forms) or refused research participation for another reason. See Appendix Attachment O

Collaboration form. A one-time assessment was conducted half-way through the intervention to assess inter-agency collaboration. The form was developed by the evaluator, and drew from literature on collaboration. The form was completed by facilitators, who answered questions about the strength and value of existing community partnerships in meeting the goals of the family meetings. See Appendix Attachment P

Qualitative Interviews

Qualitative Interviews were conducted at two time points of this research. The first interview was with all program facilitators after the first year of data was analyzed. The interview was conducted via live online chat. Facilitators were asked to respond to the data information, and asked whether they thought any changes needed to be made to the intervention.

The second qualitative interviews were one-on-one and in person with all but one facilitator, who was unavailable, and conducted at the end of the study. These interviews were recorded and coded by the primary investigator and the project data manager, and the interviews consisted of the following seven questions: (1) What is going well, (2) What can be improved, (3) Describe a successful meeting, (4) describe an unsuccessful meeting, (5) describe the characteristics of a perfect meeting, if any resources were available, (6) what data might the research evaluation neglect, and (7) what are the challenges of conducting family team meetings with American Indian families compared to other families?

North Dakota Department of Human Services Data

The Department of Human Services provided data related to the children who were the primary foci of family team meetings. The data they provided included information about occurrences that happened in the window from six months before to six months after an initial family team meeting. The data included (a) financial information related to the cost of placement, (b) the number of child welfare referrals and their outcomes, (c) the status of child welfare involvement and placement category of the child/ren.

B. Process Evaluation Results

This data reports on families served through family meetings facilitated by The Village Family Services Center from September 30, 2011, through September 30, 2014. Previous semi-

annual reports submitted to the Children's Bureau provide more detailed analysis of the number of families seen in each year of the research.

i. Participant Demographics

This project researched 127 unique families through 146 meetings, including 249 minor children who lived in the households of these families, and 152 parents or legal caregivers who participated in-person at the meetings. All families indicated that at least one child member of the household was American Indian.

Adult-level participant demographics. This data reports on the caregivers who are referred to the meeting, as reported by the referring county worker, as well as self-report data that the caregiver provides during intake at The Village. In sum, 226 parents were referred or invited to the meetings. The average referred parent age was 32 years old, with an age range of 14-61 years old, as reported by the referring worker. The marital status and education reports come from the FRIENDS survey, and reflect data from only the respondents (one per household) who complete the questionnaire. These reports indicate that of the 133 parents reporting, 20 of respondents were married, 60 were single, 18 divorced, 17 separated, and 3 widowed. Of 133 respondents reporting highest education level, 13 report having completed trade/vocational school, 1 participant reported an advanced degree, 2 a 4-year degree, 14 a two-year degree, 32 reported some college, 43 high school/GED, 30 finished some high school, and 2 reported elementary or junior high.

Substance abuse, domestic violence and legal system. The referring workers can choose two primary reasons for referral. They are asked if domestic violence or substance abuse is a primary reason for referral. Of 146 referrals, 13 report domestic violence as a top-two reason for

referral, and 52 report substance abuse as a top-two reason. Of these referrals, 19 indicated that legal system involvement is a reason for the referral.

Housing. Housing status is reported by the primary caregiver on the FRIENDS survey. Of 133 primary caregivers, most were renters (n=63); 17 report they were home owners, 23 resided in a temporary or shelter situation, 13 lived with relatives, and 15 were homeless.

Child-level demographics. This data reports on children for whom the meeting is being conducted. In some cases, other children live in the home- they are not noted here. There are 249 children who were referred as primary children for whom the meeting would be held. The mean and median age of the child was 9 years old, and they ranged from 0-17. There were 298 children who lived in these households, although 49 of those were not involved in the reason for referral.

The child-level data was complex to assess due to variance in numbers based on data sources. This variance impacts reporting significantly and causes disparate reporting on some measures. The referral workers reported the number of children involved in a case (n=313), and The Village started a family file with a primary child identified for each case. There were 146 cases, but only 127 families served (some served through follow-up meetings), thus there were 126 unique primary children. DHS provided follow-up data on children who were involved in the cases of families (n=192 children, in 108 families), however we did not receive DHS data for children seen in the last six months of the grant because there was not time to report 6-month outcomes for these families. Therefore, throughout this report, we report the n of the group we refer to and the n of the pool in which the data is being reported from, and these numbers may change across variables reported.

Ethnicity. We did not inquire about race/ethnicity except for tribal affiliation. Most children involved in the families were from Turtle Mountain (n=57), followed by Spirit Lake (n=56) and Mandan, Hidatsa, Arikara (MHA Nation) (n=40). Other tribes represented include Sisseton-Wahpeton. Some of the families self-identified the children but the children were not enrolled (n=12). On The Village intake form, ethnicity data is reported for 282 children, and 270 are reported as tribally-affiliated (American-Indian by self-report, not necessarily enrolled).

Placement. At the time of the meeting, placement data was captured for 143 families. Of those, 60 were in foster care, 30 in shelter care, 28 remained home, 14 were in relative placement, and 5 were in residential care. Referring workers were asked to indicate the risk of placement. They reported risk for 129 meetings. Of those, 65 reported imminent risk, 26 reported high risk, 9 reported moderate risk, and 1 reported low risk of placement.

Previous child welfare. Of 146 cases, 94 (64%) had prior child welfare history.

Child demographics leading to referral. Of 146 cases, referral related to child mental health was reported 16 times, related to child or parent disability was reported 8 times, and child delinquency was reported 35 times.

Comparison group. We were not able to access useful comparison-group data during the course of this research. Our originally-proposed comparison group was to include children in the same counties from years prior to our research. However, because the SACWIS system that stores client information was changed at the onset of our project, the prior years' data was unavailable.

ii. Types of services. Types of services provided include Family Team Decision Meetings (FTDM) (n=98), Family Group Decision Meetings (FGDM) (n=31), or FTDM Follow-up Meetings (n= 15) or FGDM Follow-up Meetings (n= 2), for a total of 146 meetings. The

facilitator attempts to develop a case plan for each meeting, and successfully developed a case plan for 146 meetings; a parent signed all but one of the plans.

Twenty-one families did not consent to participate in the study. Seven chose not to for undisclosed reasons, 6 were incarcerated, 1 participated by phone, and 7 chose the *other* reasons including that they cannot be located, miscommunication between incoming and outgoing facilitators, one of the parents did not consent, one did not attend the meeting, and three indicated that the research did not pertain to them.

v. **Document any major changes to the plan/design.** At the outset of this investigation, we had hoped for a comparison group design. We encountered two obstacles: one, the SACWIS (“FRAME”) system was newly implemented about the same time we began this project; thus, historical data from previous years was not accessible. This prevented a historical comparison group. We considered a non-participant group sample as a comparison group; however, we were only allowed FRAME data for research participants who consented in writing to allow use of the data. Thus; only the intervention group data was available.

We also proposed follow-up phone-calls with participants. We were able to connect with almost no participants for follow-up, and eventually gave up these efforts half-way through the evaluation because it was not a fruitful use of time.

vi. **Training with program staff to help understand role of evaluation:** The meeting from the facilitators were quite engaged in evaluation, especially at the onset. There were a number of research-specific forms to use. To support the accurate reporting on the forms, a blog was developed with training videos for each form. The videos identified the research questions that are answered with each form. They also helped develop a FAQ to support fidelity and protocols, which was posted at the blog. The research blog became the repository for all forms, so

facilitators visited it frequently in order to prepare for meetings. Research-related accomplishments, local resources, and evidence-based practice articles were also posted at the blog.

We also used check-in phone calls. Meeting facilitators attended a first-year summary after the first year of data collection, followed by a focus-group. Some attended the FGDM Conferences over the course of the grant, where they received additional content about research and outcomes for FGDM meetings.

B. Process Evaluation Results

Our key process-related questions are as follows:

1. Was the intervention carried out as planned?

We assessed this question through the use of a fidelity questionnaire completed by all participants, as well as through achievement of the program goals listed below.

Our fidelity instrument asked participants to answer questions about the key elements of the meetings using a Likert scale, scored from strongly disagree (1) to strongly agree (4). Facilitators and all meeting participants reported very high scores on all items on the scale, with an average score of 3.6. There was little variance between scores, and no statistical variance between subscales or meeting types (FGDM vs FTDM) which we interpret as failure to measure individual constructs within the measurement. Instead, we believe the scores indicate a general satisfaction with the meeting process. The Village appreciated the indicator of general satisfaction, and the facilitators report that the checklist serves as a process reminder about goals related to the meeting.

After speaking to the author of the measure, we believe that several concerns exist about the use of this measure, especially immediately after a family meeting, to assess fidelity. The original survey design (Pennell, personal communication) was given via phone follow-up several weeks after the meeting.

One component of fidelity was the use of a blog to house updated forms and protocol FAQs. An article that presents a case study of this process is available in at Sage, M. (2014). Use of Web 2.0 to Train Facilitators in Fidelity: A Case Study. *Journal of Technology in Human Services*, 32(1-2), 108-118.

Barriers to fidelity. Each meeting facilitator was asked to report on barriers to fidelity at any given meeting. Twenty-three facilitators reported barriers for a total of 16% of the meetings conducted. A simple content analysis of the qualitative data revealed that missing parents (due to incarceration or inability to contact) were mentioned in a quarter of the responses. Almost all barriers were related to family participation in the meetings- either inability to contact, bad phone numbers, lack of involvement, and lack of availability. Other barriers mentioned multiple times include lack of buy-in by child welfare staff, lack of cultural information about the family, high levels of conflict, and difficulty with telephone connection during phone-based participation.

Program goal achievement is reported as follows:

- (a) *Serve 100 children per year across intervention sites.* Referrals were generated on behalf of 313 children. This goal was met.
- (b) *Conduct quarterly meetings with DHS child welfare workers in intervention sites.* This indirect assessment was reported by the Village, and is reported in their section of the report. They report that quarterly meetings were conducted with the counties.

- (c) *Serve 100% of Native American children who are taken in to protective custody with FTDM within 72 hours.* Although attempts were made to document referral rates, the counties did not release demographic statistics related to removals. They did report that they were referring all eligible participants.
- (d) *Serve 100% of Native American children each intervention year who are already in foster care through FGDM.* We were unable to get reporting from counties about the status of Native American children in care. However, based on Kids Count data, it is likely that we fell quite short of this goal. (Because iv-e funding covers some children who are in tribal social services care and therefore not eligible for this grant, and data is reported by iv-e eligibility, it is difficult to know how many children are in state custody in families.) Few FGDM meetings served children, and when they did, they were sometimes families who had been seen previously for FTDMs. We served few families at critical case-points who were in ongoing placement.
- (e) *Document demographic information of FGDM participants.* Demographic information was documented throughout the life of this research, although some documentation irregularities are problematic. For instance, since we asked only one caregiver to complete some of the documentation that captured demographics, we have adult-level demographic data related to only one person per meeting for most cases. Similarly, we captured child information for all children in household early in the case, and later decided that it was more prudent to collect data only for children for whom the case was being held. One child was identified as the “target” child for each referral. There are differing levels of data for each of these categories of participants.

(f) *Document culturally specific training for facilitators.* Culturally-specific training was documented, and all meeting facilitators participated annually in trainings that addressed culture, including the state ICWA conference and small group training. Although this training was provided, we recognize that responding to cultural issues is a difficult task, even for experienced facilitators. Even in the last year of the project, facilitators reported some difficulty in engaging families in conversations about culture. They also acknowledged a wide span in cultural identification, necessitating different approaches depending on the family. Given that only one facilitator herself identified as American Indian, an attempt was made to incorporate cultural consultants for some meetings, and to reach out to Native American agencies in the community. These efforts met with mixed success.

Facilitators were asked to document steps toward cultural engagement. They reported the following activities and meetings.

- Meeting with Native American cultural representatives and asking their input on how to best work with families (be open, patient, honest, don't talk too fast, genuine, accepting, use humor).
- City of Fargo Cultural Planner (Three Affiliated Tribes)
- Fargo/West Fargo Public Schools Indian Education Liaisons (Turtle Mountain)
- Legal Aide/Domestic Violence Advocate (Three Affiliated Tribes)
- Sacred Spirits Domestic Violence Coalition (White Earth Ojibwe Nation)
- Trainer, Activist, and Advocate (Three Affiliated Tribes)
- Attending monthly Native American Coalition meetings.

- Occasionally attend monthly City of Fargo Native American Commission meetings.
- Attended Annual Indian Child Welfare Conference in Mandan, ND.
- Attended Historical Trauma Conference put on by Sacred Spirits at White Earth Community College in Mahnomon, MN.
- Personal research (e.g. articles, books, videos) on Native American history and culture, historical/intergenerational trauma, Indian Child Welfare Act, working with Native American youth and families, urban Native Americans, national and local Native American resources, and Family Group Decision Making with Native American and other cultures.
- Reading “Working in Indian Country” by Larry D. Keown.

(g) *Document implementation issues that impact fidelity.* Several efforts were made to document implantation and fidelity issues. Besides the quantitative fidelity measure, we held group and individual meetings with meeting facilitators. Facilitators consistently reported the most significant challenge as connecting with family members. Since the value of this intervention relies heavily upon family-member participation, fidelity to the model is significantly impacted by poor family participation.

Facilitator In-Person Qualitative Interviews

In-person interviews were conducted with six facilitators who serve in five of the seven target counties. They were asked 7 open-ended questions with follow-up prompting when appropriate. The interviews were recorded, and content analysis conducted. The questions and responses follow.

1. **What is going well?** Half of the facilitators indicated that the role of neutral facilitator, separate from social services, makes clients more trusting and receptive of participation.

Two of the facilitators responded that they think the structure of the meeting is easy to manage, and procedures are followed. 4 out of 6 facilitators indicated that the strengths-based approach offering families private family time to make decisions, and allowing for self-determination is a positive attribute of the model with working with American Indian families. One of the facilitators, who works in close proximity to a reservation, works in close collaboration with the tribal ICWA worker and said this relationship fosters a better relationship between all participants. Another participant found that the meetings help address conflict and help families reconnect.

2. **What can be improved?** Five of 6 facilitators expressed a desire to have a more collaborative relationship with referral workers to increase efficacy of the model. Relational concerns impacted their work due to incomplete referral paperwork, lack of communication with workers, and workers sometimes not attending meetings.

Most of the facilitators indicated that locating family members and keeping in touch with participants was a barrier. They each expressed the challenge of the American Indian population served by this grant having inconsistent phone numbers and non-permanent addresses. Facilitators expressed non-fruitful attempts at working with tribal ICWA workers to obtain information about relatives. All of the facilitators indicated trouble with correspondence from ICWA workers, but two of the facilitators had a great working relationship with the ICWA worker from the tribe in nearest proximity to the county they work in. When prompted about what is helpful in addressing the problem of maintaining contact with families, several facilitators said they would find a family member who knew everyone and try to engage that person.

Half of the facilitators indicate that there is too much paperwork attached to the grant work, especially up front, making it time consuming.

Three facilitators indicated that developing open communication is a barrier common with the population served. One facilitator explains that there is a lot of guilt and shame for the family due to child welfare intervention, and relationships may have previously been strained making communication a challenge. Three of six facilitators listed the following as barriers: parents who are not stabilized or are under the influence at the meeting, the need for better/ more timely follow up meetings/follow up for all meeting types, getting families to a meeting prior to the need for a shelter care hearing, and father involvement.

- 3. What are indicators of a good meeting?** Facilitators were asked to think about a good meeting they had previously and describe what made it a good meeting. Again, family involvement was mentioned by almost every facilitator. Most facilitators reported that the use of a follow-up meeting led to success. They also mentioned outcomes such as keeping families out of the system, with their family, and witnessing positive change. Two of six indicated open communication and good facilitation made a meeting successful. Other responses included using the strengths-based approach, establishing and following ground rules, fidelity to the model, having good rapport with the referral source, and father involvement.
- 4. What are indicators of an unsuccessful meeting?** The facilitators were asked to think about a meeting that they had that was not so ideal, and describe why it was not ideal. Half of the facilitators interviewed indicated that they could not locate any family members. Facilitators also named family conflict, parents were unhappy with the

outcome of the meeting, or the family seemed to have unclear expectations. Other reasons for a less than desirable meeting were county workers viewing meetings as formalities and already having a predetermined plan, referral issues, parents needed to be detoxed first, and family members with lower levels of functioning.

- 5. What would create the context for an ideal meeting?** Four of six facilitators described initial prep, scheduling, planning, and working with partners would be more efficient. A third of the facilitators named increased training county referral workers, more family involvement than service provider involvement, and having follow up meetings for both meeting types. One facilitator said a solid, achievable and measurable plan would provide context for a great meeting.
- 6. What context cannot be observed from a researcher perspective, or was not documented in the research process?** The facilitators were asked what researchers miss by not being at the actual meetings, or witnessing the entire process from start to finish. Five of six participants said the researchers do not witness the difficulty in connecting with family participants. Half said the researchers miss out on conflicts and emotions present at the meetings. Other topics mentioned were difficulty in picking a date that works for a large number of participants, the structure of the meetings, and relationships with the referral workers and the tribal workers.
- 7. What is unique about FGDM/FTDM when working with American Indian families?** Half of the facilitators indicated that they sense deep mistrust from families in working with this population. Most indicated that it was more difficult to contact family members and get them to the meetings in this population. A third of facilitators reported that they were uncomfortable with or unskilled at addressing cultural contexts with the families.

Other answers were related to lack of supports (financial, emotional) for these families, and lack of connection to tribal supports for urban American Indians.

A summary of fidelity findings and recommendations are below:

- **Strengthen facilitator/county provider relationships.** Options might include co-housing, joint training, or appointing liaisons. This would support the referral process, help with demographic identification, and support case-plan focused outcomes.
- **Reduce and streamline paperwork.** Research data is important at assessing outcomes. The long fidelity form resulted in limited outcome data. By identifying key indicators of fidelity and other demographics, the paperwork burden can be reduced for clients, facilitators, and referral workers. The SACWIS data is difficult to access and navigate and match to forms created by outside agencies. Ideally, streamlined paperwork is created in collaboration with representatives of all agencies, and addresses specific outcome questions.
- **Increase family outreach.** As the top barrier to fidelity, family participation must be increased to achieve desired outcomes. Models such as Family Finding programs may be helpful in this. It may also be beneficial to extend time to the meeting (more than 72 hours) for FTDM if it might increase family participation to do so.
- **Hold routine follow-up meetings.** Most facilitators report increased success when families participated in follow-up meetings. This would also address other concerns, such as attention to the plan, and allow another opportunity to recruit family members. Outcomes (reported later in this report) indicate that the plan is

often not followed as agreed at the initial meeting. A follow-up meeting provides opportunities to make plan adjustments if the situation has changed.

- **Hold meetings before removal.** Reported barriers include that the agency has already made a decision about placement. Most referred cases involved children already in foster care. It is more difficult to plan for return when children have already been removed. Proactive planning suggests that a family should be referred for a meeting as soon as there is a moderate to high risk that an assessment may lead in removal.
- **Continue training in cultural engagement.** When families perceive barriers to working with an agency due to historical experiences, it is harder to engage the family. Facilitators report lack of comfort in cultural engagement. Concrete tools may include a measure of cultural identification, list of cultural supports, and increased general education on evidence-based practices for working across cultures. Cultural engagement includes engagement with ICWA workers and tribal communities. True partnership in these communities must move beyond “stakeholder” status, but provide financial or other incentives to honor the time it takes from tribal community leaders to participate in planning, meetings, or trainings, given that resources are already very limited and cases are very high on the reservation.

C. Outcome Evaluation Results

For the purposes of outcome evaluation, we explored the following questions. The associated outcomes are described below.

- To what extent does participation in FTDM/FGDM affect where children are placed?

- To what extent does participation in FTDM/FGDM affect future substantiated child welfare reports for Native American children?
- What are the costs associated with implementing FTDM/FGDM?
- What do Native American families identify as their greatest needs?
- To what extent are Native American families with children in foster care impacted by depression? Does this change six months after the family meeting?
- Do protective factors influence children's ability to return home?

a) Safety.

We received data for 99 families related to risks in the 6-months prior and 6-months after the first family meeting. We analyzed the maltreatment type reported in assessment outcomes. In the six months prior to the meetings, over 104 incidences of maltreatment were reported regarding 77 families, primarily due to neglect (n=50), followed by inadequate supervision (n=25). Of these assessments, 46 resulted in a "services required" disposition.

In the six months after the meeting, much fewer incidents of maltreatment were reported (n=43) for about 27 families, with neglect (n=15) most common. Only ten of these referrals resulted in a "services required" disposition.

However, there was a high rate of foster care placement in the six months following the meeting; this would certainly impact the rate of re-abuse. (See table on page 55).

In 73 of cases, child abuse/neglect was the primary risk factor for the family meeting. Fifty-two of cases were related to substance abuse. However, 31 of 146 cases were related to parent/child discord and 35 cases were related to juvenile status offenses (these categories may overlap). While these referral reasons may indicate risk to safety, they may also demonstrate the

need for more prevention and alternative response options. All risk factors are reported in Period 6.

Based on the intake-closure report completed by facilitators, a child protection report was filed during the course of services for 74 of 144 families for whom meetings were held. This data may misrepresent actual CPS reports filed during FGDM/FTDM service. Facilitators may have checked this box “yes” if receiving the referral from a child protection worker for the initiation of an FTDM meeting.

Data is available regarding post-meeting child welfare outcomes for 29 of the 32 families in which there was no open placement episode 6 months after the initial family meeting. Of those children, there were no post-meeting child welfare services for 20 of the 29 (69%), and there was 1 services required referral for 7 families; 2 referrals for 2 families.

b) Permanency and continuity.

Of the 110 families for whom placement follow-up data was provided, 6 months after the first meeting, (59) 54% of involved children resided in foster or institutional care, (16) 15% in relative care, and 35 (32%) were not in placement. At the time of initial meetings, 66% of children were in foster care, 10% with relatives, and 19% at home.

Although there were changes in the living situation of children throughout the life of the case, the meeting did not instigate a plan to return home many cases. Follow-up data that reports high foster care rates and lower relative placement rates than planned may be, in part, because relatives have become certified as foster parents for payment. SACWIS data does not differentiate between relative and foster care provider for paid placements.

	With parents/ no placement	With relatives	Foster care or institutional care	Other
Time of meeting (n= 143)	28 (19%)	14 (10%)	95 (66%)	6
Plan after meeting (n=143)	42 (29%)	41 (29%)	49 (34%)	7
Actual placement 6-months post meeting (n=110)	35 (32%)	16 (15%)	59 (54%)	0

Family permanency is affected by a number of factors, including parental incarceration. Of 142 families reporting, 55 of the families had experienced the incarceration of one parent, and 53 had experienced the incarceration of both parents. Forty-seven of the children had a parent in jail, and 4 had both parents in jail, at the time of the family meeting.

c) Well-being.

The families served by this intervention experienced high levels of child delinquency and parent/child conflict, high levels of poverty, and significant struggles with housing. A third of the families were experiencing problems related to substance abuse. They reported few problems with mental health.

One measure of well-being included a depression inventory of caregivers. Although we expect under-reporting due to the circumstances of the meeting, most parents did not indicate responses that are associated with clinical depression. The Family Needs Scale demonstrated a high need for financial resources; a third of families report need for support in paying the bills, and 12% of respondents needed help with housing. The full scores for the family needs inventory are reported in the Period 6 report.

PHQ-9 Depression inventory means (n=120)	
Scoring: 0: no symptoms; 1: Several days; 2: More than half the days; 3: Nearly every day	
I have been bothered with little interest or pleasure in doing things	.86
Over the last 2 weeks I have been bothered with feeling down depressed or hopeless	.98
Over the last 2 weeks I have been bothered with trouble falling or staying asleep or sleeping too much	1.23
Over the last 2 weeks I have been bothered with feeling tired or having little energy	1.11
I have been bothered with poor appetite or overeating	.86
Over the last 2 weeks I have been bothered with feeling bad about myself-or that I am a failure or have to let myself or my family down	1.45
Over the last 2 weeks I have been bothered with trouble concentrating on things such as reading the newspaper or watching television	.83
Over the last 2 weeks I have been bothered with moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	.60
Over the last 2 weeks I have been bothered with thoughts that I would be better off dead or of hurting myself in some way	.15
Tool Average	.90

As part of the FRIENDS survey, the primary caretaker was asked to report on the public benefits they access. There were 131 participants who completed this questionnaire. For food stamps and Medicaid, 86 reported yes, 44 no; for earned income credit, 110 reported yes and 15 no; for TANF, 16 reported yes and 109 no.

The FRIENDS survey also provided data on protective factors. The four subscales were scored, as identified in the measurement section. The means of those subscales were very similar, which may indicate a measurement error (such as respondents answering based on social desirability), although reverse-scored items lean to the expected side of the scales. Although this tool is often used as a pre-post test measurement, we were only able to assess scores at one data point prior to the family meeting. The subscale scores from our sample are below, and compared to pre-test scores presented in the manual. The test population had slightly better housing stability, slightly higher mean incomes, and represented different diversity in terms of ethnicity and region. As evidenced in the data, our sample had similar levels of attachment but lower

scores on social and concrete support. The means of each item on the FRIENDS survey are reported in the Period 6 report.

FRIENDS Protective Factors Scaled Data	Manual Pre-test Sample	Our sample
Family Functioning	4.8	4.7
Social Support	5.7	5.01
Concrete Support	5.5	4.48
Nurturing and Attachment	5.9	5.91

Safety plans were developed in every family meeting. The plan was reported as not accepted by the referral provider in only one case. Services in the case plans included referrals to formal services in 88% of the cases, and informal services in 52% of the cases.

Another way to assess family well-being is the number of family members who are able to participate in the family meetings. In our sample, family participation was low overall. Thirty-six percent of participants had no family members at attendance at the meeting. Twenty percent had only one family member participate, and 17% had two family members.

Number of maternal or paternal relatives at meeting
(n=141)

No family members	51 (35%)
1 family member	30 (20%)
2 family members	25 (17%)
3 family members	14 (10%)
4 family members	9 (6%)
5 or more	12 (12%)

We split this group and assessed outcomes for families in which at least one family member attended the meeting. We could not split this data by whether children were placed with relative, because DHS reports indicate foster care placement if the relative became licensed in the course of getting the children.

Primary referred child (n=101)	Placed with parents	Placed with relatives or in foster care	total
No relatives at meeting	12	25	37
At least one relative at meeting	23	41	64
Total	35	66	101

An odds ratio was calculated on this data. A child for whom there is at least one family member at the meeting is 1.17 more likely to be placed with parents 6 months after the meeting. This is not a statistically significant difference when calculated with a .95 confidence interval (p=.71).

D. Fidelity results (Please see section B, where we included these results.)

E. Cost Study

This basic cost analysis relies on figures provided by the line item budget and calculations of average time per meeting. This is based two periods in the middle of our grant (periods 4 and 5). We did not calculate these figures based on all grant years because the ramp-up and ramp-down years are less likely to represent actual costs.

Facilitator meeting time is broken down by type of meeting: either FTDM (which happens typically within 72 hours of referral, and takes less prep time) or FGDM (which takes more time, both for prep and meeting); see meeting descriptions earlier in this document for more information.

The chart below offers a twelve-month snapshot of program costs which are funded by the current grant. We have removed the contract labor, which includes research and evaluation costs, as well as travel for training, which includes the project trips to DC.

Village Annual Grant Program Budget

Personnel	\$278,969
Benefits	47,340
Supplies	1,783
Telephone	1,512
Occupancy	12,997
Equip./Repairs	3,769
Prtg./Publ./Dues	600
Travel/Sub. - Prog. Rel.	3,702
Client Asst. Events	20
Advertising	24
Administrative Chg.	40,684
Insurance Expense	4,109
Total:	\$395,509

Steps to arrive at cost per meeting

1. First, we took the total cost, \$395,509 for an average year.
2. Next, we calculated the total amount of project hours per meeting over two periods, comprising one year. The hours focus on facilitator time only. Facilitator hours are broken down in to prep time, conference time, private time, report time, post conference time, travel.

Periods 4 and 5 Meeting Time Data			
Time Spent	FGDM	FTDM	Combined
	Average time	Average time	Average
Prep	10.97	3.71	5.18
Conference	2.34	2.73	.89
Private	.36	.00	.25
Report	1.46	.08	.72
Post	2.36	2.08	1.55
Travel	1.07	.29	1.31
TOTAL	21.56	8.89	9.9
Periods 4 and 5 Total Time			
	FGDM (n=14)	FTDM (n=50)	Combined (64)
	Total time	Total time	
Prep	153.65	185.5	339.15
Conference	32.75	136.25	169.
Private	4.98	0	4.98
Report	20.5	4	24.5
Post	33.	103.75	136.75
Travel	15.	14.5	29.50
TOTAL	259.88	489.00	748.88
HOURS			
Total Village Budget divided by hours of services	395,509/748.88		\$528.13 per hour

FOR BOTH MEETINGS TYPES, AVERAGE IS 9.99 HOURS/MEETING

3. Then we divided the total project hours for one year by the total budget for one year, for a service rate of \$528.13 per service hour.

4. Next, we multiplied the average hours per meeting by the hourly service rate:

FTDM: 8.89 hours per meeting x \$748.88/hr = \$4,689.07 per meeting on average

FGDM: 21.56 hours per meeting x \$748.88/hr= \$11,386.48 per meeting on average

Overall, in periods four and five combined, FTDM meetings (n=50) comprise about \$235,000 and FGDM (n=14) comprise \$160,000 of the annual budget.

Because this calculation includes support for infrastructure (rent, supplies, etc.), we wanted to run it again with only facilitator personnel and benefits expenses. Using the other variables noted above, this results in an hourly cost of \$435.73, and an average cost of \$3873 per FTDM meeting or \$9394 per FGDM meeting.

Personnel only costs	
Personnel	\$278,969
Benefits	47,340
TOTAL	\$326,309

$$326,309/748.88 = \$435.73 \text{ per hour}$$

Cost of care:

Children (n=101) spent, on average, 135 days in care in the 6 months after their family meetings. A total of 101 children spent a total of 13,635 days in foster care in the six months after their family meetings. The cost of foster care for children referred in a twelve-month period (6 months before and after the family meeting) averaged \$13,701 per family for 97 families, and a total of \$1,261,000.

Per family cost of meetings (all-inclusive)	Per family 6-month cost of care for children who remained in care (direct payments to foster provider)
FTDM: \$4,689	\$13,701
FGDM: \$11,386	

Although we were not able to demonstrate that the meetings prevented child placement, the cost of a meeting compared to the cost of time in placement for only six months demonstrates that meetings are much less expensive than foster care. Many children stay in foster care for

years, especially in a high-risk sample such as this. The cost-of-care figures do not include tertiary expenses such as the costs of social service personnel and infrastructure.

F. Evaluation Discussion

- i. Challenges: As with any social science research effort, we experienced a number of challenges related to data. These can be broken down in to data access and data interpretation.

Data access: We spent approximately a year working toward a data sharing agreement with the state Department of Human Services that would offer permission to receive follow-up data. Once the permission was granted, it took extraordinary resources for DHS to have someone program the “data pulls” based on the variables we requested. Data came from multiple non-integrated systems, as financial data and child welfare data is managed in separate software. At the county level, we had hoped for (but did not receive) data on numbers of American Indian children in care and coming in to care by county so we could determine the rate of referral to FTDM/FGDM services.

We also were not able to get clear data regarding the number of children who receive IV-E funding but receive tribal case management (and therefore, are not in state custody). Because we did not have this data, we are not able to accurately count or report the number of American Indian children in state foster care.

Some follow-up data was not reported in a way that was easily usable. For instance, DHS could not run data for us on the total cost of care for a child six months before and after

placement- the data was chunked in to numerous placement episodes, which relied on a lot of hand-calculation by the evaluation team. Most of the outcome data was like this.

We were never able to access a comparison group, which we have discussed elsewhere in this report.

Data interpretation: Challenges related to data interpretation include variances in the ways different agencies (The Village, DHS, parents, counties) identified variables. For instance, for child-related variables, referring workers reported on children “involved” in the case. Village facilitators identified a “primary child” and parents reported “children in household” on various forms. When we asked the State for outcome data, they only provided information on children who were a formal part of the DHS record. This resulted in varying “child” counts depending on reporting variable.

Another example is related to placement. We wanted to report the number of children returned home, in relative placement, and in foster placement. These categories were reported as part of the current placement at time of meeting and planned placement after meeting. In the DHS 6-month follow-up data, we could only determine whether children were in paid foster care (which may include relative foster care), unpaid kinship care, or not in placement (which we assume meant that the children have been returned home, but this is only an assumption).

ii. Limitations to evaluation: In the absence of control-group data and poor follow-up telephone contact response, our one-time meeting intervention model became a major limitation as we were only able to access baseline data on measures that relied upon client report (PHQ-9, protective factors, etc.). Our other limitations are related to data access and interpretation, which are discussed above.

VII. Conclusions (written by Lead Evaluator, Dr. Melanie Sage)

A. Determine whether the project met its proposed goals and objectives.

This project met a number of output-related goals by serving nearly 300 children over a 3-year grant period, developing case plans for nearly every family involved in services, and providing a neutral facilitator who followed a structured meeting process.

Our short-term outcomes included the understanding of how FTDM/FGDM impacts placement of American Indian children. Although we were not able to compare outcomes to children who were not involved in these meetings, we do have clear outcome data on placement rates 6-months after a family meeting. This data will be helpful for future research.

We sought to demonstrate the impact of family involvement on future placement of children. This was difficult to analyze because we could not assess the difference between relative placement and foster care. However, our analysis shows that children were slightly more likely to be placed at home six months after the meeting if there were relatives at the meeting. This finding was not statistically significant.

One of our goals was to learn about the safety of children who were returned home after a meeting. In 69% of the cases in which children were returned home, there were no subsequent child welfare services required in the following 6 months.

Our last short-term goal was to understand barriers to family team implementation in working with American Indian families. We have offered a number of implementation barriers throughout this report. The most significant barriers were difficulty in making and maintaining contact with families, which impacted participation in meetings. We also note, based on needs, income, and housing data, and risk factors related to incarceration,

domestic violence, and substance abuse, that we are working with a high-needs population which complicates service delivery and impacts a brief-intervention such as the one-time meetings used in this grant project.

B. Lessons learned related to project implementation:

- It is useful to coordinate data sources upfront when they will be used to answer outcome questions to ensure similar levels of measurement are available across data sources (i.e. placement type)
- When working with high-needs populations such as American Indians involved in child welfare systems, it is very difficult to reach family members- for participation in intervention and for follow-up data gathering
- We have learned (as evaluators) about levels of data available at the state, and challenges for accessing them
- Through the Children’s Bureau sponsored meetings, we have learned a great deal about methodology, collaborations, and strategic directions of the CB
- Facilitators indicate that follow-up meetings would help assure plans are followed and improve outcomes

C. Impact on parents, children, and families (based on outcome data)

- Family plans were created in virtually every case
- Two thirds of cases involved at least one family member (besides parents) for support
- Participants generally reported high levels of satisfaction with services provided
- Facilitators generally reported high levels of fidelity to the family-centered model

- The high needs of parents involved in this project were illuminated through needs assessment and other demographic data
- Meeting facilitators received cultural competency training throughout the life of the grant, better preparing them to work with American Indian families in the future

D. Impact of project on partner organizations

- Because of this funding opportunity, all of our partners (State DHS, The Village, county offices, and University of North Dakota Department of Social Work) have worked closely together and have developed stronger partnerships
- The Village has connected with a number of community agencies, including American Indian serving agencies, during the life of this grant. This will promote future collaboration.
- We have utilized technology in creative ways to partner across wide geographic regions

E. Impact of project on child welfare community

- We have increased the amount of providers in the child welfare community who have experience and knowledge regarding working with American Indian families and providers
- As a springboard from this work, this project PI is conducting an assessment of a FTDM in other pilot counties in our state (serving non-Native American populations) for the benefit of the State DHS agency; university-state collaborations are strengthened

- Participating counties have more exposure to family-centered practice via referral to this program
- Research strengthens our capacity to demonstrate needs and request funding from our State legislature for future family-centered practice

VII. Conclusions continued. (written by The Village Project Staff)

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

See Evaluation Report for Process and Outcome questions.

Outputs and Deliverables from the Logic Model:

a) A referral form that identifies criteria and referral steps for the child welfare agency. See

Appendix Attachment F – Referral Form

b) A brochure on FGDM/FTDM Process for families. See Appendix Attachment Q –

FGDM/FTDM Brochure

c) A written FGDM/FTDM handbook is located in an online manual exclusive to Village staff

which includes all process and procedures. We utilize:

- “Guidelines for Family Group Decision Making in Child Welfare”, developed by American Humane Association and the FGDM Guidelines Committee.
- “Team Decisionmaking and Domestic Violence: An Advanced Training for TDM Facilitators and Child Protection Supervisors: A Trainer’s Guide”, developed by Family Violence Prevention Fund.
- Family to Family Website, <http://www.aecf.org/work/past-work/family-to-family/>, developed by The Annie E. Casey Foundation.

- Child Welfare Information Gateway,
https://www.childwelfare.gov/pubs/f_fam_engagement/, developed by the U.S.
 Department of Health and Human Services.

d) 10 informational meetings for child welfare workers and tribal child welfare leaders over the 3 year evaluation period. See Appendix Attachment R – Informational Meetings

e) A fidelity checklist that ensures expected meeting goals are met for each family and documents time spent for each family. – See Appendix Attachment I – Facilitator Fidelity Tool

f) A pre-post family centered survey for participants – See Appendix Attachments K, L & M – PHQ-9, Family Needs Scale and Protective Factors Survey

g) 100 FGDM/FTDM meetings each year of implementation, with over 300 Native American children served by the end of the intervention period. 313 children were served by this project.

h) Technical brief on the fiscal costs and benefits of FGDM/FTDM, demographics of children served, and outcomes of intervention. – Please see evaluation report.

i) Three scholarly/peer reviewed articles that expand on knowledge in the field about serving Native American Families with FGDM/FTDM approaches. Our lead researcher wrote and presented the following:

- Presented at FGDM Conference 2014: “Fidelity and Findings”
- Article Use of Web 2.0 to train facilitators in fidelity: A case study
- Workshop presentation at SSWR, *Using Technology to Support Research Fidelity*
- Presented at FGDM Conference 2012: “FGDM with Diverse Communities” & “The Proof is NOT Just in the Pudding: Tools for Measuring and Demonstrating the Effectiveness of an FGDM Program”

j) An implementation guide and “lessons learned” report designed for counties at project end.

See Appendix Attachment S & T – Referral Packet and Lessons Learned Handout

k) Final evaluation report at project end. – This document.

B. Describe any significant implementation facilitators and/or barriers and “lessons learned” related to project implementation.

- *Lesson Learned:* Working with the Native American population will require more extensive preparatory work by facilitators and service providers in the exploration of informal supports, including both tribal and non-tribal resources. Father involvement is still a major issue we are constantly working on improving. It has been a slow process of encouraging the maternal side of the family to build trust with the paternal side of the family when previously they have been absent or not included for various reasons. It has also been a slow process of convincing the paternal side of the family that their information is desired and valuable to their children. Facilitators are often faced with the dilemma of involving extended family members in conferences the parents do not want involved in their children’s conference. Ultimately, facilitators will follow the direction of the person who has custody of the child, whether it is parent(s) or social services. This dilemma puts two of our core principles of Family Engagement at odds, usurping the parents’ power/control/wishes and allowing social services to have more control of the invite list and the belief that widening the family circle of support is in the best interest of the children.
- *Lesson Learned:* Our experience with this project leads us to believe that urban Native families can greatly benefit from an urban Native American Center that can offer them more community support. Staff from these Native American Centers can help provide informal support.

- *Lesson Learned:* Prior to submitting a future grant it would be beneficial have more collaboration between the Department of Human Services and the counties in establishing realistic outcomes. Using that time to brainstorm with the “target counties”; and discuss with them the engagement strategies being used; barriers & needs to assist them to achieve greater success; sponsoring a champion within the county with dollars and training the staff to make the difference. In retrospect, we could have added more counties to the “target” areas in year 2, though sustainability was an issue.
- We encountered grant technical issues. Both data retrieval systems within DHS and the Village required programming and manpower needs which were not planned for.
Lessons Learned: Prior to a future grant submission, data system issues be discussed and resolved. Grant funds might need to be allocated for personnel in data management.
- *Lessons Learned:* A 72 hour FTDM model may not fit all families. As with all models, flexibility is a strength. Consideration may need to be made that the FGDM model is a better fit than FTDM for Native American families.
- *Lessons Learned:* Technology was a very important piece in implementing FGDM/FTDM in a rural state. We used technology to train and connect facilitators (WebEx, the FGDM/FTDM blog and online manual); to prepare family members for conference (FGDM/FTDM DVD); and to connect families to the conference (WebEx and phone conferencing.)

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

Our data shows that parents and family members will participate in family conferencing and safe, thoughtful family plans. Family conferencing provides the opportunity to build relationships between families and the systems of care as evidenced by the number of service

providers that attend conferences. Neutral facilitation brings a safe atmosphere for families to present their concerns and needs. The impact on children is knowing that their family and service providers are working together to make decisions and plans are being made.

We value the Satisfaction Survey as an outcome tool. Immediately following each family conference, participants are asked to complete a Satisfaction Survey. The Satisfaction Survey is the best tool in measuring the participant's response to our FTDM/FGDM process. The following are the written responses to the question "What is your best experience with The Village?" (pertaining to the FGDM/FTDM conference)

That I got to show (mom) that I support her and that she will make it through this - other
All of it – comforting - mom
The people being so understanding and helpful - mom
Just to be able to express our feelings and be listened to about our concerns - granddaughter
To discuss family strengths and beliefs
Getting to express my opinions - dad
Not bias – uncle
Helping the family- healthier and stronger – and also the process – mom's family
I felt like there was support for the family and there is a clear plan – community provider
Family comments/relationships – City of Fargo Native Commission
I like the people – they make you feel welcomed – mom
Best interest of (child) discussed where our future is headed and what to expect – Very much needed – grandma
Listening to others come together - friend
Always helpful
The facilitator was very helpful and the need to provide support for (family member) was awesome – aunt
Helping us get here
Getting to finally see and visit my little cousin after so long – mom's family
They helped me out with where I go as far as my plan and placement – child
Getting everyone together
Help with direction
The listing of concerns and strengths for the individual – I think that helped – mom's family
Acceptance of my extremely loud children's presence - mom
Referral process is easy. Facilitator established rapport. Environment was friendly and honest –
DHS Worker
All of it - other
Getting things said - child
Very interested in the needs of the children – friend of mother
Involvement – mom

Coming together and setting boundaries – aunt/dad’s family
Seeing my daughter - mom
Found out a lot – great-grandma
Good meeting – DHS caseworker
Learning that (child) will be with the family and that there is support available - aunt
Brought up some good ideas – mom’s family
Knowing once I reach my goals my child will be returned - dad
Hard meeting – good job - CPS
Talking about my family’s strengths and also concerns – mom’s family
Everyone coming together – mom’s family
I get my BB back
The helpful ideas - grandma
They were straight forward on the concerns and how they could help me with child – mom
They create both plan A and plan B. 2 plans just in case one don’t follow through. Help with a lot of classes and help - aunt
An opportunity to voice my opinion and concerns fairly! Thank you – dad’s family
Open dialogue – DHS case worker
They got all the family members included – dad
Bringing the family together – community provider
That the family could work out a plan – dad’s family
Seeing (child) – seeing what’s on her mind and why she’s doing what she’s doing – step parent
Finding a solution – child
Seeing (child) – it’s been almost a week since I’ve seen her last - mom
Calm, positive atmosphere – and chocolate – mom’s family
Organized/friendly - community provider
Everything - mom
Trying to make a plan for the children to be placed with family asap
Trying to find a plan for the kids – mom’s family
Talking to the workers and receiving the help – mom
We came to a conclusion for the kids
A plan was made – community provider
How it all turned out
Getting placement for the kid/for their sake ASAP – mom’s family
Concerns/strengths/and action plans – dad
Having the action plan - mom
Concern that was shown for my son - dad
Meeting the Village – child
Meeting everyone – foster parent
Supportive Staff - dad
Glad to be a part of the process- high school principal
The process of the meeting - other
Equal opportunity to voice concerns and speak – school social worker
Comments heard - school
Finding a solution for behavior and a plan - dad
Friendly lady - child
Talked it all out – grandma

The way people help with family – mom’s family
Getting everyone in the family together – county worker
Addressing (family member) concerns – aunt
Understanding the reasons that we are here for – aunt
Making the plan work and everyone was happy and agreed with it – child
Everyone got on the same page – child protection
Empowering the child and educating the family on our process and expectations – DHS
Caseworker
Exploration of problem – grandpa

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

We believe our greatest impact from the Family Connections grant is the intense focus and attention we have asked all of the county social services and partner organizations to have when considering this issue of disproportionality of Native American children in the state foster care system. Over the three years, we have continuously provided training for our Family Engagement Interventions to all pilot communities as well as provided constant reminders to send Native American referrals. Our conferences and meetings challenge everyone at the table to think about the solutions and the best fit to resolve family issues so children can be safely returned to the home.

We have been more involved with working with Native American families, community leaders and county social services. This has strengthened our knowledge and working relationship with Native American Families. We are finding resources and services that are unique to the Native American families. Through this grant we have tried to connect the county social workers and service providers with the services that are available to Native American families within their cultural community.

VIII. Recommendations (written by Lead Evaluator, Dr. Melanie Sage)

A. To administrators and the child welfare field, for future projects

- a. Consider Kinship Navigators as an intervention to increase family participation.

- b. Bring evaluators on early, to help develop outcome-focused questions and to assess what data will be available to answer the questions
- c. Culturally responsive practice with American Indian families relies on difficult-to-build community partnerships. Partnerships must be sustained between grants, and we must consistently invite American Indian stakeholders to join us in planning so that they are already there when we have funding to engage in system change efforts. Strengthen partnerships with tribal social services, ICWA workers, and Qualified Expert Witnesses.
- d. Intensive services may be required (and may be more expensive up-front) in order to address institutional issues such as disproportionality.
- e. Family-centered practice requires more than an invitation- it takes significant resources in order to support communication and participation with family members. The cost (of placement and resources) of not engaging family can be very high.
- f. In order to create system change in child welfare agencies, the workforce must be ready for change, and workers must support the intervention model; a family plan does not result in fewer placements if return home is not supported by the workers.
- g. Develop a state data taskforce which includes researchers and social service agencies to review data sharing procedures, discuss available data, and plan for the future of data management platforms that improve system collaboration.

B. To funders (Children's Bureau)

- a. Either build planning time into the first phase of the grant so that cross-site measures can be selected, or have a selection of cross-site measures ready to go; projects are expected to start as soon as project is funded. The late decisions about cross-site measures impacted data collection and IRB protocol (which had to be revised)
- b. Offer training and sample models to state partners on data-sharing agreements, and encourage state partners to be proactive partners in data-sharing advocacy and use of evidence
- c. Facilitate stronger linkages between cross-site program evaluators to help develop semi-formal learning network
- d. For FTDM/FGDM work, Kinship Navigators may be a useful direction given our difficulty in family outreach
- e. Annual cross-site meetings are very helpful in refocusing work, sharing information, and encouraging collaboration. We were disappointed that our meeting was cancelled in the last year.
- f. Pre-funding webinars are very helpful to kick-start a successful application.
- g. Consider a structured mentorship model for newer evaluators, especially in underserved states, and/or developmental funding for child welfare scholars as is offered by the National Institutes.
- h. Consider pilot funding so that lessons learned about best practices in one jurisdiction can be brought to scale.

This project demonstrates the need for continued capacity-building in the use of data to inform practice. In order to determine whether family team meetings affect return home and the problem of disproportionality, longitudinal and/or comparable-group data is required. We must continue striving toward good data sharing, as well as data systems that are built for data reporting.

Additionally, an intervention is only as successful as it is supported by those who influence the outcome of the case. Partnerships between county agencies and outside facilitators are necessary if case plans are to be supported; case worker decisions about placement must not precede a family meeting and plan. Although an outside neutral facilitator is best practice in family team meetings, the facilitator does not have the power to support the family plan post-meeting in an intervention such as ours. Continued public child welfare workforce development may necessary to fully implement practices that place families at the center of the decision-making process.

VIII. Recommendations continued (written by The Village Project Staff)

A. Provide recommendations to administrators for future, similar projects & to the child welfare field (A & C combined)

North Dakota has embraced the Wraparound philosophy of family engagement. There are many types of team meetings with families as they move through the Child Welfare system.

For an effective model in North Dakota, we would recommend strategic planning with all of the partners around the following topics: 1.) a comprehensive family engagement model with practice strategies and protocols for all county social service staff, 2.) establish specific measurable outcomes in FTDM and FGDM, and 3.) a data system established that could provide and track the outcome data needed for future funding.

Based on our experience with the Family Connections grant an effective model of service for Native American families would include the following: Native American families

would benefit from a parent coach/mentor to participate in every meeting and follow the family as they move through the case management/child welfare system and as they follow-up with their plan. In discussions with our Native American partners, it is felt that the peer mentor/coach be Native American and be enrolled members of each of the tribes we work with in our state. They will have a “hands on” approach to work with the family in their own environment. Exploration for the funding for this type of position would have to be explored.

This proposed model would also include a well-trained, designated champion in each of the social service offices that is trained in both interventions; acts as a team leader in their office; and attends all trainings with the facilitators.

If a social service agency did not have a designated champion in their office, the facilitator would attend staff meeting to teach and encourage and support the county staff in making referrals. As facilitators continue to attend staff meetings, they would be in a position to teach new county staff the fidelity of the Family Engagement model.

It is crucial to have clarification of whose role it is to do the family finding for all proposed family engagement meetings. We also need clarification on how to access the person(s) designated within each region to finding the names and the confidentiality and legal concerns in gaining these names.

We have learned the Native American families we serve are very isolated and without a lot of informal supports. It seems imperative that more informal support is needed to sustain a successful plan for the family. As a part of the informal support system, the Native American centers in each of the communities have the ability to reach out to the families. The possibility of a Native American Center in the major regional cities could be a discussion topic as DHS rolls out Goal #1 of their IV-B Plan.

Many of the parents were in crisis with addiction and incarceration issues, so FTDM meetings must focus the team in establishing short-term realistic goals with time frames the parents feel they can achieve. We further recommend FTDM follow-up meetings be offered after the immediate placement FTDM meeting that will address the plan developed and long-term goals. More focused plans and more timely FTDM follow-up meetings would ensure more family plan follow-through.

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

Several different types of Family Conferencing models were utilized among the 2011-2014 grantees. This makes it very difficult to establish an evidence-based practice. It is our recommendation that the Children’s Bureau select a family conferencing model that all grantees would utilize in a specific setting. Doing this will help each grantee to adhere to the fidelity of the model selected and it would give more opportunity to establish an evidence based model.

When Children’s Bureau selects a specific model of family engagement to adhere to, there would need to be staff and supervisor training in that model to ensure fidelity & continuity. That training would be funded by Children’s Bureau at the onset of the grant project. The training would be provided by one agency that would train all grantees on that model. This would properly ensure fidelity to one model. We would further recommend the Children’s Bureau establish specific outcomes to be measured with each funded project.

An additional recommendation regarding evaluation would be earlier access to an array of scales we can opt in and out of.

The grantee meetings in Washington were very helpful. Additional recommendations would be for peer sharing within the evaluation process. Other peer meetings would have been helpful in the implementation phase regarding interviewing, hiring, and retention of facilitators. On-site meetings are important and had more free time to connect with each other, brainstorm

more on articles and similarities. It was noted that the FGDM National Conference did more to get people together to discuss. A suggestion might be a monthly evaluator phone call.

It should be a requirement of the Family Connection proposals that all Family Connections facilitators, supervisors, and research evaluators budget for their attendance at the National FGDM Conference.

A final recommendation would be for Children's Bureau with the Family Connections first period implementation meeting would include not just the Project Director and Research Evaluator, but also the agency's Fiscal Manager and representatives from our partnerships. This would assist in greater implementation efforts and understanding of fiscal reports.

(Report Appendix submitted as separate file.)

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