Program Name: “Nurturing the Resiliency in Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work”

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HOMES FOR BLACK CHILDREN

Project Nurturing the Resiliency in Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work

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Nurturing the Resiliency in Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work

I. Executive Summary

Homes for Black Children, a comprehensive child welfare agency with a rich forty-two year history of offering services to children of all ethnicities, is best known for its ground breaking evidenced based practice in creating permanent outcomes for African American children through Adoption and Family Preservation Services.

Homes for Black Children proposed to demonstrate the effectiveness of Family Group Decision Making as a best practice model in reducing the number of urban children who enter foster care, as well as reduce foster care recidivism in Wayne County, Michigan. In 2004, although African American Children represented only 48.86% of the overall child population, they represented 82.05% of the foster care population in Wayne County with a disproportionality rate of 1.69 (Michigan Family Independence Agency Warehouse Data, 2004). The project focused on 100 African American families who were at risk of their child entering the foster care system or families who have had their child/ren returned from foster care. Referrals were received from the Wayne County Department of Human Services, the Detroit Public School System, and Homes for Black Children’s Foster Care Department. All referrals were voluntary.

The Project sought to develop an individualized “Family Resiliency Plan” guided by each family to achieve its overall goal of improving child and family well-being through the use of four core evidenced based, culturally competent strategies which support and build upon the family’s own strengths:

- Family Group Decision Making
- Solution Focused Family Counseling
- Parent Advocate/Mentor Support
- Family Well-Being Cluster (includes collaborative partnerships with Wayne County Department of Human Services, The Detroit Public Schools, TJ Adams Employment Service, TEAM Community Mental Health Services, National Council on Alcoholism and Drug Dependence of Greater Detroit, R&I Domestic Services, Inc. (Domestic Violence), Get Back Up (Domestic Violence Counseling and Shelter), Children’s Center (Children’s Counseling and Assessment Center), Benevolent (community foundation), Casey Family Programs and the Michigan Department of Human Services). The Well-Being Cluster also included services traditionally offered by Homes for Black Children, e.g., life enrichment activities, individualized counseling, and parent education. The Family Well-being Cluster also served as the advising board to project strategies, program design, implementation and sustainability.
Dr. Larry Gant, PhD, of the University of Michigan conducted the evaluative study utilizing the Parenting Stress Index, Protective Factors Survey, Family Needs Scale, and data pulled from the Michigan Department of Human Services. The Michigan Federation of Private Child and Family Agencies and the United States Department of Health and Human Services will continue to assist in the dissemination of findings.

The objectives of the project were to (1) To engage 100 families in case planning through the use of the Family Group Decision Making (FGDM) Model (2) To engage 100 families in Solution Focused Counseling (3) To provide Parent Advocate/Mentor Services to 100 families (4) To involve 100 families in a continuum of services and support through the Family Well Being Cluster.

The majority of the program participants were fairly isolated in their communities, and safety and well-being concerns were severely exacerbated by issues related to poverty. Most families were overwhelmed with inadequate or unstable housing, unemployment, lack of access to health care, lack of transportation, and unmet basic needs. Staff found it difficult to engage participants in the Family Group Decision Making Process. While only thirty four families accepted FGDM’s, all 222 families readily accepted other program modules. Generational poverty affected family relationships and created distrust of family, community and institutions which became a barrier to the FGDM and evaluation processes. Although originally conceptualized as one on one counseling, the solution focused counseling strategy was redesigned as an engagement strategy and a group service support model.

293 referrals were received from DHS and 222 families were served during the three year project period: 262 adults, and 606 children. Of referrals served, 10 families later had DHS protective service substantiation; thus meeting the overall objective of reducing the number of African American children at risk of entering the child welfare system in Wayne County Michigan. Other anticipated outcomes although not statistically significant trended in the direction of improvement:

- Incorporation of safety factors within the family unit
- Increased parenting skills and knowledge of child development
- Improved family ability to care for the needs of their children
- Families assume ownership of their family life and improve their decision making skills
- Families will spend quality time with their children
- Families will have reduction of stress
- Families will have improved social and family connections
- Families will become self sustained

There was not sufficient data to evaluate anticipated outcomes of improved relationships between children and family members and involvement of fathers in planning and caring for their children.

The four strategies that have been developed by the project will be sustained through Purchase of Service Contracts, United Way Funding, community donations, and volunteers. All training strategies have been permanently archived in the Agency’s learning center.
II. Overview of the Community, Population and Needs

A. Describe the grantee organization

Homes for Black Children is a nonprofit 501C3 whose mission is to assure that every child has a permanent home. HBC is a comprehensive community based child welfare agency which continues to contribute innovative ideas and program practices to the child welfare field. Homes for Black Children’s powerful influence on services to families and children in the Detroit Community has been acknowledged for the past 43 years in many publications including *The Administration for Children, Youth and Families Publication*, *The Wall Street Journal*, *The Children’s Defense Fund publication*, as well as the major Detroit area newspapers. President Ronald Reagan in his 1981 speech to the business community on private sector initiatives used Homes for Black Children as an example of the power of community based organizations to bring about positive social changes. The success of Agency services has been recorded in the Congressional Record.

In 2013, services were provided to 2,100 clients, 95% of whom were African American, and over 80% lived in the City of Detroit. Homes for Black Children provides its adoption, foster care and family reunification services through a child’s best interest criteria based effort in conjunction with the Michigan Department of Human Services, serving approximately 150 children per year. The Agency places approximately 30 children from the Michigan Child Welfare System into adoptive families each year. In the late 1990’s, Homes for Black Children was selected to participate in Michigan’s state sponsored Family to Family foster care reform program as a Placement Service. The Family to Family program focused its attention on maintaining children within their own family system, including the birth family in decision-making.
making, and keeping children in their neighborhood if out of home placement is necessary. Currently the agency employs three certified facilitators for permanency planning conferences that is based on the Family to Family Structured Decision Making Process.

Homes for Black Children regularly engages in community needs based assessments to create programs that are responsive to the needs of the community. Examples that exist within the agency that were created as responsive to community needs are as follows:

- **Life Enrichment Activities for Children and Families.** These are activities that are designed to limit family isolation, improve family interactions, and create opportunities for learning and socialization. The activities must meet one of the following criteria: social, educational, cultural, or service. Generally these activities are community funded, however the agency recently received funding from MGM Mirage Voice Foundation to support these activities.

- In fiscal year 2005, the Agency was awarded a Federal field initiated service demonstration project in the field of adoption to improve permanency outcomes for youth through open adoption plans. The project’s major accomplishment was the placement of 125 youth in an open adoption plan; of this number 31 were sibling group adoptions. Foster parents and relatives adopted the greatest number of youth.

- In April, 2003, Homes for Black Children implemented the agency’s first Parent Club at Greenfield Park Elementary School in Detroit based on a curriculum designed by the Skillman Foundation, but modified by HBC to make culturally responsive. Today, Homes for Black Children has initiated Parent Clubs in seven Detroit Public Schools, providing prevention services to 300 families living in high-risk areas. From the statistical data gathered from the agency’s Family Preservation inquiry forms, the
population served is 98% African American, approximately 80% of whom are single and head of households, 75% of whom have annual incomes below $20,000, and 85% of whom have children who qualify for title IV services.

- In 2004, the Skillman Foundation provided funding to demonstrate the effectiveness of Parent Advocates in family preservation services. Homes for Black Children’s Parent Advocacy program displayed areas of achievement and success as indicated by its final evaluation report. According to the satisfaction survey, parents overall found the program “very helpful.” The evaluation report showed that Homes for Black Children had set goals for birth parents to become capable of parenting and stabilizing their families. The outcomes were that more than 70% of birth parents successfully used the Parent Advocacy Program and agency services within four months of their child entering care. Over 50% of parents successfully completed parenting classes, post test and practicum within four months of admission. More than 50% of the parents became legally employed, developed a child care plan and household budget within 5 months of child’s admission. The Advocacy Program was unique because of the agency’s ability to engage what had been considered involuntary families into program services. It should be noted that participation was voluntary rather than court ordered. Families committed to involvement by becoming partners in establishing their own outcome goals.

- In 2008, Homes for Black Children was funded by United Way of Southeastern Michigan to create a program to assure that “all children read at grade level.” The Skillman Parent Advocate Model was used to create Parent Advocate Mentors within the school that would support parents in working with the school and create an active learning environment within the home. The Parent Advocate Mentors also helped assist the
families in crisis management and seeking assistance from other outside agencies and organizations.

- In 2011, Homes for Black Children was awarded a three year Federally funded Family Connections Grant to demonstrate the effectiveness of Family Group Decision Making in reducing recidivism, and out of home placement. The Project entitled Nurturing Resiliency in Wayne County Families: Rethinking Family Group Decision Making as Community Centered Child and Family Work, features the development of family initiated “Resiliency Plans,” which help families to build upon their strengths and avoid out of home placement.

- In 2012, Homes for Black Children was awarded a federally funded Kinship Navigator Program demonstration grant whose goal is to stabilize and support 100 kinship families through the foster home licensing process.

B. Describe the community in which the project takes place. Include cities, counties, districts, regions, States, etc.

The Project took place in Detroit (Wayne County) Michigan; an urban community. Today, with a population of 82.7% African American, the majority of the children who are in out of home care in Wayne County have families who reside in the City of Detroit.

Detroit, Michigan has been described by the largest newspaper in Michigan, the Detroit Free Press, as the poorest city in the nation. Although the national poverty rate in 2010 was 15.1 percent, in Detroit the poverty rate was a staggering 44 percent, almost two and one half times the national average. *Detroit is the nation’s poorest big city, with about one in three residents living below the federal poverty level--$19,157 in household income for a family of four.* (Detroit Free Press, August 2005).
C. Describe the primary issues the demonstration project addresses. Describe significant contextual conditions, events, and/or community changes and how they figure into these problems.

The Project was designed to reduce the recidivism rate and to reduce the number of African American children who are placed outside of their families by involving their families in the Family Group Decision Making process. Referred families were previously service recipients of the Michigan Department of Human Services, the Detroit Public Schools or community self referred. The goal of the project was to identify family strengths through the use of the family group decision making process to develop a Family Resiliency Plan (FRP). Once developed, the plan would be supported by the use of three core family support strategies: solution focused counseling, parent advocate/mentors, and the family well-being cluster (a consortium of community services and support).

There are a disproportionate number of African American Children in the Child Welfare System in Michigan. Nationally, African American children are four times more likely to enter the child welfare system, and stay twice as long as any Caucasian child. In 2009, of Michigan children in out of home placement, 7,210 were white, 8,045 black, 1,021 Hispanic, 131 American Indian/Alaskan Native, and 1,238 of other races and ethnicities, (Child Welfare League of America, 2011).

According to the Michigan KIDS COUNT data center, in 2013 64% of City of Detroit children live in families where neither parent has a full time job. 17% of Detroit’s children live in over crowded housing. 54% of the children living in Detroit live below the poverty level; 29% of whom live in extreme poverty. Nearly 81% of children in Detroit qualify for free or reduced priced lunches at school because the family’s income is less than 40,200 dollars a year (for a
A quarter of Michigan children are dependent upon Food Stamps. The report also shows a 25 percent increase in the rate of confirmed victims of abuse and neglect between 2000 and 2009. (The Detroit News, June, 2011).

There are multiple disadvantages experienced by families and children of color including poverty and poverty associated risks such as depression, isolation, unemployment, homelessness, substance abuse, poor health including mental illness and domestic violence; 2) related attitudinal factors such as racism and classism; and 3) the way these factors play out in organizational cultures and practices that influence decision making and limit positive outcomes. For example, inequities in the health care and criminal justice system make children of color more likely to be raised by single parents, heightening their economic vulnerability and increasing their risk for poverty-related neglect, the single greatest cause of entry into the child welfare system.

Black and Latina/o youth are significantly less likely than white youth in similar circumstances to receive mental health services. This absence of services likely contributes to longer stays in care, as well as lower rates of reunification and adoption for children of color, (Hill 2006, pp. 31-32).

The above risk factors that Dr. Hill delineates are exacerbated in Detroit, (Wayne County) Michigan:

- The National Center for Children in Poverty states that “Economic hardship is particularly acute in Detroit where a higher percentage of children are poorer than in any other major city in the nation except Atlanta. Detroit’s child poverty rate is 39 percent, and a startling 72 percent of Detroit’s children live in families that are low income, defined as twice the poverty level, or $40,000 a year for a family of four in 2006.”
• The loss of the manufacturing industry has created a climate of exodus from the City where employment is scarce and poverty levels are high. By and large, those who could leave the City for better opportunities have exited, leaving the most vulnerable population to struggle for limited resources. The City has become a bastion of extremes; of those who “have”, and those who “have not.” Most recently the City of Detroit declared bankruptcy. In its effort to meet the requirements of the bankruptcy agreement, the City privatized the collection of delinquent water bill revenue from the City’s poor. City water was shut off throughout the poorest neighborhoods. This strategy created major international concern as a human right’s violation when scores of people were denied access to water.

• The poverty rate in Detroit is exacerbated by unemployment and under-employment. The poverty rate among Detroit citizens who did not finish high school is 51.6%. And although approximately 65% to 70% of Detroit high school students graduate each year, National Public Radio News reports that only 25% of all Detroit freshmen go on to graduate. According to the Detroit Literacy Coalition, Detroit has a functional illiteracy rate of 47%; more than twice the national average of 21-23%.

• In an article entitled “America’s Top Ten Unhappiest Cities” by Bloomberg Businessweek, Detroit was ranked the fourth unhappiest city in the United States. The ranking assessment conducted by BusinessWeek.com was based on factors including depression rates, suicide rates, divorce rates, crime, unemployment, population loss, and job loss. The depression rate is based on aggregated insurance reporting at time of discharge, doctor’s office visits and insurance process filings. The suicide rate is for 2004 and comes from the 2007 Big Cities Health Inventory compiled by the National
Assembly of County and City Health Officials (NACCHO). The crime risk indexes for poverty and crimes used for the scoring were based on FBI crime reporting for the seven most-recent available years. Divorce rates and 2009 population change came from the U.S. Census. The information compiled for Detroit was an Overall Ranking of 1. The Depression Rank: 46, Suicide Rank: 50, Crime (property and violence) Rank: 3, Divorce Rank: 15 and Unemployment Rate (December, 2008): 18.6%.

- The Detroit Regional Workforce Fund provides statistics that 47 percent of Detroit residents are functionally illiterate. The Detroit Public School’s graduation rate was listed as one of the largest cities with the lowest graduation rate in April, 2009. While the graduation rate increased in 2009 at 62%, it is still below the national average of 72%.

- These negative trends and statistics are a result of a post industrial manufacturing economy which included massive layoffs and cutbacks in the automobile industry. In the year 2010, Michigan experienced 162 massive layoff events. The Congressional Budget Office reviews research on short and long term effects of involuntary job loss based on predictions that unemployment will remain elevated for a number of years. The report discussed possible consequences, including studies that indicate people who lose a job “tend to have more health problems later in life, their family life can suffer, and entire communities may struggle, especially if job loss is concentrated in particular geographic areas.”

- According to the National Network to End Domestic Violence, Domestic abuse is 3 times more likely to occur when a family is under financial stress. Domestic abuse is 3 times more likely to occur if a partner has been unemployed 2 or more times.
“Dialogue on Father’s Role in Child Maltreatment: Evaluation by Wayne State University Center for Social Work Practice and Policy Research” http://fathersandfamiliescoalition.org/find-your-local-affiliate/Detroit-michigan.html, the findings suggest that young children growing up without father’s involvement are ten times more likely to be extremely poor. 63% of youth suicides are from fatherless homes. 85% of all children that exhibit behavioral disorders are from fatherless homes. The majority of teen mothers come from homes without fathers. Seventy percent of juveniles in state operated institutions come from fatherless homes. Over 30,000,000 children in the United States do not have a father living with them and over one-third will not see their father at all in the next twelve months. Over 71% of high school drop outs are from fatherless homes. Eighty-five percent of all youths sitting in prison grow up in fatherless homes. If a father is engaged with the child for the first two years of life, he will stay involved. The fatherhood statistics are courtesy of the Fathers and Families Coalition of Detroit.

The last Children’s Bureau Child and Family Services Review (CFSR) was conducted in Michigan in September, 2009. The State of Michigan is now preparing for a third review in September, 2011. The highlights of the findings were that the State of Michigan met one of the six national standards, the State achieved none of the seven outcomes, and finally they achieved three of seven systemic factors. One of the outstanding non conformities was in item 18: Child and Family involvement in case planning. The findings which led to non conformity are indicate that the case plans were formulated solely by the foster care specialist and presented to the parents for signature without parental input. It was also sited that the fathers as well as children were not engaged in
the planning process. The report indicated that the efforts to involve the fathers were inadequate. It was also noted that the treatment plans were unspecific to the unique needs of the family.

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

The project sought to offer, develop and implement “Family Resiliency Plans” utilizing four core strategies to 100 urban African American families who resided in Wayne County Michigan, but primarily in the City of Detroit. Referrals were identified through:

1. The Michigan Department of Human Services (DHS). The department referred families who through their protective service risk assessment (category 4) were identified as a family that could benefit from a prevention program; *Category IV-Cases in which a preponderance of evidence of child abuse is not found. The department must assist the child’s family in voluntarily participating in community based services commensurate with risk level determined by the risk assessment (structured decision making tool).* Michigan Department of Human Services, Child Protective Services Investigation Process, November, 2008.

2. The Detroit Public Schools (DPS). Homes for Black Children conducts Parent Education Clubs in several Detroit Public Schools as well as Family Literacy Support Groups. Both programs are self-referred with Agency (HBC) assistance from Parent Club Facilitators.

3. Homes for Black Children (HBC) is a licensed child placement Agency with the State of Michigan. HBC serves over 150 children a year through its Foster Care Contract with
DHS. Families who had an approved case plan of reunification were referred for services.

4. Homes for Black Children provides Family Preservation services to the Detroit community on a crisis basis. Referrals were made to the Project through the HBC Family Preservation program. The project accepted families from the community who met the DHS category 4 at risk factor.
III. Overview of the Program Model

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

Through this demonstrate project, Homes for Black Children had an overall goal to test the efficacy of the Family Group Decision Making model in promoting child safety, permanency, and well-being within 100 urban African American families in Wayne County Michigan. The main objective was to reduce the number of children who enter the foster care system, as well as to reduce placement recidivism.

Objective One: To engage 100 families in case planning through the use of the Family Group Decision Making Model

- Child Safety Assessment
- Domestic Violence Assessment
- Utilize Family/Agency Orientation Meeting to initiate partnership between Agency and conduct Family Needs Assessment
- Initial Family Group Decision Making (FGDM) with Private Family Time, special provisions for children six years and younger
- Generate “Family Resilience Plans” for 100 families
- Quarterly follow up meetings to initial FGDM to track progress towards family goals and to identify barriers

Objective Two: To provide evidenced based solution focused family counseling to 100 families

- Develop with 100 families a Strength Based Assessment
- Develop a strength based collaborative relationship between the Family and Therapist
• 10 Solution Focused family or individual counseling sessions to each family unit

**Objective Three: To provide a Parent Advocate/Mentor Services to 100 families**

• Provide Parent/Advocate Mentors (PAM) for 100 families to assist Family in fulfilling its Family Resiliency Plan

• Provide mentorship services to 100 families

• Supportive Home Visitation

• Crisis Management

**Objective Four: To involve 100 families in a continuum of services and support through the Family Well Being Cluster**

• Job Preparation and Work Readiness

• Alcohol and Drug Treatment

• Family Life Enrichment Activities

• Domestic Violence Treatment

• Child Care Services

• Parent Education

• Community Mental Health Referrals

**Proposed Outcomes:**

• Improved relationships between children and family members

• Involvement of fathers in planning and caring for their children

• Decline in the number of children who are placed in foster care

• Reduction in the number of children who re-enter foster care

• Incorporation of safety factors within the family unit

• Increased parenting skills and knowledge of child development
- Improved family ability to care for the needs of their children
- Families assume ownership of their family life and improve their decision making skills
- Families will spend quality time with their children
- Families will have reduction of stress
- Families will have improved social and family connections
- Families will become self sustained

B. Logic Model

Attachment A

C. Describe the project’s service model.

The project was managed by the Lead Evaluator, Family Resiliency Supervisor, Program Director, and Principle Investigator. During the implementation phase (first six months), staff met in weekly action step meetings to develop program procedures, protocols, brochures, community relationships, etc. Thereafter action step meetings occurred bi weekly. Extensive minutes were recorded at each staff meeting.

Objective One: To engage 100 families in case planning through the use of Family Group Decision Making:

Our Project required the implementation of a Family Resiliency Plan (FRP) created through the Family Group Decision Making Process based on the model researched and demonstrated by the American Humane Association’s Family Group Conferencing Model. In an effort to sustain the model after conclusion of the grant, the entire agency staff participated in a
week long intensive training with American Humane Society trainers. All training materials were archived by the project Learning Coordinator for future use.

The goal of the Family Resiliency Plan was to address any issues identified by the Department of Human Services, the Detroit Public Schools, or self-referred family members which placed a child at risk of out of home placement. Each Family Resiliency Plan was coordinated by a Family Resiliency Coordinator (FCR) who served no more than fifteen families at any one time. In addition to American Humane Association training, each FRP Coordinator was trained in Child Safety Risk Assessment, Domestic Violence Screening, Solution Focused Counseling Interventions, and Community Resources.

The Family Resiliency Coordinators were newly created positions that were completely focused on supporting the Family Resiliency Plan and did not have Foster Care Case Management responsibilities. FCR’s were selected from the community and identified as people who had demonstrated maturity, people skills and resiliency in overcoming their own life challenges. For the most part, they had little or no formal social work training.

The FRC’s coordinated all activities and services related to the Family Resiliency Plan, as well as planned and conducted each Family Group Decision Making Meeting. The FRP Coordinators were supported by a program supervisor. Supervision occurred weekly as well as monthly in-service trainings on various topics related to service delivery, e.g., family engagement, active listening, cognitive behavioral therapy, trauma informed assessments and treatment strategies, social work ethics, etc.

Once a referral was made, Homes for Black Children reviewed the referral information to assure compliance with the requirements of the Program. Prior to family contact, the FCR met with the referring agency to discuss their reasons for referral. Following the acceptance of the
referral, the Coordinator and Parent Advocate/Mentor scheduled a meeting in the family home or a family identified location to initiate contact and complete an initial assessment. If crisis services were required at that time, e.g., domestic violence services, housing, food, transportation, etc. the Parent Advocate and Family Resiliency Coordinator would seek to provide such services as quickly as possible.

At the initial home visit, the family was given a brief orientation to the agency, a description of program services, and an explanation of the intent of the program. The family was asked at this time to sign an informed consent to participate in the program.

Once trust was established with the family, the family was invited to the agency for a program orientation. The family orientation was designed to initiate an authentic partnership between the family and Program Services.

The preparation phase of the Family Decision Making Process was quite extensive. For the most part, families had to be convinced of its value. Participation was completely voluntary. Too often their concrete needs in an environment of limited resources delayed their acceptance of the FDGM, or made acceptance non-existent. Often time family members proved unavailable or unreliable due to the crisis nature of their own lives. The project had to adapt its expectations to the needs and timing of the families served.

During the FGDM preparation phase, families were asked to make recommendations to the Coordinator of who should attend the meeting. The Parent Advocate/Mentor was used to assist the family in thinking through the inclusion process. Because of the important role fathers play in the lives of their family and healthy child development, they were encouraged to attend, as well as their family members. Meetings were scheduled at times and dates to assure complete family participation.
Child Care was provided during the Family Group Decision Making Meeting. Children who were seven years or older were included in the process as deemed appropriate. If child participation was not recommended by the family, or in the case of young children, the child’s contribution to the meeting was obtained by the Family Resiliency Coordinator prior to the meeting in the form of letters, or pictures. Other identified extended family or friends were encouraged to attend.

Engaging the families in the process was often times difficult. It soon became evident that one of the major hurdles faced was the aggregate secrecy, and the extreme isolation secrecy created between participants, their families, and their community. A constant theme among participants was “I don’t want them in my business.” Many times family members were reluctant to participate because they were overwhelmed by their own circumstances.

However, for those who did agree to Family Group Decision Making, participants were encouraged to agree that in order to create trust, whatever is stated during the meeting must not be shared outside of the meeting.

The Family Meeting Agenda was adapted from the agenda developed by the NC Collaborative for Children, Youth, and Families, December 2006, Revised October, 2008:

1. Welcome
2. Introductions (Who we are and how are we connected to this family)
3. Family Opening (An opportunity for the family to start the meeting in a way that honors the family)
4. Review of Ground Rules for the Meeting
5. Confidentiality (Request that family and their natural supports keep what is said in the meeting private, professional’s are bound by law to do so)
6. Information Sharing (An opportunity to celebrate strengths and acknowledge concerns)

7. Coming together to make a plan (Brainstorming and working together to determine strategies that fit with what we are able to do at this time)

8. Plans for follow up to this meeting (When should we meet again? How much time do we need to see how this plan will work?)

9. Closing thank you and acknowledgements

   After the Plan was developed, the Parent Advocate/Mentor assisted in seeing that the services were implemented and that the family was engaged with the services. For the most part Family Group Decision Making Meetings were held in the family home or at the Agency office which has flexible hours, is centrally located, and easily accessed by public transportation. Some FDGM’s did take place in outside locations comfortable to the family. When necessary, Homes for Black Children assisted with bus fare or other forms of transportation.

**Objective Two: To provide evidenced based family counseling to 100 families:**

The Project proposed to offer Solution Focused Individual or Family Counseling to 100 Families. Solution-Focused Practice is an evidenced based strategy that offers a strength based perspective which provides effective and efficient collaborations that empower the individual, the family, and the worker. It was presumed that the practice would assist the Family in parenting effectively, even while under stress. The entire staff was trained on Solution Focused strategies by Susan Kelly of Casey Family Programs, author of “Building Solutions in Child Protective Services:” Insoo Kim Berg and Susan Kelly. Ms. Kelly conducted follow-up training and mentoring throughout the first year of the project. The Project employed 2 licensed family therapists (Family Coaches) trained in solution focused practice. The Family Coaches provided in home counseling and facilitated project support groups.
Many African American families resist traditional therapies because they view them as culturally insensitive. The strengths-perspective is a way of thinking about those with whom you work. It assumes that people are doing the best they can at the moment, not without pain and struggle, but with personal strengths in the form of fortitude and personal learning over time (Sleepy, 2007). The goal of the therapy was to identify solutions to the internal as well as external stressors a family may face, e.g., relationship, behavioral, depression etc.

**Objective Three: To provide Parent/Advocate Mentor Services to 100 families**

The Parent/Advocate Mentor assisted the family in achieving its Family Resiliency Plan. In 2004, Homes for Black Children was funded by the Skillman Foundation for three years to assist families of children who were in foster care to achieve their family goal of reunification. The Parent/Advocate Mentor’s were successful graduates from our school based Parent Education Clubs and parents who had been service recipients of Homes for Black Children’s foster care program and experienced successful reunifications.

These same 4 Parent/Advocate Mentors (PAM’s) were utilized in the Family Connections project to help families successfully access necessary services, e.g. housing, employment, medical services, etc. One PAM recently graduated with a BSW, the other three have completed their Associates degree, and one will graduate with a BSW next year. The Parent Advocate/Mentor served as a role model of what can be accomplished through the mastery of new skills and ideas.

Having overcome similar life challenges, Parent/Advocate Mentors were able to establish a level of trust that surpassed that of our most gifted practitioners. All Parent Advocate Mentors participated in all project training modules and have had crisis management training. The Parent Advocate Mentors (PAM) were on 24 hour call to the family for crisis management. The PAM’s
utilized supportive family home visitation throughout the duration of the service. During the first six weeks of family resiliency planning, the PAM’s visited weekly or as determined by the plan. Thereafter, supportive visitation occurred on an as needed basis as defined by the Family Resiliency Plan.

The Parent Advocate Mentor met with the Family Resiliency Coordinator weekly to discuss progress toward stated Plan goals. The Parent Advocate Mentors had weekly case supervision and monthly group supportive supervision with Olivia Reese, Project Consultant. (Ms. Reese developed and implemented the Skillman and Family Literacy Parent Advocate Programs).

The project had four trained part-time Parent Advocate/Mentors that were rotated between each Family Resiliency Coordinator. The Staffing ratio per family was 5 to 1.

**Objective Four: To involve 100 families in a continuum of services and support through the Family Well Being Cluster**

The Family Well Being Cluster served as a consortium of services to support the successful completion of each Family Resiliency Plan (FRP). The selection of Partner Agencies and services were chosen to remove external, as well as internal barriers, the family might experience in meeting their goal of family well being.

The Project held a kick-off meeting of all Family Well Being Cluster Partners to implement the Cluster. The Program Objectives were presented and all agreements were reviewed. Thereafter the committee as a whole met bi yearly to assure regular progress, identify barriers, and make modifications to assure family participation and success. Individual planning and follow-up meetings occurred regularly.
i. Describe if this was a new service model in your community or if this was an expansion of previous work done by your agency or state.

Currently, the State of Michigan, as well as all of its contractors, is mandated to use Family Team Decision Making at all points of change in child placement service agreements. When Family Team Decision Making was initially introduced to Michigan in 2003, Homes for Black Children was one of two private agencies which supported the Annie E. Casey Family to Family Service Model and was selected by the Department of Human Services to employ this new strategy. Currently Michigan does not have Prevention Services; therefore the project was used to fulfill this gap in family services.

The Michigan Department of Human Services utilizes Parent Advocates in its foster care service delivery. As previously stated, Parent Advocate/Mentors is a model that Homes for Black Children has utilized in its foster care program, as well as with family literacy programs. It has not been tested in Michigan in prevention services.

Life enrichment services are a core service to Homes for Black Children. The Family Well-being Cluster is a service newly created for the purposes of this grant.

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

The Project proposed that the Family Group Decision Making (FGDM) meeting would occur as an early intervention and establish the agenda for all other service delivery and reoccur at quarterly intervals. We severely underestimated the crisis nature of our population and the amount of preparation work necessary to achieve a FGDM. The demand for crisis intervention
was extraordinary. (It was hard to engage in an FGDM if your lights have been disconnected or your child was excluded from school because they did not have uniforms).

For many of the families, the economic devastation of their lives proved to be too great a burden for them, and they were unable to refocus their energies toward an FGDM. Indeed for many, the idea of involving other family members in their life was incredulous as many of their own family members found themselves in similar circumstances. After consultation with other Grantees, we changed the timing of the FGDM to occur at any time during the process.

Of the 222 families served during the life of the grant, only 34 families accepted a FGDM. There was also considerable resistance to one on one solution focused counseling. This module was redesigned into an engagement strategy utilizing supportive group, and group therapy intervention.

To meet the spirit of the FGDM process and Solution Focused Counseling, the project developed several fictive family groups to support the Family Resiliency Plan that most often was developed with the nuclear family, the Family Resiliency Coordinator, and the Parent Advocate/Mentor. These groups were coordinated by the Solution Focused Family Therapists (Family Coaches):

1. MOTHERS: (Mentoring Others to Help Empower Restore and Strengthen) met bi-weekly. This group was comprised of young women bereft of positive role models or relationships, paired with former Homes for Black Children foster mothers who have a track record of successful parenting.

   The older women nurtured and mentored the young women. (Many of the participants have estranged relationships with their birth mothers and other females, and live isolated from family and community support). The group provided these young women with the
opportunity to experience the impact of acceptance and wisdom on one’s own path
toward social maturity and responsibility.

2. Family Camp: The project sponsored 2 Family camps; an opportunity for families to
bond and engage in a wholesome family environment. (Many of the families had never
traveled outside city limits, attended a campfire, taken a boat ride, experienced a family
meal, etc.).

The camp was designed to decrease family isolation and increase interaction with other
families in an effort to begin the development of a fictive community, and to further
engage families in life enrichment activities. In addition to activities, parents were
invited to attend an interactive parenting education workshop. Transportation was
provided for all participants. The camp began on Friday, and ended on Sunday morning.
The Saturday night activity was a big hit with families preparing a presentation for the
annual family talent show.

3. Parent’s Club was established in the Hutchinson-Howe Detroit Public School. The Club
provided parental support and parent education.

4. Girl’s Etiquette Club was created at Detroit Nichols Public School. The purpose of the
group was to mentor 7th and 8th grade girls and help in the development of strength based
goals. This was seen as a prevention strategy to guard against dropping out of school.
Girls were able to receive classroom credit for participation.

5. Girls and Boys Summer Leadership Groups were established for youth ages six to sixteen
to develop leadership capacity and social skills.

6. Family Resiliency Circle was created as an agency parent support group for isolated
families.
7. Prom: A prom was sponsored for young women who missed the experience of their own prom because they did not complete high school. Most program participants dropped out of high school before the 11th grade and have missed necessary developmental milestones. The goal of this activity was to heal emotional gaps that create immature life choices.

C. Describe the project’s key interventions and activities

The Project proposed to use four core culturally competent strategies to engage and ensure family participation through the development of a Family Resiliency Plan to ensure child safety and improve quality of life within the family home:

- Family Group Decision Making
- Solution Focused Counseling
- Parent Advocate/Mentors
- Family Well Being Cluster

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

Input/Totals: Before Data System (manual)
09/30/11 to 09/29/13

<table>
<thead>
<tr>
<th></th>
<th>#’s</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>FGDM’s</td>
<td>70</td>
<td>21</td>
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<tr>
<td>Standard of Care</td>
<td>113</td>
<td>96</td>
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<tr>
<td>Parent Advocate/Mentors</td>
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<td>Family Well Being Cluster</td>
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<tr>
<td>Service Category:</td>
<td># of Times</td>
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<tr>
<td>------------------------------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Case Conference (CPS)</td>
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<td></td>
</tr>
<tr>
<td>Case Conference (HBC Staff)</td>
<td>600</td>
<td></td>
</tr>
<tr>
<td>Closing Summary</td>
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<td></td>
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<tr>
<td>Home Visit</td>
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<td>Life Coach/Counseling</td>
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<td>Life Enrichment Activities</td>
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<tr>
<td>Mentoring Session</td>
<td>601</td>
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<tr>
<td>Mothers' Group</td>
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<tr>
<td>Outreach (program introduction)</td>
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<tr>
<td>Outreach to Fathers</td>
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<tr>
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<tr>
<td>Progress Notes</td>
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<td>Referral: Food Bank Assistance</td>
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<td>Referral: Furniture Assistance</td>
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<tr>
<td>Referral: Holiday Assistance</td>
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<td>Referral: Housing Assistance</td>
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<td>Referral: Mental Health Assistance</td>
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<td>Referral: Utilities Assistance</td>
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<td>SOC: Coordinator Contact</td>
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<td>SOC: Education Assistance (GED, etc.)</td>
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<td>SOC: Life Coach/Counseling</td>
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<td>FGDM: Developing Leads for Relatives and Others</td>
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<td>FGDM: Locating Relatives and Others</td>
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<tr>
<td>FGDM: Pre-Meeting Preparation</td>
<td>57</td>
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</tr>
</tbody>
</table>
ii. Note which interventions and activities were: a) evidence based practices or b) best/promising practices. Indicate which interventions and activities are culturally based.

Family Group Decision Making, Solution Focused Counseling, Parent Advocate/Mentoring Models, Wrap Around Services (Family Well-Being Cluster) are evidence based practices as well as best practices. All four have demonstrated success as culturally competent services.

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

The largest modification was the creation of fictive families and community through the development of groups to compensate for the devastating effect of poverty in an urban and oftentimes isolating environment. The Family Group Decision Making model as well as the Solution Focused Counseling model was changed to accommodate these challenges.
The grant initially funded four Family Resiliency Coordinators. Based on the needs of the community, one position was changed to a Parenting Specialist whose focus was to provide individualized parenting strategies to program participants.
IV. Collaboration

A. Describe key partners critical to providing a) referrals, b) program services, c) evaluation services, and d) other services that have a collaboration mechanism such as a contract or MOU.

The role of each partner was as follows:

- **The Department of Human Services (DHS)** (1) referred families for Prevention services who met Category IV requirements on the Protective Service Risk Assessment. (2) Participated in the Advisory Committee which made program recommendations, and contributed strategies, and resources that helped families succeed in the completion of their Family Resiliency Plan, (3) made family assistance services assessable to families in the project, (4) attended all federal Grantees meetings in Washington, DC, and (5) will participate in statewide dissemination of project results which can affect Department policy as it relates to Family Preservation Programs.

- **The Detroit Public Schools (DPS)**, (1) created space within their existing Family Resource Centers for Parent Education Clubs, Family Literacy Support Groups, and Family Group Decision Making Meetings. (2) worked with the HBC Family Resiliency Coordinator and Parent Advocate/Mentor to access school services, e.g. tutorial, special education, transportation, etc. (3) disseminated project brochures and information to the parent body and (4) provided access to the Bert Shurly family camp site.

- **Homes for Black Children** (1) coordinated and implemented all project activities. (2) trained and managed all project Staff. (3) provided parent education/support clubs to all program participants. The Parent Education Club curriculum focused on child development, managing parental expectations, physical, emotional, intellectual, and
social needs of a child, and behavior management. The 12 session curriculum subjects were: Child Protection and the Law, The Parent’s Self Esteem, The Child’s Self Esteem, Discipline, Substance Abuse, Domestic Violence, Unhealthy Relationships and Anger Management, Healthy Relationship, Nutrition, Employment, Money Management, and Housing and Maintenance. The parenting groups were called Clubs because they were supportive in nature and utilized an interactive approach which helped the family to expand its capacity for nurturing and attachment. This evidenced based Parent Education curriculum designed by The Skillman Foundation was modified to assure cultural competency and to meet the needs of project families. The Club utilized a pre and post test to determine family progress, as well as a satisfaction survey to determine what modifications to the strategy were required. A graduation celebration was held at the successful completion of each 12 week session. (3) bi-monthly Life Enrichment Services were used to reduce family isolation, and forge social connections. Activities were selected which encouraged parents to make choices, take leadership, and learn new skills, while being exposed to new and different experiences. These structured parental activities increased the amount of quality time parents spent with their children. The skills and knowledge they learned in the Parent Education Clubs could be transferred and applied while participating in these activities. The Life Enrichment Activities also helped Family members to interact with one another in a positive and trusting environment. Examples of family activities were: Cultural Center Crawl, Thanksgiving Day Parade, Harvest Festival at Eastern Market, Kite Flying, Fishing, Family Camp, Family Game Night, Back to School Activity, etc. (4) provided child care during Family Group Decision Making meetings as needed (5) provided bus tickets, staff mileage reimbursement or
agency transportation as needed for maximum program participation, and (6) made referrals to community mental health services as needed.

- **TJ Adams Staffing** was to (1) assist participants in learning and utilizing job skills, assist with resume preparation, and career training, (2) provide career and educational services related to employment training, job placement, job fairs, employment workshops, and career assessment activities, (3) utilize its contacts with various organizations in the City of Detroit to help participants gain access to employment opportunities. However due to their enrollment requirements (a group of five and a 10 week curriculum) the agreement was modified. TJ Adams Staffing trained project staff to deliver employment services on an individual basis, and served as consultants to the job placement, job fairs, and employment workshop process.

- **The National Council on Alcoholism and Drug Dependence, Greater Detroit Area**, provided substance use disorder treatment, prevention education and addiction services to program participants.

- **R and R Domestic Services, Inc.** offered Domestic Violence Assessment training to Homes for Black Children Staff.

- **“Get Back Up”** offered Domestic Violence Counseling and Shelter Services to Program Participants

- **The Michigan Federation of Private Child and Family Agencies** disseminated information to its constituents and will disseminate Best Practice and Program results to its member agencies.
- **Benevolent** a community foundation which enables striving individuals to seek financial resources to take advantage of an opportunity that will lead them toward sustainability made specific financial awards to project participants.

- **TEAM Mental Health**, accepted referrals for adult community mental health services.

- **Children’s Center of Detroit** accepted referrals for child assessments and psychological services.

- **Susan Kelly, Casey Family Programs** trained Homes for Black Children’s Staff and Therapists in the Solution Focused Practice Model, and served as a mentor/consultant throughout the program.

- **Guy Thompson, Director of Family Preservation Services, Michigan Department of Human Services** trained staff on crisis management and family engagement. Mr. Thompson served as a project consultant.

- **Olivia Reese, MSW, Program Consultant, Homes for Black Children** served as Program Consultant to the development and implementation of Core Strategy 3: To provide Parent/Advocate Mentor Services to 100 families. Ms. Reese was the architect of Parent Mentor Services in the Skillman Funded Program as well as the Family Literacy Program.

- **Larry M. Gant, PhD, Evaluator, Professor University of Michigan, School of Social Work** served as Program Evaluator. Dr. Gant has had more than twenty-five years of Program Evaluation experience. His clinical practice and research has focused in predominantly African American, urban, community based setting. He uses a combination of contextual analysis, capacity development, qualitative and quantitative analysis within an empowerment evaluation perspective.
The three community agencies: The Department of Human Services (DHS), the Detroit Public Schools (DPS), and Homes for Black Children (HBC), worked collaboratively to share referrals and resources.

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

Homes for Black Children is a licensed child placing agency of the State of Michigan’s Department of Human Services. DHS has purchase of service contracts with Homes for Black Children in Adoption and Foster Care.

Homes for Black Children has previous relationships with Olivia Reese, the Detroit Public Schools and the Michigan Federation of Child and Family Agencies. All other relationships were developed for the purpose of grant activities.

The agreement with TJ Adams Staffing was modified based on their group enrollment requirements (5 participants over 10 weeks). They provided in service training and consultation to the Family Resiliency Coordinators and Supervisor on job preparation, training, and searches. A computer lab and resource room was established in the agency to assist with job searches and resume preparation.

C. Grantee may include, at their discretion, organizations they work with as a matter of daily operations but where a formal arrangement does not exist or is needed.
• **Young Detroit Builders**, a builders training workshop for youth ages 16 to 23; helped families with necessary household renovations and improvements.

• **Cass Community Organization**, provided housing for the homeless, shelters, and transitional housing. It works across the City in areas of concentrated poverty providing programs for food, health and jobs.

• **Southwest Solutions** provided housing opportunities for program participants.

• **Second Ebenezer Church** provided holiday parties, school supplies, and adopted families at Christmas.

• **Rick Talley, Anthropologist**, presented historical and cultural workshops on the African Diaspora.

• **Victorious Women and Princess Bathsheba**, community service groups provided holiday gifts for program participants

• **Blue Cross Blue Shield** provided health workshops and financial support to program participants

• **Friends of Homes for Black Children**, funded the Family Camp and other Life Enrichment Activities

D. Describe any advisory groups or steering committees associated with the project, including group or community participants. Indicate if this was an existing group repurposed to advise Family Connection-funded activities or a new group formed to provide input into the project.
The Family Well-Being Cluster served as the steering committee to the Project. The steering committee was convened bi-yearly to review overall progress toward stated goals, review barriers, and make program adjustments. This was a newly created group.

Partners of the Well-Being Cluster were also encouraged to attend bi-weekly action step meetings. Action-step meetings were brainstorming sessions to challenge any barriers toward stated goals, and adjust strategies to meet the needs of families served. Action step meetings also bonded staff and partners to successful outcomes, and created partnerships based on transparency.

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

All members readily shared their expertise and experience in program development and implementation. There was great enthusiasm within a community with limited resources.

Sustainability planning began at onset. Membership and Participation in the Family Well-being Cluster was based on mutual interest outcomes, i.e., how the program could help a specific interest or commitment that a partner might happen. Therefore the sustainability plan was developed out of self interests. For example, Wayne County Department of Human Services would like to see Prevention Services in Wayne County, Casey Family Programs is interested in strategies which address issues of over-representation of minority children in child welfare systems, and Detroit Public Schools faced with declining resources welcomed family support services within their schools.

The three primary partners: Homes for Black Children, The Department of Social Services, and the Detroit Public Schools, as well as Casey Family Programs particularly appreciated the importance of the evaluation findings in attempting to leverage future funding. The bi-weekly
meetings and minutes created accountability and transparency which created a very strong partnership among members.
V. Sustainability

The Michigan Department of Human Services has eliminated all prevention services, yet the average cost to keep a child in foster care is $30,000 per year according to the political activist group Spark Action: For Children. For Youth. For Change. The cost of the Family Connection project averaged $10.50 per hour; each family averaging 35 hours of service. The social cost of long term out of home placement to society is immeasurable. “Honoring Emancipated Youth” gives the following Statistics:

- On any given day more than 500,000 youth are in some form of foster care cross the United States
- Nationally, each year an estimated 20,000 of these youth “age out” of the foster care system, and are discharged from the system, whether or not they are prepared to transition to adulthood.
- Within 18 months of emancipation 40-50% of foster youth are homeless
- A history of foster care correlates with becoming homeless at an earlier age and remaining homeless for a longer period of time
- 70% of teens from foster care report that they want to attend college, but less than 50% complete their high school graduation and fewer than 10% who graduate from high school enroll in college, and of those less than 1% graduate from college
- 50% of emancipated foster youth experience high rates of unemployment within 5 years of emancipation
- Forty-two percent of foster youth including 60% of women become parents within 2.5-4 years after exiting care.
• Parents with a history of foster care are almost twice as likely to see their own children placed in foster care or become homeless than parents without this history

• Former foster youth are found to suffer from post-traumatic stress disorder at 2 times the level of U.S. war veterans

• 50-60% of the children in foster care have moderate to severe mental health problems

• 33% of all foster care alumni have no health insurance

There is a considerable crossover between youth in foster care and youth in the juvenile dependency court in fact foster youth with multiple placements are 5-10 times more likely to become involved with the juvenile justice system than youth in the general population.

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

• Family Group Decision Making: The Agency is in the process of creating a second foster care unit that will focus on utilizing Family Group Decision Making in Family Reunification. Eugene Wilson who was the project supervisor will be retained as the Foster Care Supervisor. Referrals for the program will be obtained from the Michigan Department of Human Services under our current contract. The Agency has retained the services of one of the Family Resiliency Coordinators to implement Family Group Decision Making Meetings with reunified families. This unit will be funded through Homes for Black children’s foster care contract with the Department of Human Services.
• The findings of the project will be used to request prevention service funding from the Michigan Department of Social Services.

• Solution Focused Counseling: The entire staff has been trained and mentored on solution focused counseling strategies. The services of the two part-time therapists will be retained to continue the work in our Family Preservation Counseling Unit and outreach to the Detroit Public Schools. This work will be supported through United Way funds.

• Family Well Being Cluster has created a community of collaborative/supportive relationships that will continue to assist Agency programs and collaborative interests. A resource guide is in the process of being created for all Agency service recipients.

• Parent Mentoring/Advocacy model will remain within the agency through the use of volunteers. Volunteers will undergo formal training focused on agency values of respect, independence, and confidentiality. Olivia Reese, Homes for Black Children Consultant will coordinate this effort. The role of the Parent/Advocate Mentor is significant to client success having contributed to family needs for concrete service referrals and support, e.g., food, clothing, utilities, etc.

• The MOTHERS group has become incorporated as a 501c3 and will operate independently. They recently had their first fund raiser.

• The Parent Clubs: The Detroit Public Schools have requested that the Parent Club associated with the Hutchinson-Howe School remain in tact. The interest in the Club is so significant that members were prepared to meet independent of
the school should that have been necessary. The School will allocate materials, and space. Homes for Black Children will designate staff to facilitate the Club funded by United Way.

- Girls Etiquette Group: Agency United Way funding will continue the boys and girls groups, as well as the Nichols school based etiquette group.
- Family Camp will be sponsored by Friends of Homes for Black Children
- Life Enrichment Activities will be sponsored through community donations. e.g., General Motors, Blue Cross Blue Shield, Big Families of Michigan, etc.
- Data Base created for the project will be adapted to other program service areas which will help with cost studies so necessary in attracting future resources to the agency.
- Resource/ Community Information and Computer Room will remain as a parent and family resource for all agency service participants. Volunteers and Student Interns will update materials and support participants.
- Coordinator of Learning Resources: All training was mandated for all social work staff. The Coordinator of Learning Resources has archived all training materials for future agency reference and learning.

B. Describe key products (e.g., training manuals, resource guides for participants, etc.) that were developed as part of the project or for replication purposes.

Attachment B: An implementation manual was developed entitled “Project at a Glance.”

Contents are as follows:

- Project Abstract
- Leadership Team
- Evaluation Team
- Family Resiliency Coordinators
- Parent Advocate Mentors
- Family Life Coaches
- Parenting Coach
- Parent Club Facilitators
- Coordinator of Learning Resources
- Project Support Team
- Partners

Attachment C: A brochure was developed which explains project service

Attachment D: Promotional materials were developed to facilitate referrals and encourage family participation.

Attachment E: The Project also published bi-yearly newsletters aimed at engaging staff, leadership, and partners. A Resource manual for Program Participants is in the process of being developed.

Attachment F: Partner News a semi-annual report to community partners and stakeholders updating project progress to date.

Attachment G: Work Engagement Flow Chart

Attachment H: Sample Action Steps Minutes and Agenda

Attachment I: Poster Board Summary of the Project
VI. Evaluation

Outcome Evaluation Questions
We framed our questions in terms of twelve (12) proposed study outcomes and aligned these outcomes with data collection, specific measures, and time intervals between Time 1 and Time 2 collection periods:

<table>
<thead>
<tr>
<th>Proposed Outcomes</th>
<th>Data Collection/Measures/Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improved relationships between children and family members</td>
<td>Parenting Stress Index-Short Form Time 1/Time 2 (12 months)</td>
</tr>
<tr>
<td>2. Involvement of fathers in planning and caring for their children</td>
<td>Parenting Stress Index-Short Form Time1/Time 2 (12 months) [sub analysis of male parents]</td>
</tr>
<tr>
<td>3. Decline in the number of children who are placed in foster care</td>
<td>DHS generated quarterly count of children involved in 100 families who are placed in foster care (Roger Christ Data Pull)</td>
</tr>
<tr>
<td>4. Reduction in the number of children who re-enter foster care</td>
<td>DHS generated count of children involved in 100 families who were in foster care but do not re-enter within 12 months (Roger Christ Data Pull)</td>
</tr>
<tr>
<td>5. Incorporation of safety factors within the family unit</td>
<td>Protective Factors Survey</td>
</tr>
<tr>
<td>6. Increased Parenting Skills and knowledge of Child Development</td>
<td>Protective Factors Survey</td>
</tr>
<tr>
<td>7. Improved family ability to care for the needs of their children</td>
<td>Protective Factors Survey Time1/Time 2 (12 months)</td>
</tr>
<tr>
<td>8. Families assume ownership of their family life and improve their decision making skills</td>
<td>Protective Factors Survey Time1/Time 2 (12 months)</td>
</tr>
<tr>
<td>9. Families will spend quality time with their children</td>
<td>Family Needs Scale</td>
</tr>
</tbody>
</table>
10. Families will have reduction of stress | Parenting Stress Index-Short Form – Time1/Time 2 (12 months)

11. Families will have improved social and family connections | Family Needs Scale

12. Families will become self sustained | Family Needs Scale

i. Describe the evaluation research design (e.g., experimental / random assignment, quasi-experimental / comparison study, pre-post, longitudinal / historical analysis, etc.).

A program decision was made to provide the FGDM program to 100 families referred to the Family Connections Program. **Two conditions were created:** The treatment condition consisted of families who completed the FGDM specific intervention (N= 18 Families), and the standard of care condition consisted of families who did not participate in any of the FGDM components (N=294 Families). The design incorporated a pre-post study design for all participating families, with Pretest data to be collected from as many families as possible between February-March 2014 (Time 1 Pretest) and August-September 2014 (Time 2 Posttest). We collected Pretest data from 37 families and Posttest data from 37 families.

Our first statistical analyses used t-tests for unmatched groups with unequal cell sizes. We determined statistically significant differences in pre and post test response and reported these findings in the May 2014 semi-annual report. Our next data collection (post-test) took place in August –September 2014. Some of the surveys contained missing data due either to interviewer error or respondent decision not to respond to specific questions. We used advanced data imputation techniques to provide statistical responses to missing data - in about 30% of the questionnaires. We used this approach to optimize the data collected with very difficult populations in very challenging circumstances. Under this set of analyses we found significant differences in pre-post test outcomes that favored the FGDM group, and reported the findings in the October 2014 annual report.

However, in November 2014 we reviewed our analysis, concerned that the data imputation strategies – while empirically reasonable – would be increasingly challenged by other researchers. Further analysis and consultation suggested a more conservative analysis of data, using non-parametric distribution-free statistical tests for individuals matched by each respondent’s pretests and posttests. Further, we deemed responses for all measures with less than 75% of items answered inadequate for further analysis; we thus eliminated our data imputation strategy. When we re-ran the more conservative analysis, the statically significant differences between the FGDM and non-FGDM groups disappeared, although the non-significant trend was preserved.

We faced an evaluation dilemma – to go forward and proclaim statistically significant differences between FGDM and standard of care groups using statistical techniques that were
empirically defensible but programmatically and analytically problematic, or to use a more defensible, more conservative approach that would exclude surveys with missing data greater than 10% but less than 30% of the entire survey. The evaluation team leader, Dr. Gant, made the final decision to use and report the conservative, more defensible analytic approach. The differences are not statistically significant, but the trends are clearly there.

Given the lack of statistical significance between the FDGM and standard of care groups, we opted to combine both groups to determine at least whether there were significant pre-post differences among the families. We report the findings and trends in Outcome Evaluation and Results: Safety and Well-Being: Review of Survey Measures for the Study.

ii. Describe evaluation participants. Evaluation participants may be a service recipient or person otherwise involved in the program (e.g., program staff). Evaluation participants may also include a comparison group.

Table 1 summarizes the adult level similarities and distinctions between households completing the FGDM process and those not involved in the FGDM process. Both groups were nearly completely mid-thirties, single African American women, half of whom reported High School as their highest education level. The two groups are comparable in that they are both relatively young adults in their thirties, African-American single women. About half of the adults report high school as their highest educational level. Both groups report a household income of less than $10,000 annually, despite nearly three times as many adults in the FGDM households reporting employment as those in the standard of care. Both groups report a 20% history of domestic violence and about 5% homelessness. Interestingly, the FGDM households report a significantly greater percentage of history of substance abuse and involvement with the legal system than the standard of care households. There were more single parent households in FGDM than households in the standard of care condition. The FGDM households appear to have a somewhat more challenging history and configuration than the standard of care households.

| Table 1: Adult Level Demographics – FGDM and Standard of Care Households |
|---------------------------------|---------------------------------|---------------------------------|
| | FGDM Households (n=18 Households) | Non-FGDM (Standard of Care) Households (N= 268, N=141 reported data) |
| Average Age | 35.5 Years | 32.5 Years |
| Gender | 76% Female | 74% Female |
The demographics of children served in the program are consistent with the demographics of the two groups. Children in both groups were between 7-8 years of age, about half of them were female, nearly all were African-American, all were identified as dependents of parents/guardians, and nearly all of them were placed at home prior to receiving services from HBC (at intake). However, children in the FGDM households were more likely to have previous involvement with the child welfare system and reports somewhat more developmental, physical or mental health challenges than their non-FGDM counterparts. **Children in the FGDM households appear to have a somewhat more challenging history and configuration than children in the standard of care households.**

**Table 2: Child Level Demographics – FGDM and Standard of Care Households**

<table>
<thead>
<tr>
<th></th>
<th>FGDM Households (n=18 Households, 44 children)</th>
<th>Non-FGDM (Standard of Care) Households (N= 268 households, 279 children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>7.6 Years</td>
<td>7.9 Years</td>
</tr>
<tr>
<td>Gender</td>
<td>48% Female</td>
<td>53% Female</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>100% African American</td>
<td>98% African American</td>
</tr>
<tr>
<td>Home placement prior to receiving services at intake</td>
<td>98% placed at home</td>
<td>100% placed at home</td>
</tr>
<tr>
<td>Dependent</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Previous involvement with child welfare system</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>Developmental, physical or</td>
<td>11%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Agency staff took lead responsibility in administering surveys and worked extremely hard to collect the materials within the context of providing a challenging program to highly vulnerable, suspicious families with great need but tough experiences with state agencies. Incentives were used to increased response rate to some benefit; it was determined that data would be better collected during agency organized events held at the project venue. Fidelity interviews were conducted by the evaluation team. Programmatic information was collected by the evaluation team via a special database designed to collect and track program participation information over time for families, children and heads of households. Additional DHS information was provided tracking the number of HBC served families who appeared in DHS systems after participation in the Family Connections program. This important administrative information was provided during August 2014, and serves as unambiguous outcome/impact data for the project.

iii. Document any major changes made to the evaluation plan in regard to evaluation questions, evaluation design, data collection procedures, IRB or other approvals, etc. Grantees may include supporting documentation in an appendix.

We revised fidelity procedures to better align with the expectations of the evaluation consultation team at JBA, and discuss these revisions in the study fidelity section. There were no major changes to the evaluation questions, data collection procedures or IRB (exempted) approvals.

iv. Describe any training that was conducted with program staff and partners to help them understand the role of the evaluation in program work. Describe successful methods to engage program staff with the evaluation.

We were engaged in extensive debriefs with the agency staff and administration in the deployment of the program interventions. We worked with the staff and administration to clarify and explain intervention and standard of care service conditions for the project. We provided several substantial discussions with program staff in developing the database for data collection and activity recording. We worked with the staff in developing direct and indirect service categories for database. We provided extensive formal and informal training to staff on database entry of service activities. We provided an overview of cost benefit methods to the staff. We conducted several trainings using the data collection protocols, and were pleased with the program staff’s efforts in training to use the protocols. Staff kept excellent documentation of all meetings and program relevant discussions and decisions. We were fortunate in that agency administration helped staff understand the importance of the program; the evaluation team had several discussions with staff to help them understand the importance of the evaluation activities. We were invited to attend all regular and special meetings of the program staff, thus maintaining a weekly presence at the agency and the program. Through these efforts, staff were able to understand and integrate the importance of program services, database entry of effort (indirect and direct services), and collection of pre- and post-test evaluation instruments.

**Outcome Evaluation Results**
1. **Permanency and Stability/Permanency and Continuity:**

We begin with what we believe to be the most impressive major finding of the FGDM Family Connection Program. The data were provided directly from administrative data provided to HBC from State of Michigan (Wayne County) Department of Human Services (submitted by Mr. Roger Christ). A total of 293 families with an initial Child Protection Service (CPS) contact were referred to HBC’s FGDM program between April 2012 - September 2014. In October 2014, these same families were referred back to DHS for screening. A successful family services referral outcome - in accordance with DHS guidelines - occurs when a family who has had CPS contact is referred out for services and that family DOES NOT have later a CPS Referral Substantiation. The cumulative results for families served by HBC’s program are as powerful as they are simply stated:

- Cumulative total of FRP families referred to DHS for screening (as of 10/31/14): 293
- Cumulative total of FRP families with a Substantiation: 26 (8.8% of total)
  - a. Those who had program contact and/or services: 10 (3.4% of total)
  - b. Those who had no contact/services: 8 (2.7% of total)
  - c. Those with undeterminable contact: 8 (2.7% of total)

Almost 92% of participating families did not have a CPS Referral Substantiation at the end of the program. Less than 10% of all participating families had any Referral Substantiation. Of these families receiving a Referral Substantiation, only 10 families (less than 4% of the total) had FGDM program contact and/or services. Eight families had no contact or services, and the other eight families contacts could not be determined due to DHS staff departure and closure of cases.

**We were able to reasonably determine that of the ten HBC served families who had a CPS Referral Substantiation, none appeared to be families in the FGDM condition.**

2. **Safety and Well-Being: Review of Survey Measures for the Study.**

Parent Stress Index (PSI) Cumulative Findings for December 2014 Final Report:

We report the results of PSI for the 8 families that completed both the pre-test PSI and post-test PSI. We report the results within a diagnostic/assessment format. Demographic analysis of both pre and posttest families reveals no significant differences in number of children, head of household, or education/income backgrounds. For each sub-scale (unless otherwise noted), a score which falls between the 15th and 80th percentile is considered typical. High scores are those at or above the 85th percentile.

**Defensive Responding.** Parents who score high on this scale may be trying to minimize any problems, stress, or negativity in their relationship with their child. However, a high score on this scale alone cannot determine to what extent the parent is trying to respond in an untrue, yet favorable way. It needs to be thought of as one piece of information you have which brings you to the conclusion. A score on this scale of 10 or less indicates responding in a defensive manner and indicates that caution should be used in interpreting any of the subscale or total stress scores.
Low scores on this scale indicate high levels of defensive responding.

“PD” Parental Distress. This scale examines to what extent the parent is experiencing stress in his/her role as a parent. It measures sense of parenting competence, stresses associated with restrictions on his/her life, conflict with child’s other parent, social support and depression. When this score is at or above the 90th percentile in combination with a DC score below the 75th percentile, the parent could benefit from activities and education aimed at raising self esteem and/or sense of parental competency. Connecting the parent to a social support or parent-child play group may be another strategy for those who score above the 90th percentile on this subscale.

“P-CDI” Parent-Child Dysfunctional Interaction. This subscale assesses the extent to which the parent believes that his/her child does not meet their expectations and their interactions are not satisfying. High scores in this sub-scale can indicate that the parent sees the child as a disappointment, feels rejected or alienated by/from the child, or has not properly bonded with the child. These feelings can result in a lack of warmth or initiating interactions with the child by the parent. When this score is at or above the 85th percentile, the parent should be given age-appropriate activities (with the home visitor modeling the interaction when appropriate) to do with their child. They should be given information to enhance their confidence and competence in their ability to interact with their child. Every opportunity should be provided so that the parent can feel positive and good about playing/interacting. Positive feedback should be given.

“DC” Difficult Child. This sub-scale tells us how easy or difficult the parent perceives his/her child. If the child is less than 18 months old and the parent scores at or above the 90th percentile, this could indicate that the child is having problems with self-regulatory processes. In these cases, the home visitor can suggest visiting the child’s pediatrician to rule out an allergy or colic. When the child is 2 years old or older and the parent scores at or above the 90th percentile, this could indicate that the parent is having a hard time gaining the child’s cooperation and/or managing the child’s behavior. In this situation, parents will usually benefit greatly from strategies to handle challenging behavior; age appropriate discipline.

Total Stress. This is the measure of the stresses the parent is experiencing in his/her role as a parent. It does not include all life stress, just the stress they may be feeling when they are parenting. When this score is at or above the 90th percentile the parent may benefit from a referral to a social worker or mental health professional who can address parental distress.

Wilcoxon Signed Rank tests were conducted of mean score differences from pre to post surveys for each of the PSI subscales at P<0.05, 2 tailed type tests. For those that calculated a critical value of W, the results were not significant at p ≤ 0.05.

Overall for the pretest, families generally reported needing the 41 items less than “sometimes.” The same pattern was noted for the post-test, families. For both the pretest and posttest, the item that were reported the most as “almost always” needing help, relative to the other item, were:

1. Having medical and dental care for my family (42%)
2. Getting where I need to go. (33%)

The greatest decrease in need, from pretest to posttest, were items that were needed “sometimes” prior to FGDM, and needed only “seldom” post FGDM:

1. Having someone to talk to.
2. Having emergency health care.

Top mean responses were more than “sometimes” needs for the following items:

1. expanding my education, skills and interests
2. Doing things that I enjoy.
3. doing things with my family
4. exploring future educational options for my child
5. participate in parent groups or clubs

Overall for the pretest, families scored quite high on the PFS subscales of Child Development/Knowledge of Parenting and Nurturing and Attachment (5.7 and 6.2 out of 7, respectively. Families scored somewhat lower for reports of Concrete Support (4.9), Social Support (5.3) and Functioning/Resiliency (5.1). For the posttest, mean scores on family reports were significantly higher for all subscales than in pretest. The most encouraging differences were noted in Concrete Support (6.0), Social Support (6.2), and Family Functioning and Resiliency (6.3).
Wilcoxon Signed Rank tests for significance of differences were conducted for the PFS at \( P<0.05 \), 2 tailed type tests. Result: Based on the W-value, and the critical value of W for this sample size at \( p \leq 0.05 \), the result is not significant at \( p \leq 0.05 \).

Charts and brief results of the mean responses and frequency of responses for all 3 sets of pre/post surveys (PFS, PSI and FNS) are included in the previous respective survey sections. Wilcoxon Signed Rank tests were conducted for the PSI and PFS. While the analysis of matched pairs of all pre/post did not yield statistically significant differences, the trends toward positive change are nonetheless encouraging and need to placed with the contexts of profound structural inequities (e.g. profound unemployment, poverty, and diminished educational attainment) (Table 3). That FGDM made even a small trend-wise difference between FGDM and
non-FGDM families is not impressive given the brevity of the intervention and the profundity of the presenting problems and issues.

Table 3: Outcomes, Data Collection, Results/Explanations Table

<table>
<thead>
<tr>
<th>Proposed Outcomes</th>
<th>Data Collection/Measures/ Time Frames</th>
<th>Results/Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improved relationships between children and family members</td>
<td>Parenting Stress Index-Short Form Time 1/Time 2 (6 months)</td>
<td>No Significant changes; family problems may reflect structural factors beyond ability of program to impact within short term</td>
</tr>
<tr>
<td>2. Involvement of fathers in planning and caring for their children</td>
<td>Parenting Stress Index-Short Form Time 1/Time 2 (12 months) [sub analysis of male parents]</td>
<td>Insufficient number of fathers for comparison and analysis</td>
</tr>
<tr>
<td>3. Decline in the number of children who are placed in foster care</td>
<td>DHS generated quarterly count of children involved in 100 families who are placed in foster care (Roger Christ Data Pull)</td>
<td>Significant reductions for FGDM families (zero)</td>
</tr>
<tr>
<td>4. Reduction in the number of children who re-enter foster care</td>
<td>DHS generated count of children involved in 100 families who were in foster care but do not re-enter within 12 months (Roger Christ Data Pull)</td>
<td>Significant reductions for FGDM families (zero)</td>
</tr>
<tr>
<td>5. Incorporation of safety factors within the family unit</td>
<td>Protective Factors Survey</td>
<td>Nonsignificant differences but trends in positive direction for FDGM families. Issues may take longer to address than expected; Involvement in FDGM may itself may exacerbate family</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>6. Increased Parenting Skills and knowledge of Child Development</strong></td>
<td>Protective Factors Survey</td>
<td><strong>Nonsignificant differences but trends in positive direction for FDGM families.</strong> Issues may take longer to address than expected; Involvement in FDGM may itself may exacerbate family safety issues</td>
</tr>
<tr>
<td><strong>7. Improved family ability to care for the needs of their children</strong></td>
<td>Protective Factors Survey Time1/Time 2 (12 months)</td>
<td><strong>Nonsignificant differences but trends in positive direction for FDGM families.</strong> Issues may take longer to address than expected; Involvement in FDGM may itself may exacerbate family safety issues</td>
</tr>
<tr>
<td><strong>8. Families assume ownership of their family life and improve their decision making skills</strong></td>
<td>Protective Factors Survey Time1/Time 2 (12 months)</td>
<td><strong>Nonsignificant differences but trends in positive direction for FDGM families.</strong> Issues may take longer to address than expected; Involvement in FDGM may itself may exacerbate family safety issues</td>
</tr>
<tr>
<td><strong>9. Families will spend quality time with their children</strong></td>
<td>Family Needs Scale</td>
<td>Trends toward wanting more information, training and services on parenting and work with children</td>
</tr>
<tr>
<td><strong>10. Families will have reduction of stress</strong></td>
<td>Parenting Stress Index-Short Form – Time1/Time 2 (12 months)</td>
<td><strong>Nonsignificant differences but trends in positive direction for families,</strong> Less defensive responses, reduction in Difficult Child, Increases in Parent Distress and Parent Child Dysfunctional</td>
</tr>
</tbody>
</table>
### Interaction.

| 11. Families will have improved social and family connections | Family Needs Scale | Less reports of needing someone to talk to, but more reports for needed social and familial interaction |
| 12. Families will become self sustained | Family Needs Scale | Trends toward sustainability but structural challenges are factors, e.g. medical care and transportation. |

#### 5. Cost Studies: Our cost study of the FGDM program was guided by these fundamental queries:

- What is the per hour cost of the program?
- What is the per hour program cost per family served?
- What is the per hour program cost per child served?
- What is the per hour program cost per family served?

The key direct services included in the cost study included: FGDM meeting with family (4 hours/family), follow-up/home visits (10 hours/family), staff (e.g. Solution Focused Therapists, Family Resilience Plan Supervisor and Coordinators, parent advocate/mentors). Cost tracking methods included reviews of total annual allocated cost and total cost to date. We began database driven cost analysis in April 2013, and thus have data collected for 1.5 Years (72 weeks) of the program (4/1/13 - 9/30/14). As indicated below, the cost per hour of the program across all comparisons ranged between $10 – $14. Across all direct cost reports (except for cost of program per child), parent advocates easily comprise the most heavy use of services, averaging 60% of all costs. Nor surprisingly, parent advocated provided the majority of direct services for basic needs to families in the project.

Factoring Direct costs only,

- the per hour cost of the program was $11.39 (6998.905 total hours)
  - Case Manager 1593.84
  - Counselor 340.35
  - Life Enrichment 718
  - Parent Advocate 4290.015
  - School Counselor 53.2
  - Case Admin 3.0

- the cost of the program per adult (n=195) was $11.23 (6334.655 total hours)
  - Case Manager 1493.59
  - Counselor 339.35
- the cost of the program per child (n=26) was $13.67 (664.25 total hours)
  - Case Manager 100.25
  - Counselor 1
  - Life Enrichment 557.5
  - Parent Advocate 5.5

- the cost of the program per family (n=200) was $10.41 (6998.905 total hours)
  - Case Manager 1593.84
  - Counselor 340.35
  - Life Enrichment 718
  - Parent Advocate 4290.015
  - School Counselor 53.2
  - Case Admin 3.0

6. Program Fidelity.

We used the Quality and Fidelity Index from Catholic Family & Child Service and Children’s Administration Family Connections Demonstration Project (Selby, 2009) Comprised of four parts (direct observation, records review, parent interview, and facilitator form), we used records review and facilitator forms. Our families do not easily trust, and we were concerned the introduction of a disinterested observer anytime during the FGDM process could be disruptive and undermine fragile trust established. For the first fidelity assessment on September 23, 2014, facilitator interviews were conducted using the Facilitator Interview Form that has been modified to match the Family Group Decision Making intervention used for Homes for Black Children’s Resiliency program. Questions 10 and 11 were recommended to be deleted since placement is not a relevant issue for participants in the Resiliency program which focuses on prevention of out of home placement.

The fidelity assessment of the FGDM via facilitator interviews resulted in an average score of 87%, which is moderately high adherence to the project model. This is corroborated by the additional narratives shared by the facilitators in explanation of the few deviations from the model. The first departure from fidelity to the FGDM model is indicated by non-compliance with item #6 (confidentiality). An essential step of preparation for confidentiality in the FGDM was consistently overlooked by FGDM coordinators in error, perhaps not clearly understood as a requirement that is typical for clinical sessions, and as documented in the training material, “The Role of the Coordinator in FGDM”, “Essentials of Preparation”. The second departure was due to the difference in purpose of the FGDM Resiliency program that focuses on prevention of out-of-home placement, so the original questions #10 and 11 were “not applicable” in any of the family cases and those questions were removed from the scoring.

Given that the only substantial departure from the FGDM process was lack of discussion of confidentiality, the overall adherence to the material and spirit of the FGDM process has been high. The fidelity of the FGDM facilitators to this process is evident in the positive outcomes
described in their narratives as well as evident in their reported improvement of skill in repeated facilitation of the FGDM process. This assessment indicates the need for fidelity assessments earlier in the project and ongoing to collaborate and strengthen the learning process of FGDM facilitators. This should also coincide with periodic program administrative review of procedures training clearly documented for all staff and stakeholders to be able to access and identify in observation or review of the process.
VII. Conclusions

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

The standard established by our partner the Michigan Department of Human Services for success is a determination that referred families would have no further Protective Service involvement over the period of one year. According to this definition, the project met its overall prevention goal of reducing recidivism and the number of children entering the foster care system.

The project had a goal of serving 100 families. The project served 222 households, comprised of 262 adults and 606 children. Of the 293 referrals received from the Department of Human Services, 26 families had a subsequent Protective Service Complaint; 10 which received program services.

Objective One: To engage 100 families in case planning through the use of the Family Group Decision Making Model. The project was able to accomplish 34 “traditional” Family Group Decision Making Sessions; although all 222 households developed Family Resiliency Plans. Seemingly, the families which accepted the FGDM had life circumstances that were more challenging than the standard of care population: drug usage history, entanglements with the legal system, etc. Although all aspects of program participation was completely voluntary, these complications may have created a sense of urgency which accounted for their willingness to consent to the FDGM,

The project was able to create fictive families and groups which participated in the development of the Family Resiliency Plan for all 222 participants (e.g., Mother’s Group, Family Resiliency
circle, Relationship of Advocate/Mentor to Family, etc.) The path toward Family Group Decision Making was compromised by the following factors:

- **Staff Inexperience:** Non social work staff, while having valuable relationship and life skills, had to simultaneously learn basic social work skills, which compromised their ability to engage families in the Family Group Decision Making Process.
- **Families severely affected by resource limitations could not re-focus their attention toward relationship building.**
- **Families were often times in their isolation afraid of outsiders and created an atmosphere of secrecy whereby they “did not want people in their business.”**
- **Many of their families and friends were in similar situations and unable or unwilling to become involved.**

**Objective Two:** To provide evidence based solution focused family counseling to 100 families. Where as only 10 families engaged in one on one counseling with the Family Coaches; their roles were modified to deliver group services based on family needs: MOTHER’S group, Family Resiliency Circle (support group), Girl’s and Boy’s Leadership Group, Girl’s Etiquette Group, Parent Club, participation in life Enrichment Activities and Family Camp.

**Objective Three:** To provide a Parent Advocate/Mentor Services to 100 families: all 222 families had the services of a PAM. The role of the PAM was critical to the success of the Family Resiliency Plan. They were valuable in providing tangible resources and referrals to the families. They were the listening ear, and main support to the fulfillment of FRP goals.

**Objective Four:** To involve 100 families in a continuum of services and support through the Family Well Being Cluster: all 222 families utilized the services of the family well-being
cluster at some point in our service delivery. Their needs were used to access and expand cluster membership.

**Proposed and Final Outcomes:**

We were unable to survey sufficient numbers of families to definitively prove sufficient success of proposed outcomes. Even despite the use of incentives, families were sufficiently reluctant to participate in evaluation activities. Strategies such as survey parties and financial incentives were developed with little success. The survey numbers were impacted by the crisis needs of the families and the manner in which perpetual crisis affects stability. (We served a highly transient population). However for the most part, outcomes trended in the direction of improvement:

- Incorporation of safety factors within the family unit
- Increased parenting skills and knowledge of child development
- Improved family ability to care for the needs of their children
- Families assume ownership of their family life and improve their decision making skills
- Families had a reduction of stress
- Families became self sustained

We did not have sufficient evidence to indicate improvement in the following areas:

- Involvement of fathers in planning and caring for their children: Most of the households were headed by females; although 40 households had fathers present within the home. Too few of these father headed households participated in the survey process.
In many of these un-surveyed households, the fathers took an active role in planning for the well-being of their families. The paternal involvement was particularly dominant in instances where the child had been placed outside of the home and returned home. In at least three instances, the reunification plan involved return to the father.

- Families will spend quality time with their children: the Parenting Stress Index did not indicate any significant change. The environmental challenges may have been too great for those surveyed to indicate an impact; the outcomes were severely affected by structural issues such as homelessness, unemployment, lack of transportation, etc. However we do know that improvements did occur for the families who participated in the various group activities.

- Families will have improved social and family connections: Families entered the program with low levels of appreciation for social and family connections, however over time developed this into a value. Through exposure to program activities, families increased their expectations for family and social connection. The Family Needs Scale indicated that parents wanted additional information on parenting and working with their children.

- Improved relationships between children and family members: The Parenting Stress Index indicated a high level of parental stress for participants. This outcome was affected by the crisis nature of the family situation, and lack of structural resources. Family relationships were compromised by issues related to poverty, and lack of community resources

B. Describe any significant implementation facilitators and/or barriers (implementation drivers) and “lessons learned” related to project implementation.
One major challenge was the level of generational poverty and the accompanying depression our families experienced. The degree of poverty manifests itself as isolation, inability to formulate trusting relationships, inadequate and unstable housing, under-education, lack of preparedness for the work force, and apathy. Although we specifically targeted this population for service, we severely overestimated our ability to compensate for this societal disability. The power which poverty has over the mind and spirit is as devastating as the power it has over life; at most times it seems unsurmountable. Families are reluctant to engage, reluctant to try for fear of failure. Daily exposure to trauma erodes the will. Our strategies were designed to re-engage the will; however the barriers were too great for short term intervention.

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

Project Staff have learned that families travel through incremental levels of trust and change as their engagement and openness grows. Preliminary analysis indicates that although our families show clinically significant rates of parental stress they do not respond to staff in a defensive manner. The ability to develop and maintain relationships with our families is integral to our Agency’s cultural competence. It is our belief that this newly initiated ability to enter into trusting relationships will transform into a future capacity to develop healthy family and community connections.

We have discovered that families go through a cycle of peaks and valleys in movement toward their family goals. A longitudinal look is necessary to judge the impact of program success; and whether success has been sustained. Although the project clearly achieved its goal
of keeping families together, the interventions have raised other serious research questions. One such question is why on some scales the amount of parental stress increased following the intervention. We believe that it is because with education, awareness, and exposure, the parents raised the bar for what they could expect in life. We did not have instruments to measure this assumption, so at this point it is only conjecture. But for those in the project who worked with the families, we saw many signs of visible change:

- Following a Family Group Decision Making Conference, a family reached its goal of methadone independence, and purchasing their own home
- A young mother started her own business
- A mother enrolled in a literacy program
- A participant was given court probation, thus allowing her child to remain in her home
- Four families were able to secure housing; another renegotiated a rent agreement, thus negating further Protective Service Intervention
- A mother enrolled in Wayne County Community College as part of her Family Resiliency Plan
- A young mother received a “second chance” with TANF
- A woman left an abusive relationship. A shelter placement was acquired where she could live safely with her seven children

Not only is it important to continue to encourage families during these cycles, it is also important to create within the agency a supportive learning environment which keeps staff focused on their commitment to seeing the family through these cycles. Despite the fact that our families score relatively high on the family stress continuum; post test levels indicate that while
still high, the stressors had changed. We think that as they mastered a goal, other life goals were established.

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

The Department of Human Services reached its overall objective of reducing the number of children entering the child welfare system. The Detroit Public Schools had access to a family support system within a school system that has little funding for parent resources. The Family Well-Being Cluster was a system of mutual exchange of information, resources, and referrals that will continue to contribute to our service community.
VIII. Recommendations

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

- Public/Private Partnership: The effective partnership between Homes for Black Children and our public agency partner, the Department of Human Services was the backbone of our family referral system. DHS played an instrumental role throughout the proposal development phase and continued as a steadfast and invaluable partner during the entire life of the program.

- Family Well-Being Cluster Partners Strategy: This important program component required the ability of the participants to fully and actively carry forth their service roles to families. To the extent possible, there needs to be a mechanism whereby participants can receive expedited and/or preferential attention to their needs. The “Cluster” partner’s areas of expertise and service should be aligned with the stated needs of the population.

- Building Relationships: Building and nurturing relationships among the various external community partners, along with HBC staff relationships directly with the families is essential in opening the way for all to accept new paradigms and modes of dealing with each other. Agencies and service entities must be equally open and flexible in their delivery of services as our families must also learn to reduce their personal, maybe even historical, ways of engaging the “system.”

- FRP Parent/Mentor Advocates: The insights, commitment to service, and resources that they provided to families was truly invaluable not only in their scope, but also as they engaged with families on in intimate basis which could not have otherwise been achieved. The needed “listening ear,” the one-to-one
counsel provided by someone who has previously “walked in their shoes,” is an authentic relationship that cannot be pretended or duplicated.

• Program Data Entry System: Development and implementation of the program data entry system is beneficial in effectively collecting pertinent program information which could provide direction to areas that need attention and strengthening. Conversely, we could be informed about positive program elements to continue to build upon.

• Continual Outreach for Community Partners: Being aware of the community resources available is a constant process. Because there exists an organizational ebb and flow to partnerships one must be vigilant in constantly seeking potential new partners. Equally important is being able to respond to the changing volume and needs of our service population.

• The FGDM concept: Using the Family Group Decision Making format as a tool to address family needs and issues represents a new way of problem solving for most of our families. The entire process of our engaging families in this way calls for them to adopt a whole new way of thinking and behaving. Not only is this true for the primary family but also for the extended family who take on the commitment to support them. This becomes a long range process for both parties and one which tests each of them. Over time their mutual commitment and sincerity is challenged.

• FGDM Voluntary Program Participation: This element of the program proved to be a double edged sword in that those who choose to participate did so with open minds to the process; while those who declined were often the very families
which – on the surface of their referral- could have potentially benefitted from the engagement. Staff also encountered participants who would need more time to incorporate the FGDM principles into their life styles and behaviors. Working with the personal responsibility aspects of the program means “growing up” in different ways for many of our parents/families.

- Program growth and evolution: Throughout the span of the program we have been able to modify its implementation to meet and conform to the needs of our families—while always being mindful of program fidelity. Allowing the program to respond to the deep fundamental needs of some of our customers was important to giving appropriate service, trust building, and supporting real true personal change. This was borne out in many of the comments by our parents that showed their sense of confidence and self empowerment.

- The development of expertise in providing service to the families increased by leaps and bounds over the three year period. We began the Project with staff who had little or no formal social work training but who had demonstrated leadership and relationship capacity. This choice proved to become a double edge sword because basic social work principles and values had to be taught/learned during the service delivery process. This certainly compromised the findings as it took longer than anticipated for staff to fully embrace family group decision making. It is fairly significant that of the 16 families referred from April to June, 2014, staff were able to achieve 9.

- Refresh the Message: Periodically it became necessary to meet, and re-meet, with DHS staff (Children’s Protective Services-Supervisors/workers) to reiterate the
purpose, goals, and capabilities of the program. The goal was to ensure that a consistently accurate message was being conveyed to our referral families. This would, hopefully, prepare the parent for our outreach.

- **Ongoing Staff Training:** A planned schedule of periodic in-service training on topics like, Effective Family Engagement and Family Assessment Skills does buttress the experiential field learning the Coordinators and Parent Advocates develop.

- A program or agency cannot assume a level of cultural competence among staff that have the same ethnicity as those served. Cultural competence requires constant vigilance, as our individual points of view are commonly shaped by the dominant culture. We were constantly called to challenge staff bias against families. In-service trainings were developed to focus on understanding and appreciating African American culture.

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

- Regular Grantees meetings offer an excellent opportunity to exchange program ideas and strategies with other programs.

- The emphasis on sustainability planning has been extremely helpful

- A longer period of demonstration would be helpful, as the first and last six months are primarily devoted to implementation and sustainability planning

C. **Provide recommendations to the child welfare field.**

The following are lessons learned by the Family Resiliency Coordinators:
• The art of being a Coordinator is getting the family to see a different possibility
• Point out and acknowledgment of all small and large growth steps to parents
• Recognize the concept of family of choice (fictive family)
• Success is defined by the family
• Parent surveys as a guide to meeting family needs
• Importance of the supportive role of the Parent Advocate/Mentor
• Engender hope to the family
• Coordinators and Parent Advocates need to be able to let go when the time comes so that the families can “spread their own wings.”
• Important to set a time limit in the beginning, like six months, and try to work within that parameter if possible.
• Don’t become enablers by having preconceived notions that parents aren’t capable or willing to do things for themselves; give them a chance.
• It is essential to have the FDGM in the beginning so that we have a plan to work from
• Coordinators and Parent Advocates must present a united front no matter what.
• Importance of Trust: In nearly every area of the program’s implementation and service delivery – trust – is an essential element. Whether it is the engagement with families, agency partners, the internal HBC support team, or the direct Resiliency team themselves; one cannot overstate the impact of trusting relationships as we all learned and grew with the program.
• Enabling / Crippling: Allow parents to do for themselves when possible, such as, providing their own transportation to and from events generated by the program.
• Partnership – stressing the importance of “partnership” is vital to helping others feel empowered by knowing that their own efforts were key to producing a positive outcome.

• FGDM - ASAP: Striving to have the FGDM within the first 2 to 3 weeks puts a plan in place right away. We can still address immediate needs as well. However, having a plan in place provides a focal point regardless of what other needs or services become necessary.

• Roles Clearly Defined: It is important for the roles of the Coordinator and Parent Advocate to be clearly defined.

• United Front: The Coordinator and Parent Advocate/Mentor must present a united front no matter what may be going on behind the scenes, so as not to negatively affect the integrity of the program and the families we serve.

• Letting Go: It is important to not create an atmosphere of dependency on the part of the families. The program is about strengthening families so that they can fly on their own. The idea is to provide the tools so that when it is time to “let go”, the families can feel confident that they can manage without our assistance.

• Time Limits: I like the idea of having a “target” time-frame with which to work with a family.

• Mothers needing “Mothering”: 100% of clients that I engaged with never had an established basic “mother/child” relationship

• Negative Education trend: Many of the mothers dropped out of school in the 11th grade for undetermined reasons. This may be a trend to observe in the future.
• Better life aspirations: Most of the clients that I engaged with wanted a better life condition for their children and themselves. This basic desire was always present even if they did not know how to make it happen.

• Meeting families where they are: Each family has its’ own dynamic(s) and to engage the family in this practice the FRC must establish trust, before the family will enlighten you to their methods and/or willingness to change.

• FGDM as Empowerment: The greatest benefit of the FGDM is when the family leaves with a plan that invokes a feeling within them that things can be better.

• HOPE: This is the key that motivates and moves the family members into practicing these new behaviors and outlooks.
**NURTURING THE RESILIENCY IN WAYNE COUNTY FAMILIES: RETHINKING THE FAMILY**

**DECISION MAKING MODEL TO BUILD PROTECTIVE FACTORS FOR CHILDREN AND YOUTH**

**Detailed Work Plan – GANTT CHART**

**Objective 1: To engage 100 families in case planning through the use of Family Group Decision Making**

<table>
<thead>
<tr>
<th>TASK</th>
<th>Quarter</th>
<th>YEAR</th>
<th>Responsible Staff*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hire FRPS and FRPC’s</td>
<td>X</td>
<td></td>
<td>PI, PD</td>
</tr>
<tr>
<td>Develop and Implement Staff Training</td>
<td>X</td>
<td>X</td>
<td>PI, PD, PC, FRPC, RPS, CLR</td>
</tr>
<tr>
<td>Develop and disseminate Project promotional materials and media information</td>
<td>X</td>
<td>X</td>
<td>PD, FRPC, PAC, FRPS, PA</td>
</tr>
<tr>
<td>Secure Referral Sources for Intake/ Initiate Parent Clubs in School</td>
<td>X</td>
<td></td>
<td>PD, FRPS, PCF</td>
</tr>
<tr>
<td>Implement Family Group Decision Making</td>
<td>X</td>
<td>X</td>
<td>PD, FPRS, FFRPC</td>
</tr>
<tr>
<td>Develop assessment and Evaluation tools</td>
<td>X</td>
<td></td>
<td>PI, PD, PC, FRPC, FRPS, E</td>
</tr>
<tr>
<td>Evaluate Process and Activities</td>
<td>X</td>
<td>X</td>
<td>E, PA</td>
</tr>
</tbody>
</table>

**Objective 2: To provide evidenced based solution focused family counseling to 100 families**

<table>
<thead>
<tr>
<th>TASK</th>
<th>Quarter</th>
<th>YEAR</th>
<th>Responsible Staff*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hire Therapist</td>
<td>X</td>
<td></td>
<td>PI, PD</td>
</tr>
<tr>
<td>Implement Training on Solution Focused Counseling</td>
<td>X</td>
<td>X</td>
<td>PD, FT, FPRS, CLR FRPC, PC</td>
</tr>
<tr>
<td>Establish Referral Process within Agency</td>
<td>X</td>
<td></td>
<td>PD, FT, FRPS, FRPC</td>
</tr>
</tbody>
</table>
### Objective 3: To provide Parent Advocate/Mentor Services to 100 Families

<table>
<thead>
<tr>
<th>TASK</th>
<th>Quarter</th>
<th>YEAR</th>
<th>Responsible Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hire Male Parent Advocate Mentors</td>
<td>X</td>
<td></td>
<td>PI, PD, PAC, PA</td>
</tr>
<tr>
<td>Train Parent Advocate Mentors and Coordinator</td>
<td>X X X X X</td>
<td>X X</td>
<td>PD, PAC, CLR, PAM, PC</td>
</tr>
<tr>
<td>Assign Parent Advocate Mentors to Families; Implement Parent Advocacy Mentors</td>
<td>X X X X X</td>
<td>X X</td>
<td>PD, PAC, PC</td>
</tr>
<tr>
<td>Develop Assessment and Evaluation Tools</td>
<td>X</td>
<td></td>
<td>PD, PI, E, PAC, PAM, PA</td>
</tr>
<tr>
<td>Evaluate process and activities</td>
<td>X X X X X</td>
<td>X X</td>
<td>E, PA</td>
</tr>
</tbody>
</table>

### Objective 4: To involve 100 families in a continuum of services and support through the Family Well Being Cluster

<table>
<thead>
<tr>
<th>TASK</th>
<th>Quarter</th>
<th>YEAR</th>
<th>Responsible Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convene Family Well Being Cluster Member to review and implement commitments and roles</td>
<td>X X X X X</td>
<td>X X</td>
<td>PI, PD, FRPS, PA</td>
</tr>
<tr>
<td>Develop Individualized Referral Processes</td>
<td>X</td>
<td></td>
<td>FWBC, FRPS, PD</td>
</tr>
<tr>
<td>Implement Cluster Activities</td>
<td>X X X X X</td>
<td>X X</td>
<td>PD, FRPC, FRPS</td>
</tr>
<tr>
<td>Develop Assessment and Evaluation Tools</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate process and activities</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Responsible Staff Codes:**

- PI = Principal Investigator
- FRPS = Family Resiliency Plan Supervisor
- PD = Project Director
- PAM = Parent Advocate/Mentor
- FRPC = Family Resiliency Plan Coordinator
- PC = Program Consultant
- PAC = Parent Advocate Coordinator
- E = Evaluator
- CLR = Coordinator of Learning Resources
- PA = Project Assistant
- PCF = Parent Club Facilitators
- FT = Family Therapist
- FWBC = Family Well Being Cluster
VI. Evaluation

Outcome Evaluation Questions
We framed our questions in terms of twelve (12) proposed study outcomes and aligned these outcomes with data collection, specific measures, and time intervals between Time 1 and Time 2 collection periods:

<table>
<thead>
<tr>
<th>Proposed Outcomes</th>
<th>Data Collection/Measures/Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improved relationships between children and family members</td>
<td>Parenting Stress Index-Short Form Time 1/Time 2 (12 months)</td>
</tr>
<tr>
<td>2. Involvement of fathers in planning and caring for their children</td>
<td>Parenting Stress Index-Short Form Time 1/Time 2 (12 months) [sub analysis of male parents]</td>
</tr>
<tr>
<td>3. Decline in the number of children who are placed in foster care</td>
<td>DHS generated quarterly count of children involved in 100 families who are placed in foster care (Roger Christ Data Pull)</td>
</tr>
<tr>
<td>4. Reduction in the number of children who re-enter foster care</td>
<td>DHS generated count of children involved in 100 families who were in foster care but do not re-enter within 12 months (Roger Christ Data Pull)</td>
</tr>
<tr>
<td>5. Incorporation of safety factors within the family unit</td>
<td>Protective Factors Survey</td>
</tr>
<tr>
<td>6. Increased Parenting Skills and knowledge of Child Development</td>
<td>Protective Factors Survey</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7.</td>
<td>Improved family ability to care for the needs of their children</td>
</tr>
<tr>
<td>8.</td>
<td>Families assume ownership of their family life and improve their decision making skills</td>
</tr>
<tr>
<td>9.</td>
<td>Families will spend quality time with their children</td>
</tr>
<tr>
<td>10.</td>
<td>Families will have reduction of stress</td>
</tr>
<tr>
<td>11.</td>
<td>Families will have improved social and family connections</td>
</tr>
<tr>
<td>12.</td>
<td>Families will become self sustained</td>
</tr>
</tbody>
</table>

i. Describe the evaluation research design (e.g., experimental / random assignment, quasi-experimental / comparison study, pre-post, longitudinal / historical analysis, etc.).

A program decision was made to provide the FGDM program to 100 families referred to the Family Connections Program. **Two conditions were created:** The treatment condition consisted of families who completed the FGDM specific intervention (N= 18 Families), and the standard of care condition consisted of families who did not participate in any of the FGDM components (N=294 Families). The design incorporated a pre-post study design for all participating families, with Pretest data to be collected from as many families as possible between February-March 2014 (Time 1 Pretest) and August-September 2014 (Time 2 Posttest). We collected Pretest data from 37 families and Posttest data from 37 families.

Our first statistical analyses used t-tests for unmatched groups with unequal cell sizes. We determined statistically significant differences in pre and post test response and reported these findings in the May 2014 semi-annual report. Our next data collection (post-test) took place in August –September 2014. Some of the surveys contained missing data due either to interviewer error or respondent decision not to respond to specific questions. We used advanced data imputation techniques to provide statistical responses to missing data - in about 30% of the questionnaires. We used this approach to optimize the data collected with very difficult populations in very challenging circumstances. **Under this set of analyses we found significant differences in pre-post test outcomes that favored the FGDM group, and reported the findings in the October 2014 annual report.**

However, in November 2014 we reviewed our analysis, concerned that the data imputation strategies – while empirically reasonable – would be increasingly challenged by other
researchers. Further analysis and consultation suggested a more conservative analysis of data, using non-parametric distribution-free statistical tests for individuals matched by each respondent’s pretests and posttests. Further, we deemed responses for all measures with less than 75% of items answered inadequate for further analysis; we thus eliminated our data imputation strategy. When we re-ran the more conservative analysis, the statically significant differences between the FGDM and non-FGDM groups disappeared, although the non-significant trend was preserved.

We faced an evaluation dilemma – to go forward and proclaim statistically significant differences between FGDM and standard of care groups using statistical techniques that were empirically defensible but programmatically and analytically problematic, or to use a more defensible, more conservative approach that would exclude surveys with missing data greater than 10% but less than 30% of the entire survey. The evaluation team leader, Dr. Gant, made the final decision to use and report the conservative, more defensible analytic approach. The differences are not statistically significant, but the trends are clearly there.

Given the lack of statistical significance between the FDGM and standard of care groups, we opted to combine both groups to determine at least whether there were significant pre-post differences among the families. We report the findings and trends in Outcome Evaluation and Results: Safety and Well-Being: Review of Survey Measures for the Study.

ii. Describe evaluation participants. Evaluation participants may be a service recipient or person otherwise involved in the program (e.g., program staff). Evaluation participants may also include a comparison group.

Table 1 summarizes the adult level similarities and distinctions between households completing the FGDM process and those not involved in the FGDM process. Both groups were nearly completely mid-thirties, single African American women, half of whom reported High School as their highest education level. The two groups are comparable in that they are both relatively young adults in their thirties, African-American single women. About half of the adults report high school as their highest educational level. Both groups report a household income of less than $10,000 annually, despite nearly three times as many adults in the FGDM households reporting employment as those in the standard of care. Both groups report a 20% history of domestic violence and about 5% homelessness. Interestingly, the FGDM households report a significantly greater percentage of history of substance abuse and involvement with the legal system than the standard of care households. There were more single parent households in FGDM than households in the standard of care condition. The FGDM households appear to have a somewhat more challenging history and configuration than the standard of care households.
Table 1: Adult Level Demographics – FGDM and Standard of Care Households

<table>
<thead>
<tr>
<th></th>
<th>FGDM Households (n=18 Households)</th>
<th>Non-FGDM (Standard of Care) Households (N= 268, N=141 reported data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>35.5 Years</td>
<td>32.5 Years</td>
</tr>
<tr>
<td>Gender</td>
<td>76% Female</td>
<td>74% Female</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>100% African American</td>
<td>98% African American</td>
</tr>
<tr>
<td>Marital Status</td>
<td>67% Single</td>
<td>50% Single</td>
</tr>
<tr>
<td>Highest Educational Level</td>
<td>50% HS</td>
<td>41% HS</td>
</tr>
<tr>
<td>Employment Level (Part-time or Full time)</td>
<td>29% Employed</td>
<td>10% Employed</td>
</tr>
<tr>
<td>Household Family Type</td>
<td>78% Single Parent</td>
<td>67% Single Parent</td>
</tr>
<tr>
<td>History of domestic violence</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>History of substance abuse</td>
<td>14%</td>
<td>1%</td>
</tr>
<tr>
<td>Current housing reported as “homeless”</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Involvement with the legal system</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>Household income (Less than $10,000 annually)</td>
<td>50%</td>
<td>46%</td>
</tr>
</tbody>
</table>

The demographics of children served in the program are consistent with the demographics of the two groups. Children in both groups were between 7-8 years of age, about half of them were female, nearly all were African-American, all were identified as dependents of parents/guardians, and nearly all of them were placed at home prior to receiving services from HBC (at intake). However, children in the FGDM households were more likely to have previous involvement with the child welfare system and reports somewhat more developmental, physical or mental health challenges than their non-FGDM counterparts. *Children in the FGDM households appear to have a somewhat more challenging history and configuration than children in the standard of care households.*

Table 2: Child Level Demographics – FGDM and Standard of Care Households

<table>
<thead>
<tr>
<th></th>
<th>FGDM Households (n=18 Households, 44 children)</th>
<th>Non-FGDM (Standard of Care) Households (N= 268 households, 279 children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>7.6 Years</td>
<td>7.9 Years</td>
</tr>
<tr>
<td>Gender</td>
<td>48% Female</td>
<td>53% Female</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>100% African American</td>
<td>98% African American</td>
</tr>
<tr>
<td>Home placement prior to receiving services at intake</td>
<td>98% placed at home</td>
<td>100% placed at home</td>
</tr>
<tr>
<td>Dependent</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Previous involvement with child welfare system</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>Developmental, physical or mental health challenges</td>
<td>11%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Agency staff took lead responsibility in administering surveys and worked extremely hard to collect the materials within the context of providing a challenging program to highly vulnerable, suspicious families with great need but tough experiences with state agencies. Incentives were used to increased response rate to some benefit; it was determined that data would be better collected during agency organized events held at the project venue. Fidelity interviews were conducted by the evaluation team. Programmatic information was collected by the evaluation team via a special database designed to collect and track program participation information over time for families, children and heads of households. Additional DHS information was provided tracking the number of HBC served families who appeared in DHS systems after participation in the Family Connections program. This important administrative information was provided during August 2014, and serves as unambiguous outcome/impact data for the project.

iii. Document any major changes made to the evaluation plan in regard to evaluation questions, evaluation design, data collection procedures, IRB or other approvals, etc. Grantees may include supporting documentation in an appendix.

We revised fidelity procedures to better align with the expectations of the evaluation consultation team at JBA, and discuss these revisions in the study fidelity section. There were no major changes to the evaluation questions, data collection procedures or IRB (exempted) approvals.

iv. Describe any training that was conducted with program staff and partners to help them understand the role of the evaluation in program work. Describe successful methods to engage program staff with the evaluation.

We were engaged in extensive debriefs with the agency staff and administration in the deployment of the program interventions. We worked with the staff and administration to clarify and explain intervention and standard of care service conditions for the project. We provided several substantial discussions with program staff in developing the database for data collection and activity recording. We worked with the staff in developing direct and indirect service categories for database. We provided extensive formal and informal training to staff on database entry of service activities. We provided an overview of cost benefit methods to the staff. We conducted several trainings using the data collection protocols, and were pleased with the program staff’s efforts in training to use the protocols. Staff kept excellent documentation of all meetings and program relevant discussions and decisions. We were fortunate in that agency administration helped staff understand the importance of the program; the evaluation team had
several discussions with staff to help them understand the importance of the evaluation activities. We were invited to attend all regular and special meetings of the program staff, thus maintaining a weekly presence at the agency and the program. Through these efforts, staff were able to understand and integrate the importance of program services, database entry of effort (indirect and direct services), and collection of pre- and post-test evaluation instruments.

Outcome Evaluation Results

1. **Permanency and Stability/ Permanency and Continuity:**

We begin with what we believe to be the most impressive major finding of the FGDM Family Connection Program. The data were provided directly from administrative data provided to HBC from State of Michigan (Wayne County) Department of Human Services (submitted by Mr. Roger Christ). A total of 293 families with an initial Child Protection Service (CPS) contact were referred to HBC’s FGDM program between April 2012 - September 2014. In October 2014, these same families were referred back to DHS for screening. A successful family services referral outcome - in accordance with DHS guidelines - occurs when a family who has had CPS contact is referred out for services and that family DOES NOT have later a CPS Referral Substantiation. The cumulative results for families served by HBC’s program are as powerful as they are simply stated:

- Cumulative total of FRP families referred to DHS for screening (as of 10/31/14): 293
- Cumulative total of FRP families with a Substantiation: 26 (8.8% of total)
  - a. Those who had program contact and/or services: 10 (3.4% of total)
  - b. Those who had no contact/services: 8 (2.7% of total)
  - c. Those with undeterminable contact: 8 (2.7% of total)

Almost 92% of participating families did not have a CPS Referral Substantiation at the end of the program. Less than 10% of all participating families had any Referral Substantiation. Of these families receiving a Referral Substantiation, only 10 families (less than 4% of the total) had FGDM program contact and/or services. Eight families had no contact or services, and the other eight families contacts could not be determined due to DHS staff departure and closure of cases. **We were able to reasonably determine that of the ten HBC served families who had a CPS Referral Substantiation, none appeared to be families in the FGDM condition.**

2. **Safety and Well-Being: Review of Survey Measures for the Study.**

Parent Stress Index (PSI) Cumulative Findings for December 2014 Final Report:

We report the results of PSI for the 8 families that completed both the pre-test PSI and post-test PSI. We report the results within a diagnostic/assessment format. Demographic analysis of both pre and posttest families reveals no significant differences in number of children, head of household, or education/income backgrounds. For each sub-scale (unless otherwise noted), a score which falls between the 15th and 80th percentile is considered typical. High scores are
those at or above the 85th percentile.

**Defensive Responding.** Parents who score high on this scale may be trying to minimize any problems, stress, or negativity in their relationship with their child. However, a high score on this scale alone cannot determine to what extent the parent is trying to respond in an untrue, yet favorable way. It needs to be thought of as one piece of information you have which brings you to the conclusion. A score on this scale of 10 or less indicates responding in a defensive manner and indicates that caution should be used in interpreting any of the subscale or total stress scores. Low scores on this scale indicate high levels of defensive responding.

**“PD” Parental Distress.** This scale examines to what extent the parent is experiencing stress in his/her role as a parent. It measures sense of parenting competence, stresses associated with restrictions on his/her life, conflict with child’s other parent, social support and depression. When this score is at or above the 90th percentile in combination with a DC score below the 75th percentile, the parent could benefit from activities and education aimed at raising self esteem and/or sense of parental competency. Connecting the parent to a social support or parent-child play group may be another strategy for those who score above the 90th percentile on this subscale.

**“P-CDI” Parent-Child Dysfunctional Interaction.** This subscale assesses the extent to which the parent believes that his/her child does not meet their expectations and their interactions are not satisfying. High scores in this sub-scale can indicate that the parent sees the child as a disappointment, feels rejected or alienated by/from the child, or has not properly bonded with the child. These feelings can result in a lack of warmth or initiating interactions with the child by the parent. When this score is at or above the 85th percentile, the parent should be given age-appropriate activities (with the home visitor modeling the interaction when appropriate) to do with their child. They should be given information to enhance their confidence and competence in their ability to interact with their child. Every opportunity should be provided so that the parent can feel positive and good about playing/interacting. Positive feedback should be given.

**“DC” Difficult Child.** This sub-scale tells us how easy or difficult the parent perceives his/her child. If the child is less than 18 months old and the parent scores at or above the 90th percentile, this could indicate that the child is having problems with self-regulatory processes. In these cases, the home visitor can suggest visiting the child’s pediatrician to rule out an allergy or colic. When the child is 2 years old or older and the parent scores at or above the 90th percentile, this could indicate that the parent is having a hard time gaining the child’s cooperation and/or managing the child’s behavior. In this situation, parents will usually benefit greatly from strategies to handle challenging behavior; age appropriate discipline.

**Total Stress.** This is the measure of the stresses the parent is experiencing in his/her role as a parent. It does not include all life stress, just the stress they may be feeling when they are parenting. When this score is at or above the 90th percentile the parent may benefit from a referral to a social worker or mental health professional who can address parental distress.

Wilcoxon Signed Rank tests were conducted of mean score differences from pre to post surveys for each of the PSI subscales at P<0.05, 2 tailed type tests. For those that calculated
a critical value of W, the results were not significant at $p \leq 0.05$.


Overall for the pretest, families generally reported needing the 41 items less than “sometimes.” The same pattern was noted for the post-test, families. For both the pretest and posttest, the item that were reported the most as “almost always” needing help, relative to the other item, were:

1. Having medical and dental care for my family (42%)
2. Getting where I need to go. (33%)

The greatest decrease in need, from pretest to posttest, were items that were needed “sometimes” prior to FGDM, and needed only “seldom” post FGDM:

1. Having someone to talk to.
2. Having emergency health care.

Top mean responses were more than “sometimes” needs for the following items:

1. expanding my education, skills and interests
2. Doing things that I enjoy.
3. doing things with my family
4. exploring future educational options for my child
5. participate in parent groups or clubs

Overall for the pretest, families scored quite high on the PFS subscales of Child Development/Knowledge of Parenting and Nurturing and Attachment (5.7 and 6.2 out of 7, respectively. Families scored somewhat lower for reports of Concrete Support (4.9), Social Support (5.3) and Functioning/Resiliency (5.1). For the posttest, mean scores on family reports were significantly higher for all subscales than in pretest. The most encouraging differences were noted in Concrete Support (6.0), Social Support (6.2), and Family Functioning and Resiliency (6.3).
Wilcoxon Signed Rank tests for significance of differences were conducted for the PFS at P<0.05, 2 tailed type tests. Result: Based on the W-value, and the critical value of W for this sample size at p≤0.05, the result is not significant at p≤0.05.

Charts and brief results of the mean responses and frequency of responses for all 3 sets of pre/post surveys (PFS, PSI and FNS) are included in the previous respective survey sections. Wilcoxon Signed Rank tests were conducted for the PSI and PFS. While the analysis of matched pairs of all pre/post did not yield statistically significant differences, the trends toward positive change are nonetheless encouraging and need to placed with the contexts of profound structural inequities (e.g. profound unemployment, poverty, and diminished educational attainment) (Table 3). That FGDM made even a small trend-wise difference between FGDM and
non-FGDM families is not impressive given the brevity of the intervention and the profundity of the presenting problems and issues.

Table 3: Outcomes, Data Collection, Results/Explanations Table

<table>
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<tr>
<th>Proposed Outcomes</th>
<th>Data Collection/Measures/Time Frames</th>
<th>Results/Explanations</th>
</tr>
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<tbody>
<tr>
<td>1. Improved relationships between children and family members</td>
<td>Parenting Stress Index-Short Form Time 1/Time 2 (6 months)</td>
<td>No significant changes; family problems may reflect structural factors beyond ability of program to impact within short term</td>
</tr>
<tr>
<td>2. Involvement of fathers in planning and caring for their children</td>
<td>Parenting Stress Index-Short Form Time 1/Time 2 (12 months) [sub analysis of male parents]</td>
<td>Insufficient number of fathers for comparison and analysis</td>
</tr>
<tr>
<td>3. Decline in the number of children who are placed in foster care</td>
<td>DHS generated quarterly count of children involved in 100 families who are placed in foster care (Roger Christ Data Pull)</td>
<td>Significant reductions for FGDM families (zero)</td>
</tr>
<tr>
<td>4. Reduction in the number of children who re-enter foster care</td>
<td>DHS generated count of children involved in 100 families who were in foster care but do not re-enter within 12 months (Roger Christ Data Pull)</td>
<td>Significant reductions for FGDM families (zero)</td>
</tr>
<tr>
<td>5. Incorporation of safety factors within the family unit</td>
<td>Protective Factors Survey</td>
<td>Nonsignificant differences but trends in positive direction for FDGM families. Issues may take longer to address than expected; Involvement in FDGM may itself may exacerbate family</td>
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<tr>
<td><strong>6. Increased Parenting Skills and knowledge of Child Development</strong></td>
<td>Protective Factors Survey</td>
<td><strong>Nonsignificant differences but trends in positive direction for FDGM families.</strong> Issues may take longer to address than expected; Involvement in FDGM may itself may exacerbate family safety issues</td>
</tr>
<tr>
<td><strong>7. Improved family ability to care for the needs of their children</strong></td>
<td>Protective Factors Survey Time1/Time 2 (12 months)</td>
<td><strong>Nonsignificant differences but trends in positive direction for FDGM families.</strong> Issues may take longer to address than expected; Involvement in FDGM may itself may exacerbate family safety issues</td>
</tr>
<tr>
<td><strong>8. Families assume ownership of their family life and improve their decision making skills</strong></td>
<td>Protective Factors Survey Time1/Time 2 (12 months)</td>
<td><strong>Nonsignificant differences but trends in positive direction for FDGM families.</strong> Issues may take longer to address than expected; Involvement in FDGM may itself may exacerbate family safety issues</td>
</tr>
<tr>
<td><strong>9. Families will spend quality time with their children</strong></td>
<td>Family Needs Scale</td>
<td>Trends toward wanting more information, training and services on parenting and work with children</td>
</tr>
<tr>
<td><strong>10. Families will have reduction of stress</strong></td>
<td>Parenting Stress Index-Short Form – Time1/Time 2 (12 months)</td>
<td><strong>Nonsignificant differences but trends in positive direction for families,</strong> Less defensive responses, reduction in Difficult Child, Increases in Parent Distress and Parent Child Dysfunctional</td>
</tr>
</tbody>
</table>
11. Families will have improved social and family connections

Family Needs Scale

Less reports of needing someone to talk to, but more reports for needed social and familial interaction

12. Families will become self sustained

Family Needs Scale

Trends toward sustainability but structural challenges are factors, e.g. medical care and transportation.

5. Cost Studies: Our cost study of the FGDM program was guided by these fundamental queries:

- What is the per hour cost of the program?
- What is the per hour program cost per family served?
- What is the per hour program cost per child served?
- What is the per hour program cost per family served?

The key direct services included in the cost study included: FGDM meeting with family (4 hours/family), follow-up/home visits (10 hours/family), staff (e.g. Solution Focused Therapists, Family Resilience Plan Supervisor and Coordinators, parent advocate/mentors). Cost tracking methods included reviews of total annual allocated cost and total cost to date. We began database driven cost analysis in April 2013, and thus have data collected for 1.5 Years (72 weeks) of the program (4/1/13 - 9/30/14). As indicated below, the cost per hour of the program across all comparisons ranged between $10 – $14. Across all direct cost reports (except for cost of program per child), parent advocates easily comprise the most heavy use of services, averaging 60% of all costs. Nor surprisingly, parent advocated provided the majority of direct services for basic needs to families in the project.

Factoring Direct costs only,

- the per hour cost of the program was $11.39 (6998.905 total hours)
  - Case Manager 1593.84
  - Counselor 340.35
  - Life Enrichment 718
  - Parent Advocate 4290.015
  - School Counselor 53.2
  - Case Admin 3.0

- the cost of the program per adult (n=195) was $11.23 (6334.655 total hours)
  - Case Manager 1493.59
  - Counselor 339.35
the cost of the program per child (n=26) was $13.67 (664.25 total hours)

- Case Manager 100.25
- Counselor 1
- Life Enrichment 557.5
- Parent Advocate 5.5

the cost of the program per family (n=200) was $10.41 (6998.905 total hours)

- Case Manager 1593.84
- Counselor 340.35
- Life Enrichment 718
- Parent Advocate 4290.015
- School Counselor 53.2
- Case Admin 3.0

6. Program Fidelity.

We used the Quality and Fidelity Index from Catholic Family & Child Service and Children’s Administration Family Connections Demonstration Project (Selby, 2009) Comprised of four parts (direct observation, records review, parent interview, and facilitator form), we used records review and facilitator forms. Our families do not easily trust, and we were concerned the introduction of a disinterested observer anytime during the FGDM process could be disruptive and undermine fragile trust established. For the first fidelity assessment on September 23, 2014, facilitator interviews were conducted using the Facilitator Interview Form that has been modified to match the Family Group Decision Making intervention used for Homes for Black Children’s Resiliency program. Questions 10 and 11 were recommended to be deleted since placement is not a relevant issue for participants in the Resiliency program which focuses on prevention of out of home placement.

The fidelity assessment of the FGDM via facilitator interviews resulted in an average score of 87%, which is moderately high adherence to the project model. This is corroborated by the additional narratives shared by the facilitators in explanation of the few deviations from the model. The first departure from fidelity to the FGDM model is indicated by non-compliance with item #6 (confidentiality). An essential step of preparation for confidentiality in the FGDM was consistently overlooked by FGDM coordinators in error, perhaps not clearly understood as a requirement that is typical for clinical sessions, and as documented in the training material, “The Role of the Coordinator in FGDM”, “Essentials of Preparation”. The second departure was due to the difference in purpose of the FGDM Resiliency program that focuses on prevention of out-of-home placement, so the original questions #10 and 11 were “not applicable” in any of the family cases and those questions were removed from the scoring.

Given that the only substantial departure from the FGDM process was lack of discussion of confidentiality, the overall adherence to the material and spirit of the FGDM process has been high. The fidelity of the FGDM facilitators to this process is evident in the positive outcomes
described in their narratives as well as evident in their reported improvement of skill in repeated facilitation of the FGDM process. This assessment indicates the need for fidelity assessments earlier in the project and ongoing to collaborate and strengthen the learning process of FGDM facilitators. This should also coincide with periodic program administrative review of procedures training clearly documented for all staff and stakeholders to be able to access and identify in observation or review of the process.
Family Connections Grants: Using Family Group Decision Making to Build Protective Factors for Children and Families
HHS-2011-ACF-ACYF-CF-0181 LOGIC MODEL - Nurturing the Resiliency in Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work

**PROBLEM**
Disproportionate number of African American Children in the Child Welfare System in Michigan, Lack of family income and resources, Lack of parenting and decision making skills, Lack of interpersonal support

**SUBPROBLEM(S)**
Lack of funding for culturally sensitive strategies to effect change, support self-worth, teach conflict resolution, and improve social behavior. Need for mentors and role models

**ACTIVITIES**
HBC will collaborate with community partners to implement the Family Well Being Cluster, to provide a continuum of services that will provide families with Family group decision making opportunities, Solution focused family Counseling, Parent, Advocate/ Mentors, as well as employment and child care services, parent education, individualized counseling and life enrichment activities

**OUTPUT MEASURES**
100 families will obtain emotional support, exposure to positive role models and increase involvement with their children and families
100 families will actively participate in parenting and employment services
100 families will participate in Family Group Decision Making Meetings
100 families will participate in 10 hours of individualized counseling, and/or family counseling
100 families will participate in bi monthly life enrichment activities

**OUTCOME MEASURES**
Families will improve their decision making skills,
Families will obtain employment
Families will spend quality time with their children
Families will have reduction or elimination of stress
100 families will have improved social and family connections

**Funded by United States Department of Health & Human Services Children’s Bureau**
In October, 2011, Homes for Black Children was awarded a Family Connections Grant through the United States Department of Health and Human Services. The goal of the grant is to reduce the number of African American children who live in Wayne County from entering or returning to the child welfare system through the use of four core strategies: Family Group Decision Making, Solution Focused Counseling, Parent Advocate/Mentors, and the Family Well-being Cluster. Our target is to affect 100 families.

After a year and a half, we are as excited as ever about the possibilities these strategies offer the field of knowledge. During our last six months, we have served 54 families with a total of 119 total families served. The Project has coordinated 6 Family Group Decision Making Meetings (FGDM) during this period with a combined total of 12. Somewhat beleaguered by the fact that we have been unable to engage as many of our families in the FGDM process as we had hoped, we continued to explore varying strategies of engagement as we move forward. For an Agency which prides itself on Cultural Competence and Family Engagement, this has been somewhat of a bitter pill to swallow.

For those families not yet involved in the FGDM process, we continue to offer the other three strategies. We have put some of our preliminary findings into varying engagement strategies, e.g., Project Family Orientation, School Based Parent Support Groups, Family Life Enrichment Activities, Parent Coaching, etc.

Despite these efforts, we are beginning to see signs that our staff is becoming a bit “road weary” in the sometimes insurmountable task of engaging families in program services. It is all too easy to become overwhelmed by the multitude of challenges which face our families. In order to remain culturally competent/relevant we have expanded our training curriculum to keep staff energized and focused.

We have learned that on average FGDM’s occur about two months after initial contact, because usually the family is focused on the crisis which brought them to the attention of the Department of Human Services, e.g., homelessness, lack of basic needs, truancy, etc. Our value to the family at this time is measured by our effectiveness in helping them to resolve the crisis. If we are successful we see a measured increase in trust, and our relationship capacity to the family is enhanced.

We have completed the implementation of our evaluation plan, and we will soon have analysis to share with you from our lead program evaluator: Larry Gant, PhD from the University of Michigan. In the meantime, we appreciate your support, and wish you well in our joint efforts for family well-being.

For more information contact Eugene Wilson, 511 E. Larned, Detroit, MI 48226. Phone Number (313) 961-4777 Fax Number (313) 961-2994. Email hbchildren@aol.com.
HOMES FOR BLACK CHILDREN

Nurturing the Resiliency in Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work

Project Overview

Homes for Black Children, a comprehensive child welfare agency with a rich forty-five year history of offering services to children of all ethnicities, is best known for its ground breaking evidenced based practice in creating permanent outcomes for African American children through Adoption and Family Preservation Services. This Project seeks to demonstrate with 100 families the effectiveness of Family Group Decision Making as a best practice model in reducing the number of urban children who enter foster care, as well as reduce foster care recidivism in Wayne County, Michigan.

In 2004, although African-American children represented only 48.86% of the overall child population, they represented 82.05% of the foster care population in Wayne County with a disproportionality rate of 1.69 (Michigan Family Independence Agency Warehouse Data, 2004).

Fathers are encouraged to participate in planning for their children, as well as all aspects of program activities. All referrals are voluntary.

The Project seeks to develop individualized “Family Resiliency Plans” guided by each family to achieve its overall goal of improving child and family well-being through the use of four core evidenced based strategies which support and build upon the family’s own strengths.

It is the belief of HBC that this continuum of service will assist families with strengthening child protective factors in decreasing overall family stress by providing emotional as well as concrete support, parent education, and improve social and family connections.

Strength-Based Solutions

- M.O.T.H.E.R.S Mentoring Group
- Sankofa Male Mentors
- Girls’ Youth Group
- Parenting Support
- Well-being Cluster/Life Enrichment activities
- D.P.S. Parent Club

Survey Findings

Source of Referral

- Families referred through the Department of Human Services C.P.S.
- HBC Internal
- Community Stakeholders
- Family Self-Referrals

Four Core Strategies

- Parent Advocates
- Family Group Decision Making
- Solution-Focused Counseling
- Well Being Cluster

Findings

Mean Subscale Scores (N=37)

- Total Stress Score
- Difficult Child
- Parent Child Dysfunctional Interaction
- Parental Distress
- Defensive Responding

Protective Factors Survey mean subscales scores (N=34)

- Family Functioning/Resiliency
- Social Support
- Concrete Support
- Nurturing and Attachment

Partner Organizations

- P.A.T.H.
- Detroit Public Schools
- Benevolent, Inc.
- Neighborhood Service Organization
- Team Mental Health Services, Inc.
- Wayne County Department of Human Services
- T.J. Adams Employment Services
- National Council on Alcoholism & Drug Dependence of Greater Detroit
Nurturing the Resiliency in Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work

“At A Glance”

Project of

HOMES FOR BLACK CHILDREN

FUNDED BY THE UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES
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Project Abstract

Homes for Black Children, a comprehensive child welfare agency with a rich forty-two year history of offering services to children of all ethnicities is best known for its ground breaking evidenced based practice in creating permanent outcomes for African American children through Adoption and Family Preservation Services.

Homes for Black Children proposes to demonstrate the effectiveness of Family Group Decision Making as a best practice model in reducing the number of urban children who enter foster care, as well as reduce foster care recidivism in Wayne County, Michigan. In 2004, although African American Children represented only 48.86% of the overall child population, they represented 82.05% of the foster care population in Wayne County with a disproportionality rate of 1.69 (Michigan Family Independence Agency Warehouse Data, 2004). The proposed project will focus on 100 African American families who are at risk of their child entering the foster care system or families who have had their child/ren returned from foster care. Referrals are anticipated from the Wayne County Department of Human Services, the Detroit Public School System, and Homes for Black Children’s Foster Care Department. Fathers will be encouraged to participate in planning for their children, as well as all aspects of program activities. All referrals will be voluntary.

The Project will develop an individualized “Family Resiliency Plan” guided by each family to achieve its overall goal of improving child and family well-being through the use of four core evidenced based strategies which support and build upon the family’s own strength:

- Family Group Decision Making
- Solution Focused Family Counseling
- Parent Advocate/Mentors
- Family Well-Being Cluster (includes collaborative partnerships with Wayne County Department of Human Services, The Detroit Public Schools, TJ Adams Employment Service, Community Mental Health Services, National Council on Alcoholism and Drug Dependence of Greater Detroit, R&R Domestic Services, Inc. (Domestic Violence), and the Family Place (child care services). The Well-Being Cluster will also include services traditionally offered by Homes for Black Children, e.g., life enrichment activities, individualized counseling, and parent education.

Homes for Black Children is certain that this continuum of services will assist families in strengthening child protective factors in decreasing overall family stress by providing emotional as well as concrete support, parent education, and improved social and family connections. Dr. Larry Gant, PhD, of the University of Michigan will conduct a rigorous evaluation of the project, and the Michigan Federation of Family and Children Agencies will assist in the dissemination of findings.

Funded by United States Department of Health & Human Services Children’s Bureau
Program Participants

**Leadership Team**

Jacquelynn Moffett, ACSW  
*Principal Investigator*  
Overall accountability for Project development and leadership

Eugene Wilson, BA  
*Supervisor of Family Resiliency Services*  
Responsible for Program implementation and supervision. Eugene also coordinates the Family Well Being Cluster (consortium of community family resource).

**Evaluation Team**

Justin Gant

Larry Gant, PhD

Responsible for the development and implementation of the evaluation plan.
Family Resiliency Coordinators

Constance Armstrong, BA  CaSaundra Hendricks, BA  Eloma Simpson-Barnes, BA

Coordinates the development of the Family Reunification Plan, and supporting services.
Family Life Coaches

Doris Alexander, MSW
Provide in home solution focused counseling, conducts support groups and school based parent education groups (Parent Club),

Hattie Sanders, MSW
Parenting Coach

Joan Blount, MA

Coordinates Agency Family Resource Room, works with family to develop individualized child management plan. Conducts monthly child development/treatment staff in-service trainings.
Parent Club Facilitators

Keith Campbell
Facilitates School Based and Agency Parent Education Club

Doris Alexander, MSW

Homes for Black Children: “Nurturing the Resiliency In Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work”
Life Enrichment Coordinator

Janet McDonald
Plans and implements all Life Enrichment Activities, Drummers for Peace, and Co-Facilitates Girl’s Group.
Coordinator of Learning Resources

Linda Lipscomb, LMSW
Plans, implements, and archives all Project related training
Parent Advocate/Mentors

Dana Hill Belton  Jennifer Johnson  Bernadine Simmons  Valerie Smith

Not Pictured

Provides role modeling, supporting services and community resources to the families
Project Support Team

Pamelia Burner  Steve Simpson  Gwendolyn Walker

Administrative assistance to all meetings, activities, schedules, notices, and reports
Homes for Black Children: “Nurturing the Resiliency In Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work”

Partners

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<td>Roger Christ, MSW</td>
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<td>Michigan Department of Health and Human Services</td>
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Dianna Pyles, MSW
District Manager
Wayne County Department of Human Services

Annie Ray, MSW
Director of Child Welfare

Detroit Public Schools: Marcus Garvey, Nichols, Hutchinson Howe
Identifies and Refers Category 4 Families at Risk. Participates in Program planning and recommendations. Assists with the dissemination plan.