Engaging, Encouraging, and Empowering Families To Succeed

Family Group Decision Making — Family Team Conferencing Process Manual

CHILDREN’S BUREAU FAMILY CONNECTION GRANT 2011-2014: USING FAMILY GROUP DECISION-MAKING TO BUILD PROTECTIVE FACTORS FOR CHILDREN AND FAMILIES
Acknowledgements

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Also, we would like to thank the following agencies for their participation and support: the Department of Children and Families, Child & Family Connections, Inc., Ocala/Marion County Domestic Violence/Sexual Assault Center, The Centers, Children’s Home Society Mid-Florida Division, Fifth Circuit Guardian Ad Litem Program, and Youth and Family Alternatives. Finally, a special thanks to J.K. Elder and Associates and the grant-funded staff members who participated in this project for their hard work and dedication to Family Group Decision-Making.
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Chapter 1: Introduction

Staff Biographies

The following individuals have played key roles in the development, execution and evaluation of the Family Group Decision Making Project. Without their leadership, dedication and perseverance, this work would not have been able to achieve meaningful outcomes for children and families and Florida’s 5th Judicial Circuit.

**Penny Beehler, Project Coordinator:** Penny Beehler has more than 19 years experience in the field of child welfare. She worked for the Florida Department of Children and Families as a Protective Services Counselor, Protective Services Supervisor, and a liaison between the Department and the 17th Judicial Circuit Court. In 2002, Penny transitioned her knowledge and abilities to professional development. From 2002-2006, she worked for Florida International University and ChildNet, a community-based care child welfare agency, as a Coordinator of Training and Education programs. With these organizations, she provided training for case workers and supervisors in child welfare. From 2006-present, Penny is the Director of Training and Professional Development at Kids Central, Inc. Her training unit provides state child welfare certification for new employees and provides professional development in a five county area. Penny has been selected as a speaker in statewide and national conferences.

**MaryEtta Clarkson, Co-Project Manager:** MaryEtta P. Clarkson has served as Devereux Kids Project Coordinator for Family Group Decision-Making in Florida Judicial Circuit 5. In this capacity, Ms. Clarkson was responsible for directly supervising skilled professionals who worked closely with, provided support to, and advocacy for family participating in the Family Group Decision-Making process. MaryEtta earned both her undergraduate and graduate degrees in Criminal Justice from the University of South Carolina. She has more than 25 years of experience in child welfare and working with at-risk populations. Some of her past work includes working for the South Carolina Juvenile Parole Board as a State Parole Examiner, the University of South Carolina Center for Child and Family Studies as a statewide Victim’s Assistance Certification Trainer, Boys and Girls Clubs of America National Headquarters as a National Director, and Children’s Home Socie-
MaryEtta has also received and conducted extensive training in the areas of Risk Assessment, Managing Adolescent Behavior, Juvenile Justice Prevention, Child Abuse Prevention, Conflict Resolution, Basic Investigative Techniques, Solution-Focused Casework, and Family Team Conferencing.

MaryEtta continues to perpetuate her passion for service and helping others by recently being promoted to Service Director for Devereux Kids Programs in Polk County, Florida where she will oversee Case Management and Child Welfare Programs, Specialized and Therapeutic Foster Care Programs and the GAP Program which is designed to help relative/non relative care givers during the gap between placement and engagement with case management.

**Malveria Cox-Carter, Co-Project Manager:**

Malveria Cox-Carter currently serves as the Program Director for Devereux Kids programming in Florida’s Judicial Circuit 5. She earned Bachelor of Science in Psychology from the University of Florida and a Master of Business Administration in Human Resource Management from Florida Metropolitan. She is also certified as a Green Belt in Six Sigma and was a Licensed Chemical Depend-ency Counselor in Texas.

Malveria has worked as an Area Manager with Child Protective Services in Houston, Texas, and has served as a Child Protective Investigator in Alachua County, Florida. She was also a chemical dependency counselor for Marion-Citrus Mental Health Center, currently know as The Centers, and the Drug Abuse Comprehensive Coordinating Office in Tampa. She has ten years of experience in child welfare and 14 years in substance abuse counseling. She received specialized training in Family Team Conferencing, Solution-Focused Family Engagement, the Joan Sherman Program for Resilient Children (3.0) and Suicide Prevention (QPR).

During the Family Group Decision-Making Grant, Malveria was responsible for the direct supervision of the facilitators in this process. She provided guidance, training, and consultation to the facilitators and other diversion providers, as well as, information dissemination and reporting to federal funders and community partners. She has a passion for strengthening families, engaging communities and protecting children.

**Jean K. Elder, Principle Investigator:**
Jean K. Elder, PhD has been engaged in best practice and policy development in human services for
more than 35 years. Currently serving as the founder of JKE&A, Dr. Elder is immersed in projects focused on organizational development, program assessment and redesign, community assessment, data-driven accountability systems, performance-based contracting in the area of child welfare and family services. Prior to founding JKE&A, Dr. Elder served as an Assistant Secretary, Office of Human Development Services as well as the Commissioner, Administration of Developmental Disabilities, United States Department of Human Services. Additionally, she held positions as the Deputy Director, Michigan Department of Mental Health; Vice President of Marketing and Governmental Relations, Council on Accreditation for Children and Families; and Senior Vice President, Children Welfare Division, Maximus, Inc.. Dr. Elder’s ongoing professional focus involves connecting applied research to the implementation of best practice, which results in improving the lives of children and families. With her extensive background and experience in child welfare policy development and best practice standards and evaluation, Dr. Elder has proven to be a valuable resource to numerous child welfare agencies and States as they engage in system redesign with the goals of improving service delivery and outcomes for children and families in need in their communities.

Nicole Pulcini Mason, Director of Community Affairs: Nicole Pulcini Mason is a non-profit public relations specialist and marketer. In 2007, Nicole joined the child welfare case management agency in Gainesville, Florida. While employed, she completed her Bachelor of Arts in English from the University of Florida. In 2009, Partnership for Strong Families was awarded the Family Connection grant to study three models of Family Team Conferencing. Nicole helped implement and coordinate the grant for the first two years. During the grant, she scheduled over 400 FTCs across 13 counties. Uniting her marketing experience, college education and child welfare experience, she joined Kids Central’s Community Development Department. As Director of Community Affairs, Nicole boasts an 86% media landing rate and has increased the organization’s Facebook reach by 1,000%. Since joining Kids Central, she continued her education and earned her Master of Nonprofit Management from the University of Central Florida in 2013. As part of Kids Central and Devereux’s Family Group Decision-Making grant team, Nicole led the grant steering committee, ensured information dissemination, and produced the grant replication manual.
Project Abstract


The proposed initiative focused on implementing Family Group Decision-Making as a component of a strong system-of-care supporting family connections. This project is a variation on an evidence-based theme, effectively engaging families in order to affect positive change in their circumstances through education, empowerment and encouragement so children can be safe in their homes. Through the systematic implementation of a strength-based, family-inclusive framework that educates on protective factors in a non-threatening environment, children and families experience positive and successful outcomes. Families will be empowered to make purposeful, educated choices as they use their strengths to create a plan for addressing their identified needs.
Chapter 1: Introduction

Florida’s Child Welfare System

Florida boasts a unique child welfare system-of-care. Beginning in 1998, a series of laws were passed to reform Florida’s child welfare system and privatize it. The Florida Department of Children and Families procures and contracts with community-based care lead agencies (CBCs) to create local systems-of-care. As of 2014, 17 Community-Based Care agencies across the state are responsible for the provision of services ranging from child abuse prevention and protective supervision through foster care and adoption. However, the Department of Children and Families maintains the oversight, contract management, state abuse hotline, and initial abuse investigations.

Under the Department of Children and Families’ Safety Framework, there are three levels of service intervention: in-home diversion/family support, in-home judicial and non-judicial, and out-of-home judicial. After a call is made to the abuse hotline, a Department of Children and Families’ Child Protective Investigator (CPI) investigates the abuse report. If the children are safe and the family is willing to accept services, the family is referred to in-home diversion/family support. If the children are safe, abuse is substantiated, and higher level of supervision needed, the family is referred to in-home judicial (or non-judicial) services. If the children are unsafe, abuse is substantiated, and the highest level of supervision needed, the children are removed from the home and the family is recommended for judicial involvement.

Florida’s Fifth Judicial Circuit System-of-Care

Kids Central, Inc. is the lead nonprofit community-based care organization in Florida’s Fifth Judicial Circuit consisting of Citrus, Hernando, Lake, Marion and Sumter Counties. As the lead agency, Kids Central is contractually responsible for the coordination, integration, and management of all foster care, adoption, and related child and family services in the community ensuring continuity of care from entry to exit for all children referred. Simply, Kids Central concentrates on the prevention, diversion, and treatment of child abuse in its designated circuit. As the community-based care agency, Kids Central procures and contracts service delivery and case management services to local nonprofits that deliver direct and indirect services to clients. Additionally, Kids Central maintains a host of internal prevention, diversion and treatment programs.
Devereux Florida is part of the national Devereux Foundation, which was founded in 1912 and provides programs and services in ten states across the nation. Dev FL, with nearly 1,000 employees, provides mental health and child and family services to over 12,500 children and families annually through 46 programs throughout Florida. Devereux’s mission is to engage and collaborate with community stakeholders to ensure that the services collectively provided meet the needs of those served.

Beginning in May 2005, Devereux Florida partnered with Kids Central to provide diversion services in Circuit 5 using the Family Team Conferencing model. In 2008, Devereux, again partnering with Kids Central and DCF, began to develop a network of neighborhood-based prevention projects in Florida Circuit 5 to address the prevention of abuse and neglect by engaging families in services that promote family well-being, safety and health.

As part of the Family Connection Grant: Using Family Group Decision-Making to Build Protective Factors for Children and Families, Kids Central was the grant administrator and Devereux was the program administrator. Kids Central was responsible for ensuring quality assurance, model fidelity, grant reporting requirements and other administrative duties. Devereux was responsible for program implementation, service delivery, program staffing and data collection.

For the Family Connection Grant, only families referred to in-home diversion/family support services were eligible to receive the Family Group Decision-Making intervention. To determine program involvement and service interventions, diversion cases were brought to a Multidisciplinary/Community-Based Staffing. The Community-Based Staffing is a roundtable case discussion which includes the CPI, CPI Supervisor (CPIS), community providers and contracted providers. During the meeting, cases are staffed by DCF and assigned to appropriate service providers which included the FGDM.

Introduction and Explanation of FGDM and FTC

Family Group Decision Making (FGDM) is an effective model of practice which addresses the needs and incorporates the strengths of families in relation to child safety, permanency and wellbeing. The FGDM approach considers family strengths, family engagement, and informed family decision-making as core values when working with children and families. FGDM empowers families to take an active and leadership role in developing plans and making decisions to promote the safety, permanency, and well-being of their children. The FGDM service models are considered best practice approaches to serving the needs of families who are at risk of
entering the child welfare system. Utilizing a model that supports family involvement over the entire course of the case, as opposed to a one-time event, truly demonstrates actualization of a family-centered, empowerment-focused paradigm.

Family Team Conferencing (FTC) is a model of FGDM. Family Team Conferencing is a decision-making process in which members of the family group are invited and joined by members of their informal network, friends, family members, faith community, community groups, and child welfare professionals in a meeting to jointly develop an individualized plan to strengthen family capacity, assure safety, increase stability, and build natural supports to sustain the family over time. Family Team Conferencing is a collaborative family-focused intervention approach.

The FTC should be convened at a time and location accessible to the family. The conference is held to assess needs, develop an action plan, coordinate actions, and to assign and hold responsible collaborators. Team members are crucial to identifying the family’s strengths, brainstorming opportunities, contributing their skills and knowledge, holding other accountable, and providing feedback.

Family conferencing works because it focuses on needs rather than symptoms; is based on the tenet that all people have strengths and are capable of change when helped in a caring supportive way to find solutions; that solutions developed by family teams are more successful because they are based upon the unique strengths and needs identified by the family; and that said plans generate long-term sustainable solutions outside of the formal child welfare system.

Within this manual, the term, FGDM, will be used to describe the grant project and overarching practice or theory. While the term, Family Team Conferencing, will be used to describe the specific practice of holding a family-focused meeting.

**Kids Central’s Service Model**

Kids Central utilized the Family Team Conferencing service model rooted in FGDM. As part of the overall FGDM intervention, Family Team Conferencing is a specific intervention involving a family meeting. The Family Team Conference (FTC) is a non-threatening environment where a family can come together with identified supports and develop a plan to improve skills and access resources, which allow for the safety, permanency, and well-being of children. The FTC approach encourages convening a child and family team to address major child welfare decisions from safety planning to case closure. Following the FTC, case coordination continues to involve family supports and family-centered decision making while the family carries out its family’s plan.
The intervention targets families receiving diversion services. These families were the subject of an abuse call to the Florida Abuse Hotline, but were diverted from the formal child welfare system. As a result, they are not involved with the judicial system and the family is voluntarily participating in the service.

The FGDM model implemented was developed based on Alabama’s Family Team Conferencing Approach. A neutral Community Facilitator engages and prepares the family for the FTC. During a preparatory interview, the facilitator learns more about the family, assists them in identifying strengths, and encourages them to identify formal and informal supports for the FTC. The facilitator schedules and completes the FTC with the family and their supports.

The benefits of the neutral facilitator versus a case manager conducting the process include:

1) Many of the families hold preconceived opinions about the child welfare system and are more open and trusting with a facilitator who is not a case manager.

2) Families perceive the neutral facilitators as advocates for their family, who are there to help prepare a plan based on the family’s needs versus a dictated plan that best suits the agency’s needs, goals or requirements.

3) A neutral facilitator is seen as an objective third party who can combine the goals of the family and the case manager in a viable action plan.

4) A neutral facilitator can help reframe the family’s concerns to case management staff without feeling pressure to justify actions of the child welfare system.

5) A neutral facilitator helps make sure the conference is with the family not just about the family.

6) Facilitation is an advanced skill set, which differs from that of case management or social work.

7) As a neutral, non-case carrying facilitator they are free to devote more time to exploration of resources for families and to focus on the needs of the entire family.

8) Both formal and informal resources are incorporated into the family’s plan of action thus helping families develop relationships that will sustain them over time.

The FTC results in the development of an Individualized Course of Action Plan (ICAP) outlining tasks to be completed and identifies the individual responsible for those tasks. After the FTC, the case is transferred to a Diversion Care Coordinator (DCC). Coordinators are assigned based on the needs of the case and are trained to address specific needs. For example, a designated group of DCCs received specialized training in domestic violence and engaging domestic violence victims. The role of the DCC is to act as a family advocate and assist them in mitigating bar-
riers while the family completes their ICAP. The DCC supports the family through completion of the ICAP and is then responsible for closing the case.

**Protective Factors**

The Protective Factor Survey (PFS) is an evidence-based tool created by FRIENDS National Resource Center in collaboration with the University of Kansas Institute for Educational Research and Public Service. The PFS is a pre-post evaluation tool (Appendix H) to be used with caregivers. The survey is completed by the parent or caregiver and measures protective factors in five areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development.

Protective Factors are defined as:

- **Family Functioning and Resiliency:** Having adaptive skills and strategies to persevere in times of crisis; Family’s ability to openly share positive and negative experiences and mobilize to accept, solve, and manage problems.
- **Social Emotional Support:** Perceived informal support (from family, friends, and neighbors) that helps provide for emotional needs.
- **Concrete Support:** Perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.
- **Knowledge of Parenting and Child Development:** Understanding and using effective child management techniques and having age-appropriate expectations for children’s abilities.
- **Nurturing and Attachment:** The emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

Prior to the FTC, the facilitator administered the PFS to the caregiver to assess and record their beginning protective factors prior to intervention. A post-PFS was administered after the FTC and diversion case management to assess and record the family’s resulting protective factors. The change in protective factors between case initiation and case closure provided evidence to improved functioning over the course of the intervention.

The primary purpose of PFS is to afford feedback for continuous quality improvement and evaluation purposes. The pre-survey was utilized to assess the parent’s protective factors and identify areas for improvement. Through the FTC, the ICAP included action tasks aimed at increasing the protective factors needing improvement. After the family completed the post-survey, the change in protective factors was used to quantify the family’s changes and validate or delay case closure.
Dunst Needs Scale

At the request of the Children’s Bureau, all Family Connections FGDM grantees were required to administer the Dunst Needs Scale (Appendix C) to target families during the preparatory meeting. This scale provides family members the opportunity to identify areas they need assistance. Each item is rated on a five point Likert scale ranging from “not applicable” to “almost always.” The items are related to daily childcare and family routines. For example, budgeting money, transportation, school placement, and having someone to talk to (Dunst, Trivette, & Deal, 1988).1

Project Goals

The overarching goal of FGDM project was to empower and enhance families so they can self-regulate and safely parent. FGDM incorporates strength-based, family-centered practice through family engagement and empowerment in a culturally sensitive environment. Furthermore, the goal was to enhance protective factors for all families, but specifically for those dealing with domestic violence, substance abuse, and mental health issues.

Additionally, the project was designed to reduce number of children entering the formal child dependency system and reduce recidivism through measurable improvements to safety, permanency, and wellbeing outcomes by: engaging pertinent service providers and informal support networks in FTCs that develop ICAPs that address family functioning related to child safety, wellbeing and permanency. Improvements in safety, permanency, and wellbeing outcomes can be measured through the Child and Family Services Review (CFSR) performance measures. The CFSR is the federal government’s program for assessing the performance of state child welfare agencies with regard to achieving positive outcomes for children and families. CFSR outcomes, current performance measures and the goal to achieve optimum service provision to children and families, lead to the following objectives:

1) **Reduce** the number of children entering the formal child dependency system through measurable improvements in safety, permanency, and wellbeing outcomes (particularly those related to CFSR Permanency Outcomes 1 & 2 and Wellbeing Outcome 1)

2) **Achieve** reductions in recidivism (cases experiencing substantiated allegations of abuse or neglect) six to twelve months after closure through measurable improvements to safety, permanency, and wellbeing for families who successfully complete an Individualized Course of Action Plans.

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3) **Increase** rate of successful closure through family youth outcomes identified in the FGDM-EEE logic model

4) **Increase** the use of protective factors through pre- and post-test knowledge gains about FGDM strategies

All four objectives were incorporated into the project’s design and used to guide all aspects of service provision. The project operated under the hypothesis: *Through successful engagement and inclusion in the development of an individualized treatment plan, families would experience improvements in the domains of family functioning and be less likely to experience subsequent, substantiated instances of abuse or neglect.*

Finally, as a result of the FGDM process, the local system-of-care sought to improve the ability to effectively engage and intervene with engage families without court intervention.
Chapter 2: Implementation

Project Structure

Kids Central’s Chief of Operations was responsible for administration and oversight of the project while day-to-day coordination of project activities was the responsibility of the Director of Training. As the Project Coordinator, this individual: acted as the liaison with the Children’s Bureau’s Federal Project Officer, collaborated with the external grant evaluators, J.K. Elder and Associates, ensured project staff and collaborative partners received appropriate training, and partnered with Devereux Kids to oversee implementation of FGDM service provision and ongoing coordination of family activities.

As the external evaluator, J.K. Elder and Associates was engaged to document implementation procedures and assess the overall impact of the project on children and families served.

Devereux maintained responsibility for providing the intervention to families engaged in the program. Devereux’s project management provided professional development and supervision to Community Facilitators and Diversion Care Coordinators.

Finally, Kids Central’s Quality Assurance team examined program fidelity through quarterly a random selection using a fifteen-element review protocol (Appendix D). This protocol was used to ensure facilitators and coordinators adhered to the Family Team Conferencing model implemented and was assessed by the evaluators to determine whether the FGDM model was being implemented appropriately and with fidelity.
Implementation Timeline

Project implementation was guided by a comprehensive plan detailing key tasks and activities. Given the fairly short grant cycle (three years), it was imperative that project activities were executed in a timely manner and all appropriate parties were engaged at all stages of planning and implementation. The following table demonstrates the project team’s efforts to plan and execute project start-up in a brief four-month timeframe:

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hire Staff</td>
<td></td>
</tr>
<tr>
<td>Hire Facilitators</td>
<td>1/2012</td>
</tr>
<tr>
<td>Hire Diversion Care Coordinators</td>
<td>1/2012</td>
</tr>
<tr>
<td>Roles and Responsibilities</td>
<td></td>
</tr>
<tr>
<td>Establish FGDM Implementation meetings</td>
<td>12/2011</td>
</tr>
<tr>
<td>Finalize roles and responsibilities of staff and community partners. Establish Memorandums of Understanding</td>
<td>2/2012</td>
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<tr>
<td>Establish Advisory Committee</td>
<td>9/2012</td>
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<tr>
<td>Communication Plan</td>
<td>2/2012</td>
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<tr>
<td>Protocols and Processes</td>
<td></td>
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<tr>
<td>Finalize FGDM protocol and time lines</td>
<td>4/2012</td>
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<tr>
<td>Protective Factors Survey</td>
<td>4/2012</td>
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<tr>
<td>Dunst Survey</td>
<td>4/2012</td>
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<tr>
<td>Budget planning and reporting schedules and process</td>
<td>4/2012</td>
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<tr>
<td>Finalize MindShare and data entry process and other program tools for data collection</td>
<td>4/2012</td>
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<tr>
<td>Training and Outreach</td>
<td></td>
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<tr>
<td>Training for staff with Butler Institute</td>
<td>4/12/2012</td>
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<tr>
<td>Training for community partners</td>
<td>6/2012</td>
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<tr>
<td>Community outreach meetings</td>
<td>Ongoing</td>
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<tr>
<td>Design Data Collection and Research</td>
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<tr>
<td>J.K. Elder and Associates Cost Analysis Data process</td>
<td>1/2012</td>
</tr>
<tr>
<td>Commencement of data collection</td>
<td>1/2012</td>
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Staff Roles and Responsibilities

To ensure consistency of implementation, roles and responsibilities of direct service staff were carefully defined and aligned with key factors of the FGDM model implemented.

The following descriptions offer a brief synopsis of these responsibilities:

**Lead Facilitators**

1. Trains new Community Facilitators
2. Audits assigned Community Facilitator files
3. Shadow Community Facilitators

**Community Facilitators**

1. Reviews available case information upon case assignment
2. Engages families from a strength-based perspective and empowers them to identify support members
3. Completes preparatory interview with family including explaining the benefits of FTCs, completing Dunst Needs Scale, and administering the Protective Factors Survey
4. Effectively facilitate the FTC and redirects discussion from problems to strengths
5. Maintains integrity of the FTC and the FGDM project
6. Ensures ICAP is completed at FTC
7. Addresses safety concerns

**Diversion Care Coordinators**

1. Assists Community Facilitator and provides follow-up services preceding the FTC
2. Supports families’ participation in community services and activities within the community
3. Assists in identifying and referring families to appropriate community resources
4. Holds families accountable for goal achievement and ICAP tasks completion through empowerment
5. Administers the post-PFS and post-service evaluation
Chapter 3: Procedures

The project team developed clear policies and procedures and refined them as needed over the duration of the grant. Procedures integrated key fidelity measures and ensured consistency in expectations and performance amongst project management and between individual facilitators and coordinators.

FGDM Family Criteria

1) The FTC referral must be for a family who has minor children living in the home.
2) The FTC referral must be made to prevent the removal of child(ren) from the home.
3) The FTC referral must be for the purpose of engaging the family and its supports in preparing an Individualized Course of Action Plan (ICAP), which will develop or enhance at least two of the five protective factors.
4) The purpose of the FTC referral must be to help the family create a system-of-support that will sustain them over time.
5) The FTC referral must be made to help match services/interventions to the needs of the family as identified by the family and the protective investigator.
6) The FTC referral must be made for families who are likely to participate in the FTC voluntarily.
7) The FTC referral must be for family participants who do not have a current legal issue that would prohibit their involvement in the conference, i.e. injunction for no contact or pending criminal charges for maltreatment towards child(ren) - Especially in cases involving domestic violence, family conflict, or sexual abuse.
8) The investigator must disclose any history of violence towards child welfare, current threats of violence towards the child welfare system, any active drug use, untreated mental illness or current gang involvement of target family members to be served by the FTC.
**Intake and Case Assignment**

1) Child Protective Investigator (CPI) determines a case will be referred for diversion services
2) CPI staffs case with Family Preservation Specialist at a diversion staffing or appropriate team meeting and determines if diversion services are necessary
3) Staffing members determine which service(s) are best suited for the family
4) FGDM criteria considered before assigning FGDM (please see criteria above).
5) If FGDM is determined to be the best service, staffing and facilitator assignment forms are completed and provided to administration.
6) Tentative joint visit with the FGDM Facilitator and CPI date set for family engagement and hand off.
7) Case entered into Mindshare and FSFN case assignment made to FGDM facilitator.
8) Joint visit occurs with CPI, FGDM facilitator and family.

**FGDM Service Delivery**

1) FGDM facilitator and family begin communication regarding the case info, participants involved and FGDM process and goals. If Diversion Care Coordinator (DCC) is available for any engagement efforts, the DCC will join the pre-planning meetings.
2) The FGDM facilitator completes the Dunst Needs Scale while conducting the preparation interviews.
3) FGDM facilitator begins the scheduling process and notifies both the CPI of any barriers
4) Finalized conference time and location set by the FGDM facilitator and family and notice provided to all involved in the case are invited to the conference.
5) The conference is held with the identified family team members and the Individual Course of Action Plan is determined.
6) The DCC will be at the conference and will describe the role of the DCC as they begin implementing the family’s ICAP.
7) Internal case transfer and supervision occur.
**Care Coordination Service Delivery**

1) The DCC provides necessary referrals and service provision while conducting home visits.
2) The DCC provides a minimum of one face-to-face visit with the children in the home and documents this visit in FSFN.
3) The case remains under the supervision of the DCC as the ICAP is implemented and the family participates.
4) Regular supervision is provided to the DCC while working with the family to ensure that service provision is in place.

**Case Closure**

1) The DCC will recommend case closure when it appears that the family has met the following criteria:
   - The risk to the children as been alleviated and the family as identified a family leader.
   - The protective factors post-survey is completed.
   - The DCC receives approval from supervision.
2) To close the case successful, the family must increase in two protective factors.
3) Administrative and system processes are completed for closure including, MindShare and FSFN.
4) FTC and DCC checklists completed.
5) Complete the Family Intake Form ensuring the “Reason Closed” is checked off.
6) Supervisor approves case closure and completes closure form.
7) The family is mailed a Certificate of Completion and closure letter.

**Preparation and Engagement Process**

Meaningful family engagement is the cornerstone of FGDM and is the key to achieving positive outcomes. Service providers must communicate clearly and honestly to build trust and rapport with the family in crisis. Without shared trust, the family cannot meaningfully engage. Distrust and skepticism negates the FGDM process. Facilitators, coordinators, and other service providers involved in FGDM must adopt a strength-based, family-centered mindset to motivate, empower and ultimately engage families in a successful FTC.

The family as a whole is an integral part of the process, and, in order to be successful and comprehensive,
non-custodial parents, namely fathers, must be involved as due diligence allows. Facilitators and coordinators diligently worked to engage fathers, paternal relatives, and paternal supports in FGDM and the FTC.

Including and engaging the children in the FTC was considered based on the children’s ages, availability and maturity. The option of full or partial participation in the FTC allowed for children to participate depending on the issues to be addressed during the FTC and the children’s maturity.

---

### Engagement Process

1) Once referral is accepted, the facilitator contacts the family within two days of referral receipt to schedule a preparatory interview and meet the family.

2) Facilitator reviews FSFN notes and family history documentation.

3) At the preparatory interview, the facilitator:
   - Introduces FGDM,
   - Gains the family’s perspective of what led to the abuse call,
   - Helps the family identify strengths, challenges, needs and supports to prepare for the FTC,
   - Listens to the family’s story,
   - Helps the family identify any prospective barriers to a successful FTC,
   - Explains the case coordination services and necessity to see the children every 25 days,
   - Completes paperwork with the family,
   - Completes Prep Interview (Appendix G),
   - Administers the PFS (Appendix H),
   - Administers the Dunst Needs Scale (Appendix C),
   - Identifies family support members to invite to the FTC, and
   - Gathers contact information of support members.

4) Schedule the FTC to be held within 21 days of the initial referral and contact family support members.

5) Educate support members on the FGDM and the FTC process.

6) Conduct the FTC.
Engaging Family Supports

The inclusion of children, paternal relatives, and child welfare professionals benefits the FTC and enhances the ICAP. Facilitators and coordinators were not only encouraged but expected to engage fathers, paternal relatives and supports in the process. It was understood that the engagement of paternal supports can be difficult, but the long-term benefit to the child(ren) gaining connection with family should be emphasized and encouraged. The facilitator considered including the focus children in the FTC whenever appropriate because they too could benefit from full or partial participation depending upon their maturity level and the issues the family had to address. Also, participation by Dependency Case Managers and Child Protective Investigators offered positive reinforcement and supported the family’s ability to make positive changes resulting in the safety and well-being of the child(ren).

Steps to Attempt Engagement with Unresponsive Families

Prior to closing a case, when the family does not engage in services, the following tasks should occur:

1. Attempt contact with the family at least three different times to valid phone numbers;

2. Contact the Child Protective Investigator’s (CPI) if a new contact number is needed, the family is not returning calls, or if a joint visit would be helpful;

3. Mail the family a letter explaining FGDM services and providing staff contact information;

4. Attempt a home visit with the family and leave contact information if the family is not home or refused to answer; and

5. If the above results in no change, the case is staffed with the Lead Facilitator or Supervisor, and the CPI is informed that the case would be re-staffed for closure.

Family Team Conference

The Family Team Conference brings the focus family together with their identified family support members, service providers, and other informal or formal supports in a structured meeting. The primary focus of the FTC is the keeping the children safe while strengthening the family. During the FTC, each participant was provided opportunities to give input and to decide whether or not they were able to support the developed plan. Including and engaging the family supports provides various prospective and levels of expertise producing holistic, realistic, and positive ICAPs. The location of the FTC is determined by the family while taking

Engagement Techniques

Reflective Listening, Reframing, Solutions Focused Questioning, Family Life Cycle and Everyday Life Events, and Agreeing with a Twist proved to be effective engagement techniques.
into account the logistics and suitability. Commonly, families chose their homes; however, this is only possible if the home can accommodate the expected number of attendees. Using family-identified locations reduces anxiety and reiterates the tenet that FGDM is a family-centered approach. With this in mind, participants each have their own roles and objectives

Facilitator:
- Help the family develop a meaningful plan to keep the children safe and stable over time;
- Educate the family on services in the community in order to empower the family to self-regulate and manage safe care of the children;
- Enhance family relations by increasing Protective Factors;
- Encourage sustainability of safety and wellbeing of the children;
- Help families have a voice to acknowledge, assess and address their needs and strengths; and
- Reduce recidivism.

Parent:
- Identify and request family team members’ participation;
- Develop the family’s outcome statement;
- Talk about the family’s strengths, challenges and needs during team meetings;
- Ask questions when they do not understand;
- Allow the team to know if the plan is meeting their needs; and
- Call the Facilitator if unable to attend the team meeting.

Support Members:
- Identify the family’s strengths,
- Brainstorms opportunities,
- Contributes their skills and knowledge,
- Helps hold others accountable, and
- Provides feedback.

Children (If age appropriate)
- Help set goals;
- Communicate strengths, needs and opinions to the team;
- Work on developing trust in parents and the family team;
- Stay committed;
- Know and communicate, as able, his/her limits;
- Ask questions in the team process; and
- Ask for help from the team.

Individualized Course of Action Plan

During the FTC, an Individualized Course of Action Plan (ICAP) is developed with the family, their supports and the professionals in attendance. The ICAP:
- Documents the goal statement,
- Includes targeted objectives with related protective factors,
- Defines action steps,
- Assigns responsible parties, and
- Establishes target dates.
At the conclusion of the FTC, all parties sign the document and a copy of the ICAP is provided to the family, facilitator and coordinator. Its purpose is to clearly outline the family’s agreed upon tasks with action steps and responsible parties stated. It serves as a road map for those involved in the case.

**Case Coordination**

After the FTC, the families are engaged by a Diversion Care Coordinator (DCC) responsible for the continuing oversight of the case, engagement with the family, service referrals and progress monitoring. Through this process, the coordinator assists the family to implement and achieve their ICAP.

*Case Coordination Goals:*

- Help family implement the plan created at the FTC,
- Add support and advocacy,
- Connect and link families to services and resources in their own communities,
- Work with these services and resources to make sure they are delivered timely and efficiently,
- Help families to connect their progress towards the action plan goals to increases in their protective factors,
- Assess child safety through home visits to be completed at least every 25 days, and
- Support families in creating and maintaining a safe environment for their children.

**Domestic Violence**

Domestic violence is one of the top three child maltreatments in Circuit 5. The other two commonly co-occurring maltreatments were substance misuse and mental health issues. Approximately 57% of all FGDM cases involved domestic violence as the primary maltreatment.

Domestic violence is a significant challenge for FGDM staff and families since its prevalence created safety concerns and legal issues. When domestic violence occurs, the perpetrator is commonly forbidden to contact the victim with a no contact order or other injunction order. It causes logistical barriers for scheduling and holding an FTC. When parents or family members were separated by no contact orders, the FGDM staff members held the FTC with the caregiver of the children, generally the victim. This excluded the perpetrator, who arguably, was most in need of intervention services. As a countermeasure, the FGDM staff engaged the excluded member’s family to represent their perspective and establish connections to the respective familial side.
Overview of the FGDM Process – Domestic Violence

Pre-screen:
- At the community staffing, the coordinator or facilitator discusses the family’s current and past domestic violence involvement including any safety concerns and court-mandated orders.
- During the initial visit, the coordinator and facilitator complete a joint visit and complete a risk assessment with the family.

FTC:
- Hold the FTC with the family respecting their wishes while reducing safety concerns.
- Make alternative arrangements based on the dynamics of the parents/caregivers.
- If court mandated orders are in effect or the victim desired separate FTCS, hold separate meetings to include both sides of the family, engage the perpetrator via written communication or telephone conference, and/or include the perpetrator's family and supports in the FTC.

Referrals:
- Based on the ICAP, the coordinator makes appropriate referrals to domestic violence treatment and therapy for the victim, children and perpetrator.
- Through case coordination, follow up with the family and provider to ensure their engagement in the services.

Case Coordination:
- The coordinator visits the family and children a minimum of every 25 days regularly assessing risk.

Closure:
- After the ICAP tasks are completed, develop an after care plan with the family to determine short- and long-term goals.

Follow Up:
- 90 days after case closure, the coordinator calls the family to inquire as to their completion of the after care plan and needs unmet.
Conducting the Family Team Conference

Welcome and Introductions:
- The facilitator welcomes participants as they arrive and then the entire team conducts introductions stating names and relations to the child/family, beginning with the family.

Purpose:
- The facilitator reviews the reason for the meeting, provides an overview of the steps to be followed, and addresses questions and/or concerns.

Outcome Statement:
- Share the outcome statement and express the need for child safety, as the overarching goal of the meeting.

Non-Negotiables:
- Child safety is first.
- The facilitator provides an overview of non-negotiable factors influencing the meeting.

Confidentiality:
- The facilitator explains the circulating confidentiality agreement and clarifies that any information about the family is only shared on a “need to know” basis in order to obtain additional services or accomplish the family’s desired outcomes.

Ground Rules:
- The facilitator asks the family to identify how they would like to govern the meeting and for ways to manage behaviors to keep the meeting focused and productive.

Family Story:
- The family shares their story, providing their perspective on the current circumstances and the reason for the meeting.

Strengths:
- Family strengths are identified by all participants based upon what worked well in the past and character traits that could positively influence the success of the action plan.

Challenges and Needs:
- The facilitator encourages the family and supports to share the family's challenges and needs with the team.

Action Planning:
- The action-planning phase addresses the primary issues.
- This section delineates family-driven tasks that address child safety and outline steps for improving the family condition by positively impacting the identified challenges and needs.
- A minimum of three protective factors are addressed in the target objectives.
- Responsible parties and timeframes are assigned to each task of the action plan.

Key Action Planning Steps:
- Identify the Team Lead: Who will help to ensure the plan is followed?
- Develop the Backup Plan: Contingency planning that clarifies the team and/or Team Lead’s responsibilities to help the family maintain the safety and wellbeing of the children in the long run.

Closure:
- The family is provided the opportunity to make changes and confirm their satisfaction with the plan.
- The plan is recapped and transferred onto action plan forms.
- Individual tasks are initialed by assigned persons, and the form is signed by the family and facilitator.

Evaluation:
- Once the FTC concluded, participants complete an anonymous survey of the process and facilitator.
- Evaluations are placed in a sealed envelope by participants submitted.
Chapter 4: Evaluation

K. Elder & Associates, Inc. implemented a comprehensive evaluation of the FGDM grant. The evaluation encompassed both outcome and process components and was designed to answer the following research questions:

**Outcome Evaluation Questions**
1. Does the FGDM-EEE result in measurable improvements in safety, permanency and well-being outcomes?
2. To what extent are FGDM-EEE strategies successful in achieving caregiver and family/youth outcomes identified in the program Logic Model?
3. Does the FGDM-EEE lead to increased staff knowledge about FGDM strategies?
4. What is the cost/benefit effectiveness of the FGDM-EEE?

**Process Evaluation Questions**
1. In what ways do specific FGDM-EEE characteristics or components influence the effectiveness of the initiative (e.g., program fidelity, staff requirements, the presence of other family engagement strategies, and contextual variables)?
2. What key considerations must be taken into account when implementing FGDM programs (e.g., lessons learned, how to integrate into current model of practice, necessary collaborations and partnerships, significant barriers)?
3. To what extent were the key components outlined in the Approach implemented as intended?

The local evaluation design had to be flexible enough to accommodate all evaluation activities, yet sufficiently rigorous to assure the internal and external validity of both the process and outcome data for the site. The outcome evaluation design allowed for an examination of intermediate and long-term outcomes for staff, caregivers, and youth. In order to assess system, caregiver, and staff outcomes, a pre-post design was utilized while the effectiveness of the program on youth and family outcomes employed a quasi-experimental design using treatment and comparison populations. These populations were defined as

**Treatment Population:** The treatment unit of analysis is at the case level (utilizing case ID’s with one ID per family) for client outcomes. The participant unit of analysis for staff outcomes is the individual staff or partner (individual person).

**Comparison Population:** The comparison unit of analysis is at the case level (utilizing case ID’s with one ID per family) for client out-

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**Outcomes**

Families participating in FGDM demonstrated statistically better outcomes than families receiving other diversion services.
comes (non-FGDM diversion cases)

The process evaluation involved a mixed-method design using quantitative and qualitative data collection to assess key program activities and outputs. Multiple sources of data were used, which allowed evaluators to assess components from administrative, staff, and client perspectives with a focus on quality of implementation, the effect of contextual facilitators and impact of implementation barriers. The process evaluation also assessed the degree to which fidelity to the selected FGDM Model was maintained over the course of the grant. Data elements and sources used to answer the research questions are described in the following tables:

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Measures</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the FGDM-EEE result in measurable improvements in safety, permanency and well-being outcomes?</td>
<td>CFSR Permanency Outcome 1 (Children have permanency and stability in their living situations)</td>
<td>FSN data system (State SACWIS System)</td>
</tr>
<tr>
<td></td>
<td>CFSR Permanency Outcome 2 (Continuity of family relationships and connections)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CFSR Well-being Outcome 1 (Families—including foster families—have enhanced capacity to provide for children's needs)</td>
<td></td>
</tr>
<tr>
<td>To what extent are FGDM-EEE strategies successful in achieving caregiver, and family/youth outcomes identified in the program Logic Model?</td>
<td>Increased rate of successful diversion plan closures (successful engagement of families in diversion plan completion)</td>
<td>FSN data system (including new diversion tracking measures)</td>
</tr>
<tr>
<td></td>
<td>Decreased recidivism (families who successfully complete their diversion plans and services will not experience subsequent substantiated child maltreatment)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decrease the number of children entering the formal child welfare system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enhanced parental/caregiver knowledge about protective factors and the health, safety, and well-being of children</td>
<td>Parent survey (FRIENDS National Resource center protective factor survey)</td>
</tr>
<tr>
<td>Does the FGDM-EEE lead to increased staff knowledge about FGDM strategies?</td>
<td>Increased staff and partner knowledge of FGDM/FTC strategies (including engagement of fathers/relatives) and protective factors</td>
<td>Pre/Post training assessments; Annual surveys of staff (FTC facilitators and diversion case coordinators) and diversion partners</td>
</tr>
<tr>
<td></td>
<td>Increased partner knowledge about the benefits of FGDM/FTC including roles and responsibilities in the approach</td>
<td></td>
</tr>
</tbody>
</table>
Outcome Evaluation

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Measures</th>
<th>Data Source</th>
</tr>
</thead>
</table>
| What is the cost/benefit effectiveness of FGDM-EEE? | Cost analysis  
Cost variation analysis  
Cost effectiveness analysis  
Cost comparison analysis | Kids Central expenditure reports, cost allocation plans, financial reports, staff time reports, diversion service utilization management reports (quarterly), and program staff interviews |

Process Evaluation

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Measures</th>
<th>Data Source</th>
</tr>
</thead>
</table>
| In what ways do specific FGDM-EEE characteristics / components influence the effectiveness of the initiative? | Qualitative examination of the relationship between the success of the Demonstration Project and program fidelity, staff requirements, the presence of other family engagement strategies, and other contextual variables | Bi-annual interviews with project leadership  
Focus groups or surveys involving staff (FTC facilitators and diversion case coordinators) and diversion partners |
| What key considerations must be taken into account when implementing FGDM programs? | Documentation of lessons learned and perceptions on how to best integrate FGDM strategies into current model of practice, necessary collaborations and partnerships, significant barriers, etc. | Bi-annual Document & Record Review  
Bi-annual interviews with project leadership  
Annual focus groups and surveys involving staff (FTC facilitators and diversion case coordinators) and diversion partners |
| To what extent were the key components outlined in the Approach implemented as intended? | Documentation of adherence to the implementation timeline; mapping progress onto key benchmarks  
Documentation of adherence to program components; noting any significant deviations from the original proposal in terms of key activities and approach |  |

While data related to cost effectiveness, and wellbeing related outcomes continue to be evaluated at the time of this publication, preliminary results demonstrate some promising trends.

Results

Fidelity to the FGDM Model Implemented: To ensure fidelity to the selected FGDM model, Quality Assurance staff completed an independent review of fidelity at regular intervals. Using a FGDM Case Review Tool (Appendix D) developed by the project team, a representative sample of case files was assessed for compliance with key components of the model including:

- Multi-disciplinary staffing is held and risk level is determined appropriate for diversion?
- FGDM facilitator completes all pre-planning activities for family?
- FGDM facilitator meets with family and other participants
for Prep Interview?

- FGDM facilitator completes Protective Factors pre-test with family?
- FGDM meeting is scheduled at a time and place convenient for the family (see section III of Prep Interview)?
- Individualized Course of Action plan (ICAP) developed and shows clear evidence of family input?
- ICAP is developed and shows clear evidence of building on family strengths, not just deficits?
- FGDM Care Coordinator acts as an advocate to assure plan is completed successfully as evidenced in progress or contact notes?
- Are services comprehensive and address all major areas of need?
- Did FGDM process created a stronger informal support system for this family? Describe how.
- Do the progress notes document the record level of completion/compliance with plan by family?
- FGDM Care Coordinator completes Protective Factors post-test with the family?
- FGDM coordinator closes case; and case record supports the closing risk level?
- FGDM coordinator closes case; and case record supports the recorded closure reason?
- Case was not closed prematurely before sufficient supports were put in place (applicable to cases where the family is willing to continue participation)?

Over the course of the grant, fidelity to these components improved from 88% to 94%. During the last reporting period (October 2013 – March 2014) all measures were addressed in each case; however, some measures were not addressed to the degree necessary to meet the threshold or definition of compliance with requirements of the model.

Staff Impressions of FGDM: Evaluators assessed staff impressions and changes to opinions over time regarding FGDM as an intervention. Project staff identified key characteristics of an effective Family Team Conference as:

1) Engagement and attendance of family members as the presence of an extended / stronger support system increases the effectiveness of the meeting and resulting ICAP.
2) Individualized the family engagement and treatment. Successful FTC facilitation requires facilitators to acknowledge the unique nature of families and understand a single approach will not meet the needs of the children and families. For example, some families preferred conducting their conference at home while others preferred to hold the meeting in a neutral setting, such as an office or
3) A family’s immediate needs must be identified and addressed first. To this end, facilitators identified and engaged community resources and service providers to assist families with basic needs in order to help them become stable prior to the FTC.

Barriers to effective family engagement included:

1) The family’s lack of understanding of FGDM,
2) Difficulty encouraging families to identify support members,
3) Difficulty convincing support members to attend the FTC, and
4) General distrust of child welfare professionals and service providers.

FGDM facilitators identified the following strategies as effective in overcoming barriers:

1) Empowering the family to take the lead during the FTC process,
2) Acknowledging unique characteristics of the family and remaining flexible during the FGDM process,
3) Maintaining a family-focused approach, and
4) Providing clear information in a culturally sensitive manner in order to ensure families and their support members were fully prepared for the FTC and understood their roles and responsibilities.

Annually, the evaluation team conducted a system-wide survey of staff (CBC Lead Agency, Project Staff, and Collaborating Partners) knowledgeable about the FGDM project. Respondents indicate increased knowledge and understanding surrounding the use of FGDM as an intervention. The following table provides an overview of these responses:

<table>
<thead>
<tr>
<th>Sample Size</th>
<th>Wave 1 Baseline</th>
<th>Wave 2 FY 2013</th>
<th>Wave 3 FY 2014</th>
<th>Wave 4 Project Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of Role/Initiative</td>
<td>Mean=3.82 /5</td>
<td>Mean=4.25 out of 5</td>
<td>Mean=4.37 out of 5</td>
<td>In progress</td>
</tr>
<tr>
<td>Perceived Benefits of FGDM</td>
<td>Mean=3.55 out of 5</td>
<td>Mean=3.77 out of 5</td>
<td>Mean=4.26 out of 5</td>
<td>In progress</td>
</tr>
<tr>
<td>Wave 1 Baseline</td>
<td>Wave 2 FY 2013</td>
<td>Wave 3 FY 2014</td>
<td>Wave 4 Project Completion</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>---------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Sample Size</td>
<td>49</td>
<td>39</td>
<td>41</td>
<td>TBD</td>
</tr>
<tr>
<td>Knowledge of Role/Initiative</td>
<td>Mean=3.82 /5</td>
<td>Mean=4.25 out of 5</td>
<td>Mean=4.37 out of 5</td>
<td>In progress</td>
</tr>
<tr>
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<td>Mean=3.55 out of 5</td>
<td>Mean=3.77 out of 5</td>
<td>Mean=4.26 out of 5</td>
<td>In progress</td>
</tr>
</tbody>
</table>

Participant Satisfaction

100% of families participating in FGDM reported satisfaction with the process. Similarly, 100% of families indicated they would recommend FGDM to others.
Over time, staff showed a significant improvement in their knowledge surrounding Family Group Decision Making and its role as a family-centered practice. With their improved understanding, there has been a corresponding increase to their perceptions surrounding the overall benefit of providing FGDM as an intervention.

**Participant Outcomes:** Through the Dunst Needs Scale, participating families identified their most prevalent needs. Using a 5-point Likert Scale (0 – Almost Never, 1 – Seldom, 2 – Sometimes, 3- Often, 4– Almost Always), families ranked the extent to which they experience the need for specific items ranging from basic necessities (food, medical / dental care, clothing, shelter, child care) to personal desires (vacation, do things I enjoy, have personal time).

During the most recent reporting period (October 2013 – March 2014), the mean score for all 41 items queried in the survey was 2.33 (N=64). Items with responses falling above mean represent the most significant needs for participating families. These are identified in the following table:

<table>
<thead>
<tr>
<th>Need</th>
<th>Mean Response</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>v8 Feeding my child</td>
<td>2.91</td>
<td>1.69</td>
</tr>
<tr>
<td>v6 Having food for two meals a day</td>
<td>2.87</td>
<td>1.61</td>
</tr>
<tr>
<td>v28 Managing the daily needs of my child at home</td>
<td>2.84</td>
<td>1.60</td>
</tr>
<tr>
<td>v15 Having a satisfying job</td>
<td>2.83</td>
<td>1.36</td>
</tr>
<tr>
<td>v5 Having clean water to drink</td>
<td>2.82</td>
<td>1.76</td>
</tr>
<tr>
<td>v10 Having plumbing, lighting, heat</td>
<td>2.81</td>
<td>1.64</td>
</tr>
<tr>
<td>v9 Getting a place to live</td>
<td>2.74</td>
<td>1.62</td>
</tr>
<tr>
<td>v35 Having time to take my child to appointments</td>
<td>2.73</td>
<td>1.62</td>
</tr>
<tr>
<td>v3 Paying for special needs of my child</td>
<td>2.65</td>
<td>1.35</td>
</tr>
<tr>
<td>v29 Caring for my child during working hours</td>
<td>2.65</td>
<td>1.67</td>
</tr>
<tr>
<td>v39 Doing things with my family</td>
<td>2.65</td>
<td>1.46</td>
</tr>
<tr>
<td>v25 Having emergency health care</td>
<td>2.64</td>
<td>1.70</td>
</tr>
<tr>
<td>v19 Transporting my child</td>
<td>2.63</td>
<td>1.63</td>
</tr>
<tr>
<td>v33 Finding a school placement for my child</td>
<td>2.62</td>
<td>1.61</td>
</tr>
<tr>
<td>v17 Getting where I need to go</td>
<td>2.58</td>
<td>1.55</td>
</tr>
<tr>
<td>v23 Having medical and dental care for my family</td>
<td>2.56</td>
<td>1.72</td>
</tr>
<tr>
<td>v14 Getting a job</td>
<td>2.51</td>
<td>1.51</td>
</tr>
<tr>
<td>v7 Having time to cook healthy meals for my family</td>
<td>2.47</td>
<td>1.67</td>
</tr>
<tr>
<td>v18 Getting in touch with people I need to talk to</td>
<td>2.46</td>
<td>1.40</td>
</tr>
<tr>
<td>v20 Having special travel equipment for my child</td>
<td>2.44</td>
<td>1.76</td>
</tr>
<tr>
<td>v21 Finding someone to talk to about my child</td>
<td>2.43</td>
<td>1.59</td>
</tr>
<tr>
<td>v36 Exploring future educational options for my child</td>
<td>2.36</td>
<td>1.53</td>
</tr>
<tr>
<td>v22 Having someone to talk to</td>
<td>2.34</td>
<td>1.55</td>
</tr>
</tbody>
</table>
These results are statistically similar to prior reporting periods and are, therefore, representative of the population served over the entire grant.

To date, 371 families have been served through the grant and positive results have been achieved in the following outcome measures:

1) Six-month recidivism rates for cases closed successfully,
2) Six-month removal rates for cases closed successfully, and
3) Family participation in case planning.

The table, below, provides an overview of subsequent substantiated findings of abuse /neglect and removals at six and twelve months post case closure:

<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>Comparison Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=371</td>
<td>n=2174</td>
</tr>
<tr>
<td>Subsequent Substantiated Findings at 6 months 12 (3.2%)</td>
<td>Subsequent Substantiated Findings at 6 months 194 (8.9%)</td>
</tr>
<tr>
<td>Child Removal at 6 months 0 (0%)</td>
<td>Child Removal at 6 months 59 (2.7%)</td>
</tr>
<tr>
<td>Subsequent Substantiated Findings at 12 months 16 (4.1%)</td>
<td>Subsequent Substantiated Findings at 12 months 309 (14.2%)</td>
</tr>
<tr>
<td>Child Removal at 12 months 6 (1.7%)</td>
<td>Child Removal at 12 months 107 (4.9%)</td>
</tr>
</tbody>
</table>

Initial findings are promising for families participating in the FGDM process. For each of the above measures, statistical analysis indicates a significant difference between treatment and comparison groups at p < .01. However, additional data stratification and analysis is required to ensure the two populations are similar in nature and, therefore, comparable.

The FRIENDS Protective Factors Survey was used to assess change in family functioning pre and post FGDM participation. Successful case closure was defined as an increase to two or more factors. Participant’s demonstrated improvements in the following scales:

<table>
<thead>
<tr>
<th>Protective Factor Survey Scales</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Functioning and Resiliency</td>
<td>4.66</td>
<td>5.54</td>
</tr>
<tr>
<td>Social Supports</td>
<td>5.47</td>
<td>5.72</td>
</tr>
<tr>
<td>Concrete Supports</td>
<td>5.13</td>
<td>5.55</td>
</tr>
<tr>
<td>Nurturing and Attachment</td>
<td>6.39</td>
<td>6.48</td>
</tr>
</tbody>
</table>

2 Statistically significant at p > .05
The Protective Factors Survey also assessed the family’s knowledge of child development and parenting. Though improvement between pre and post test scores were not readily apparent for most of these factors, there was a statistically significant improvement to the measure “There are many times I don’t know what to do as a parent.”

<table>
<thead>
<tr>
<th>Factor</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are many times I don’t know what to do as a parent</td>
<td>4.37</td>
<td>5.67</td>
</tr>
<tr>
<td>I know how to help my child learn</td>
<td>6.02</td>
<td>5.93</td>
</tr>
<tr>
<td>My child misbehaves just to upset me</td>
<td>4.77</td>
<td>4.84</td>
</tr>
<tr>
<td>I praise my child when they behave well</td>
<td>6.35</td>
<td>6.37</td>
</tr>
<tr>
<td>When I discipline my child I lose control</td>
<td>6.37</td>
<td>6.37</td>
</tr>
</tbody>
</table>

Measures of maternal and paternal family involvement in the case were compared to assess the degree to which extended family members were engaged as support networks for participants. Families participating in FGDM (treatment group) showed significantly greater participation by extended family members when compared to families receiving other interventions (comparison group).

<table>
<thead>
<tr>
<th>Factor</th>
<th>Treatment</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Family Participation</td>
<td>37%</td>
<td>3%</td>
</tr>
<tr>
<td>Paternal Family Participation</td>
<td>9%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Finally, a survey of participant satisfaction was completed. Over the course of the grant, 100% of families indicated satisfaction with their FGDM experience and 100% they would recommend the process to another family.
Chapter 5: Lessons Learned and Recommendations

Participation

At times, garnering the participation of families was difficult. FGDM staff report initial participation of the family in the initial FTC but failure to engage and accept case coordination on a long term basis. Completion of case coordination and execution of the ICAP is crucial to a family’s success and achievement of reduced recidivism on a systemic level. Community Facilitators and Diversion Care Coordinators (DCC) received expert training in strength-based approaches to partner with families in the areas of: decision making, goal setting and actualizing desired outcomes. Utilizing open, genuine, respectful and empathic communication served to improve engagement with even the most resistant families.

It is recommended that DCCs attend FTCs in order to facilitate the family’s transition from the FTC phase to case coordination. Further, the FTC was also an appropriate time to reiterate timeframes for seeing the children in the home, connect with the identified family lead person, and answer any questions the family may have regarding the function of the DCC.

Family Supports

A continuous challenge involved assisting families to identify supports, particularly supports with whom the targeted families may have created inharmonious relationships, but who could assist the family in accomplishing their Individualized Course of Action Plan. Many families recognized their limitations as well as their need for assistance, yet there was often hesitation or reluctance to access family members and friends because of unresolved matters, misunderstandings, previous history, perceived loss of control, generational issues, and other concerns. FGDM staff was trained in solution-focused techniques in order to generate dialog and discourse with families around sensitive issues. If the sensitive issues were addressed respectfully, genuinely and empathically, communication barriers were more likely to be broken down.

Information gathered though the social connections/emotional support section of the Protective Factors Pre-Survey was utilized to assess the respondent’s readiness to engage familial supports. The degree to which this information was helpful was dependent on whether the family provided honest and credible information. This section of the survey assessed the level of
inclusion or isolation the family felt and could be used as a point of discussion to help the family identify, acknowledge or begin to develop supports for the FTC.

It is recommended that FGDM staff be encouraged from the onset to think outside the box and be prepared to help the family identify or cultivate supports. In addition, it was imperative the facilitator be afforded sufficient time to assist the family in developing appropriate supports when the family was isolated or surrounded by inappropriate persons.

Paternal Relatives

The program saw a slight increase in Family Team Conferences where two or more paternal supports attended; however, there remained a great need to identify, locate and engage paternal relatives of children involved in the FGDM process. Due to the imperativeness of providing every child with viable lifelong family connections from both sides of their family, efforts were made to identify experts in the area of paternal family engagement to train FGDM staff in how to effectively address this need.

It is recommended the identification, location and inclusion of paternal relatives be emphasized in the FGDM process, as excluding fathers and paternal kin could limit “the range of informal supports” (Schmid, 2006, p. 23). Furthermore, including them can “widen the circle” of support and empower fathers and paternal relatives to make meaningful investments and commitments in the lives of their children (Pennell & Burford, 1994).

Timeframes

During the FGDM project, facilitators were expected to develop the ICAP within 21 days of case acceptance. Meeting this timeframe proved to be challenging in many cases. It is recommended that a longer timeframe be implemented to allow facilitators to build stronger rapport and trust with family members and to allow ample time for the development of extended support systems for the FTC.

Systems-of-care would be prudent to take a distinctive view of the FGDM process and acknowledge the importance of engaging not only the core family group, but their system of support, which takes time. This is particularly important when family members are resistant, slow to identify paternal or even other maternal relatives, or the family does not have positive supports systems readily available. Holistically engaging the “team” (relatives) in the FGDM process.

Protecting Children, 21(1), 20-29.

laws for a more purposeful and productive FTC, a more impactful Individualized Course of Action Plan, and subsequently, a more successful family outcome, which mitigates risk and positively impacts the children’s safety and wellbeing. The successful engagement of the family and their support system also positively impacts the family’s willingness to follow through with ongoing Case Coordination services once the FTC has taken place.

Protective Factors Surveys (PFS)

The PFS is a self-reporting tool. Staff reported concerns that PFS responses were not accurate and were influenced by other variables, such as dishonesty or trying to “save face,” not taking the tool seriously, and the family’s desire to avoid judgment by professionals/service providers. Individually or in total, the PFS responses impact validity and were often the solitary reason a case was not closed successfully when the remaining criteria were met.

Since an increase in at least two protective factor domains was a primary measure for successful case closure, this matter presented difficulties. At times, families completed their ICAP while demonstrating significant behavioral changes linked to reduced risk and improved family safety, yet the families did not show an increase in at least two Protective Factor Survey domains.

Training on the PFS tool was provided to FGDM staff to ensure the tool was understood, its purpose clear and the best ways to administer it to families. This training was expected to enhance the reliability and trustworthiness of family responses. FGDM staff members were instructed to review the tool with families to gauge their level of understanding of each domain/area requiring their rating. Early in the grant, the facilitators and coordinators discussed possible discrepancies in regard to how the families were answering certain questions on the PFS and how the families were actually behaving.

It is recommended that the PFS be used as a tool to gauge the growth of families as they work through the FGDM process but not as the determining factor of their success or failure. As stated above, families may not demonstrate much change in their survey responses while successfully completing their ICAP and demonstrating significant behavioral changes. This meant families essentially failed because of the PFS, even though each action step they successfully completed was linked to a protective factor.

Engagement of Other Service Providers

Originally, Kids Central intended FGDM to provide the framework for service engagement with the family and serve as a forum in which other service providers would engage with the family and become part of the ICAP. This format was expected to allow FGDM staff to collaborate with other service pro-
viders and establish the most appropriate continuum of services for the family. Unfortunately, rather than becoming the focal point for determining the best course of action, FGDM was viewed as a competitive service intervention in and of itself by the provider community. As such, FGDM functioned as one of many “competitive services” to which a family could be assigned during the Community-Based Services Staffing. Because multiple service providers were then attempting to engage the family, this structure of service assignment presented obstacles to the effective implementation of FGDM.

Access to family information from both external sources and the sharing and coordination of information, records and service data became as a barrier when multiple service providers attempted to engage with a family. Over time, FGDM staff appeared to gain a better grasp on the process; and consequently, could better explain the FGDM process and solicit needed information from other service providers who were serving the same families. This also allowed information to be synthesized and distributed to multiple providers as a single, comprehensive report detailing relevant insights, perspectives, and understandings.

It is highly recommended that any organization adopting to implement FGDM integrate specific responsibilities and processes into contract and / or memorandum of understanding in order to clearly define the role of FGDM within the system-of-care. Furthermore, it is important to establish a comprehensive communication plan designed to inform partners and stakeholders about the intent and benefits of FGDM. Following these recommendations will enhance collaboration between service providers while promoting improved family engagement and "buy-in" to the FGDM process.
Appendices

Appendix A: Closure Report - Diversion Care Coordinator

### FAMILY GROUP DECISION MAKING

**CLOSURE**

<table>
<thead>
<tr>
<th>Family Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Number:</td>
<td></td>
</tr>
<tr>
<td>Reason Closed:</td>
<td>(Children Sheltered; Closed Successful; Duplication of Services; Family Refused Services; Formal Case Management; Inappropriate Referral; Moved after Contact; Other Unsuccessful; Unable to Contact)</td>
</tr>
<tr>
<td>Level of Cooperation:</td>
<td>(Compliant; Non-Compliant; Not Engaged)</td>
</tr>
<tr>
<td>Closing Risk Level:</td>
<td>(Low; Medium; High)</td>
</tr>
<tr>
<td>Date Closed:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diversion Care Coordinator</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Date started working with family:</td>
<td></td>
</tr>
<tr>
<td>Number of Face to Face Visits:</td>
<td></td>
</tr>
<tr>
<td>Dates of Face to Face Visits</td>
<td></td>
</tr>
</tbody>
</table>

**Closure Criteria:**

1. Family identified a “LEAD” person to assist should any problems emerge in the future that would compromise the safety and well-being of the child(ren). The Lead Person’s Name is:

2. Family has knowledge of community resources and are capable of accessing them on their own in the future if needed:

3. Family has taken proper steps to mitigate any future risk to the child(ren). Action Plan items address original maltreatment and progress towards or completion of tasks associated with these items:

4. Family shows an increase in at least two (2) Protective Factors (list number increased):
• **Action Plan progress:**

1. LIST PROGRESS OF ACTION PLAN HERE. PLEASE NUMBER EACH ONE.

• **Protective Factors related to Action Plan:**

• LIST EACH PROTECTIVE FACTOR AND THEIR PROGRESS UNDER EACH.

LIST COMMENTS HERE!

**KCI TOOLKIT:** SUMMARIZE FTC, CASE COORDINATION AND CLOSURE INFORMATION

Devereux Kids FGDM Diversion Care Coordinator name and title:

________________________
Signature and Date: (handwritten not electronic)

MaryEtta Clarkson, Project Coordinator
Devereux Kids Program Manager name and title:

________________________
Signature and Date: (handwritten not electronic)
Appendix B: Closure Report – Community Facilitator

---

## Family Group Decision Making
### Family Team Conference

### Summary

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Name</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Case Number</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Number of Children</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Date Referral Rec’d</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Referral Source Name</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Date Family Contact</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Date of Family Prep</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Date of FTC</td>
<td>[Blank]</td>
</tr>
</tbody>
</table>

---

**Persons in Attendance at the Family Team Conference** (relationship to the family):

**History** (reason for referral, a synopsis of the family's story etc.)

**Family Strengths**

**Challenges/Goals**
- **Goals:**
- **Challenges:**

**Family Plan** (summary/outline of what happened, what is going to happen, who is going to do what, and what the plan for follow up is)

**Summary Statement** ('Statement of how this may result in a positive outcome for children and families')

---

DEVEREUX KIDS Facilitator name and title:

________________________

Signature and Date: (handwritten, not electronic)

MALVERIA CARTER, Program Manager
DEVEREUX KIDS name and title:

________________________

Signature and Date: (handwritten, not electronic)
Appendix C: Dunst Needs Scale

Dunst et al. (1985)

Listed below are 41 different needs that families sometimes identify. Please circle the response that best describes your family’s need in each area. THERE ARE NO RIGHT OR WRONG ANSWERS. Give your honest feelings and thoughts.

<table>
<thead>
<tr>
<th></th>
<th>Not Applicable</th>
<th>Almost Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Having money to buy necessities and pay bills:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Budgeting money:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Paying for special needs of my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Saving money for the future</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Having clean water to drink:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Having food for two meals a day:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Having time to cook healthy meals for my family:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Feeding my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>Getting a place to live:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>Having plumbing, lighting, heat:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td>Getting furniture, clothes, toys:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12</td>
<td>Completing chores, repairs, improvements:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>Adapting my house for my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14</td>
<td>Getting a job:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>Having a satisfying job:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Score</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------</td>
<td>-------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>16</td>
<td>Planning for future job of my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>Getting where I need to go:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18</td>
<td>Getting in touch with people I need to talk to:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19</td>
<td>Transporting my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20</td>
<td>Having special travel equipment for my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21</td>
<td>Finding someone to talk to about my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22</td>
<td>Having someone to talk to:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23</td>
<td>Having medical and dental care for my family:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24</td>
<td>Having time to take care of myself:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25</td>
<td>Having emergency health care:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26</td>
<td>Finding special dental &amp; medical care for my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27</td>
<td>Planning for future health needs:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>Managing the daily needs of my child at home:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29</td>
<td>Caring for my child during working hours:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>Having emergency child care:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31</td>
<td>Getting respite care for my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>-----</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>32</td>
<td>Finding care for my child in the future:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33</td>
<td>Finding a school placement for my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34</td>
<td>Getting equipment or therapy for my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35</td>
<td>Having time to take my child to appointments:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36</td>
<td>Exploring future educational options for my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37</td>
<td>Expanding my education, skills, and interests:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38</td>
<td>Doing things I enjoy:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39</td>
<td>Doing things with my family:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40</td>
<td>Participating in parent groups or clubs:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41</td>
<td>Traveling/vacationing with my child:</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### Appendix D: FGDM Case Review Tool

#### Family Group Decision Making Case Review Tool

<table>
<thead>
<tr>
<th>Measurements</th>
<th>Fully Met?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Multi-disciplinary staffing is held and risk level is determined appropriate for Diversion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 FGDM Facilitator completes all pre-planning activities for family? (EXPAND with details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 FGDM Facilitator meets with family and other participants for Prep Interview?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 FGDM Facilitator completes Protective Factors pre-test with family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 FGDM meeting is scheduled at a time and place convenient for the family (see section III of Prep Interview)?</td>
<td></td>
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<tr>
<td>6 Individualized Course of Action plan (ICA) developed AND SHOWS CLEAR EVIDENCE OF FAMILY INPUT?</td>
<td></td>
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<tr>
<td>7 Individualized Course of Action plan (ICA) is developed AND SHOWS CLEAR EVIDENCE OF BUILDING ON FAMILIES STRENGTHS NOT JUST DEFICITS?</td>
<td></td>
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<tr>
<td>8 FGDM Case Coordinator acts as a family advocate to assure plan is completed successfully AS EVIDENCED IN THE PROGRESS OR CONTACT NOTES?</td>
<td></td>
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<tr>
<td>9 Services are comprehensive and address all major areas of need</td>
<td></td>
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<tr>
<td>10 FGDM process created a stronger informal support system for this family. Describe how.</td>
<td></td>
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<tr>
<td>11 Do the progress notes document the record level of completion/compliance with plan by family?</td>
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<tr>
<td>12 FGDM Case Coordinator completes Protective Factors post-test with the family?</td>
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<tr>
<td>13 FGDM Coordinator closes case; Case record supports the closing risk level?</td>
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<tr>
<td>14 FGDM Coordinator closes case; Case record supports the recorded closure reason?</td>
<td></td>
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<tr>
<td>15 Case was not closed prematurely before sufficient supports were put in place (applicable to cases where the family is willing to continue participation)</td>
<td></td>
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</tbody>
</table>

Comments:
Appendix E: Five Protective Factors Brochure

Our Purpose...

engaging, encouraging and empowering families to succeed

The Protective Factors Survey is part of the Family Group Decision Making initiative—a partnership between Kids Central, Inc., Devereux Kids, and J.K. Elder and Associates. It is funded in part by the Administration on Children, Youth and Families (ACYF).

Kids Central, Inc. and its partners believe in a strong system of care that supports family connections. Our purpose is to engage families in affecting positive change in their circumstances through education, empowerment and encouragement, so that children can remain safely in their homes.

The Protective Factors Survey is a pre-post evaluation tool for use with caregivers receiving prevention services. It is a self-administered survey that measures protective factors in five areas: family functioning and resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development.

What are Protective Factors?

Kids Central, Inc.
2117 SW Highway 46
Ocala, FL 34473
352.873.6332
www.kidsontrack.org

Devereux Kids
5079 N. Market Street
Bushnell, FL 33513
352.903.0801
www.devereuxkids.org

A Strengthening Families Approach

Protective Factors...

...are conditions in families and communities that, when present, increase the health and well-being of children and families. They are attributes that serve as buffers, helping parents find resources, supports, or coping strategies that allow them to parent effectively, even when under stress. They include the following areas:

Parental Resilience

...addresses the parent's ability to handle everyday stressors, to bounce back from adversity and maintain hope.

Knowledge of Parenting and Child Development

...refers to the parental understanding of knowledge about raising children and appropriate expectations for their children at different developmental stages.

Social Connections

...addresses the need for trusted and caring family and friends, who help provide emotional support to parents by offering encouragement and assistance in facing the daily challenges of raising a family.

Concrete Supports

...includes basic needs, like food, clothing, housing, financial resources, transportation and access to essential services that address family-specific needs.

Nurturing and Attachment

...refers to the bond between parent and child. It reflects children's trust that their parents will provide what they need to thrive, including love, acceptance, positive guidance and protection. This protective factor also allows for development of social and emotional competence of children or their ability to interact positively with others and to communicate their feelings effectively.
Appendix F: Individualized Course of Action Plan

Devereux Kids
Family Team Conference

Family Name: ___________________________    Date: __________

GOAL: __________________________________

<table>
<thead>
<tr>
<th>Target Objective</th>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Initial</th>
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</table>

Family acknowledges that they have received a copy and understands the content of the family plan.

Family Signature _______    Date _______    Facilitator Signature _______    Date _______

Family Signature _______    Date _______
Family Team Conference Prep Interview

Family Name ___________________________ Date ___________________________

ENGAGEMENT EFFORTS: Help them show DCF they can come up with a plan

1. Have the family sign the consent, interpreter and rights and responsibility forms
2. Provide them with a copy of the Rights and Responsibilities
3. Talk to them about our FTC process
4. Explain our strength based approach and that the FTC will focus on the needs the family identifies. Also, explain that the family will share its story as a part of the FTC.
5. Ask their permission to take notes

FAMILY STORY: Tell me about your present situation and how you got involved with DCF. I would like to hear your side of the story.

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________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CHALLENGES/NEEDS: What are some things that could help you at this time? (Delve into their whole picture not just present report)

- Are your children having any difficulties at school at this time? What about at home? Are they diagnosed with medical or educational issues – special or advanced? (If they share any info from above question, then ask them what they have tried so far and has anything worked)

STRENGTHS: Ask them what they consider to be functional strengths
OUTCOME STATEMENT:
________________________________________
________________________________________
________________________________________
________________________________________

(You may have to give example: I would like to become independent, financially stable, free from domestic violence, substance free. Ensure my child is never in an abusive situation again)

SUPPORTS TO INVITE: Whom do you presently have in your corner for help and support? (Use the circles and boxes of support if needed.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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</tbody>
</table>

- Are there any paternal supports?

- Where is Dad? His parents, siblings, and friends?

- Would it be alright if we had input and feedback from him regarding what he is willing to do to improve the quality of life for the children?

- Is there something you feel he could do to improve this situation?

- I would like to be able to explain this process to them. May I have their numbers? Would you prefer I call them or talk to them in person?
FAMILY INTAKE FORM:
Family Structure: □ married □ single female □ single male □ unmarried couple □ pregnant teenager
Relation of primary CG to child: □ parent □ grandparent □ aunt/uncle/sibling □ other relative □ not related
Income: □ zero □ <$12,000 □ $12,000-19,999 □ $20,000-29,999 □ $30,000-39,999 □ $40,000-49,999 □ >$50,000
Education Level: □ Elementary School □ Middle School □ GED □ High School □ Some College □ Professional
cert/equiv □ Bachelor’s Degree □ Master’s Degree □ Doctoral Degree

<table>
<thead>
<tr>
<th>Income</th>
<th>Expenses</th>
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</thead>
<tbody>
<tr>
<td>Net Income:</td>
<td>Rent:</td>
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<tr>
<td>SSI:</td>
<td>Electric:</td>
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<td>SSDI:</td>
<td>Water:</td>
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<tr>
<td>VA:</td>
<td>House phone:</td>
</tr>
<tr>
<td>Unemployment:</td>
<td>Cell phone:</td>
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<tr>
<td>Food Stamps:</td>
<td>Gas:</td>
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<td>WIC:</td>
<td>Cable:</td>
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<tr>
<td>Workers Comp:</td>
<td>Food:</td>
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<tr>
<td>Child Support:</td>
<td>Car Paymt:</td>
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<tr>
<td>Other:</td>
<td>Car Insurance:</td>
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<tr>
<td>TOTAL:</td>
<td>Medical Exp:</td>
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<td></td>
<td>Diapers:</td>
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<td></td>
<td>Daycare:</td>
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<tr>
<td></td>
<td>Other:</td>
</tr>
<tr>
<td></td>
<td>Income Left:</td>
</tr>
</tbody>
</table>

Open case with DCF? □ YES □ NO Children involved with Dept. Juvenile Justice? □ YES □ NO

Support Family receiving at case initiation:

- Food Stamps □ Yes □ No
- Social Security □ Yes □ No
- Family Support □ Yes □ No
- Day Care □ Yes □ No
- Access/Wages □ Yes □ No
- Informal Support □ Yes □ No

- Medicaid □ Yes □ No
- Unemployment □ Yes □ No
- Faith Based Support □ Yes □ No
- Child Support □ Yes □ No
- Relative Caregiver □ Yes □ No
- DATE and Time of FTC: We will need to schedule it soon to keep within our 21 day timeline.

Revised: 5/17/13Page 4
• **PLACE OF FTC**: would you like to have your Family Team Conference in your home or somewhere else?

• **NEEDS and PROTECTIVE Surveys**: Have them fill out the needs survey and protective factors survey before you leave. Explain the Protective Factors in depth and that no one will see it but us and they will not get in trouble for being honest.

• **EXTRA SERVICES “AS NEEDED”**: If you feel there is a good program that can assist them, explain it, and ask them if they would be open to trying it, and then re-staff for such.

---

**THINGS TO DO:** (such as info to bring to the next visit, calls to make, referrals to submit, etc...)

---

**SUPPLIES NEEDED:**
PROTECTIVE FACTORS SURVEY
(Program Information--For Staff Use Only)

Agency ID ____________________________  Participant ID # _______________

Is this a  ☐ Pretest?  ☐ Post test?

1. Date survey completed: __/__/____

2. How was the survey completed?
   ☐ Completed in face to face interview
   ☐ Completed by participant with program staff available to explain items as needed
   ☐ Completed by participant without program staff present

3. Has the participant had any involvement with Child Protective Services?
   ☐ NO  ☐ YES  ☐ NOT SURE

4. (A) Date participant began program (complete for pretest) __/__/____

4. (B) Date participant completed program (complete at post test) __/__/____

5. Type of Services: Identify the type of program that most accurately describes the services the participant is receiving. Check all that apply.
   ☐ Parent Education
   ☐ Parent Support Group
   ☐ Parent/Child Interaction
   ☐ Advocacy (self, community)
   ☐ Fatherhood Program
   ☐ Planned and/or Crisis Respite
   ☐ Homeless/Transitional Housing
   ☐ Resource and Referral
   ☐ Family Resource Center
   ☐ Skill Building/Ed for Children
   ☐ Adult Education (i.e. GED/Ed)
   ☐ Job Skills/Employment Prep
   ☐ Pre-Natal Class
   ☐ Family Literacy
   ☐ Marriage Strengthening/Prep
   ☐ Home Visiting
   ☐ Other (if you are using a specific curriculum, please name it here) ____________________________

6. Participant's Attendance: (Estimate if necessary)
   A) Answer at Pretest: Number of hours of service offered to the consumer: ________
   B) Answer at Post-test: Number of hours of service received by the consumer: ________

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.
PROTECTIVE FACTORS SURVEY

Agency ID ____________________________ Participant ID # ____________________________

1. Date Survey Completed: / / 2. Sex: □ Male □ Female 3. Age (in years): ________

4. Race/Ethnicity. (Please choose the ONE that best describes what you consider yourself to be)

□ A Native American or Alaskan Native □ B Asian
□ C African American □ D African Nationals/Caribbean Islanders
□ E Hispanic or Latino □ F Middle Eastern
□ G Native Hawaiian/Pacific Islanders □ H White (Non Hispanic/European American)
□ I Multi-racial □ J Other ____________________________

5. Marital Status:

□ A Married □ B Partnered □ C Single □ D Divorced □ E Widowed □ F Separated

6. Family Housing:

□ A Own □ B Rent □ C Shared housing with relatives/friends
□ D Temporary (shelter, temporary with friends/relatives) □ E Homeless

7. Family Income:

□ A $0-$10,000 □ B $10,001-$20,000 □ C $20,001-$30,000
□ D $30,001-$40,000 □ E $40,001-$50,000 □ F more than $50,000

8. Highest Level of Education:

□ A Elementary or junior high school □ B Some high school □ C High school diploma or GED
□ D Trade/Vocational Training □ E Some college □ F 2-year college degree (Associate’s)
□ G 4-year college degree (Bachelor’s) □ H Master’s degree □ I PhD or other advanced degree

9. Which, if any, of the following do you currently receive? (Check all that apply)

□ A Food Stamps □ B Medicaid (State Health Insurance) □ C Earned Income Tax Credit
□ D TANF □ E Head Start/Early Head Start Services □ F None of the above

10. Please tell us about the children living in your household.

Child 1: □ Male □ Female Your relationship to child □ A Birth parent □ B Adoptive parent □ C Grand/Grandparent
DOB / / Your relationship to child □ D Sibling □ E Other relative □ F Foster-parent □ G other

Child 2: □ Male □ Female Your relationship to child □ A Birth parent □ B Adoptive parent □ C Grand/Grandparent
DOB / / Your relationship to child □ D Sibling □ E Other relative □ F Foster-parent □ G other

Child 3: □ Male □ Female Your relationship to child □ A Birth parent □ B Adoptive parent □ C Grand/Grandparent
DOB / / Your relationship to child □ D Sibling □ E Other relative □ F Foster-parent □ G other

Child 4: □ Male □ Female Your relationship to child □ A Birth parent □ B Adoptive parent □ C Grand/Grandparent
DOB / / Your relationship to child □ D Sibling □ E Other relative □ F Foster-parent □ G other

If more than 4 children, please use space provided on the back of this sheet.

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.
# PROTECTIVE FACTORS SURVEY

## Part I.

Please circle the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. The number 4 means that the statement is true about half the time.

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<tr>
<th></th>
<th>Never</th>
<th>Very Rarely</th>
<th>Rarely</th>
<th>About Half the Time</th>
<th>Frequently</th>
<th>Very Frequently</th>
<th>Always</th>
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## Part II.

Please circle the number that best describes how much you agree or disagree with the statement.

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<tr>
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<th>Strongly Disagree</th>
<th>Mostly Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Mostly Agree</th>
<th>Strongly Agree</th>
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<td>5</td>
<td>6</td>
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</tbody>
</table>

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.
PROTECTIVE FACTORS SURVEY

Part III. This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child’s age or date of birth and then answer questions with this child in mind.

Child’s Age ___________ or DOB ___/___/____

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Mostly Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Mostly Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. There are many times when I don’t know what to do as a parent.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>13. I know how to help my child learn.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>14. My child misbehaves just to upset me.</td>
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<td>2</td>
<td>3</td>
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<td>5</td>
<td>6</td>
<td>7</td>
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</table>

Part IV. Please tell us how often each of the following happens in your family.

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<thead>
<tr>
<th></th>
<th>Never</th>
<th>Very Rarely</th>
<th>Rarely</th>
<th>About Half the Time</th>
<th>Frequently</th>
<th>Very Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. I praise my child when he/she behaves well.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>16. When I discipline my child, I lose control.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>17. I am happy being with my child.</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>18. My child and I are very close to each other.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>19. I am able to soothe my child when he/she is upset.</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>20. I spend time with my child doing what he/she likes to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

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