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Lifelong Connections Initiative: Final Progress Report

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EXECUTIVE SUMMARY

Seneca Family of Agencies (Seneca) was founded in 1985 to promote the success and well-being of children, youth, and families involved with the child welfare and special education systems, no matter how challenging their needs and circumstances. For over 30 years, Seneca's steadfast belief in the potential of all children and families has remained at the heart the agency's philosophy of Unconditional Care, which integrates behavioral, attachment, and ecological system theories into a comprehensive assessment and treatment process.

Seneca, along with its affiliate organization, the National Institute for Permanent Family Connectedness (NIPFC), has long been a proponent of Family Finding practices meant to connect youth and their families with lifelong systems of supports to promote their safety, permanency, and well-being. With funding from the Children's Bureau, Seneca partnered with the San Francisco Human Services Agency (SF-HSA) to implement the Lifelong Connections Initiative (LCI), a project utilizing a randomized experimental design to study the effectiveness of a combined Family Finding and Family Group Decision Making (FF/FGDM) model for improving key outcomes of children entering foster care. The LCI sought to promote the safety, permanency, and well-being of children entering care in San Francisco, and in particular the need for youth to attain timely permanency outcomes, with family whenever possible. At a system level, the LCI also sought to integrate the Family Finding model into the regular agency practices of SF-HSA.

Family Finding and Family Group Decision Making are approaches that are well-aligned with general principles of high-quality child welfare intervention and family-centered social work practice. The core values of these practices - to connect youth to permanent and meaningful familial supports, and to engage and involve families in the decisions that impact their lives - are fundamentally embedded in the goals of the child welfare system to improve child and family outcomes while preserving family autonomy and empowerment.

Rooted in the framework of these practice values, the goals of the LCI fell into four broad categories. The process and outcome evaluations indicated that findings in relation to these project goals were mixed, with some more successfully realized than others.

- **Goal #1: Improved permanency outcomes.** This goal encompassed multiple objectives, including increasing placements with relatives, decreasing time to permanency, increasing meaningful and lasting connections for youth and their families, and increasing the involvement of family connections in permanency and case planning.
 - **Finding:** The outcome evaluation indicated that children who received the FF/FGDM services had *significantly more connections identified* (8.5 treatment vs. 5 control) *and engaged* (5.5 treatment vs. 3.6 control) than children who



received only usual child welfare services. In addition, the evaluation produced a *marginally significant finding* that children receiving FF/FGDM services were slightly more likely to be placed with relatives than those receiving services as usual (50% of treatment group children vs. 39% of control group children). *No statistically significant* differences were observed in the length of time from entry to permanency across treatment and control conditions.

- **Goal #2: Improved child safety outcomes.** The objectives under this goal included decreasing re-allegations of maltreatment and re-entries to care following reunification.
 - **Finding:** There were *no significant differences* in rates of re-entry or re-allegation across treatment and control conditions.

- **Goal #3: Improved child well-being outcomes.** This goal included the objectives of increasing caregiver capacity to meet child needs, and increasing family protective factors.
 - **Finding:** Differences in well-being across treatment and control groups could not be measured because county officials in the San Francisco Department of Public Health were not able to provide the data that were intended for use as well-being indicators (scores from the Child and Adolescent Needs and Strengths assessment).

- **Goal #4: System-level practice changes.** This goal was comprised of the related objectives of increasing the integration of family finding practices in child welfare caseworker and increasing caseworker focus on permanency.
 - **Finding:** This goal was primarily answered through qualitative components of the evaluation, which indicated that there were both successes and challenges in meeting the objectives. While the infusion of Seneca-delivered family finding activities into the services of SF-HSA was not without tensions due to such factors as increased workload, meeting fatigue, and philosophical differences in approach, ultimately this shared work forged positive professional relationships and increased implementation of family finding principles and processes into the child welfare services provided by SF-HSA.

In addition to the outcome evaluation, the LCI project also studied fidelity and cost effectiveness. The fidelity analysis indicated that fidelity to the model decreased at each of the six model stages, and that level of fidelity (high, medium, or low) did not correlate to any permanency or placement outcomes for children in the sample. The cost study indicated that documentation and administrative tasks comprised a majority of the work for those delivering



the Family Finding intervention, and that the amount of time spent on each model stage did not correlate to case outcomes. However, the cost analysis could not clearly explicate how much time each intervention required per family or per child, making it difficult to determine how much it would cost a jurisdiction to continue the intervention as a regular agency function.

Despite some mixed evaluation findings, the LCI project yielded important lessons that can inform future Family Finding implementation efforts. The following report provides a detailed description of the project and the intervention model, the community in which it was implemented, the evaluation findings, the collaborative work of implementing the intervention, the sustainability of the services at the close of the grant, and conclusions and recommendations for the field.



I. Overview of Community Populations and Needs

A. Grantee Organization

The Lifelong Connections Initiative (LCI) represented a partnership between the grantee organization, Seneca Family of Agencies (Seneca), and San Francisco Human Services Agency (SF-HSA). Seneca was founded in 1985 to promote the success and well-being of children, youth, and families involved with the child welfare and special education systems, no matter how challenging their needs and circumstances. For over 30 years, Seneca's steadfast belief in the potential of all children and families has remained at the heart of the agency's mission and drives the programs and services offered. Originally founded as a residential treatment provider, Seneca has shifted its focus to developing and delivering community-based services and family-focused interventions that strengthen youth permanency and reduce out-of-home placements. Throughout this evolution, all Seneca programs have maintained an unwavering commitment to the agency's philosophy of Unconditional Care, which integrates behavioral, relational, and ecological theories into a comprehensive assessment and treatment process. Our Unconditional Care model informs the agency's mission of helping children and families to succeed through the most difficult times of their lives.

Seneca serves over 8,000 youth and families per year in 147 programs across California and in Washington State. Permanency services, an integral part of Seneca's continuum of care, include intensive family finding and engagement, kinship support, foster-adopt, special needs adoption services, and permanency-informed family therapy. All of these permanency services are designed to enhance each young person's natural support system by identifying and engaging relatives and caregivers, non-relative fictive kin, and other significant adults who can provide enduring care and support during the youth's transition into adulthood. For youth and families entering the child welfare system, the LCI focused on merging the Family Finding model promoted by the National Institute for Permanent Family Connectedness (NIPFC) with Family Group Decision-Making to involve families in the process of developing permanency plans for youth entering dependent care in San Francisco.



B. Project Community

For the LCI, Seneca partnered with San Francisco Human Services Agency (SF-HSA), which encompasses the public child welfare agency for the City and County of San Francisco. At any given time, SF-HSA serves 121,000 individuals, providing not only child welfare services, but welfare, employment, and aging and adult services. The county's commitment to keeping children with their families whenever possible is evidenced by the high rate of kinship care placements for maltreated children and youth. Following intensive efforts over recent years, SF-HSA has significantly reduced the number of youth placed in out-of-home care, with a current out-of-home placement rate roughly half of what it was a decade ago (Webster et al., 2016).

San Francisco County, located in Northern California, is a densely-populated region occupying roughly 47 square miles at the tip of the San Francisco peninsula, bordered by the Pacific Ocean to the west and San Francisco Bay to the north and east. With the second highest urban population density of any city in the country, San Francisco has rich cultural and ethnic diversity, a large immigrant population, residents living at extreme ends of the socioeconomic spectrum, and a dearth of affordable housing (Mayor's Office of Housing, 2010; U.S. Census Bureau, 2010). Only 13.4 percent of San Francisco's residents are younger than 18, the smallest percentage of any major city in the United States (Mayor's Office of Housing, 2010).

Another important contextual factor in San Francisco is the considerable disparity between the wealthy and the poor. Between 2007 and 2013, rich households in San Francisco grew by nearly 18 percent, and the average annual income among the top 20 percent of households is currently \$263,000 greater than the average annual income among the bottom 20 percent (Silicon Valley Institute for Regional Studies, 2014). Due to dramatically rising housing costs, lower income families within San Francisco are concentrated in the most disadvantaged neighborhoods (Mayor's Office of Housing, 2010). This has implications for the child welfare system, since research indicates that children living in poverty are disproportionately represented in the child welfare system (Jonson-Reid, Drake & Kohl, 2008). In San Francisco, 85% of children who entered child welfare custody during the year that the LCI project began were removed due to neglect (Webster et al., 2016), which is associated with poverty and housing insecurity (Duva & Metzger, 2010).



C. Issues Addressed by the Demonstration Project and Population Served

The LCI sought to address the safety, permanency, and well-being needs of children entering care in San Francisco, and in particular the need to achieve timely permanency outcomes, with family whenever possible. At a system level, the LCI also sought to integrate the Family Finding model into the regular agency practices of SF-HSA. Through a combined Family Finding and Family Group Decision-Making model, the LCI was designed to mobilize informal resources and build natural supports for youth and family to promote permanency and well-being.

In 2012, the year the LCI project was initiated, children who entered care in San Francisco were disproportionately youth of color. Notably, of all children who entered care during 2012 in San Francisco County, 47% were African-American, despite the fact that African-American children only comprised 5.7% of the total child population of San Francisco that same year (Webster et al., 2016). By contrast, White children made up 28% of the full child population of San Francisco in 2012, but only 13.6% of the children entering care (Webster et al., 2016).

The LCI targeted children and youth at the point of entry to foster care, which included youth entering for the first time and youth re-entering care following prior reunification. In 2012, when the study was initiated, about 70% of the children entering care in San Francisco were first time entries, and 30% were re-entries (Webster, et al., 2016).

Additional demographic characteristics of the population of children who entered foster care in San Francisco County in 2012 are summarized in the tables below, with the full population of foster care entries for California during the same time frame presented for comparison (Webster, et al., 2016).



Demographics of children who entered foster care in 2012

Reason for Removal		
	San Francisco County	California
Neglect	367 (84.8%)	26,138 (82.4%)
Physical	30 (6.9%)	2,754 (8.7%)
Sexual	7 (1.6%)	687 (2.2%)
Voluntary Reentry	10 (2.3%)	159 (0.5%)
Other	19 (4.4%)	1,987 (6.3%)
Total	433	31,725

Ethnicity		
	San Francisco County	California
Black	203 (46.9%)	5,830 (18.8%)
White	59 (13.6%)	8,157 (26.3%)
Hispanic	116 (26.8%)	15,922 (51.2%)
Asian/P.I.	53 (12.2%)	860 (2.8%)
Nat Amer	2 (0.5%)	486 (1.6%)
Missing	0	141 (0.5%)
Total	433	31,725

Entry		
	San Francisco County	California
First Entries	301 (70%)	24,648 (78%)
Reentries	132 (30%)	7,077 (22%)
Total	433	31,725

Gender		
	San Francisco County	California
Female	242 (55.9%)	16,094 (50.7%)
Male	191 (44.1%)	15,627 (49.3%)
Missing	0	4
Total	433	31,725

Age		
	San Francisco County	California
<1 mo	61 (14.1%)	2,752 (8.7%)
1-11 mo	34 (7.9%)	3,063 (9.7%)
1-2 yr	43 (9.9%)	4,652 (14.7%)
3-5 yr	60 (13.9%)	5,734 (18.1%)
6-10 yr	79 (18.2%)	6,828 (21.5%)
11-15 yr	100 (23.1%)	6,165 (19.4%)
16-17yr	45 (10.4%)	2,259 (7.1%)
18-20 yr	11 (2.5%)	272 (0.9%)
Total	433	31,725

II. Overview of Program Model

A. Project Goals

The goals of the LCI project were based on the rationale that safety, permanency, and well-being for foster children can be improved by addressing the emotional and resource needs of the child and caregivers through the process of building a lifetime network support team of family and community supports. Embedding this practice within the county child welfare system was meant to promote system-level changes utilizing family and community resources to meet the needs of each family served. Family finding efforts associated with the LCI were intended to locate and engage family members in the decision-making and planning process, so that children



entering care, and their families, would be supported by a large, involved network of social and emotional supports.

The overarching goal of the LCI was to increase safety, permanency, and well-being for youth who enter the child welfare system, and to promote system-level adoption of Family Finding principles and practices. The following table illustrates the goals and related outcomes for the project.

Goals	Outcome Objectives
Improved child safety outcomes	Decrease in re-allegations of child abuse/neglect following reunification
	Decrease in re-entries to out-of-home care following reunification
Improved permanency outcomes	Increase in permanent placements with relatives
	Decrease in time to permanency
	Increase in meaningful and lasting connections
	Increased involvement of child/youth and relatives in permanency and case planning
Improved outcomes related to child well-being	Increased caregiver capacity to meet the needs of the child/youth
	Increase in birth family protective factors
System-level changes to practice	Increased integration of family finding practices in child welfare casework
	Increase in child welfare caseworker focus on permanency

B. Project Service Model

The LCI project utilized the intensive Family Finding model promoted by the National Institute for Permanent Family Connectedness (NIPFC) and originally developed by Kevin



Campbell. Recognizing that all child welfare systems have deep-rooted practices, policies, and protocols that are not easily altered, this model provides flexibility that allows for implementation within existing systems of care. This approach was selected to support the goals of the LCI in creating sustained system change rather than merely providing a program or service that would be detached from the larger system of child welfare practice.

There are six essential components of the Family Finding model (NIPFC, 2016).

1. **Urgency:** Family Finding views meaningful, supportive, permanent relationships with loving adults to be an essential need that is closely tied to youth safety. Family Finding asks practitioners to urgently pursue these relationships for youth by assertively engaging family and strongly challenging the structural barriers to developing or strengthening these relationships.
2. **Expanded definition of permanency:** Although physical legal permanence is an explicit outcome for most cases, Family Finding defines permanency as a state of permanent belonging, which includes knowledge of personal history and identity, as well as a range of involved and supportive adults rather than just one legal resource.
3. **Effective relative search:** Family Finding employs a variety of effective and immediate techniques to first identify no fewer than 40 relatives or other meaningful connections for each youth. The number 40 serves to create a large group of people from which to form a smaller tight-knit, unconditionally committed permanency team.
4. **Family-driven processes:** Family Finding recognizes that families are disempowered by the placement of relative children outside of the family system, and it seeks to remediate that harm through identifying the strengths and assets of each family member and facilitating processes through which families are able to effectively support their relative children.
5. **Development of multiple plans:** The Family Finding process will result in not just one plan for legal permanency, but multiple plans that are each able to meet the needs of disconnected youth. No fewer than three plans are developed and evaluated by family members to ensure that they are realistic, sustainable, and safe.
6. **Well-defined and tactical procedures:** Family Finding begins first with careful preparation and alignment of current team members in order to pursue the six steps of the



Family Finding model. While it is a strongly values-based model, it also has clear and definable goals and activities that are easily tracked with a fidelity tool.

C. Key Interventions and Activities

There are six stages of action in the NIPFC Family Finding model: 1) discovery, 2) engagement of family members and natural supports, 3) planning, which includes as many engaged family members and natural supports as possible, 4) decision-making, incorporating the perspectives of family members and natural supports, 5) evaluation of the planning and decision-making processes, and 6) follow-up. These stages are not viewed as linear, as engagement is integrated into all aspects of the model, and discovery is considered an ongoing process throughout the life of a case.

These six steps were the basis for the intervention services provided to the treatment group in the LCI study. In addition to internet searches and case mining to locate family members, discovery and engagement processes included creating ecomaps, when appropriate, to identify all natural supports, relative and non-relative, who might be accessed as informal resources for the youth and family. All located relatives were documented in a standard report provided to the caseworker for each child. Permanency specialists (comprised of Seneca staff) engaged natural supports in person whenever possible, or by phone if necessary, to explain the types of support that they could provide and the value of providing these supports. Identified individuals were assessed through in-person engagements and background checks by the SF-HSA worker to ensure safety. Education was provided to help identified supports understand the impact of the youth's experience of disrupted attachments and traumatic exposure, as well as the importance of long-term, sustainable connections. The planning phase included coordinating and scheduling initial Family Team Meetings (FTMs) to link the natural support team with the SF-HSA caseworker. This phase also included helping the identified supports access services that might be needed to better support the youth, including referrals to kinship and caregiver supports. Decision-making included group discussions on the options for permanency and determining plans for permanent placements and relationships. These stages provided a framework that helped ensure consistency in approach while providing flexibility to address the complex challenges and varied trajectories of families and youth involved in the child welfare



system.

The following paragraphs summarize some of the practices that were used to deliver the intervention during the study period. The various team meetings used to incorporate family voice into the planning and decision-making process for youth are described, along with training and service delivery components of the Family Finding intervention model.

Family Group Decision-Making: In the course of regular service provision, SF-HSA utilizes two types of meetings for Family Group Decision-Making: 1) Team Decision-Making meetings (TDMs) and 2) Family Team Meetings (FTMs). The goal of the LCI was to build on the existing infrastructure and resources already implemented by SF-HSA by integrating family finding principles and practices into all family meetings. Certain philosophies are consistent across the two types of meetings utilized by SF-HSA. Both meetings are informed by an explicit commitment to including family input in case decision-making processes, with conversations and decisions about youth and families occurring with those people in the room. In addition, while both meetings strive to connect youth with formal supports (such as community and public agency services) and resources, the overall goal is for youth to be cared for in the most natural, sustainable way. Therefore, informal supports such as family members, community members, and fictive kin are brought together as a lifetime support network team for the youth and family and are included in case planning activities.

Team Decision Making Meetings: TDM meetings are held soon after a child's removal to out-of-home care and also prior to any placement changes during the case. Because these meetings are held at times of high tension, the TDM model was selected because it allows for a facilitator to mediate potential conflict between the family and caseworker. TDM meetings are led by a county-employed facilitator and adhere to the values that every youth deserves a family, every family needs the support of the community, and public child welfare agencies need community partners. TDM meetings are structured sequentially to include the same ordered steps, including introductions, defining and assessing strengths and needs, brainstorming ideas for solutions, and reviewing any agreements reached.



Family Team Meetings: FTMs are utilized at SF-HSA under many programs and projects. While they are usually facilitated by an SF-HSA caseworker, the FTMs under the LCI project were facilitated by Seneca Permanency Specialists. These meetings are held when a youth is nearing transition to adulthood or lacks a permanency plan. Review of a case during an administrative hearing can also result in scheduling of an FTM. In the LCI project, the FTMs were intended to be held every three months for each case, more frequently than is typical than in usual child welfare services, however this did not always occur due to scheduling and workload barriers. FTMs begin with a review of meeting purpose and desired outcomes, followed by a review of ground rules including confidentiality. The family shares their experience, perspective, and knowledge, and family strengths are identified to inform the development of an action plan that supports family in meeting their goals (see Attachment A for the Permanency Action Plan Worksheet). FTMs were selected for the LCI because they activate teams of family members, community supports, and formal agency resources to collaboratively create, implement, and update a plan with the family that builds upon existing strengths and addresses the needs of the youth and family.

Blended Perspective Meetings: These meetings were developed during service provision to replace FTMs as the initial meeting held for children after the identification and engagement stages of the family finding process. These meetings included the youth and family, any engaged connections who wanted to participate, as well as attorneys and SF-HSA social workers, and they were meant to explain and explore relational and legal permanency for the child. Participants in the Blended Perspective Meetings developed a greatest unmet needs statement that served as the foundation for future permanency planning.

Training: The National Institute for Permanent Family Connectedness (NIPFC) provided training and consultation in intensive family-finding and engagement practices for this project. NIPFC is a nationally recognized leader in training and implementation of family finding practices. Permanency is a focus across Seneca's programs, and many Seneca staff are already trained in and practicing intensive family finding, which allowed for quick startup of the LCI as Seneca staff transferred to their new roles as Permanency Specialists in the project. Staff continued to be trained and coached in the implementation of family finding practices by NIPFC



experts throughout the 3-year grant period. To support the private-public collaborative efforts of the project and build capacity to sustain project services beyond the grant period, a special training series was provided by the NIPFC to SF-HSA workers, community partners, stakeholders, and Seneca staff in San Francisco.

Service Delivery: Upon removal to child welfare custody, youth were randomized into treatment and control conditions. Seneca Permanency Specialists performed relative identification and notification as required by law for all children, both treatment and control. This process included conversations with the youth's parents and other relatives to identify family members, as well as the mining of available case files. Utilizing the expertise and resources of the NIPFC, a search specialist identified estranged or previously unidentified family members using multiple search tools. In compliance with federal law, the Permanency Specialists sent letters in the appropriate language notifying relatives of the youth's removal to out-of-home care (see Attachment B for sample letters). The notice also included options for relatives to participate in care or placement, a description of the requirements to become a foster family home, as well as additional services and supports that are available if the child were to be placed in their home. Relative notification occurred for children in the treatment/intervention group as well as the control group.

Following initial identification and notification, contact information for identified family members was provided to SF-HSA workers (see Attachment C for sample worksheet). For control group children and families, the Permanency Specialist services ended at this point. For families in the intervention group, the Permanency Specialist reached out to relatives who were identified in order to engage these individuals in the subsequent steps of the family finding process. The Permanency Specialist assessed the relatives' willingness and appropriateness to serve as meaningful supports for the youth and their caregivers. Throughout this process, the SF-HSA worker was apprised of the work of the Permanency Specialist. As appropriate, SF-HSA personnel began to screen interested relatives for possible kinship placement or connection for the youth. Screening of relatives included (1) checking the Child Welfare Service/Case Management System (CMS/CWS) administrative data system to see if they have been alleged perpetrators of child maltreatment, and (2) conducting a Department of Justice search to check for prior criminal justice system involvement. Based on information gathered from these efforts,



decisions were made by the SF-HSA worker in consultation with the Permanency Specialist as to whether the family member would be safe to have contact with the child.

An FTM was organized for youth in the treatment group within 45 days of their removal to out-of-home care. Relatives and natural supports identified through the family finding process were invited (with the approval of the SF-HSA workers and with the support of the youth's immediate family) to participate in the meetings. These meetings were scheduled by the Permanency Specialist, who prepared participants on the goals and expectations for the upcoming meeting. The FTMs were family-driven and included strength-based planning to address obstacles preventing reunification and/or kinship placement (for example, mental health challenges or housing instability). Concurrent planning was implemented, building on the idea that "plans fail, youth do not." Each meeting culminated in the development of a case plan, providing individualized action steps to connect youth and families with needed resources and increase positive, meaningful interactions between the youth and his or her supportive family members. A critical outcome target for these meetings was for at least three adults, approved by the youth and by the SF-HSA worker, to commit to lifelong relationships with the youth, including assurances of concrete support to promote permanency.

An important component of the Family Finding model was the ongoing engagement of family members between meetings. This process included assisting natural supports to identify formal resources, such as case management, mental health support, substance abuse treatment, parenting classes, or kinship support services. Many resources were available from the project's community partners, such as San Francisco's network of Family Resource Centers and Family Support Services of the Bay Area. Visitation between the youth and their identified supports was coordinated by the SF-HSA worker and were supervised as needed at the Family Resource Centers, Seneca's First Stop Visitation Center, or by the youth's other service providers.

III. Collaboration

A. Key Partners

Along with Seneca, the key partners in the LCI were SF-HSA and Child Trends (the contracted third-party evaluator). All three entities participated in the grant application process and were cooperating partners throughout the grant period. All children who participated in the



study were dependents of the San Francisco juvenile courts following removal by SF-HSA personnel.

Seneca and SF-HSA have been co-involved in multiple federally-funded activities and projects that provided mutual benefit to the LCI. Seneca currently partners with four counties, including San Francisco, to provide trainings for practitioners and agencies that serve youth in or at risk of out-of-home placement. Seneca and SF-HSA also are currently partnering on a Workforce Excellence Project through the National Child Welfare Workforce Institute; SF-HSA was one of three child welfare jurisdictions in the country to be selected for this effort to promote effective organizational change and improve the workforce environment.

The relationship between Seneca and SF-HSA extends back a number of years. In 1997, Seneca opened the only locked treatment facility in San Francisco to serve children and youth who, because of their high level of behavioral health needs, were turned away by other treatment programs. Seneca's Community Treatment Facility (CTF) in San Francisco was a cornerstone of the agency's mission to serve children and families through the most difficult times of their lives and provide them with unconditional care, a vision that has reflected throughout the agency since its inception in 1985.

As this relationship grew, Seneca began providing new services to meet the needs of the population and shifted to supporting children and families in their communities. In the mid-2000s, Seneca was introduced to Kevin Campbell and the core concept of family finding - that all children, especially those in foster care, deserve to have connectedness and a forever family. Mr. Campbell was invited to come to San Francisco and train Seneca staff, and as a result of that training, Seneca's definition of "unconditional care" began to shift toward a focus on helping to find and develop networks and community for families.

While Seneca was going through this shift, changes were occurring at local, state, and national levels that would continue to support family involvement in service provision. In 2009 in California, Assembly Bill 938 was passed to implement national guidelines laid out in the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. Among other provisions, this bill stated that child welfare agencies must provide written notice of a child's placement into foster care to all adult relatives within 30 days of the child's removal.



Because of Seneca’s well established relationship with the City and County of San Francisco and embrace of the family finding philosophy, Seneca was selected as a contract provider to implement the AB 938 law beginning in 2011. However, despite the large numbers of relatives being notified, an analysis of relative placements after initiation of relative notification services showed no change from previous years. This served as an indication that merely notifying families and providing light engagement with little or no additional support and follow-up was not translating to changes in the rate of relative placements among children in care.

From 2009 to 2012, Seneca participated in a previous 3-year research project in partnership with SF-HSA and Child Trends to empirically test the effectiveness of family finding strategies at improving permanency outcome for foster youth using an experimental design. The service model implemented during the previous study involved Seneca personnel conducting basic discovery and engagement of families in the system, and to then transmitting this information to the case-carrying worker at SF-HSA to complete the rest of the family finding process. The prior study’s findings indicated that the family finding services did not result in the hoped-for improvements in permanency outcomes among study participants. Due to concerns that the lack of positive findings from that study may have been related to inconsistent implementation of the intervention, the LCI project was designed to attend to the perceived implementation issues of the first study.

B. Project Advisory Groups

LCI Implementation Team

An Implementation Team was convened to promote communication and partnership in decision-making between SF-HSA, Seneca, and Child Trends. This team was comprised of key personnel from all three collaborating entities. In addition, Permanency Specialists would periodically attend meetings to orient them to broader goals and administration of the project.

The agenda consisted of implementation issues and barriers to consistent and effective service delivery, along with updates from research, training, and program staff. The team



responded to implementation issues as they arose and sometimes worked in between meetings if additional attention was required. Additional meetings at SF-HSA were scheduled to promote effective communication and a shared understanding of how the project was progressing, and to develop a sustainability plan upon the completion of the project.

One of the first tasks the team undertook was the development of the fidelity measures to establish shared understanding and agreement about what tasks were associated with each aspect of the intervention, and who was responsible for those tasks. The team also constructed five separate presentations for national conferences and attended a grantee meeting over the course of the project.

Seneca Leadership Team

The Seneca Leadership Team for the LCI project consisted of the Project Director, the Research Director, and the Director of the NIPFC, who was responsible for overseeing the training for the project. The team met monthly in order to promote communication and accountability, and to plan the agenda for the monthly LCI Implementation Team. The Seneca Leadership Team also attended to issues that the LCI Implementation Team identified, and provided guidance and feedback to the LCI Implementation Team on the study's progress and direction.

C. Methods of Collaboration and Lessons Learned

As noted previously, the lessons learned from the first Family Finding study were integrated into the LCI project design in order to attend to potential implementation gaps that had been identified. The design improvements included:

Co-location

Drawing on lessons learned during the prior family finding study, it was determined that co-location of services was desirable in order for the work be integrated and for SF-HSA social workers and Seneca Permanency Specialists to work together as peers. It was believed that for family finding to be successful, the model should be integrated as part of the HSA's core practice rather than as an adjunct service. To support this goal, SF-HSA leadership created the necessary space (including wiring for computers and phones) for the co-location of services during the LCI



project. Not only did the Seneca Permanency Specialists have access to the information in the county database in a timely manner, this co-location also facilitated immediate communication between Seneca personnel and SF-HSA workers.

Training

The vision for training shifted a number of times between the initial design that was submitted in the research grant proposal to the Children’s Bureau and what was ultimately delivered. This was primarily due to a change in the executive leadership position at SF-HSA. The original plan was for Seneca staff to serve as coaches for SF-HSA staff, who would deliver the Family Finding model to treatment group families. However, shortly after receiving the grant, and precipitated by a leadership change at SF-HSA, it was decided that Seneca would take the role of delivering the services, with supplemental training provided to SF-HSA workers on the Family Finding model. The initial plans for training of SF-HSA staff to learn and practice the Family Finding model were condensed by the new SF-HSA Director, who requested a shorter version of the training due to concerns from SF-HSA staff and managers that the training plan was prohibitively long. The training was initially intended to consist of 8 full day sessions (48 hours total), but was ultimately shortened to 4 half day sessions (12 hours total). While some Seneca personnel felt that the shortened training schedule was not ideal, the Implementation Team worked to craft the most viable training plan given the condensed time frame.

Supervisor Relationships and Problem Solving

Key grant personnel from Seneca and HSA felt that, in order for the intervention to be successful, the relationships between the Seneca Permanency Specialist supervisor and the SF-HSA supervisors should be well-established. During his ten years of serving San Francisco County through a multitude of roles at Seneca, the supervisor of the Permanency Specialists was able to cultivate relationships throughout SF-HSA, which created a basis for resolving issues as they arose over the course of the project. More often than not, a simple e-mail from supervisor to supervisor was all that was needed in order to resolve occasional disagreements or misunderstandings. When situations were more complicated, all parties involved would meet, and through open dialogue, create plans for proceeding in a way that would maximize the satisfaction of all parties. Another integral part of the successful collaboration was the involvement of Dr. Elizabeth Harris, a senior program analyst for SF-HSA. Dr. Harris



participated in project level discussions and provided support and consultation on interagency collaboration as well as day-to-day technical issues.

Coaching

As part of the ongoing collaboration efforts, Seneca staff implemented services and provided ongoing support to SF-HSA staff through a coaching model in order to help promote the adoption of family finding practices at every level of the agency. During the first year of the grant, the permanency supervisor and trainer met with each unit at SF-HSA, whether they were participating in the grant services or not, and provided an overview of the Family Finding model and coaching around service strategies. The permanency supervisor and trainer initially met with each unit supervisor in order to create shared agreement around what would be presented. After the initial supervisor meeting, training and coaching was provided over the course of three to four visits to the unit. Throughout the life of the grant, the permanency supervisor and trainer continued to provide consultation and/or training on specific skills as needed.

Lessons Learned

While deliberate efforts were made to dovetail the LCI into existing initiatives with SF-HSA, there were challenges with providing the desired amount of training content on Family Finding model. The training hours were reduced substantially in order to reduce the demands on the SF-HSA workforce, which likely resulted in a dilution of SF-HSA social workers' knowledge of the intervention. In addition, interviews with SF-HSA and Seneca staff indicated uneven buy-in from social workers on the Family Finding model. In retrospect, it may have been beneficial to have invested more time on securing buy-in from HSA workers with a wide spectrum of views and opinions on the utility of family finding practices. Seneca personnel who were interviewed during the evaluation felt that when there was buy-in from the SF-HSA social worker, collaboration and teamwork on cases was optimal, and this facilitated engagement with family members. Conversely, when that buy-in was less robust, Seneca staff felt that it may have inhibited the effectiveness of the service model. Both of these lessons illustrate some of the inherent tensions that can exist in a partnership between committed agencies that may lack the time, resources, or capacity to fully implement a new initiative, especially when there are competing priorities and demands. Building a lengthier planning phase prior into the timeline, prior to the start of the study, may have helped establish and/or clarify the roles, responsibilities,



and expectations of the collaborating agencies and the individuals from those agencies involved with the project.

The final evaluation findings also provided a key lesson related to research design for assessing the effectiveness of social interventions. Project leaders felt that the lack of differences in permanency outcomes between treatment and control groups might have been related to some aspects of the research design. Providing Family Finding model training to SF-HSA workers who were serving control cases *during* the study instead of *after* the study may have diffused the treatment services into control cases, thereby “contaminating” the control group and possibly masking the true impact of the intervention. In hindsight, the study may have had more potential to detect true effects if the SF-HSA trainings for workers serving control group cases had occurred at the end of the study, or alternately, if a quasi-experimental design had been employed in lieu of a randomized experimental design where both treatment and controls were served within a single county agency.

Some lessons learned were more encouraging. Having a liaison from SF-HSA on the LCI Implementation Team provided the project leaders with important insight into how processes and decision-making worked with the child welfare agency. The SF-HSA liaison, Dr. Harris, also helped to identify advocates within SF-HSA, provided access to data and analyses during the course of the study, and kept Seneca apprised of agency-wide decisions that could potentially affect the work of the LCI.

IV. Sustainability

Over the life of the LCI project, the plans for sustaining family finding services post-grant as an in-house function at SF-HSA have been, and continue to be, in flux. During the second year of the study, preliminary data analyses conducted by Dr. Elizabeth Harris at SF-HSA, provided an early indication that increases in the number of *engaged* family connections among treatment group children (particularly younger children) were associated with faster exits from foster care to relative placements. Based on this preliminary data, there was early buy-in at the leadership levels of SF-HSA to sustain the program as a regular agency function after the end of the LCI project.



Since that time, a few factors have influenced the initial sustainability plan, with the current status of the plan to continue family finding services as an in-house SF-HSA function unknown as of June 2016. One factor is that the economy of San Francisco continues to boom, which has resulted in very low unemployment, making it challenging for SF-HSA to recruit and maintain full staffing levels to support core functions or add new functions. In addition to the macro-economic issues that have affected county staffing capabilities, the final evaluation report for the LCI project indicated that the increased numbers of identified and engaged connections among the children receiving treatment services did not result in expected improvements regarding length of stay or permanency outcomes. Without demonstrated impacts to key permanency outcomes, there is a less robust buy-in among SF-HSA leadership to expend agency resources to continue family finding services as an agency function now that grant-funded services have ended.

Upon the close of the LCI grant-funded study period, open cases were transitioned back to the SF-HSA workers. During the three months after the study ended, from October through December 2015, SF-HSA piloted a modified version of the Family Finding model. During this period, workers from the placement unit at SF-HSA received training (via shadowing and coaching) from the Seneca Permanency Specialist supervisor on delivering the intervention model. The placement unit workers who received the training only performed the searching and relative notification functions of the Family Finding model, not the FGDM components of the LCI services. At the end of the 3-month transition/pilot period, the supervisor of the placement unit met with the SF-HSA director to present a proposal for how family finding could be implemented as an in-house function moving forward. There were three suggestions considered: 1) Create a new unit of SF-HSA workers to carry out the full Family Finding model as a permanent agency function, 2) Add a new team member to each existing SF-HSA unit who would be responsible for family finding activities within that unit, or 3) Continue to have the placement unit carry out the relative notification component of the Family Finding model.

As of May 2016, the SF-HSA placement unit supervisor reported that the third option was currently in effect, with the placement unit holding the 30-day relative notification component, without implementation of the full Family Finding model. While creation of a new unit to sustain family finding services as a regular agency function is the preferred strategy of



SF-HSA leadership, that plan is currently on hold due to budgetary constraints, and it is unknown (as of June 2016) whether the new unit will be created.

In summary, scarce budgetary and human resources, coupled with mixed findings on the efficacy of the Family Finding model at improving permanency outcomes, have contributed to a sustainability plan that remains unsettled as of the end of this reporting period. While there are indications that the agency would like to continue at least some components of the family finding services initiated during the LCI project, it is unknown at this time whether the agency will be willing or able to commit the resources to sustaining the full Family Finding model as a core service, or whether the current status quo of maintaining relative notification services and family engagement strategies will be the components that are adopted as regular SF-HSA functions moving forward. (For reference, the sustainability plan from the final semi-annual progress report is included as Attachment D.)

V. Evaluation

The formal evaluation for the LCI study was conducted by Child Trends, a third party evaluator. Upon completion of the study period, Child Trends wrote a full evaluation report that included process, outcome, cost, and fidelity analyses. Due to the length of the full Child Trends report, the methods and findings sections are inserted here, with the complete report (with appendices) included as Attachment E at the end this report.

A. Evaluation Design

The goal of this evaluation was to examine the impact of the FF/FGDM model on the permanency, stability and well-being of children in foster care, as well as describe how the program was implemented and to what degree of fidelity to the FF/FGDM model. The evaluation included both impact and implementation studies. The overarching research questions¹ the evaluation sought to answer were:

Impact Study

¹ A detailed list of research questions is available in Appendix A of the full Child Trends report, attached at the end of this document.



- How does the integrated FF/FGDM model impact permanency, stability and well-being?
- How do permanency, stability and well-being vary by child characteristics?
- How does the integrated FF/FGDM model impact the caregiver’s well-being?

Implementation Study

- Are Permanency Specialists implementing the integrated FF/FGDM model as intended?
- What key linkages/partnerships/activities between HSA and Seneca contribute to the successful integration of the FF/FGDM model?

Cost Study

- What is a typical week for a Permanency Specialist?
- How do Permanency Specialists salaries break down by FF/FGDM component?
- How, if at all, is the amount of time Permanency Specialists spend on specific components associated with FF/FGDM outputs (e.g., number of connections discovered, engaged, etc.)?
- What are the out-of-home costs associated with children served by Permanency Specialists compared to the out-of-home costs for children not served by Permanency Specialists?

Building on the previous family finding evaluation mentioned above, Child Trends used a randomized controlled trial design for the impact study. Children were randomly assigned to receive the integrated FF/FGDM model (treatment group) or typical child welfare services (control group). The experimental nature of the study ensured that there was no bias in the selection of participants. While systematic differences between the two groups can occur by chance, we controlled for such differences in our analysis models. Random assignment of children to receive the FF/FGDM intervention allows us to more confidently attribute observed differences between treatment conditions to the intervention.

Study enrollment began in March 2013 and continued through March 2015. Seneca received a list of children who had been removed from their home from the court clerk’s office. The Seneca program supervisor randomly assigned cases² to the treatment or control group using

² For the purposes of this report, “case” refers to family or group of related children, which could be a single child or a sibling group.



the randomization function in the Child Trends Database. Treatment cases were then assigned to a Permanency Specialist based on caseloads and language ability.³ All control cases were assigned to and served by the Seneca Relative Notification Coordinator.

A complement to the impact study, the qualitative implementation study focused on the details of program implementation, fidelity of program implementation to the FF/FGDM model, and contextual factors that may influence program implementation or outcomes. The implementation study was informed by yearly site visits, program fidelity measures, and focus groups with relatives of children enrolled in the program. The evaluation team analyzed detailed notes from focus groups and interviews using NVivo qualitative software for the final analysis. The team then developed and refined initial themes based on the focus group and interview guides.

Data Collection

Data collection for the impact study utilized several sources, which provided information on child permanency and well-being outcomes.

Administrative Data. The evaluation team received extracts from Child Welfare Services/Case Management System (CWS/CMS), the state’s administrative data system, semi-annually between March 2013 and October 2015. The extracts contained demographic, referral, medical, placement, and discharge information for all children in the treatment and control groups. We created outcome variables using Statistical Analysis Software (SAS) and conducted data analysis using Stata.

Structured Decision Making (SDM) Assessment Tool – Protective Capacities Section.

To measure changes in parent and family protective factors, HSA provided Child Trends with regular data extracts from their SDM tool for children enrolled in the evaluation. This tool is intended to be used during the initial home visit and when closing the child welfare case. However, social workers did not complete these assessments regularly; therefore we were unable to use them in our impact study.

³ San Francisco has a large Spanish-speaking population, and Seneca has two bilingual Permanency Specialists on staff to work with Spanish-speaking families. It is not always possible to assign Spanish-speaking families to bilingual Permanency Specialists, but the Seneca program supervisor makes every attempt to do so.



Child and Adolescent Needs and Strengths – Mental Health Assessment. To measure changes in child well-being, Seneca agreed to provide Child Trends with assessment records for the Child and Adolescent Needs and Strengths – Mental Health (CANS-MH) assessment.⁴ The San Francisco Department of Public Health maintains these data and has a data sharing agreement with Seneca that covers the children they serve. However, due to changes in staffing and data sharing agreements, as well as delayed responses from the Department of Public Health, we were unable to obtain the CANS data in time for the final analysis.

The implementation study utilized several other data sources, which provided information on program activities and costs.

Child Trends FF/FGDM Database. A web-based database, developed with the earlier Stuart Foundation funds, was modified⁵ and continued as part of the new FF/FGDM federal grant project. The database is a tool for storing, compiling, and analyzing data on the FF/FGDM model. Permanency Specialists entered information on the demographics of the children they served, the connections they identified, the interactions they had with connections, meetings held for children, and any plans made to support the child. Child Trends also used the database to randomly assign children to the treatment or control group. The evaluation team trained users via live webinars and a user’s guide that provided step-by-step instructions on how to enter data. Child Trends conducted quarterly data audits to ensure data quality. Data collection ended in September 2015.

FF/FGDM Fidelity Assessment Tool. Permanency Specialists completed the FF/FGDM Fidelity Assessment Tool during their regular supervision sessions (see Appendix B for the full instrument). They used the tool throughout the life of each FF/FGDM case. The purpose of the tool was to determine if and to what degree the essential components of the program model were completed. Permanency Specialists rated how successful they

⁴ This tool was developed to assist public child welfare agencies in managing and planning services for children and adolescents and their families with the primary objectives of permanency, safety, and improved quality of life. The domains assessed include general symptomology, risk behaviors, developmental functioning, personal/interpersonal functioning, and family functioning.

⁵ Modifications to the database included functions to make it more user-friendly (e.g., copy interactions with connections and meetings from one sibling to another, recording specific commitments from connections at meetings and case closure).



were in completing specific action steps in each model component, as well as how well the family team meetings aligned with the model’s principles. The grant team worked together to develop a score for the assessment, providing input on whether or not certain items or program components should be weighted more heavily than others. Fidelity tool scores were linked to other data sources (e.g., administrative and case management data) using the child’s public agency identification number.

Family Team Meeting Survey. At the end of each meeting held as part of the FF/FGDM model, the Permanency Specialists invited participants (e.g., social workers, professional team members, and relatives of the child) to complete a survey about the meeting (see Attachment C for the full survey). The purpose of the survey was to measure how well the meeting adhered to the program’s guiding principles. The instrument covered topics including alignment with the meeting’s purpose, inclusion of the child’s perspective in the meeting, addressing the needs of all meeting participants, and the development of clear action steps and plans. This instrument uses a Likert scale to determine how strongly a respondent agrees or disagrees⁶ with the 12 items on the survey.

Site Visits. Child Trends conducted three annual site visits to San Francisco County. The site visits supported the implementation component of the evaluation by capturing information on grant implementation and the local context in which the model is operating, as well as documented changes in implementation over time. During these site visits, two-person evaluation teams conducted focus groups and interviews with Permanency Specialists and other Seneca program staff; HSA social workers, supervisors and administrators; and relatives of children who received FF/FGDM services. For a detailed description of site visit participants, see Appendix D. The evaluation team asked Seneca staff to detail their work processes, community outreach and training about the program, barriers and facilitators to implementing the model, the level of fidelity with which they were implementing the model, and any contextual issues that may influence child, family, and system outcomes. Evaluators also conducted focus groups and interviews with HSA staff to gather information about their level of involvement and

⁶ Survey respondents were asked to rate their level of agreement on 12 meeting-related items. The scale ranged from “strongly disagree” to “strongly agree” with options for “didn’t apply” and “don’t know.”



engagement with the program, the relationship between Seneca and HSA, as well as any changes in agency culture, policies, or practices related to family engagement. In addition, Child Trends convened focus groups of relatives of children receiving the intervention to assess their satisfaction with the program and elicit input on the strengths and challenges from the client perspective.

Time Tracking. As a part of the cost study, Seneca Permanency Specialists completed three rounds of time tracking between May 2014 and March 2015. They kept track of the number of hours spent on each phase of the model. The time tracking data was then linked to program outputs, such as number of connections discovered or meetings held. The data also informed the implementation study, as it painted a picture of a typical week for a Permanency Specialist.

Social Worker Knowledge Survey. Child Trends developed an online survey for ongoing social workers and other child welfare staff at HSA to evaluate changes in knowledge of and experiences with family search and engagement practices. This included staff members' (1) understanding of FF/FGDM service implementation, (2) degree to which FF/FGDM activities are integrated into casework, (3) thoughts on key FF/FGDM principles, and (4) views of barriers to implementation and thoughts on how to overcome barriers. The surveys were administered prior to and following Seneca-facilitated trainings for HSA staff; the first survey was fielded in June 2013, and a follow-up survey was fielded in October 2014. See Appendix E for a full report on the pre-/post-surveys.

Modification to Evaluation Design

In July 2014, the evaluation team modified the random assignment process. Cases were originally randomly assigned using the Child Trends Database, which required having at least two cases available to be randomized against one another. The number of detentions slowed down, and the Permanency Specialist Supervisor responsible for random assignment felt that Seneca was losing valuable service-delivery time while waiting to have multiple cases to randomize together. To remedy this issue, Child Trends deactivated the random assignment function in the database and took over the random assignment of cases. We created a pre-randomized list of treatment and control slots that mirrored the way in which the database randomized cases. The Permanency Specialist Supervisor contacted Child Trends when a new



case was detained, and the case was assigned to the next available slot – either treatment or control. Random assignment continued in this manner through the end of the study enrollment period (March 2015).

The evaluation team revised the approach to the cost study in April 2014, concluding that some of the original cost study questions were outside of the scope of the grant (e.g., What is the full cost of developing and implementing the FF/FGDM model? What are the potential cost savings of the model?). Upon approval from the Federal Project Officer, we modified our cost analysis approach to focus on time tracking and associated personnel costs, as well as costs associated with out-of-home permanency outcomes. See the Cost Study section below for more information.

B. Program Implementation

Children Served

All 145 treatment children enrolled in the study were served by a Permanency Specialist, even for a short period of time. Children were on average 6.5 years old when they began services. Roughly half were female (54%), and over one-third were African-American (43%) and Hispanic (33%). Children had been in care for an average of 11.4 days prior to random assignment. Half (52%) of the children were in foster care or a group home at the start of services; on average, children had experienced 1.3 out-of-home placements at the time of random assignment. The most common reason for removal from home was general neglect (51%), and half of the children (49%) had a goal to return home. See Appendix D for more detailed information.

At the end of the data collection, 110 cases had been closed⁷ by the Permanency Specialist, with the remaining 35 children still receiving FF/FGDM services at the end of the grant period. Overall, children were served by Permanency Specialists for an average of nine months (see Appendix D for more detailed information). Among closed cases average service length was 7 months, compared to 14 months for cases that were still open. Almost two-thirds (62%) of the cases completed FF/FGDM services, and almost one-quarter (22%) were reunited

⁷ This refers to the closure of the FF/FGDM case. A FF/FGDM case could be closed by a Permanency Specialist, but still be an open case with HSA.



with their parents before the full array of FF/FGDM were completed. Other cases were closed due to FF/FGDM services being inappropriate for the child, parents declining FF/FGDM services, and the child moving out of the area.

FF/FGDM Model Description

The intensive FF/FGDM model was developed by an interdisciplinary team lead by the National Institute for Permanent Family Connections (NIPFC), which included content experts, program implementers, and HSA staff. Adapted from Kevin Campbell’s original family finding model, the FF/FGDM model incorporated lessons learned from previous implementation experiences to provide flexibility and to integrate the practice into HSA’s existing system of care. The Kevin Campbell model described six stages: Discovery, Engagement, Planning, Decision-Making, Evaluation, and Follow-up support; for a description of the stages and how they were implemented see Table 1 on the next page. The Permanency Specialists in this project placed more emphasis on bringing relatives and other key connections to meetings to plan for permanency for the child/ren. They attempted to hold a minimum of three meetings for every child, and to include the social worker wherever possible.

The planning and decision making stages tended to overlap and, in some cases, were implemented as one stage. The Permanency Specialists reported that at times they rushed to have a meeting with relatives before adequately preparing them for what the meeting entailed. In these cases, the meetings were not always successful in engaging relatives in the planning process. In retrospect, the Permanency Specialists thought this may have been premature and perhaps delayed finding permanent connections for the child in some instances, as relatives were more reluctant to come to planning meetings later in the process.

A change in practice also took place during the study period: the Blended Perspective Meeting – described in further detail below – became a requirement for all cases, rather than on an as-needed basis. According to the Permanency Specialists, some relatives experienced “meeting fatigue” which made it more difficult to engage them in the planning process. As a result, the Permanency Specialists focused more on securing concrete short-term commitments from relatives at the initial meetings. Some Permanency Specialists reported that there had been too few family meetings, which they believed was partly due to lack of support from the social workers who were sometimes reluctant to attend a Family Team Meeting. The Permanency



Specialists expressed a concern this contributed to cases remaining open longer than necessary rather than progressing to a permanent placement for the children.



Table 1. Family Finding/Family Group Decision Making Model Stages

Stage	Description/Purpose	Relevant Outputs	
Discovery	Identify as many connections for the child as possible. Within 10 days of the child’s removal, Permanency Specialists begin reviewing the child’s case file (both physical and electronic), requesting “Cliff searches,” ⁸ conducting internet searches, and communicating with the child’s social worker. Permanency Specialists also send out Relative Notification letters to all known and possible relatives to the 5 th degree, and begin contacting relatives to verify their relationship to the child. With each contact they begin the engagement process. All connections are documented on a discovery sheet that is then passed on to the social worker.	On average, Permanency Specialists identified 29 connections per child, the majority of which were new discoveries (i.e., they were not already known to the agency). The majority of connections discovered were maternal (8 per child) and paternal (6 per child) relatives. The most common method of identifying connections was through talking with connections already known and maternal and paternal relatives. See Appendix D for more detailed information on program outputs.	<p>Challenges:</p> <ul style="list-style-type: none"> Permanency Specialists and social workers did not always agree which relatives were appropriate to contact. Social workers sometimes felt burdened by the number of connections that contacted them as a result of the Permanency Specialists’ efforts. <p>Facilitators:</p> <ul style="list-style-type: none"> This stage was seen as the most helpful to social workers, as the discovery sheet provided additional information on the child’s history, and was especially helpful for cases that remained in or returned to care.
Engagement	Engage the relatives and connect them with the social worker to provide support for the child. This began with the first contact and continued throughout the life of the case. This is done in person as much as possible. Techniques include mobility mapping, genograms and drawing a family tree. Background checks are completed on relatives who expressed interest in being a placement option for the child.	Permanency Specialists contacted on average 14 people per child. Out of these contacts made, Permanency Specialists engaged an average of 7 connections per child, the majority of which were maternal relatives.	<p>Challenges:</p> <ul style="list-style-type: none"> Characteristics of the family, such as mental health, criminal background, geographic location and prior negative experiences with CW making them reluctant to engage with the Permanency Specialists. <p>Facilitators:</p> <ul style="list-style-type: none"> Permanency Specialists being able to spend time engaging families (which social workers

⁸ Seneca staff member named Cliff completed searches using multiple internet search strategies to identify family members.



Stage	Description/Purpose	Relevant Outputs
Planning/ Decision- Making	<p>Planning and decision making are done in tandem, with discovery and engagement continuing throughout the process. The Blended Perspective Meeting (BPM) is the first meeting planned and held to create a team for the child. This includes any engaged relatives or other connections, as well as attorneys and the social worker. Relational, physical and legal permanency are explained and explored. If there is sufficient relative interest, the Permanency Specialists held Family Team Meetings (FTM), to start the planning process with the family. The social worker usually attends to answer technical questions. Permanency Specialists focus on getting specific commitments from relatives, and used the Kevin Campbell permanency pact.</p>	<p>are not always able to do), and showing respect for them.</p> <p>Sixty-two percent of children had at least one meeting, with an average of 1.9 meetings per child. Permanency Specialists held 92 BPM and 145 FTM. There were on average 5 attendees at each meeting, with most commonly relative connections.</p> <p>Challenges:</p> <ul style="list-style-type: none"> • Allowing families to take the lead sometimes slowed the process down and contributed to cases not getting to the point of having the BPM or other meetings. • Permanency Specialists sometimes called meetings before all parties were adequately prepared. • Permanency Specialists felt inadequately trained to act as facilitators and had difficulty managing conflict, and reported being uncertain as to the roles of each meeting participant. • Families experienced “meeting fatigue”. • Permanency Specialists were frustrated that they did not have decision making power with regard to visitation for the child. <p>Facilitators:</p> <ul style="list-style-type: none"> • Social workers began to include the family as the starting point in the decision making, rather than the worker. • Permanency Specialists were viewed as “expert” facilitators. • Short term planning helped bring people in who were not yet ready to commit to long term plans. • Relatives described the meetings as being very helpful, building bridges and making them feel included in the planning process.



Stage	Description/Purpose	Relevant Outputs
Evaluation	Evaluation is ongoing and part of each step of the FF/FGDM process. Permanency Specialists were instrumental in evaluating appropriateness of placements.	<p>Challenges:</p> <ul style="list-style-type: none"> • Permanency Specialists thought the social workers ruled out other relatives as placement options once they had made a decision.
Follow-Up	Cases are kept open for 3-6 months after placement. The Permanency Specialists work to maintain the stability of the placement and keep family supports involved with the child. They also encourage the social worker to remain involved with the child, without infringing on the social worker's role.	<p>Challenges:</p> <ul style="list-style-type: none"> • Cases may have been closed too quickly, especially when the child reunified with the parent. • HSA did not provide needed mental health services to the relatives. <p>Facilitators:</p> <ul style="list-style-type: none"> • Permanency Specialists emphasized that placement with a relative is preventive work, keeping the child out of foster care. • They used Skype and Facebook to maintain contact.



Table 2. Trainings Received by the HSA Social Workers and the Permanency Specialists

Title	Description	Attendees	Takeaways
Introduction to the FF/FGDM Model	Training developed by Seneca that outlines the philosophy of the FF/FGDM model, including the purpose, development and progress of the grant program; the key stages of the model; and what the roles and responsibilities of the Permanency Specialist and social worker are. It detailed the tools and processes used to create multiple permanency options and an enduring network of support for the young people and families served in the project. It used role play and case examples as training techniques.	310 HSA staff at all levels attended one of four half day trainings, as well as Seneca Permanency Specialists	<ul style="list-style-type: none"> • Some social workers reported trainings were very good, and geared towards ways to fit FF/FGDM practice into existing case work structure. • Some social workers reported "training fatigue" and did not see the practical application of FF/FGDM. • Post-training consultation was very helpful. • Social workers wanted training on preparing the caregivers for their children's difficult behaviors. • Social workers wanted booster trainings on the FF/FGDM model.
Implementation of the FF/FGDM Model and facilitation of Blended Perspective Meetings (BPM) and Family Team Meetings (FTM)	Training developed by Seneca that builds on the introduction and trains workers on how to implement each stage, as well as facilitate Blended Perspective Meetings and Family Team Meetings.	Seneca Permanency Specialists	<ul style="list-style-type: none"> • Permanency Specialists reported the appreciative inquiry technique was very helpful to their work. • Permanency Specialists liked being able to shadow more seasoned workers. • Permanency Specialists reported having a range of new to seasoned workers participate in the training was helpful to their learning the model. • Permanency Specialists who did not receive formal training report lacking skills. • The Permanency Specialists would have liked to have a standardized, formal curriculum to be able to refer to, and as a repository of agency knowledge. • Permanency Specialists felt unprepared to facilitate BPM or FTM, and wanted more guidance on sharing information with relatives and confidentiality.



Safety Organized Practice (SOP)

A practice approach that focuses on the safety of the child within the family system and includes group supervision, Signs of Safety, Motivational Interviewing, and solution-focused treatment. Safety-organized practice brings a common language and framework for all workers to facilitate working collaboratively.

HSA social workers and Seneca Permanency Specialists

- Training gave a shared language all workers could use and increased the level of understanding among workers.
- Permanency Specialists gained skills in how to lead meetings including how to interact with the social workers during meetings.



Staff Training

Both the social workers and the Permanency Specialists received training on the FF/FGDM model, as well as the Safety-Organized Practice Model (SOP). Table 2 on page 13 describes each training, the participants, and lessons learned reported by the focus group and interview participants. Overall, they reported that the training was a positive experience but identified specific areas that could be improved.

In general, the social workers and Permanency Specialists reported that trainings were helpful to them in their work. The Permanency Specialists reported wanting to receive more training on how to facilitate meetings, but noted that the SOP training gave them greater insight and skills into how to run meetings. Both the social workers and Permanency Specialists used the SOP terms and definitions, which helped them to develop a common language. In turn, this increased the social workers' understanding of what the Permanency Specialists were trying to accomplish with the FF/FGDM work. The social workers reported wanting more training on how to support relatives in caring for children with behavior challenges.

C. Impact Study Findings

The impact study sought to determine how the FF/FGDM model influenced permanency-related outcomes. Our “confirmatory”⁹ outcome was whether the child reached legal permanency (discharged from care to reunification, adoption or guardianship) by the end of the study period (September 29, 2015). Additional “exploratory” outcomes included: length of time to permanency, placement with relatives or fictive kin (hereafter, “relatives”), and experiencing re-allegations and re-entry among those who did achieve permanency.¹⁰ We also analyzed “mediating outcomes;”¹¹ specifically, the number of family connections identified and the number of family connections potentially interested in being involved in the case (hereafter,

⁹ The “confirmatory” outcome is the outcome expected to change and the focus of the intervention. We selected a single outcome to be the focus of a “confirmatory” analysis because examining impacts on multiple outcomes would result in an elevated likelihood of finding one or more significant impacts by chance. We examined additional outcomes, including those available only for a subset of the sample (re-entry and re-allegation), as “exploratory,” an approach recommended by Schochet (2008).

¹⁰ Note that our findings for re-allegation and re-entry cannot be considered experimental as the analytic sample for this part of the analysis is limited to children who achieved permanency and the sample is not randomized among children receiving permanency.

¹¹ Mediating outcomes must be achieved in order to reach the other outcomes of interest.



“engaged”). All data for the impact analyses, with the exception of the indicators that identify the child’s experimental group status and start date of services, are derived from administrative data provided by the San Francisco County’s administrative child welfare data system (CWS/CMS).¹²

Analytic Sample

Our sample totaled 280 children who represented 197 cases (children with siblings were assigned together, so a case may include a single child or a sibling group). See Table 3 below for breakdown of the sample by treatment condition. Case size ranged from 1 to 5 children and averaged 1.2 children. Eight percent of the treatment children were reunified with their family within 30 days of beginning FF/FGDM activities and therefore did not receive the full complement of services. However, the Intent-to-Treat design,¹³ requires that all children enrolled are included in the analyses.

Table 3. Children and cases enrolled by treatment condition

	Treatment	Control	Total
Children enrolled	145	135	280
Cases enrolled	99	98	197

Our sample was well-balanced¹⁴ across treatment status with a few exceptions: treatment children were less likely than control children to be male, and to be missing information on disability status; and treatment children were more likely than control children to have entered foster care as a result of experiencing physical abuse (see Appendix D for more detailed information). We examined county-level data¹⁵ from April 2013 to March 2015 (the study enrollment period) in order to assess the similarity of our sample to the general child welfare

¹² Though limited demographic data and information on the children’s placement histories were collected in the Child Trends Database, we relied completely on the administrative data for the impact analyses to avoid any bias in our analyses.

¹³ In ITT analyses, children who are assigned to the treatment group remain in the treatment group for analysis purposes regardless of whether they actually received treatment. ITT analyses are frequently used because they maintain the statistical similarities of the treatment and control group, thus maintaining our ability to attribute causality for any observed impacts on outcomes to assignment to the intervention.

¹⁴ We examined differences in the following characteristics: child demographics, disabilities, placements with siblings, reasons for removal into foster care, and foster care history. All variables are measured at the time of referral to family finding services.

¹⁵ Data were extracted from the CWS/CMS Direct Reporting System maintained by the Center for Social Services Research at the University of California at Berkeley, at http://cssr.berkeley.edu/ucb_childwelfare/



population in San Francisco County. The analytic sample for the impact study is reasonably representative of the broader population of San Francisco County children new to foster care (see Appendix D for more detailed information).

Description of Analysis

To analyze the impact of the FF/FGDM model on our outcomes of interest, we used linear or logistic regression with treatment status as the predictor of interest.¹⁶ We also used survival analysis to assess if the FF/FGDM model had an impact on how long it took to reach permanency.¹⁷ We used robust standard errors to adjust for the fact that children were randomized by sibling group. Literature on randomized controlled design evaluations (Knol et al., 2011; Egbewale, 2015) recommends not only controlling for variables on which the study groups are not equivalent (in this study: gender, disability status unknown and physical abuse as removal reason), but also variables that are associated with the outcome of interest. Inclusion of additional covariates makes the measurement of the treatment effect more precise. Thus, we included measures associated with permanency in all regression models.¹⁸

Analysis Results

Our analysis revealed that children who were served by Permanency Specialists were more likely to be placed with relatives when compared with children in the treatment group. Treatment children also had more connections identified and connections engaged in their case than children in the control group (see Table 4 on the next page). However, the two study groups

¹⁶ Logistic regression was used for binary outcomes including: permanency, placement with kin, and whether the child experienced a re-allegation or re-entry into foster care. Linear regression was used for continuous outcomes, the number of connections, and the number of potentially interested connections.

¹⁷ Survival analysis is used to measure the time to a particular event (permanency in our study) and also allows for the inclusion of cases that have not yet reached that event. We ran Kaplan-Meier estimates of the time to permanency, comparing the survival functions (where failure = permanency) of the treatment and control groups. We also ran Cox proportional hazard models in which we included the additional covariates as well as controlled for sibling clusters.

¹⁸ Covariates included: age five or younger, gender, race/ethnicity, disability status, reason for removal, in a sibling group, two or more removals, number of out of home placements (none, one or two or more), length of time in foster care from removal to random assignment (in days). There were five children that were missing data on both reason for removal and length of time in foster care because they were never removed from home, we imputed these as “other reason” and zero days. We included a flag indicating that the case was imputed as recommended in the evaluation literature (Puma et al, 2009). All covariates are measured at the time the child was randomly assigned. For each outcome, we ran one regression with all covariates.



did not differ with regard to permanency, length of time to permanency, or re-entries and re-allegations. The results are described in further detail below.

Discharge to Permanency

Children in the treatment group were no more likely to be discharged from care to permanency (i.e., adoption, reunification or guardianship) than were children in the control group. Across the entire sample, approximately half (55%) of the children were discharged to permanency, the majority (69%) of whom were reunified with their parents. As shown in Table 4, among those who did exit to permanency, there were no significant differences in the type of permanent outcome between children in the treatment group compared to children in the control group.

Time to Permanency

We also investigated whether or not children in the treatment group exited care more quickly than those in the control group. There was no significant difference in the average number of days to permanency by experimental group status (292 treatment vs. 274 control). Children who reached permanency were in care for an average of 283 days. Children who did not achieve permanency had been in care an average of 496 days at the end of the study period.¹⁹ Again, there were no significant differences by experimental group status in length of time in care (478 treatment vs. 520 control), and the results of our survival analysis suggested that there was no significance difference in how quickly permanency was achieved between the treatment and control groups.²⁰

¹⁹ Days in care is measured from the removal date of the foster care episode associated with random assignment to family finding to either the date that permanency was achieved or the end of the study period (Sep. 29, 2015).

²⁰ The survival functions for the Kaplan-Meier survival curves were not significantly different and the hazard ratio on the treatment variable in the Cox proportional hazard models was not statistically significant.



Table 4. Impact analysis results

	Treatment (n=145)	Control (n=135)	All (n=280)
Permanency ¹	52%	59%	55%
Permanency outcomes among those reaching permanency			
Reunification	73%	66%	69%
Adoption	16%	19%	18%
Guardianship	11%	15%	13%
Average time in care			
Time to permanency (days)	292	274	283
Time among those still in care (days)	478	520	496
Re-allegation			
Re-allegation	10%	8%	9%
Re-entry			
Re-entry	8%	9%	8%
Placement with relatives			
Placement with relatives	50%	39%	* 45%
Number of connections identified			
Number of connections identified	8.5	5.0	** 6.8
Number of connections engaged			
Number of connections engaged	5.5	3.6	** 4.6

* $p < .10$, ** $p < .05$

¹Permanency, re-allegation and re-entry outcomes are measured as of September 29, 2015.

Placement with Relative

As shown in Figure 1 below, treatment children were significantly more likely to be placed with relatives²¹ than children in the control group. The percentage of treatment children

²¹ Placement with relatives includes placement with adults who are related by blood to the child (relative) or with a nonrelative extended family member (NREFM). This is either the child's placement at the end of the study period (if they were still in care), or the last placement before exiting care.



placed with relatives was also higher (by 17 percentage points) than the percentage of children in the general child welfare population in San Francisco County (33%).²²

Figure 1. Treatment children were significantly more likely to be placed with relatives



Re-entry and Re-allegations

There were no significant differences in rates of re-entry and re-allegations across treatment and control groups. Overall, rates of re-entry and re-allegation were low; 8% re-entered foster care after the episode associated with random assignment to FF/FGDM²³ and 9% had a re-allegation. Children receiving FF/FGDM had the same likelihood of re-entry or re-allegation as children in the control group. These results should be interpreted with caution as the evaluation timeline did not allow adequate time for such outcomes to occur.

Family Connections

While the FF/FGDM model did not impact our confirmatory outcome, it did impact our mediating outcomes. Children who received FF/FGDM had more connections identified and engaged²⁴ than did their counterparts in the control group. As shown in Figure 2 below, children in FF/FGDM, on average, had 8.5 connections identified versus 5.0 connections for children in the control group. Treatment children also had an average of 1.9 more engaged connections compared to control children.

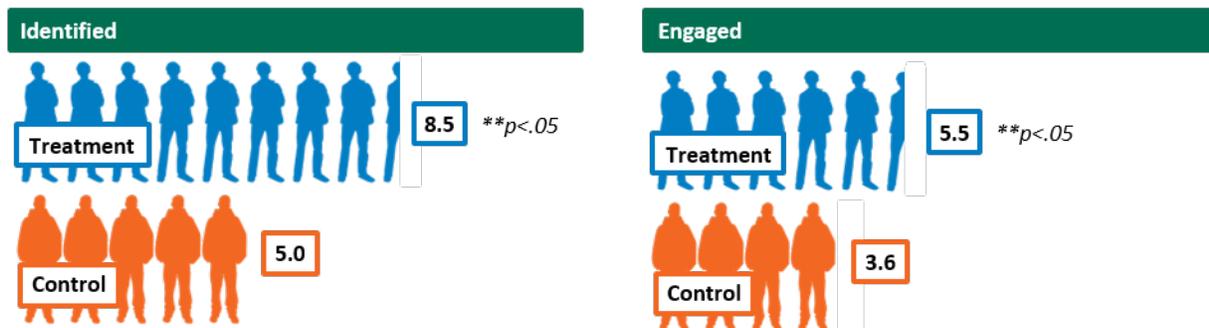
²² According to figures provided by a senior data analyst at HSA, as of January 6, 2016.

²³ Only one child had more than one re-entry.

²⁴ “Identified” means that the Seneca worker initiated contact with and confirmed that the person is related to the child. “Engaged” means that the relative indicated they would be potentially interested in being involved with the child’s case in some way (e.g., providing support to child or birth parent, attending meetings, being a placement resource). Like all variables used in the impact analysis, these are taken from CWS/CMS in order to detect differences between the treatment and control groups. For children who received the FF/FGDM model, Permanency Specialists also entered more detailed information into the Child Trends Database on the connections they identified. Unlike in CWS/CMS, for a connection to be recorded in the Child Trends Database, it was not a requirement for the Permanency Specialist to have actually made contact or have interacted with the person.



Figure 2. Treatment children had more connections identified and engaged



Differences by child characteristics

We also examined differences in outcomes by age and race/ethnicity. The treatment effect only differed significantly by race/ethnicity for placement with relatives. Being in the treatment group had a significantly larger impact on whether or not Latino children were placed with relatives when compared to non-Latino children. In other words, Latinos in the control group were less likely to be placed with kin versus non-Latinos in the control group (24% compared with 45%), while Latinos in the treatment group were slightly more likely to be placed with kin than non-Latinos (56% compared with 47%). The only other significant finding by subgroup was age and reallegations. For children under the age of five, being in the treatment group made them more likely to experience a reallegation than those over the age of five. However with so few children experiencing a reallegation ($n=10$ for treatment children and $n=4$ for control children), we should be cautious in assuming these results are generalizable.

D. Implementation Study Findings

The first analysis step for the implementation study was the development of a coding structure closely aligned with the interview and focus group protocols from the site visits (description of service components, impressions of and experiences with services, challenges and facilitators to service delivery, and contextual factors). Two-person teams conducted the qualitative field work with one researcher serving as the interviewer/facilitator and one serving as note taker. Detailed notes from each completed interview and focus group were coded thematically according to the coding structure. Themes that emerged through coding are presented as the subheadings in this section. Unfortunately the small numbers of site visit



participants precludes us from detailing the number of participants who expressed each theme as doing so might divulge identities.

Implementation Challenges

During annual site visits, the evaluation team assessed the challenges that the grant implementation team experienced in implementing the program, including barriers related to philosophical differences between the Permanency Specialists and social workers, Permanency Specialist workload, communication challenges, meeting fatigue, training and supervision of the Permanency Specialists, and characteristics of the relatives that made it harder to serve them.

Philosophical Differences Regarding Family Engagement

Some social workers did not agree with the FF/FGDM approach and were wary of contacting family members, who they thought would be inappropriate and create instability for the children rather than serve as positive supports. At times, the Permanency Specialists felt that this attitude negatively impacted their work with the children and relatives and may have slowed the process down. This also translated into disagreements over who to engage, especially when it came to paternal relatives when paternity had not been established. While HSA administrators decided that relative notification can and should include alleged paternal family members, some social workers thought they were overstepping their bounds in not waiting until paternity had been established before making contact with possible connections for the child. Some Permanency Specialists thought that social workers would often accept the first available placement option (which may have been a non-relative placement) before considering all relative options. Some social workers thought their priority was to keep the child safe, and their loyalty was to the child, not the relatives. This was a different approach than that of the Permanency Specialists who, although cognizant of the importance of safety, also prioritized the child's right to keep contact with family and have them involved in the planning process. To a social worker more relatives engaged in the process could mean more people to vet, whereas to a Permanency Specialist more relatives involved meant more possibilities for emotional and legal permanency.

Results from the social worker survey (see Appendix E) indicate that in general the social workers had reservations about considering a long-term placement without legal permanency as a successful outcome, and their reservations grew from pre- to post-test. Their perspectives differed from the Permanency Specialists, who placed a higher value on relational permanence



than did the social workers. Some social workers thought that relational permanence²⁵ was a less than adequate goal in and of itself, and felt that they needed to focus on legal permanence instead. Some believed that, even though family is important, the balance of emotional and legal permanence for the child with the appropriateness and availability of family is important. This differed from the Permanency Specialists, who strived for and believed that relational permanence could provide tremendous support to children who had not been connected to relatives in the past.

Perception of Increased Workload

Initially, some social workers felt that the discovery and engagement stages of FF/FGDM, specifically the relative notification process, increased their workload significantly. Some social workers were overwhelmed by the number of relatives who contacted them wanting to get information about their relative child and participate in the case planning process, which took up a lot of their time. They also felt that the Permanency Specialists could have done a better job managing the relatives' expectations regarding contact with the child. Over time, the social workers came to appreciate the Permanency Specialists' work and the benefits of increased family engagement for the children on their caseload.

Communication Barriers

The Permanency Specialists felt a sense of urgency to contact relatives, especially early on in the project, and some expressed impatience if the social worker did not respond in a timely manner to their queries about which relatives would be unsafe to contact. Permanency Specialists would often proceed with contacting relatives without contact with the social worker first. This raised concerns for some of the social workers that they were being left out of the loop, and they worried that the Permanency Specialists would contact people the social worker deemed inappropriate. Both sides believed that better communication could have alleviated this problem, and over time it did improve. Some of the Permanency Specialists thought that more in-depth training in the FF/FGDM model in general, the discovery and engagement process, and the Permanency Specialists' role in particular, including how they approached relatives, could have

²⁵ Relational permanence refers to connections made between the child and relatives that remain constant over time, but do not include the child living with the relative. This can include visitation, emotional, social and/or financial support.



alleviated some of the concerns the social workers had and facilitated better understanding and communication between parties.

Seneca Staff Training and Supervision

The Permanency Specialists hired after the start of the project reported receiving more on-the-job training than any formal training on the model. This included shadowing more experienced Permanency Specialists, but they reported they would have benefited from more formal training, in particular on facilitating meetings (one of their expressed weaknesses). Some Permanency Specialists also felt that having a standardized manual would have increased their ability to learn more on their own. They reported that their supervisors were very good at explaining the stages of the model and the accompanying tasks, and communicated very well with HSA. However, due to the clinical nature of the work, they felt they would have benefited from more clinical supervision.

Overabundance of meetings

There appeared to be “meeting fatigue” among both the relatives and the social workers at HSA. According to one social worker’s count, there were 37 different types of meetings held at HSA. At times, this meant that the social worker did not have the time to attend Seneca-run meetings. The Family Team Meetings run by the Permanency Specialists were not required by HSA, so social workers did not always attend. Without the social worker present the meeting was not considered an official HSA meeting and did not carry any weight with HSA regarding permanency plans made at the meeting. Some of the Permanency Specialists thought that the relatives also “lost steam” after the first couple of FF/FGDM meetings, especially as these were often in addition to HSA meetings they were asked to attend, and it became harder for the Permanency Specialists to engage them to continue the planning process. Permanency Specialists encouraged families to make short term plans at the initial meetings to establish momentum with some successful engagements early on, in turn leading to the development of long term plans later on in the process.

Family Characteristics

Due to prior contact with HSA, some parents and relatives were distrustful of the agency, and therefore reluctant to engage with the Permanency Specialists and share information about other relatives. The Permanency Specialists also had trouble engaging relatives who could not



pass criminal background checks, had mental health challenges, or lived far from their relative children. These same issues made contact with their relative children difficult. Some social workers were concerned that contact with such relatives would not be in the best interest of the child. Many of the Permanency Specialists reported that encouraging the relatives to take the lead in the planning process slowed the process down and may have contributed to cases not progressing to the Blended Perspective Meeting or other FF/FGDM meetings.

Implementation Facilitators

Site visit participants reported several facilitators, or drivers, in implementing the FF/FGDM model, including the integration of FF/FDM principles into HSA practice, features of the social work staff, commitment of the Permanency Specialists, revision of the relative notification process, and co-location of the Permanency Specialists within HSA offices. Family engagement was also a facilitator of FF/FDM implementation.

Integration of FF/FGDM Principles

Over time, many social workers began to adopt the principles of family discovery and engagement of the FF/FGDM model and appreciate the ways in which it could help them in their work. They saw that the discovery process was useful both for children who had relatives who were interested in caring for the child as well as those that did not. One social worker expressed that they were able to explore adoptive homes faster for children when as a result of FF/FGDM they knew there were no relatives available as placement options. Results from the social worker survey indicated that, both at pre- and post-test, the social workers strongly agreed that it is important for relatives to be involved in a child's life even if they cannot serve as a permanent placement. Survey results also suggest that the social workers agreed that relative involvement could enhance a child's overall well-being.

Many of the social workers reported that, as a result of observing the work of the Permanency Specialists in Family Team Meetings, they began to incorporate the family engagement principles of FF/FGDM into other agency-run meetings, and began to include the family's opinions and ideas into the planning process. One of the HSA administrators reported that, even in agency-led meetings, they were now looking to the family as the starting point in decision making, not the social worker. Many of the social workers reported that in the Permanency Specialist-led Family Team Meeting they appreciated having the Permanency



Specialists as the facilitator and saw them as “experts” in the process. They saw the benefit of having family meet face to face, and appreciated the value of developing concurrent plans with the relatives. Results from the social worker survey indicated that the social workers agreed that it is important to involve relatives as a life-long supportive network for the child. All relatives reported that they felt included in the process and that the meetings linked people together to focus on the needs of the child. Even though some of the social workers did not like the randomization aspect of the evaluation, they supported the principles of FF/FGDM overall.

Staff characteristics

Some of the Permanency Specialists reported that social workers who were younger and newer to the agency appeared to be more supportive of the FF/FGDM model in general compared to older more experienced social workers. This was in contrast to the results of the social worker survey, which indicated that more experienced workers’ opinions more closely aligned with the grounding principles of FF/FGDM. In general, the Permanency Specialists perceived FF/FGDM to be a desirable and reputable practice among new HSA social workers who held a Masters in Social Work (MSW) degree.

During the second year of the project, Seneca changed the job description for the Permanency Specialist position to require an MSW. Seneca also reported improved screening and selection process for new Permanency Specialists. There was a fair amount of staff turnover, and as Permanency Specialists left they were replaced with Permanency Specialists who had more clinical training. They had the preparation and skills to engage hard-to-reach relatives, which is a core activity of the model and can be quite challenging for less experienced workers.

Commitment from Seneca Staff

All Permanency Specialists were strong believers in the FF/FGDM principles, which helped promote the model with the social workers and the relatives. They reported that they felt they went above and beyond the bare requirements of the model and put in extra effort to try to find and engage connections for the children they served. They had strong communication skills and were willing to reach out to family who had been overlooked. One Permanency Specialist reported:



“The relationships we build...we are able to find families just through cold calls. That’s amazing to me. We are able to find connections just based on the fact that we are willing to listen to them and hear them out. I don’t think that happens in child welfare often. It’s huge. Responding to them. You couple that with in-person engagement and following through on what you say and it’s huge.”

Partnership between SF-HSA and Seneca

The positive working relationships built between the Permanency Specialists and social workers contributed significantly to the successful implementation of FF/FGDM and its integration into HSA. All the Permanency Specialists and the social workers talked about building good communication pathways over time, and the social workers were especially appreciative of the Permanency Specialist supervisor’s communication, organization and negotiation skills. This was enhanced by having the Permanency Specialists embedded in the agency offices. A critical element of the relationship was the Permanency Specialists conducting the relative notification process. The Permanency Specialists entered information about connections discovered and engaged for each treatment child into the agency data system, which helped the social workers in their work with the families. The social workers also relied on the Permanency Specialists to talk with relatives and engage them in the planning process, which saved the social workers some time and allowed them to occasionally skip the Permanency Specialist-led Family Team Meeting.

Revision to Relative Notification Process

Initially the relative notification letters were misconstrued by many relatives as promising a relationship with their relative child that may or may not have been possible and caused them to have unrealistic expectations. In some cases it was the first time the relative found out their related child/ren was in agency custody and was quite upsetting for them. The Permanency Specialists said that they rewrote the letters to be less specific yet still encourage the relative to make contact with the Permanency Specialists. This improved the process overall and yielded better engagement with relatives. It also eased some of the burden on the social workers, some of whom reported that fewer upset and confused relatives were calling.



Co-Location of Seneca Staff at HSA

The fact that the Permanency Specialists had physical office space in county offices helped improve communication and collaboration between HSA and Seneca staff. The Permanency Specialists were integrated into the day to day practice of HSA and participated in the service provision teams, which increased agency acceptance of the FF/FGDM program. Their role as facilitators and coordinators of the FTM was appreciated by the social workers, and being on-site made it easier for the social workers to attend meetings.

Critical Elements for Program Success

The Permanency Specialists believed that building relationships with all parties was critical to the success of the program. As one Permanency Specialist explained:

“At the end of the day, this is about relationship building with the parents, the families, and the social workers. It’s really meeting people where they are and helping them understand why it’s important to do this.”

Overall, the Permanency Specialists believed that being open to listening to families and really engaging them in the planning and decision making process was vital to the success of their work. This included kindness and curiosity and the confidence that you can work with the family to engage them. Another critical step was establishing a supportive network for each child, as this was a framework that would allow the child to “get out of the system.” Techniques that they felt were critical included: the statement position map, appreciative inquiry, and the family tree exercise. They also viewed a good working relationship with the social worker as critical to successful FF/FGDM.

One Permanency Specialist said that finding family was the easy part, bringing them to a meeting and facilitating the meeting was much harder and required more skill, especially clinical and family therapy skills. Direct care experience was valuable and helpful in doing the work. Another Permanency Specialist thought that discovery was the critical component, as without discovery you would have no-one to work with as a potential placement option for the child.

Family Engagement and Involvement in Decision Making

Overall, relatives who participated in FF/FGDM services were positive about the Permanency Specialists and felt the Permanency Specialists were engaging, respectful, and



responsive to their concerns. The relatives saw the relationships between the Permanency Specialists and child as supportive and enduring over time. They understood the value of FF/FGDM for themselves and their relative children and felt it increased communication between themselves and their relative children. One relative reported having a positive relationship with the foster family as a result of FF/FGDM. Another relative commented “They were magnificent. I don’t have a single complaint.” S/he felt included in making decisions about the child’s permanency options. This was true for the FF/FGDM process in general, as well as the Permanency Specialist-run meetings, such as the Blended Perspective and Family Team Meetings. Most of the relatives reported that many of the FF/FGDM activities were useful, such as the family tree.

To further understand what meeting participants, including the relatives, thought of the meeting overall, we examined the results from the Family Team Meeting surveys. We received surveys from meetings held for only 16 of the 88 children for whom meetings were held; a total of 175 surveys were completed at 34 meetings. The majority (46%) were completed by relatives, but one-third (34%) were missing information regarding who completed the survey. We sought input from Seneca staff on a composite meeting fidelity score, where some items are weighted higher than others. The raw composite score was then converted into a percentage of total possible points for easier interpretation. However, with surveys completed for only 18 percent of children for whom meetings were held, the results should be interpreted with caution.

The survey corroborated the opinions expressed by relatives in the focus groups. Overall, they reported that the meetings were inclusive of their opinions and stories, well run by the facilitators and that the “right” people were at the meeting. For details on each response item, see Appendix C. The scores indicate that, from the viewpoint of relatives, the meetings were run with fidelity to the guiding principles. The average meeting score was 75 percent for relatives; however, their scores varied widely (12% to 100%). The children who completed surveys rated the meetings highly, giving an average score of 92 percent, with less variance in their scores (75% to 100%).

These survey results indicate that the Permanency Specialists are doing a good job at engaging the family and team members, at explaining the purpose of the meeting and encouraging participation of all at the meeting. They suggest that Permanency Specialists are less



successful in identifying the current stressors and barriers impacting participants, clearly outlining the agency's concerns, and discussing the permanency options. Some of the team members thought that the child's ideas were not included in the plan.

Contextual Factors

In order to understand what other factors may have affected the successful implementation of the FF/FGDM model, we looked at the context of practice as usual in the agency, what other programs and practices were available in the area that were similar to FF/FGDM, and community characteristics that could have an impact on the implementation of FF/FGDM.

HSA Practices Similar to FF/FGDM

In addition to the full-time HSA staff person that facilitates FGDMs, there were other practices in the agency that were similar to the FF/FGDM model. Children in the control group may have been involved in these services. In particular, the agency has many meeting formats to facilitate permanency, several of which were frequently mentioned during site visits:

- Meeting to Assess Permanency (MAP) is a panel of staff that discusses permanency options for children in care.
- Family Team Meeting (FTM) focuses on creating plans to meet child and family needs as the case continues in the CW system.
- Team Decision Making (TDM) is focused on the placement and safety issues.
- Multi-Agency Services Team (MAST) is a coordinated leadership approach to meeting the needs of complex cases involved in one or more systems of care
- Placement and Review Committee (PARC) is a case consultation meeting to discuss permanency options for a case.
- Child Family Team (CFT) meetings focus on the mental health needs of the child.

The agency had other programs that support permanency for children, including the kin-gap program which offers child care, a clothing allowance, and medical care for the child until they turn 21; a process to license non relative extended family members (NREFM) which included a background check, a home study and an orientation. In August 2014, HSA began a resource family assessment (RFA) process which offers a relative caregiver the same training as a licensed foster parent. This process entitles the relative caregiver to legal status six months after they complete training. This made them eligible for some financial assistance and may have



increased the number of relatives interested in becoming permanent placement options for their relative children.

Children in the control group were eligible to receive similar services from their social worker, and some social workers reported that they believed they did the same work as the Permanency Specialists (including holding family meetings similar to the Blended Perspective Meeting with relatives), but it took them longer than the Permanency Specialists. Other social workers reported they did not have time to do the in-depth work the Permanency Specialists did, although they wished they had the time to do so. Some social workers were more proactive about making contact with family members than others. Initially, some social workers saw the relative notification letter as an end in itself and did not follow up with relatives who did not respond to the letter. As a result of exposure to FF/FGDM, the social workers began to view this as the beginning of the engagement process and placed more emphasis on engaging relatives.

Other Agencies that Offer Similar Services

The Permanency Specialists and social workers mentioned other agencies that provide similar services to the FF/FGDM service. Edgewood is a private residential treatment social service agency in the San Francisco area that also provides family conferencing and family search and engagement services for the children in their care. The HSA administrator described their services as assisting youth to identify at least three adult/sibling connections in their life, and having the same goals of family engagement as FF/FGDM.

The San Francisco school district also attempts to find adult and sibling connections for the children in foster care in their schools. Family Builders (which serves about one in every six to seven children in care in San Francisco) is another private agency whose mission is to help find permanent, loving families for children and youth in the foster care system. They have a team of permanency workers that does work similar to the Permanency Specialists.

It is possible that some of the children in the control group received services from these agencies. Because these services are similar in nature to the FF/FGDM services, children in the control group may have experienced some of the same outcomes as the treatment group, such as increased connections with relatives and increased chance of a permanent placement with a relative.



Community Characteristics

Permanency Specialists reported that the high cost of living in San Francisco has driven many people out of the city to more affordable communities. With so many relatives living outside of the city, it is difficult for children to maintain regular contact with their family. San Francisco has a large transient population (with people moving both in and out as well as around the city): this means that relatives are often not in the same area as their related children, which makes it difficult for them to establish and maintain contact with each other. These factors could have affected both the treatment and control group children.

E. Fidelity Assessment

One of the goals of the evaluation was to measure the fidelity with which Permanency Specialists implement the FF/FGDM model. We used two sets of measures to determine the level of model fidelity on each case: FF/FGDM fidelity tool and fidelity “benchmarks.” The fidelity tool (see Attachment B) is principle-based, focusing on how successful the Permanency Specialists felt in completing the essential components and action steps of the model as well as how closely the team meetings aligned with the model’s principles. The benchmarks are more output-based, focusing on the concrete results of the Permanency Specialists’ actions. Taken together, they allowed the grant team to assess how well the model was being implemented.

Fidelity Tool

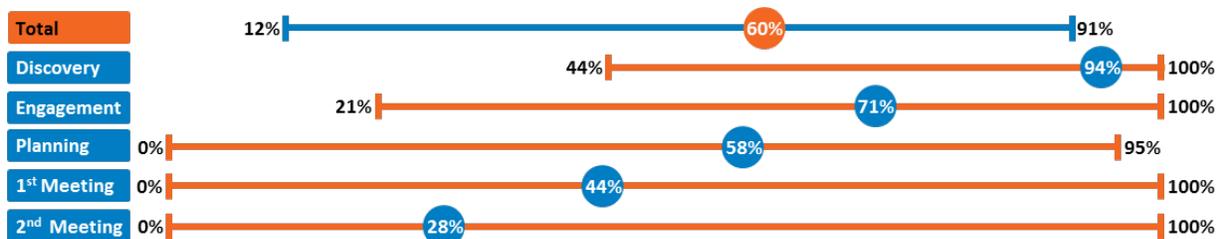
Permanency Specialists completed the fidelity tool for each case during their regular supervision sessions. In the discovery section, Permanency Specialists indicated whether or not each action step was completed. In the engagement and planning sections, they rated how successful they felt in completing each action step. In the final two sections Permanency Specialists rated how closely the meetings aligned with the model’s guiding principles. Each case was given a fidelity score based on the Permanency Specialists’ ratings of the action steps.²⁶ Fidelity tools were completed for 93 cases. Almost one quarter (23%) of the cases with a completed fidelity index were served by a Permanency Specialist for less than 60 days. Including

²⁶ As mentioned earlier, the evaluation team, in collaboration with Seneca program staff, developed a score for the assessment. The engagement and planning stages were weighted more heavily than the discovery and decision making stages. Action items in each stage were also weighted. See Appendix B for more detailed information on the development of the fidelity score.



these cases in our assessment could bias the results, as they did not have the opportunity to receive the full model; therefore we excluded these cases from our examination, yielding a sample of 72 cases. In order to more easily compare scores across each stage of the model, the evaluation team converted raw scores into the percentage of total possible points for each section. As shown in Figure 3 below, the average percentage scores on the fidelity index were lower as the Permanency Specialists progressed through each stage of the model. For many cases, the lower scores in the planning and meeting stages can be attributed to not having family meetings.

Figure 3. Average and range of percentage scores on each stage of the model



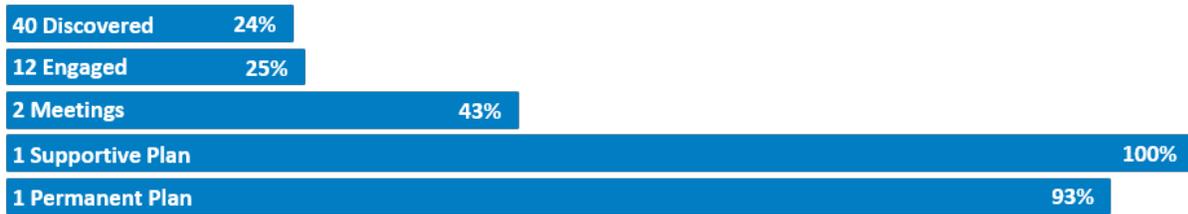
Fidelity Benchmarks

In addition to rating how successful Permanency Specialists were in completing each action step, the fidelity tool also emphasizes meeting specific “benchmarks” for each phase of the model: 40 connections discovered, 12 connections engaged, 2 meetings held, leading to 1 plan developed for the child. Figure 4 shows the number and percentages of cases where each benchmark is met.²⁷ Permanency Specialists were able to meet more of the benchmarks in the later stages of the model. All cases had at least one family member agree to a supportive plan, and almost all (93%) had at least one connection agree to a permanent plan.

²⁷ “Connection discovered” is defined as a person/relative that was identified as being connected to the child during the discovery process, as entered into the Child Trends Database. The Permanency Specialist did not necessarily have any contact with this person, they just identified them as being related to the child. “Connection was engaged” is defined as connections who were interested in attending a meeting or agreed to a permanent or supportive plan at any interaction with the Permanency Specialists. “Meetings held” is defined as having two meetings (either Blended Perspective or Decision Making). “Supportive plan made” is defined as having at least one connection agree to a supportive plan at case closure. “Permanent plan made” is defined as having at least one connection agree to a permanent plan at case closure.



Figure 4. Percentage of cases that met each fidelity benchmark

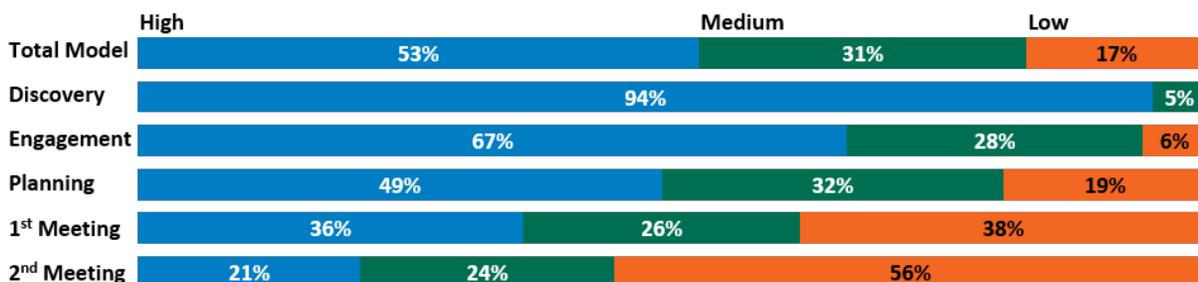


As shown in Figure 3 above, the degree of fidelity to the model (according to the fidelity index) went down as cases proceeded through the different stages of the model. The opposite was true for the fidelity benchmarks. While Permanency Specialists were not rating their actions as successful in the later stages of the model, or as aligning well with model principles, they were still able to reach the benchmarks set out by program developers.

Fidelity and Child Outcomes

As a part of the fidelity assessment, we examined how the level of fidelity with which the model was implemented was associated with positive child outcomes. To do so, we broke the fidelity index scores down into “high,” “medium,” and “low” categories (see Figure 5 below for the percentage of cases in each category). We then explored any differences in exits to permanency, placement with kin, and number of connections identified and engaged with the case among the different levels of fidelity, as well as by cases that met the different fidelity benchmarks. Half (53%) of cases reached a high overall level of fidelity to the model.

Figure 5. Percentage of cases in each fidelity category, by stage of model



The level of fidelity to the model or fidelity within its different stages was not associated with exits to permanency or placement with relatives.²⁸ Similar percentages of cases with high

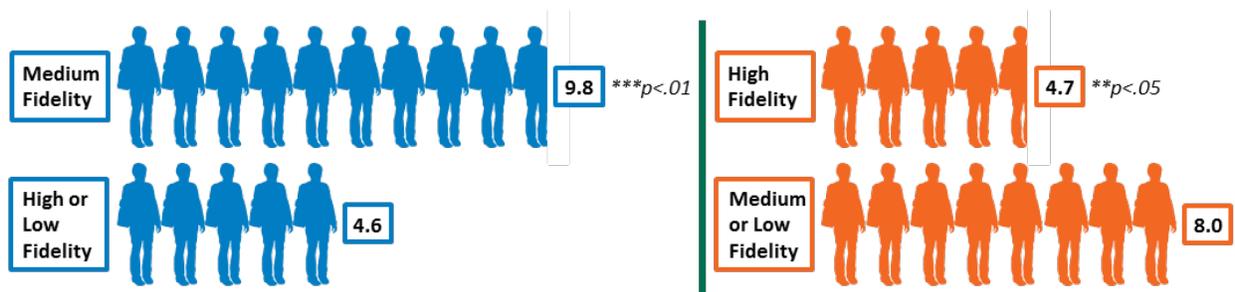
²⁸ Logistic regression was used to determine whether or not the different levels of fidelity predicted a positive permanency or relative placement outcome. There were no significant findings in this analysis.



fidelity to the model (according to the total index score) compared to cases without high fidelity exited to permanency (51% vs. 54%) or were placed with relatives (56% vs. 51%).

We also examined differences in the number of connections identified or engaged with the case²⁹ between the cases with high, medium, and low fidelity. As shown in Figure 6 below, the number of connections identified was significantly higher for the cases with medium fidelity to the overall model than those with high or low fidelity to the model. However, cases with high fidelity to the model had significantly *fewer* connections identified than those with medium or low fidelity.

Figure 6. Difference in number of connections identified by level of fidelity



Based on the available measures, we found that the level of fidelity did not influence exits to permanency or placement with relatives. This is consistent with our findings during the annual site visits. Overall, Permanency Specialists thought that they kept fidelity to the model to the best of their ability, and even went beyond the basic requirements of the model (e.g., transporting relatives to meetings, etc.), but ran into challenges that were out of their control. For example, Permanency Specialists often had trouble engaging relatives because they lived far away or were reluctant to engage with the child welfare system. They also reported struggles with the planning and decision making stages, in particular convening meetings. These later stages of the model require cooperation from other members of the child’s team to adopt and implement the family-driven plans, which Permanency Specialists felt like they did not always receive. Given these challenges, it makes sense that Permanency Specialists would perceive the implementation of the later stages as less successful than the earlier stages.

²⁹ As entered by Permanency Specialists into CWS/CMS. We used this measure to be consistent with the way mediating outcomes were presented in the impact study.



Permanency Specialists reported that they did not necessarily strive to (and in most cases did not) find 40 connections for each child, but they did their due diligence and identified as many relatives as could be reasonably expected. Seneca supervisors and program staff emphasized the importance of going beyond simply *looking* for relatives to simultaneously *engaging* them, and how the process was continuous throughout the life of the case. This emphasis on continued family engagement may help to explain why every child had at least one connection agree to a supportive plan. Permanency Specialists also reported that they focused on getting specific commitments from relatives, and made an effort to give concrete examples of those commitments.

F. Cost Study

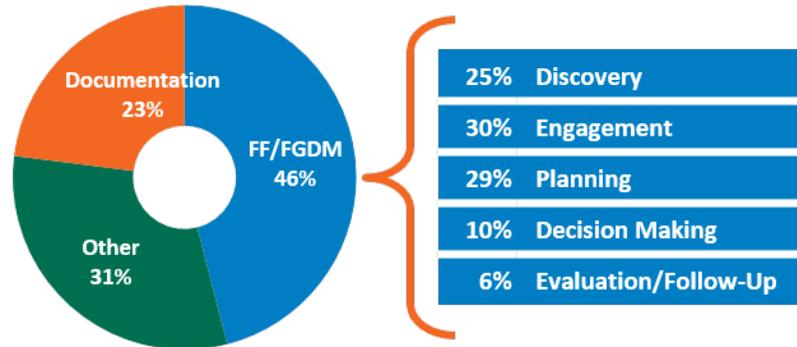
As mentioned earlier, the grant team modified the cost study approach. The revised approach can be broken down into two parts: a time study and a cost study. The time study sought to identify on what tasks Permanency Specialists spend their time and to explore whether or not the number of hours spent on specific stages of the model is associated with program outputs. The cost study sought to examine how Permanency Specialists' salaries break down by model component as well as explore differences in out-of-home care costs by treatment condition.

Typical Week for Permanency Specialists

Overall, Permanency Specialists spend more time on non-FF/FGDM activities, such as documentation, training, transportation, meetings, or coaching (see Figure 7) than on FF/FGDM activities. When looking specifically at FF/FGDM activities, Permanency Specialists spend roughly equal percentages of time on discovery, engagement, and planning, but less time on decision making and evaluation. It should be noted that as a part of the implementation study, we found that engagement was considered an ongoing process and occurred throughout each stage of the FF/FGDM model.



Figure 7. Time spent on case-related activities



When broken down by Permanency Specialist, time spent on different activities varies greatly. Some Permanency Specialists spent the majority of their time on FF/FGDM activities, where others spent more time on other types of activities. This variation is most likely due to caseload size, case length, and Permanency Specialist tenure. When looking specifically at time spent on FF/FGDM activities, results also varied by Permanency Specialists for many of the same reasons listed above. Based on the available time tracking data, the engagement and planning phases tend to take up most of the Permanency Specialists' time, followed by discovery.

Time vs. Outputs

There does not appear to be a relationship between the amount of time spent on each stage of the model and program outputs. The Permanency Specialists who spent the most time on discovery activities identified half as many connections as Permanency Specialists who spent half as much time on discovery. The Permanency Specialists who spent the most time on engagement and planning did not have the highest number of connections engaged or contacted, as one might expect. What this information does tell us is that even though time may not be spent specifically on engagement activities, Permanency Specialists continue to engage relatives through the planning and decision making stages.

Salary Breakdown by Stage of Model

We planned to examine how Permanency Specialists' salaries break down by each stage of the model to determine if it would be more cost effective to have a different staff person complete certain activities (e.g., discovery and case mining). We found in our implementation study that in practice these activities cannot always be broken down into discreet components;



that the stages overlap. Therefore we are unable to break Permanency Specialists' salaries down by stage of the model in a meaningful way. However, the time study shows us that Permanency Specialists spend almost one-quarter of their time on case documentation (much of which was related to the grant). That breaks down to \$15,813 per Permanency Specialist spent on case documentation. If those administrative tasks were pushed down to support staff, not only would it cost less in terms of salary, but would also free up more of the Permanency Specialists' time to conduct FF/FGDM activities or serve more cases.

Out-of-Home Care Costs

We were also interested in differences in out-of-home care costs³⁰ by treatment condition. As FF/FGDM services had positive impacts on placement with relatives, we examined differences in out-of-home care costs by placement type (relative vs. non-relative³¹). We were not able to obtain child-level information on out-of-home care costs for children served, and therefore unable to make comparisons by treatment condition. However, HSA provided county-level information on differences in costs by placement type for the general child welfare population. For children in care on November 30, 2015, HSA pays relative caregivers an average monthly payment of \$715 per child, compared to \$2,253 per child to non-relative caregivers. While we are unable to determine an exact cost-savings in terms of out-of-home care payments, by moving more children to relative placements, FF/FGDM services could theoretically save HSA \$1,538 a month for every child placed with a relative.

VI. Conclusions

In assessing the results of the LCI outcome evaluation study, findings are somewhat mixed in regard to the desired goals and outcomes of the project. The most positive finding relates to the objectives of increasing meaningful and lasting family connections, and increasing involvement of relatives in permanency and case planning. The evaluation study found that, in

³⁰ For the purpose of this cost study, "out-of-home care cost" is defined as the average payment to a placement per month. This does not include any additional service or administrative costs.

³¹ Non-relative placements include all placements that are not classified as "relative placement," including foster care, treatment foster care, group homes, therapeutic settings, transitional housing programs, or supervised independent living programs.



the aggregate, children in the treatment group had more connections identified (8.5 treatment vs. 5 control) and engaged (5.5 treatment vs. 3.6 control) compared to children in the control group, and these differences were statistically significant. However, these differences in identified and engaged connections did not translate to observable differences in permanency outcomes or length of stay in this sample.

While a number of hypotheses can be generated to explain these findings, it is ultimately not possible to determine the reason for the lack of observed differences in permanency outcomes by condition with certainty. The null findings on key outcomes of interest could be due to any number of factors, such as the design and implementation of the study (e.g., diffusion of the treatment intervention to the control group or low statistical power due to a relatively small sample size), ineffectiveness of the Family Finding intervention model for changing permanency outcomes, lack of close fidelity to the intervention model during implementation, or exogenous policy/practice changes that occurred in the child welfare agency context during the study period. It is also possible that, had the time period for the study been longer to allow for all cases to reach closure, differences in permanency outcomes may have emerged once all children in the study sample discharged from care or otherwise reached a final case outcome. However, any estimates about what outcomes may have been observed with a longer study window are speculative.

In addition to the findings indicating that children who received the Family Finding intervention had more connections identified and engaged than those who received only usual services, the outcome study also produced a tenuous finding that treatment children were more likely to be placed with relatives (either as their final placement prior to discharge from care, or as their placement type at the end of the study period) than control children (50% for treatment vs. 39% for controls). While this is a potentially promising endorsement of the Family Finding model for promoting relative placements, it is uncertain whether this finding represents a true difference between the two study conditions, as it only attains significance when the threshold for making this statistical determination is inflated above what is standard for quantitative outcome research. As is true for the other permanency outcomes examined in this study, a clearer picture of the true effects of the intervention would be more readily identifiable with a larger sample size and/or a longer study period allowing for more cases to resolve to completion.



In order to examine whether the permanency outcomes observed in this sample (among both treatment and control groups) may have reflected broader system-level changes in San Francisco over time, Seneca examined publicly available data from the California Child Welfare Indicators Project from 2002 to the present to look at whether any permanency outcomes among all San Francisco foster youth exhibited notable changes that coincided with the study period. While length of stay, re-allegation, and reentry figures did not show any clear pattern of change during the study period compared to previous years, there was a notable pattern related to Kin-GAP exits from care. The data showed a notable and sustained increase in Kin-GAP exits beginning in 2012 and continuing through 2015. For the period from 2002 to 2011, the mean percentage of children exiting to a Kin-GAP permanency outcome was 6 percent. This more than doubled, to 13.9 percent, during the period from 2012 to 2015 when LCI project activities were being implemented (Webster et al., 2016). While there is no way to discern whether the LCI project was a causal driver of this county-wide increase in permanent placements with relatives during the study, especially since the annual percentage of youth exiting to Kin-GAP was already trending upward prior to the initiation of the LCI, this observation offers potential support for the notion that system-level efforts and/or treatment diffusion may have been improving this outcome for *all* children in care in San Francisco during the study period.

The Child Trends evaluation also showed some tentative evidence of differences in likelihood of placement with relatives (as a final placement type at discharge or study closure) by ethnicity and age. The analysis found that that Latino children may have gained a greater benefit from the treatment intervention with regard to relative placement than children of other races/ethnicities who received the treatment intervention (56% of Latinos in the treatment group were placed with kin vs. 47% of all other races/ethnicities in the treatment group). This finding could reflect some difference in how the intervention worked within a Latino cultural context, such as Latino children having more family members available and interested in placement than children of other races/ethnicities, or potential differences in practices within the bilingual/bicultural units who often serve Latino children at SF-HSA. Ultimately, due to the small sample sizes involved in the subgroup analyses, further research is needed to establish this as a true effect and to identify potential explanations for the observed differences in placement by ethnicity.



The only other significant finding in the analysis of outcomes by child characteristics was a very tentative finding that children under 5 who received the intervention model were more likely to have a re-allegation to child welfare than children 5 and older who received the intervention model. However, with so few children experiencing a re-allegation (n=10 for treatment children and n=4 for control children), this finding should be interpreted with great caution with regard to generalizability outside of the observed sample, since such small numbers cannot support robust statistical testing.

Though the intervention did not appear to impact permanency outcomes, it is worth noting that it is possible that the intervention had effects that are unknown because they were not measured by the indicators used for this study. For example, it is possible that the increased number of connections identified and engaged among treatment group children compared to controls may translate to longer-term improvements in child or family well-being that were not captured by this research design and the outcome variables selected. Though this cannot be tested with these data due to the lack of well-being indicators in the available data sources, it is conceivable that there are potential relational, emotional, or other well-being benefits associated with having increased family involvement in the lives of these youth, even if that family involvement did not result in aggregate changes in permanency timelines or outcomes. Future longitudinal research should select meaningful well-being indicators as outcomes of interest for children and families who receive family finding services.

In addition to the quantitative outcomes examined through statistical analysis, this study also examined qualitative data from interviews, surveys, and focus groups with key stakeholders (including Seneca personnel, county social workers, and family members). One of the prominent themes that emerged from this portion of the study relates directly to the clinical significance of the finding that more connections were identified and engaged on average among children in the treatment group compared to those in the control group. The qualitative portion of the evaluation indicated that there may have been some tensions between Seneca personnel and SF-HSA personnel on the relative importance of *relational permanency* (family connections that may support the child over time regardless of whether placement with those connections occurs) and the *legal permanency* which is the federally-mandated focus of child welfare agencies. Qualitative interviews suggested that SF-HSA caseworkers may have placed a stronger emphasis



on legal permanency by focusing their time and efforts on connections who could potentially be considered as placement options, while Seneca personnel may have placed equal or stronger emphasis on relational permanency as an outcome in and of itself. Other key themes relevant to the implementation of the intervention model emerged in qualitative interviews, including: the increased workload associated with responding to relatives subsequent to notification, issues with communication and shared understanding between Permanency Specialists and SF-HSA social workers, the perceived need for more formal training and supervision on the intervention model among permanency specialists, “meeting fatigue” among family members and county social workers involved in the intervention services, and uncertainty with regard to which family members should be involved with children’s cases and who should initiate that involvement. The factors that were identified as facilitators of model implementation included agreement on the importance of relative involvement for children in care, greater support for family finding among younger/newer SF-HSA workers, commitment of Seneca Permanency Specialists to the Family Finding model, emphasis on family engagement and involvement in case decision-making, and the co-location and overall positive working relationships between Seneca and SF-HSA personnel.

Fidelity to the Family Finding intervention model was assessed through fidelity tools administered during supervision sessions for each case. Fidelity analyses indicated that fidelity to the model decreased at each of the six model stages, and that level of fidelity (high, medium, or low) did not correlate to any permanency or placement outcomes for children in the sample. That there was no discernable association between fidelity and outcomes suggests a need to further examine what, exactly, are the active ingredients in the Family Finding model. It is conceivable that the components of the intervention model likely to produce desired changes in permanency outcomes are concentrated in the later stages, when fidelity was demonstrated to be lower.

In lieu of a full cost analysis, Child Trends reported on how permanency specialists divided their time between intervention components, administrative tasks, and other ancillary activities. They did not produce definitive information on how much time each intervention required per family or per child. Without this information, it is difficult to determine how much it would cost a jurisdiction to continue the intervention.



VII. Recommendations

Stemming from lessons learned through this project, the following recommendations are suggested for project funders and for the child welfare field, in order to maximize the utility of future research, and to optimize the implementation of the intervention in practice settings.

A. Project Funders

- Fund future research with longer time frames for planning, implementation and data collection, and follow-up.
 - A longer planning period would allow more time to develop the working relationships and maximize buy-in among all project partners prior to data collection. A longer study period would allow more time to bring the intervention to optimal fidelity and to work through any barriers that arise during implementation. A longer follow-up period after data collection would allow more cases to reach their final outcomes prior to data analysis, thus increasing the number of cases included in the evaluation and maximizing statistical power to detect true differences in outcomes where they exist.
- Attend to barriers related to study design in future funding opportunities.
 - While randomized experimental designs reflect the gold standard for research on intervention effectiveness, there are some unique challenges associated with implementing this design in a practice setting. In this study, there are concerns that the treatment intervention may have diffused to control cases in SF-HSA during the study period via trainings for HSA staff on the intervention model and an enhanced agency focus on permanency and family engagement resulting from the project implementation. In retrospect, a modified study design could have prevented this potential diffusion by either waiting until the end of the study period to train SF-HSA staff in the intervention model, or perhaps by utilizing a sophisticated quasi-experimental design to minimize diffusion of the intervention to the control group that may have arisen from having treatment and control groups sampled from the same agency during the same time frame.



- Measure longer-term outcomes not associated with permanency, length of stay, or recidivism.
 - Requiring the inclusion of robust child and family well-being indicators would augment the focus on permanency to address whether the intervention improves the lived experiences and emotional/relational outcomes of foster youth and their families.

B. Child Welfare Administration and Practice

- Seek ways to integrate family finding processes and family engagement strategies into larger, existing case management systems from the outset.
 - The workload and resource implications of identifying and engaging a larger number of family members per child should be thoroughly assessed and well understood in advance of implementation. For example, staffing may need to be shifted to handle changes in workload stemming from more relatives needing background checks and other screening processes. Seemingly minor tasks like these can easily derail projects if they are not anticipated and incorporated into the implementation plans. Planning for this integration in advance may promote buy-in and shared understanding of process at all levels of the collaborating organizations and pave the way for successful execution and sustainability.
- Implement the intervention in a way that minimizes burden on caseworkers, and anticipate the need for workload changes to support successful implementation and support sustainability.
 - Workload increases that result from the implementation of new service activities may lead to resistance among child welfare caseworkers and supervisors. If staff will have new responsibilities as a result of added family finding and engagement processes, there should be pre-planning around what components of their existing work can be changed or re-assigned, since simply adding more tasks to an already



burdensome workload is unlikely to result in successful integration of new activities.

- Plan ahead for the fact that sometimes things will not go as intended when undertaking work around family engagement.
 - Implementation of intensive family engagement strategies will likely entail things occasionally “going wrong.” For example, family members may be difficult to engage, even with the best intentions and strategies, or may not turn out to be positive resources for youth. Accepting that these challenges are intrinsic to family engagement work and the implementation of new services, and being honest from the outset about the potential for these issues to arise, may mitigate the negative impact of these problems when they do occur.



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ATTACHMENTS

- Attachment A: Permanency Action Plan Worksheet
- Attachment B: Search Letters
- Attachment C: Discoveries Worksheet
- Attachment D: Sustainability Plan
- Attachment E: Child Trends Fostering Connections Grant Evaluation Report



ATTACHMENT A

Permanency Action Plan Worksheet

Permanency Action Plan

Family Name	Date of Meeting/Plan	Next Meeting
		Date: Time: Location:
Team Members in Attendance (Name and Role)		
Youth and Family's Values, Strengths, Skills, and Points of Pride		
Permanency Goals (<i>Long Term Goal for Relational, Physical, Legal Permanency</i>) Short-Term Objectives (<i>What needs to be done now for the Permanency Goal to be successful</i>) Action Steps (<i>Who/What/When/Outcome</i>)		
<p>1. Permanency Goal 1:</p> <p>Short-Term Objective A:</p> <p style="padding-left: 40px;">Action Steps:</p> <p style="padding-left: 60px;">1.</p> <p>Short-Term Objective B:</p> <p style="padding-left: 40px;">Action Steps:</p> <p style="padding-left: 60px;">2.</p> <p>2 Permanency Goal 2:</p> <p>Short-Term Objective A:</p> <p style="padding-left: 40px;">Action Steps:</p> <p style="padding-left: 60px;">3.</p> <p>Short-Term Objective B:</p> <p style="padding-left: 40px;">Action Steps:</p> <p style="padding-left: 60px;">4.</p>		
Important Discussion Points/Comments		

Permanency Action Plan

Concurrent Plan (Long Term Goal for Reunification & Permanency)
Short-Term Objectives (What needs to be done now for the Concurrent Plan to be successful)
Action Steps (Who/What/When/Outcome)

1. Concurrent Plan A:

Short Term Objective A:

Action Steps:

5.

Short Term Objective B:

Action Steps:

1.

2. Concurrent Plan B:

Short Term Objective A:

Action Steps:

1.

Short Term Objective B:

Action Steps:

1.

3. Concurrent Plan C:

Short Term Objective A:

Action Steps:

1.

Short Term Objective B:

Action Steps:

1.

Important Discussion Points/Comments

Permanency Action Plan

Permanency Plans and Lifetime Support Network			
Lifetime Support Network	Name	Relationship	Contact Information
*Please include Name and Relationship and indicate whether individuals are an overnight or daytime childcare option.			
Concurrent Planning			
Plan A:			
Plan B:			
Plan C:			



ATTACHMENT B

Search Letters

City and County of San Francisco

Human Services Agency

Department of Human Services
Department of Aging and Adult Services

Trent Rhorer, Executive Director



Edwin M. Lee, Mayor

June 29, 2016

[Potential Relative Name]
[Address]

Dear Mr./Ms./Mrs. [Last Name],

My name is [Name] and I am a Family Finding Specialist for children who find themselves in foster care within the San Francisco County system. I am currently working with a(n) **[Parent First Name, Last Initial]** (Whom you may know) and [his/her] **[Age of Child]** **[son/daughter]**, an [infant/minor/youth] whose wellbeing I am extremely concerned about. It's very possible that you may have valuable information concerning the relatives of this child that could ultimately provide him with a greater sense of self and belonging down the road. Please call me as soon as possible at **[Contact #]**. It would be an honor for me to speak with you so that I can tell you in greater detail about my work.

If you believe that you have received this message in error, please contact me regardless at **[Contact #]** so that I can remove you from my list and concentrate my efforts elsewhere in trying to locate the relatives of this **[infant/minor/youth]**.

I thank you in advance for your prompt attention to this message; I look forward to hearing from you soon.

Warm Regards,

[Name]
[Title]
[Contact #]
[E-mail]

Apreciable Sr. y Sra. -----,

Mi nombre es **(RNC NAME)** y soy coordinador**(a) (female or male RNC)** del programa especializado de búsqueda de familiares para niños/jóvenes que se encuentran actualmente en el sistema de servicios sociales del Condado de San Francisco.

Le escribo esta carta concerniente **(MOTHER'S NAME)** (a quien Ud. quizás conoce) y su **(niño/ nina de AGE (meses= months, anos=years))**, una **niño (a)** por la cual me preocupa extremadamente su bien estar. Es muy posible que Ud. tenga información de mucho valor y que conozca a familiares de esta **niño/a**, quienes pudieran en un futuro brindarle apoyo y darle sentido de seguridad.

Sírvase llamarme por favor lo más pronto posible al **(415) PHONE #** . Sería un honor para mí hablar con Uds. y así poder compartir más detalles acerca de mi trabajo.

Si Ud. cree haber recibido esta carta por error, de todas formas póngase en contacto conmigo al número antes mencionado y así podre borrarlos de la lista y concentrar mis esfuerzos en tratar de localizar parientes de esta **niño/a**.

Agradeciéndole anticipadamente su pronta atención a este mensaje, espero su llamada.

Atentamente,

RNC NAME

Coordinador(a) del Notificar Familiares

#

relativesearch@senecacenter.org

City and County of San Francisco

Human Services Agency

Department of Human Services
Department of Aging and Adult Services

Trent Rhorer, Executive Director



Edwin M. Lee, Mayor

June 29, 2016

[Potential Relative Name]
[Address]

Dear Mr./Ms./Mrs. [Last Name],

My name is [Name] and I am a Family Finding Specialist for children who find themselves in foster care within the San Francisco County system. I am currently working with a(n) **[Parent First Name, Last Initial]** (Whom you may know) and a **[Age of Child]**, an [infant/minor/youth] that may be connected to you and **[Parent First Name]**, whose wellbeing I am extremely concerned about. It's very possible that you may have valuable information concerning the relatives of this child that could ultimately provide him with a greater sense of self and belonging down the road. Please call me as soon as possible at **[Contact #]**. It would be an honor for me to speak with you so that I can tell you in greater detail about my work.

If you believe that you have received this message in error, please contact me regardless at **[Contact #]** so that I can remove you from my list and concentrate my efforts elsewhere in trying to locate the relatives of this **[infant/minor/youth]**.

I thank you in advance for your prompt attention to this message; I look forward to hearing from you soon.

Warm Regards,

[Name]
[Title]
[Contact #]
[E-mail]

Apreciable Sr. y Sra. -----,

Mi nombre es **(RNC NAME)** y soy coordinador**(a)** (**female or male RNC**) del programa especializado de búsqueda de familiares para niños/jóvenes que se encuentran actualmente en el sistema de servicios sociales del Condado de San Francisco.

Le escribo esta carta concerniente **(ALLEGED FATHER'S NAME)** (a quien Ud. quizás conoce) y **(un niño/ una nina de AGE (meses= months, anos=years))**, un**(a)** niño **(a)** quien quizás esta conectado **(a)** a Uds. y **(ALLEGED FATHER'S NAME)**, por **la** (female) **lo** (male) cual me preocupa extremadamente su bien estar. Es muy posible que Ud. tenga información de mucho valor y que conozca a familiares de esta **niño/a**, quienes pudieran en un futuro brindarle apoyo y darle sentido de seguridad.

Sírvase llamarme por favor lo más pronto posible al **(415) PHONE #** . Sería un honor para mí hablar con Uds. y así poder compartir más detalles acerca de mi trabajo.

Si Ud. cree haber recibido esta carta por error, de todas formas póngase en contacto conmigo al número antes mencionado y así podre borrarlos de la lista y concentrar mis esfuerzos en tratar de localizar parientes de esta **niño/a**.

Agradeciéndole anticipadamente su pronta atención a este mensaje, espero su llamada.

Atentamente,

RNC NAME

Coordinador(a) del Notificar Familiares

#

relativesearch@senecacenter.org



ATTACHMENT C

Discoveries Worksheet



ATTACHMENT D

Sustainability Plan

Sustainability Planning Worksheet for Children’s Bureau Discretionary Grantees v.5 Seneca Family of Agencies/SF Human Services Agency Lifelong Connections Program

Grantees often wish to sustain key elements of their grant projects which they have found to be beneficial. Sustainability planning should begin early, include key partners, and address the following questions:

1. WHAT to sustain? What is your vision for 5 years from now?	<i>Your best response to this question at this point</i>	<i>Next steps? Who’ll do them? When?</i>
<ul style="list-style-type: none"> Keep all or part of the project going (as is or modified), e.g., services, staff salaries, training, infrastructure, data collection, evaluation, CQI, fidelity monitoring 	<p>San Francisco is now a Title IV E Waiver county. This will create change in mental health and child welfare services to be preventative and/or not necessitate opening a child welfare case.</p> <p>SF Human Service Agency(HSA)deputy director would like Seneca to use a CQI process to evaluate the FF-FGDM work in order to plan for next steps, specifically looking at how to integrate this aspect of the work into the changes in services due to Title IVE.</p>	<p>Seneca and HSA leadership team and evaluators will initiate a CQI process in the next couple of months and create a plan that reflects what is needed.</p>
<ul style="list-style-type: none"> Integrate the project’s activities into your ongoing practices - institutionalizing necessary program strategies and activities into organizational policy and infrastructure 	<p>Continued discussion between HSA and Seneca leadership about what elements of the model will continue to be held and implemented by contract agencies (Seneca) and which will fall within their workers’ responsibilities.</p>	<p>Evaluation team will continue to gather data looking more closely at individual worker/supervisor/unit adherence to the model and how this affects the data. Present data and CQI output to HSA and Seneca Leadership</p>
<ul style="list-style-type: none"> Embed the key elements of the project in the broader system 	<p>San Francisco HSA leadership would like their Child Welfare Workers (CWW) to embed pieces of the model into their jobs. The question that remains is, what will Seneca’s continued role be?</p>	<p>Identify differences in data from grant cases and control cases and assess the reasons behind the differences.</p>
<ul style="list-style-type: none"> Expand, take to scale- e.g., replicate in other communities, statewide, nationally 	<p>Continue to disseminate positive findings at conferences and to Seneca’s leadership in other counties that are doing similar work.</p>	<p>Seneca’s evaluation team will identify key conferences for dissemination of information</p>
<ul style="list-style-type: none"> Leave a legacy of knowledge that informs the field and which can be used by others who wish to replicate your project or implement something similar 	<p>Utilize the training/coaching model implemented this previous year for CWWs, to train other mental health workers providing contract services to HSA so all providers speak a common FF-FGDM language.</p>	<p>The National Institute for Permanent Family Connectedness, which is a branch of Seneca’s training institute has helped FF-FGDM staff adapt the “Six Stages of Family Finding” Training to fit with the needs of other non-profit mental health agencies that are involved with SF HSA. We are currently training at two organizations.</p>
2. WHY sustain? Why do you believe part or all of your project should be sustained?		
<ul style="list-style-type: none"> What are early indicators that program elements should or should not be sustained? 	<ul style="list-style-type: none"> Positive data on shortened length of stay and higher rate of youth moving to permanency. County Social Worker response to trainings, collaboration, model adherence. 	<p>Evaluation and leadership teams will identify which aspects of the model will be implemented into future practice and who will hold these responsibilities.</p>

<ul style="list-style-type: none"> When will you know “for sure”? How will you know? 	<ul style="list-style-type: none"> There is clear evidence that adherence to the current model necessitates time that right now is not something the CWWs feel they have in their role. Figuring out what elements are critical and lead to positive data and then infusing these back into the role of the CWW is the work for the next year. 	
<ul style="list-style-type: none"> How will you assess and gather evidence to identify the particular strategies and activities initiated under this grant that should be sustained after the grant ends? 	<p>Continue to gather more micro level data on specific workers/supervisors/units to assess how to proceed with training/coaching model in year three.</p>	<p>Begin to identify “high flyers” (CWWs and Supervisors that are already doing aspects of the model on their own) and interview them on reasons for adapting this practice and what extra time is needed to include in current way of doing business.</p>
<ul style="list-style-type: none"> Are there other sources of evidence for sustainment (e.g., cross cluster findings or findings from other similar initiatives)? What are they and how will you gain access to and use this evidence to build your case? 	<ul style="list-style-type: none"> More county wide referrals for permanency services for youth not involved in grant (not front end cases) County Worker attendance at FF-FGDM trainings – shows what units and workers are interested in learning about model with the goal of implementing the FF model into their roles. 	<p>Continual dissemination of positive work and successes of FF-FGDM work resulting in lower lengths of stay and more relative placements.</p>

3. HOW to sustain?		
<ul style="list-style-type: none"> What changes will be required in order to sustain program benefits? What systems, legislation, policy, procedures, training and funding sources would need to change? What are the barriers to these changes happening? What are the opportunities (e.g., how do your sustainment goals fit with other current systems change initiatives)? 	<p>SF HSA has made a decision to add permanent civil service positions in order to carry on the gains in practice improvement.</p> <p>These positions are being added in the context of SF HSA's CFSR goals and CQI process as well as opting in to the Title IV-E Waiver. This signals a significant impact on the system of care here in SF. There is recognition of the value of this approach and a strong commitment to making sure it endures and is woven into child welfare practice.</p>	<p>A request for a budget modification for FY15/16 will be included in SF HSA budget for commission approval in March 2015.</p>
<ul style="list-style-type: none"> How much will it cost to sustain key program elements? If you don't know, how can you find out? How will you secure funding and other resources that will be needed to sustain program benefits? 	<p>We can find out from HSA the cost of adding 3 additional civil service positions.</p>	<p>Liz Harris will identify budget impact in order to maintain the permanency work internally.</p>
4. WHO can help? Can you succeed by your efforts alone or will you need help?		
<ul style="list-style-type: none"> Who are the key individuals and organizations whose support will be required? 	<p>Liz Harris from SF HSA will continue to be the lead in terms of developing the transition plan from Seneca back to HSA.</p>	<p>Leadership from HSA and Seneca (Sylvia Deporto, Barry Johnson, Liz Harris, Mark Nickell, Amy Kirsztajn, Bob Friend and Leticia Galylean) will be briefed on the transition plan.</p>
<ul style="list-style-type: none"> How and when to engage partners to develop and implement your sustainability plan? 	<p>We have assisted in the process by providing a description of roles and activities conducted by our permanency specialists. We have also provided descriptions of how to blend Safety Organized Practice with Family Finding and Family Group Decision Making. This information was used by HSA in their planning process and decision to add this role to their ongoing staffing infrastructure.</p> <p>The next phase of planning involves developing a timeline for ending the intakes into the evaluation portion of the grant and for training the new staff from HSA.</p>	<p>Liz is coordinating a meeting of the grant leadership along with other key stakeholders in SF HSA.</p>
<ul style="list-style-type: none"> What support is needed from each of them? 	<p>Liz will bring together a planning team where we will begin to develop timelines and activities for the transition.</p>	<p>Liz will coordinate a planning team meeting.</p>
<ul style="list-style-type: none"> What evidence would convince them that they should provide this support? 	<p>There is consensus on the team, based on the experience of participants and the early evaluation results from Child Trends that San Francisco HSA has begun the hiring process for the additional civil service positions to continue the work.</p>	<p>Child Trends will continue to share their evaluation results with the team as they are completed.</p>

<ul style="list-style-type: none"> How will you maintain the involvement of key project partners on an ongoing basis in the planning and operation of your program, during and after the grant project? 	<p>We will continue to have monthly grant team meetings to ensure follow through on each action step from our transition plan.</p>	<p>The grant leadership team meeting each month will include ongoing planning and implementation of the sustainability plan.</p>
<p>5. TRANSITION - If there are parts of your project that will NOT be sustained, how will you manage the transition?</p>		
<ul style="list-style-type: none"> Which parts will NOT be sustained? Why? 	<p>Seneca will transition off of this project on a timeline based on mutual planning with SF HSA. There is potential for Seneca to maintain a coaching/training role as SF HSA builds their internal capacity. It seems clear that direct family engagement on the part of the child welfare workforce will improve outcomes for families in the foster care system.</p>	<p>The grant leadership team and Liz will determine timeline as well as develop the training/coaching plan moving forward.</p>
<ul style="list-style-type: none"> Who needs to know? How will you tell them? When? 	<p>We have notified the Seneca team (permanency specialists) and our evaluators at Child Trends of the transition plan.</p> <p>We will include planning around notifying staff at HSA as part of our overarching transition and sustainability plan.</p>	<p>Liz and Mark began the notification process in January, with the most recent notifications to the grant team occurring in early February.</p> <p>Next steps are to develop a broader communication and dissemination plan. The planning team meeting will address this at their first meeting.</p>
<ul style="list-style-type: none"> How will you manage this transition to minimize impact on service recipients, your organization and staff, and your partners? 	<p>We will continue to work with the families we are currently serving and as the conclusion of the grant nears, we will make individual plans for each family we are serving.</p> <p>We will begin planning transition plans for each Seneca staff over the course of the next few months.</p>	<p>With the help of Child Trends and HSA we will determine the timeline for the evaluation portion of the grant. Once this is determined, Liz and the planning/leadership team will make a plan both for each open family and for families that need this support prior to the new positions being hired and trained.</p> <p>Mark and Antoine will work with the Seneca staff to develop a transition plan for each of them so that they know what they will be doing at Seneca after the conclusion of the grant.</p>
<p>6. DISSEMINATION & COMMUNICATION - How can effective dissemination help you achieve your sustainment goals?</p>		
<ul style="list-style-type: none"> For each sustainment goal, identify: How can dissemination help us achieve this goal? Who to target? When? What are the key messages? How to communicate them most effectively? 	<p>We plan to use dissemination to help share information about the blended model, lessons learned, and impact on the youth and families involved with Child Welfare. We have submitted an application for the Innovations Conference and are waiting to hear if our presentation was selected. There are a couple conferences we plan to attend/present at next year and we will update as we plan our strategy for dissemination after the grant ends.</p>	<p>Bob, Mark, Leticia, and Liz will monitor conference presentation opportunities and submit proposals when appropriate.</p>



ATTACHMENT E

Child Trends Fostering Connections Grant Evaluation Report

Seneca Family of Agencies Family Finding/Family Group Decision Making

Fostering Connections Grant Evaluation Report

January 29, 2016

Sarah Catherine Williams, MSW
Berenice Rushovich, MSW
Kate Welti, MPP



Overview

In September 2012, the Seneca Family of Agencies (hereafter “Seneca”), in partnership with San Francisco Human Services Agency (HSA) and Child Trends, was awarded a three-year federal Family Connections Grant to implement an integrated family finding/family group decision making (FF/FGDM) model. The FF/FGDM model was implemented in San Francisco County by Permanency Specialists from Seneca and targeted any child who enters foster care for the first time, as well as his/her siblings. Seneca provided integrated FF/FGDM services with the goal of improving child outcomes through increased meaningful engagement of family members.

Building on a previous evaluation of Seneca’s family finding efforts, Child Trends conducted a rigorous evaluation of the FF/FGDM model using a randomized controlled trial design. Children were randomly assigned to receive the integrated FF/FGDM model (treatment group) or typical child welfare services, which included relative notification services (control group).

The primary grant activity was intensive relative search and engagement services provided by Seneca Permanency Specialists, utilizing the integrated FF/FGDM model developed by the National Institute for Permanent Family Connections (NIPFC). The model consists of six stages: discovery, engagement, planning, decision-making, evaluation, and follow-up support. A Relative Notification Specialist from Seneca provided relative notification services to the children in the control group.

Grant-funded activities also included training for HSA staff on the FF/FGDM model. Initial trainings were held with HSA unit supervisors, which provided an overview of the model and an introduction to the grant. Subsequent trainings for HSA social workers focused both on providing an overview of the FF/FGDM services, and also on educating participants on their role in services, including collaboration with the Permanency Specialists.

Key Findings and Recommendations

The evaluation demonstrates that FF/FGDM had no positive impact on permanency outcomes. However, it demonstrates that the model *did* have a positive impact on placements with relatives, as well as the number of connections identified and the number of connections who expressed interest in being involved with the child’s case.

- Children who received FF/FGDM were significantly more likely to be placed with relatives than children who did not receive the intervention (50% compared with 39%).
- Latinos in the control group were less likely to be placed with kin versus non-Latinos in the control group (24% compared with 45%), while Latinos in the treatment group were slightly more likely to be placed with kin than non-Latinos (56% compared with 47%).
- Children who received FF/FGDM had significantly more connections identified and engaged than did their counterparts in the control group. Treatment children had 3.5 more connections identified and 1.9 more connections engaged than control children.
- Children in the treatment group were no more likely to discharge to permanency than were children in the control group (52% compared with 59%).
- While exits to permanency did not differ by experimental status, a larger, although not statistically significant, percentage of the treatment group was reunified during the study period than the control group (73% compared with 66%).
- There was no significant difference in the average number of days to permanency by experimental group status (292 treatment compared with 274 control).

- There were no significant differences in rates of re-entry and re-allegations across treatment and control groups.

The evaluation had several limitations, including a small sample size, a short study period, and potential “contamination” of the control group. A larger sample would increase the power to detect program impacts; however, we cannot assume that the outcomes for children in a larger sample would be similar to those in the present study. Additionally, the relatively short study period (30 months) may be insufficient to measure some of the outcomes of interest (i.e., exits to adoption and guardianship as well as re-allegations and re-entries). Another potential reason for not finding significant impacts on some outcomes is potential “contamination” of the control group; meaning, exposure to other services among the control group children (e.g., HSA workers implementing FF/FGDM activities, or control children referred to other agencies for similar services), which could dissipate impacts of the intervention.

The FF/FGDM program met its goal of increased family involvement in case planning. While Permanency Specialists were not always able to maintain fidelity to the FF/FGDM model, they continuously upheld the principle of ongoing and authentic family engagement. The focus on effective engagement was a common theme among Seneca program staff. When asked which component of the model is the most critical to success, program staff consistently cited planning and engagement, emphasizing that engagement was a continuous process throughout the case.

While FF/FGDM is more effective in identifying connections for children than traditional or basic relative notification services, the question remains, do more connections equal better permanency outcomes? Many in the field believe that they do. Since treatment children had a “wider net cast” (i.e., had more connections identified) as well as more connections interested in being involved, one could argue that this wider net means a better chance of finding relatives who will be engaged and become permanency resources. This also raises the question, is there a point at which the number of connections identified no longer adds any value to the child’s case? Is it more important to find the *right* connections, as opposed to the *most* connections?

Recommendations

Based on findings from this evaluation, we make the following recommendations:

- Conduct a follow-up analysis of exits to permanency among the study sample, allowing a longer observation period in which to observe outcomes including re-entries into out-of-home care.
- Examine changes in child and family well-being (e.g., protective capacities, child’s perceptions/feelings of connectedness, birth parent support systems, emotional permanency, etc.) to determine if FF/FGDM impacts children and families in ways that go beyond legal permanency.
- Include larger sample sizes (e.g., by expanding the study enrollment period, or the size of the geographic area served) in any future evaluation efforts.
- Examine the extent to which social workers are applying FF/FGDM principles and conducting FF/FGDM activities in their ongoing casework practices. While some contamination of the control group was likely in this evaluation, a more in-depth review of social worker practices could inform the extent to which social workers can fully implement the FF/FGDM.
- Continue to explore additional ways to measure FF/FGDM model fidelity. More in-depth case studies may reveal additional factors that influence the outcome on a case.
- Examine the extent to which connections and family members are utilized in case planning and making decisions in terms of the child’s well-being.

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Appendix D. Detailed Statistics

Appendix E. Social Worker Survey

Evaluation Overview

Current Evaluation

In September 2012, the Seneca Family of Agencies (hereafter “Seneca”), in partnership with San Francisco Human Services Agency (HSA) and Child Trends, was awarded a three-year federal Family Connections Grant to implement an integrated family finding/family group decision making (FF/FGDM) model. The FF/FGDM model was implemented in San Francisco County by Permanency Specialists from Seneca and targeted children upon their entry to the child welfare system. Seneca provided integrated FF/FGDM services with the goal of improving child outcomes through increased meaningful engagement of family members.

Child Trends was contracted to perform a rigorous evaluation of the FF/FGDM model, which consists of two components: an impact study and an implementation study (which includes a cost study). The experimental impact study measures changes in permanency, stability and well-being, as well as changes in HSA social worker knowledge and attitudes toward family engagement in permanency planning for children in foster care. The implementation study describes program implementation, including barriers and facilitators to implementation; assesses if the program is being implemented with fidelity to the model; measures system level partnerships between the provider agency and the public agency; and provides feedback for program refinements.

Prior Evaluation

Seneca staff had prior experience participating in a rigorous evaluation of family finding services in partnership with Child Trends, from 2007 to 2013. The Stuart Foundation provided both programmatic funding (to fund family finding specialist positions) as well as funding for the evaluation. The prior evaluation was the first to examine how the family finding intervention would work for children new to out-of-home care, as opposed to children who had been lingering in foster care. In shifting the target population to the “front end” of the system, Seneca and HSA hoped to increase the frequency and timeliness of reunification and, if reunification was not possible, to place more children with relatives. The prior evaluation also involved random assignment of children and this experience proved beneficial in that both Seneca and HSA staff understood the importance of the rigorous evaluation design. Overall, the prior evaluation findings did not align with initial expectations. The likelihood of reunification did not differ significantly between the treatment and control group children, though a larger, but not statistically significant, percentage of the treatment group was reunified during the study period (57% compared with 47%). Children in the treatment group were significantly more likely to have a goal of reunification (than a goal of adoption) but they also were more likely to return to care after being reunified.

Program Overview

FF/FGDM Services

Grant-funded services provided by Permanency Specialists from Seneca were initiated in March 2013 and continued through September 2015. Seneca utilized the intensive family finding model developed by the National Institute for Permanent Family Connections (NIPFC), which consists of six stages: discovery, engagement, planning, decision-making, evaluation, and follow-up support. However, these stages are not seen as linear; engagement is integrated into all aspects of the model and discovery is an ongoing process. Evaluation is also ongoing through monitoring and assessing how permanency plans are being implemented

and carried out through family meetings. For a detailed description of each of the six service components, see the Program Implementation section below. Both the treatment and control cases received relative notification services² from Seneca. Only the treatment group received the full FF/FGDM intervention.

Training for HSA Staff

As a part of the grant, Seneca provided training to HSA staff on the FF/FGDM model. Beginning in February 2013, initial trainings were held with HSA unit supervisors, which provided an overview of the model and an introduction to the grant. Subsequent trainings for HSA social workers focused both on providing an overview of the FF/FGDM services, and also on educating participants on their role in services, including collaboration with the Permanency Specialists. (See Program Implementation below.)

Evaluation Design

The goal of this evaluation was to examine the impact of the FF/FGDM model on the permanency, stability and well-being of children in foster care, as well as describe how the program was implemented and to what degree of fidelity to the FF/FGDM model. The evaluation included both impact and implementation studies. The overarching research questions³ the evaluation sought to answer were:

Impact Study

1. How does the integrated FF/FGDM model impact permanency, stability and well-being?
2. How do permanency, stability and well-being vary by child characteristics?
3. How does the integrated FF/FGDM model impact the caregiver's well-being?

Implementation Study

4. Are Permanency Specialists implementing the integrated FF/FGDM model as intended?
5. What key linkages/partnerships/activities between HSA and Seneca contribute to the successful integration of the FF/FGDM model?

Cost Study

6. What is a typical week for a Permanency Specialist?
7. How do Permanency Specialists salaries break down by FF/FGDM component?
8. How, if at all, is the amount of time Permanency Specialists spend on specific components associated with FF/FGDM outputs (e.g., number of connections discovered, engaged, etc.)?
9. What are the out-of-home costs associated with children served by Permanency Specialists compared to the out-of-home costs for children not served by Permanency Specialists?

Building on the previous family finding evaluation mentioned above, Child Trends used a randomized controlled trial design for the impact study. Children were randomly assigned to receive the integrated FF/FGDM model (treatment group) or typical child welfare services (control group). The experimental nature of the study ensured that there was no bias in the selection of participants. While systematic differences between the two groups can occur by chance, we controlled for such differences in our analysis models. Random assignment of children to receive the FF/FGDM intervention allows us to more confidently attribute observed differences between treatment conditions to the intervention.

² The state of California requires that within 30 days of detention (i.e., a child's removal from their home) the public agency notify relatives to the 5th degree of relation that the child is in the agency's custody. Relatives can be notified via written letter or telephone, and must be asked if they are interested in being a placement option for the child. Relative notification services did not include any engagement of relatives, simply notifying them that the child was in care.

³ A detailed list of research questions is available in Appendix A.

Study enrollment began in March 2013 and continued through March 2015. Seneca received a list of children who had been removed from their home from the court clerk's office. The Seneca program supervisor randomly assigned cases⁴ to the treatment or control group using the randomization function in the Child Trends Database. Treatment cases were then assigned to a Permanency Specialist based on caseloads and language ability.⁵ All control cases were assigned to and served by the Seneca Relative Notification Coordinator.

A complement to the impact study, the qualitative implementation study focused on the details of program implementation, fidelity of program implementation to the FF/FGDM model, and contextual factors that may influence program implementation or outcomes. The implementation study was informed by yearly site visits, program fidelity measures, and focus groups with relatives of children enrolled in the program. The evaluation team analyzed detailed notes from focus groups and interviews using NVivo qualitative software for the final analysis. The team then developed and refined initial themes based on the focus group and interview guides.

Data Collection

Data collection for the impact study utilized several sources, which provided information on child permanency and well-being outcomes.

Administrative Data. The evaluation team received extracts from Child Welfare Services/Case Management System (CWS/CMS), the state's administrative data system, semi-annually between March 2013 and October 2015. The extracts contained demographic, referral, medical, placement, and discharge information for all children in the treatment and control groups. We created outcome variables using Statistical Analysis Software (SAS) and conducted data analysis using Stata.

Structured Decision Making (SDM) Assessment Tool – Protective Capacities Section. To measure changes in parent and family protective factors, HSA provided Child Trends with regular data extracts from their SDM tool for children enrolled in the evaluation. This tool is intended to be used during the initial home visit and when closing the child welfare case. However, social workers did not complete these assessments regularly; therefore we were unable to use them in our impact study.

Child and Adolescent Needs and Strengths – Mental Health Assessment. To measure changes in child well-being, Seneca agreed to provide Child Trends with assessment records for the Child and Adolescent Needs and Strengths – Mental Health (CANS-MH) assessment.⁶ The San Francisco Department of Public Health maintains these data and has a data sharing agreement with Seneca that covers the children they serve. However, due to changes in staffing and data sharing agreements, as well as delayed responses from the Department of Public Health, we were unable to obtain the CANS data in time for the final analysis.

The implementation study utilized several other data sources, which provided information on program activities and costs.

⁴ For the purposes of this report, "case" refers to family or group of related children, which could be a single child or a sibling group.

⁵ San Francisco has a large Spanish-speaking population, and Seneca has two bilingual Permanency Specialists on staff to work with Spanish-speaking families. It is not always possible to assign Spanish-speaking families to bilingual Permanency Specialists, but the Seneca program supervisor makes every attempt to do so.

⁶ This tool was developed to assist public child welfare agencies in managing and planning services for children and adolescents and their families with the primary objectives of permanency, safety, and improved quality of life. The domains assessed include general symptomology, risk behaviors, developmental functioning, personal/interpersonal functioning, and family functioning.

Child Trends FF/FGDM Database. A web-based database, developed with the earlier Stuart Foundation funds, was modified⁷ and continued as part of the new FF/FGDM federal grant project. The database is a tool for storing, compiling, and analyzing data on the FF/FGDM model. Permanency Specialists entered information on the demographics of the children they served, the connections they identified, the interactions they had with connections, meetings held for children, and any plans made to support the child. Child Trends also used the database to randomly assign children to the treatment or control group. The evaluation team trained users via live webinars and a user's guide that provided step-by-step instructions on how to enter data. Child Trends conducted quarterly data audits to ensure data quality. Data collection ended in September 2015.

FF/FGDM Fidelity Assessment Tool. Permanency Specialists completed the FF/FGDM Fidelity Assessment Tool during their regular supervision sessions (see Appendix B for the full instrument). They used the tool throughout the life of each FF/FGDM case. The purpose of the tool was to determine if and to what degree the essential components of the program model were completed. Permanency Specialists rated how successful they were in completing specific action steps in each model component, as well as how well the family team meetings aligned with the model's principles. The grant team worked together to develop a score for the assessment, providing input on whether or not certain items or program components should be weighted more heavily than others. Fidelity tool scores were linked to other data sources (e.g., administrative and case management data) using the child's public agency identification number.

Family Team Meeting Survey. At the end of each meeting held as part of the FF/FGDM model, the Permanency Specialists invited participants (e.g., social workers, professional team members, and relatives of the child) to complete a survey about the meeting (see Attachment C for the full survey). The purpose of the survey was to measure how well the meeting adhered to the program's guiding principles. The instrument covered topics including alignment with the meeting's purpose, inclusion of the child's perspective in the meeting, addressing the needs of all meeting participants, and the development of clear action steps and plans. This instrument uses a Likert scale to determine how strongly a respondent agrees or disagrees⁸ with the 12 items on the survey.

Site Visits. Child Trends conducted three annual site visits to San Francisco County. The site visits supported the implementation component of the evaluation by capturing information on grant implementation and the local context in which the model is operating, as well as documented changes in implementation over time. During these site visits, two-person evaluation teams conducted focus groups and interviews with Permanency Specialists and other Seneca program staff; HSA social workers, supervisors and administrators; and relatives of children who received FF/FGDM services. For a detailed description of site visit participants, see Appendix D. The evaluation team asked Seneca staff to detail their work processes, community outreach and training about the program, barriers and facilitators to implementing the model, the level of fidelity with which they were implementing the model, and any contextual issues that may influence child, family, and system outcomes. Evaluators also conducted focus groups and interviews with HSA staff to gather information about their level of involvement and engagement with the program, the relationship between Seneca and HSA, as well as any changes in agency culture, policies, or practices related to family engagement. In addition, Child Trends convened

⁷ Modifications to the database included functions to make it more user-friendly (e.g., copy interactions with connections and meetings from one sibling to another, recording specific commitments from connections at meetings and case closure).

⁸ Survey respondents were asked to rate their level of agreement on 12 meeting-related items. The scale ranged from "strongly disagree" to "strongly agree" with options for "didn't apply" and "don't know."

focus groups of relatives of children receiving the intervention to assess their satisfaction with the program and elicit input on the strengths and challenges from the client perspective.

Time Tracking. As a part of the cost study, Seneca Permanency Specialists completed three rounds of time tracking between May 2014 and March 2015. They kept track of the number of hours spent on each phase of the model. The time tracking data was then linked to program outputs, such as number of connections discovered or meetings held. The data also informed the implementation study, as it painted a picture of a typical week for a Permanency Specialist.

Social Worker Knowledge Survey. Child Trends developed an online survey for ongoing social workers and other child welfare staff at HSA to evaluate changes in knowledge of and experiences with family search and engagement practices. This included staff members' (1) understanding of FF/FGDM service implementation, (2) degree to which FF/FGDM activities are integrated into casework, (3) thoughts on key FF/FGDM principles, and (4) views of barriers to implementation and thoughts on how to overcome barriers. The surveys were administered prior to and following Seneca-facilitated trainings for HSA staff; the first survey was fielded in June 2013, and a follow-up survey was fielded in October 2014. See Appendix E for a full report on the pre-/post-surveys.

Modification to Evaluation Design

In July 2014, the evaluation team modified the random assignment process. Cases were originally randomly assigned using the Child Trends Database, which required having at least two cases available to be randomized against one another. The number of detentions slowed down, and the Permanency Specialist Supervisor responsible for random assignment felt that Seneca was losing valuable service-delivery time while waiting to have multiple cases to randomize together. To remedy this issue, Child Trends deactivated the random assignment function in the database and took over the random assignment of cases. We created a pre-randomized list of treatment and control slots that mirrored the way in which the database randomized cases. The Permanency Specialist Supervisor contacted Child Trends when a new case was detained, and the case was assigned to the next available slot – either treatment or control. Random assignment continued in this manner through the end of the study enrollment period (March 2015).

The evaluation team revised the approach to the cost study in April 2014, concluding that some of the original cost study questions were outside of the scope of the grant (e.g., What is the full cost of developing and implementing the FF/FGDM model? What are the potential cost savings of the model?). Upon approval from the Federal Project Officer, we modified our cost analysis approach to focus on time tracking and associated personnel costs, as well as costs associated with out-of-home permanency outcomes. See the Cost Study section below for more information.

Program Implementation

Children Served

All 145 treatment children enrolled in the study were served by a Permanency Specialist, even for a short period of time. Children were on average 6.5 years old when they began services. Roughly half were female (54%), and over one-third were African-American (43%) and Hispanic (33%). Children had been in care for an average of 11.4 days prior to random assignment. Half (52%) of the children were in foster care or a group home at the start of services; on average, children had experienced 1.3 out-of-home placements at the time of random assignment. The most common reason for removal from home was general neglect (51%), and half of the children (49%) had a goal to return home. See Appendix D for more detailed information.

At the end of the data collection, 110 cases had been closed⁹ by the Permanency Specialist, with the remaining 35 children still receiving FF/FGDM services at the end of the grant period. Overall, children were served by Permanency Specialists for an average of nine months (see Appendix D for more detailed information). Among closed cases average service length was 7 months, compared to 14 months for cases that were still open. Almost two-thirds (62%) of the cases completed FF/FGDM services, and almost one-quarter (22%) were reunited with their parents before the full array of FF/FGDM were completed. Other cases were closed due to FF/FGDM services being inappropriate for the child, parents declining FF/FGDM services, and the child moving out of the area.

FF/FGDM Model Description

The intensive FF/FGDM model was developed by an interdisciplinary team lead by the National Institute for Permanent Family Connections (NIPFC), which included content experts, program implementers, and HSA staff. Adapted from Kevin Campbell's original family finding model, the FF/FGDM model incorporated lessons learned from previous implementation experiences to provide flexibility and to integrate the practice into HSA's existing system of care. The Kevin Campbell model described six stages: Discovery, Engagement, Planning, Decision-Making, Evaluation, and Follow-up support; for a description of the stages and how they were implemented see Table 1 on the next page. The Permanency Specialists in this project placed more emphasis on bringing relatives and other key connections to meetings to plan for permanency for the child/ren. They attempted to hold a minimum of three meetings for every child, and to include the social worker wherever possible.

The planning and decision making stages tended to overlap and, in some cases, were implemented as one stage. The Permanency Specialists reported that at times they rushed to have a meeting with relatives before adequately preparing them for what the meeting entailed. In these cases, the meetings were not always successful in engaging relatives in the planning process. In retrospect, the Permanency Specialists thought this may have been premature and perhaps delayed finding permanent connections for the child in some instances, as relatives were more reluctant to come to planning meetings later in the process.

A change in practice also took place during the study period: the Blended Perspective Meeting – described in further detail below – became a requirement for all cases, rather than on an as-needed basis. According to the Permanency Specialists, some relatives experienced “meeting fatigue” which made it more difficult to engage them in the planning process. As a result, the Permanency Specialists focused more on securing concrete short-term commitments from relatives at the initial meetings. Some Permanency Specialists reported that there had been too few family meetings, which they believed was partly due to lack of support from the social workers who were sometimes reluctant to attend a Family Team Meeting. The Permanency Specialists expressed a concern this contributed to cases remaining open longer than necessary rather than progressing to a permanent placement for the children.

⁹ This refers to the closure of the FF/FGDM case. A FF/FGDM case could be closed by a Permanency Specialist, but still be an open case with HSA.

Table 1. Family Finding/Family Group Decision Making Model Stages

Stage	Description/Purpose	Relevant Outputs	Challenges:
Discovery	Identify as many connections for the child as possible. Within 10 days of the child’s removal, Permanency Specialists begin reviewing the child’s case file (both physical and electronic), requesting “Cliff searches,” ¹⁰ conducting internet searches, and communicating with the child’s social worker. Permanency Specialists also send out Relative Notification letters to all known and possible relatives to the 5 th degree, and begin contacting relatives to verify their relationship to the child. With each contact they begin the engagement process. All connections are documented on a discovery sheet that is then passed on to the social worker.	On average, Permanency Specialists identified 29 connections per child, the majority of which were new discoveries (i.e., they were not already known to the agency). The majority of connections discovered were maternal (8 per child) and paternal (6 per child) relatives. The most common method of identifying connections was through talking with connections already known and maternal and paternal relatives. See Appendix D for more detailed information on program outputs.	<p>Challenges:</p> <ul style="list-style-type: none"> • Permanency Specialists and social workers did not always agree which relatives were appropriate to contact. • Social workers sometimes felt burdened by the number of connections that contacted them as a result of the Permanency Specialists’ efforts. <p>Facilitators:</p> <ul style="list-style-type: none"> • This stage was seen as the most helpful to social workers, as the discovery sheet provided additional information on the child’s history, and was especially helpful for cases that remained in or returned to care.
Engagement	Engage the relatives and connect them with the social worker to provide support for the child. This began with the first contact and continued throughout the life of the case. This is done in person as much as possible. Techniques include mobility mapping, genograms and drawing a family tree. Background checks are completed on relatives who expressed interest in being a placement option for the child.	Permanency Specialists contacted on average 14 people per child. Out of these contacts made, Permanency Specialists engaged an average of 7 connections per child, the majority of which were maternal relatives.	<p>Challenges:</p> <ul style="list-style-type: none"> • Characteristics of the family, such as mental health, criminal background, geographic location and prior negative experiences with CW making them reluctant to engage with the Permanency Specialists. <p>Facilitators:</p> <ul style="list-style-type: none"> • Permanency Specialists being able to spend time engaging families (which social workers are not always able to do), and showing respect for them.
Planning/ Decision-Making	Planning and decision making are done in tandem, with discovery and engagement continuing throughout the process. The Blended Perspective Meeting (BPM) is the first meeting planned and held to create a team for the child. This includes any engaged relatives or other connections, as well as attorneys and the social worker. Relational, physical and legal permanency are explained and explored. If there is sufficient relative interest, the Permanency	Sixty-two percent of children had at least one meeting, with an average of 1.9 meetings per child. Permanency Specialists held 92 BPM and 145 FTM. There were on average 5 attendees at each meeting, with most commonly relative connections.	<p>Challenges:</p> <ul style="list-style-type: none"> • Allowing families to take the lead sometimes slowed the process down and contributed to cases not getting to the point of having the BPM or other meetings. • Permanency Specialists sometimes called meetings before all parties were adequately prepared. • Permanency Specialists felt inadequately trained to act as facilitators and had difficulty managing conflict, and reported being uncertain as to the roles of each meeting

¹⁰ Seneca staff member named Cliff completed searches using multiple internet search strategies to identify family members.

Stage	Description/Purpose	Relevant Outputs
	<p>Specialists held Family Team Meetings (FTM), to start the planning process with the family. The social worker usually attends to answer technical questions. Permanency Specialists focus on getting specific commitments from relatives, and used the Kevin Campbell permanency pact.</p>	<p>participant.</p> <ul style="list-style-type: none"> • Families experienced “meeting fatigue”. • Permanency Specialists were frustrated that they did not have decision making power with regard to visitation for the child. <p>Facilitators:</p> <ul style="list-style-type: none"> • Social workers began to include the family as the starting point in the decision making, rather than the worker. • Permanency Specialists were viewed as “expert” facilitators. • Short term planning helped bring people in who were not yet ready to commit to long term plans. • Relatives described the meetings as being very helpful, building bridges and making them feel included in the planning process.
Evaluation	<p>Evaluation is ongoing and part of each step of the FF/FGDM process. Permanency Specialists were instrumental in evaluating appropriateness of placements.</p>	<p>Challenges:</p> <ul style="list-style-type: none"> • Permanency Specialists thought the social workers ruled out other relatives as placement options once they had made a decision.
Follow-Up	<p>Cases are kept open for 3-6 months after placement. The Permanency Specialists work to maintain the stability of the placement and keep family supports involved with the child. They also encourage the social worker to remain involved with the child, without infringing on the social worker’s role.</p>	<p>Challenges:</p> <ul style="list-style-type: none"> • Cases may have been closed too quickly, especially when the child reunified with the parent. • HSA did not provide needed mental health services to the relatives. <p>Facilitators:</p> <ul style="list-style-type: none"> • Permanency Specialists emphasized that placement with a relative is preventive work, keeping the child out of foster care. • They used Skype and Facebook to maintain contact.

Table 2. Trainings Received by the HSA Social Workers and the Permanency Specialists

Title	Description	Attendees	Takeaways
Introduction to the FF/FGDM Model	Training developed by Seneca that outlines the philosophy of the FF/FGDM model, including the purpose, development and progress of the grant program; the key stages of the model; and what the roles and responsibilities of the Permanency Specialist and social worker are. It detailed the tools and processes used to create multiple permanency options and an enduring network of support for the young people and families served in the project. It used role play and case examples as training techniques.	310 HSA staff at all levels attended one of four half day trainings, as well as Seneca Permanency Specialists	<ul style="list-style-type: none"> • Some social workers reported trainings were very good, and geared towards ways to fit FF/FGDM practice into existing case work structure. • Some social workers reported "training fatigue" and did not see the practical application of FF/FGDM. • Post-training consultation was very helpful. • Social workers wanted training on preparing the caregivers for their children's difficult behaviors. • Social workers wanted booster trainings on the FF/FGDM model.
Implementation of the FF/FGDM Model and facilitation of Blended Perspective Meetings (BPM) and Family Team Meetings (FTM)	Training developed by Seneca that builds on the introduction and trains workers on how to implement each stage, as well as facilitate Blended Perspective Meetings and Family Team Meetings.	Seneca Permanency Specialists	<ul style="list-style-type: none"> • Permanency Specialists reported the appreciative inquiry technique was very helpful to their work. • Permanency Specialists liked being able to shadow more seasoned workers. • Permanency Specialists reported having a range of new to seasoned workers participate in the training was helpful to their learning the model. • Permanency Specialists who did not receive formal training report lacking skills. • The Permanency Specialists would have liked to have a standardized, formal curriculum to be able to refer to, and as a repository of agency knowledge. • Permanency Specialists felt unprepared to facilitate BPM or FTM, and wanted more guidance on sharing information with relatives and confidentiality.
Safety Organized Practice (SOP)	A practice approach that focuses on the safety of the child within the family system and includes group supervision, Signs of Safety, Motivational Interviewing, and solution-focused treatment. Safety-organized practice brings a common language and framework for all workers to facilitate working collaboratively.	HSA social workers and Seneca Permanency Specialists	<ul style="list-style-type: none"> • Training gave a shared language all workers could use and increased the level of understanding among workers. • Permanency Specialists gained skills in how to lead meetings including how to interact with the social workers during meetings.

Staff Training

Both the social workers and the Permanency Specialists received training on the FF/FGDM model, as well as the Safety-Organized Practice Model (SOP). Table 2 on page 13 describes each training, the participants, and lessons learned reported by the focus group and interview participants. Overall, they reported that the training was a positive experience but identified specific areas that could be improved.

In general, the social workers and Permanency Specialists reported that trainings were helpful to them in their work. The Permanency Specialists reported wanting to receive more training on how to facilitate meetings, but noted that the SOP training gave them greater insight and skills into how to run meetings. Both the social workers and Permanency Specialists used the SOP terms and definitions, which helped them to develop a common language. In turn, this increased the social workers' understanding of what the Permanency Specialists were trying to accomplish with the FF/FGDM work. The social workers reported wanting more training on how to support relatives in caring for children with behavior challenges.

Impact Study Findings

The impact study sought to determine how the FF/FGDM model influenced permanency-related outcomes. Our “confirmatory”¹¹ outcome was whether the child reached legal permanency (discharged from care to reunification, adoption or guardianship) by the end of the study period (September 29, 2015). Additional “exploratory” outcomes included: length of time to permanency, placement with relatives or fictive kin (hereafter, “relatives”), and experiencing re-allegations and re-entry among those who did achieve permanency.¹² We also analyzed “mediating outcomes;”¹³ specifically, the number of family connections identified and the number of family connections potentially interested in being involved in the case (hereafter, “engaged”). All data for the impact analyses, with the exception of the indicators that identify the child’s experimental group status and start date of services, are derived from administrative data provided by the San Francisco County’s administrative child welfare data system (CWS/CMS).¹⁴

Analytic Sample

Our sample totaled 280 children who represented 197 cases (children with siblings were assigned together, so a case may include a single child or a sibling group). See Table 3 below for breakdown of the sample by treatment condition. Case size ranged from 1 to 5 children and averaged 1.2 children. Eight percent of the treatment children were reunified with their family within 30 days of beginning FF/FGDM activities and therefore did not receive the full complement of services. However, the Intent-to-Treat design,¹⁵ requires that all children enrolled are included in the analyses.

¹¹ The “confirmatory” outcome is the outcome expected to change and the focus of the intervention. We selected a single outcome to be the focus of a “confirmatory” analysis because examining impacts on multiple outcomes would result in an elevated likelihood of finding one or more significant impacts by chance. We examined additional outcomes, including those available only for a subset of the sample (re-entry and re-allegation), as “exploratory,” an approach recommended by Schochet (2008).

¹² Note that our findings for re-allegation and re-entry cannot be considered experimental as the analytic sample for this part of the analysis is limited to children who achieved permanency and the sample is not randomized among children receiving permanency.

¹³ Mediating outcomes must be achieved in order to reach the other outcomes of interest.

¹⁴ Though limited demographic data and information on the children’s placement histories were collected in the Child Trends Database, we relied completely on the administrative data for the impact analyses to avoid any bias in our analyses.

¹⁵ In ITT analyses, children who are assigned to the treatment group remain in the treatment group for analysis purposes regardless of whether they actually received treatment. ITT analyses are frequently used because they maintain the

Table 3. Children and cases enrolled by treatment condition

	Treatment	Control	Total
Children enrolled	145	135	280
Cases enrolled	99	98	197

Our sample was well-balanced¹⁶ across treatment status with a few exceptions: treatment children were less likely than control children to be male, and to be missing information on disability status; and treatment children were more likely than control children to have entered foster care as a result of experiencing physical abuse (see Appendix D for more detailed information).

We examined county-level data¹⁷ from April 2013 to March 2015 (the study enrollment period) in order to assess the similarity of our sample to the general child welfare population in San Francisco County. The analytic sample for the impact study is reasonably representative of the broader population of San Francisco County children new to foster care (see Appendix D for more detailed information).

Description of Analysis

To analyze the impact of the FF/FGDM model on our outcomes of interest, we used linear or logistic regression with treatment status as the predictor of interest.¹⁸ We also used survival analysis to assess if the FF/FGDM model had an impact on how long it took to reach permanency.¹⁹ We used robust standard errors to adjust for the fact that children were randomized by sibling group. Literature on randomized controlled design evaluations (Knol et al., 2011; Egbewale, 2015) recommends not only controlling for variables on which the study groups are not equivalent (in this study: gender, disability status unknown and physical abuse as removal reason), but also variables that are associated with the outcome of interest. Inclusion of additional covariates makes the measurement of the treatment effect more precise. Thus, we included measures associated with permanency in all regression models.²⁰

Analysis Results

Our analysis revealed that children who were served by Permanency Specialists were more likely to be placed with relatives when compared with children in the treatment group. Treatment children also had more connections identified and connections engaged in their case than children in the control group (see Table 4

statistical similarities of the treatment and control group, thus maintaining our ability to attribute causality for any observed impacts on outcomes to assignment to the intervention.

¹⁶ We examined differences in the following characteristics: child demographics, disabilities, placements with siblings, reasons for removal into foster care, and foster care history. All variables are measured at the time of referral to family finding services.

¹⁷ Data were extracted from the CWS/CMS Direct Reporting System maintained by the Center for Social Services Research at the University of California at Berkeley, at http://cssr.berkeley.edu/ucb_childwelfare/

¹⁸ Logistic regression was used for binary outcomes including: permanency, placement with kin, and whether the child experienced a re-allegation or re-entry into foster care. Linear regression was used for continuous outcomes, the number of connections, and the number of potentially interested connections.

¹⁹ Survival analysis is used to measure the time to a particular event (permanency in our study) and also allows for the inclusion of cases that have not yet reached that event. We ran Kaplan-Meier estimates of the time to permanency, comparing the survival functions (where failure = permanency) of the treatment and control groups. We also ran Cox proportional hazard models in which we included the additional covariates as well as controlled for sibling clusters.

²⁰ Covariates included: age five or younger, gender, race/ethnicity, disability status, reason for removal, in a sibling group, two or more removals, number of out of home placements (none, one or two or more), length of time in foster care from removal to random assignment (in days). There were five children that were missing data on both reason for removal and length of time in foster care because they were never removed from home, we imputed these as “other reason” and zero days. We included a flag indicating that the case was imputed as recommended in the evaluation literature (Puma et al, 2009). All covariates are measured at the time the child was randomly assigned. For each outcome, we ran one regression with all covariates.

on the next page). However, the two study groups did not differ with regard to permanency, length of time to permanency, or re-entries and re-allegations. The results are described in further detail below.

Discharge to Permanency

Children in the treatment group were no more likely to be discharged from care to permanency (i.e., adoption, reunification or guardianship) than were children in the control group. Across the entire sample, approximately half (55%) of the children were discharged to permanency, the majority (69%) of whom were reunified with their parents. As shown in Table 4, among those who did exit to permanency, there were no significant differences in the type of permanent outcome between children in the treatment group compared to children in the control group.

Time to Permanency

We also investigated whether or not children in the treatment group exited care more quickly than those in the control group. There was no significant difference in the average number of days to permanency by experimental group status (292 treatment vs. 274 control). Children who reached permanency were in care for an average of 283 days. Children who did not achieve permanency had been in care an average of 496 days at the end of the study period.²¹ Again, there were no significant differences by experimental group status in length of time in care (478 treatment vs. 520 control), and the results of our survival analysis suggested that there was no significance difference in how quickly permanency was achieved between the treatment and control groups.²²

Table 4. Impact analysis results

	Treatment (n=145)	Control (n=135)	All (n=280)
Permanency ¹	52%	59%	55%
Permanency outcomes among those reaching permanency			
Reunification	73%	66%	69%
Adoption	16%	19%	18%
Guardianship	11%	15%	13%
Average time in care			
Time to permanency (days)	292	274	283
Time among those still in care (days)	478	520	496
Re-allegation	10%	8%	9%
Re-entry	8%	9%	8%
Placement with relatives	50%	39% *	45%
Number of connections identified	8.5	5.0 **	6.8
Number of connections engaged	5.5	3.6 **	4.6

* $p < .10$, ** $p < .05$

¹Permanency, re-allegation and re-entry outcomes are measured as of September 29, 2015.

²¹ Days in care is measured from the removal date of the foster care episode associated with random assignment to family finding to either the date that permanency was achieved or the end of the study period (Sep. 29, 2015).

²² The survival functions for the Kaplan-Meier survival curves were not significantly different and the hazard ratio on the treatment variable in the Cox proportional hazard models was not statistically significant.

Placement with Relative

As shown in Figure 1 below, treatment children were significantly more likely to be placed with relatives²³ than children in the control group. The percentage of treatment children placed with relatives was also higher (by 17 percentage points) than the percentage of children in the general child welfare population in San Francisco County (33%).²⁴

Figure 1. Treatment children were significantly more likely to be placed with relatives



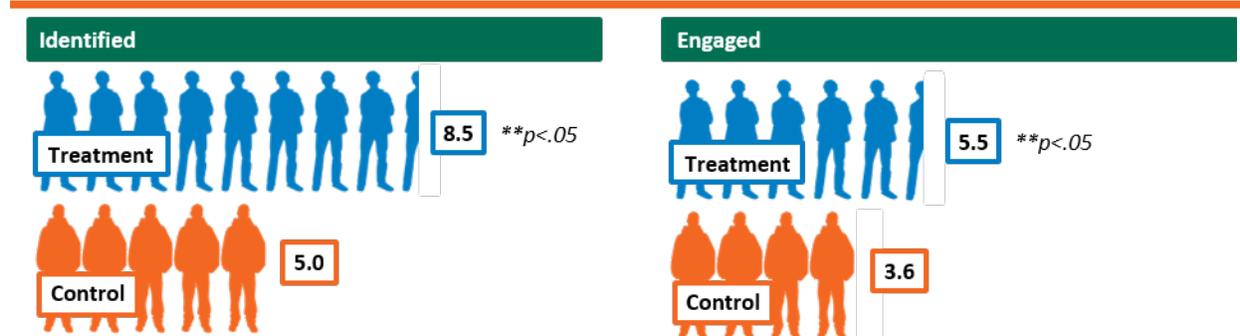
Re-entry and Re-allegations

There were no significant differences in rates of re-entry and re-allegations across treatment and control groups. Overall, rates of re-entry and re-allegation were low; 8% re-entered foster care after the episode associated with random assignment to FF/FGDM²⁵ and 9% had a re-allegation. Children receiving FF/FGDM had the same likelihood of re-entry or re-allegation as children in the control group. These results should be interpreted with caution as the evaluation timeline did not allow adequate time for such outcomes to occur.

Family Connections

While the FF/FGDM model did not impact our confirmatory outcome, it did impact our mediating outcomes. Children who received FF/FGDM had more connections identified and engaged²⁶ than did their counterparts in the control group. As shown in Figure 2 below, children in FF/FGDM, on average, had 8.5 connections identified versus 5.0 connections for children in the control group. Treatment children also had an average of 1.9 more engaged connections compared to control children.

Figure 2. Treatment children had more connections identified and engaged



²³ Placement with relatives includes placement with adults who are related by blood to the child (relative) or with a nonrelative extended family member (NREFM). This is either the child's placement at the end of the study period (if they were still in care), or the last placement before exiting care.

²⁴ According to figures provided by a senior data analyst at HSA, as of January 6, 2016.

²⁵ Only one child had more than one re-entry.

²⁶ "Identified" means that the Seneca worker initiated contact with and confirmed that the person is related to the child. "Engaged" means that the relative indicated they would be potentially interested in being involved with the child's case in some way (e.g., providing support to child or birth parent, attending meetings, being a placement resource). Like all variables used in the impact analysis, these are taken from CWS/CMS in order to detect differences between the treatment and control groups. For children who received the FF/FGDM model, Permanency Specialists also entered more detailed information into the Child Trends Database on the connections they identified. Unlike in CWS/CMS, for a connection to be recorded in the Child Trends Database, it was not a requirement for the Permanency Specialist to have actually made contact or have interacted with the person.

Differences by child characteristics

We also examined differences in outcomes by age and race/ethnicity. The treatment effect only differed significantly by race/ethnicity for placement with relatives. Being in the treatment group had a significantly larger impact on whether or not Latino children were placed with relatives when compared to non-Latino children. In other words, Latinos in the control group were less likely to be placed with kin versus non-Latinos in the control group (24% compared with 45%), while Latinos in the treatment group were slightly more likely to be placed with kin than non-Latinos (56% compared with 47%). The only other significant finding by subgroup was age and reallegations. For children under the age of five, being in the treatment group made them more likely to experience a reallegation than those over the age of five. However with so few children experiencing a reallegation (n=10 for treatment children and n=4 for control children), we should be cautious in assuming these results are generalizable.

Implementation Study Findings

The first analysis step for the implementation study was the development of a coding structure closely aligned with the interview and focus group protocols from the site visits (description of service components, impressions of and experiences with services, challenges and facilitators to service delivery, and contextual factors). Two-person teams conducted the qualitative field work with one researcher serving as the interviewer/facilitator and one serving as note taker. Detailed notes from each completed interview and focus group were coded thematically according to the coding structure. Themes that emerged through coding are presented as the subheadings in this section. Unfortunately the small numbers of site visit participants precludes us from detailing the number of participants who expressed each theme as doing so might divulge identities.

Implementation Challenges

During annual site visits, the evaluation team assessed the challenges that the grant implementation team experienced in implementing the program, including barriers related to philosophical differences between the Permanency Specialists and social workers, Permanency Specialist workload, communication challenges, meeting fatigue, training and supervision of the Permanency Specialists, and characteristics of the relatives that made it harder to serve them.

Philosophical Differences Regarding Family Engagement

Some social workers did not agree with the FF/FGDM approach and were wary of contacting family members, who they thought would be inappropriate and create instability for the children rather than serve as positive supports. At times, the Permanency Specialists felt that this attitude negatively impacted their work with the children and relatives and may have slowed the process down. This also translated into disagreements over who to engage, especially when it came to paternal relatives when paternity had not been established. While HSA administrators decided that relative notification can and should include alleged paternal family members, some social workers thought they were overstepping their bounds in not waiting until paternity had been established before making contact with possible connections for the child. Some Permanency Specialists thought that social workers would often accept the first available placement option (which may have been a non-relative placement) before considering all relative options. Some social workers thought their priority was to keep the child safe, and their loyalty was to the child, not the relatives. This was a different approach than that of the Permanency Specialists who, although cognizant of the importance of safety, also prioritized the child's right to keep contact with family and have them involved in the planning process. To a social worker more relatives engaged in the process could mean more people to vet, whereas to a Permanency Specialist more relatives involved meant more possibilities for emotional and legal permanency.

Results from the social worker survey (see Appendix E) indicate that in general the social workers had reservations about considering a long-term placement without legal permanency as a successful outcome, and their reservations grew from pre- to post-test. Their perspectives differed from the Permanency Specialists, who placed a higher value on relational permanence than did the social workers. Some social workers thought that relational permanence²⁷ was a less than adequate goal in and of itself, and felt that they needed to focus on legal permanence instead. Some believed that, even though family is important, the balance of emotional and legal permanence for the child with the appropriateness and availability of family is important. This differed from the Permanency Specialists, who strived for and believed that relational permanence could provide tremendous support to children who had not been connected to relatives in the past.

Perception of Increased Workload

Initially, some social workers felt that the discovery and engagement stages of FF/FGDM, specifically the relative notification process, increased their workload significantly. Some social workers were overwhelmed by the number of relatives who contacted them wanting to get information about their relative child and participate in the case planning process, which took up a lot of their time. They also felt that the Permanency Specialists could have done a better job managing the relatives' expectations regarding contact with the child. Over time, the social workers came to appreciate the Permanency Specialists' work and the benefits of increased family engagement for the children on their caseload.

Communication Barriers

The Permanency Specialists felt a sense of urgency to contact relatives, especially early on in the project, and some expressed impatience if the social worker did not respond in a timely manner to their queries about which relatives would be unsafe to contact. Permanency Specialists would often proceed with contacting relatives without contact with the social worker first. This raised concerns for some of the social workers that they were being left out of the loop, and they worried that the Permanency Specialists would contact people the social worker deemed inappropriate. Both sides believed that better communication could have alleviated this problem, and over time it did improve. Some of the Permanency Specialists thought that more in-depth training in the FF/FGDM model in general, the discovery and engagement process, and the Permanency Specialists' role in particular, including how they approached relatives, could have alleviated some of the concerns the social workers had and facilitated better understanding and communication between parties.

Seneca Staff Training and Supervision

The Permanency Specialists hired after the start of the project reported receiving more on-the-job training than any formal training on the model. This included shadowing more experienced Permanency Specialists, but they reported they would have benefited from more formal training, in particular on facilitating meetings (one of their expressed weaknesses). Some Permanency Specialists also felt that having a standardized manual would have increased their ability to learn more on their own. They reported that their supervisors were very good at explaining the stages of the model and the accompanying tasks, and communicated very well with HSA. However, due to the clinical nature of the work, they felt they would have benefited from more clinical supervision.

Overabundance of meetings

There appeared to be "meeting fatigue" among both the relatives and the social workers at HSA. According to one social worker's count, there were 37 different types of meetings held at HSA. At times, this meant that the social worker did not have the time to attend Seneca-run meetings. The Family Team Meetings run by the Permanency Specialists were not required by HSA, so social workers did not always attend. Without the social worker present the meeting was not considered an official HSA meeting and did not carry any weight with

²⁷ Relational permanence refers to connections made between the child and relatives that remain constant over time, but do not include the child living with the relative. This can include visitation, emotional, social and/or financial support.

HSA regarding permanency plans made at the meeting. Some of the Permanency Specialists thought that the relatives also “lost steam” after the first couple of FF/FGDM meetings, especially as these were often in addition to HSA meetings they were asked to attend, and it became harder for the Permanency Specialists to engage them to continue the planning process. Permanency Specialists encouraged families to make short term plans at the initial meetings to establish momentum with some successful engagements early on, in turn leading to the development of long term plans later on in the process.

Family Characteristics

Due to prior contact with HSA, some parents and relatives were distrustful of the agency, and therefore reluctant to engage with the Permanency Specialists and share information about other relatives. The Permanency Specialists also had trouble engaging relatives who could not pass criminal background checks, had mental health challenges, or lived far from their relative children. These same issues made contact with their relative children difficult. Some social workers were concerned that contact with such relatives would not be in the best interest of the child. Many of the Permanency Specialists reported that encouraging the relatives to take the lead in the planning process slowed the process down and may have contributed to cases not progressing to the Blended Perspective Meeting or other FF/FGDM meetings.

Implementation Facilitators

Site visit participants reported several facilitators, or drivers, in implementing the FF/FGDM model, including the integration of FF/FDM principles into HSA practice, features of the social work staff, commitment of the Permanency Specialists, revision of the relative notification process, and co-location of the Permanency Specialists within HSA offices. Family engagement was also a facilitator of FF/FDM implementation.

Integration of FF/FGDM Principles

Over time, many social workers began to adopt the principles of family discovery and engagement of the FF/FGDM model and appreciate the ways in which it could help them in their work. They saw that the discovery process was useful both for children who had relatives who were interested in caring for the child as well as those that did not. One social worker expressed that they were able to explore adoptive homes faster for children when as a result of FF/FGDM they knew there were no relatives available as placement options. Results from the social worker survey indicated that, both at pre- and post-test, the social workers strongly agreed that it is important for relatives to be involved in a child’s life even if they cannot serve as a permanent placement. Survey results also suggest that the social workers agreed that relative involvement could enhance a child’s overall well-being.

Many of the social workers reported that, as a result of observing the work of the Permanency Specialists in Family Team Meetings, they began to incorporate the family engagement principles of FF/FGDM into other agency-run meetings, and began to include the family’s opinions and ideas into the planning process. One of the HSA administrators reported that, even in agency-led meetings, they were now looking to the family as the starting point in decision making, not the social worker. Many of the social workers reported that in the Permanency Specialist-led Family Team Meeting they appreciated having the Permanency Specialists as the facilitator and saw them as “experts” in the process. They saw the benefit of having family meet face to face, and appreciated the value of developing concurrent plans with the relatives. Results from the social worker survey indicated that the social workers agreed that it is important to involve relatives as a life-long supportive network for the child. All relatives reported that they felt included in the process and that the meetings linked people together to focus on the needs of the child. Even though some of the social workers did not like the randomization aspect of the evaluation, they supported the principles of FF/FGDM overall.

Staff characteristics

Some of the Permanency Specialists reported that social workers who were younger and newer to the agency appeared to be more supportive of the FF/FGDM model in general compared to older more experienced social workers. This was in contrast to the results of the social worker survey, which indicated that more experienced workers' opinions more closely aligned with the grounding principles of FF/FGDM. In general, the Permanency Specialists perceived FF/FGDM to be a desirable and reputable practice among new HSA social workers who held a Masters in Social Work (MSW) degree.

During the second year of the project, Seneca changed the job description for the Permanency Specialist position to require an MSW. Seneca also reported improved screening and selection process for new Permanency Specialists. There was a fair amount of staff turnover, and as Permanency Specialists left they were replaced with Permanency Specialists who had more clinical training. They had the preparation and skills to engage hard-to-reach relatives, which is a core activity of the model and can be quite challenging for less experienced workers.

Commitment from Seneca Staff

All Permanency Specialists were strong believers in the FF/FGDM principles, which helped promote the model with the social workers and the relatives. They reported that they felt they went above and beyond the bare requirements of the model and put in extra effort to try to find and engage connections for the children they served. They had strong communication skills and were willing to reach out to family who had been overlooked. One Permanency Specialist reported:

“The relationships we build...we are able to find families just through cold calls. That’s amazing to me. We are able to find connections just based on the fact that we are willing listen to them and bear them out. I don’t think that happens in child welfare often. It’s huge. Responding to them. You couple that with in-person engagement and following through on what you say and it’s huge.”

Partnership between SF-HSA and Seneca

The positive working relationships built between the Permanency Specialists and social workers contributed significantly to the successful implementation of FF/FGDM and its integration into HSA. All the Permanency Specialists and the social workers talked about building good communication pathways over time, and the social workers were especially appreciative of the Permanency Specialist supervisor's communication, organization and negotiation skills. This was enhanced by having the Permanency Specialists embedded in the agency offices. A critical element of the relationship was the Permanency Specialists conducting the relative notification process. The Permanency Specialists entered information about connections discovered and engaged for each treatment child into the agency data system, which helped the social workers in their work with the families. The social workers also relied on the Permanency Specialists to talk with relatives and engage them in the planning process, which saved the social workers some time and allowed them to occasionally skip the Permanency Specialist-led Family Team Meeting.

Revision to Relative Notification Process

Initially the relative notification letters were misconstrued by many relatives as promising a relationship with their relative child that may or may not have been possible and caused them to have unrealistic expectations. In some cases it was the first time the relative found out their related child/ren was in agency custody and was quite upsetting for them. The Permanency Specialists said that they rewrote the letters to be less specific yet still encourage the relative to make contact with the Permanency Specialists. This improved the process overall and yielded better engagement with relatives. It also eased some of the burden on the social workers, some of whom reported that fewer upset and confused relatives were calling.

Co-Location of Seneca Staff at HSA

The fact that the Permanency Specialists had physical office space in county offices helped improve communication and collaboration between HSA and Seneca staff. The Permanency Specialists were integrated into the day to day practice of HSA and participated in the service provision teams, which increased agency acceptance of the FF/FGDM program. Their role as facilitators and coordinators of the FTM was appreciated by the social workers, and being on-site made it easier for the social workers to attend meetings.

Critical Elements for Program Success

The Permanency Specialists believed that building relationships with all parties was critical to the success of the program. As one Permanency Specialist explained:

“At the end of the day, this is about relationship building with the parents, the families, and the social workers. It’s really meeting people where they are and helping them understand why it’s important to do this.”

Overall, the Permanency Specialists believed that being open to listening to families and really engaging them in the planning and decision making process was vital to the success of their work. This included kindness and curiosity and the confidence that you can work with the family to engage them. Another critical step was establishing a supportive network for each child, as this was a framework that would allow the child to “get out of the system.” Techniques that they felt were critical included: the statement position map, appreciative inquiry, and the family tree exercise. They also viewed a good working relationship with the social worker as critical to successful FF/FGDM.

One Permanency Specialist said that finding family was the easy part, bringing them to a meeting and facilitating the meeting was much harder and required more skill, especially clinical and family therapy skills. Direct care experience was valuable and helpful in doing the work. Another Permanency Specialist thought that discovery was the critical component, as without discovery you would have no-one to work with as a potential placement option for the child.

Family Engagement and Involvement in Decision Making

Overall, relatives who participated in FF/FGDM services were positive about the Permanency Specialists and felt the Permanency Specialists were engaging, respectful, and responsive to their concerns. The relatives saw the relationships between the Permanency Specialists and child as supportive and enduring over time. They understood the value of FF/FGDM for themselves and their relative children and felt it increased communication between themselves and their relative children. One relative reported having a positive relationship with the foster family as a result of FF/FGDM. Another relative commented “They were magnificent. I don’t have a single complaint.” S/he felt included in making decisions about the child’s permanency options. This was true for the FF/FGDM process in general, as well as the Permanency Specialist-run meetings, such as the Blended Perspective and Family Team Meetings. Most of the relatives reported that many of the FF/FGDM activities were useful, such as the family tree.

To further understand what meeting participants, including the relatives, thought of the meeting overall, we examined the results from the Family Team Meeting surveys. We received surveys from meetings held for only 16 of the 88 children for whom meetings were held; a total of 175 surveys were completed at 34 meetings. The majority (46%) were completed by relatives, but one-third (34%) were missing information regarding who completed the survey. We sought input from Seneca staff on a composite meeting fidelity score, where some items are weighted higher than others. The raw composite score was then converted into a percentage of total possible points for easier interpretation. However, with surveys completed for only 18 percent of children for whom meetings were held, the results should be interpreted with caution.

The survey corroborated the opinions expressed by relatives in the focus groups. Overall, they reported that the meetings were inclusive of their opinions and stories, well run by the facilitators and that the “right” people were at the meeting. For details on each response item, see Appendix C. The scores indicate that, from the viewpoint of relatives, the meetings were run with fidelity to the guiding principles. The average meeting score was 75 percent for relatives; however, their scores varied widely (12% to 100%). The children who completed surveys rated the meetings highly, giving an average score of 92 percent, with less variance in their scores (75% to 100%).

These survey results indicate that the Permanency Specialists are doing a good job at engaging the family and team members, at explaining the purpose of the meeting and encouraging participation of all at the meeting. They suggest that Permanency Specialists are less successful in identifying the current stressors and barriers impacting participants, clearly outlining the agency’s concerns, and discussing the permanency options. Some of the team members thought that the child’s ideas were not included in the plan.

Contextual Factors

In order to understand what other factors may have affected the successful implementation of the FF/FGDM model, we looked at the context of practice as usual in the agency, what other programs and practices were available in the area that were similar to FF/FGDM, and community characteristics that could have an impact on the implementation of FF/FGDM.

HSA Practices Similar to FF/FGDM

In addition to the full-time HSA staff person that facilitates FGDMs, there were other practices in the agency that were similar to the FF/FGDM model. Children in the control group may have been involved in these services. In particular, the agency has many meeting formats to facilitate permanency, several of which were frequently mentioned during site visits:

- Meeting to Assess Permanency (MAP) is a panel of staff that discusses permanency options for children in care.
- Family Team Meeting (FTM) focuses on creating plans to meet child and family needs as the case continues in the CW system.
- Team Decision Making (TDM) is focused on the placement and safety issues.
- Multi-Agency Services Team (MAST) is a coordinated leadership approach to meeting the needs of complex cases involved in one or more systems of care
- Placement and Review Committee (PARC) is a case consultation meeting to discuss permanency options for a case.
- Child Family Team (CFT) meetings focus on the mental health needs of the child.

The agency had other programs that support permanency for children, including the kin-gap program which offers child care, a clothing allowance, and medical care for the child until they turn 21; a process to license non relative extended family members (NREFM) which included a background check, a home study and an orientation. In August 2014, HSA began a resource family assessment (RFA) process which offers a relative caregiver the same training as a licensed foster parent. This process entitles the relative caregiver to legal status six months after they complete training. This made them eligible for some financial assistance and may have increased the number of relatives interested in becoming permanent placement options for their relative children.

Children in the control group were eligible to receive similar services from their social worker, and some social workers reported that they believed they did the same work as the Permanency Specialists (including holding family meetings similar to the Blended Perspective Meeting with relatives), but it took them longer

than the Permanency Specialists. Other social workers reported they did not have time to do the in-depth work the Permanency Specialists did, although they wished they had the time to do so. Some social workers were more proactive about making contact with family members than others. Initially, some social workers saw the relative notification letter as an end in itself and did not follow up with relatives who did not respond to the letter. As a result of exposure to FF/FGDM, the social workers began to view this as the beginning of the engagement process and placed more emphasis on engaging relatives.

Other Agencies that Offer Similar Services

The Permanency Specialists and social workers mentioned other agencies that provide similar services to the FF/FGDM service. Edgewood is a private residential treatment social service agency in the San Francisco area that also provides family conferencing and family search and engagement services for the children in their care. The HSA administrator described their services as assisting youth to identify at least three adult/sibling connections in their life, and having the same goals of family engagement as FF/FGDM.

The San Francisco school district also attempts to find adult and sibling connections for the children in foster care in their schools. Family Builders (which serves about one in every six to seven children in care in San Francisco) is another private agency whose mission is to help find permanent, loving families for children and youth in the foster care system. They have a team of permanency workers that does work similar to the Permanency Specialists.

It is possible that some of the children in the control group received services from these agencies. Because these services are similar in nature to the FF/FGDM services, children in the control group may have experienced some of the same outcomes as the treatment group, such as increased connections with relatives and increased chance of a permanent placement with a relative.

Community Characteristics

Permanency Specialists reported that the high cost of living in San Francisco has driven many people out of the city to more affordable communities. With so many relatives living outside of the city, it is difficult for children to maintain regular contact with their family. San Francisco has a large transient population (with people moving both in and out as well as around the city): this means that relatives are often not in the same area as their related children, which makes it difficult for them to establish and maintain contact with each other. These factors could have affected both the treatment and control group children.

Fidelity Assessment

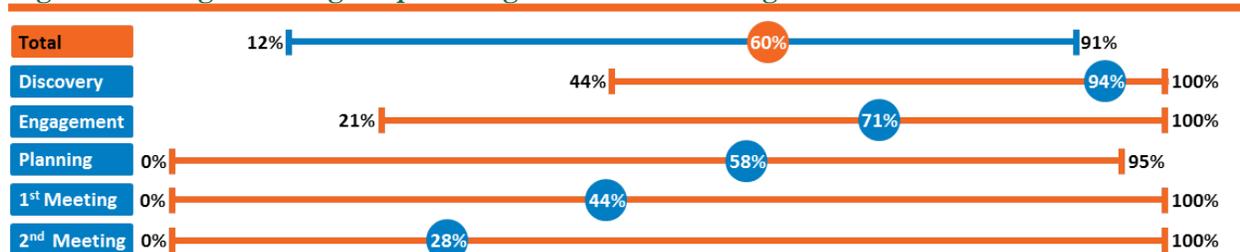
One of the goals of the evaluation was to measure the fidelity with which Permanency Specialists implement the FF/FGDM model. We used two sets of measures to determine the level of model fidelity on each case: FF/FGDM fidelity tool and fidelity “benchmarks.” The fidelity tool (see Attachment B) is principle-based, focusing on how successful the Permanency Specialists felt in completing the essential components and action steps of the model as well as how closely the team meetings aligned with the model’s principles. The benchmarks are more output-based, focusing on the concrete results of the Permanency Specialists’ actions. Taken together, they allowed the grant team to assess how well the model was being implemented.

Fidelity Tool

Permanency Specialists completed the fidelity tool for each case during their regular supervision sessions. In the discovery section, Permanency Specialists indicated whether or not each action step was completed. In the engagement and planning sections, they rated how successful they felt in completing each action step. In the final two sections Permanency Specialists rated how closely the meetings aligned with the model’s guiding principles. Each case was given a fidelity score based on the Permanency Specialists’ ratings of the action

steps.²⁸ Fidelity tools were completed for 93 cases. Almost one quarter (23%) of the cases with a completed fidelity index were served by a Permanency Specialist for less than 60 days. Including these cases in our assessment could bias the results, as they did not have the opportunity to receive the full model; therefore we excluded these cases from our examination, yielding a sample of 72 cases. In order to more easily compare scores across each stage of the model, the evaluation team converted raw scores into the percentage of total possible points for each section. As shown in Figure 3 below, the average percentage scores on the fidelity index were lower as the Permanency Specialists progressed through each stage of the model. For many cases, the lower scores in the planning and meeting stages can be attributed to not having family meetings.

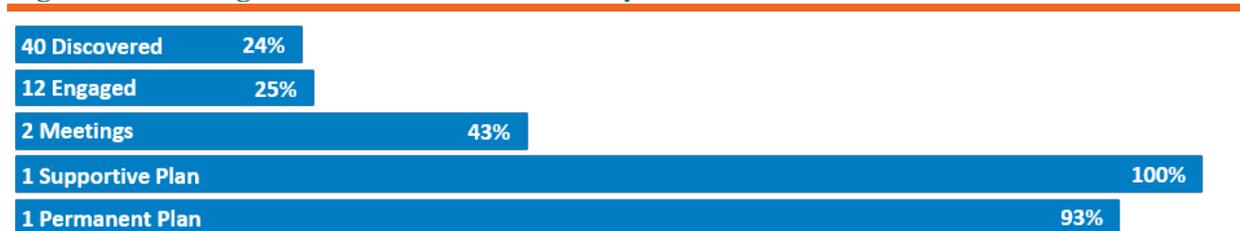
Figure 3. Average and range of percentage scores on each stage of the model



Fidelity Benchmarks

In addition to rating how successful Permanency Specialists were in completing each action step, the fidelity tool also emphasizes meeting specific “benchmarks” for each phase of the model: 40 connections discovered, 12 connections engaged, 2 meetings held, leading to 1 plan developed for the child. Figure 4 shows the number and percentages of cases where each benchmark is met.²⁹ Permanency Specialists were able to meet more of the benchmarks in the later stages of the model. All cases had at least one family member agree to a supportive plan, and almost all (93%) had at least one connection agree to a permanent plan.

Figure 4. Percentage of cases that met each fidelity benchmark



As shown in Figure 3 above, the degree of fidelity to the model (according to the fidelity index) went down as cases proceeded through the different stages of the model. The opposite was true for the fidelity benchmarks. While Permanency Specialists were not rating their actions as successful in the later stages of the model, or as

²⁸ As mentioned earlier, the evaluation team, in collaboration with Seneca program staff, developed a score for the assessment. The engagement and planning stages were weighted more heavily than the discovery and decision making stages. Action items in each stage were also weighted. See Appendix B for more detailed information on the development of the fidelity score.

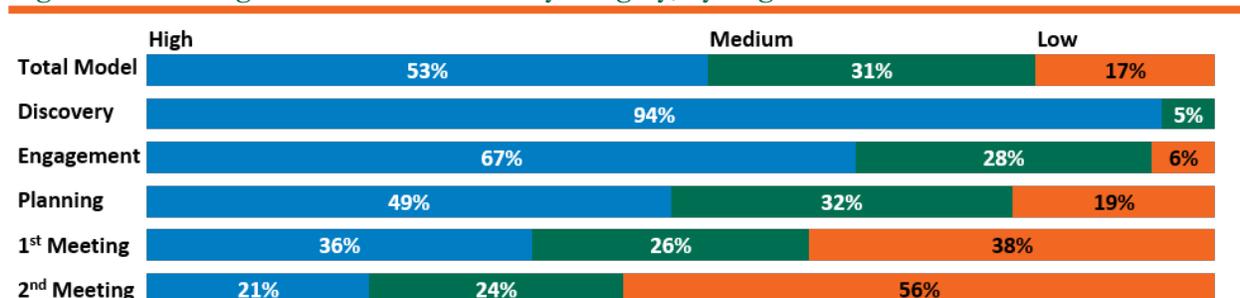
²⁹ “Connection discovered” is defined as a person/relative that was identified as being connected to the child during the discovery process, as entered into the Child Trends Database. The Permanency Specialist did not necessarily have any contact with this person, they just identified them as being related to the child. “Connection was engaged” is defined as connections who were interested in attending a meeting or agreed to a permanent or supportive plan at any interaction with the Permanency Specialists. “Meetings held” is defined as having two meetings (either Blended Perspective or Decision Making). “Supportive plan made” is defined as having at least one connection agree to a supportive plan at case closure. “Permanent plan made” is defined as having at least one connection agree to a permanent plan at case closure.

aligning well with model principles, they were still able to reach the benchmarks set out by program developers.

Fidelity and Child Outcomes

As a part of the fidelity assessment, we examined how the level of fidelity with which the model was implemented was associated with positive child outcomes. To do so, we broke the fidelity index scores down into “high,” “medium,” and “low” categories (see Figure 5 below for the percentage of cases in each category). We then explored any differences in exits to permanency, placement with kin, and number of connections identified and engaged with the case among the different levels of fidelity, as well as by cases that met the different fidelity benchmarks. Half (53%) of cases reached a high overall level of fidelity to the model.

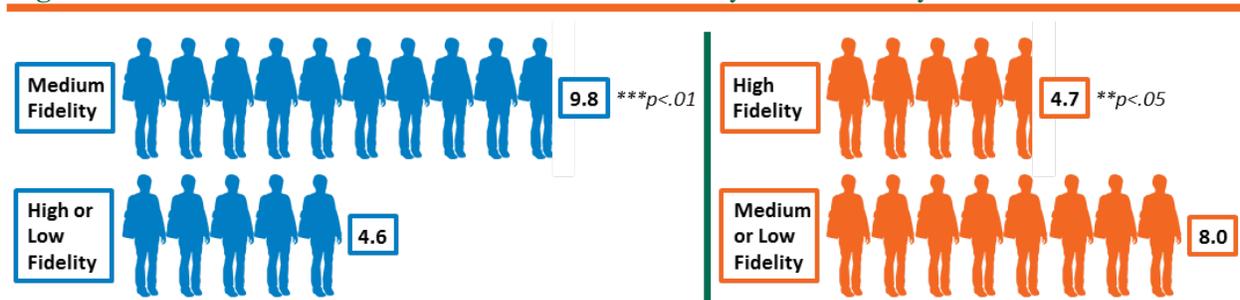
Figure 5. Percentage of cases in each fidelity category, by stage of model



The level of fidelity to the model or fidelity within its different stages was not associated with exits to permanency or placement with relatives.³⁰ Similar percentages of cases with high fidelity to the model (according to the total index score) compared to cases without high fidelity exited to permanency (51% vs. 54%) or were placed with relatives (56% vs. 51%).

We also examined differences in the number of connections identified or engaged with the case³¹ between the cases with high, medium, and low fidelity. As shown in Figure 6 below, the number of connections identified was significantly higher for the cases with medium fidelity to the overall model than those with high or low fidelity to the model. However, cases with high fidelity to the model had significantly *fewer* connections identified than those with medium or low fidelity.

Figure 6. Difference in number of connections identified by level of fidelity



Based on the available measures, we found that the level of fidelity did not influence exits to permanency or placement with relatives. This is consistent with our findings during the annual site visits. Overall,

³⁰ Logistic regression was used to determine whether or not the different levels of fidelity predicted a positive permanency or relative placement outcome. There were no significant findings in this analysis.

³¹ As entered by Permanency Specialists into CWS/CMS. We used this measure to be consistent with the way mediating outcomes were presented in the impact study.

Permanency Specialists thought that they kept fidelity to the model to the best of their ability, and even went beyond the basic requirements of the model (e.g., transporting relatives to meetings, etc.), but ran into challenges that were out of their control. For example, Permanency Specialists often had trouble engaging relatives because they lived far away or were reluctant to engage with the child welfare system. They also reported struggles with the planning and decision making stages, in particular convening meetings. These later stages of the model require cooperation from other members of the child’s team to adopt and implement the family-driven plans, which Permanency Specialists felt like they did not always receive. Given these challenges, it makes sense that Permanency Specialists would perceive the implementation of the later stages as less successful than the earlier stages.

Permanency Specialists reported that they did not necessarily strive to (and in most cases did not) find 40 connections for each child, but they did their due diligence and identified as many relatives as could be reasonably expected. Seneca supervisors and program staff emphasized the importance of going beyond simply *looking* for relatives to simultaneously *engaging* them, and how the process was continuous throughout the life of the case. This emphasis on continued family engagement may help to explain why every child had at least one connection agree to a supportive plan. Permanency Specialists also reported that they focused on getting specific commitments from relatives, and made an effort to give concrete examples of those commitments.

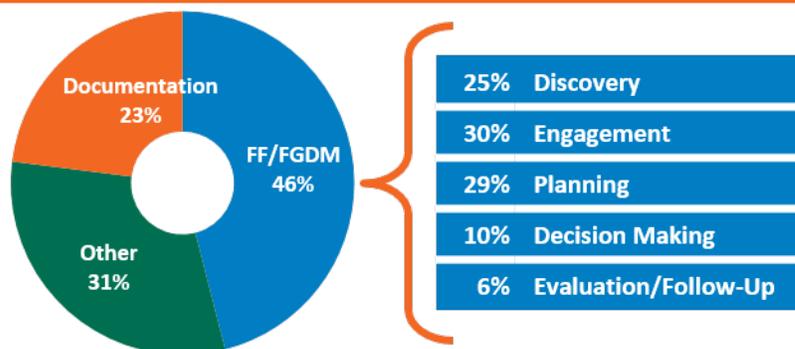
Cost Study

As mentioned earlier, the grant team modified the cost study approach. The revised approach can be broken down into two parts: a time study and a cost study. The time study sought to identify on what tasks Permanency Specialists spend their time and to explore whether or not the number of hours spent on specific stages of the model is associated with program outputs. The cost study sought to examine how Permanency Specialists’ salaries break down by model component as well as explore differences in out-of-home care costs by treatment condition.

Typical Week for Permanency Specialists

Overall, Permanency Specialists spend more time on non-FF/FGDM activities, such as documentation, training, transportation, meetings, or coaching (see Figure 7) than on FF/FGDM activities. When looking specifically at FF/FGDM activities, Permanency Specialists spend roughly equal percentages of time on discovery, engagement, and planning, but less time on decision making and evaluation. It should be noted that as a part of the implementation study, we found that engagement was considered an ongoing process and occurred throughout each stage of the FF/FGDM model.

Figure 7. Time spent on case-related activities



When broken down by Permanency Specialist, time spent on different activities varies greatly. Some Permanency Specialists spent the majority of their time on FF/FGDM activities, where others spent more time on other types of activities. This variation is most likely due to caseload size, case length, and Permanency Specialist tenure. When looking specifically at time spent on FF/FGDM activities, results also varied by Permanency Specialists for many of the same reasons listed above. Based on the available time tracking data, the engagement and planning phases tend to take up most of the Permanency Specialists' time, followed by discovery.

Time vs. Outputs

There does not appear to be a relationship between the amount of time spent on each stage of the model and program outputs. The Permanency Specialists who spent the most time on discovery activities identified half as many connections as Permanency Specialists who spent half as much time on discovery. The Permanency Specialists who spent the most time on engagement and planning did not have the highest number of connections engaged or contacted, as one might expect. What this information does tell us is that even though time may not be spent specifically on engagement activities, Permanency Specialists continue to engage relatives through the planning and decision making stages.

Salary Breakdown by Stage of Model

We planned to examine how Permanency Specialists' salaries break down by each stage of the model to determine if it would be more cost effective to have a different staff person complete certain activities (e.g., discovery and case mining). We found in our implementation study that in practice these activities cannot always be broken down into discreet components; that the stages overlap. Therefore we are unable to break Permanency Specialists' salaries down by stage of the model in a meaningful way. However, the time study shows us that Permanency Specialists spend almost one-quarter of their time on case documentation (much of which was related to the grant). That breaks down to \$15,813 per Permanency Specialist spent on case documentation. If those administrative tasks were pushed down to support staff, not only would it cost less in terms of salary, but would also free up more of the Permanency Specialists' time to conduct FF/FGDM activities or serve more cases.

Out-of-Home Care Costs

We were also interested in differences in out-of-home care costs³² by treatment condition. As FF/FGDM services had positive impacts on placement with relatives, we examined differences in out-of-home care costs by placement type (relative vs. non-relative³³). We were not able to obtain child-level information on out-of-home care costs for children served, and therefore unable to make comparisons by treatment condition. However, HSA provided county-level information on differences in costs by placement type for the general child welfare population. For children in care on November 30, 2015, HSA pays relative caregivers an average monthly payment of \$715 per child, compared to \$2,253 per child to non-relative caregivers. While we are unable to determine an exact cost-savings in terms of out-of-home care payments, by moving more children to relative placements, FF/FGDM services could theoretically save HSA \$1,538 a month for every child placed with a relative.

³² For the purpose of this cost study, "out-of-home care cost" is defined as the average payment to a placement per month. This does not include any additional service or administrative costs.

³³ Non-relative placements include all placements that are not classified as "relative placement," including foster care, treatment foster care, group homes, therapeutic settings, transitional housing programs, or supervised independent living programs.

Evaluation Discussion

Overall, while the evaluation found FF/FGDM had no impact on permanency outcomes, the evaluation did find a positive impact on placements with relatives, as well as the number of connections identified and the number of connections who expressed interest in being involved with the child's case. Compared to findings from the previous evaluation, a smaller percentage of the total sample experienced placement with relatives, highlighting possible changes over time in HSA's ability to place children with relatives (e.g., many relatives being displaced from the city, changes in agency practices, etc.). In this context, FF/FGDM may be viewed as a potential protective factor, increasing the number of connections and the number of interested connections appears to assist in the children being placed with relatives. In fact, the percent of children receiving FF/FGDM who were placed with relatives (50%) was far greater than in the general San Francisco County child welfare population during the same time period (33%).

FF/FGDM services appear to have a stronger effect on Latino children in terms of placement with relatives than on non-Latino children. Latinos in the treatment group were slightly more likely to be placed with relatives than non-Latinos in the treatment group, where Latinos in the control group were *less* likely to be placed with relatives. Many of the FF/FGDM principles of family support and engagement align closely with the value of *familismo*³⁴ common in Latino communities, suggesting that FF/FGDM aligns well culturally with Latino families. However, this finding warrants further examination given the small sample size.

Both the current evaluation and the previous evaluation show that a larger, although not statistically significant, percentage of the treatment group was reunified during the study period. One limitation in the current study is the sample size. As is true in all research studies, a larger sample would increase the power of statistical tests to detect program impacts. However, readers cannot assume that the outcomes for the treatment and control groups observed in the present study would be different (either positively or negatively), had the study enrolled a greater number of children.

Additionally, the relatively short study period (30 months) may be insufficient to measure some of the outcomes of interest (i.e., exits to adoption and guardianship as well as re-allegations and re-entries). Specifically, at the end of the study period, 41 percent of children remained in care. We do not know if those children ultimately achieved permanency, nor whether or not those children were subject to subsequent allegations of maltreatment or re-entered foster care. Further, because exits to adoption or guardianship take longer on average than reunification, we would expect that the majority of adoptions/guardianships that will ultimately be finalized for the study sample had not yet occurred by the end of the study period. Recent data for San Francisco County show that children exiting to adoption or guardianship had been in care an average of 25 and 28 months, respectively. In contrast, exits to reunification tended to occur much more quickly, with an average of 11 months. Thus, it is possible that the difference in the outcomes ultimately achieved by the study sample in the long term might vary from what was observed during the study period.

Another possible reason we did not find significant impacts on some outcomes is potential "contamination" of the control group; meaning, exposure to other services among the control group children. HSA workers participated in numerous trainings on FF/FGDM, both during this study period and as part of the previous evaluation. Social workers reported implementing some of the model components with cases assigned to the control group and children in the control group also received family finding-like services from other outside agencies. This "contamination" of the control group would dissipate impacts of the intervention.

The FF/FGDM program met its goal of increased family involvement in case planning. While Permanency Specialists were not always able to maintain fidelity to the FF/FGDM model, they continuously upheld the

³⁴ A core cultural value in Latino communities which stresses the importance of family loyalty and commitment, and a preference for maintaining close connections with extended family.

principle of ongoing and authentic family engagement. In addition, fidelity did not translate into more positive outcomes. All of the children in the fidelity assessment had at least one connection agree to a supportive plan, and 93 percent had a connection agree to a permanent plan. Similar to findings from the previous evaluation, it could be that Permanency Specialists are not *able* to maintain fidelity to the model since they do not retain control over the later stages of the model and the ultimate outcome of the case. It is also possible that the fidelity instruments used were limited in their ability to accurately measure model fidelity.

However, the stage over which the Permanency Specialists had the *most* control, engagement, is associated with numbers of connections identified. The focus on effective engagement was a common theme among Seneca program staff. When asked which component of the model is the most critical to success, program staff consistently cited planning and engagement, emphasizing that engagement was a continuous process throughout the case. While relative notification services for the control children were similar to those for the treatment children, the control children did not receive intensive family engagement services through FF/FGDM. The implementation findings are clear: FF/FGDM goes beyond simply confirming that people are relatives of the child to eliciting relatives' interest in being involved with the child's case.

While FF/FGDM is more effective in identifying connections for children than traditional or basic relative notification services, the question remains, does more connections equal better permanency outcomes? Many in the field believe that it does. Since treatment children had a "wider net cast" (i.e., had more connections identified) as well as more connections interested in being involved, one could argue that this wider net means a better chance of finding relatives who will be engaged and become permanency resources. This also raises the question, is there a point at which the number of connections identified no longer adds any value to the child's case? The data collected under the current study does not capture the quality of connection-child relationships, nor the degree to which emotional permanency is reached. Is it more important to find the *right* connections, as opposed to the *most* connections?

Another question that remains unanswered is whether or not FF/FGDM affects children and families in non-legal permanency ways, for example, enhanced child and family well-being. We intended to measure child well-being using the Child and Adolescent Needs and Strength (CANS) Assessment; however, we were unable to obtain the CANS records from the San Francisco Department of Public Health due to changes in staffing and data sharing agreements. We also intended to measure parental protective capacities, but pre- and post-data were not available for all children, thus eliminating our ability to measure changes in parental outcomes.

Recommendations

Based on findings from this evaluation, we make the following recommendations:

- Conduct a follow-up analysis of exits to permanency among the study sample, allowing a longer observation period in which to observe outcomes including re-entries into out-of-home care.
- Examine changes in child and family well-being (e.g., protective capacities, child's perceptions/feelings of connectedness, birth parent support systems, emotional permanency, etc.) to determine if FF/FGDM impacts children and families in ways that go beyond legal permanency.
- Include larger sample sizes (e.g., by expanding the study enrollment period, or the size of the geographic area served) in any future evaluation efforts.
- Examine the extent to which social workers are applying FF/FGDM principles and conducting FF/FGDM activities in their ongoing casework practices. While some contamination of the control group was likely in this evaluation, a more in-depth review of social worker practices could inform the extent to which social workers can fully implement the FF/FGDM.

- Continue to explore additional ways to measure FF/FGDM model fidelity. More in-depth case studies may reveal additional factors that influence the outcome on a case.
- Examine the extent to which connections and family members are utilized in case planning and making decisions in terms of the child's well-being.

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Appendix A

Detailed Research Questions

Impact Study

1. How does the integrated FF/FGDM model impact child safety, permanency, and well-being? Specifically how does the model impact:
 - Number of children who achieve permanency? Permanency with relatives?
 - Amount of time to reach permanency, including reunification?
 - Number of children who are maltreated?
 - Child's connection to family?
 - Children's social, emotional, behavioral functioning?
2. How do safety, permanency, and well-being vary by various child characteristics?
3. How does the integrated FF/FGDM model impact the caregiver's well-being? In particular how does it affect the following protective factors:
 - Family functioning
 - Access to identified services
 - Social supports
 - Parenting knowledge
 - Nurturing and attachment

Implementation Study

4. Are Permanency Specialists implementing the integrated FF/FGDM model as intended?
5. What key linkages/partnerships/activities between HSA and Seneca contribute to the successful integration of the FF/FGDM model?

Cost Study

6. What is a typical week for a Permanency Specialist?
 - a. What is the percent time spent on each FF/FGDM component?
 - b. What is the variability of hours spent on each activity across Permanency Specialists?
7. How do Permanency Specialists salaries break down by FF/FGDM component?
 - a. Would it be more cost effective to have a different type of worker complete the discovery and case mining?
8. How, if at all, is the amount of time Permanency Specialists' spend on specific components associated with FF/FGDM outputs (e.g., number of connections discovered, engaged, etc.)?
 - a. Do specialists who spend more time on 'discovery' identify more family connections than workers who spend less time on 'discovery' activities?
 - b. Do cases in which permanency specialists spend more time on 'engagement' activities result in a greater number of engaged family members than do cases in which permanency specialists spend less time on 'engagement' activities?
 - c. Does the greater amount of time spent on engagement activities translate into more family connections attending meetings?
9. What are the out-of-home costs associated with children served by Permanency Specialists compared to the out-of-home costs for children not served by Permanency Specialists?

Appendix B

Fidelity Index



Family Finding/Family Team Meeting Fidelity Tool

Youth/Family ID: _____ Unit: _____
 Permanency Specialist: _____ Assigned Social Worker: _____
 Date Opened: _____ Date Assigned: _____
 Date Case Closed: _____ Date form completed: _____

Discovery Within 30 days of detainment hearing.....

Goal of the Discovery phase is to identify at least 40 family members and important people (“natural supports”) in the youth and caregivers lives. Relative Notification is state mandated and takes place during the first 30 days. Discovery efforts continue throughout the case timeline.

ACTION STEP	Progress Rating			
	Please check this box if this step was completed during the first 30 days	Completed	In Progress	Not able to Complete
1. Mine the File <i>Complete a structured review of the electronic and written record for safety and relative information.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Interview assigned and previous Social Workers to gather information on the case. known relatives, and natural supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Mail out Relative Notification Letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Interview Parents, relatives and others including adult siblings, and other known relationships of support to gather contact information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Log interview strategies and contact information in client contact sheet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Interview youth to gather information on past and current supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Initiate computer database searches e.g. Seneca Search and/or Public Welfare Records done <i>Make a specific effort to identify non-relatives, siblings, and non-custodial parents</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Transmit contact strategies and information of natural supports identified to Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>9. State mandated Relative Notification efforts are completed during the first 30 days of the grant. Please indicate the number of baseline connections and the number discovered during these first 30 days.</p>	<p>At the end of the first 30 days:</p> <p>Baseline #: Discovered #</p>
<p>Continue discovery work until 40+ family members and important (including historical) people in the child's/youth's life have been identified.</p>	<p>Baseline #: Discovered #</p>

Engagement and ongoing Discovery From detention hearing until FTM

Goal of the Engagement phase is to continue to gather information about the family and safety network to identify caring adults who are willing and able to contribute to permanency planning. Ongoing Discovery work continues to reach the goal of at least 40 total discovered connections during this phase.

ACTION STEP	PROGRESS RATING										
<p>1. Reach out to those who have a personal relationship with the child and family to gather information about natural supports</p>	<table style="width: 100%; text-align: center;"> <tr> <td colspan="3">Very Unsuccessful</td> <td colspan="2">Very Successful</td> </tr> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </table>	Very Unsuccessful			Very Successful		0	1	2	3	4
Very Unsuccessful			Very Successful								
0	1	2	3	4							
<p>2. Discuss the purpose of the safety network and permanency planning process with each natural support contacted</p>	<table style="width: 100%; text-align: center;"> <tr> <td colspan="3">Very Unsuccessful</td> <td colspan="2">Very Successful</td> </tr> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </table>	Very Unsuccessful			Very Successful		0	1	2	3	4
Very Unsuccessful			Very Successful								
0	1	2	3	4							
<p>3. Complete discovery/engagement tools measuring connectedness</p> <p>Check all that were completed:</p> <p>Mobility Map <input type="checkbox"/> Connectedness Map <input type="checkbox"/></p> <p>Genogram <input type="checkbox"/> Ecomap <input type="checkbox"/></p> <p>Safety Circles <input type="checkbox"/> Three Houses <input type="checkbox"/></p>	<table style="width: 100%; text-align: center;"> <tr> <td colspan="3">Very Unsuccessful</td> <td colspan="2">Very Successful</td> </tr> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </table>	Very Unsuccessful			Very Successful		0	1	2	3	4
Very Unsuccessful			Very Successful								
0	1	2	3	4							
<p>4. Identify any past and current acts of protection newly discovered natural supports/family members have shown that the team needs to be aware of</p>	<table style="width: 100%; text-align: center;"> <tr> <td colspan="3">Very Unsuccessful</td> <td colspan="2">Very Successful</td> </tr> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </table>	Very Unsuccessful			Very Successful		0	1	2	3	4
Very Unsuccessful			Very Successful								
0	1	2	3	4							
<p>5. Identify any past and current safety threats of newly discovered natural supports/family members the team needs to be aware of</p>	<table style="width: 100%; text-align: center;"> <tr> <td colspan="3">Very Unsuccessful</td> <td colspan="2">Very Successful</td> </tr> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </table>	Very Unsuccessful			Very Successful		0	1	2	3	4
Very Unsuccessful			Very Successful								
0	1	2	3	4							
<p>6. Invite identified natural supports/family members who are able and want to be involved into the team process</p>	<table style="width: 100%; text-align: center;"> <tr> <td colspan="3">Very Unsuccessful</td> <td colspan="2">Very Successful</td> </tr> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </table>	Very Unsuccessful			Very Successful		0	1	2	3	4
Very Unsuccessful			Very Successful								
0	1	2	3	4							
<p>Continue engagement work until at least 12 adult relative and non-relative team members are identified and willing to participate in the planning and decision making process</p>	<p># of natural supports/family members able and eager to participate in the permanency process: _____</p>										
<p>Update on total connections discovered up until this point. Ultimate goal is 40 relatives and non-relative connections</p>	<p># of total connections discovered up to this point: _____</p>										

Planning, Ongoing Discovery and Engagement up until Family Team Meeting

Goal of the planning stage is prepare potential family team/safety network members for the Family Team Meeting and to gain the family’s support and input for permanency plans for (with) the youth. Ongoing Discovery and Engagement activities also continue during this phase as a result from planning activities. This phase marks the end of discovery work and the process cannot continue until the Relative Notification and Discovery work are completed with at least 40 relative and non-relative connections.

ACTION STEP	PROGRESS RATING
1. Invite newly discovered and engaged family members/important people to the Initial Family Team meeting	Very Unsuccessful Very Successful 0 1 2 3 4
2. Talk to the youth and inquire about their safety concerns and ideas for support. <i>Use the tools like the “Miracle Question” prompt, Safety House, or Three Houses</i>	Very Unsuccessful Very Successful 0 1 2 3 4
3. Host an initial family meeting to discuss strengths/needs, develop the greatest unmet need statement and identify who else needs to be there	Very Unsuccessful Very Successful 0 1 2 3 4
4. Initial Family meeting held with more natural supports present than paid professionals	Very Unsuccessful Very Successful 0 1 2 3 4
5. During initial family team meeting (or during individual conversations) brainstorm legal guardianship, placement, and emotional support plans and encourage family members to advocate for them	Very Unsuccessful Very Successful 0 1 2 3 4
6. Prepare family members for the FTM with county worker(s). <i>This may include coordinating/assisting transportation to the meeting</i>	Very Unsuccessful Very Successful 0 1 2 3 4
7. At least 12 committed natural supports (appropriate and willing to offer support) are planning to participate in the permanency planning process	Very Unsuccessful Very Successful 0 1 2 3 4
8. FTM location date and time identified and confirmed	Address: _____ Date: _____ Time: _____
9. Total number of connections engaged and planning to participate in the permanency planning process: _____	10. Total number of connections up to this point: _____



The end of the Planning phase marks an important milestone in the Family Finding model. The goal is to have identified at least 40 connections, and involve 12 committed connections in the planning process, in order to create 3 permanency options – resulting in 1 permanent plan. If there are fewer than 40 connections and/or fewer than 12 committed connections in the planning process, please review the tools and outreach efforts you’ve made with your supervisor to ensure all viable methods have been attempted prior to moving towards decision making evaluation and ongoing support.

Decision Making, Evaluation, Follow-on Supports; Ongoing Discovery, Engagement and Planning

Ongoing discovery, engagement, and planning work may continue during this phase, as decisions are made regarding what permanency options are available. It may require a revisiting of the 40 connections and 12 committed connections.

This section will be completed for the first Family Team Meeting	RATING				
Date of first meeting: _____ Is this a Blended Perspective Meeting? Yes <input type="checkbox"/> No <input type="checkbox"/>	Strongly Disagree	Disagree	Doesn't Apply/ Don't know	Agree	Strongly Agree
1. The right people were at the family team meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The safety plan the group came up with will meet the concerns of the current situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The safety network members were identified and each person understands their role and responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The child's placement plans (with options A, B, & C) were discussed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The child's legal permanency plans discussed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The child's emotional/relational support plan was decided on and each person understands their role and responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The team understands that long term foster care placement without permanency is not a successful outcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This section will be completed for the second Family Team Meeting	RATING				
Date of second meeting: _____ Please indicate which type of meeting the information below pertains to: Blended Perspective Meeting <input type="checkbox"/> FTM <input type="checkbox"/> TDM <input type="checkbox"/>	Strongly Disagree	Disagree	Doesn't Apply/ Don't know	Agree	Strongly Agree
1. The right people were at the family team meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The safety plan the group came up with will meet the concerns of the current situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The safety network members were identified and each person understands their role and responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family Finding/Family Team Meeting Fidelity Tool

4. The child's placement plans (<i>with options A, B, & ,</i>) were decided on with group agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The child's legal permanency plans were decided on with group agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The child's emotional/relational support plan was decided on and each person understands their role and responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The team understands that long term foster care placement without permanency is not a successful outcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This section will be completed for the third Family Team Meeting	RATING				
Date of third meeting: _____ Please indicate which type of meeting the information below pertains to: Blended Perspective Meeting <input type="checkbox"/> FTM <input type="checkbox"/> TDM <input type="checkbox"/>	Strongly Disagree	Disagree	Doesn't Apply/ Don't know	Agree	Strongly Agree
1. The right people were at the family team meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The safety plan the group came up with will meet the concerns of the current situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The safety network members were identified and each person understands their role and responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The child's placement plans (<i>with options A, B, & C</i>) were decided on with group agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The child's legal permanency plans were decided on with group agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The child's emotional/relational support plan was decided on and each person understands their role and responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The team understands that long term foster care placement without permanency is not a successful outcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At the grant case closure: How many total connections were discovered? _____ How many connections committed to the permanency planning efforts? _____	What are the 3 Permanency Options? Plan 1: _____ Plan 2: _____ Plan 3: _____				
Has the primary permanency option been identified? If so, please provide status. For example: Adoption Home-Study Order etc.: _____					

To create the fidelity score, Child Trends asked Seneca program staff to rank the action items in each section/stage of the fidelity index from the most critical to the least critical. There were several discussions during monthly grant meetings, as well as the yearly site visits, as to what stage(s) were the most critical to achieve successful outcomes on a case. This information was used to create a weighted score for the fidelity index. While each stage of the model is important, and is thought to contribute to successful outcomes, overall, the engagement and planning stages were felt to more critical than other stages. Therefore, these stages were weighted more heavily than other stages. The tables below explain how specific actions items were weighted to create the overall score. Items that are italicized were not applicable for children age 5 and younger, and were therefore omitted from the scores of children of that age range.

Discovery (range of possible points per item: 0 – 2)	Multiplied by...
2. Interview assigned and previous Social Workers to gather information on the case, known relatives, and natural supports.	3
4. Interview Parents, relatives and others including adult siblings, and other known relationships of support to gather contact information.	3
6. <i>Interview youth to gather information on past and current supports.</i>	3
1. Mine the file. Complete a structured review of the electronic and written record for safety and relative information.	2
7. Initiate computer database searches e.g. Seneca Search and/or Public Welfare Records done. Make a specific effort to identify non-relatives, siblings, and non-custodial parents.	2
3. Mail out Relative Notification Letters.	1
5. Log interview strategies and contact information in client contact sheet.	1
8. Transmit contact strategies and information of natural supports identified to Social Worker.	1
Range of possible points for Discovery stage: 0 – 32	

Engagement (range of possible points per item: 0 – 4)	Multiplied by...
1. Reach out to those who have a personal relationship with the child and family to gather information about natural supports.	10
6. Invite identified natural supports/family members who are able and want to be involved into the team process.	10
3. Complete discovery/engagement tools measuring connectedness.	5
4. Identify any past and current acts of protection newly discovered natural supports/family members have shown that the team needs to be aware of.	5
2. Discuss the purpose of the safety network and permanency planning process with each natural support contacted.	1
5. Identify any past and current safety threats of newly discovered natural supports/family members the team needs to be aware of.	1
Range of possible points for Engagement stage: 0 – 128	

Planning (range of possible points per item: 0 – 4)	Multiplied by...
2. <i>Talk to the youth and inquire about their safety concerns and ideas for support. Use the tools like the “Miracle Question” prompt, Safety House, or Three Houses.</i>	10
6. Prepare family members for the FTM with county worker(s). This may include coordinating/assisting transportation to the meeting.	10
4. Initial Family meeting held with more natural supports present than paid professionals.	10
7. At least 12 committed natural supports (appropriate and willing to offer support) are planning to participate in the permanency planning process.	5
3. Host an initial family meeting to discuss strengths/needs, develop the greatest unmet need	1

statement and identify who else needs to be there.

- | | | |
|----|--|---|
| 1. | Invite newly discovered and engaged family members/important people to the Initial Family Team meeting. | 1 |
| 5. | During initial family team meeting (or during individual conversations) brainstorm legal guardianship, placement, and emotional support plans and encourage family members to advocate for them. | 1 |

Range of possible points for Planning stage: 0 – 152

Decision Making (range of possible points per item: 0 – 3)		Multiplied by...
2.	The safety plan the group came up with will meet the concerns of the current situation.	3
3.	The safety network members were identified and each person understands their role and responsibility.	3
7.	The team understands that long term foster care placement without permanency is not a successful outcome.	3
1.	The right people were at the family team meeting.	2
5.	The child's legal permanency plans discussed.	2
4.	The child's placement plans (<i>with options A, B, & C</i>) were discussed.	1
6.	The child's emotional/relational support plan was decided on and each person understands their role and responsibility.	1

**This section included ratings for two Family Team Meetings.
 Range of possible points per Family Team Meeting: 0 – 45
 Range of possible points for Decision Making stage: 0 - 90**

Child/Family: _____

Family Team Meeting Date: _____

Your Name(Optional): _____

Your Relationship to/or Role with the child/family: _____

Family Team Meeting						
Goal is to host a Family Team Meeting to move forward with permanency plans to ensure the youth's safety and connectedness						
During the meeting please rate how you observed the following.	Rating					
	Strongly Disagree	Disagree	Doesn't Apply	Don't know	Agree	Strongly Agree
1. The primary purpose of the meeting was explained to everyone	<input type="checkbox"/>					
2. The child welfare worker clearly described the agency's concerns about the current situation; <i>safety issues, state laws, and agency policies were explained if necessary</i>	<input type="checkbox"/>					
3. Family members/ family friends were able to share their story related to the current situation	<input type="checkbox"/>					
4. Family members/family friends were able to identify strengths, resources, and capacities they have to address the current concern(s)	<input type="checkbox"/>					
5. Current stressors/barriers were identified	<input type="checkbox"/>					
6. Everyone at the meeting was able to share their ideas to help develop a plan that addresses the safety, permanence and well-being of the child	<input type="checkbox"/>					
7. Action steps were discussed and each person knows what they need to do after the meeting	<input type="checkbox"/>					
8. Permanency plans (with options) were discussed	<input type="checkbox"/>					
9. The facilitator was flexible in meeting the needs of everyone at the meeting	<input type="checkbox"/>					
10. There was a chance to ask questions about the information presented by the child welfare worker and professionals	<input type="checkbox"/>					
11. The right people were at the family meeting	<input type="checkbox"/>					
12. The child's ideas or needs were included in the plan	<input type="checkbox"/>					

Appendix D

Detailed Statistics

Table 1. Number and type of site visit participants

Participant Type	Number of Interviews/ Focus Groups	Total Number of Respondents*	Average Number of Respondents per Interview/Focus Group
HSA Administrators	5	12	2
HSA Supervisors	5	10	2
HSA Workers	7	39	6
Relatives	5	17	3
Seneca Director	1	1	1
Seneca Permanency Specialists	3	12	4
Seneca Supervisors	2	3	2
Total	28	94	

*Some participants participated in more than one round of interviews or focus groups

Table 2. Children served (n=145)

	Percent (unless specified otherwise)
Gender	
Female	54
Male	46
Average age (years)	6.5
Race/ethnicity	
African-American	43
White	16
Other	8
Latino	33
Length of time in foster care from removal to random assignment (days)	11.4
Placement type	
Foster Family Agency Certified Home	29
Foster Family Home	14
Group Home	9
Relative/NREFM Home	39
Missing	9
Number of out of home placements	1.3
Reason for removal	
Neglect	49
Physical abuse	18
Sexual abuse	1
Missing	32
Permanency Goal (at referral)	
Return Home	49
Remain Home	9
Long Term Foster Care w/ Relative	2
Adoption	1
Adoption with sibling(s)	1
Permanent Connections for Independence	1
Legal Guardianship	0

Long Term Foster Care w/ Non-Relative	0
Self-Maintenance	0
Missing	37

Table 3. Length of FF/FGDM services (months)

	N	Average	Minimum	Maximum
All Cases	145	9	<1	28
Closed Cases	110	7	<1	26
Open Cases	35	14	6	28

Table 4. Reasons for FF/FGDM case closure

	%
Completed FF Services	62
Reunited with Parent	22
FF Service Not Appropriate	8
Other Reasons	7
Parent Declined Service	4
Child Moved	3

Table 5. Description of analytic sample (n=280)

	Treatment (n=145) (%)	Control (n=135) (%)	All (n=280) (%)
Age 5 or younger	50	53	51
Male	46 *	56	51
Race/ethnicity			
White	16	14	15
African-American	43	48	45
Other	8	13	10
Latino	33	25	29
Disability			
None	28	19	24
One or more	27	24	26
Missing	45 *	57	51
Reason for removal			
Neglect	49	51	50
Physical abuse	18 *	7	13
Sexual abuse	1	1	1
Missing	32	40	36
In a sibling group	50	45	48
Two or more removals	17	23	20
Number of out of home placements			
None	6	4	5
One	78	73	76
Two or more	17	23	20
Length of time in foster care from removal to random assignment (days)	11.4	8.8	10.2

* $p < .10$

N = 5 children were missing data on reason for removal and length of time in foster care because they were never removed from home during the foster care episode associated with family finding assignment. They are excluded from the tabulations for those measures.

Characteristics measured at the time of random assignment to family finding services

Table 6. Demographic characteristics among children new to foster care: San Francisco County child welfare population 2013-2015 and analytical sample

	Analytic Sample (%)	San Francisco County (%)
Male	51	51
Age		
Under 1 year	22	26
1-2 years	14	13
3-5 years	16	18
6-10 years	19	20
11-15 years	19	16
16-20 years	11	6
Race		
Black	45	40
White	15	18
Hispanic	29	33
Asian/Pacific Islander	9	8
Native American	1	1

*Data were extracted from the CWS/CMS Direct Reporting System maintained by the Center for Social Services Research at the University of California at Berkeley, at http://cssr.berkeley.edu/ucb_childwelfare/

Table 7. Search strategies by Permanency Specialists (n=146)*

# and % of children for whom search strategies were employed	# of times used
Talking with caseworker	77
Case record review	416
Talking with child	120
Talking with mother	451
Talking with father	166
Talking with maternal relative	697
Talking with paternal relative	652
Internet search	4
Federal/state/local government database	45
Cliff search*	195
Connection already known	1,336
Other	107
Total	4,266
Average per child	29.2

* While there were 145 children in the treatment group in analytic sample, there was 1 treatment child for whom we did not have administrative data, who was therefore not included in the analytic sample. That child is included in the tables below about program outputs.

* Cliff searches refer to searches done by an experienced Seneca staff member employed to conduct exhaustive internet searches.

Table 8. Number and type of family connections discovered (n=146)

# and % of children for whom connections were discovered		137 (94%)
		# connections
Baseline Connections		
Maternal		845
Paternal		332
Sibling		115
Other		302
Total Baseline Connections		1,635
Newly Discovered Connections		
Maternal		1,123
Paternal		841
Sibling		7
Other		674
Total Newly Discovered Connections		2,645
Total		4,280
Average per child		29.3

Table 9. Number and type of family connections contacted* (n=146)

# and % of children for whom a connection was contacted		132 (90%)
		# connections
Maternal		926
Paternal		605
Sibling		37
Other		439
Total		2,007
Average per child		13.7

* A connection is defined as have been "contacted" if they had an interaction with the Permanency Specialist, regardless of the manner of interaction (letter, phone call, meeting, etc.) or the result of the interaction.

Table 10. Number and type of family connections engaged* (n=146)

# and % of children for whom a connection was engaged		130 (89%)
		# connections
Maternal		448
Paternal		334
Other		270
Total		1,052
Average per child		7.2

* A connection is defined as have been "engaged" if they had an interaction with the Permanency Specialist and were interested in attending a meeting or contributing to any permanent or supportive plan for the child.

Table 11. Number and type of meetings held (n=146)

		# meetings
# and % of children for whom a meeting was held		92 (63%)
		# meetings
Type of meeting		
Blended Perspective		92
Family Team Meeting		145
Lifetime Network		35
Total		273
Average per child		1.9
		# attendees
Attendees		
Children		42
Connections		1,224
Case Managers		229
Therapists		26
CASAs		2
Total		1,523
Average per meeting		5.6

**Note: type of meeting was not reported for all meeting records.*

Table 12. Number of connections who agreed to supportive or permanent plans (n=110)*

	# connections	Average per child
Permanent Plan		
Adoption	148	1.3
Fostering	109	0.9
Guardianship	114	1.0
Supportive Plan		
Occasional Communication	140	1.3
Occasional Financial or Material Support	91	0.8
Occasional Visits	137	1.2
Regular Communication	397	3.7
Regular Overnight Visits	257	2.3
Regular Visits	342	3.1
Any plan, permanent or supportive	839	7.6

**Of cases that closed.*

Table 13. Logistic Regression Results – Discharge to permanency

Discharge to permanency	Odds ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
treatment	.700133	.2349562	-1.06	0.288	.3626833	1.351554
under5	.8727472	.2529393	-0.47	0.639	.494531	1.540222
male	.7761181	.1966339	-1.00	0.317	.4723577	1.275218
black	.6505808	.3085084	-0.91	0.365	.256837	1.647953
other	.8297249	.558548	-0.28	0.782	.2217832	3.104128
latino	1.076162	.5352822	0.15	0.883	.4059669	2.852756
more than 1 disability	1.103648	.4300021	0.25	0.800	.514264	2.368508
disability info missing	1.139332	.4585912	0.32	0.746	.5176475	2.507647
removal: neglect	1.339479	.4871543	0.80	0.422	.6566934	2.732177
removal: physical abuse	1.138103	.6961153	0.21	0.832	.3432008	3.774114
in a sibling group	.9981761	.3462195	-0.01	0.996	.5057853	1.969918
two or more removals	.9006483	.7833937	-0.12	0.904	.163746	4.953813
out of home placement: 1	2.79096	1.970999	1.45	0.146	.699243	11.13984
out of home placement: 2+	1.930604	1.945158	0.65	0.514	.2679632	13.9095
days from removal to RA	.956882	.0308729	-1.37	0.172	.8982457	1.019346

Table 14. Logistic Regression Results – Reentry

Reentry	Odds ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
treatment	.9337611	.6773009	-0.09	0.925	.2253301	3.869478
under5	.8566247	.4352326	-0.30	0.761	.316456	2.318824
male	1.978525	1.02694	1.31	0.189	.715371	5.472074
black	7.638639	7.929501	1.96	0.050	.9986255	58.42912
latino	6.111974	7.367731	1.50	0.133	.5755638	64.90372
more than 1 disability	2.359576	1.645447	1.23	0.218	.6015195	9.25589
disability info missing	1.85468	1.328646	0.86	0.389	.4555011	7.551762
removal: neglect	.8829864	.5560992	-0.20	0.843	.2569643	3.034138
removal: physical abuse	2.510646	2.007445	1.15	0.250	.5238266	12.03326
in a sibling group	.1478722	.1515527	-1.86	0.062	.0198381	1.102235
two or more removals	9.958039	14.25172	1.61	0.108	.6024948	164.5866
out of home placement: 1	.4995679	.4427167	-0.78	0.434	.087955	2.837453
out of home placement: 2+	.0249071	.0372524	-2.47	0.014	.0013281	.4671173
days from removal to RA	1.002774	.0052034	0.53	0.593	.9926271	1.013024

**No children of 'other' race had a reentry so they were combined with White in the reference category*

Table 15. Logistic Regression Results – Reallegation

Reallegation	Odds ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
treatment	.9827243	.6219565	-0.03	0.978	.2842593	3.397416
under5	.9266501	.425249	-0.17	0.868	.3769561	2.277932
male	1.266482	.5101688	0.59	0.558	.5750628	2.789222
black	4.914011	3.872231	2.02	0.043	1.048796	23.02403
latino	5.02589	4.954256	1.64	0.101	.7280204	34.69623
more than 1 disability	.7037603	.4634486	-0.53	0.594	.1935893	2.558398
disability info missing	.7147767	.5784323	-0.41	0.678	.146331	3.491438
removal: neglect	3.560304	2.399703	1.88	0.060	.9500871	13.34169
removal: physical abuse	4.997812	4.686119	1.72	0.086	.7955439	31.39754
in a sibling group	1.596531	.9143838	0.82	0.414	.5195975	4.905547
two or more removals	.3391812	.3277455	-1.12	0.263	.0510422	2.253899
out of home placement: 1	.7392861	.855834	-0.26	0.794	.0764574	7.148344
out of home placement: 2+	.7505718	.7639802	-0.28	0.778	.1020903	5.518231
days from removal to RA	.9561401	.0512055	-0.84	0.402	.8608667	1.061957

**No children of 'other' race had a reallegation so they were combined with White in the reference category*

Table 16. Logistic Regression Results – Placement with relatives

Placement with relatives	Odds ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
treatment	1.784909	.6074375	1.70	0.089	.9160863	3.477728
under5	2.780228	.8472217	3.36	0.001	1.530005	5.052053
male	.9159437	.2364239	-0.34	0.734	.552276	1.519082
black	2.565754	1.226481	1.97	0.049	1.005365	6.547962
other	3.098339	2.065773	1.70	0.090	.8386924	11.44604
latino	1.87775	.9294028	1.27	0.203	.7117557	4.953871
more than 1 disability	.9101518	.371007	-0.23	0.817	.4093897	2.023442
disability info missing	.9284817	.377343	-0.18	0.855	.4186371	2.05925
removal: neglect	.7724952	.2735605	-0.73	0.466	.3858899	1.546423
removal: physical abuse	.9147184	.5725795	-0.14	0.887	.2682051	3.119663
in a sibling group	.9586189	.3441485	-0.12	0.906	.4743084	1.937453
two or more removals	3.303473	3.530982	1.12	0.264	.4065813	26.84073
out of home placement: 1	1.958839	1.84806	0.71	0.476	.3082729	12.44693
out of home placement: 2+	.4869793	.6869883	-0.51	0.610	.0306697	7.732358
days from removal to RA	1.002089	.0032127	0.65	0.515	.9958119	1.008406

Table 17. Logistic Regression Results – Number of connections identified

Number of connections identified	Odds ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
treatment	4.221699	.9141868	4.62	0.000	2.418793	6.024604
under5	2.421546	.7638093	3.17	0.002	.9152059	3.927886
male	-.630324	.720261	-0.88	0.383	-2.05078	.7901325
black	.7156721	1.261746	0.57	0.571	-1.77267	3.204013
other	2.823595	2.080536	1.36	0.176	-1.27952	6.926706
latino	-.182029	1.280676	-0.14	0.887	-2.70770	2.343645
more than 1 disability	2.166594	1.136507	1.91	0.058	-.074758	4.407946
disability info missing	.0173122	1.02063	0.02	0.986	-1.99552	2.030139
removal: neglect	1.658997	.9209171	1.80	0.073	-.157182	3.475176
removal: physical abuse	-1.98748	1.284952	-1.55	0.124	-4.52159	.5466259
in a sibling group	-1.13601	.9147071	-1.24	0.216	-2.93994	.6679223
two or more removals	2.347834	1.314336	1.79	0.076	-.244222	4.93989
out of home placement: 1	.0678088	1.0952	0.06	0.951	-2.09208	2.227697
out of home placement: 2+	-.205911	1.395749	-0.15	0.883	-2.95853	2.546703
days from removal to RA	-.005129	.006404	-0.80	0.424	-.017759	.0075005

Table 18. Logistic Regression Results – Number of connections engaged

Number of connections engaged	Odds ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
treatment	2.185343	.8331866	2.62	0.009	.5421815	3.828505
under5	1.690917	.6507658	2.60	0.010	.4075151	2.974319
male	-.845458	.6185087	-1.37	0.173	-2.06524	.3743291
black	-.908831	1.092606	-0.83	0.407	-3.06360	1.245943
other	1.030676	2.024253	0.51	0.611	-2.96144	5.022788
latino	-.358707	1.154226	-0.31	0.756	-2.63500	1.91759
more than 1 disability	.707533	1.158395	0.61	0.542	-1.57699	2.992051
disability info missing	-.546675	.9826418	-0.56	0.579	-2.48458	1.391234
removal: neglect	1.012379	.8291251	1.22	0.224	-.622773	2.647531
removal: physical abuse	-1.38912	1.099751	-1.26	0.208	-3.55798	.7797488
in a sibling group	.2475279	.8803422	0.28	0.779	-1.48863	1.983687
two or more removals	.5367452	1.390912	0.39	0.700	-2.20633	3.279819
out of home placement: 1	-.708802	1.319957	-0.54	0.592	-3.31194	1.894339
out of home placement: 2+	-.488522	1.745713	-0.28	0.780	-3.93131	2.95427
days from removal to RA	.003236	.0048614	0.67	0.506	-.006351	.0128233

Table 19. Survival Analysis – Time to permanency

	Time at risk	Incidence rate	No. of subjects	Survival time		
				25%	50%	75%
control	50759	.0015564	135	180	501	.
treatment	55320	.0013557	145	236	513	.
total	106079	.0014517	280	229	513	.

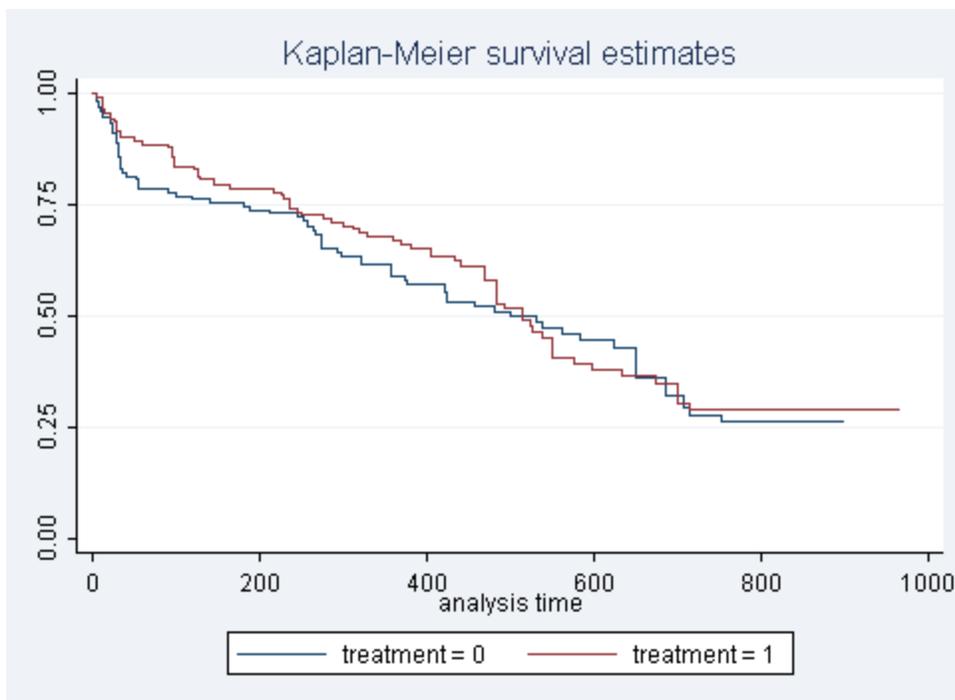


Table 20. Survival Analysis – Log-rank test for equality of survivor functions

	Events observed	Events expected
treatment	79	74.71
control	75	79.29
total	154	154.00
	chi2(1) =	0.48
	Pr>chi2 =	0.4871

Table 21. Survival Analysis – Cox regressions without controls

	Haz. Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]
treatment	.8942833	.1926634	-0.52	0.604	.586264 1.364134

Table 22. Survival Analysis – Cox regressions with controls

	Haz. Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]
treatment	.9054908	.1965024	-0.46	0.647	.5917838 1.385495
male	.9188261	.1465538	-0.53	0.596	.6721492 1.256033
more than 1 disability	1.07986	.2811164	0.30	0.768	.6483015 1.798697
disability info missing	1.142787	.3112056	0.49	0.624	.6701388 1.948794
removal: physical abuse	.9695294	.4348824	-0.07	0.945	.4024895 2.335433

Table 23. Logistic Regression Results – Subgroups – Latino children and placement w/ relatives

Placement with relative	Odds ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
treatment	1.105513	.4300204	0.26	0.796	.515781	2.369532
latino	.3649679	.2162183	-1.70	0.089	.1142816	1.165556
latino*treatment	4.43224	3.33497	1.98	0.048	1.014261	19.36853
under5	2.651169	.8048201	3.21	0.001	1.462301	4.806602
male	.9464542	.2471245	-0.21	0.833	.5673435	1.578895
more than 1 disability	.9220566	.362618	-0.21	0.837	.4265843	1.993014
disability info missing	.8793019	.3488879	-0.32	0.746	.4040171	1.913711
removal: neglect	.8233255	.297972	-0.54	0.591	.4050521	1.673525
removal: physical abuse	1.098037	.6701607	0.15	0.878	.3319755	3.631847
removal: missing	.3678623	.5212543	-0.71	0.480	.0228848	5.913201
in a sibling group	1.121528	.388224	0.33	0.740	.5690641	2.210339
two or more removals	3.288612	3.306541	1.18	0.236	.4583216	23.5969
out of home placement: 1	1.880542	1.729013	0.69	0.492	.3102197	11.39979
out of home placement: 2+	.5203506	.6657108	-0.51	0.610	.0423946	6.38677
days from removal to RA	1.0027	.0032453	0.83	0.405	.9963597	1.009081

Table 24. Logistic Regression Results – Subgroups – Younger children and reallegations

Reallegations	Odds ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
treatment	.3778195	.3002246	-1.22	0.221	.0795974	1.79337
under5	.3392472	.2159578	-1.70	0.089	.0974224	1.181337
under5*treatment	5.99362	4.779557	2.25	0.025	1.255759	28.60698
male	1.365773	.5517118	0.77	0.440	.6187722	3.014576
other	4.881887	3.753659	2.06	0.039	1.08169	22.03294
latino	5.202336	5.001485	1.72	0.086	.7904238	34.24024
more than 1 disability	.7281085	.4943476	-0.47	0.640	.1924309	2.754974
disability info missing	.7314296	.5945394	-0.38	0.700	.1486884	3.598057
removal: neglect	3.515812	2.4114	1.83	0.067	.9166629	13.48471
removal: physical abuse	5.342125	5.021675	1.78	0.075	.8463932	33.71754
in a sibling group	1.601542	.8953361	0.84	0.400	.5353986	4.790705
two or more removals	.337036	.3294662	-1.11	0.266	.0496127	2.289602
out of home placement: 1	.5444915	.6545024	-0.51	0.613	.051619	5.743442
out of home placement: 2+	.4931269	.5291005	-0.66	0.510	.0602091	4.038829
days from removal to RA	.9594212	.0520846	-0.76	0.445	.8625806	1.067134

Appendix E

Social Worker Survey (aka, Caseworker Survey)

Caseworker Knowledge Survey

PRE-TEST

CONSENT INFORMATION

Please read the following information before proceeding with the survey.

The purpose of this survey is to better understand your experiences with and views about family finding/family group decision-making services (FF/FGDM) and how your experiences and views may or may not change over time. This will be the first of three yearly surveys that we would like for you to complete. The information you provide will be used to inform the evaluation of FF/FGDM services being conducted through 2015.

Your participation in this survey is voluntary. You will not be penalized if you decide not to complete the survey and you are not giving up any rights. Also, once you begin the survey, you may choose to stop the survey at any time. If you come to a question you do not wish to answer, you may skip that question and move on to the next question.

Your participation is anonymous. No San Francisco Human Service Agency (SF-HSA) staff will know who did or did not complete this survey. Only the Child Trends evaluation team will have access to your responses. Your responses will also be combined with those of others when results are described, although it is possible that some specific quotes will also be reported. However, all identifying information will be removed. There are no direct benefits to you in participating in this survey.

There are minimal risks in participating in this survey although some participants may feel uncomfortable describing and rating their work practices with children in foster care. You will be mailed a \$5 gift card after completion of this survey as a thank you for participating.

If you have questions or complaints, please contact the Child Trends study director Tiffany Allen, tallen@childtrends.org, 240-223-9316. If you have questions or complaints that you do not wish to talk to Child Trends, you may contact Child Trends' Institutional Review Board (IRB), a group that reviewed this study for your protection. The phone number for Child Trends' IRB is 1-855-288-3506. You may also e-mail the IRB at irbparticipant@childtrends.org.

Do you agree to complete the survey? Yes No

[If YES, respondents are taken to the following screen]

Thank you for agreeing to complete the survey. Please be as honest as possible when responding to the questions in this survey. Your participation is greatly appreciated.

Enter your 3-digit evaluation ID here: _____

[If NO, respondents are taken to the following screen]

Thank you for your consideration. Have a good day!

FAMILY FINDING/FAMILY GROUP DECISION-MAKING SURVEY

I. Background

1. What is your current position? Supervisor Caseworker
2. What program area do you work for? ER CDU FSU TPU Other _____

II. Family Finding Knowledge

Please check the box that reflects how well you **understand** how to implement the family finding service components.

3. **Discovery:** Examining internet search results and performing an extensive case file review to identify relatives and other caring adults who can or have in the past been a key support to the foster child.
Very well Somewhat well Not very well Not at all
4. **Engagement:** Engaging relatives and other caring adults to explore their current or past relationship with the child and preparing those engaged to assist with decision-making and supporting the child through committed relationships.
Very well Somewhat well Not very well Not at all
5. **Planning:** Convening blended perspective and family team meetings with the participation of parents, family members and others important to the child to plan for the successful future of a child.
Very well Somewhat well Not very well Not at all
6. **Decision-Making:** Preparing relatives and other caring adults to make key, informed decisions about the future of the child, including their safety, physical and emotional well-being and belonging in a life-time family.
Very well Somewhat well Not very well Not at all
7. **Evaluation:** Completing an inclusive, individualized, and unconditional primary and back-up plan during team meetings to achieve legal and emotional permanency and a timeline for the plan's completion has been created.
Very well Somewhat well Not very well Not at all

8. **Follow-up Supports:** Encouraging relatives and other caring adults to actively support the child and caregiver to successfully access formal and informal services, supports, and key relationships as needed.

Very well Somewhat well Not very well Not at all

III. Family Finding Practice (questions 9-16 are only to be completed by caseworkers, not supervisors)

*Please check the box near the response that best reflects **your current practice** with children on your caseload **where family finding activities have been initiated.***

9. I engage previously uninvolved **maternal** family or other caring adults in the lives of _____ of the foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

10. I engage previously uninvolved **paternal** family or other caring adults in the lives of _____ of foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

11. I convene family meetings to develop a plan for the safety, permanency and well-being of _____ of the foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

12. I create a sense of shared responsibilities among relatives and other caring adults for ensuring the **well-being** of _____ of the foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

13. I create a sense of shared responsibilities among family and other caring adults in **achieving permanency** for _____ of the foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

14. I encourage relatives and other caring adults to play a supportive role in the life of _____ of the foster children on my caseload even if they cannot be a placement option.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

15. I work with relatives and other caring adults of _____ of the foster children on my caseload to create a plan that includes family members and other adults willing to offer their support if Plan "A" is unsuccessful.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

16. I work with the family and other caring adults to assist _____ of the foster children and their caregivers in accessing services and supports as needed.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

IV. Opinions about Family Finding Integration

The next set of questions asks about your impressions of how well family finding activities have been integrated into your practice and the practice of others in your local office.

17. *All Respondents:* Overall, how well do you think you've been integrating the Family Finding activities into your practice?

Very well Somewhat well Not very well Not at all

18. *If you are a Supervisor:* Overall, how well do you think those you supervise have been integrating the Family Finding activities into their practice?

Very well Somewhat well Not very well Not at all

19. *All Respondents:* Overall, how well do you feel the caseworkers in your office have been integrating the Family Finding activities into their practice (e.g. providing guidance to you that reflects Family Finding principles)?

Very well Somewhat well Not very well Not at all

V. Opinions about Family Finding Work

Please check the box near the response that best reflects your opinion about each statement. Please remember that this survey is anonymous.

20. Relatives are important to involve in a foster child's life even if they cannot serve as a placement resource.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

21. **Paternal** relatives are just as important as **maternal** relatives to engage and involve in the case planning of foster children.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

22. Having relatives involved in the lives of foster children can enhance their overall well-being.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

23. Developing an informal supportive network for foster children is an important part of child welfare practice.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

24. Involvement of family members to serve as a life-long supportive network for children in foster care is important.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

25. Having relatives and other connections involved in case planning can generally be beneficial to **my work in achieving permanency for children.**

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

26. Stability in a long-term placement without legal permanency is a successful outcome.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

27. Involving relatives and other connections in case planning and activities is more burdensome than it is helpful.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

VI. Family Finding Service Challenges and Strategies

34. What, if any, are the biggest barriers to including family members in case planning?

35. What strategies might be helpful to overcome these barriers?

VII. Demographics

The following questions inquire about your current position, experience, education and background. This information will help us in describing who participated in the survey.

36. How many years of experience do you have working in child welfare services? _____

37. How many years experience do you have working human services in total? _____

38. What is the **highest** level of education you have completed?

Bachelor's degree in Social Work (BSW)

Bachelor's degree- not in Social Work (please specify discipline) _____

Master's degree in Social Work (MSW)

Master's degree- not in Social Work (please specify discipline) _____

39. What is your gender?

Male

Female

40. How would you describe your ethnic/racial background?

African-American/Black

Caucasian/White

Hispanic/Latino

Asian/Pacific Islander

Native American

Other (please specify) _____

Thank you for your participation.

Caseworker Knowledge

POST SURVEY

CONSENT INFORMATION

Please read the following information before proceeding with the survey.

The purpose of this survey is to better understand your experiences with and views about family finding/family group decision-making services (FF/FGDM) and how your experiences and views may or may not change overtime. This is a follow-up survey that we would like for you to complete. The information you provide will be used to inform the evaluation of FF/FGDM services being conducted through 2015.

Your participation in this survey is voluntary. You will not be penalized if you decide not to complete the survey and you are not giving up any rights. Also, once you begin the survey, you may choose to stop the survey at any time. If you come to a question you do not wish to answer, you may skip that question and move on to the next question.

Your participation is anonymous. No San Francisco Human Service Agency (SF-HSA) staff will know who did or did not complete this survey. Only the Child Trends evaluation team will have access to your responses. Your responses will also be combined with those of others when results are described, although it is possible that some specific quotes will also be reported. However, all identifying information will be removed. There are no direct benefits to you in participating in this survey.

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Do you agree to complete the survey? Yes No

[If YES, respondents are taken to the following screen]

Thank you for agreeing to complete the survey. Please be as honest as possible when responding to the questions in this survey. Your participation is greatly appreciated.

Enter your 3-digit evaluation ID here: _____

[If NO, respondents are taken to the following screen]

Thank you for your consideration. Have a good day!

Caseworker Knowledge Pre and Post Surveys

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FAMILY FINDING SURVEY

I. Background

1. What is your current position? Supervisor Caseworker
2. What program area do you work for? ER CDU FSU TPU Other _____

II. Family Finding Knowledge

Please check the box that reflects how well you **understand** how to implement the family finding service components.

1. **Discovery:** Examining internet search results and performing an extensive case file review to identify relatives and other caring adults who can or have in the past been a key support to the foster child.

Very well Somewhat well Not very well Not at all

2. **Engagement:** Engaging relatives and other caring adults to explore their current or past relationship with the child and preparing those engaged to assist with decision-making and supporting the child through committed relationships.

Very well Somewhat well Not very well Not at all

3. **Planning:** Convening blended perspective and family team meetings with the participation of parents, family members and others important to the child to plan for the successful future of a child.

Very well Somewhat well Not very well Not at all

4. **Decision-Making:** Preparing relatives and other caring adults to make key, informed decisions about the future of the child, including their safety, physical and emotional well-being and belonging in a life-time family.

Very well Somewhat well Not very well Not at all

5. **Evaluation:** Completing an inclusive, individualized, and unconditional primary and back-up plan during team meetings to achieve legal and emotional permanency and a timeline for the plan's completion has been created.

Very well Somewhat well Not very well Not at all

6. **Follow-up Supports:** Encouraging relatives and other caring adults to actively support the child and caregiver to successfully access formal and informal services, supports, and key relationships as needed.

Very well Somewhat well Not very well Not at all

III. Family Finding Practice (this section is only to be completed by caseworkers, not supervisors)

Please check the box near the response that best reflects **your current practice** with children on your caseload **where family finding activities have been initiated.**

7. I engage previously uninvolved **maternal** family or other caring adults in the lives of _____ of the foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

8. I engage previously uninvolved **paternal** family or other caring adults in the lives of _____ of foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

9. I convene family meetings to develop a plan for the safety, permanency and well-being of _____ of the foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

10. I create a sense of shared responsibilities among relatives and other caring adults for ensuring the **well-being** of _____ of the foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

11. I create a sense of shared responsibilities among family and other caring adults in **achieving permanency** for _____ of the foster children on my caseload.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

12. I encourage relatives and other caring adults to play a supportive role in the life of _____ of the foster children on my caseload even if they cannot be a placement option.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

13. I work with relatives and other caring adults of _____ of the foster children on my caseload to create a plan that includes family members and other adults willing to offer their support if Plan "A" is unsuccessful.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

14. I work with the family and other caring adults to assist _____ of the foster children and their caregivers in accessing services and supports as needed.

All (100%) Most (51-99%) Some (21-50%) Few (1-20%) None (0%)

IV. Opinions about Family Finding Integration

The next set of questions asks about your impressions of how well family finding activities have been integrated into your practice and the practice of others in your local office.

15. *All Respondents:* Overall, how well do you think you've been integrating the Family Finding activities into your practice?

Very well Somewhat well Not very well Not at all

16. *If you are a Supervisor:* Overall, how well do you think those you supervise have been integrating the Family Finding activities into their practice?

Very well Somewhat well Not very well Not at all

17. *All Respondents:* Overall, how well do you feel the caseworkers in your office have been integrating the Family Finding activities into their practice (e.g. providing guidance to you that reflects Family Finding principles)?

Very well Somewhat well Not very well Not at all

V. Permanency Specialists

18. Has a Permanency Specialist been assigned to work on any of your cases? Yes No (*NOTE: those who report no will be skipped out of this section*)

19. *If you are a Caseworker:* How effective do you think the Permanency Specialist is in assisting you in integrating Family Finding activities into your practice?

Very effective Somewhat effective Not very effective Not effective at all

20. *If you are a Supervisor:* How effective do you think the Permanency Specialist is in assisting the caseworkers you supervise integrating Family Finding activities into their practice?

Very effective Somewhat effective Not very effective Not effective at all

21. Please describe why you rated the Permanency Specialist in this way?

22. Please describe any particular Family Finding activities that the Permanency Specialist is **most** helpful with and why?

23. Please describe any particular Family Finding activities that the Permanency Specialist is **least** helpful with and why?

24. How, if in any way, can the Permanency Specialist improve in assisting you with your work?

VI. Opinions about Family Finding Work

Please check the box near the response that best reflects your opinion about each statement. Please remember that this survey is anonymous.

25. Relatives are important to involve in a foster child's life even if they cannot serve as a placement resource.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

26. **Paternal** relatives are just as important as **maternal** relatives to engage and involve in the case planning of foster children.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

27. Having relatives involved in the lives of foster children can enhance their overall well-being.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

28. Developing an informal supportive network for foster children is an important part of child welfare practice.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

29. Involvement of family members to serve as a life-long supportive network for children in foster care is important.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

30. Having relatives and other connections involved in case planning can generally be beneficial to **my work in achieving permanency for children.**

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

31. Stability in a long-term placement without legal permanency is a successful outcome.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

32. Involving relatives and other connections in case planning and activities is more burdensome than it is helpful.

Strongly Disagree Disagree Somewhat Disagree Somewhat Agree Agree Strongly Agree

VI. Family Finding Service Challenges and Strategies

40. What, if any, are the biggest barriers to including family members in case planning?

41. What strategies might be helpful to overcome these barriers?

VII. Demographics

The following questions inquire about your current position, experience, education and background. This information will help us in describing who participated in the survey.

42. How many years of experience do you have working in child welfare services? _____

43. How many years experience do you have working human services in total? _____

44. What is the **highest** level of education you have completed?

Bachelor's degree in Social Work (BSW)

Bachelor's degree- not in Social Work (please specify discipline) _____

Master's degree in Social Work (MSW)

Master's degree- not in Social Work (please specify discipline) _____

45. What discipline is your highest level of degree in? _____

46. What is your gender?

Male

Female

47. How would you describe your ethnic/racial background?

- African-American/Black
- Caucasian/White
- Hispanic/Latino
- Asian/Pacific Islander
- Native American
- Other (please specify)_____

Thank you for your participation.

Knowledge and Impressions of Family Finding/Family Group Decision-Making Services

Post-Survey Findings

December 2014

Submitted to:

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Director of Performance Improvement
Seneca Family of Agencies

Submitted by:

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Child Trends
7315 Wisconsin Ave, Ste 1200W
Bethesda, MD 20814



Introduction

This report presents the findings from the second of three annual surveys on knowledge and impressions of family finding/family group decision-making services (FF/FGDM). The survey's purpose is to better understand staff experiences with and views about FF/FGDM and how those experiences and views may or may not change over time. This includes staff members' (1) understanding of FF/FGDM service implementation, (2) degree to which FF/FGDM activities are integrated into casework, (3) thoughts on key FF/FGDM principles, and (4) views of barriers to implementation and thoughts on how to overcome barriers.

A Seneca staff member sent email invitations to all staff at the San Francisco Human Services Agency asking them to participate in the survey.¹ Data collection began on October 8, 2014 and ended on October 31, 2014.

A total of 39 case managers and supervisors out of 224 completed the survey representing a response rate of 15 percent. The majority (71%) of participants were case managers, while the remainder (29%) were supervisors. Sixty-one percent of participants had ten or more years of experience in child welfare, and 75 percent had more than ten years in human services. The majority (62%) of the respondents were from the Family Services, Transitions to Permanency, or Emergency Response Units. The following table presents the characteristics of the survey participants.

Table 1. Characteristics of Survey Participants (N=39)

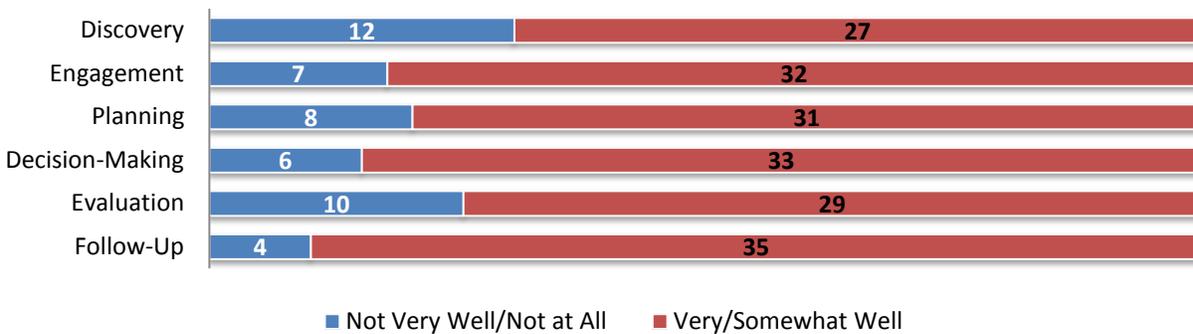
Characteristics	n	Percentage (%)
Gender		
Female	33	94
Male	2	6
Race/Ethnicity		
Hispanic/Latino	7	28
White	10	19
Asian/Pacific Islander	6	19
African American	7	8
Multi-racial	3	17
Highest Level of Education		
Masters	24	86
Bachelors	4	14
Unit		
Family Services Unit	14	36
Transitions to Permanency	7	18
Emergency Response	3	8
Placement Assessment Unit	3	8
Child Dependency Unit	2	5
Other	10	31

¹ The invitation included a 3-digit identification number and a link to the web-based survey. The number provides a way to link staff responses to both the pre- and post-surveys, while keeping their identity anonymous. Those who agreed to participate were instructed to enter this identification number at the beginning of the survey.

Knowledge of Model

Respondents were asked how well they understand how to implement the five core FF/FGDM service components. Overall, the majority of respondents reported understanding all five FF/FGDM model components “somewhat well” or “very well.” However, more respondents reported not understanding the Discovery and Evaluation components than the other components. This may be due to the fact that permanency specialists from Seneca do the bulk of these activities, which could lead to less familiarity. The findings are summarized in Figure 1.

Figure 1. Number of Participants by Level of Understanding of FF/FGDM Model Components (N=39)



Differences in post-test scores by respondent characteristics. Respondents with ten years or more experience in child welfare or human services were slightly more likely to report a better understanding of all FF/FGDM components than those with less experience.² The same trend was seen with supervisors and case managers. The numbers of respondents in each unit was too small to make any comparisons across units.

Integration into Practice

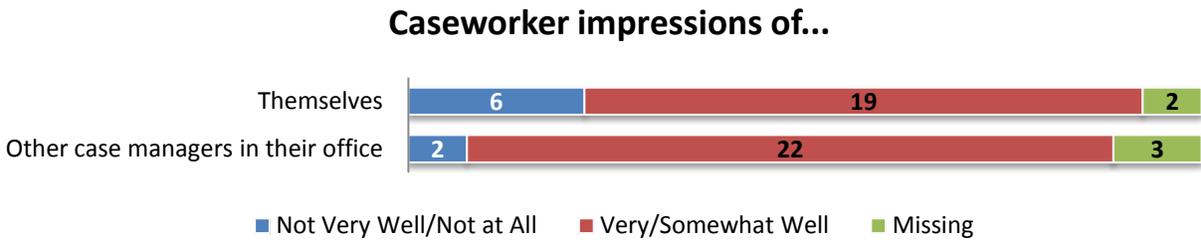
Overall Practice

Case managers and supervisors were asked how well FF/FGDM activities are integrated into their own practice, as well as the practice of others in their local office. The findings are summarized in Figures 2 and 3.

As shown in Figure 2 below, case managers generally had a better impression of how other case managers in their office are integrating FF/FGDM into their practice than they did of themselves. Overall, the majority of case managers report that all staff members in their offices do very or somewhat well integrating FF/FGDM into their daily practice.

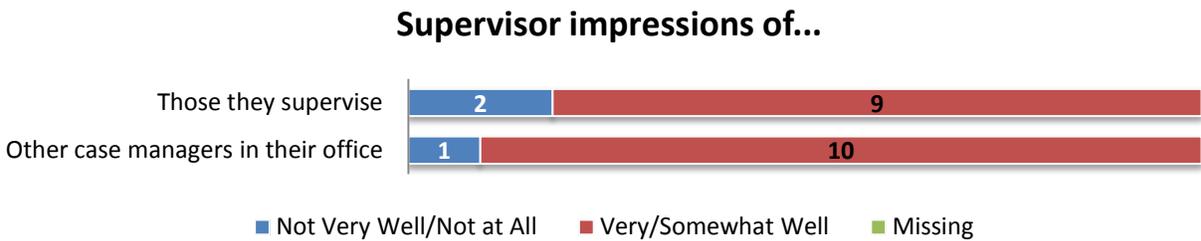
² To assess this, we assigned a value of 1 to 4 to each response option, with responses of “very well” assigned a 1 and responses of “not at all” assigned a 4. We then calculated the mean value across all 6 FF/FGDM components and compared those means for subgroups of respondents. A mean score of 1 is considered the “best” or optimal score.

Figure 2. Number of Case Managers, by Opinions about Level of Integration of FF/FGDM into Practice (N=27)



Almost all of the supervisors report that all staff (both those they supervise and other case managers in their office) do somewhat or very good job integrating FF/FGDM into daily practice.

Figure 3. Number of Supervisors, by Opinions about Level of Integration of FF/FGDM into Practice (N=11)

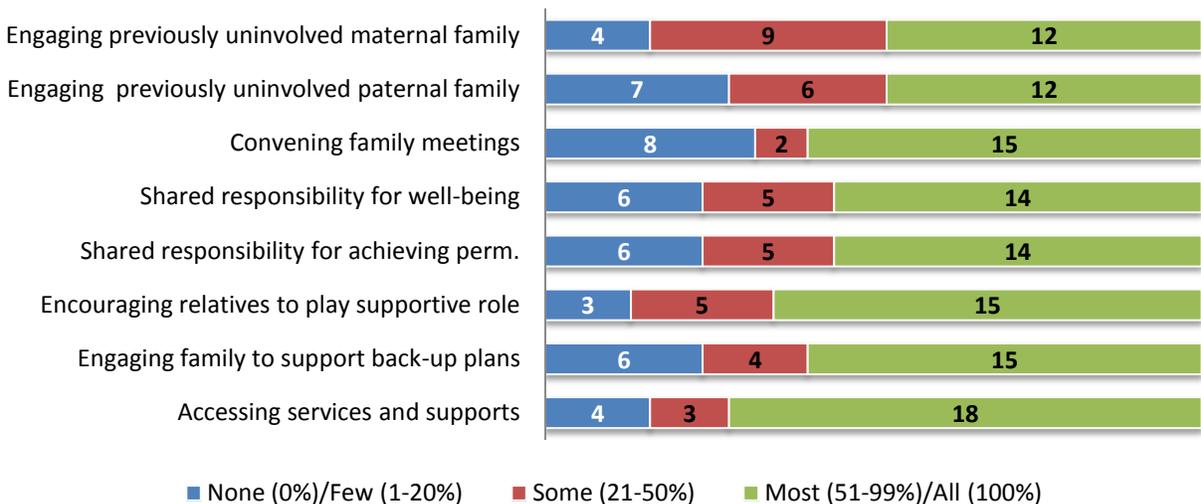


Differences in post-test scores by respondent characteristics. Impressions of the level of integration of FF/FGDM activities into daily practice differed by years of experience in child welfare and human services. Respondents with ten or more years of experience in human services were more likely to report that others in their office do very well in implementing FF/FGDM than those with nine years or less (33% compared to 0%). The same was seen with respondents with ten years or more in child welfare (33% compared to 8%).

Specific FF/FGDM Activities

Case managers were asked the extent to which they utilize specific FF/FGDM activities in their current practice. Overall, the majority reported using each activity with most or all of their cases. The findings are summarized in Figure 4. Note that these activities may be outside the respondent’s scope of regular responsibilities based on the unit in which they work.

Figure 4. Number of Participants, by the Percentage of Cases in which FF/FGDM Activities were Used (N=25)



Differences in post-test scores by respondent characteristics: On average, the overall use of FF/FGDM activities did not differ by respondent characteristics.³ However, respondents with less than 10 years of experience in child welfare reported performing these activities on more (“most” or “all”) cases than those with ten years or more of experience.

Opinions about Model Principles

The survey also obtained information about case managers’ and supervisors’ impressions about FF/FGDM principles and practices.⁴ The findings are summarized in the section below, with detailed findings in Appendix A.

Involvement of Relatives in a Foster Child’s Life. Respondents agreed that it is important for relatives to be involved in a child’s life, even if they cannot serve as a permanent placement. Relative involvement is not seen to be harmful to the child, and is thought to enhance the child’s overall well-being.

Involvement of Relatives in Case Planning. When it comes to relatives’ involvement in case planning, respondents agreed that this is beneficial both to the children as well as to the agency, in achieving permanency for the child. It was also agreed that it is just as important to involve paternal family members in permanency planning as maternal family members.

³ To assess this, we assigned a value of 1 to 5 to each response option, with responses of “all” assigned a 1 and responses of “none” assigned a 5. A score of 1 is considered an optimal score. We then calculated the mean value across all 8 family finding activities and compared those means for subgroups of respondents. The mean score for respondents did not differ by respondent characteristics.

⁴ Respondents were asked to report their level of agreement with a series of statements about the principles of FF/FGDM, from “strongly disagree” to “strongly agree.” The principles were categorized according to responses concerning the involvement of relatives in a foster child’s life, in case planning, and as a supportive network for the child.

Supportive Networks and Stability. Respondents agreed that the involvement of family members as part of the child’s life-long supportive network is important, and they are in favor of the development of that network. Respondents were mixed in their feelings as to whether or not long-term placement without legal permanency is a successful outcome.

Differences in post-test scores by respondent characteristics. More experienced workers’ opinions more closely aligned with the grounding principles of FF/FGDM. Respondents with ten or more years of experience in human services had a slightly higher average FF/FGDM opinion score than those with less than ten years of experience⁵; and, respondents with ten or more years of experience in child welfare scored higher than respondents with less experience.

Implementation Challenges

Case managers and supervisors were asked to identify challenges to including family members in case planning, as well as strategies that might be helpful in overcoming challenges. Lack of time to spend on family engagement was frequently reported to be a challenge. Many family members are difficult to locate, while the geographic location or transient nature of other members make engagement difficult. Respondents felt that lower caseloads and additional resources and/or support staff would assist them in being able to reach out to more relatives.

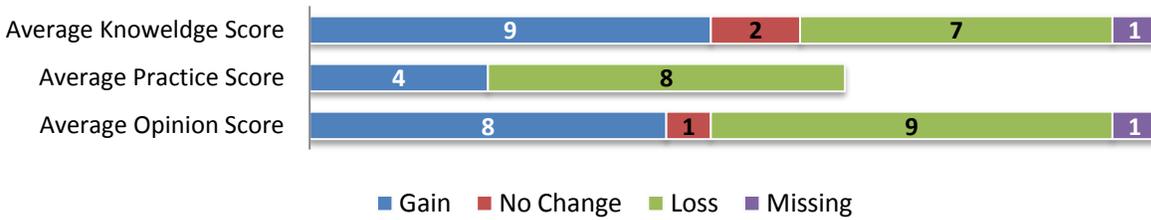
Lack of commitment and/or involvement from relatives in the FF/FGDM process was also seen as a major challenge. Birth parents are often hesitant to share information on family members, which can delay the FF/FGDM process. Negative views of child protective services and challenging family dynamics often make it difficult for case managers to engage family members. Respondents suggested focusing on building positive, respectful, and proactive relationships with relatives in an effort to overcome these barriers.

⁵ To assess the average opinion score, we assigned values of 1 to 6 to the responses that participants gave, with responses of “strongly disagree” assigned a 1 and responses of “strongly agree” assigned a 6. The values of two of the items were reversed to more accurately reflect positive response. We then calculated the mean value across all 8 FF/FGDM opinions and compared those means for subgroups of respondents.

Comparing Pre- and Post-Test Findings

Only 19 staff completed both the pre- and post-test surveys (representing 22% of all respondents). We compared changes in responses in the two groups, but the sample size did not allow for analyses to assess whether or not these changes were significant. Figure 5 below shows the number of participants who either demonstrated gains, no change, or losses in scores from the pre-assessment to the post-assessment.

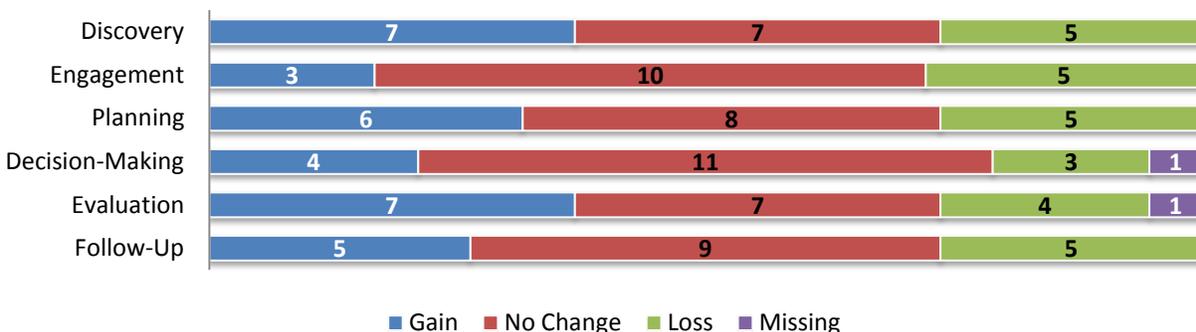
Figure 5. Number of Participants who Demonstrated Gains or Losses on Average Scores



Knowledge of Model

There was not much change seen between the pre- and post-assessment when comparing the average score across all of the knowledge items (1.7 compared to 1.8). However, as seen in Figure 6 below, 7 out of the 19 respondents showed a loss in overall knowledge from the pre-assessment to the post-assessment. Respondents showed fewer gains in knowledge of the Engagement and Decision-Making phases of the model, but the number of participants with losses in knowledge was more or less the same across the different phases. One potential explanation for this decrease in knowledge is that as case managers and supervisors learn more about FF/FGDM, they actually feel like they know *less* about the model. Conversely, more respondents had a better understanding of the evaluation phase of the model on the post-assessment than on the pre-assessment. See Appendix B for more detailed information of pre- and post-assessment responses.

Figure 6. Number of Participants who Demonstrated Gains or Losses in Knowledge of FF/FGDM Model Components

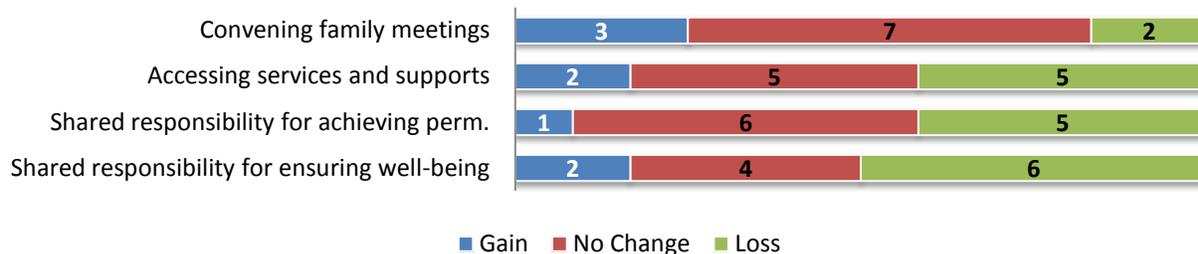


Integration into Practice

In general, supervisors and case managers did not differ from the pre- to the post-assessment about how well FF/FGM is integrated into regular practice. However, when it came to integrating specific

activities and principles into practice, case managers showed a decline in the percentage of cases where they were used (see Appendix B). The average practice score went from 2.3 on the pre-assessment to 2.7 on the post-assessment, which means that FF/FGDM principles were reported being used on fewer cases on the post-assessment.⁶ As shown in Figure 5 above, 8 out of the 12 case managers showed decreases in average practice scores from the pre-assessment to the post-assessment. Figure 7 below shows the activities/principles that had the most gains and losses.

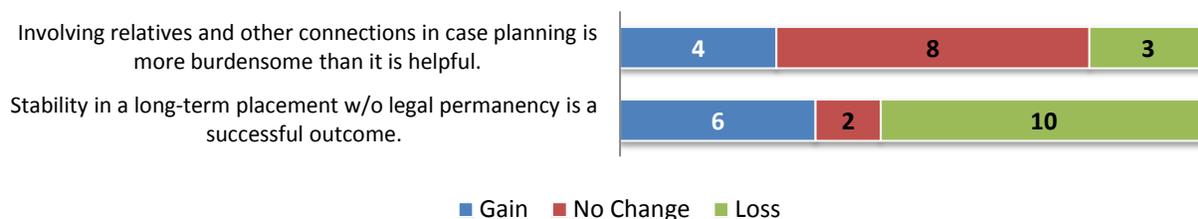
Figure 7. Number of Participants who Demonstrated Gains or Losses in Integrating FF/FGDM into Practice



Opinions about Model Principles

There was not much change seen between the pre- and post-assessment when comparing the average score across all of the opinion items (5.2 compared to 5.1). However, as shown in Figure 5 above, 9 out of the 19 respondents had lower opinion scores on the post-assessment than on the pre-assessment. Figure 8 below shows the two opinion questions that showed the greatest gains and losses between the pre- and post-assessment.

Figure 8. Number of Participants who Demonstrated Gains or Losses in FF/FGDM Opinions



Involvement of Relatives in a Foster Child’s Life. While respondents still agreed overall that relative involvement was important, they agreed to a lesser extent; fewer respondents strongly agreed to these statements on the post-assessment than on the pre-assessment. See Appendix B for more detailed information on each survey item.

Involvement of Relatives in Case Planning. In regards to relative involvement in case planning, respondents still agreed that overall, it is beneficial in achieving permanency. Fewer respondents strongly agreed that paternal relatives are important. However, it is worth noting that no one agreed or

⁶ An optimal practice score is 1, so the lower the number the better the score.

strongly agreed on the post-assessment that involving relatives is more burdensome than helpful in case planning.

Supportive Networks and Stability. While respondents agreed in general that the involvement of family members as part of the child's life-long supportive network is important, it was to a lesser degree, with fewer respondents strongly agreeing on the importance of family involvement. Respondents continued to report mixed feelings about whether or not long-term placement without legal permanency is a successful outcome, but more respondents disagreed with that statement on the post-assessment than the pre-assessment survey.

Conclusions and Implications

This report presents findings on the knowledge, opinions and practices of case managers and supervisors related to FF/FGDM. Findings point to several areas of strength as well as areas that need improvement.

Areas of Strength

- A majority of respondents understand all five of the FF/FGDM model components, and utilize almost all of the FF/FGDM activities with most or all of their cases.
- Of all FF/FGDM activities, creating a shared sense of responsibility for achieving permanency and assisting children and their caregivers in accessing needed services and supports were completed on more cases than any others.
- The majority of respondents were closely aligned with nearly all FF/FGDM principles, most notably:
 - All but one respondent agreed that engaging paternal family in case planning for foster children is just as important as engaging maternal family.
 - All but one respondent agreed that involvement of family to serve as a life-long supportive network for foster children is important.

Areas Needing Improvement

- Even though the majority of respondents report an understanding of all FF/FGDM model components, there were more respondents who reported not understanding the discovery and evaluation stages compared to the other stages of the model.
- While respondents reported having the highest level of understanding of the engagement phase, as well as agreeing that paternal family members are important, only a little under half (48%) reported engaging previously uninvolved maternal and paternal family members on most or all of their cases.
- Unlike other topics, where the majority of respondents tended to strongly agree or strongly disagree, responses varied widely about two of the FF/FGDM principles: (1) whether or not stability in a long-term placement without legal permanency is a successful outcome for children in out-of-home care, and (2) involving relatives and other connections in case planning and activities is more burdensome than it is helpful. Offering trainings on family engagement techniques could be helpful for staff. Training on effective family engagement could also be beneficial in light of respondents reporting that a lack of commitment and involvement from relatives is as another barrier.

- Given that time was identified as one of the biggest barriers to involving families in case planning, it would be advantageous for Seneca and the Human Services Agency to explore current case manager responsibilities to identify how family engagement activities could be better integrated into current case practice—that is, to explore how new techniques can replace and/or enhance existing activities. Areas where support staff could assist in the engagement of family can also be identified.

Appendix A

Opinions about Family Finding/Family Group Decision-Making Principles

Response options of “strongly disagree,” “disagree,” “somewhat disagree,” “somewhat agree,” “agree,” “strongly agree” were combined to form the three new response categories used below.

Figure 9. Number of Survey Participants, by Opinions on the Involvement of Relatives in a Foster Child’s Life (N=36)

Relatives are important to involve in a foster child’s life even if they cannot serve as a placement resource.



Having relatives involved in the lives of foster children can enhance their overall well-being.



Developing an informal supportive network for foster children is an important part of child welfare practice.



Figure 10. Opinions on the Involvement of Relatives in Case Planning (N=36)

Having relatives and other connections involved in case planning can generally be beneficial to their work in achieving permanency for children.



Involving relatives and other connections in case planning and activities is more burdensome than it is helpful.



Paternal relatives are just as important as maternal relatives to engage and involve in the case planning of foster children.



Figure 11. Opinions on Supportive Networks and Stability (N=36)

Involvement of family to serve as a life-long supportive network for foster children in foster care is important.



Stability in a long-term placement without legal permanency is a successful outcome.



Appendix B

Pre/Post-Assessment Comparisons

This appendix contains comparisons in pre- and post-assessment responses for the respondents who completed both assessments.

Figure 12. Number of Participants by Level of Understanding of FF/FGDM Model Components, Pre/Post Comparison (N=19)

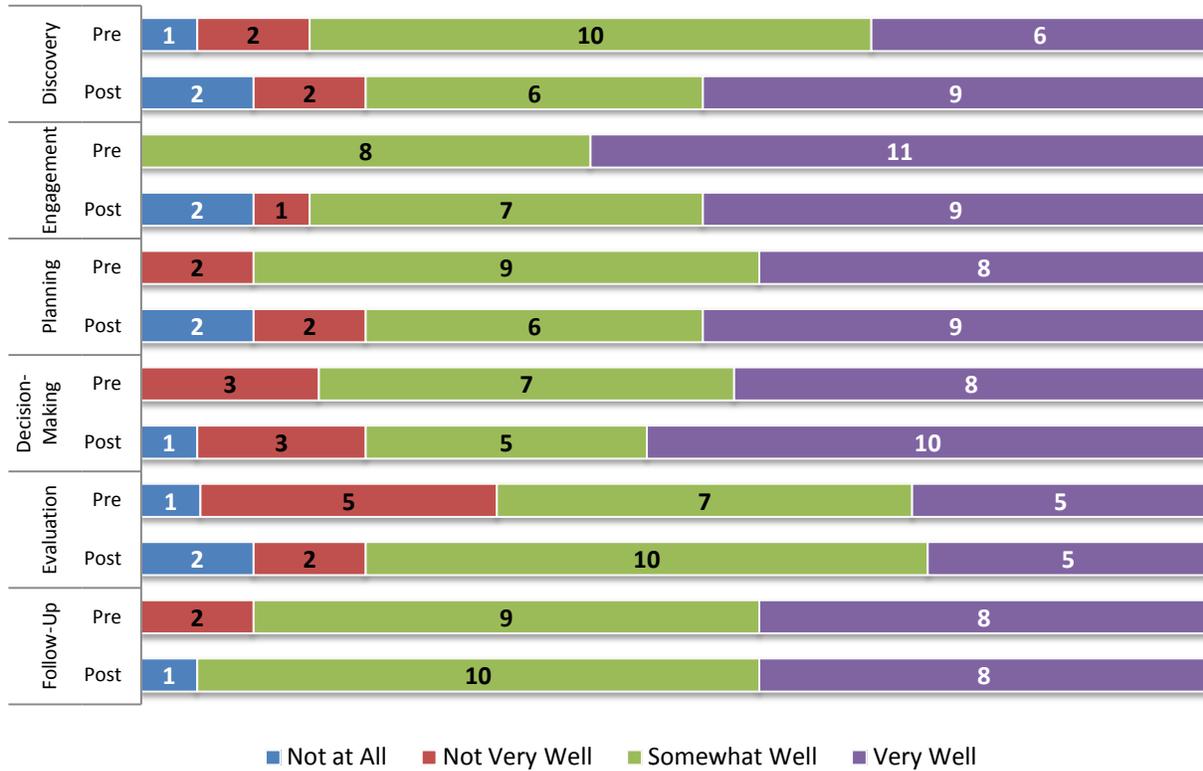


Figure 13. Number of Case Managers, by Opinions about Level of Integration of FF/FGDM into Practice, Pre/Post Comparison (N=12)

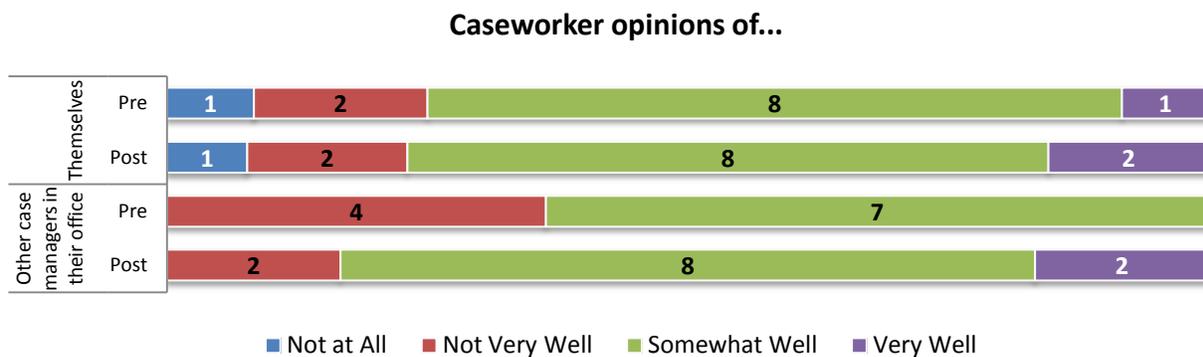


Figure 14. Number of Supervisors, by Opinions about Level of Integration of FF/FGDM into Practice, Pre/Post Comparison (N=6)

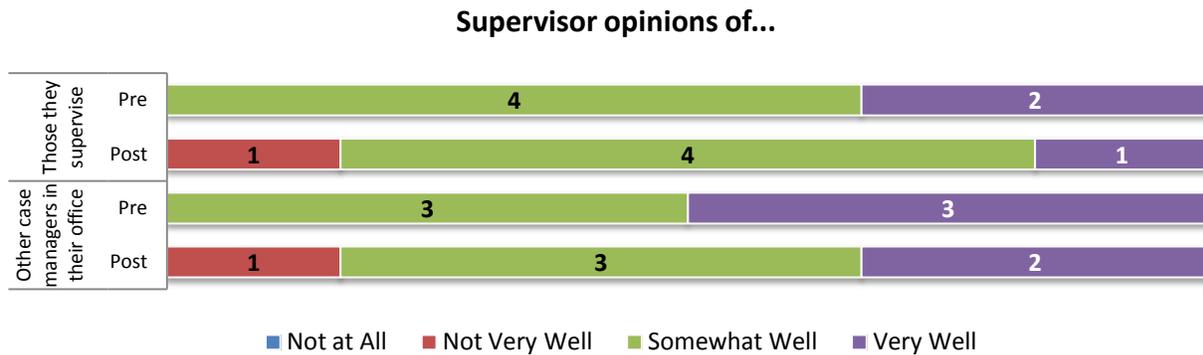
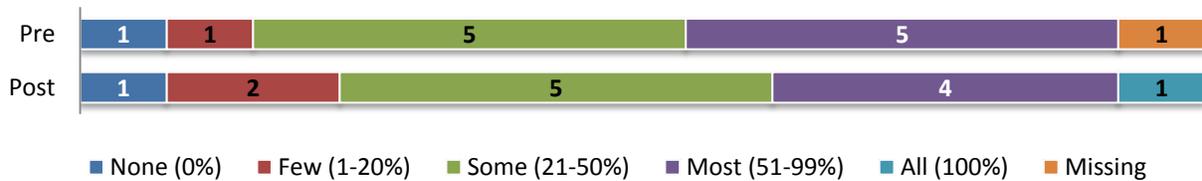
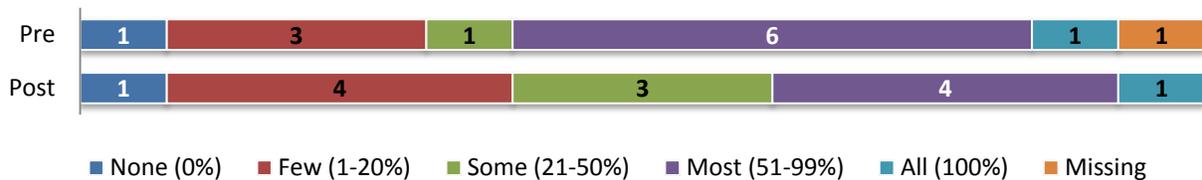


Figure 15. Number of Participants, by the Percentage of Cases in which FF/FGDM Activities were Used, Pre/Post Comparison (N=13)

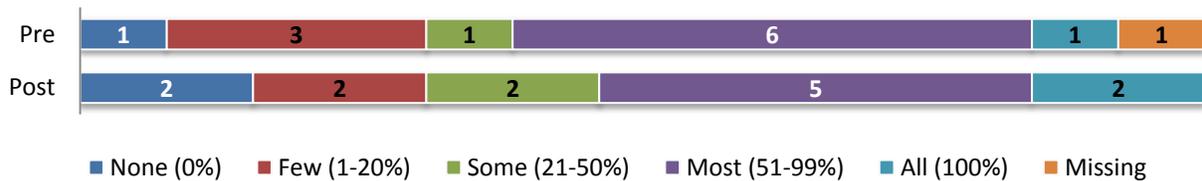
I engage previously uninvolved maternal family or other caring adults in the lives of _____ of the foster children on my caseload.



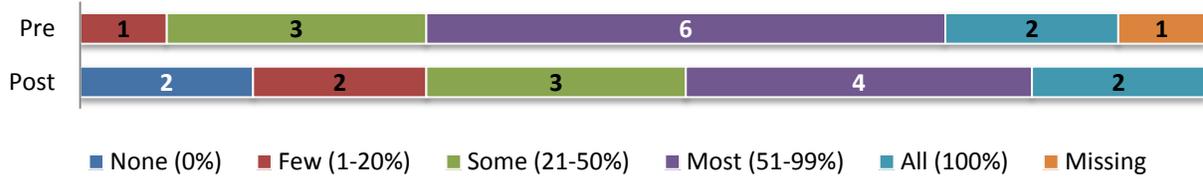
I engage previously uninvolved paternal family or other caring adults in the lives of _____ of the foster children on my caseload.



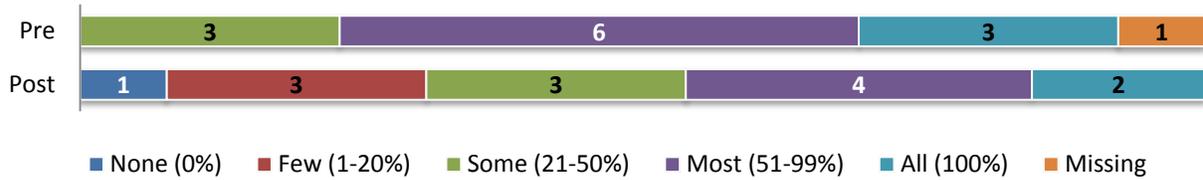
I convene family meetings to develop a plan for the safety, permanency and well-being of _____ of the foster children on my caseload.



I create a sense of shared responsibility among relatives and other caring adults for ensuring the well-being of _____ of the foster children on my caseload.



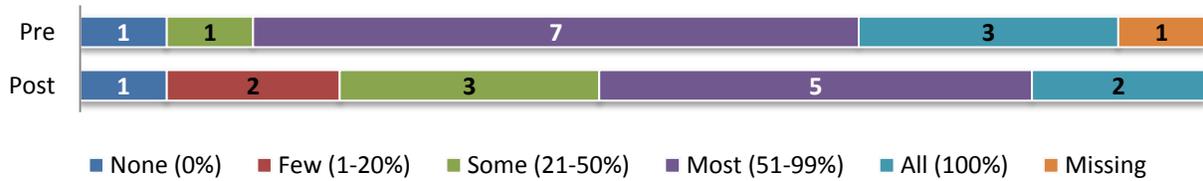
I create a sense of shared responsibility among relatives and other caring adults for achieving permanency for _____ of the foster children on my caseload.



I encourage relatives and other caring adults to play a supportive role in the life of _____ of the foster children on my caseload even if they cannot be a placement option.



I work with relatives and other caring adults of _____ of the foster children on my caseload to create a plan that includes family members and other adults willing to offer their support if Plan "A" is unsuccessful.



I work with the family and other caring adults to assist _____ of the foster children and their caregivers in accessing services and supports as needed.

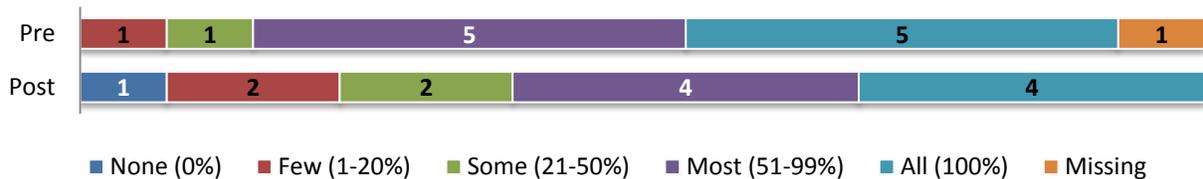
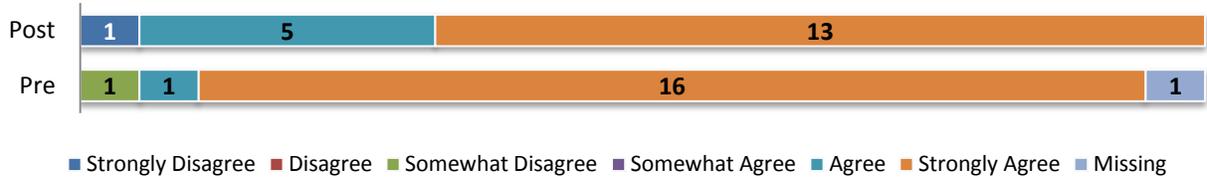
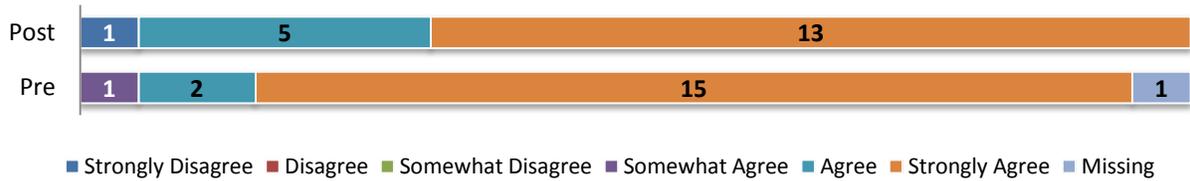


Figure 16. Number of Survey Participants, by Opinions on the Involvement of Relatives in a Foster Child's Life (N=19)

Relatives are important to involve in a foster child's life even if they cannot serve as a placement resource.



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Developing an informal supportive network for foster children is an important part of child welfare practice.

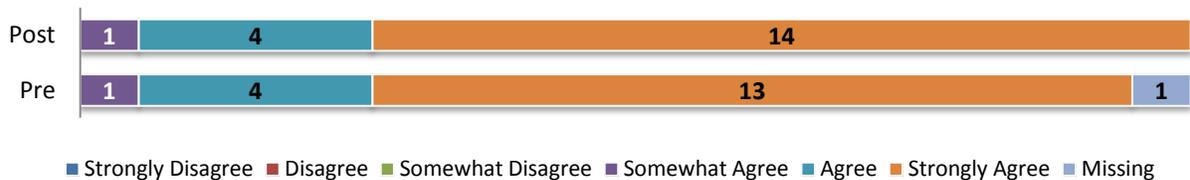
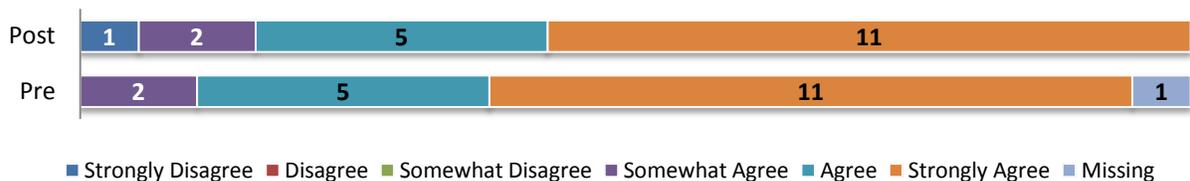


Figure 17. Opinions on the Involvement of Relatives in Case Planning (N=19)

Having relatives and other connections involved in case planning can generally be beneficial to their work in achieving permanency for children.



Involving relatives and other connections in case planning and activities is more burdensome than it is helpful.



Paternal relatives are just as important as maternal relatives to engage and involve in the case planning of foster children.

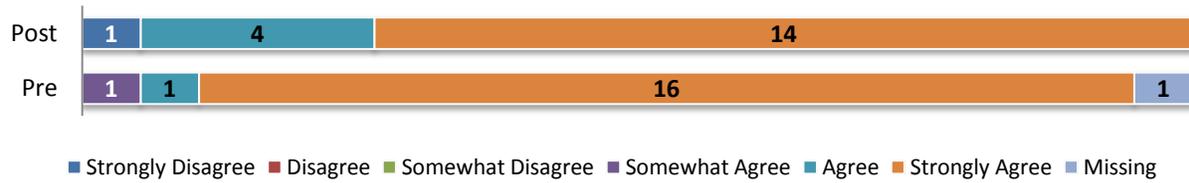
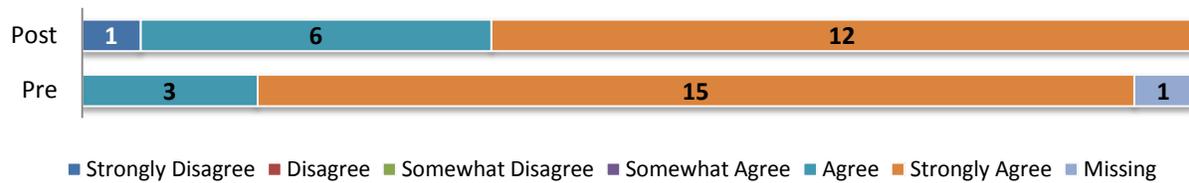


Figure 18. Opinions on Supportive Networks and Stability (N=19)

Involvement of family to serve as a life-long supportive network for foster children in foster care is important.



Stability in a long-term placement without legal permanency is a successful outcome.

