General Appendix

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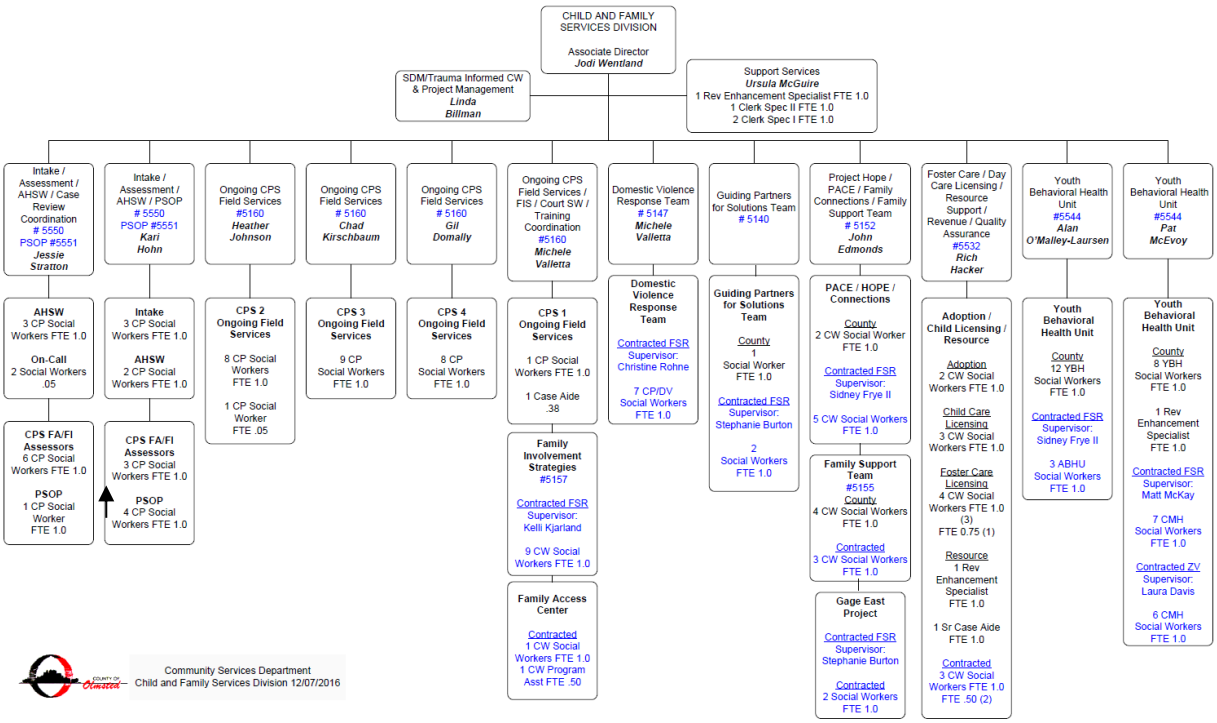
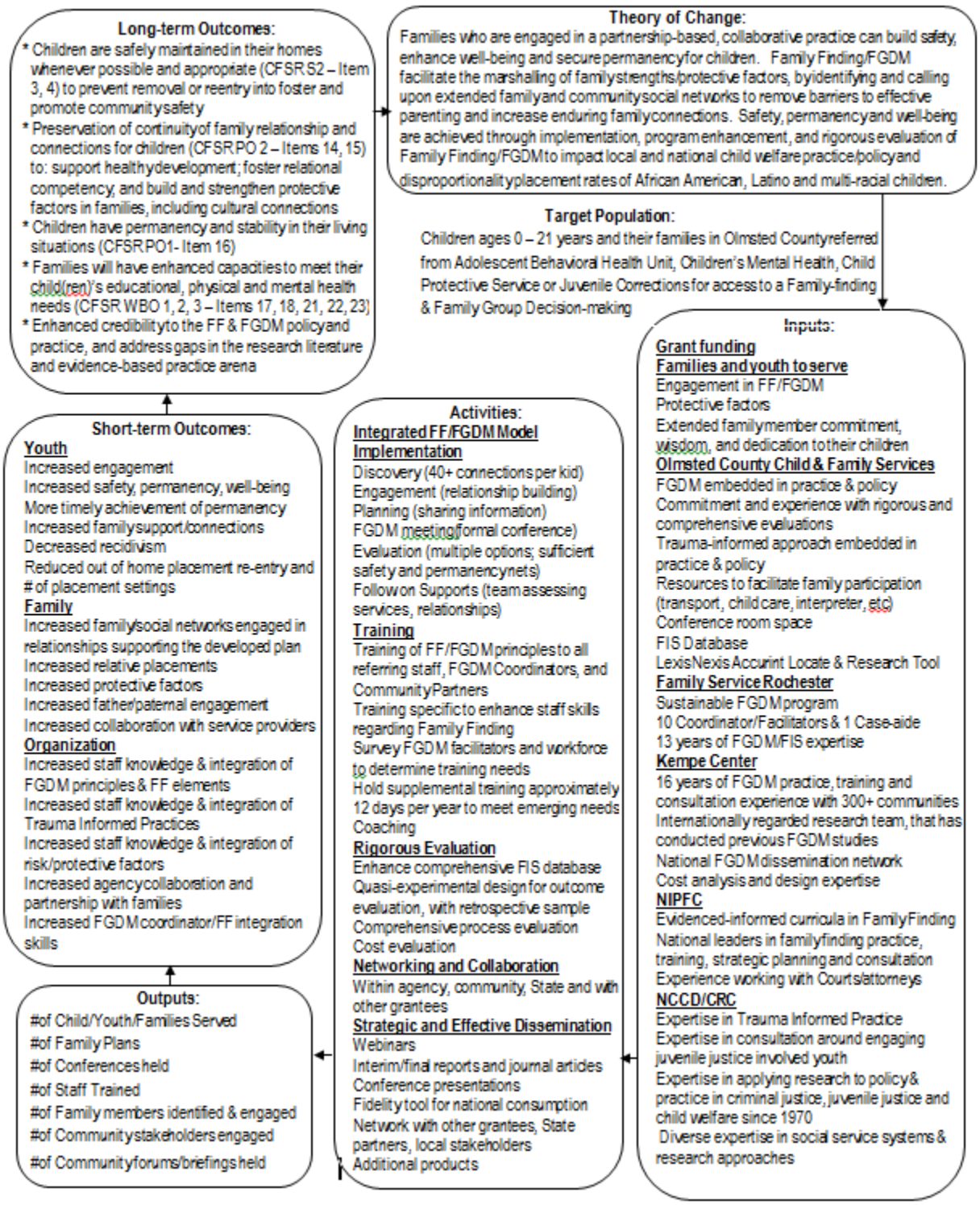
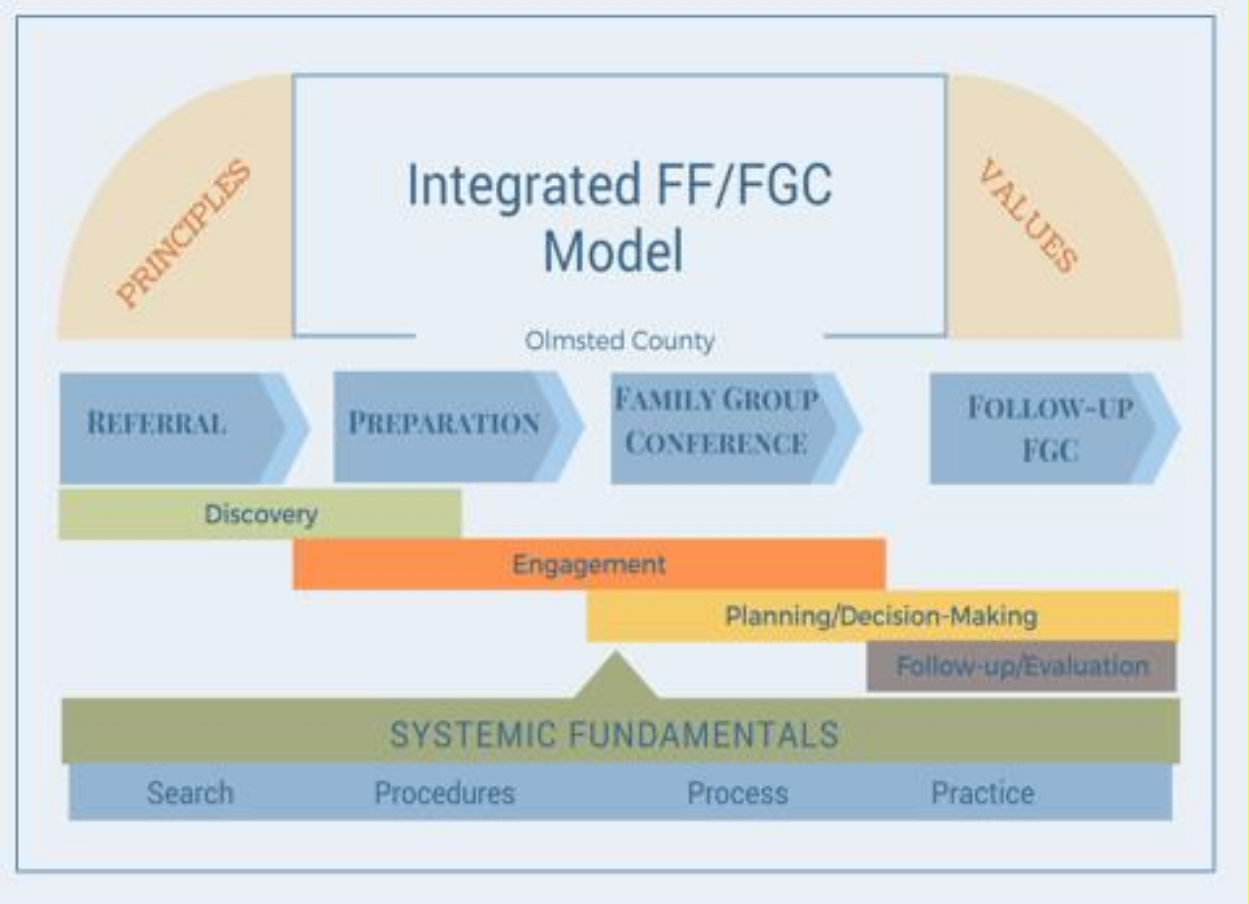
Appendix A-1 Organizational Chart



Appendix B-1 Logic Model



Appendix C-1 Family Finding/Family Group Decision Model



Appendix D-1 Olmsted County Training Plan

Olmsted County Child and Family Services

Strategic Plan for 2015 Training

The Child & Family Services Division values training and consultation that increases the capacity of social workers and case aides to perform their respective position responsibilities and develop their professional competencies; thereby serving families to the best of their abilities. Additionally, training is offered in an effort to support family-driven practice that honors the family's ability to make decisions regarding their children and youth. Engagement strategies, tools, and skills are key to working alongside of families.

PRINCIPLES: The following overarching principles hold true for the entire Child and Family Services Division. We will strive daily to try to uphold these practice principles on behalf of the families we serve.

- Respect all people as worthy of partnership
- Engage with the person, not the problem
- Recognize that engagement is possible even where motivational congruency or strategic use of authority is necessary
- Recognize that all families have signs of safety
- Maintain a focus on safety, well being and permanency
- Learn what the individual wants
- Always search for detail
- Focus on creating change, one step at a time
- Don't confuse case details with judgments
- Offer choices
- Treat all interaction as a forum for change
- Treat the practice principles as aspirations, not assumptions

As Adapted from Andrew Turnell

FOUNDATION: The Child & Family Service Division has established a set of training and consultation opportunities that are made available for social workers entering the child welfare system in Olmsted County. These mandatory trainings (Unless excused by supervisor) may take a couple of years to complete as they may not be offered yearly. Inasmuch as they are considered foundational trainings, it is also suggested that these trainings can be taken more than one time. (Refresh and renew one's skills)

- Social Work Ethics
- Cultural Diversity
- Advanced Best Practice (Research to Practice…. evidence based risk and protective factors)
- Trauma Informed Practice (Including Child Welfare Trauma Training Toolkit)***
- Social Work Core Foundation (DHS requirement)
- Domestic Violence
- Brain Development of Children
- Secondary Stress/Vicarious Trauma
- Alcohol and drug use/abuse
- Sexually Exploited Youth
- Worker Safety
- FIS Orientation (Family Involvement Strategies)

Specialized Foundation Training: (Mandated, depends on each area of expertise)

- Rule 79/CMH-TCM core training
- SDM Safety
- SDM Risk
- SDM Strength and Needs
- SDM Reunification
- SDM Risk Reassessment
- SDM Refresher, Yearly
- Forensic Interviewing

1. PRACTICE: Olmsted County Child and Family Services believes the use of some and or all of the below listed, forms the basis of the social work practice in the division. We believe strongly in this practice and it is congruent with the vision, mission and goals of the division.

- Constructive engagement
- Solution Focus
- Safety organized
- Narrative
- Group supervision and consultation
- Team work
- Reflective Supervision
- Collaboration with community
- Inclusion of family, kinship and community
- Stages of Change
- Responsible use of authority
- Utilization of research
- Comprehensive assessment
- Family System Theory

2. SKILLS: An ability and capacity acquired through deliberate, systematic, and sustained effort to smoothly and adaptively carryout complex activities or job functions involving ideas (cognitive skills), things (technical skills), and/or people (interpersonal skills). (Business Dictionary) The following skills form the basis to successful interactions with children and families:

- Engagement
- Use of Framework
- Searching for detail
- Exception questions
- Relationship questions
- Scaling
- Critical thinking
- Balanced assessment risks and strengths
- Vision statements
- Forensic interviewing

- Appreciative inquiry
- Motivational interviewing

3. TOOLS: There are many ways to successfully engage and interact with children and families. As social workers it is helpful to have as many tools in our tool belt as possible to aid us in successful interactions with families. Olmsted County Child and Family Social Services strive to provide training on the tools below:

- SDM Safety (SDM is Structured Decision Making)
- SDM Risk
- SDM Strength and Needs
- SDM Reunification
- SDM Risk Reassessment
- Scaling
- Three Houses
- Safety House
- Genograms
- Group consultation and decision making
- Fairies and Wizards
- CASII
- SDQ (Strengths & Difficulty Questionnaire, Informs CASII)
- Trauma screening
- Sexually exploited youth screening
- Words and Pictures
- ASQ
- PSC (Pediatric Symptom Checklist)
- DVI (Domestic Violence Inventory)
- Campbell (Lethality for domestic violence)
- FIS Strategies (Rapid Response, PPP, Case Planning, and Family Group Conferences)

Trainings for 2015/2016:

- Larry Hopwood 2 times for 3 days in Spring and Fall, plus consultation **June 2-5, 2015**
- Nicki Weld **Relational Trauma September 29 & 30, 2015**
- Teya Dahle **Reflective Supervision (Groups, Dates and Times TBD)**
- Diversity Training **May 1, 8, 15, 22, 2015**
- Barium Springs **August 3-5, 2015**
- The Importance of Kinship **(June 23, 2015)**
- Advanced Best Practice **January 7, 2016** to pick up manuals, January 14, 21, 28, February 4, 11, 17 (Test), 19 (Graduation)

- Rochester Region Foundation Training:
  1. Wednesday May 13, 2015 to Friday May 15 2015, RM 235 – 2117 Campus Dr
  2. Wednesday June 10, 2015 to Friday June 12 2015, RM 242 and Lab – 2100 Campus Dr
  3. Wednesday July 8 2015 to Friday July 10 2015, RM 242 and Lab- 2100 Campus Dr

Trainings for 2015/2016 continued:

- SDM Aug 29-30=reunification assessment tool training, August 13, 2015 SDM Refresher, October 15, 2015 SDM Basic Training
- Child Welfare Trauma Training Toolkit (TBD)

Possible Trainings for 2015:

- Safe Generations (Connected Families) (Safety and Safety Planning)
- Bonnie Martin, Washington DC, AOD (September 10, 2015)
- DV Training and Advanced DV Training (Working with offenders, safety planning)
- Communities of Practice Child Welfare Conference May 4-5, 2015
- DR Conference October 27-30, 2015

Appendix E-1: Kinship Literature Review/Brief

Building Connection and Creating Stability:

Considering a Kinship Foster Care Placement

A Research Brief

Amanda Miller May 2015

Summary

Kinship foster care is increasingly becoming a preferred placement for children and youth within the child welfare system, yet many within the field still debate its viability as an appropriate placement for youth. Kinship care differs in significant ways from the more traditional non-kin foster care, but until the past few years much of what we knew about kinship care was speculation with limited research to support the movement towards kinship care as a more beneficial placement for youth. Now, the body of research on kinship care has grown to the point that we can begin to make conclusions regarding both the benefits and the challenges of kinship foster care placements and better understand when and how youth benefit from placement in kinship care.

Overall, research to date supports kinship care as a placement that overwhelmingly results in more positive outcomes for youth in out-of-home care, from improved safety and stability, to increased sense of belonging and connection and greater social and emotional well-being. However, this does not mean there are not challenges that arise within kinship placements, and research has also identified some areas of concern around ensuring the quality of kinship placements. Consequently, caseworkers, administrators and policymakers must be thoughtful about the support relative caregivers need to be successful as well as how to define success within this unique form of out-of-home care. What follows is a summary of the current research and what this research points to as the benefits of kinship care that support its growing prominence within the child welfare field as well as the considerations that must be made when moving towards placing a child in kinship care.

Introduction

Kinship care is defined as "the full-time care, nurturing, and protection of a child by relatives, members of their Tribe or clan, godparents, stepparents, or other adults who have a family relationship to a child," as opposed to adults unrelated to or without prior connection to the child (Children's Bureau). Legislators, researchers and organizations have been moving towards this form of out-of-home care in an effort to preserve the child's connections to their family culture and values, to preserve the child's relationships and emotional ties to their family, to reduce placement trauma, to increase stability and continuity in care and to reinforce a sense of identity, self-esteem and belonging for the child (Children's Bureau; Winokur, Holtan, & Batchelder, 2014; Cuddeback, 2004; Lin, 2014; Winokur, Crawford, Graig, & Longobardi, 2008).

In 1997, the Adoption and Safe Families Act made kinship placements the preferred placement type for children in out-of-home care (Lin, 2014; Falconnier, Tomasello, Doueck, Wells, Luckey, & Agathen, 2010). Despite this movement towards kinship care in both federal and state laws as well as agency and organizational policies, there still remains uncertainty around the use of kinship care as a placement option. According to the latest published reports, there are 402, 378 children in the foster care system in the United States – of those children 47% are in a non-kin foster home while only 28% are in kinship care, despite kinship care being considered the least restrictive and safest option for out-of-home placement (USDHHS, 2013; Winokur, Holtan, & Batchelder, 2014). This may partially be due to unclear messages from researchers and practitioners regarding the realities of kinship care. Much is still to be learned, but great strides have been made to understand both the benefits and the challenges of kinship foster care placements. By understanding the current research findings, practitioners should be better equipped when leading the decision-making process for determining appropriate placement for a child.

The Benefits of Kinship Care

Improved Outcomes

The current research on outcomes for children in kinship care is diverse with a variety of differing measurements and methods, making it challenging to determine the true impact of kinship care. However, a systematic review of the literature and analysis of 102 quality experimental studies on the effects of kinship care on children found a plethora of improved outcomes for children placed in kinship care compared to those placed in non-kin foster homes (Winokur, Holtan, & Batchelder, 2014). The research shows that children placed in kinship care experience:

- Decreases in internalizing and externalizing behavior problems
- Increases in adaptive behaviors
- Decreased odds of experiencing mental illness
- Increased likelihood of reporting positive emotional health
- Increased placement stability (both fewer placements and fewer disruptions)
- Decreased likelihood of experiencing abuse or maltreatment while in care
- Decreased risk of re-entry into the child welfare system
- Increased likelihood for relatives to assume guardianship

(Winokur, Holtan, & Batchelder, 2014). Other studies have also found that children in kinship care are less likely to run away or have truancy and substance abuse issues than children in non-kin care (Cuddeback, 2004; Courtney & Zinn, 2009). Furthermore, in addition to all of these improved outcomes for children within kinship care, the literature also shows no difference in educational attainment, attachment outcomes, reunification rates or length of stay in out-of-home care by placement type (Winokur, Holtan, & Batchelder, 2014). One study on the length of stay in out-of-home care for infants – the population with the longest average stays in out-of-home care – found that infants placed in kinship care spent a significantly shorter time in out-of-home care (Stacks & Partridge, 2011).

Safety

The mission of child welfare is to protect children from harm. While kinship placements tend to be located in neighborhoods with a higher risk for social disorder and kinship caregivers tend to be of a lower socioeconomic status than non-kin caregivers, kinship homes generally provide safer environments than that of the birth parents and case workers find they meet the same safety standards as licensed non-kin homes (Stacks & Partridge, 2011; Hong, Algood, Chiu, & Lee, 2011; Shlonsky & Berrick, 2001; Gibbs & Muller, 2000). While environmental safety may be comparable between kin and non-kin foster homes, there is a significant difference when comparing instances of abuse and neglect while in out-of-home care. In a matched comparison study of children in kinship and non-kinship foster homes, it was over ten times more likely for a new allegation of institutional abuse or neglect to be made after entry into care for children in non-kin homes than those placed in kinship care (Winokur, Crawford, Longobardi, & Valentine,

2008). Researchers theorized that this may be due to the increased cultural bonds and familial relations between children and their caregivers within kinship care, which may act as a protective factor against abuse (Winokur, Crawford, Longobardi, & Valentine, 2008).

Stability

Kinship placements have been consistently found to be more stable than non-kin placements (Gibbs & Muller, 2000). Kinship care provides connectedness and continuity that generally make the placement easier for children to understand and accept, while also alleviating some of the trauma experienced by being separated from their biological parents (Hong, Algood, Chiu, & Lee, 2011; Gibbs & Muller, 2000). The result is not only physical but also emotional permanence for the child (Schwartz, 2010). Children in kinship care are more likely to maintain family connections not only within, but also outside of the household, providing a greater network of enduring connection and support (Schwartz, 2007; Schwartz, 2010). Kinship parents are also more likely to strive to maintain high involvement in the child's life (Hong, Algood, Chiu, & Lee, 2011).

Children in kinship care also show stronger attachment due to the increased placement stability in kinship care (Hong, Algood, Chiu, & Lee, 2011). Looking at matched samples of children in kin and non-kin placements, kinship placements are equally likely to result in legal permanency as non-kin placements, however the kinship placements provide greater stability for the children in care as disruption is less likely than for non-kin placements (Koh & Testa, 2008; Cuddeback; Chamberlain, Price, Reid, Landsverk, Fisher, & Stoolmiller, 2006). This implies that there must be qualities intrinsic to kinship care – a sense of duty or altruism on the part of the caregiver, who is providing enhanced stability for the child (Koh & Testa, 2008; Hong, Algood, Chiu, & Lee, 2011). This sense of duty and altruism leads to the belief more commonly held by kinship caregivers that they will care for the child until emancipation, as well as contributing to their greater sense of responsibility in helping the child to process their emotions surrounding the separation from or conflict with their birth parent (Falconnier, Tomasello, Doueck, Wells, Luckey, & Agathen, 2010; Hong, Algood, Chiu, & Lee, 2011).

Kinship care also enables and encourages the placement of siblings together, which contributes to improved connections with caregivers and increases a child's sense of belonging, thereby further supporting stability of the placement and improving outcomes for the child in out-of-home care (Gustavsson & MacEachron, 2010; Schwartz, 2010). In fact, older children who were given a say in their placement often chose to stay with relatives in order to remain with their siblings (Messing, 2006).

Cultural Connection

The connections to a child's birth family and ethnic culture are key elements in a child's creation of their identity and positive sense of self (Schwartz, 2007). Kinship care provides these connections for a child to their heritage while also serving as a buffer against negative cultural interactions (Schwartz, 2007). Children in kinship care consequently tend to see their ethnic identity in a more positive light than their peers in non-kin placements despite also being more aware of the negative stereotypes associated with their ethnicity (Schwartz, 2007). Differences in cultural, ethnic and religious backgrounds between foster parents and foster children leads to a number of more negative outcomes. Differences in ethnic identity are correlated with increased mental health symptoms and behavior problems in the children in care, including depression and a decreased sense of belonging (Anderson & Linares, 2012). In a survey of foster parents, it was found that having a shared culture with the child resulted in smoother transitions, less conflict, lower stress and made caregivers better able to function as foster parents (Brown, George, Sintzel, & Arnault, 2009). Therefore, the shared family connections and culture in a kinship placement are a protective factor for the child and contribute to a healthier and more positive sense of identity for the child.

The Child's Experience

While any transition can be difficult for a child, many youth in care report feeling happy with their placement with a relative (Messing, 2006). As one child explained, "I felt like I was wanted," and another shared "You're happy… she came, she took you in, because you want…[to] see all your family members and stuff. Because if I had gone to foster care, I wouldn't have never saw my cousins or nobody" (Messing, 2006). Children in kinship care do not report significant experiences of stigma associated with being in out-of-home care and said that living with relatives felt natural, some even having difficulty with understanding the difference between living with their biological parents and living with other family members (Messing, 2006). Children transitioning to kinship care are also less likely to perceive these disruptions as losses because they see kinship care as a restoration of relationships and environment (Schwartz, 2010). Children in kinship care have also reported that being connected to family members was critical to having an easy transition at removal (Hong, Algood, Chiu, & Lee, 2011).

Children in kinship care also report feeling closer to their caregivers and more cared for by them than their matched peers in non-kin foster care placements (Chapman, Wall, & Barth, 2004). This additional connection and support directly contributes to greater social and emotional well-being for children and youth in kinship care. The children and youth in kinship care report that their connection to their caregivers has led them to more readily seek out guidance and support from their caregivers regarding challenges in areas of their personal life, such as dating and school, reducing risk behaviors in these areas (e.g. dating violence or risky sexual behavior), as well as improving school performance (Chapman, Wall, & Barth, 2004).

Clearly the increased emotional and relational permanence these youth feel within kinship placements is an asset of kinship care as it reduces the loss and stigma associated with foster care placements, improves the youth's sense of connection and belonging, and increases the youth's overall social and emotional well-being. Within child welfare, these outcomes are often sought by obtaining legal permanency for the child, yet these goals of improved connection and well-being can be met prior to achieving legal permanency through placement in kinship care. At the same time, due to this pre-established connection with family, children in kinship care are less likely to state adoption as their desired goal since they already perceive a more stable and permanent commitment by their caregivers than those in non-kin foster care, a factor to which we will return (Merritt, 2008).

Things to Consider when Choosing Kinship Care

Caregiver Support

Kinship caregivers tend to be older, single, African American, less educated, of poorer mental and physical health and of lower socioeconomic status, while also having fewer resources and less training and support than non-kin foster parents. However, despite these additional challenges, there is no conclusive evidence that this makes them less fit to care for the children in their care (Cuddeback, 2004; Smithgall, Yang, & Weiner, 2013; Lin, 2014; Hong, Algood, Chiu, & Lee, 2011; Gibbs & Muller, 2000). This does mean that kinship caregivers face additional challenges when agreeing to care for a child, and yet they commonly have less access to resources and supports than non-kin foster parents (Smithgall, Yang, & Weiner, 2013; Winokur, Holtan, & Batchelder, 2014). Therefore, when placing children in kinship care, caseworkers should ensure kinship caregivers are provided with the knowledge and resources needed to both identify the child's as well as their own need for services and to be able to connect with the appropriate services so that those identified needs are met (Smithgall, Yang, & Weiner, 2013).

One of the many critical resources needed for those in kinship care is access to mental health services. Over a quarter of all children in kinship care have mental health symptoms in need of treatment and yet children in kinship care are less likely to receive mental health services than their peers in non-kin foster care (Winokur, Holtan, & Batchelder, 2014; Smithgall, Yang, & Weiner, 2013). This is likely because kinship caregivers tend to be less aware of appropriate resources and services. Therefore, caseworkers should ensure kinship caregivers are being supported and connected to mental health service providers for the child.

As many kinship homes are not licensed foster care homes, it is also critically important to provide them with training to educate them on parenting and behavior management strategies (Barth et al., 2008). The

Adoption and Safe Families Act was amended in 2002 to provide financial assistance for kinship caregivers who can meet certain placement standards and requiring states to develop programs and services to support kinship caregivers (Falconnier, Tomasello, Doueck, Wells, Luckey, & Agathen, 2010; Lin, 2014). Since its passage, some training programs have been developed and have shown positive results upon evaluation (Falconnier, Tomasello, Doueck, Wells, Luckey, & Agathen, 2010). One of the most evaluated and successful programs is the Kinship Navigator Program, which has been shown to improve child well-being and the support of caregivers as well as increase involvement in services and produce higher rates of permanency for children in kinship care (Lin, 2014).

Social support for the caregivers is especially critical for ensuring quality kinship care, as it has a significant effect on parenting practices, child-caregiver relationship and the caregiver's psychological well-being (Hong, Algood, Chiu, & Lee, 2011). A variety of support group services have been evaluated, showing increased well-being and educational outcomes for youth in kinship care as well as caregiver's mental health (Lin, 2014).

Kinship caregivers are also more likely to need financial assistance and caseworkers should do what they can to inform kinship caregivers of financial assistance options available, such as Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) and Medicaid (Falconnier, Tomasello, Doueck, Wells, Luckey, & Agathen, 2010; Lin, 2014). Many states have also created their own programs for increasing the resources available for relative caregivers and for informing them of the resources available. One of the first and most well reviewed of these programs is Texas' Relative Assistance Program, which is older than but similar to Minnesota's Northstar Care for Children (Brown & Clark, 2013; Skallet, 2013). Research has shown benefits to the Texas program, however evaluations of the overall success of these state-level programs are currently limited (Lin, 2014).

While there is an effort to improve the supports for relative caregivers, much is still needed in this regard, both in the development of programs to increase the availability of support structures and resources for relative caregivers and in increasing the awareness of these resources among relative caregivers.

Redefining Success in Kinship Care

A systematic review of the literature showed that children in non-kin placements were more likely to be adopted, whereas kin caregivers were more likely to obtain guardianship for the children within their care (Winokur, Holtan, & Batchelder, 2014). The reasons for this are currently not well understood, but could be due to a difference in how the cases are handled (Cuddeback, 2004). Others suggest that it is due to the kinship caregivers not wanting to confuse the child or create conflict within the family, or simply not

seeing the necessity when a familial bond already exists (Messing, 2006; Gibbs & Muller, 2000). Therefore, it is important to consider the unique nature of kinship care when comparing adoption rates for youth in kin and non-kin foster care placements. Family members who already have an established familial connection to the child may not see adoption in the same way as unrelated caregivers, and therefore what is typically considered an undesirable outcome, i.e. lack of adoption and possibly a longer time in care, may in-fact be a positive outcome for the child in care once other well-being factors are considered (Winokur, Holtan, & Batchelder, 2014). When considering reunification and guardianship as equally desirable outcomes rather than comparing with adoption, kinship placements have a greater likelihood of leading to children living in permanent homes with biological family (Winokur, Crawford, Longobardi, & Valentine, 2008). For those kin who do adopt, the quality of kinship adoptions is higher, with a strong likelihood of a positive relationship between the caregiver and the child and a decreased likelihood of dissolution (Ryan, Hinterlong, Hegar, & Johnson, 2010). It is for these reasons that some suggest placement disruption or re-entry to be more appropriate measures of placement success or failure in these cases (Winokur, Holtan, & Batchelder, 2014).

A fairly new consideration in the literature is the differing outcomes based on different types of kinship care families. One researcher has begun to examine this question and found that the kinship family's relationship with the child's biological parents and extended family, as well as if they are caring for their own children concurrently (which is also a factor in non-kin placements) are factors that play an important role in the success of the kinship placement. Therefore, investigating these elements of the kinship placement is an important part of assessing the home as a placement option (Zinn, 2012; Zinn, 2010). A lower quality kinship placement, particularly in combination with their reduced resources, can negatively impact child well-being (Hong, Algood, Chiu, & Lee, 2011).

Implications and Remaining Questions

There is good reason for the movement towards kinship care across the country – children do better when placed with family who are committed to their success and well-being. Despite some confusion in the literature that is largely due to small sample sizes, unmatched comparison samples or poor research design, kinship placements overwhelmingly result in better, more stable placements with significantly improved outcomes for children in out-of-home care (Winokur, Crawford, Longobardi, & Valentine, 2008; Winokur, Holtan, & Batchelder, 2014). Kinship care placements significantly improve the safety, stability, cultural connections, and well-being of children in out-of-home care. These positive outcomes are despite the additional challenges kinship caregivers face regarding reduced resources and support.

With what we know now from the research, caseworkers can now more confidently support kinship placement as an option that may be in the best interest of the child. However, there are still several

factors that must be thoughtfully assessed when considering placing a child in kinship care, as with any placement option, to help ensure its success. Some of the questions to answer may include:

- How do we foster relative support for this child and best achieve emotional and relational permanence to improve this child's safety, stability and overall well-being?
- How can we encourage familial and cultural connections for this youth? How can we further develop and support these connections to foster the child's sense of identity and belonging?
- What does a positive outcome look like for this child? How would a kinship care placement help them achieve it?
- Is there support available for the relative caregivers relationally, educationally and financially? Are they aware of and connected to these supports?

The answers to these questions will vary depending on the child, the child's family structure, the family's culture and heritage, and numerous other individual characteristics of the child and family, all of which must be considered when answering these questions and determining if kinship placement is in the child's best interest. Knowing and understanding the research findings on kinship care outcomes and challenges should aid caseworkers in placing these individual and family factors within the context of what is often achieved through kinship care placements more broadly, i.e. increased child safety and well-being, enhanced placement stability, improved social and emotional health, and greater sense of identity and belonging for the child. It should also help caseworkers and the family to better prepare for the challenges often faced in kinship care, and take proactive steps to ensure the caregiver will have access to the resources and support they need to become a successful placement for the child.

There still remain unanswered questions about how to best capitalize on the power of kinship care and to best enable kinship caregivers to meet the needs of the children within their care. More effort is particularly needed in determining effective programs for caregiver support as this will also allow more children with greater needs to be successfully served in kinship care.

This research also raises the question of appropriate outcome goals for children in kinship care, for while these children tend to have better experiences in out-of-home care, they are less likely to meet the standard metric of permanency, i.e. adoption. Therefore, other metrics for measuring a successful placement should be considered when evaluating kinship care, as kinship care allows children to achieve permanency through a less traditional but perhaps more successful and powerful way by obtaining not

just a legal permanency, but emotional and relational permanency as well (Gustavsson & MacEachron, 2010).

Many of the goals we hope to achieve through more traditional permanency options – that of safety, stability and lifelong connection – can be achieved rapidly and effectively through kinship foster care placements. By raising awareness of the multiplicity of improved outcomes realized for children and youth placed in kinship care, better supporting relative caregivers and redefining what success looks like for kinship placements, we can ensure more children receive the stability, comfort and connection provided through kinship care placements and increase the number of children and youth who achieve positive outcomes in out-of-home care.

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Noticing and Responding to Trauma and Children's Mental Health Needs in the Course of CPS Assessment/Investigation

Date: January 2015

Olmsted County, Minnesota

Community Services Child and Family Services Division

This product was funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CF0034. The contents of this publication do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products, or organizations imply endorsement by the US Department of Health and Human Services.

NCCD | Children's Research Center

TRAINER INSTRUCTIONS Overview

The purpose of this course is to deepen child protection worker awareness of, and response to, trauma and other mental health concerns in the children with whom we work. Structured Decision Making® (SDM) assessments, already in use by workers, are the tools of choice for this course to gather information, make decisions, and take action. Using this approach, workers also expand their skills using the SDM® system.

- The course is designed to take 1.5 days.
- Prerequisite understanding includes basic child protection skills, basic SDM skills, and basic case planning.

Preparation

This trainer guide provides images of each slide, suggested content for each slide, handouts, exercises, and instructions for processing exercises. Ideally, the trainer has already attended one or more sessions of the class and has pre-read and studied the manual. The trainer is encouraged to develop stories from his/her own work experience that illustrate points along the way.

Modifications to the slides or course are permitted. The National Council on Crime and Delinquency Children's Research Center (CRC) encourages a jurisdiction to make modifications collectively rather than individually to ensure consistency. CRC should be consulted about major modifications.

To announce the course, a flyer can be prepared describing the course material as covering:

1. Importance of recognizing and responding to children's trauma and mental health needs
2. Review of what we know about trauma and children's mental health
3. Leveraging SDM assessments
4. Role of trauma screens
5. Role of full mental health assessment
6. Case planning

Class size should be limited to about 25 to allow for effective discussion and small-group report-backs.

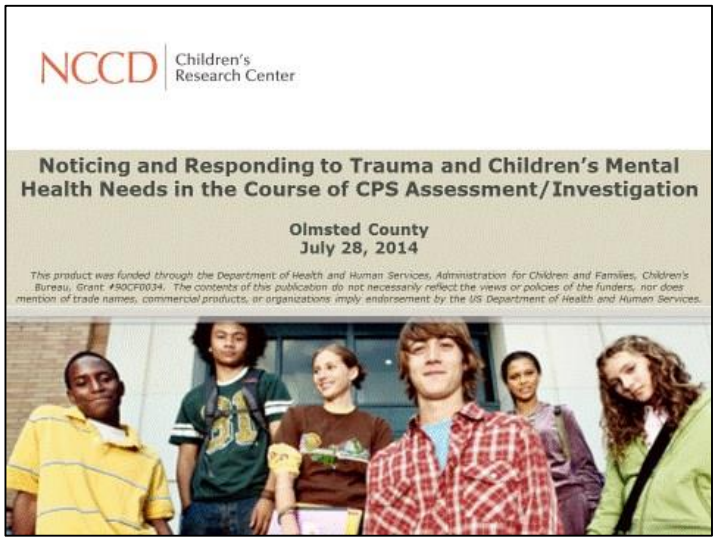
Materials and Equipment

- PowerPoint file
- Copy of SDM manual for each participant
- Handout: Unpacking CSN1 (one copy per participant)
- Whiteboard and/or flipchart paper and markers
- Blank paper for participants to write case plans

Set Up

Ideal seating is at tables, in groups of four to six, without any participants forced to sit with their backs facing the front of the room.

Slide 1



9:00–9:15 a.m.: Welcome and introductions

Get a sense of participants' baseline knowledge regarding trauma and children's mental health by asking one or both of the following questions.

On a scale of 0 to 10, with 10 being that you have participated in numerous trainings on trauma-informed practice, fully incorporated everything you learned into your work, and now can teach others; and 0 being that traumainformed practice is a new term for you, where would you place yourself?

On a scale of 0 to 10, with 10 being that you are familiar with every trauma/child mental health screening tool available and the psychometric properties of each, know by memory developmental milestones and mental health symptoms for children of every age, and are confident that you accurately assess every child; and 0 being that you have no idea how to assess whether a child has been traumatized or has mental health issues, where would you place yourself?

Slide 2

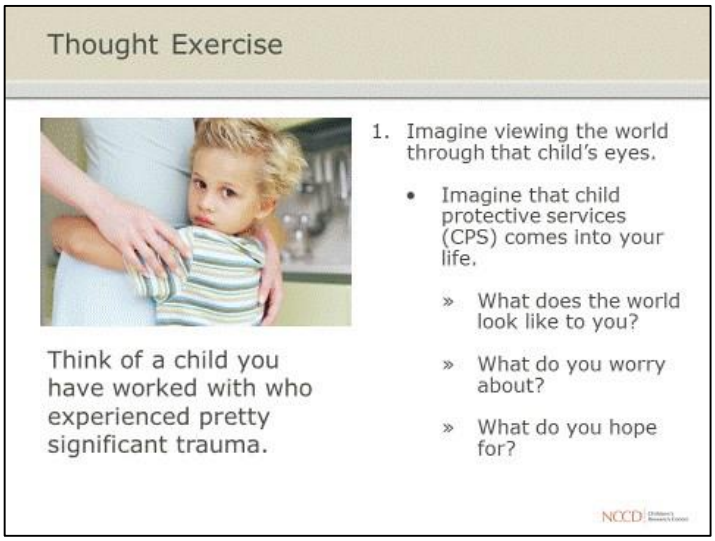
Agenda for the day

Slide 3

9:15–10:15 a.m.

We are about to spend more than a day of valuable time to discuss this topic. Why is it so important?

Slide 4



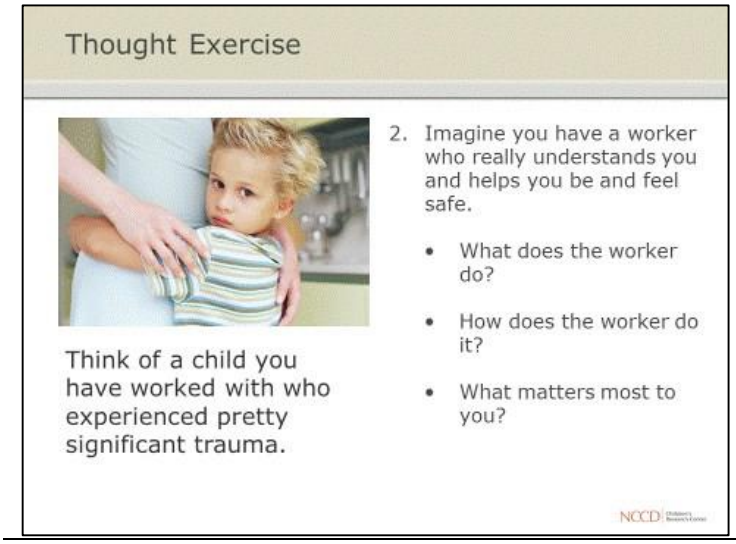
Invite participants to try this thought exercise, noting that calling to mind a child who has been harmed can trigger emotions. Remind participants to do what they need to take care of themselves during this time.

Let them know that discussions in pairs will follow, and then a voluntary report-out in the larger group.

Allow several moments for each participant to bring to mind a particular child. Once they do that, ask them to imagine what the world looks like through the eyes of that child.

Read the questions on the right of the slide slowly, pausing a few moments after each one. Then allow about two minutes for reflection.

Slide 5

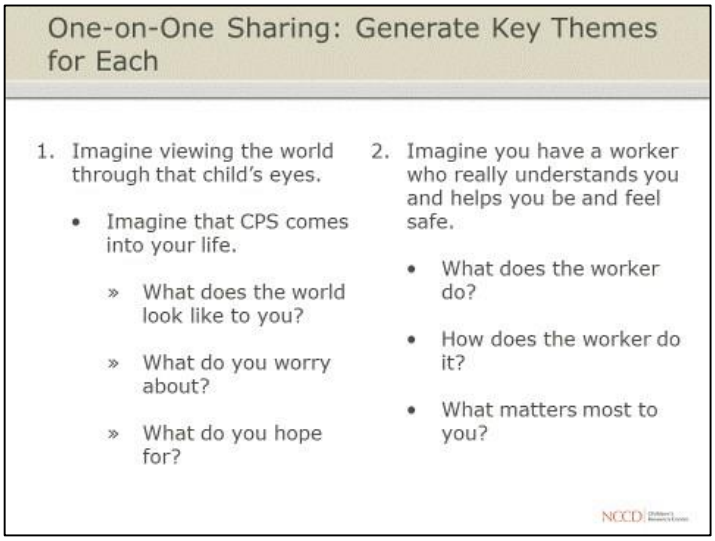


In the second part of this exercise, imagine that this child is one of the fortunate children who receive help.

Read the questions on the right side of the slide slowly, pausing after each one. Then allow about two minutes for reflection.

Invite participants back into present awareness.

Slide 6



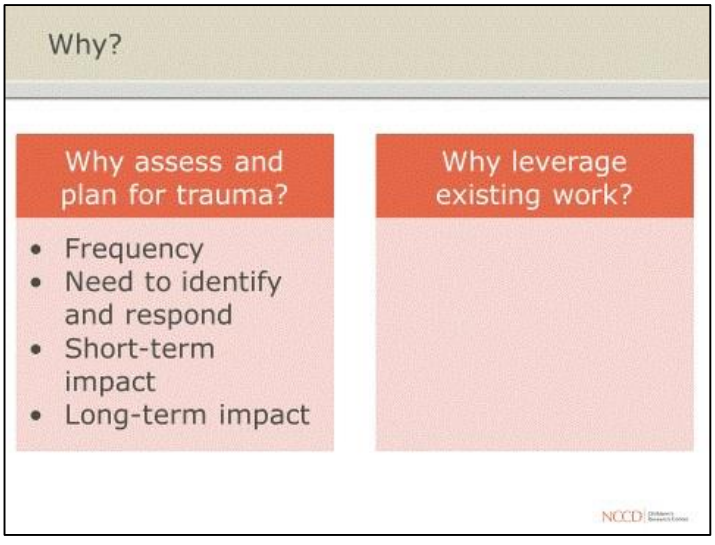
Ask participants to pair off and share with each other some of the salient thoughts that emerged. They do not need to go over each question.

Provide time (10 minutes) for one-on-one conversations.

Then report out and collect themes for both 1 and 2 (10 minutes).

Jot down emerging themes on flip chart paper or white board. Keep this list up, as you may refer back to it periodically as these themes emerge.

Point out that while some new material will be presented during this training, a solid foundation of understanding, compassion, and a desire to help children who have been harmed already exists.



Slide 7

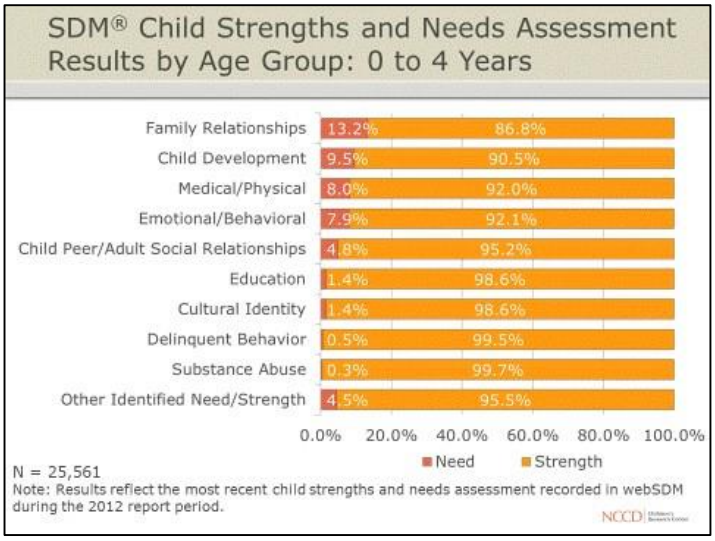
We have talked about "why" from the child's perspective. (If not raised, discuss short-term impacts like placement

disruption and long-term impacts like Adverse Childhood Experiences [ACE] study results.)

If this is so important, why not do trauma/mental health assessments for every child?

Trainer Note: When mentioning "frequency," scroll through the next three slides. After slide 10, return to this slide to resume with "need to identify and respond." Then skip ahead to slide 11.

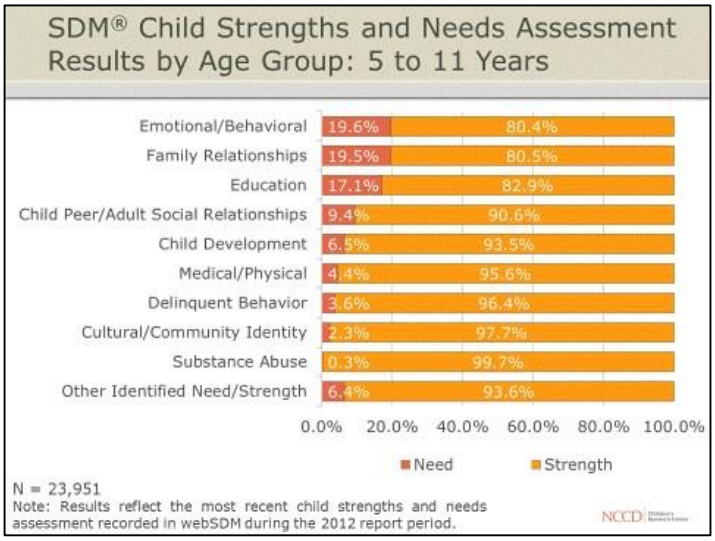
Slide 8



By frequency we mean that many system-involved children have experienced trauma and/or other adverse events and already have symptoms of emotional or behavioral difficulties. These three slides show actual data from the family strengths and needs assessment (FSNA) in California. They show the percentage of children in each age group identified as having various needs.

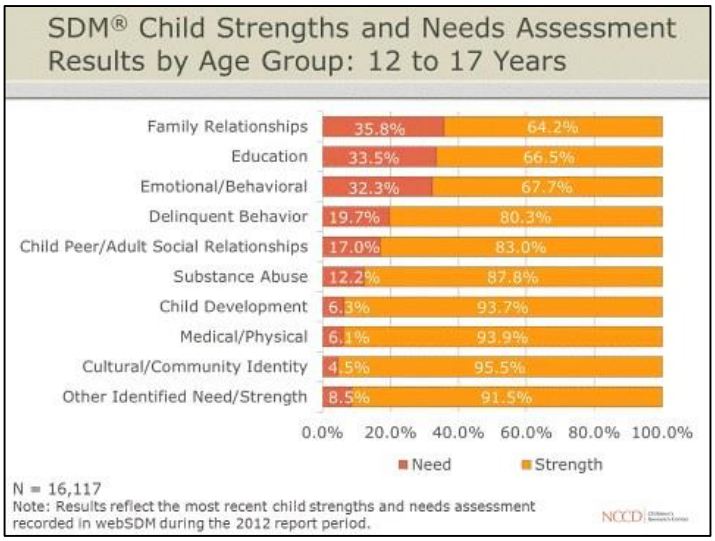
Nearly 8% of children ages 0 to 4 years have identified emotional/behavioral needs. This may be an underestimate, as identifying these needs in very young children can be difficult. One hope for this course is to improve our recognition of these needs in very young children.

Slide 9



For those ages 5 to 11 years, about one in five children are assessed as having these needs.

Slide 10

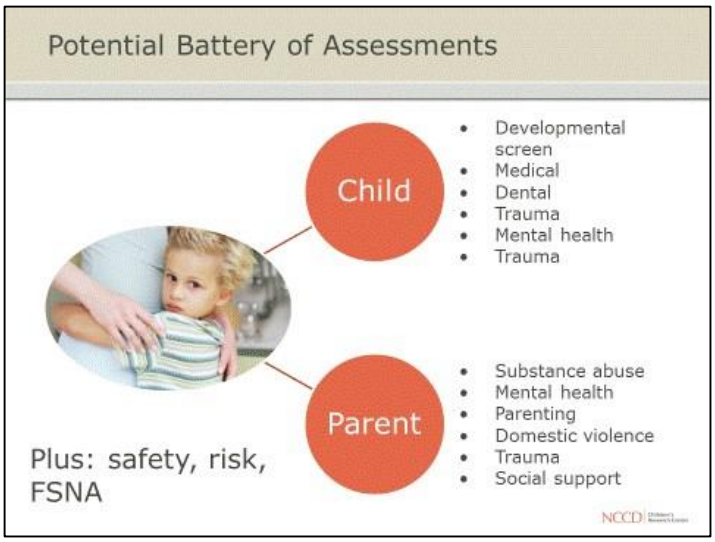


By age 12, about one in three have these needs.

This is cross-sectional, not longitudinal. But it makes us wonder: If we identified and responded to needs earlier, could we reduce the number of adolescents facing these difficulties?

(return to slide 7)

Slide 11

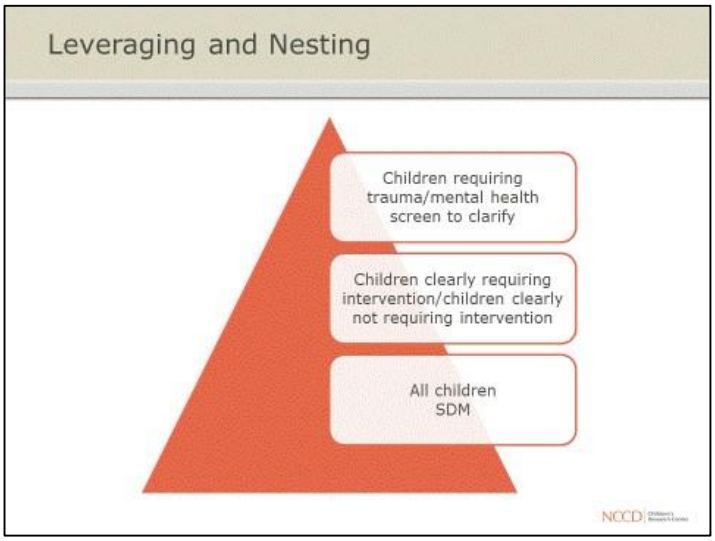


CPS is complex, with the potential to adversely impact children and get in the way of change for parents. We could invest a lot of time and energy conducting screenings for all of these-the tools are out there.

What is the primary function of CPS? How does this fit with the system in a community? What does CPS do best? Who best provides trauma and mental health services? "It is not my job" is not the answer. What is the best role for CPS? How can CPS effectively assess and respond to children's trauma and mental health needs without

compromising the time needed to assess safety and risk and planning well?

Slide 12



This slide is about what CPS must do in every assessment in order to determine which children clearly need trauma intervention and which children need further screening in order to clarify their needs.

Is enough information gathered in the course of the safety, risk, and family strengths and needs assessments to identify children for whom mental health intervention is so clearly needed that there is no value in screening for trauma? Or those for whom a screen is so unlikely to yield positive findings that performing the screening adds no

value?

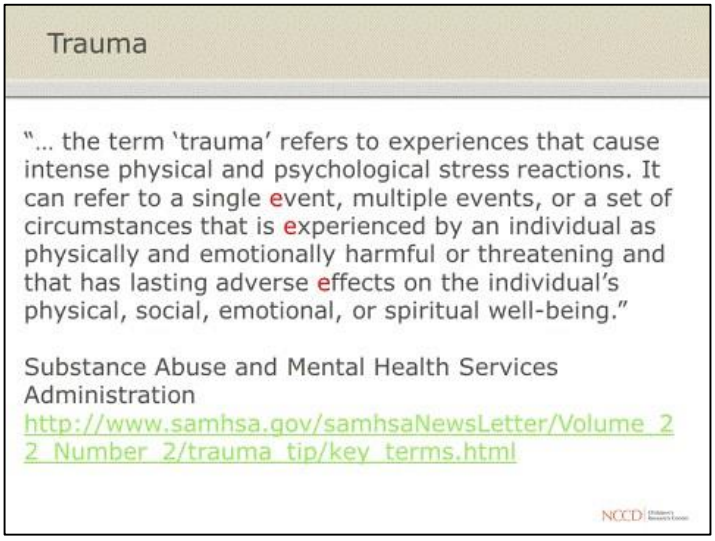
The final answer is unknown. Some exploratory studies are underway to confirm this idea. Today, we will share an approach to try. If you are not screening every child now, this will help identify more children who need intervention. If you are screening every child now, this may help reduce the burden without compromising child needs. This should also be tested empirically.

Break: 10:15–10:30 a.m.

Slide 13

10:30–11:30 a.m.

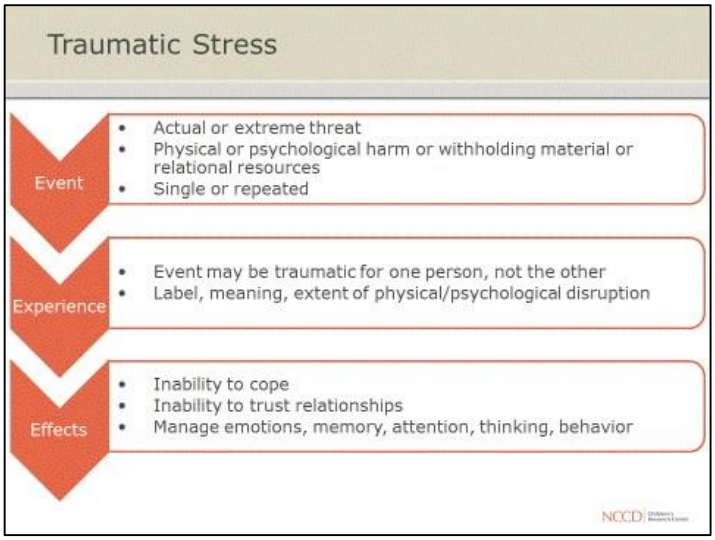
Slide 14



The word "trauma" has become a buzzword with many definitions. We will use this one.

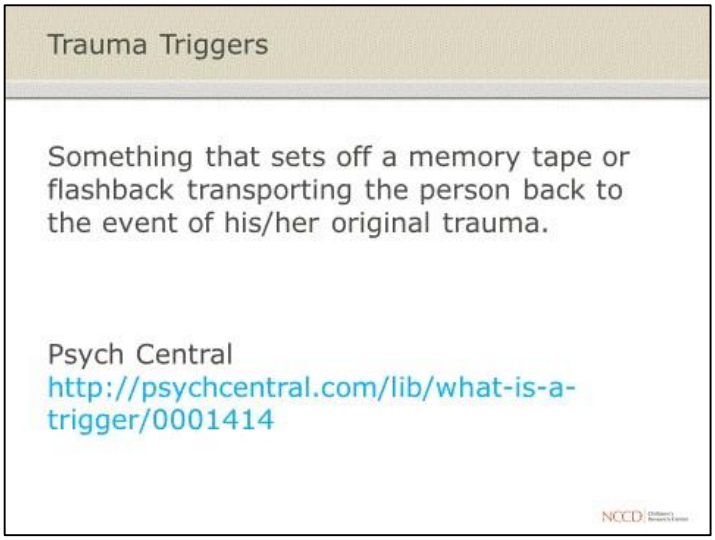
Notice the three red "e"s.

Slide 15



Discuss how some definitions require a life-threatening event. DSM-5 added new categories and a new preschool subcategory.

Slide 16



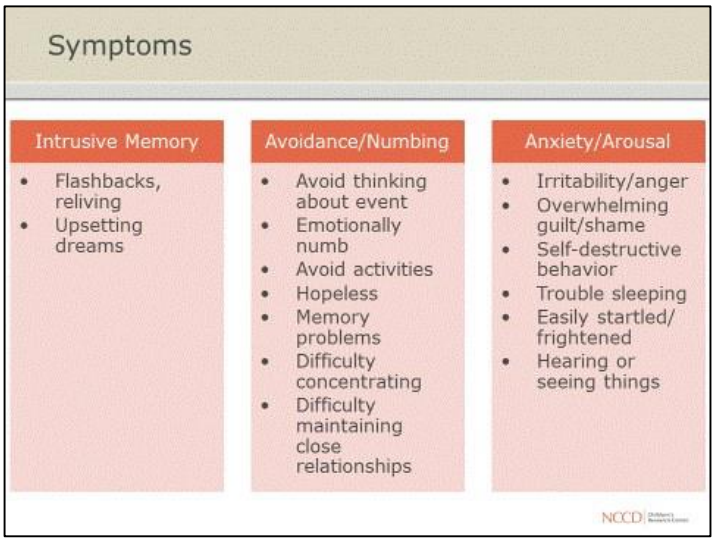
Discuss why this is important for parents, foster parents, and workers to understand.

One key is that some of our interventions MAY be experienced as either primary trauma or trauma triggers. The child's response can be the same, OR it may not be experienced as trauma or trigger. We cannot assume one way or the other.

Triggers can be very individualized.

Ask for examples. (Trainer: If there are none, offer a couple.)

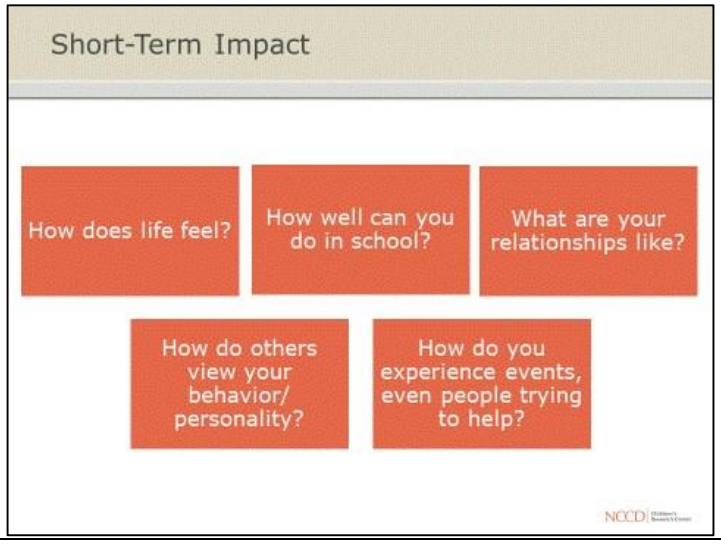
Slide 17



Discussion Questions

- How might these symptoms look different depending on the age of the child?
- With what could these be confused? (i.e., other mental health concerns)
- DSM-5 separates anxiety and arousal clusters.

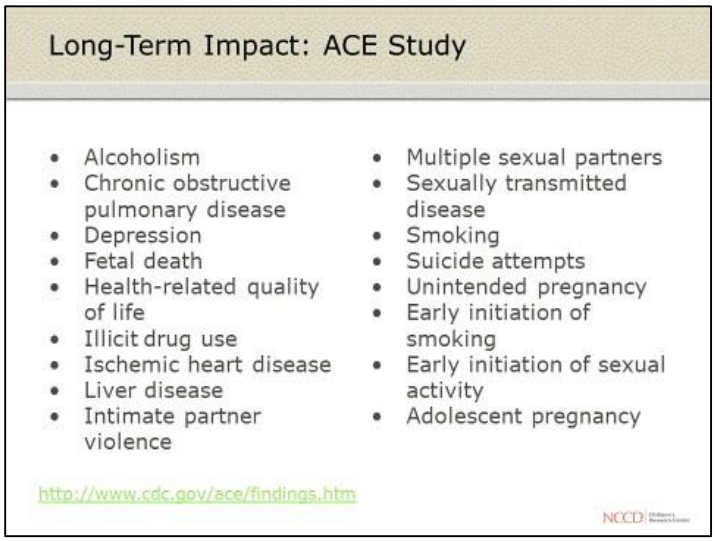
Slide 18



Ask for ideas about what it might feel and look like to be a child who has experienced traumatic events.

Mention that many of the "problems" attributed to a child MAY be reactions to trauma. (Also note that these things can occur for other reasons. It is important not to assume a child is reacting to trauma.)

Slide 19



Briefly describe these and provide context.

- Child trauma does not mean these will happen, but in a large study, those with more adverse childhood experiences were at slightly increased risk of experiencing these outcomes. Still, most did NOT experience these.

- We do not know why some individuals with trauma symptoms experience some of these and not others, or why some experience none at all.

Slide 20

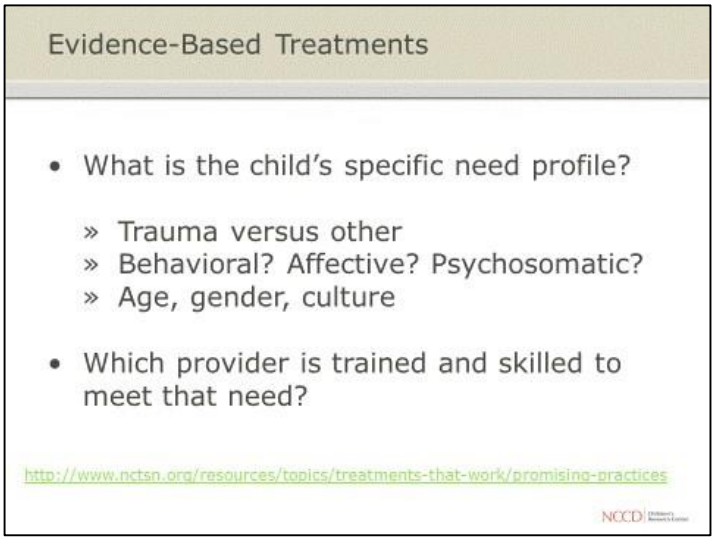
Trauma is an important reason, but not the only possible reason, a child may need mental health assessment and treatment.

Slide 21

Briefly discuss these other common mental health concerns.

Today is not designed to be a primer on diagnosis. But we should be aware of the basic presenting features of these disorders.

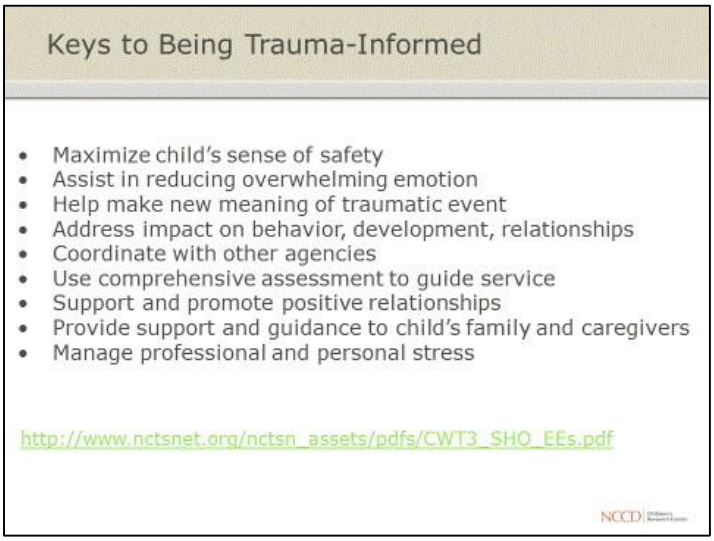
Slide 22



The purpose is not to review all treatments—but to increase awareness that selecting the treatment and provider matters.

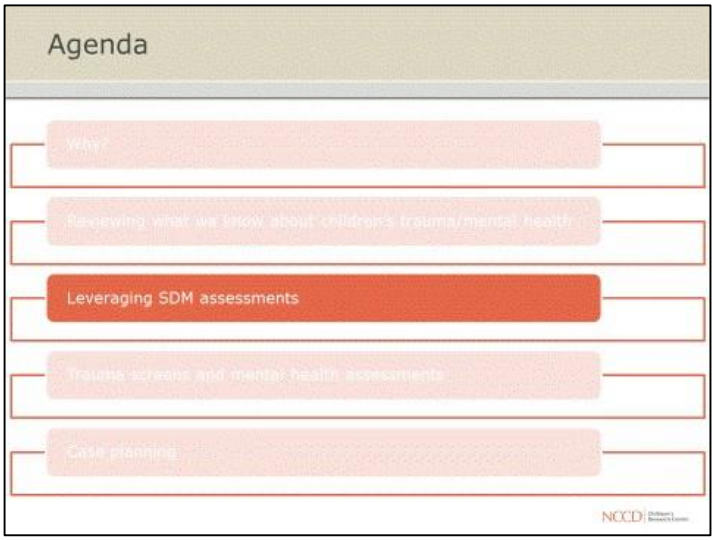
We will talk more about this in a discussion about case planning. The key is that we have an opportunity to individualize our response to the child versus simply referring to generic "counseling."

Slide 23



Discuss briefly. If time allows, we will come back at the end of the day and check what we have learned against this list.

Slide 24

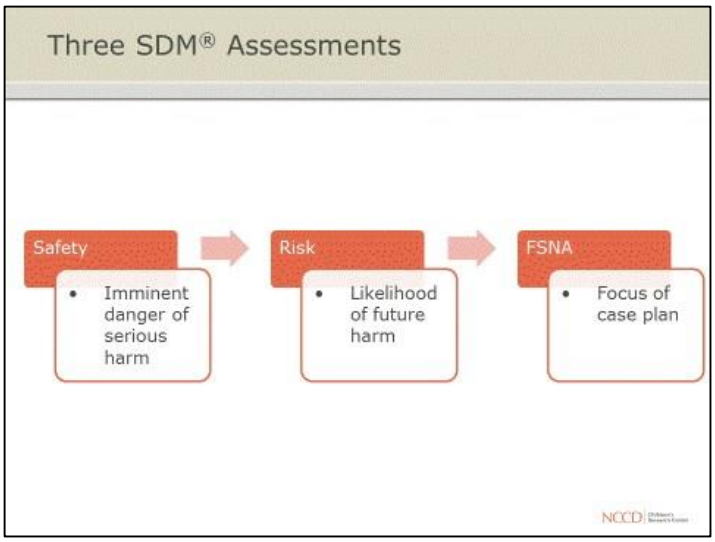


11:30 a.m. – 12:00 p.m., followed by lunch break

Continue from 1:00–2:15 p.m.

In this section, we will walk through the SDM assessments you already use and further explore areas that can be used to help us identify trauma and mental health needs in children.

Slide 25



Knowing what we do about trauma/mental health, what might we look for while completing these assessments?

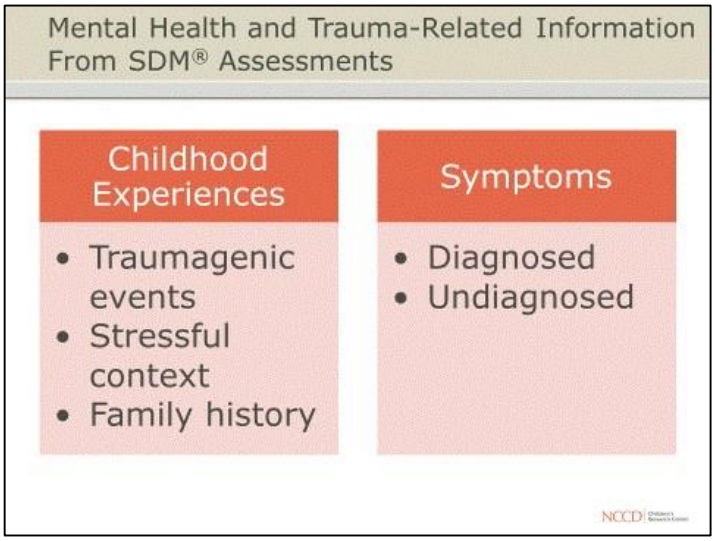
Divide the room into three groups, asking each group to be the voice of each of these three SDM assessments.

Spend a moment reviewing the main purpose of each tool. These assessments are not designed to diagnose traumatic stress or other mental health concerns.

However, they can be quite helpful and

may be enough in most instances to notice and respond to children's trauma and mental health needs.

Slide 26



While completing an assessment, we need to look for information that may alert us to the need for a full mental health evaluation for a child. This information can be divided into two groups: experiences and symptoms.

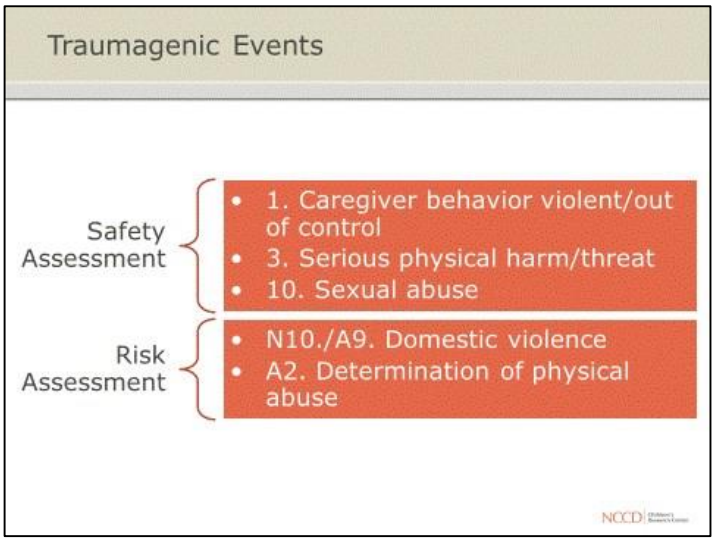
Traumagenic events are those that are very frightening for a child.

Stressful context is a continuous state of living in which there may or may not be traumagenic events, but a sense of safety, consistency, and/or development promotion is lacking. For example, living with a parent with a significant substance abuse or mental health issue would be a stressful context.

Family history is important for mental health concerns that may be genetic.

We have discussed symptoms. It is important to note both the symptoms a child with a diagnosed condition displays AND behaviors that are present even in the absence of an existing diagnosis.

Slide 27

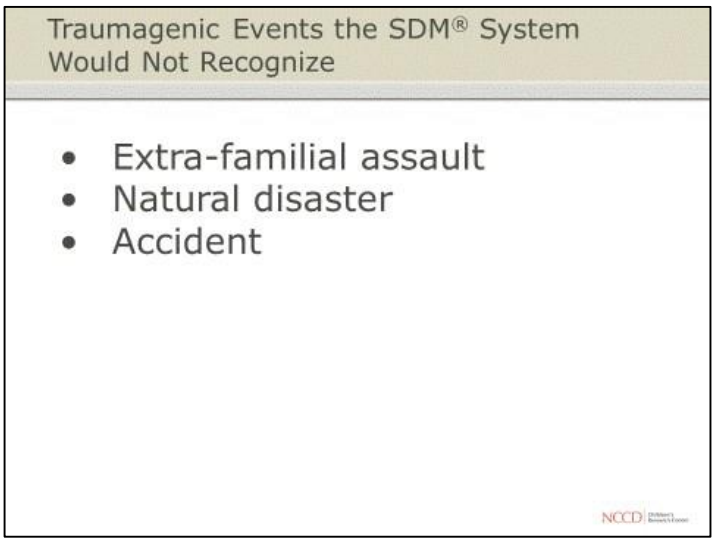


In this next section, ask the three groups to look over their assigned tool and see what items (including definitions) on that tool could shed light on the presence or absence of these things.

Present as blank slide and ask them to find the items. Allow a few minutes. Then ask them to report out what they found.

Then show suggested answers on slide. This is not "right" or "wrong." If they suggest another item, ask why. If it makes sense, that is fine.

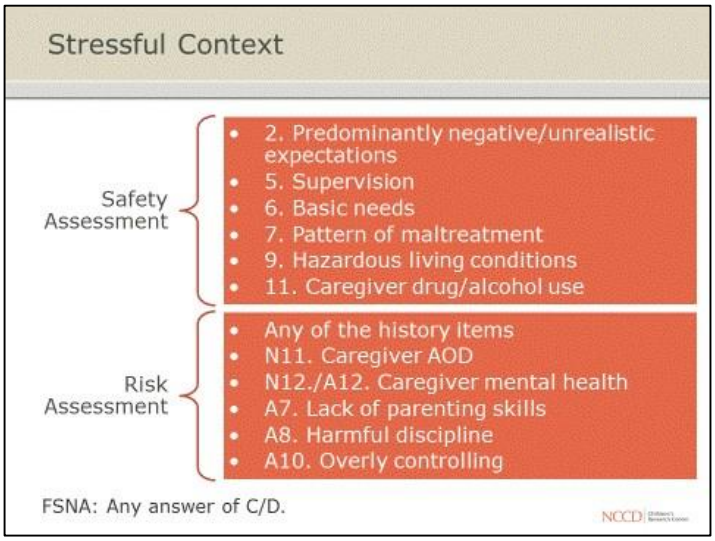
Slide 28



It is also important to know that SDM assessments may miss aspects of trauma or children's mental health.

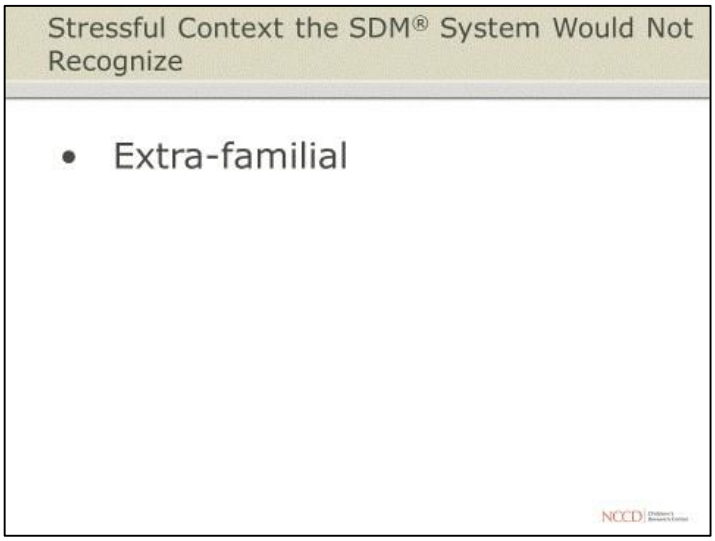
For traumagenic events, the SDM system would not pick up on assaults by strangers or other non-family members. It would not pick up on natural disasters or accidents experienced by the child.

Slide 29

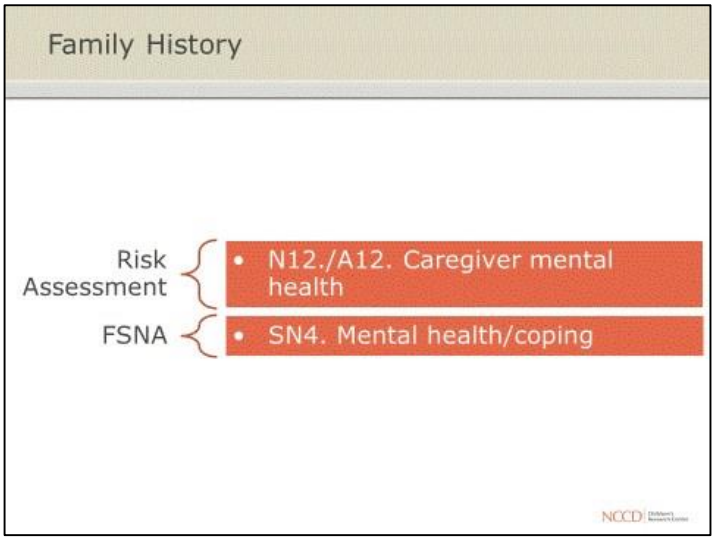


Repeat the process for slides 29–34.

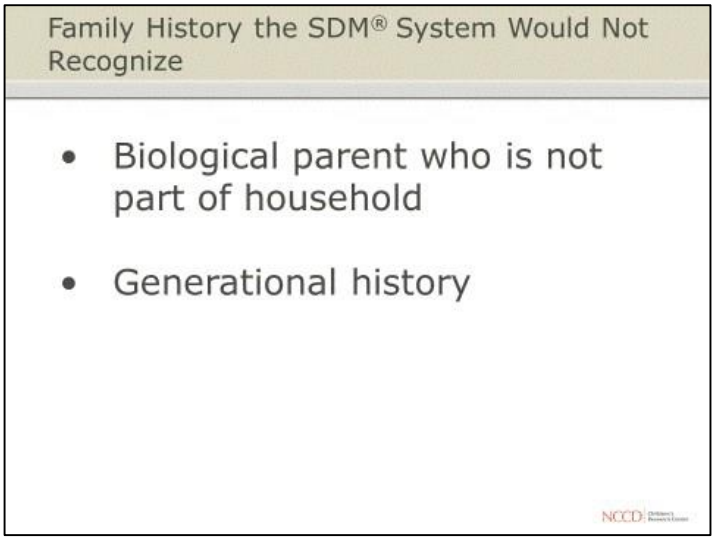
Slide 30



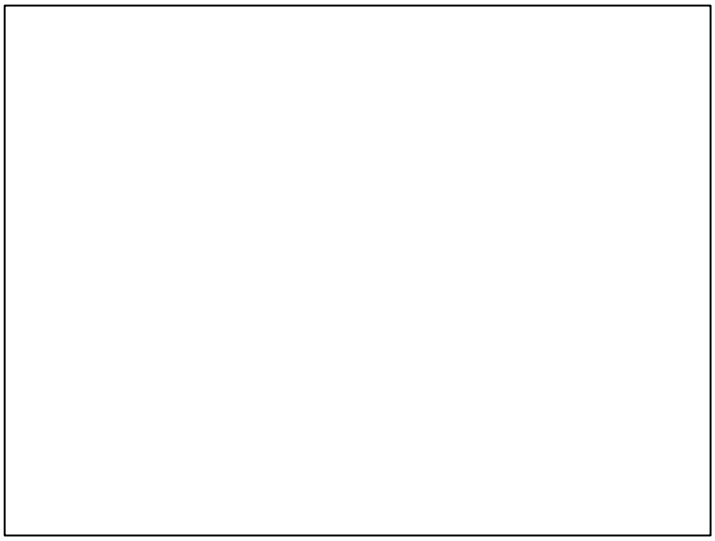
Slide 31



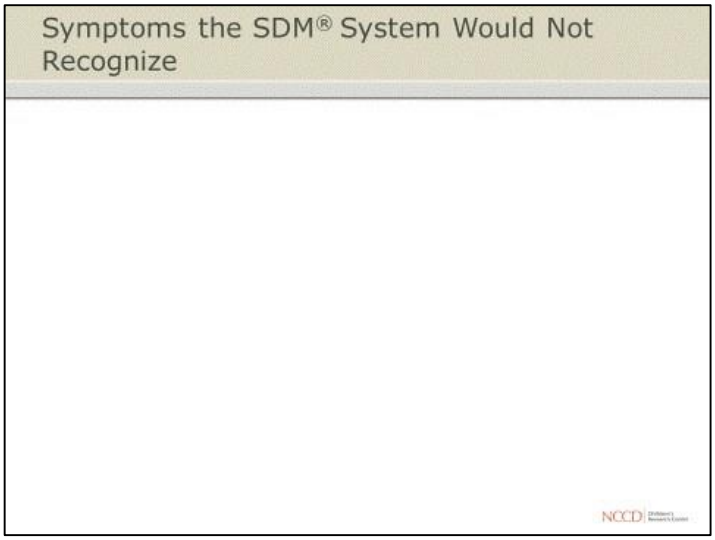
Slide 32



Slide 33



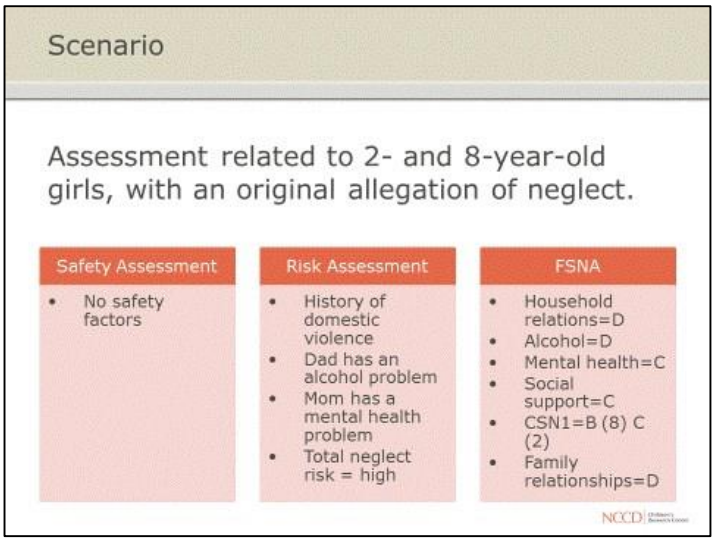
Slide 34



None—if we have a strong enough understanding of what to look for at all ages. We will come back later to CSN1 for a closer look. But first, realizing that clues are scattered throughout the SDM assessments, how would we use these?

Trainer Note: Try to get to this point by lunchtime.

Slide 35

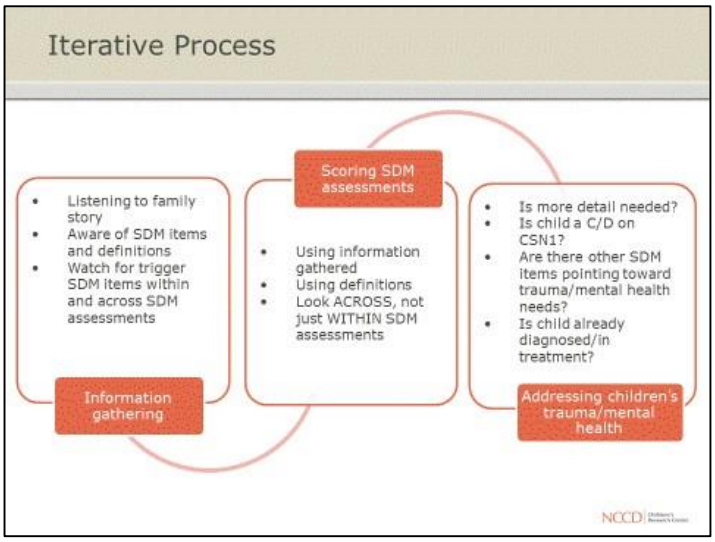


How does knowing that these items were marked inform our thinking about whether either girl should have a mental health assessment?

What fact patterns might have led to marking these items?

(Lead participants to understand that a huge range can exist. For example, history of domestic violence could range from just barely enough to meet the definition—and the children did not witness it—to life-threatening and constant danger.)

Slide 36



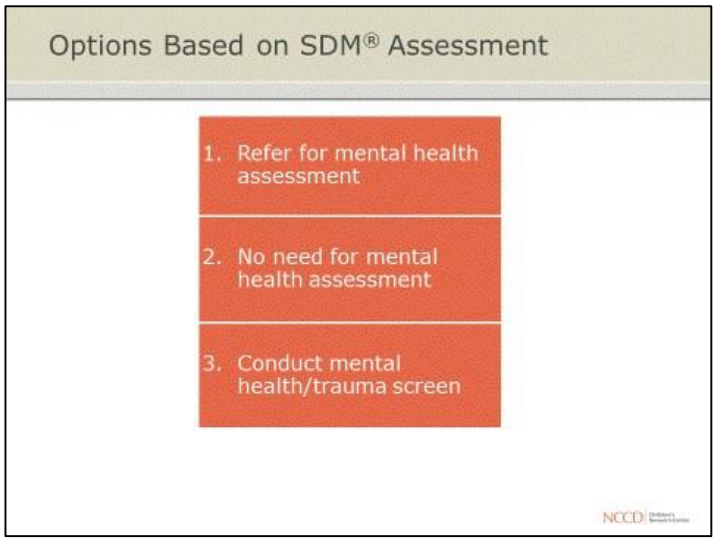
Walk through this slide, which contains two key points.

1. In gathering information, use SDM items and definitions as a guide, but not an interview guide.

2. We often think of SDM assessments in isolation. If we begin to think about using the complete suite of SDM assessments in order to gain a full picture of a family, we may notice things that help us go deeper. For example, if the safety assessment identifies traumatic events, but the CSNA does not identify an emotional/behavioral need, we might explore more. It is possible the child is simply resilient. It also

is possible that we have not asked the right questions.

Slide 37



Discuss that while no "formula" exists, there are patterns that would likely place a child in one of these groups.

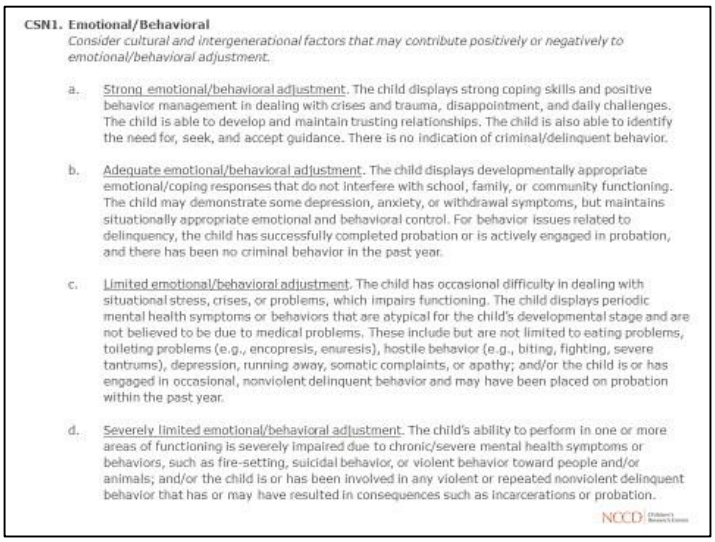
What sort of things would you have marked cumulatively that would lead to each?

- If CSN1 is C or D and child is not already in treatment.
- No emergence of any trauma, stressful context, or symptoms, and CSN1 is A or B.
- Unclear how to score C or D; marginal and confusing pattern of symptoms/exposure/context.

Divide into three groups.

Each group should create a scenario that shows what was marked on the SDM assessments (group makes this up). Include a brief genogram and reason for referral.

Slide 38



CSN1. Emotional/Behavioral

Consider cultural and intergenerational factors that may contribute positively or negatively to emotional/behavioral adjustment.

a. Strong emotional/behavioral adjustment. The child displays strong coping skills and positive behavior management in dealing with crises and trauma, disappointment, and daily challenges. The child is able to develop and maintain trusting relationships. The child is also able to identify the need for, seek, and accept guidance. There is no indication of criminal/delinquent behavior.

b. Adequate emotional/behavioral adjustment. The child displays developmentally appropriate emotional/coping responses that do not interfere with school, family, or community functioning. The child may demonstrate some depression, anxiety, or withdrawal symptoms, but maintains situationally appropriate emotional and behavioral control. For behavior issues related to delinquency, the child has successfully completed probation or is actively engaged in probation, and there has been no criminal behavior in the past year.

c. Limited emotional/behavioral adjustment. The child has occasional difficulty in dealing with situational stress, crises, or problems, which impairs functioning. The child displays periodic mental health symptoms or behaviors that are atypical for the child's developmental stage and are not believed to be due to medical problems. These include but are not limited to eating problems, toileting problems (e.g., encopresis, enuresis), hostile behavior (e.g., biting, fighting, severe tantrums), depression, running away, somatic complaints, or apathy; and/or the child is or has engaged in occasional, nonviolent delinquent behavior and may have been placed on probation within the past year.

d. Severely limited emotional/behavioral adjustment. The child's ability to perform in one or more areas of functioning is severely impaired due to chronic/severe mental health symptoms or behaviors, such as fire-setting, suicidal behavior, or violent behavior toward people and/or animals; and/or the child is or has been involved in any violent or repeated nonviolent delinquent behavior that has or may have resulted in consequences such as incarcerations or probation.

NCCD

A key item is CSN1. A C/D answer requires a mental health assessment and warrants a closer look.

Discuss that the definition is not intended to diagnose or even provide a complete list of symptoms to look for. It is a high-level THRESHOLD, setting guidelines.

Distribute the "CSN1 Elements" handout.

Looking at the definition for CSN1, we noticed repeating elements. This chart shows each of those elements. Note that delinquent behavior has all four (A, B, C, and D) options. Others detail that element in just two or three of the levels.

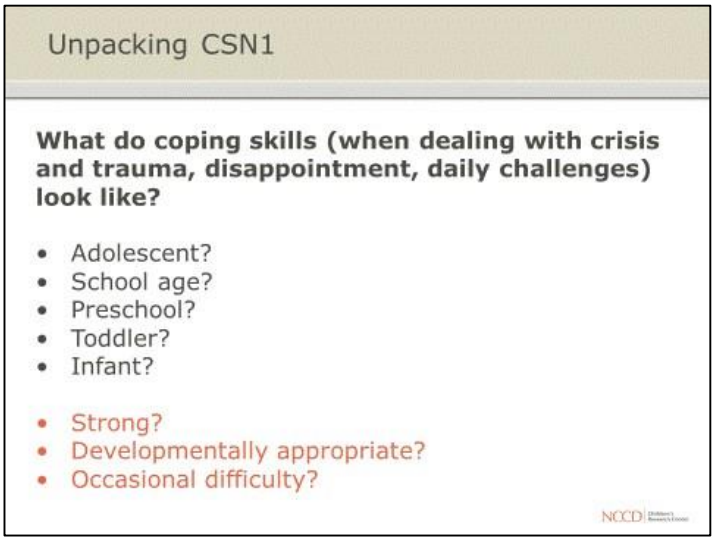
As we walk through each of these elements, we will explore what we might see ourselves, or ask about, to get a better picture of whether the child best fits as an A, B, C, or D response.

Trainer Note: Divide participants into five small groups, one for each age group.

CSN1 Elements	Developmental Stage/Age	A	B	C	D
Coping skills	Adolescent				
	School age				
	Preschool				
	Toddler				
	Infant				
Behavior management	Adolescent				
	School age				
	Preschool				
	Toddler				
	Infant				
School, family, community functioning	Adolescent				
	School age				
	Preschool				
	Toddler				
	Infant				
Symptoms	Adolescent				
	School age				
	Preschool				
	Toddler				
	Infant				
Trusting relationships	Adolescent				
	School age				
	Preschool				
	Toddler				
	Infant				
Identify need for, seek, and accept guidance	Adolescent				
	School age				
	Preschool				
	Toddler				

	Infant				
Delinquent behavior	Adolescent				
	School age				
	Preschool				
	Toddler				
	Infant				

Slide 39



Starting with coping skills, ask each small group to write some descriptive language for what they might notice in a child of that age who has:

- Strong coping skills
- Developmentally appropriate coping skills
- Occasional difficulty coping

Allow five minutes.

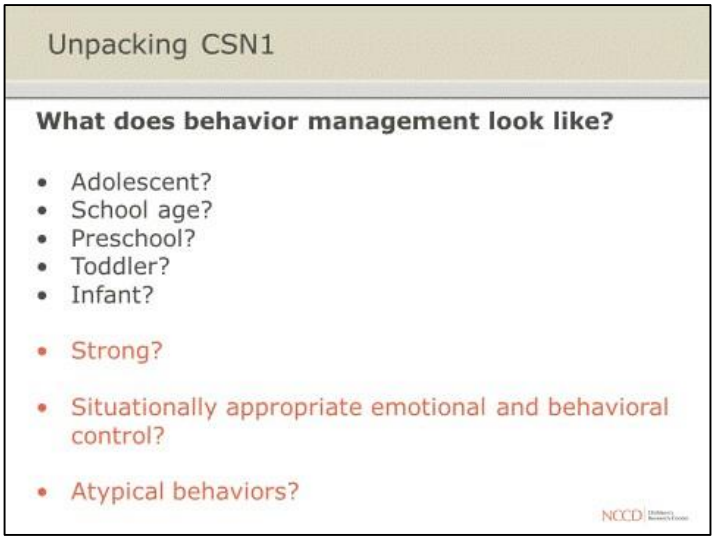
down.

Ask a couple of groups to report out.

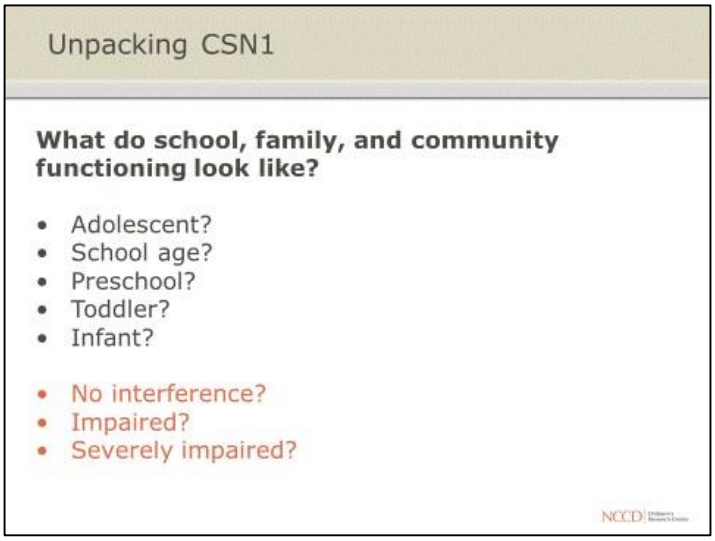
You do not need to write anything

Repeat process through slide 45.

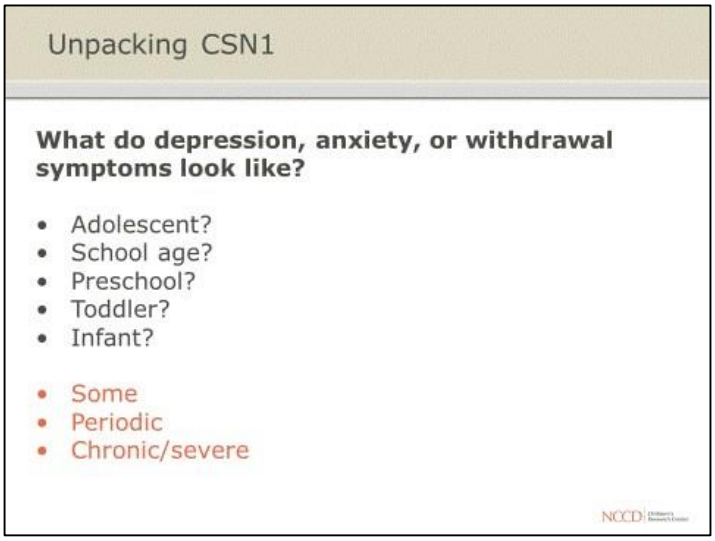
Slide 40


Unpacking CSN1
What does behavior management look like?
Adolescent?
School age?
Preschool?
Toddler?
Infant?
Strong?
Situationally appropriate emotional and behavioral control?
Atypical behaviors?
NCCD

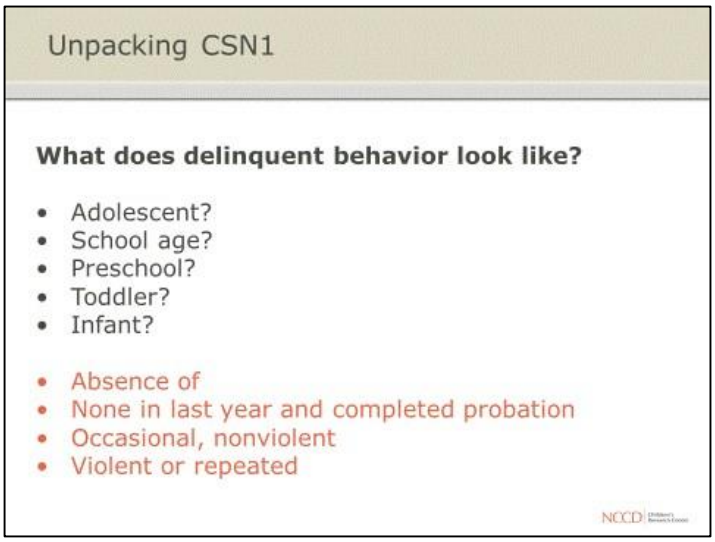
Slide 41



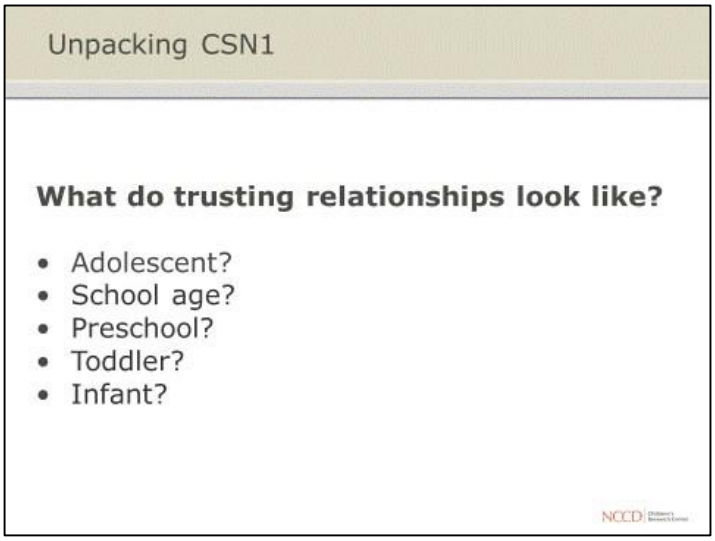
Slide 42



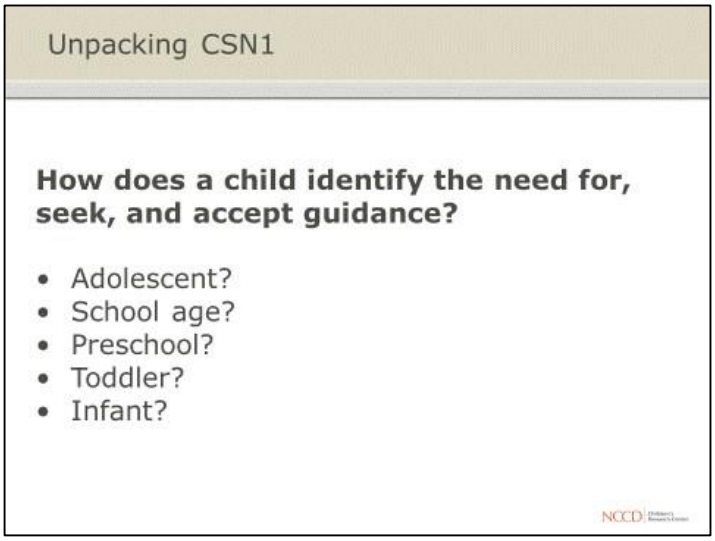
Slide 43



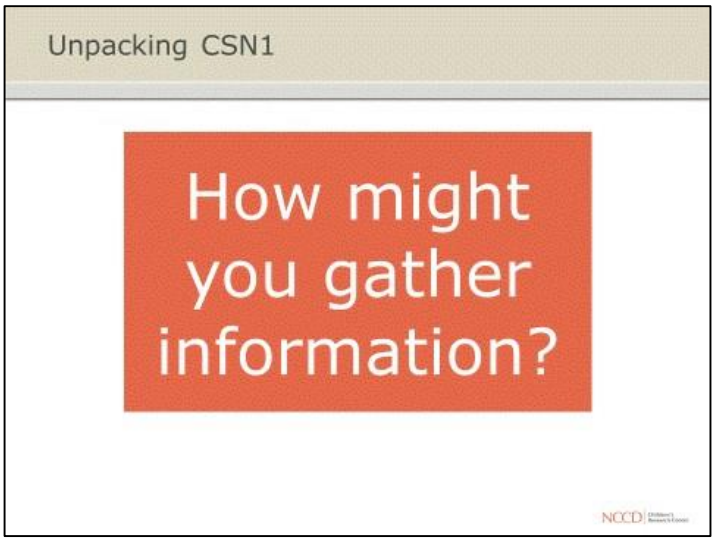
Slide 44



Slide 45

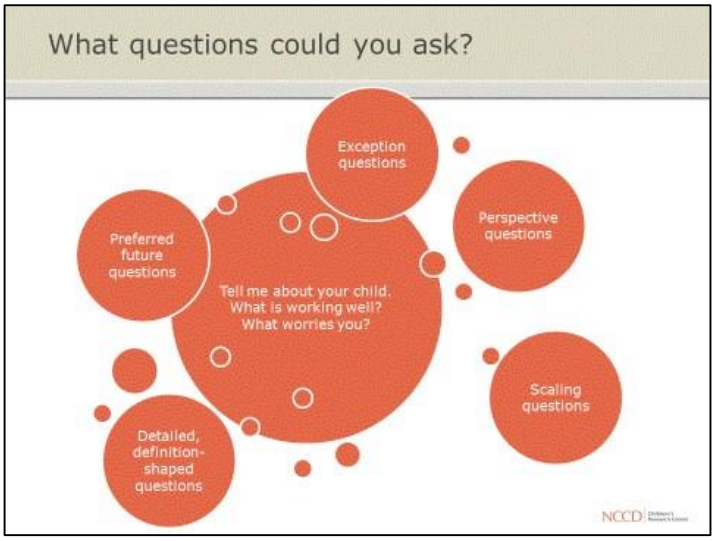


Slide 46



Discuss how the information to answer CSN1 would not come about by asking: "How is your child emotionally and behaviorally?" Rather, it comes from hearing the story and hearing different perspectives.

Slide 47



Start with a blank slide and generate answers. Then show and discuss any that were not brought up.

There are many ways to learn information.

In groups, create as many questions as you can in 10 minutes by picking a question type and a CSN1 element. Craft a question. Then craft another.

Trainer Note: At the end, report out. Collect these. Maybe someone could type up as a resource.

Slide 48

Start with blank screen and generate ideas. Then show and discuss any that were not mentioned.

Discuss ways to approach each and how to decide whether to approach them.

Address confidentiality questions.

Slide 49

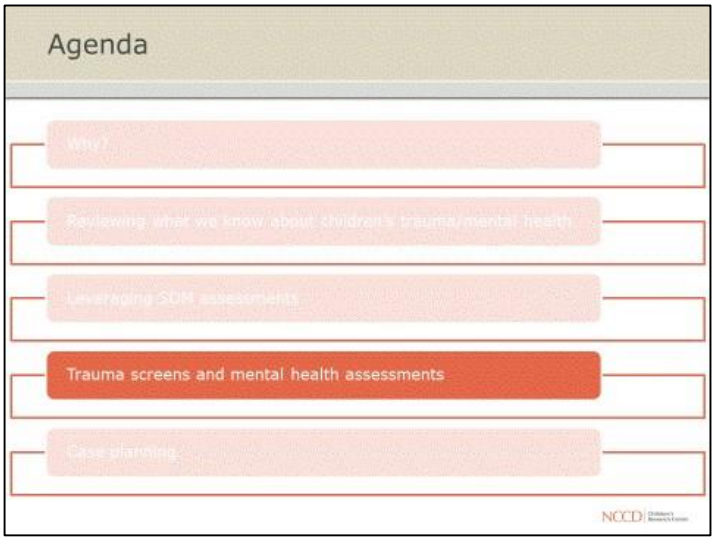
Focus on child and siblings. What special considerations should you have, especially if exposure to trauma is becoming evident?

Discuss giving them some control and how to do that.

- Three Houses, Safety House
- General child interview ideas

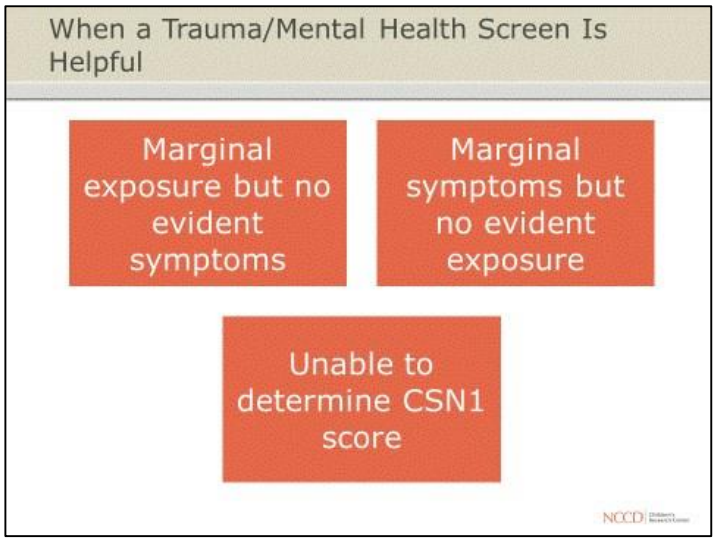
Break: 2:15–2:30 p.m.

Slide 50



2:30–2:45 p.m.: The purpose is not to train on assessment use, but to show there is a place for these.

Slide 51



Discuss some situations. For example:

- Child has lived through serious domestic violence but shows no symptoms.

- Child has a tendency to sadness and isolation but is otherwise

fine, and there is no known trauma or stressful context.

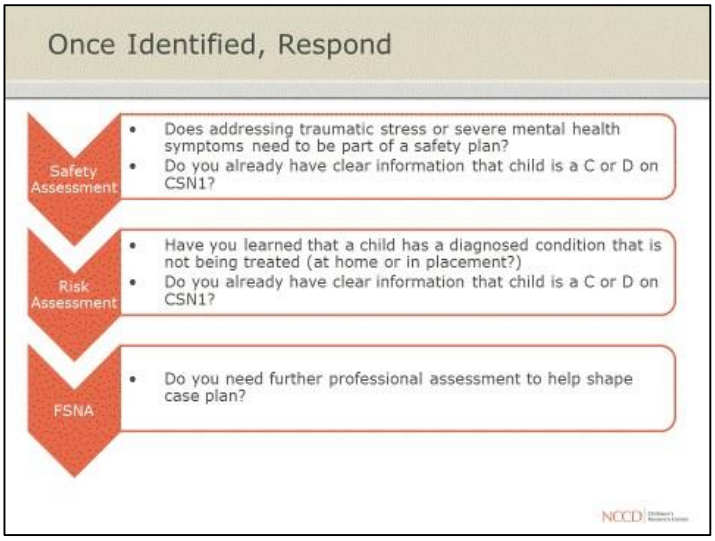
- Few informants are able to provide information about the child to discern CSN1, and information is conflicting.

Slide 52

2:45–3:45 p.m.

We will introduce case planning today and go into the topic more tomorrow.

Slide 53



Discuss what to do prior to the case plan.

Regarding safety, point out that the first safety assessment is completed on day one, and case planning may not happen for a month or more. It is important to do two things.

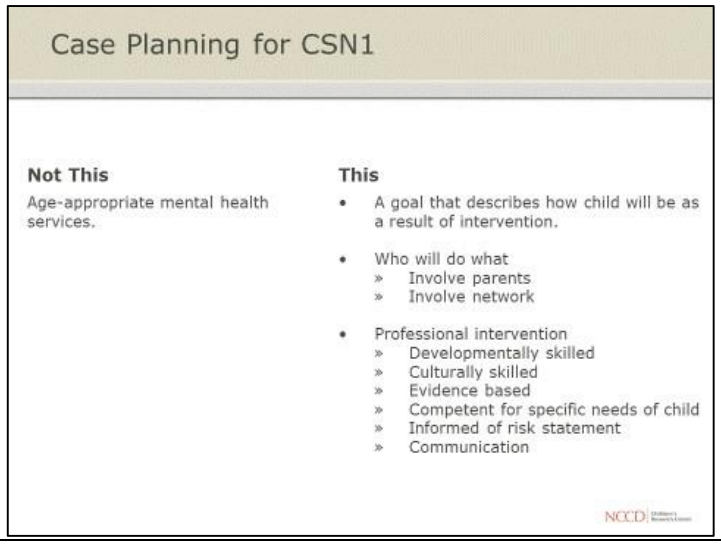
1. Determine if the SAFETY PLAN needs to include elements to respond to trauma or mental health. For example, the first step in responding to trauma is to stop the danger. Also, if the child is suicidal, self-harming, or other dangerous behavior is happening, the safety plan must address this.

2. If enough information has already surfaced to suggest the child is experiencing traumatic stress or other mental health concerns, do not wait for the case plan to take action.

Similarly, the risk assessment will be completed prior to the FSNA and case plan. If you learn about trauma or mental health needs while conducting the risk assessment, you can initiate a full mental health assessment right away.

Finally, as you complete the FSNA, consider whether you have enough information to reach a conclusion on CSN1 or if this is a "grey area" and obtaining an assessment, or doing a trauma screen, would help to score.

Slide 54



Tomorrow will be devoted to planning. As a brief introduction to the idea, here are some basics:

We want to avoid case plans that prescribe generic "mental health services."

Instead, begin with a goal that paints a picture of the child at the end of a successful intervention.

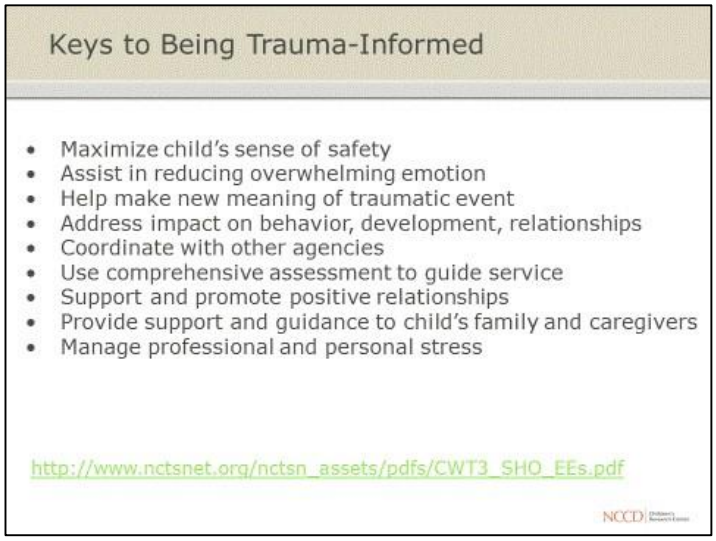
Make this plan not just about a referral to a professional, but also about what other people will do. The parents need to be part of the plan. The network may be part of the plan. If you do involve professionals (and you almost always should), be thoughtful about who you select for each individual child. Be sure the professional gets the information needed to work effectively with the child. At a minimum, the therapist needs to know the risk statement you developed with the family. Once the plan is in action, you must stay abreast of how the child is progressing and keep the therapist informed of what is happening with your work with the family.

Slide 55

3:45–4:00 p.m.: Summary

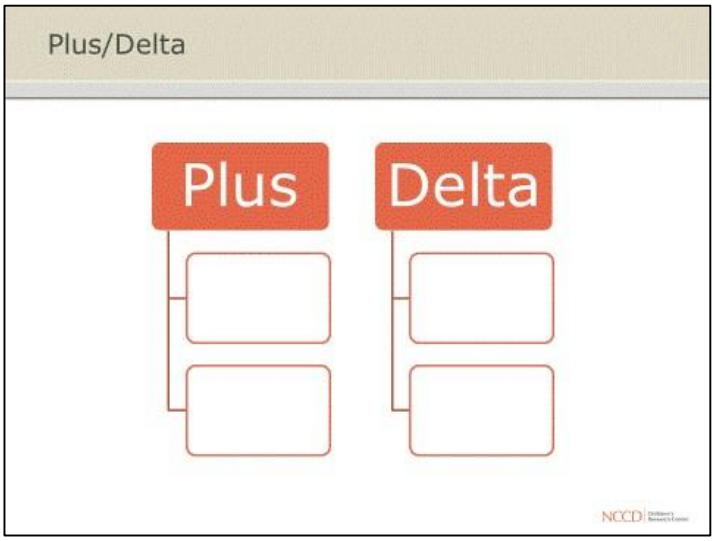
Invite participants to write down one thing they remember from each portion of the agenda. Share a few.

Slide 56



How does what we learned today stack up?

Slide 57

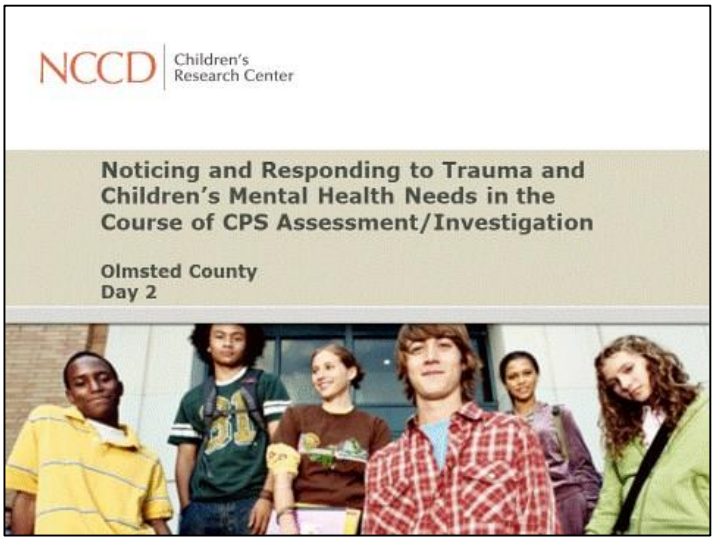


Close the day's session by gathering what went well today (plus) and what participants would like to change (delta).

This may impact Day 2 and/or future sessions.

Slide 58

Slide 59



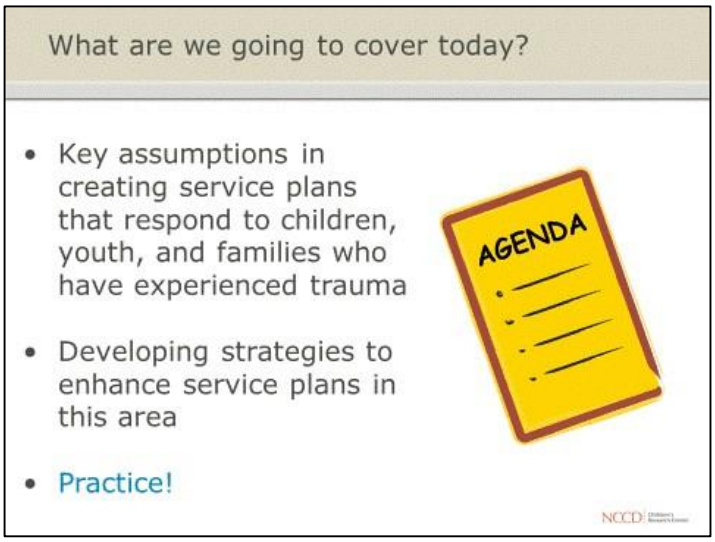
Welcome and reconnections/ introductions (9:00-9:15 a.m. for slides 59–62)

Today we will refocus on the actual making of plans. While the county has many different kinds of plans (placement plans, child protection service plans, etc.), we will be talking about an overall set of

principles and practices that can be applied to all of these plans.

Trainer Note: Ask group for thoughts/reflections about first-day materials.

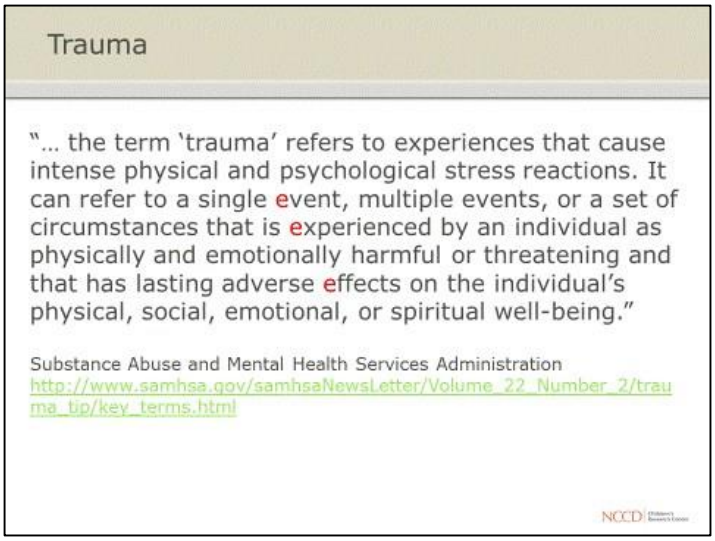
Slide 60



Purpose
To introduce agenda.

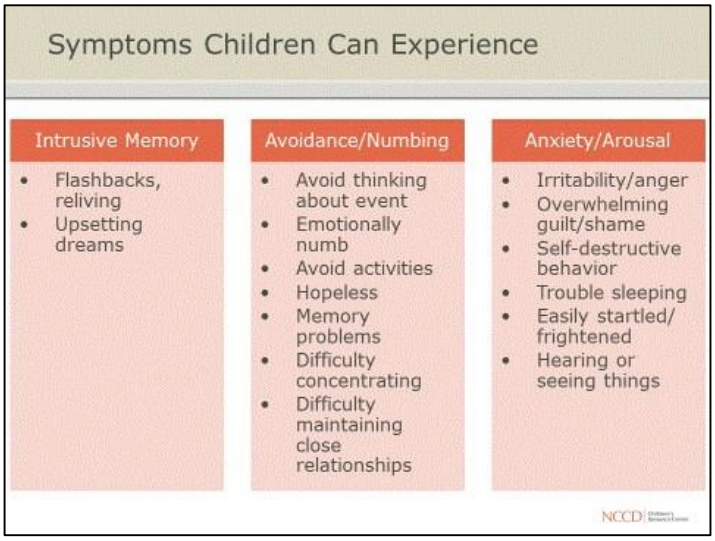
Example
There is no doubt that you already are doing many forms of planning in your work. Today we will talk about how these plans can be even more rigorous, collaborative, and focused on action steps. We will look at a framework for creating goals on these plans.

Slide 61



Just a quick reminder of a key point from Day 1: The Three Es. Trainers should read the quote (or have participants read the quote) and ask if participants had any more thoughts about this since Day 1.

Slide 62

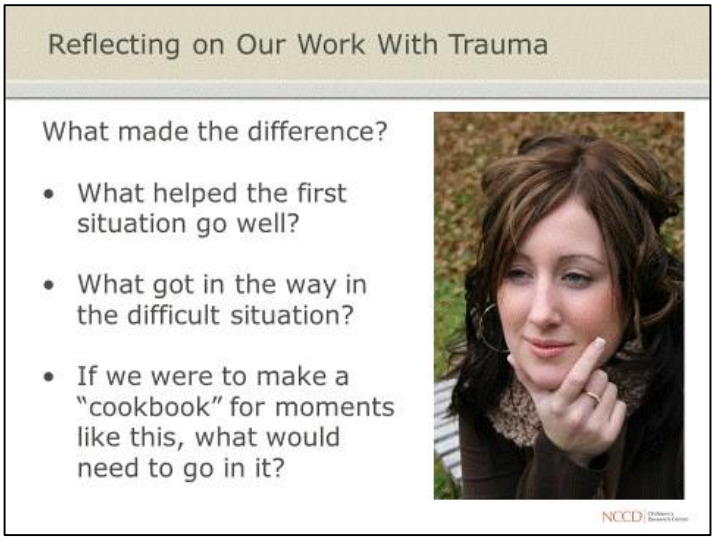


Reminder of these ideas from Day 1: These are the major symptoms or effects that can come from experiencing trauma. Workers need to be mindful of these kinds of effects as they make plans with children, youth, and families.

Slide 63

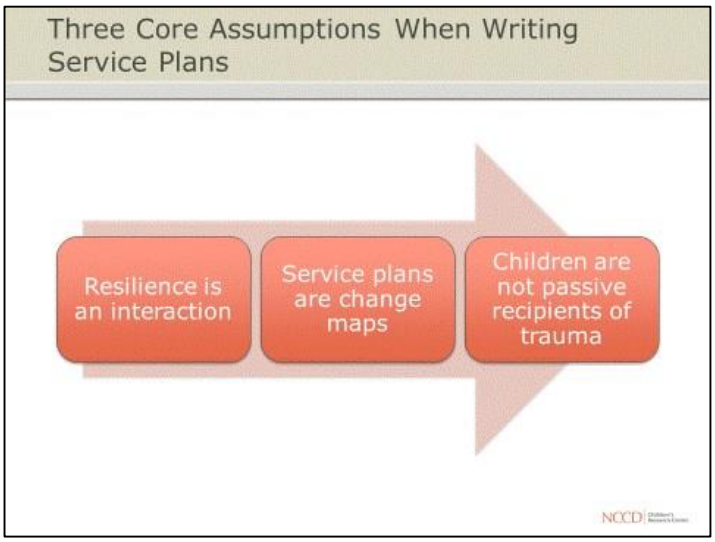
Opening exercise (9:15–9:30 a.m., slides 63–64 and discussion): This is a visualization with two parts. Trainers should read opening paragraph. PAUSE. Give participants time to conjure a particular memory or image. Then read the second paragraph, again giving time for participants to find an image or memory.

Slide 64



Opening exercise (second of two slides): This slide is a discussion placeholder. It can be helpful early in the day to ask participants to get into pairs, discuss this, and then share with the rest of the group. If the group seems ready to have a large discussion right away, trainers can proceed to that without the pairs discussion.

Slide 65

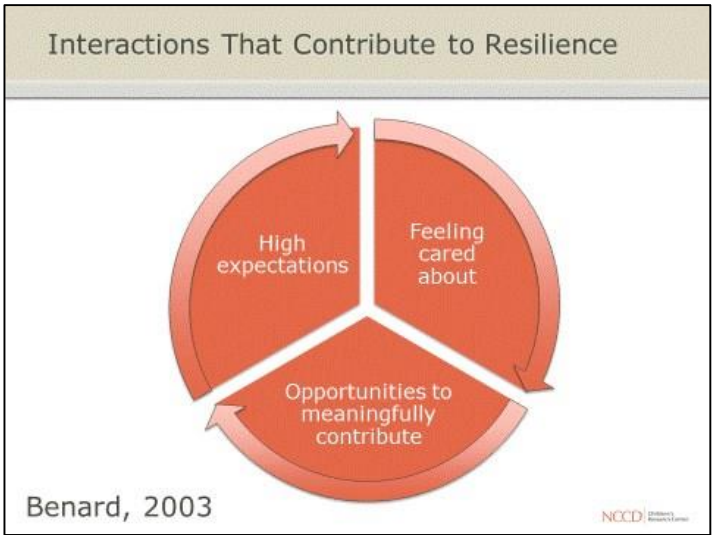


(9:30–10:15 a.m. for slides 65–73 with discussion; can take break after) These are the core assumptions trainers will be reviewing today when helping participants think about creating trauma-informed service plans.

Slide 66

This quote can be read by participants, followed by a brief discussion. Main point: Most times "resilience" is thought of as a quality that resides (or does not reside) within an individual. Ungar's work (and that of other scholars studying resilience) suggests that resilience is better understood as something that is created as a result of an *interaction* between a person and his/her environment. This has profound implications for child welfare professionals: It suggests that the work we do and the kind of plans we make can increase the resilience of our clients--even clients who have experienced trauma.

Slide 67



This slide shows the findings of Bonnie Benard, who also believes that resilience can be achieved (or enhanced) as a result of an interaction. In her research, she found three major kinds of interactions that help enhance individuals' resilience.

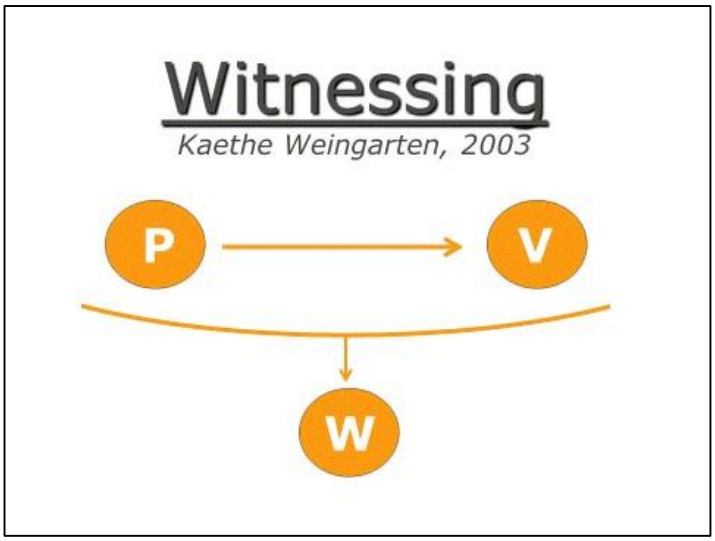
- Someone in the client's life who cares deeply about him/her.

- Someone in the client's life who holds high expectations for him/her (not so high that they are unachievable, but
goals and expectations that take hard work to achieve).

- Someone in the client's life who offers him/her opportunities to use his/her unique skills, abilities, and gifts in meaningful ways.

Trainers should explain this formulation, then have a brief discussion with the group: Can participants think of past clients they thought of as resilient? Can participants see where these kinds of relationships and interactions may have helped enhance their client's resilience?

Finally, trainers wishing to take this deeper can ask the group if these qualities and interactions are present for workers and staff within the organization. Trainers could ask the group: Would these kinds of interactions help us deepen our own organizational resilience?



The following section highlights another piece of work to describe both the impact of trauma and a strategy for creating plans that respond to it. This is a framework for understanding the impact of witnessing violence and violation developed by Kaethe Weingarten for her book *Common Shock*, which was published in 2003.

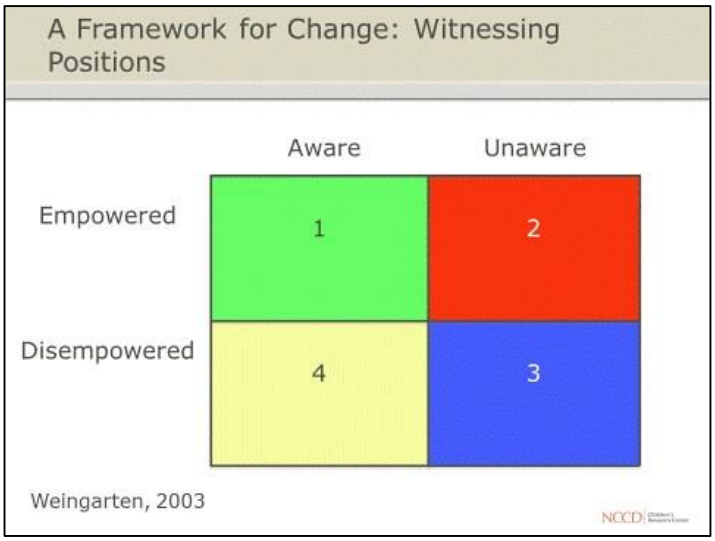
- Whenever a perpetrator acts on a victim, there are always witnesses.

- These witnesses could be child, parent, child welfare workers, supervisors, or managers.

Slide 68

- Witnesses to trauma experience the effects of the trauma to some degree as well.

Slide 69



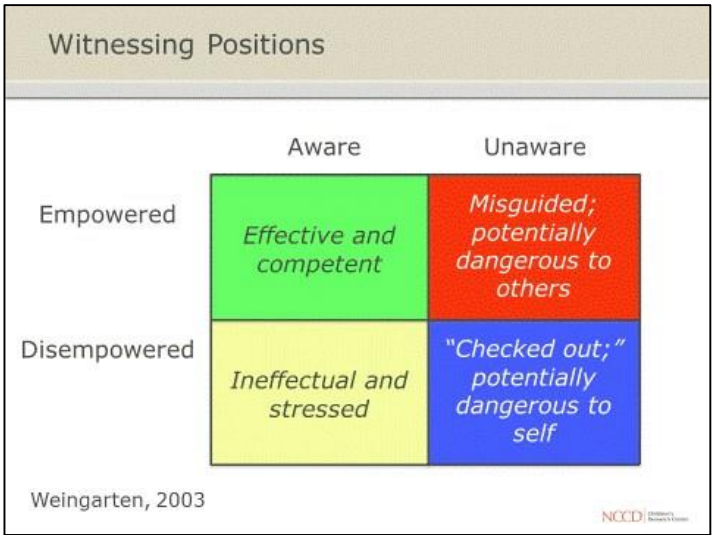
Weingarten created this "witnessing grid" to show the different ways people can experience trauma and how they can move into effective action (essentially, how they can become more resilient) after.

All people who have witnessed any kind of trauma—either by directly being affected themselves or watching someone else—fit onto this grid.

The east/west grid asks the question: Were the people who experienced or witnessed the trauma aware of the trauma and the effects it had on them? Could they make the connection between the traumatic event and the impact it had on their behavior or symptoms? Awareness is a critical component to responding to trauma because if clients (or workers) are not aware of the impact of trauma, they will be unable to address or improve the situation. Not everyone is aware of trauma and its effects; clients sometimes think symptoms are personal failings of some kind. (Trainers: You can ask participants if they know clients who are unaware of the effects of trauma on their lives).

The north/south axis asks the question: Was the person who experienced or witnessed the trauma empowered to do something about it or disempowered? Clients who are empowered to do something about the trauma (adults who can leave relationships safely, for example) are likely to have an easier time moving forward and addressing trauma than clients (like children) who are disempowered and perhaps unable to make changes in their lives.

Putting these two axes together creates a grid that helps us understand how clients who have witnessed violence or violation can be experience that (more in next slide).



Slide 70

Continuing with this witnessing framework:

- Clients who are aware and empowered likely are able to be

effective and competent when responding to violence and trauma. This is the group that is likely to show the most resilience and will be most able to find strategies to help themselves.

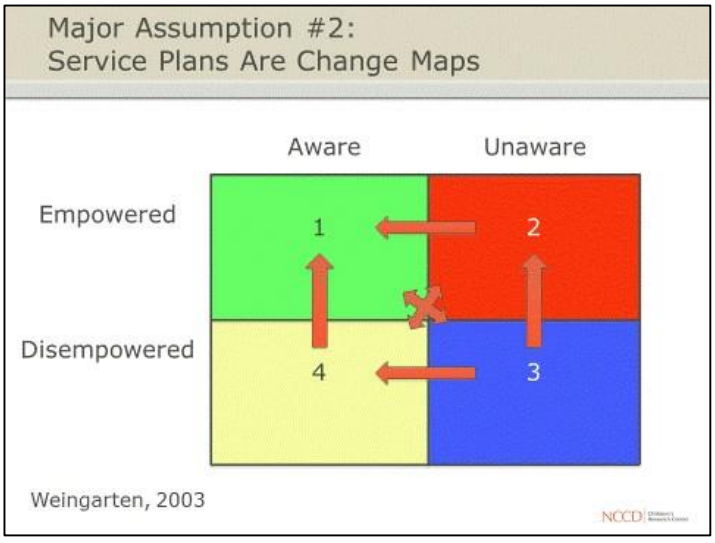
- Clients who are unaware but empowered can be misguided and potentially dangerous to others. An example of this might be a parent who experienced trauma at some point in his/her life and has a large amount of power over his/her own children. Because this parent cannot recognize trauma's impact, he/she is not aware of how his/her parenting may affect the children.

- Clients who are aware but disempowered are able to recognize that they are/were subject to trauma but are unable to do anything about it. An example of this can be a parent who is a likely victim of domestic violence or an older child who has been subject to ongoing neglect. In both examples, the clients are aware of what is/was happening to them but are unable to do anything about it. This leaves them feeling ineffectual and stressed.

- Finally, clients who are disempowered and unaware are likely to struggle with their own self-care. This group is both unaware of the impact of trauma and has little power to make any changes. This is a group that may turn to some self-harm or, more likely, will struggle with managing symptoms.

Trainer Note: Ask participants if any particular clients come to mind when they see these descriptions. Also ask if these descriptions have any implications for helping professionals.

Slide 71



Finally, what this grid helps make clear is the second major assumption of the work in creating trauma-informed service plans: Service plans are "change maps"—plans that help people begin to shift their relationships to the experience of trauma. Workers and families can work together to build service plans that help create movement from the unaware/disempowered positions to more awareness and more empowerment.

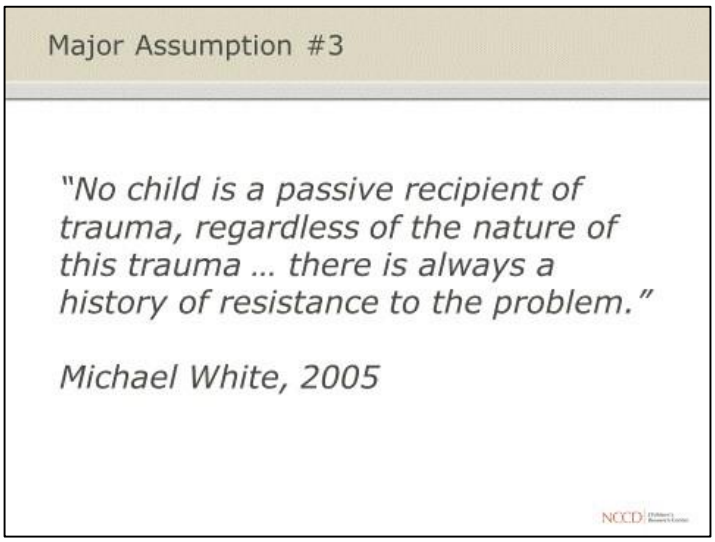
Trainer Note: It is useful to prepare a story from your own experiences where you were able to help a client develop a plan to move to more awareness about the impact or effects of trauma and to develop increasing empowerment or choices in dealing with it. Look for moments from your own work where:

- *You had conversations with clients or created plans that helped them to become more aware of the impact of trauma; and/or*

- *You had conversations with clients and their networks and created plans that helped to give them more control, choices, and power in responding to what was happening.*

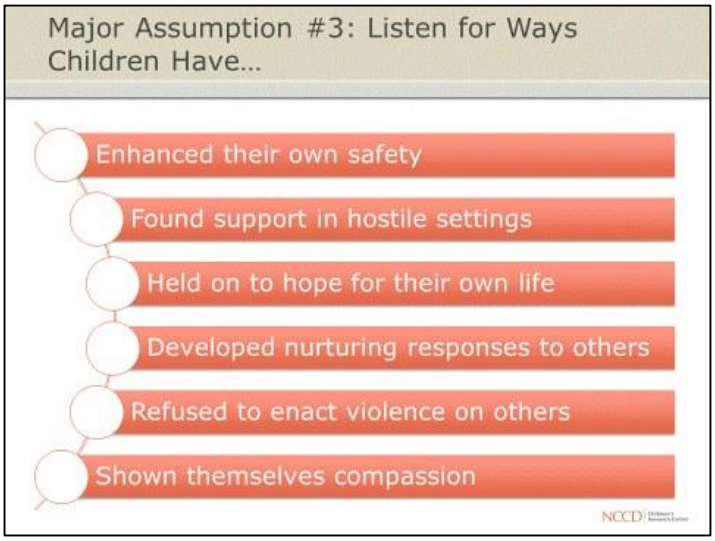
Then have a discussion with participants and ask them to come up with some of their own examples as well.

Slide 72



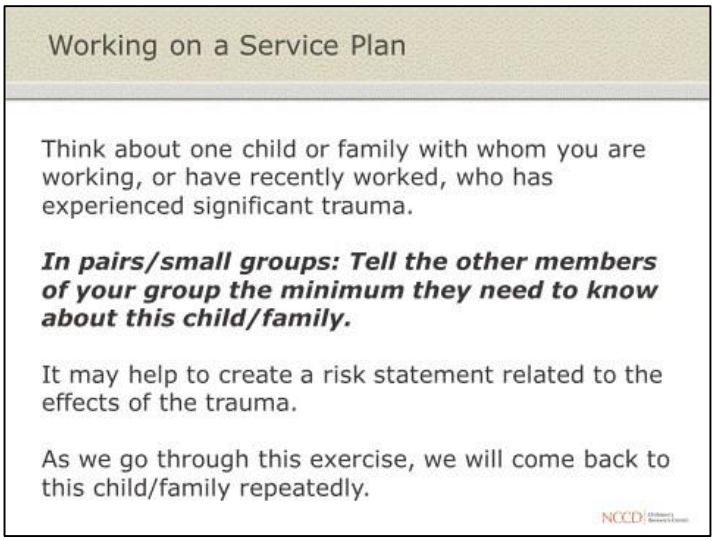
Finally, the third major assumption that underpins this approach to creating trauma-informed service plans is related to the children themselves. Children are never "passive recipients of trauma," as family therapist Michael White says. They always are trying to help themselves and resist the worst parts of the trauma.

Slide 73



Once we are aware that children are help-seeking and looking for ways to resist the worst parts of the trauma, we can start to look for examples when children themselves were able to move into the empowered/aware space. Workers can look at the areas on this slide (trainers review) and use these as a way to build on what is already working for these children.

Slide 74



Trainer Note: The next 11 slides constitute a lengthy practice session that should take approximately one hour and 15 minutes (10:30-11:45 a.m.). Ask participants to form pairs or small groups in which to consider one child or family, who has experienced some kind of trauma, with whom one of the group members has worked. As the exercise progresses, the small groups will develop action steps for a service plan for each particular family.

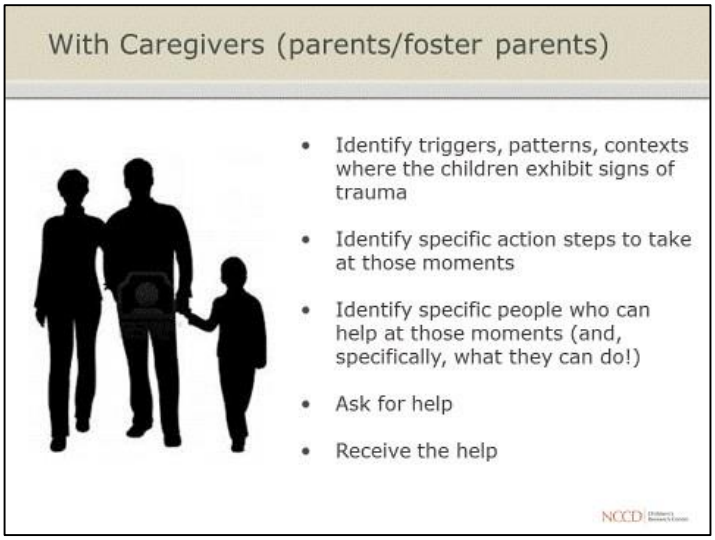
In particular, this exercise will help participants develop action steps, not service referrals. Service referrals are a critical part of trauma-informed service plans, but helping families think through action steps to take in the face of trauma is likely to be even more healing and empowering.

In this initial phase of the exercise, it may be useful for the person who worked with the family to create or share the risk statement about the family.

Slide 75

When workers are creating these kinds of trauma-informed service plans, they need to work with four groups of people in order to create effective plans: the caregivers (likely parents or foster parents if the child is in care), the child or youth, the extended family network that cares about the child or youth and is willing to be part of the plan in some way, and the providers assisting with the family.

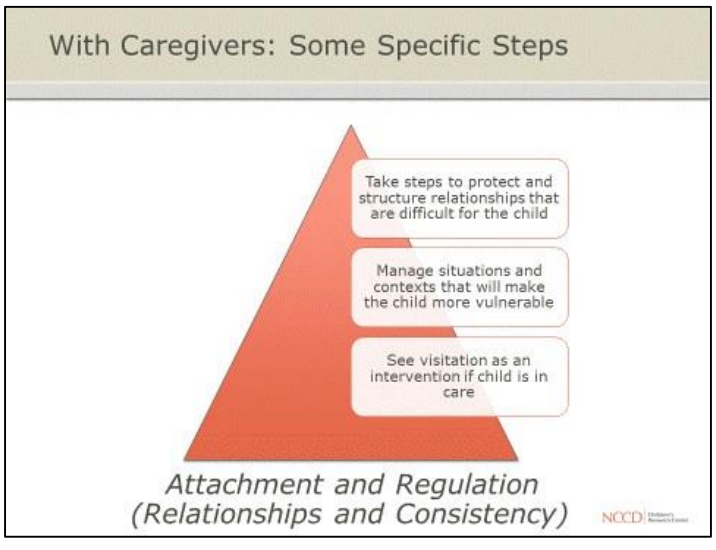
Slide 76



When making trauma-informed service plans, the work with caregivers includes these items.

Trainer Note: Read key points on slide.

Slide 77



In particular, plans with caregivers should help them assist the child by:

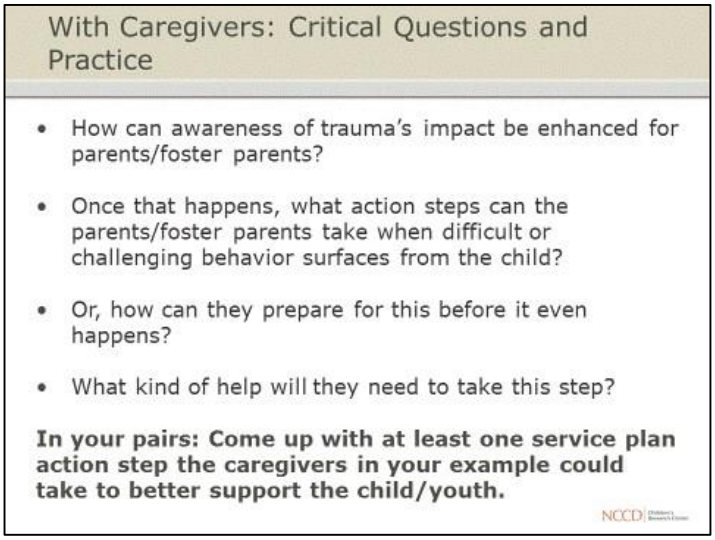
- Taking steps to protect or structure relationships the child has that could be difficult;

- Managing situations that make the child more vulnerable; and

- If children are in care, ensuring visitation is consistent and a chance to both maintain connections and improve parenting capacity.

The goal is for caregivers to help their children deepen attachments and more consistently regulate their emotions; it is another way of maintaining good relationships and consistency in children's lives.

Slide 78



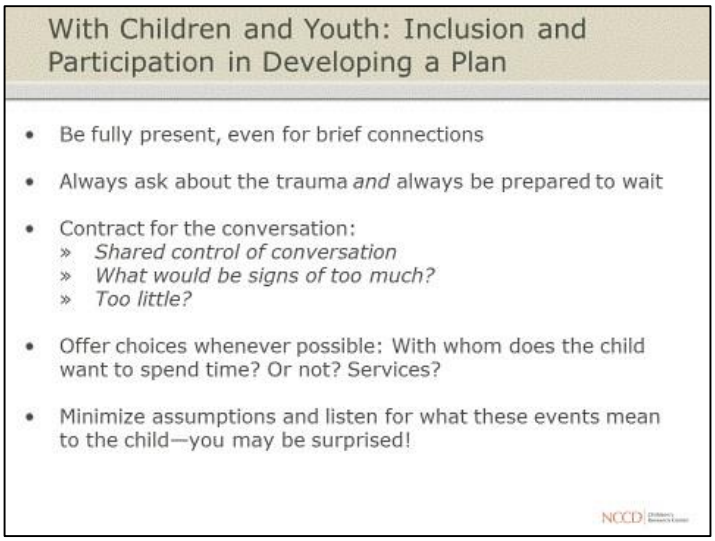
Trainer Note: The small groups will work on part 1 of this exercise using the family they have already talked about to develop actions steps. Ask participants to work in their pairs or small groups. They should come up with at least one service plan action step that caregivers in their example could take to better support children or youth in their care. This should be an action step the caregivers could take, not a service referral.

Give each group about 10 minutes to come up with the action step; then debrief with the large group. Use the large group to highlight action steps the small groups have come up with that caregivers could take that would increase awareness and empowerment in the face of the trauma or help create more opportunities for children/youth to develop resilience.

Slide 79

The second critical group to consider is the children and youth. One of the best ways to make sure your service plans are trauma-informed is to ensure that children and youth voices are included in the plans. Workers should use some best-practice strategies they likely already know (Three Houses, Safety House, or a good child interview) to help children participate in plan development.

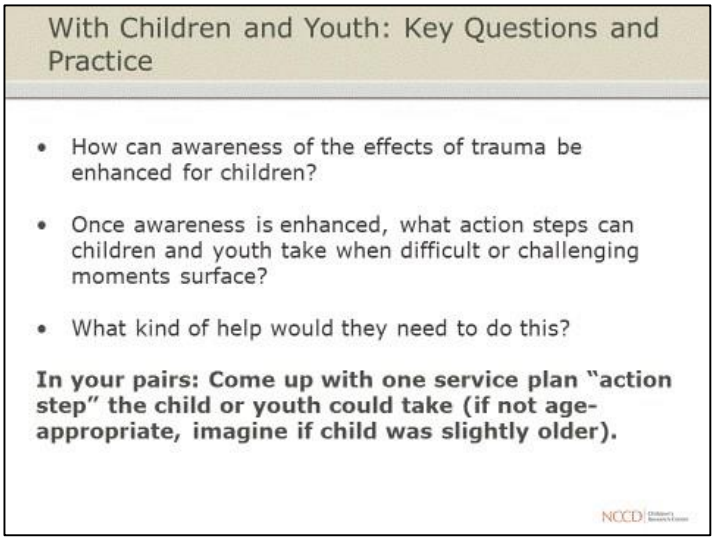
Slide 80



Here are some strategies workers can use when trying to help children and youth participate in developing the plans.

Trainer Note: Read key ideas and seek participants' ideas and enhancements. Do participants think these ideas would help children feel more included when building service plans? What else do the participants do to help children feel included when developing plans?

Slide 81



Trainer Note: This is part 2 of the exercise. Ask participants to get back into their pairs or small groups and think about service plan action steps that the children themselves could take. These again should be actions the child/youth could take that would help to increase his/her awareness about the trauma or feel more power over it, not a service referral.

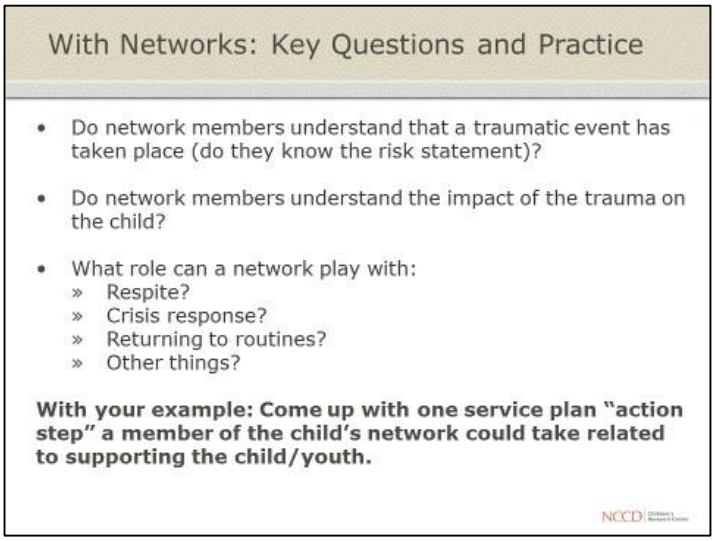
If the child in the example is too young to take any action steps, ask the group to imagine the child is older. What steps could the child take then?

Trainers should give these small groups another 10 minutes to brainstorm action steps for their examples, then debrief with the whole group. Look for themes and creative small steps children could learn that would help increase their awareness, empowerment, or resilience.

Slide 82

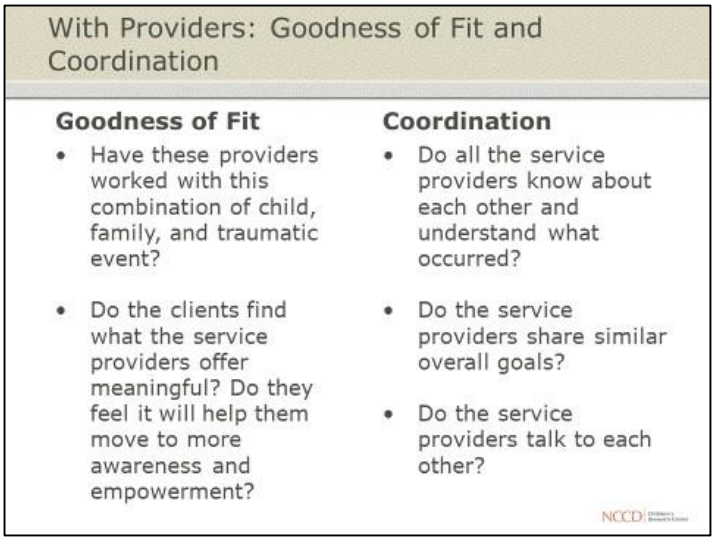
The third critical group to address in a trauma-informed service plan is the network that surrounds the child and family. While families that have experienced trauma often struggle in their relationships with others, every family and every child have some people who care about them. Using safety and support circles is one way to identify this network; family team meetings become a way to help gather these people together. However it is done, it is critical that these people become a part of some of the service plan action steps.

Slide 83



Trainer Note: This is part 3 of the exercise. Read the key ideas on the slide, then ask participants to get back into their pairs or small groups and consider what kinds of action steps could be taken by network members to better help the caregivers or children respond to the trauma. Once again, give participants 10 minutes to brainstorm ideas, then debrief with the large group.

Slide 84



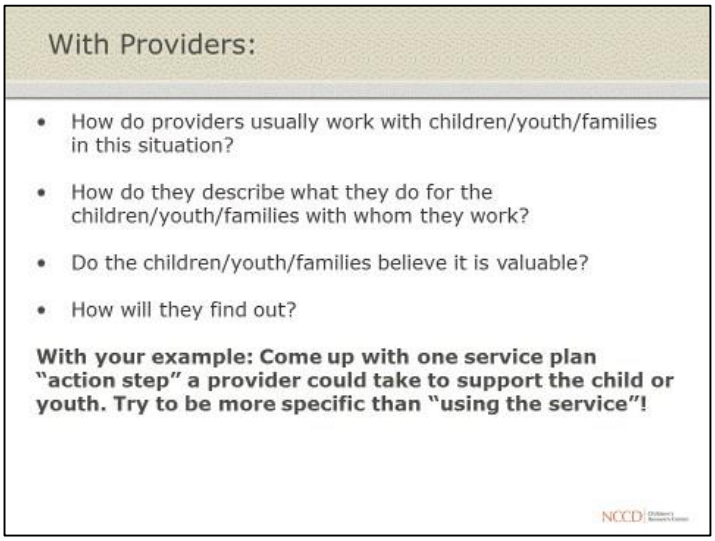
Finally, providers make up the fourth key group to include in a service plan. While this exercise has focused primarily on action steps caregivers, children, and network members can take, providers obviously play an important role as well.

Social workers need to do more than just make the referral. What work do they hope the provider will accomplish? How will this provider help the caregivers or youth respond to the effects of trauma?

Two key ideas for social workers to think about with providers: The goodness of fit between the provider and the family/child and the level of coordination that exists when multiple providers are involved.

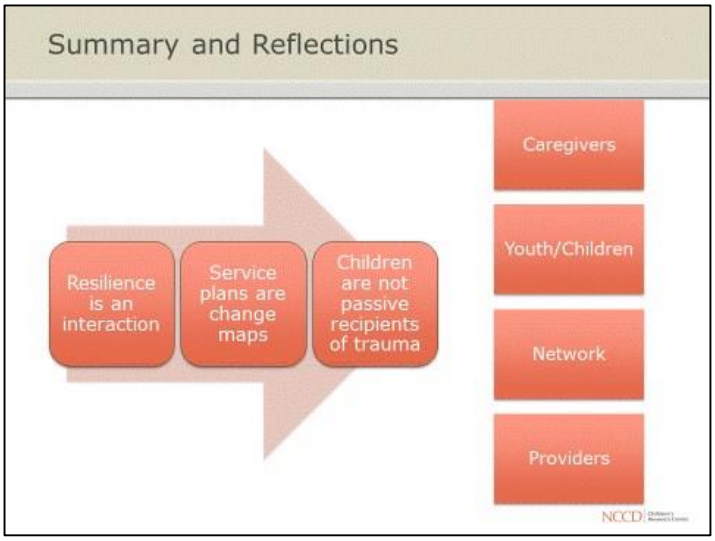
Trainer Note: Read key ideas.

Slide 85



Trainer Note: This is the last part of the exercise. Ask participants to get back into their small groups and come up with action steps they hope providers can take with child, youth, or family. The group may need less than 10 minutes on this round. The small groups should still be followed by a small-group debrief.

Slide 86

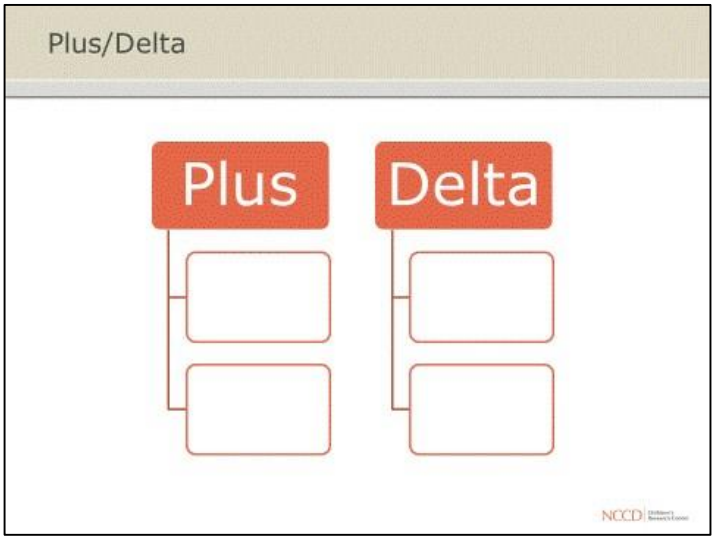


Summarize major points:

- Three core assumptions when working to create trauma-informed service plans with families
- Four key groups that social workers need to work with and create action steps for when creating these service plans

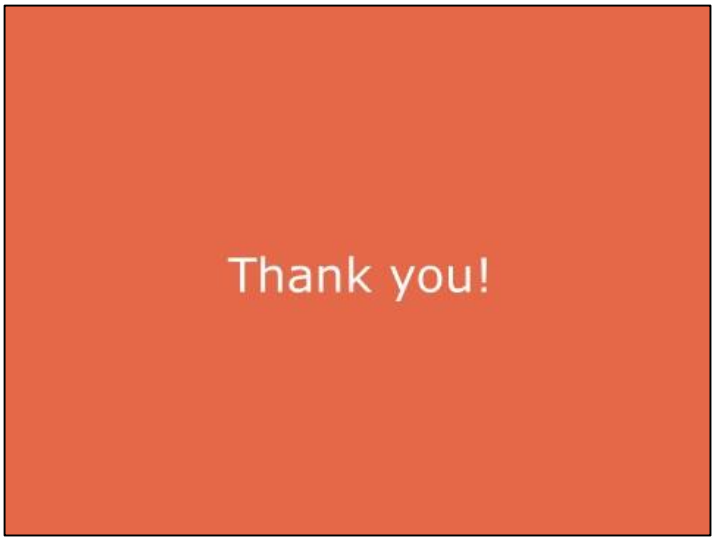
Trainers can also review any key learnings from the exercise just completed, highlighting any action steps that seemed particularly useful.

Slide 87



Repeat the plus/delta. They can speak to Day 2, but also invite comments in general.

Slide 88



Slide 89

Trainer Note: You may use these contacts if you have questions while preparing for this course.

When you are ready to deliver this course, replace with your own contact information.

Appendix G-1: Talking Points with Families Tip Sheet

Extended Family Engagement

Quick Reference Cards

Tips for talking with family when children are in out of home care:

Overview: Share that Olmsted County values the participation and involvement of caring family members to support and assist those in their time of need. Family members can provide a range of supports beyond placement of children, including assistance with visitation, maintaining a cultural connection with their kin, becoming an educational advocate, connecting children to community resources or assets, transportation, periodic check-ins with kin. Tell callers that they can also participate in Olmsted's Family Involvement Strategies, which provide family and friends a number of opportunities to join together, develop plans and make decisions that concern their kin. Inform them that when families become involved with an agency like _____ (CPS, Juvenile Probation or Children's Mental Health) they can often feel that decisions are taken out of their hands. Family participation is critical to ensure that those who know most about their family influence the development of plans to further their kin's safety and well-being.

Half Sheet 1 (BLUE)

Tip Sheet #1: Overview Reference: Talking Points:

- Olmsted County Values involvement of families.
- Family members can provide a range of supports. (visitation, cultural connections, education, transportation, check-ins, beyond 24/7 care option)
- Family members can also attend meetings to contribute more directly to the planning and decision making re: their kin.
- Sometimes it feels like decisions are made by agencies…welcome family participation as they know their families best.

Half Sheet 2 (Back BLUE)

Questions and Affirmations Overview: When talking to family members who were notified that their kin has come to the attention of the agency and inviting their participation:

At this point we are working to determine the full breadth and extent of the child's family, and would appreciate knowing about your relationship and history to the child and parents, as well as information as to the identity and whereabouts of other family members we can notify. State and federal law requires us to find out how big the family is and to notify those members that their kin may be in need of their help. While we would like to tell you more about the family's circumstances, we are not allowed to do so at this time to protect the rights of the parents. We recognize this is an awkward request in which we are asking for information. For those family members who become more involved with children and /or family, more information can be shared on a "need to know" basis to promote safe and healthy relationships and support.

Half Sheet 3 (Yellow)

Questions and Affirmations: Additional Talking Points:

- We would like as much as possible for the decisions regarding the health and wellbeing of your kin to be informed by you and what you stand for.

- You have the right to know what is happening to your kin.

- We want to know people in ways outside of the problems they face. We learn this through your active participation in the process.

"Need to Know" means… We are limited by personal privacy laws about the type and amount of information we can communicate about families. However, through your participation with the agency and with your family members we are able to share with you information as you need to know at the time you need to know it to have input. For example, family members with caregiving responsibilities require more background and updated information than those who are occasionally in contact with the children/youth. Family members always have the option to contact other family members for more information. Half Sheet 4 (Backside Yellow)

Deepening Family Engagement:

If family members are at first a bit reluctant to be involved, you can begin a dialogue to help them translate the importance of support in their lives to the situation at hand. Helpful questions include:

- Who was/is important in your life? Who does or can provide that type of support to this family in their time of need right now?
- Who do you have in your life that you rely on?
- What about your family will we appreciate once we get to know you?
- What is your direct or indirect experience of the system?

How does that shape your belief about the system?

- What is the story of childhood that you hope your children will tell at 25?
- What celebrations and family culture do you value and hold important?

Half Sheet 5 (Green)

Key reminders:

Listen--give family/kin members the opportunity to say what's on their minds. Provide them with the experience of being truly heard. You may find that family members initially direct their frustration, fear and anger at you, since you represent the agency. Give them a chance to express their feelings, experiences and values; they will be more likely to listen to whatever you want to share once they've had the chance to express themselves.

Understand -- most people are naturally protective and passionate about the children/youth they love. When they first hear that the system is involved and that there are concerns about the children/youth, family/kin members are likely to have strong emotional reactions. They have a right to take the time and space they need in order to deal with their reactions, digest the news they've just heard, organize their thoughts and questions, and receive the information they will need to make well-informed decisions and plans.

Convey --that there are no pre-determined outcomes. Successful extended family engagement rely on the genuine inclusion and participation of family members and kin to participate in a number of ways that ensure lasting safety and well-being. Olmsted County has been committed to this practice for over 15 years, and we welcome/rely on the involvement of all who are about the family. Welcome their involvement at whatever level they can provide at present—remember that commitments can change over time as circumstances change. Half Sheet 6 (Green)

This product was funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CF0034. The contents of this publication do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services.

Appendix H-1: Relevant Person List

Relevant Person List – Relatives/Kin

Date Created:_____ Workgroup Name:_____

Regarding the following child(ren):_____
_____

Full Name	Relationship*	Address	Phone Number(s)	Date Notice Sent	Response

*please identify if maternal or paternal (ie: maternal uncle, paternal grandparent)

File in Section 2 – Place on Top 9/2013

Relevant Person List – Service Providers

Date Created:_____ Workgroup Name:_____

Regarding the following child(ren):

_____

_____ _

Full Name	Title	Phone Number(s)	Agency (Full Name & Acronym)

August 23, 2013

Re: _____

Dear _____,

I am contacting you because you have been identified as a relative of Name of child(ren) or as having a significant relationship with Name of child(ren). The child(ren) has/have been placed outside their parent's care through Olmsted County Community Services (OCCS).

As an adult relative or one who has a significant relationship with Name of child(ren), OCCS is required by law to notify you that (the child/ren) has/have been placed outside their parent's care, as well as to notify you of the following rights:

- You may have the right to be involved in the support or planning for the child/(ren). Some examples *may* include: Participating in case planning for child(ren) and/or parent(s); suggesting other relatives who might be able to help support the family in some way; providing transportation for an appointment; and many other ways of your choice.

- You may have the right to be notified of any court proceedings regarding the child/(ren), to attend court hearings and to have the opportunity to be heard by the court.

- You may have the right to receive notice of progress reviews for the child(ren). It will be your responsibility to notify Olmsted County Social Services or the court of your address and any changes to your address and contact information or you may forfeit your right to receive notice of progress reviews for the child(ren).

- You may have the right to be considered as the temporary foster placement for the child(ren). If needed, you may have the right to be considered as a permanency option for the child(ren) if he/she/they cannot be returned to their parent's care.

Often times, when a child is placed outside their parent's care, a family meeting called a "Family Group Conference" is held for the purpose of involving family members in the planning process for children. In such a case, you may be contacted by an independent meeting coordinator, from the Family Group Decision Making Team, to discuss your participation in the Family Group Conference.

If you have any questions regarding your rights and/or desire to further discuss, please contact me at **(507) 328-_____.**

Thank you for your attention and response to this matter. Your involvement in the life/lives of Name of child(ren) is valued and appreciated.

Sincerely,

Name
Social Worker
Olmsted County Community Services
2117 Campus Drive SE, Suite 200
Rochester MN 55904

Appendix J-1: Family Notification Pamphlet

You may have the right to be considered as the temporary foster placement for the child(ren). If needed, you may have the right to be considered as a permanency option for the child(ren) if he/she/they cannot be returned to their parents.

Thank you for your attention and response to this matter. Your involvement in the life/lives of the child(ren) is valued and appreciated.

If you have any questions regarding your rights and/or desire to further discuss, please contact

_____
Social Worker

_____
Direct Phone Number

Olmsted County
Child and Family Services
2117 Campus Dr. SE
Rochester, MN 55904
507-328-6400

COUNTY OF Olmsted

Family Notification Brochure

February 2014

Because you have been identified as a relative or person who has a significant relationship in a child(ren's) life you have rights.

As an adult relative or one who has a significant relationship with the child(ren), Olmsted County Community Services is required by law to notify you that the child(ren) has/have been placed outside their parent's care, as well as to notify you of the following rights. . .

- You may have the right to be involved in the support or planning for the child(ren). Such as: participate in case planning, suggest other relatives who may be able to offer support, provide transportation, etc.
- You may have the right to be notified of any court proceedings regarding the child(ren), to attend court hearings and to have the opportunity to be heard by the court.

- You may have the right to receive notice of progress reviews for the child(ren). It will be your responsibility to notify Olmsted County Social Services or the court of your address and any changes to your address and contact information or you may forfeit your right to receive notice of progress reviews for the child(ren).

Evaluation Appendix

Appendix A: FEC Evaluation Case Flow and Eligibility Triggers

Appendix B: General Staff Survey Results

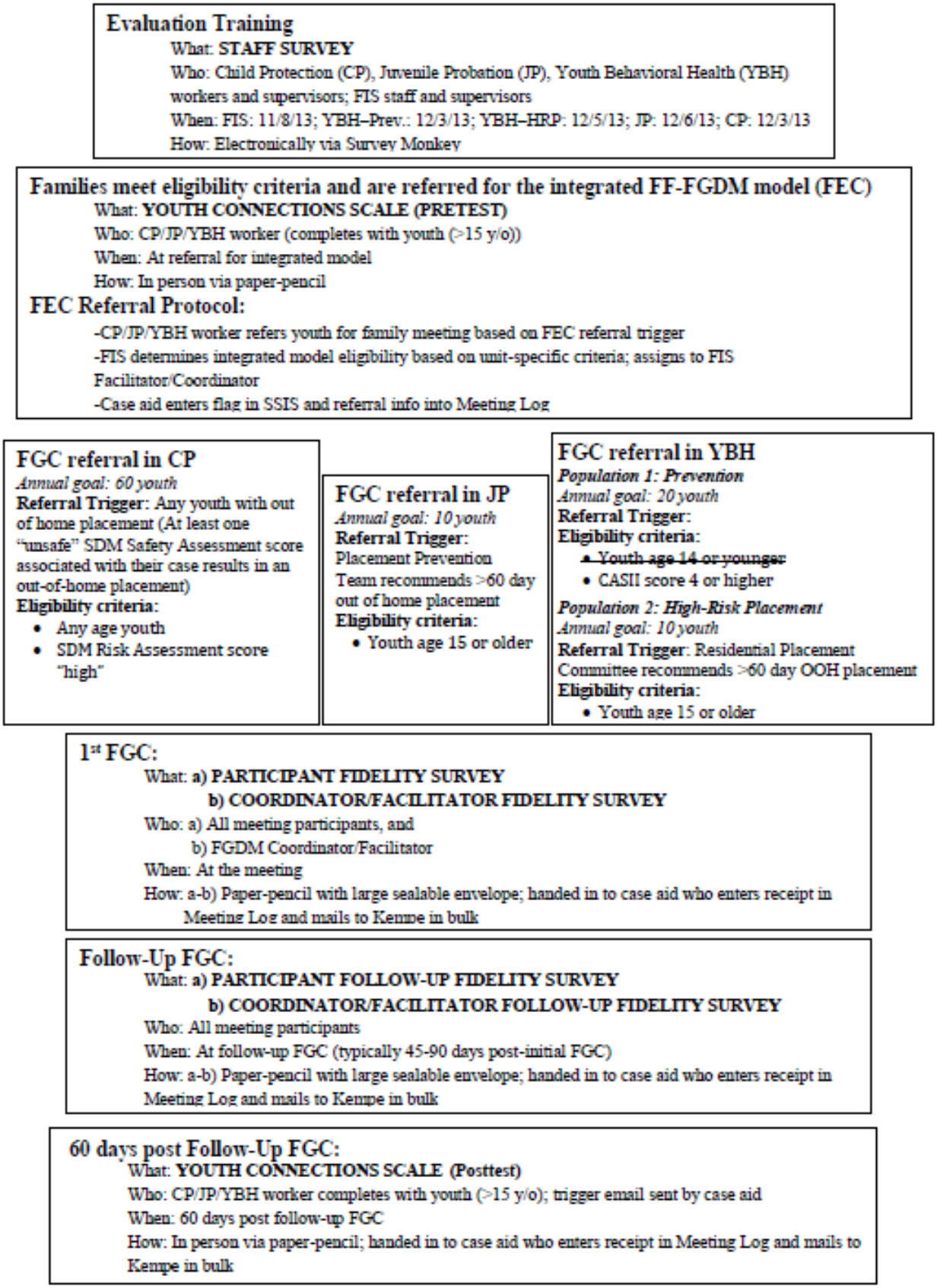
Appendix C: General Staff Survey Results by Unit

Appendix D: Focus Group Summaries

Appendix E: FEC Fidelity and Meeting Log Results

Appendix F: FGC Fidelity Domain Composition

Appendix G: Youth Connections Scale Sub-Scale Analyses


Evaluation Training
What: STAFF SURVEY
Who: Child Protection (CP), Juvenile Probation (JP), Youth Behavioral Health (YBH) workers and supervisors; FIS staff and supervisors
When: FIS: 11/8/13; YBH–Prev.: 12/3/13; YBH–HRP: 12/5/13; JP: 12/6/13; CP: 12/3/13
How: Electronically via Survey Monkey
Families meet eligibility criteria and are referred for the integrated FF-FGDM model (FEC)
What: YOUTH CONNECTIONS SCALE (PRETEST)
Who: CP/JP/YBH worker (completes with youth (>15 y/o))
When: At referral for integrated model
How: In person via paper-pencil
FEC Referral Protocol:
-CP/JP/YBH worker refers youth for family meeting based on FEC referral trigger
-FIS determines integrated model eligibility based on unit-specific criteria; assigns to FIS Facilitator/Coordinator
-Case aid enters flag in SSIS and referral info into Meeting Log
FGC referral in CP
Annual goal: 60 youth
Referral Trigger: Any youth with out of home placement (At least one "unsafe" SDM Safety Assessment score associated with their case results in an out-of-home placement)
Eligibility criteria:
Any age youth
SDM Risk Assessment score "high"
FGC referral in JP
Annual goal: 10 youth
Referral Trigger:
Placement Prevention Team recommends >60 day out of home placement
Eligibility criteria:
Youth age 15 or older
FGC referral in YBH
Population 1: Prevention
Annual goal: 20 youth
Referral Trigger:
Eligibility criteria:
Youth age 14 or younger
CASII score 4 or higher
Population 2: High-Risk Placement
Annual goal: 10 youth
Referral Trigger: Residential Placement Committee recommends >60 day OOH placement
Eligibility criteria:
Youth age 15 or older
1st FGC:
What: a) PARTICIPANT FIDELITY SURVEY
b) COORDINATOR/FACILITATOR FIDELITY SURVEY
Who: a) All meeting participants, and
b) FGDM Coordinator/Facilitator
When: At the meeting
How: a-b) Paper-pencil with large sealable envelope; handed in to case aid who enters receipt in Meeting Log and mails to Kempe in bulk
Follow-Up FGC:
What: a) PARTICIPANT FOLLOW-UP FIDELITY SURVEY
b) COORDINATOR/FACILITATOR FOLLOW-UP FIDELITY SURVEY
Who: All meeting participants
When: At follow-up FGC (typically 45-90 days post-initial FGC)
How: a-b) Paper-pencil with large sealable envelope; handed in to case aid who enters receipt in Meeting Log and mails to Kempe in bulk
60 days post Follow-Up FGC:
What: YOUTH CONNECTIONS SCALE (Posttest)
Who: CP/JP/YBH worker completes with youth (>15 y/o); trigger email sent by case aid
When: 60 days post follow-up FGC
How: In person via paper-pencil; handed in to case aid who enters receipt in Meeting Log and mails to Kempe in bulk

Findings below are presented for the full sample of Staff Survey respondents. Additionally, we looked at responses to subsets of certain questions separately for each study unit to determine whether there was variation across study units. Full details of the responses for each study unit (mean, median, minimum and maximum values) are provided in Appendix C. Analysis of Variance (ANOVA) tests were run to test whether there were statistically significant differences in responses across study units. Because respondents from FIS were expected to differ predictably from the other study units in terms of tenure and experience, FIS was excluded from the ANOVA tests. When an ANOVA test was significant, we ran post-hoc Tukey HSD or Least Squares Differences tests to determine which study units accounted for the significant difference.

Demographic Characteristics of Staff Survey Respondents. Overall, 73% (*n*=49) of the survey respondents were female and 27% (*n*=18) were male. The average age of respondents was 39.6 years (SD: 10.9 years), and the median age was 38 years.

Table 1 presents the breakdown of respondents by gender, self-identified race, and Hispanic ethnicity. The majority of respondents (81%) identified as non-Hispanic White. The second most common identity selected was non-Hispanic Black (9%). Overall, 4% of the sample identified as Hispanic. All Hispanic respondents were female.

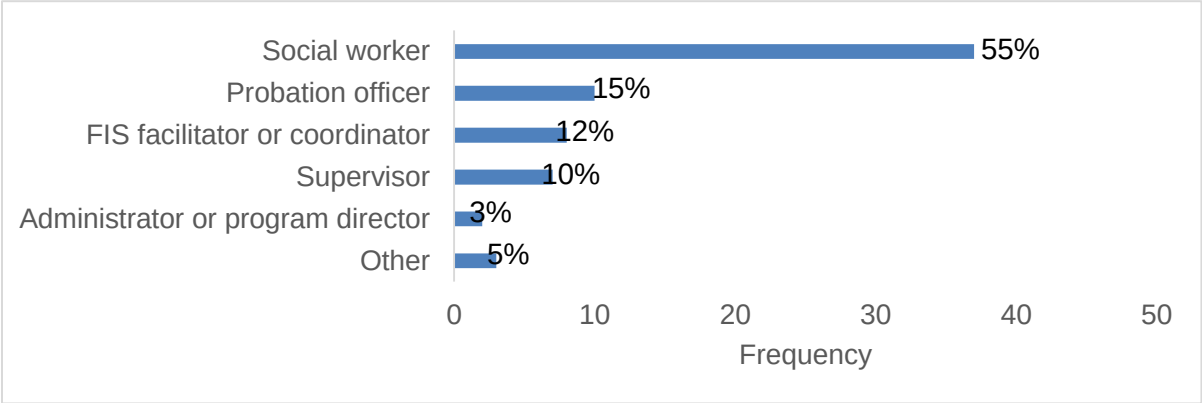
Table 1. Racial and Ethnic Identities of Staff Survey Respondents
(with % for non-zero responses)

	Male		Female		
	Hispanic	Non-Hispanic	Hispanic	Non-Hispanic	Total
White	0	11 (17%)	2 (3%)	41 (61%)	54 (81%)
Black	0	4 (6%)	0	2 (3%)	6 (9%)
Asian	0	2 (3%)	0	0	2 (3%)
Multi-racial	0	0	0	3 (4%)	3 (4%)
Not specified	0	1 (1%)	1 (1%)	0	2 (3%)
Total	0	18 (27%)	3 (4%)	46 (69%)	67 (100%)

Only four respondents (6% of the sample) indicated that they were bilingual. Among the bilingual respondents, two reported that they spoke Somali, one spoke Spanish, and one spoke Hindi, Nepali, and other dialects.

Worker characteristics. As shown in Figure 1, the primary job responsibility for the majority of respondents was social worker (55%). Around 10-15% of respondents indicated that their primary job responsibility was probation officer, supervisor, or FIS facilitator or coordinator. Two percent indicated that they were an administrator or program director, and three percent stated 'other'.

Figure 1. Primary job responsibility (*n* = 67)



As shown in Figure 2, the majority of respondents reported that their study unit was Youth Behavioral Health (YBH; *n*=28, 42%). The second most common study unit was CP (*n*=18, 27%), followed by JP (*n*=11, 16%) and FIS (*n*=10, 13%).

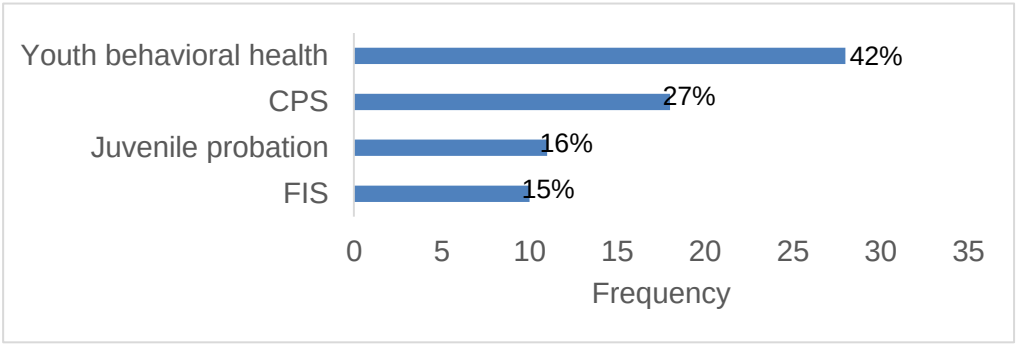


Figure 2. Study unit (*n* = 67)

Tenure. The average length of time spent working with children and families in OCCS was 8.18 years (SD: 4.84 years). The median length of time was 10 years. The minimum was one year, and the maximum was 16 years. A breakdown of the average length of time spent working with OCCS by study unit is provided in Appendix C (Table A1). Average length of time spent working with OCCS did not differ significantly as a function of study unit, $F(2, 54)=2.19$, $p = .12$.

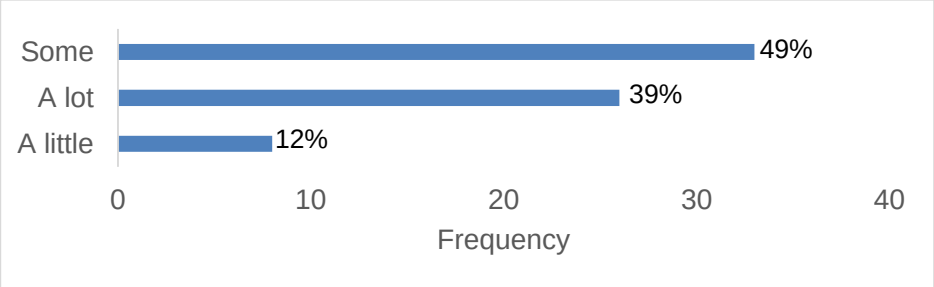
The average length of time that respondents had spent in their current position was 6.52 years (SD: 4.82 years). The median length of time was four years. The minimum was one year, and the maximum was 14 years. A breakdown of the average length of time spent working in current position by study unit is provided in Appendix C (Table A2). Average length of time in current position did not differ significantly as a function of study unit, $F(2, 54)=2.41$, $p = .10$.

Caseload. All respondents reported that they carried a caseload.[1] The average number of cases was 9.51 (SD: 8.17). The median number of cases was eight; the minimum was one and the maximum was 42. When we removed supervisors (n = 10) from this analysis, the average number of cases in a caseload was 7.04 (SD: 5.23; n = 57). The median number of cases was seven. The minimum number of cases was one and the maximum was 18.

A breakdown of respondent caseload (including supervisors) by study unit is provided in Appendix C (Table A3). There was a significant effect of study unit on number of cases on current caseload, $F(2, 54)=21.38$, $p < .01$. Post-hoc comparisons indicated that respondents working in JP had significantly larger caseloads, on average ($p < .01$; M: 21.6 cases; SD: 10) compared with respondents working in YBH (M: 8.84 cases, SD: 5.76) and CP (M: 8.84 cases, SD: 5.76).

Experience with Family Involvement Strategies. Respondents were asked to rate their experience with Family Involvement Strategies (FIS) on a 4-point Likert scale, where 1 = "None", 2 = "A little", 3 = "Some", and 4 = "A lot". As shown in Figure 3, the majority of the sample reported that they had at least some experience with FIS (n =33, 49%), followed by "a lot" (n =26, 39%), followed by "a little" (n =8, 12%).

Figure 3. Experience with Family Involvement Strategies (n = 67)

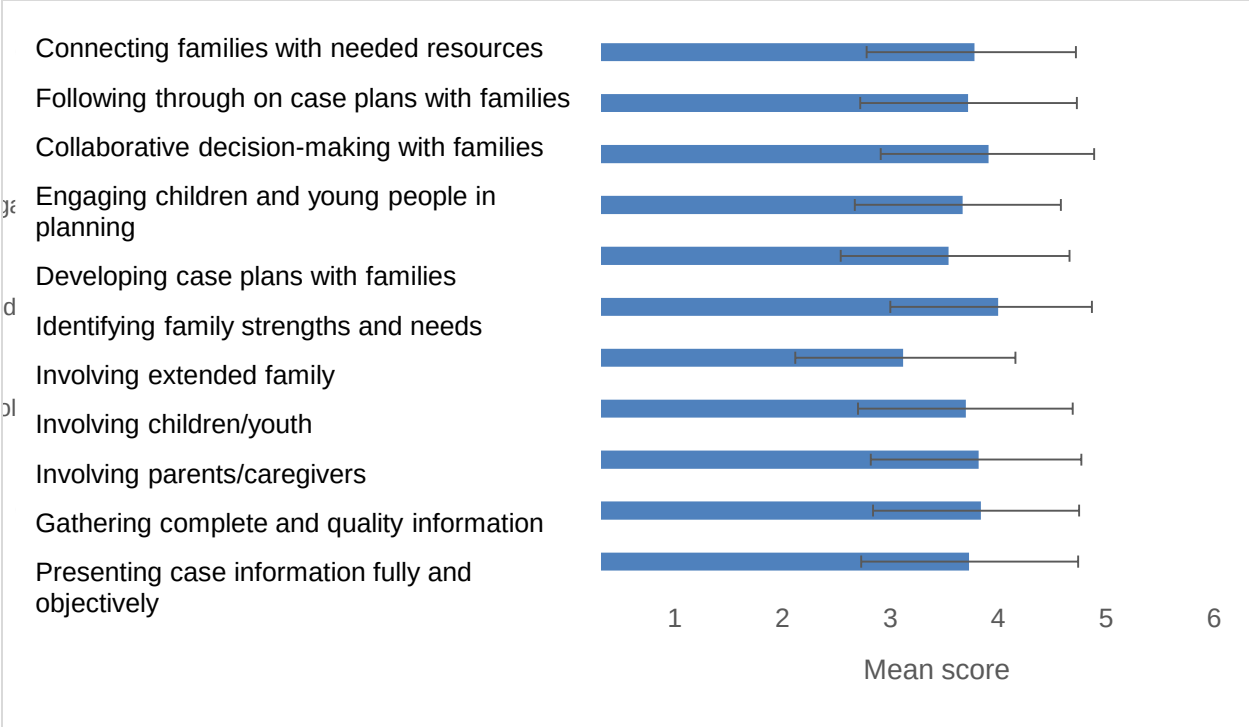


A breakdown of caseload by study unit is provided in Appendix C (Table A4). There was a significant effect of study unit on experience with FIS, $F(4, 62)=2.62$, $p = .04$. Post-hoc comparisons indicated that respondents working in JP (M: 2.91, SD: .54) reported having significantly less experience with FIS compared with respondents working in CP ($p = .04$; M: 3.50; SD: .62).

Case skills. Respondents' self-reported case skills are shown in Figure 4. Respondents were asked to rate each skill on a 5-point Likert scale, where 1 = Basic and 5 = Advanced. Generally, respondents rated their skills favorably. For each skill, the median score across the whole sample was four.

Figure 4. Average (Mean) Self-Rated Case Skills (with standard deviation)

[1] Although FIS staff are technically non-case carrying, they may have interpreted this question to ask how many conferences they were coordinating at the time of survey response.



A breakdown of case skills by study unit is provided in Appendix C (Table A5). There was a significant effect of study unit on self-reported skill in involving children or youth in assessment processes, $F(2, 54)=4.68$, $p = .01$. Respondents working in CP rated their ability to involve children/youth in the assessment process significantly lower (M: 3.44, SD: .78) than respondents working in YBH ($p = .02$; M: 4.08, SD: .70) and JP ($p = .05$: M: 4.09, SD: .54). This result may be partially explained by the fact that the CP workers completing the GSS were from the ongoing stage of service and may have associated the concept of assessment with the assessment/investigation stage of service more so than their own.

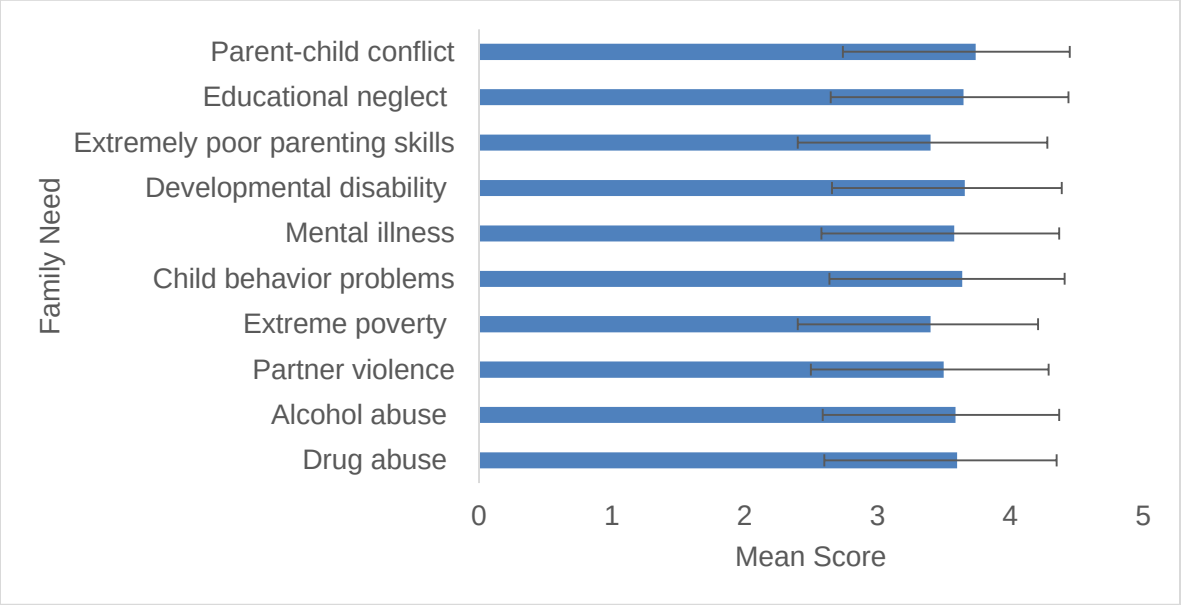
Perceived effectiveness of CPCs and FGCs. Respondents were asked to rate the perceived effectiveness of Case Planning Conferences (CPCs) using a 5-point Likert scale, where 1 = Not at all effective and 5 = Completely effective. Respondents were given an N/A option. As shown in Table 2 and Figure 5, respondents were generally positive about the perceived effectiveness of CPCs. A breakdown of perceived effectiveness of the use of CPCs by study unit is provided in Appendix C (Table A9).

Table 2. Effectiveness of use of CPCs in working with families with various need

Family Need	*n*	Mean	SD	Median	Min	Max	n/a (%)
Drug abuse	57	3.60	.75	4	1	5	10 (14.9)
Alcohol abuse	56	3.59	.78	4	1	5	11 (16.4)
Partner violence	52	3.50	.79	4	2	5	15 (22.4)
Extreme poverty	60	3.40	.81	4	2	5	7 (10.4)
Child behavior problems	67	3.64	.77	4	1	5	6 (9)
Mental illness	65	3.58	.79	4	1	5	2 (3)
Developmental disability	53	3.66	.73	4	2	5	14 (20.9)

Extremely poor parenting skills	65	3.40	.88	4	1	5	2 (3)
Educational neglect	63	3.65	.79	4	1	5	4 (6)
Parent-child conflict	66	3.74	.71	4	2	5	1 (1.5)

Figure 5. Effectiveness of CPCs in working with families with various needs (with standard deviation)

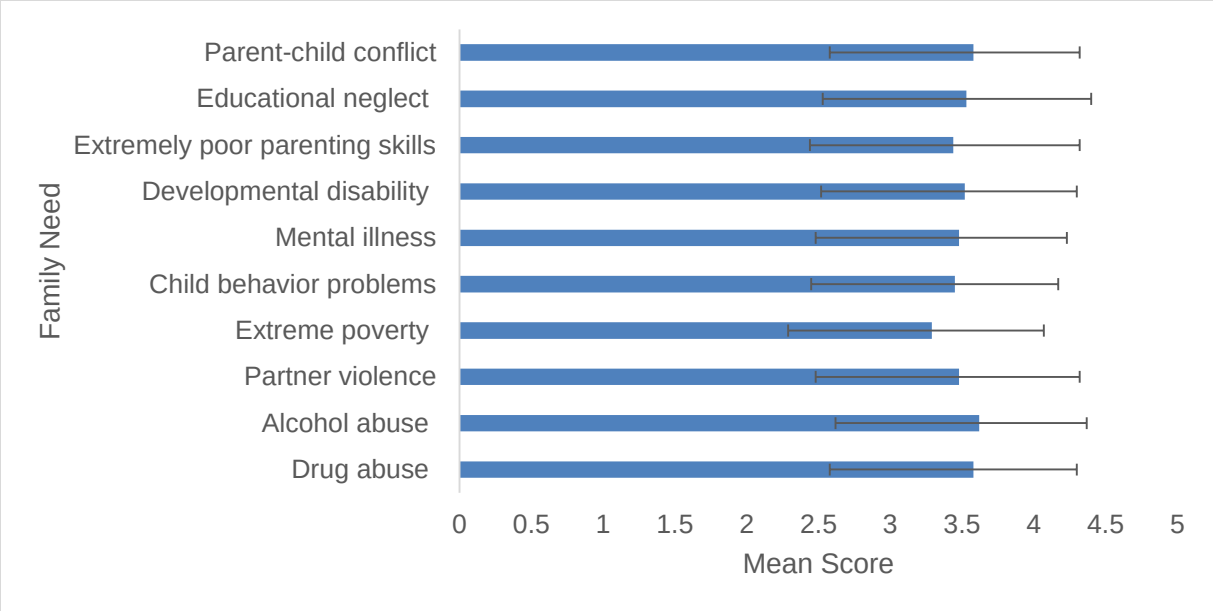


Respondents were asked to rate the perceived effectiveness of Family Group Conferences (FGCs) using a 5-point Likert scale, where 1 = Not at all effective and 5 = Completely effective. Respondents were given an N/A option. As shown in Table 3 and Figure 6, respondents were generally positive about the perceived effectiveness of FGCs.

Table 3. Effectiveness of use of FGCs in working with families with various need

Family Need	*n*	Mean	SD	Median	Min	Max	n/a (n)
Drug abuse	52	3.58	.72	4	1	5	15 (22.4)
Alcohol abuse	52	3.62	.75	4	1	5	15 (22.4)
Partner violence	46	3.48	.84	4	1	5	21 (31.3)
Extreme poverty	51	3.29	.78	4	2	5	16 (23.9)
Child behavior problems	55	3.45	.72	4	2	5	12 (17.9)
Mental illness	54	3.48	.75	4	2	5	13 (19.4)
Developmental disability	46	3.52	.78	4	2	5	21 (31.3)
Extremely poor parenting skills	55	3.44	.88	4	1	5	12 (17.9)
Educational neglect	53	3.53	.87	4	1	5	14 (20.9)
Parent-child conflict	55	3.58	.74	4	2	5	12 (17.9)

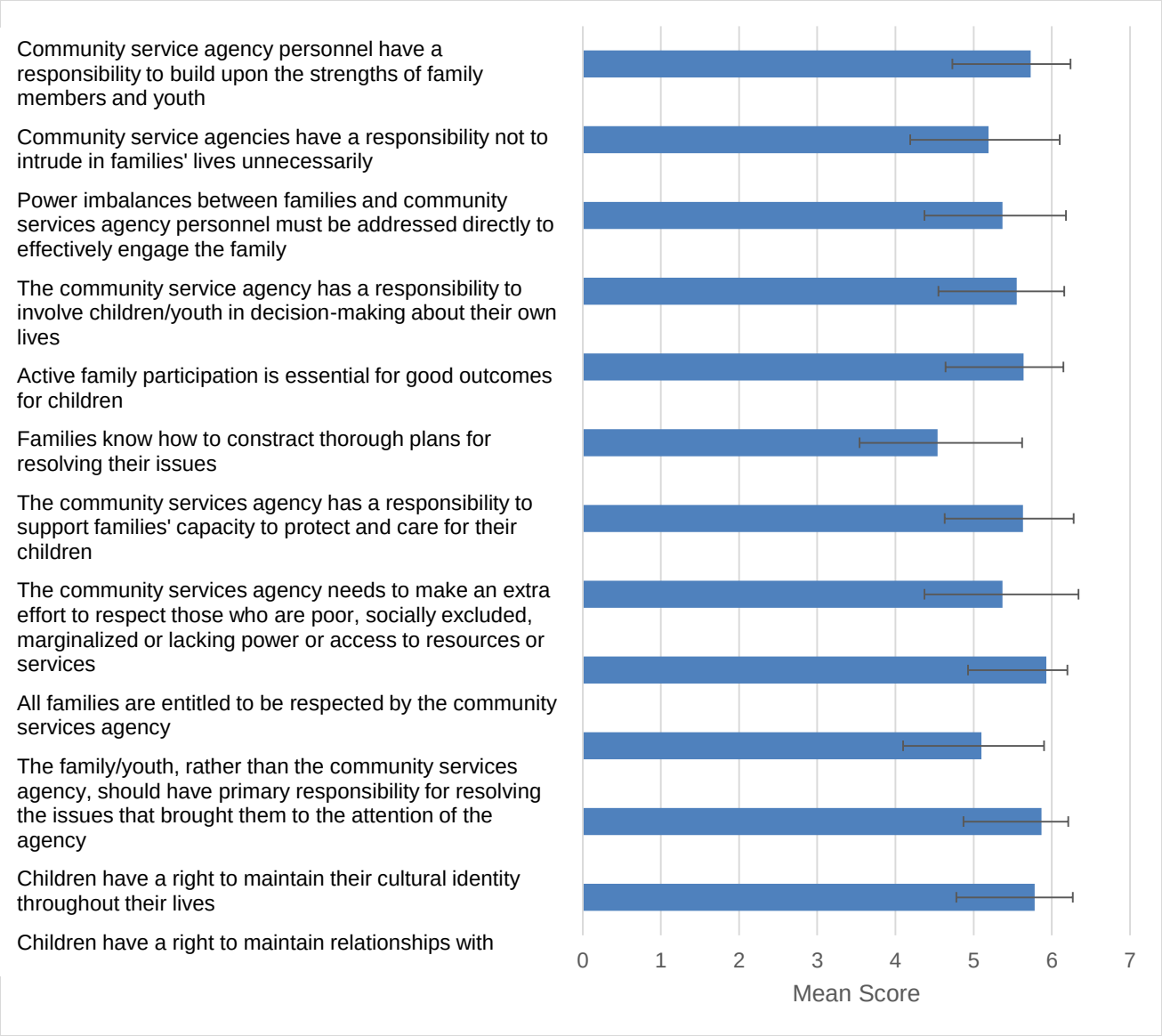
Figure 6. Effectiveness of FGCs in working with families with various needs (with standard deviation)



A breakdown of perceived effectiveness of the use of FGCs by study unit is provided in Appendix C (Table A10). There were no significant differences in the perceived effectiveness of FGCs in providing services except for services to address mental illness. Post-hoc comparisons indicated that respondents working in CP (M: 3.89; M: .58) rated the effectiveness of FGCs in working with families with mental illness significantly higher than respondents working in JP (p = .03; M: 2.83; SD: .75).

Family Involvement Strategies: Knowledge and Attitudes. Respondents were asked about their attitudes toward Family Involvement Strategies (FIS). Specifically, they were asked to rate their agreement with a series of statements using a 6-point Likert scale, where 1 = Strongly Disagree and 6 = Strongly Agree. As shown in Figure 7, respondents generally showed high agreement with all statements. There were no significant differences in attitudes towards FIS by study unit. A breakdown of attitudes by study unit is provided in Appendix C (Table A8).

Figure 7. Attitudes toward FIS (with standard deviation)



Respondents were asked whether the use of FIS had caused an increase or decrease in their overall workload, based on a 5-point Likert scale were 1 = Large decrease, 3 = No effect, and 5 = Large increase. The average score was three (SD: 1.03). The median score was also three. The minimum was one and the maximum was five. Thus, in most cases, the use of FIS did not affect their perceived workload size.

A breakdown of perceived change in workload by study unit is provided in Appendix C (Table A11). There was a significant effect of study unit on change in perceived workload, $F(2, 54)=6.59$, $p < .01$. Post-hoc comparisons indicated that respondents working in probation services perceived a significant increase in workload, on average ($p = .01$; M: 3.55; SD: .69) compared with respondents working in CP (M: 2.39; SD: .86).

Usefulness of Family Involvement Strategies*:* Respondents were asked whether they found FIS to be useful in the work they do with families, based on a 5-point Likert scale where 1 = Not at all useful and 5 =

Completely useful. Perceived usefulness of Family Involvement Strategies was generally high; the average score was 3.90 (SD: .74) and the median score was four. The minimum score was two and the maximum was five.

There was a significant effect of study unit on perceived usefulness of FIS, $F(2, 54)=3.36$, $p = .04$. Post-hoc comparisons indicated that respondents working in CP has significantly more favorable perceptions of the usefulness of FIS ($p = .03$; M: 4.11; SD: .83) compared with respondents working in JP (M: 3.55; SD: .52).

Organizational Culture. Respondents were asked a series of questions about shared vision and professionalism amongst workers in their unit, based on a 6-point Likert scale where 1 = Strongly Disagree and 6 = Strongly Agree. As shown in Figure 8, responses were generally positive. A breakdown of worker attitudes by study unit is provided in Appendix C (Table A13). There were no significant differences in perceived worker attitudes by study unit except for the statement, "Workers in my unit are proud to work with children/youth/families," $F(2, 54)=3.91$, $p = .03$. Respondents working in JP (M: 5.67, SD: .50) showed higher levels of agreement with this statement compared with respondents working in YBH ($p = .01$; M: 5.20; SD: .71).

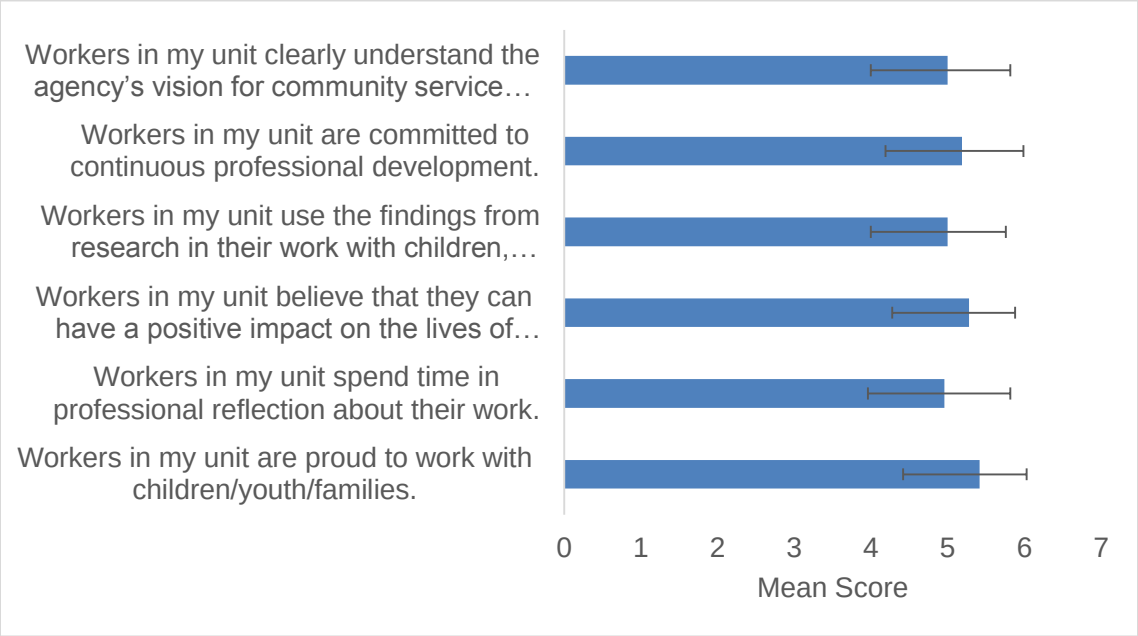


Figure 8. Perceptions of worker attitudes (with standard deviation)

Family Involvement Strategies: Effectiveness Barriers. A total of 43 respondents answered this open-ended question around what barriers existed to the effective implementation of FIS. Four respondents wrote 'none', or 'n/a' as their response; and some responded with answers other than barriers (e.g. everything working great). Themes related to the barriers are summarized below.

- Amount of time between FGC referral and meeting is too long.

- Families' lack of willingness and/or ability to participate.
- I think we could do better with preparation work by the case manager with the family prior to and follow up on the FIS meeting.
- Inability to share some information due to confidentiality (e.g. genograms developed with FIS can't be shared with OCCS staff).
- It seems to be an extra step/additional paperwork; I typically lead my own team meetings with clients.
- Turnover and low staffing in FIS leads to challenges holding timely meetings.
- Families can be distrustful of OCCS and/or have unrealistic expectations.

Services in the community. Respondents were asked whether they could usually find services in their community to help keep children safe in their home, based on a 6-point Likert scale were 1 = Strongly Disagree and 6 = Strongly Agree. Responses were generally positive. The average score was 4.66 (SD: .75). The median score was five. The minimum was two and the maximum was six.

Respondents were also asked whether it was easy to work with most of the service providers in his or her community, based on a 6-point Likert scale were 1 = Strongly Disagree and 6 = Strongly Agree. Again, responses were generally positive. The average score was 4.78 (SD: .71). The median score was five. The minimum was three and the maximum was six. There was no significant effect of study unit on finding services in the community or the perceived ease of working with service providers in the community. A breakdown of perceived services in the community is provided in Appendix C (Table A14).

Respondents were asked about their confidence in the ability of local community providers to meet family needs, based on a 5-point Likert scale were 1 = Not at All Confident and 5 = Completely Confident. As shown in Table 4, confidence was lowest for tribal services and highest for medical services, which is unsurprising given the community context (e.g. low tribal population and presence of Mayo Clinic). Responses were generally positive. The average score was 4.66 (SD: .75). The median score was five. The minimum was two and the maximum was six. A breakdown of confidence in local community providers by study unit is provided in Appendix C (Table A15).

Table 4. Confidence that family needs can be met by a local community provider

Service	Mean	SD	Median	Min	Max
Child care/day care	3.45	.80	4	2	5
Early childhood services	3.82	.70	4	2	5
Respite care/crisis nursery	3.45	.91	4	1	5
Mental health services	3.69	.74	4	2	5
Substance abuse treatment	3.57	.86	4	1	5
Developmental disability services	3.67	.68	4	2	5
Medical services	4.04	.73	4	2	5
Dental services	3.15	.99	3	1	5
Transportation services	2.99	.84	3	1	5
Domestic violence services/shelter	3.49	.82	4	1	5
Food services/food pantry	3.64	.73	4	2	5
Housing assistance	2.76	.99	3	1	5

Service	Mean	SD	Median	Min	Max
Utilities & other household assistance	3.01	.84	3	2	5
Employment services	3.31	.82	3	2	5
Adult education/vocational services	3.51	.73	4	2	5
Child education/vocational services	3.58	.84	4	2	5
Parenting classes, household management	3.22	.69	3	2	5
Youth recreational activities	3.33	.76	3	1	5
Legal services	3.25	.73	3	2	5
Support groups (e.g. parents anonymous)	3.15	.70	3	2	5
Mentoring	2.78	.79	3	1	5
Tribal services	2.31	.81	2	1	5
Immigration services	2.85	.77	3	1	5
Faith-based services	3.42	.80	3	2	5
Bilingual services	3.27	.83	3	2	5

Lastly, respondents were asked to indicate how responsive services in his/her community were to the needs of culturally diverse groups, based on a 5-point Likert scale were 1= Not at All Responsive and 5=Completely Responsive. Respondents were fairly positive. The average score was 3.28 (SD: .78). The median score was three. The minimum score was two and the maximum score was five. A breakdown of scores by study unit is provided in Appendix C (Table A16). There was no significant effect of study unit on the perception of the responsiveness of services in the community to the needs of culturally diverse groups.

Table A1. Length of time spent working with Olmsted County Community Services, by study unit.

	N	Mean	SD	Median	Minimum	Maximum
Overall	67	8.18	4.84	10	1	16
YBH	25	9.24	5.19	12	1	16
CP	18	7.22	4.10	7	1	13
Juvenile Probation	11	10.82	3.84	12	1	13
FIS	9	4.78	4.74	2	1	12

Note. YBH: Youth Behavioral Health; CP: Child Protective Services; FIS: Family Intervention Services.

Table A2. Length of time in current position, by study unit.

	N	Mean	SD	Median	Minimum	Maximum
Overall	67	6.52	4.82	4	1	14
YBH	25	8.84	5.76	11	1	18
CP	18	5.33	3.84	3.50	1	13
Juvenile Probation	11	9.09	5.28	12	1	13
FIS	9	2.89	3.22	2	1	11

Note. YBH: Youth Behavioral Health; CP: Child Protective Services; FIS: Family Intervention Services.

Table A3. Number of cases on current caseload, by study unit.

	N	Mean	SD	Median	Minimum	Maximum
Overall	67	9.51	8.17	8	1	42
YBH	25	8.84	5.76	11	1	18
CP	18	6.89	3.22	7	1	16
Juvenile Probation	11	21.55	10.04	22	1	42
FIS	9	1.67	2	1	1	7

Note. YBH: Youth Behavioral Health; CP: Child Protective Services; FIS: Family Intervention Services.

Table A4. Experience with Family Involvement Strategies, by study unit.

	N	Mean	SD	Median	Minimum	Maximum
Overall	67	3.27	.67	3	2	4
YBH	25	3.24	.60	3	2	4
CP	18	3.50	.62	4	2	4
Juvenile Probation	11	2.91	.54	3	2	4
FIS	9	3.56	.73	4	2	4

Note. Scored on a 4-point scale, where 1 = None and 4 = A lot.

Table A5. Self-rated skills level by study unit.

	Overall	YBH	CP	JP	FIS
Presenting case information fully and objectively	3.73 (1.01)	3.88 (.88)	3.78 (.88)	4.09 (.83)	2.89 (1.54)
Gathering complete and quality information	3.84 (.91)	4.00 (.65)	3.83 (.71)	4.27 (.65)	2.89 (1.62)
Involving parents/caregivers in assessment processes	3.82 (.95)	4.12 (.83)	3.78 (.55)	4.00 (.45)	3.00 (1.73)

Involving children/youth in assessment processes	3.70 (.99)	4.08 (.70)	3.44 (.78)	4.09 (.54)	2.89 (1.69)
Involving extended family in assessment processes	3.12 (1.04)	3.12 (.88)	3.39 (.92)	2.91 (.70)	3.11 (1.83)
Identifying family strengths and needs	4.00 (.87)	4.24 (.78)	4.00 (.69)	3.91 (.54)	2.44 (1.59)
Developing case plans with families	3.54 (1.12)	3.68 (1.22)	3.78 (.65)	3.73 (.65)	2.44 (1.59)
Engaging children and young people in planning	3.67 (.91)	3.84 (.90)	3.56 (.71)	3.64 (.67)	3.44 (1.59)
Collaborative decision making with families	3.91 (.98)	4.00 (1.04)	3.94 (.80)	3.82 (.60)	3.78 (1.64)
Following through on case plans with families	3.72 (1.01)	4.08 (.95)	3.78 (.65)	2.91 (.54)	2.56 (1.42)
Connecting families with needed resources	3.78 (.94)	4.20 (.71)	3.83 (.51)	2.82 (.60)	2.44 (1.42)

Note. Rated on 5-point Likert scale, where 1 = Basic and 5 = Advanced. YBH: Youth Behavioral Health; CP: Child Protective Services; JP: Juvenile Probation; FIS: Family Intervention Services.

Table A6. Job satisfaction by study unit.

	N	Mean	SD	Median	Minimum	Maximum
Overall	67	3.72	.57	4	2	5
YBH	25	3.64	.64	4	2	5
CP	18	3.78	.65	4	2	5
Juvenile Probation	11	3.91	.30	4	3	4
FIS	9	3.89	.33	4	3	4

Note. YBH: Youth Behavioral Health; CP: Child Protective Services; FIS: Family Intervention Services.

Table A7. Likelihood of continuing to work in Community Services, by study unit.

	N	Mean	SD	Median	Minimum	Maximum
Overall	67	3.40	1.12	3	1	5
YBH	25	2.96	1.17	3	1	5
CP	18	3.78	.81	4	3	5
Juvenile Probation	11	3.18	.98	3	1	4
FIS	9	4.44	.73	4	3	5

Table A8. Agreement with statements about attitudes toward FIS, by study unit.

	Overall	YBH	CP	JP	FIS
Children have a right to maintain relationships with relatives throughout their lives.	5.78 (.49)	5.84 (.47)	5.83 (.38)	5.64 (.67)	5.78 (.44)
Children have a right to maintain their cultural identity throughout their lives.	5.87 (.34)	5.88 (.33)	5.89 (.32)	5.73 (.47)	6.00 (.00)
The family/youth, rather than the community services agency, should have primary responsibility for resolving the issues that brought them to the attention of the agency.	5.10 (.80)	5.32 (.69)	5.06 (.73)	4.73 (.91)	5.22 (.83)
All families are entitled to be respected by the	5.93	5.88	5.94	6.00	6.00

community services agency.	(.27)	(.33)	(.24)	(.00)	(.00)
The community services agency needs to make an extra effort respect those who are poor, socially excluded, marginalized or lacking power or access to resources and services.	5.37 (.97)	5.20 (1.16)	5.61 (.78)	5.18 (.98)	5.67 (.71)
The community services agency has a responsibility to support families' capacity to protect and care for their children.	5.63 (.65)	5.52 (.77)	5.78 (.55)	5.55 (.69)	5.89 (.33)
Families know how to construct thorough plans for resolving their issues.	4.54 (1.08)	4.48 (1.05)	4.67 (1.09)	4.00 (1.18)	4.89 (.78)
Active family participation is essential for good outcomes for children.	5.64 (.51)	5.68 (1.05)	5.78 (.43)	5.36 (.67)	5.67 (.50)
The community service agency has a responsibility to involve children and young people in decision making about their own lives	5.55 (.61)	5.64 (.49)	5.44 (.71)	5.55 (.69)	5.67 (.50)
Power imbalances between families and community services agency personnel must be addressed directly to effectively engage the family.	5.37 (.81)	5.40 (.76)	5.50 (.79)	5.18 (.87)	5.44 (1.01)
Community service agencies have a responsibility not to intrude in families' lives unnecessarily.	5.19 (.91)	5.28 (.79)	5.28 (.83)	4.73 (.91)	5.67 (.50)
Community service agency personnel have a responsibility to build upon the strengths of family members and youth.	5.73 (.51)	5.64 (.57)	5.89 (.32)	5.55 (.69)	6.00 (.00)

Note. Rated on 6-point Likert scale, where 1 = Strong disagree and 6 = Strongly Agree. YBH: Youth Behavioral Health; CP: Child Protective Services; JP: Juvenile Probation; FIS: Family Intervention Services.

Table A9. Effectiveness of use of CPCs in working with families with various needs, by study unit.

	Overall *n* = 52-66	YBH *n* = 17-25	CP *n* = 13-18	JP *n* = 7-11	FIS *n* = 8-9
Drug abuse	3.60 (.75)	3.28 (.89)	3.76 (.44)	3.30 (.82)	4.00 (.53)
Alcohol abuse	3.59 (.78)	3.24 (.90)	3.82 (.53)	3.30 (.82)	4.00 (.53)
Partner violence	3.50 (.78)	3.35 (.79)	3.62 (.87)	3.30 (.67)	4.00 (.53)
Extreme poverty	3.40 (.81)	3.23 (.87)	3.35 (.70)	2.88 (.83)	4.13 (.35)
Child behavior problems	3.64 (.77)	3.52 (.87)	3.56 (.81)	3.27 (.79)	4.11 (.33)
Mental illness	3.58 (.79)	3.26 (.83)	3.69 (.70)	2.90 (.88)	4.00 (.50)
Developmental disability	3.66 (.73)	3.56 (.78)	3.71 (.73)	2.86 (.69)	4.11 (.33)
Extremely poor parenting skills	3.40 (.88)	3.08 (.93)	3.78 (.55)	3.00 (.94)	4.00 (.71)
Educational neglect	3.65 (.79)	3.36 (.95)	3.72 (.75)	3.20 (.63)	4.22 (.44)

Parent-child conflict	3.74 (.71)	3.56 (.95)	3.72 (.75)	3.55 (.52)	4.33 (.50)

Note. Rated on 5-point Likert scale, where 1 = Not at all effective and 5 = Completely effective. YBH: Youth Behavioral Health; CP: Child Protective Services; JP: Juvenile Probation; FIS: Family Intervention Services. Respondents were also given an n/a option; however, the summary statistics above exclude n/a responses.

Table A10. Effectiveness of use of FGCs in working with families with various needs, by study unit.

Family Need	Overall *n* = 46-55	YBH *n* = 17-25	CP *n* = 13-18	JP *n* = 6-8	FIS *n* = 8-9
Drug abuse	3.48 (.72)	2.29 (.92)	3.82 (.39)	3.25 (.71)	4.00 (.53)
Alcohol abuse	3.62 (.75)	3.29 (.92)	3.88 (.49)	3.38 (.74)	4.00 (.53)
Partner violence	3.48 (.84)	3.12 (.93)	3.46 (.88)	3.50 (.55)	4.00 (.53)
Extreme poverty	3.29 (.78)	3.28 (.75)	3.50 (.71)	2.67 (.82)	3.75 (.89)
Child behavior problems	3.45 (.72)	3.33 (.73)	3.72 (.67)	3.25 (.46)	3.88 (.64)
Mental illness	3.48 (.75)	3.40 (.68)	3.89 (.58)	2.88 (.83)	3.88 (.64)
Developmental disability	3.52 (.78)	3.25 (.77)	3.80 (.56)	2.83 (.75)	4.13 (.35)
Extremely poor parenting skills	3.44 (.88)	3.20 (1.01)	3.67 (.69)	3.00 (1.00)	3.63 (.92)
Educational neglect	3.53 (.87)	3.33 (1.03)	3.83 (.51)	3.14 (.69)	3.75 (.89)
Parent-child conflict	3.58 (.74)	3.42 (.77)	3.76 (.66)	3.63 (.52)	3.63 (.92)

Note. Rated on 5-point Likert scale, where 1 = Not at all effective and 5 = Completely effective. YBH: Youth Behavioral Health; CP: Child Protective Services; JP: Juvenile Probation; FIS: Family Intervention Services. Respondents were also given an n/a option; however, the summary statistics above exclude n/a responses.

Table A11. Change in workload, by study unit.

	N	Mean	SD	Median	Minimum	Maximum
Overall	67	3.00	1.03	3	1	5
YBH	25	2.92	.86	3	1	5
CP	18	2.39	.92	2	1	5
Juvenile Probation	11	3.55	.69	4	2	4
FIS	9	3.89	1.36	4	1	5

Note. YBH: Youth Behavioral Health; CP: Child Protective Services; FIS: Family Intervention Services.

Table A12. Usefulness of Family Involvement Strategies, by study unit.

	N	Mean	SD	Median	Minimum	Maximum
Overall	67	3.90	.74	4	2	5
YBH	25	3.64	.64	4	2	4
CP	18	4.11	.83	4	2	5
Juvenile Probation	11	3.55	.52	4	3	4
FIS	9	4.67	.50	5	4	5

Note. YBH: Youth Behavioral Health; CP: Child Protective Services; FIS: Family Intervention Services.

Table A13. Agreement with statements about worker attitudes, by study unit.

	Overall	YBH	CP	JP	FIS
Workers in my unit are proud to work with children/youth/families.	5.42 (.61)	5.20 (.71)	5.50 (.51)	5.73 (.47)	5.67 (.50)
Workers in my unit spend time in professional reflection about their work.	4.96 (.86)	4.68 (1.11)	5.17 (.51)	4.91 (.54)	5.56 (.73)
Workers in my unit believe that they can have a positive impact on the lives of most of their clients.	5.28 (.60)	5.08 (.57)	5.33 (.69)	5.55 (.52)	5.56 (.53)
Workers in my unit use the findings from research in their work with children, youth and families.	5.00 (.76)	4.84 (.85)	5.22 (.55)	5.09 (.54)	5.22 (.83)
Workers in my unit are committed to continuous professional development.	5.19 (.80)	4.96 (.94)	5.39 (.61)	5.18 (.75)	5.78 (.44)
Workers in my unit clearly understand the agency's vision for community service programs.	5.00 (.82)	4.80 (1.00)	5.28 (.58)	5.09 (.70)	5.00 (.87)

Note. Rated on 6-point Likert scale, where 1 = Strong disagree and 6 = Strongly Agree. YBH: Youth Behavioral Health; CP: Child Protective Services; JP: Juvenile Probation; FIS: Family Intervention Services.

Table A14. Agreement with statements about services in the community, by study unit.

	Overall	YBH	CP	JP	FIS
I can usually find services in my community that can help keep children safe in their home.	4.66 (.75)	4.52 (.92)	5.00 (.49)	4.45 (.69)	4.44 (.73)
It is easy to work with most of the service providers in my community.	4.78 (.71)	4.96 (.68)	4.56 (.62)	4.45 (.82)	5.11 (.78)

Note. Rated on 6-point Likert scale, where 1 = Strong disagree and 6 = Strongly Agree. YBH: Youth Behavioral Health; CP: Child Protective Services; JP: Juvenile Probation; FIS: Family Intervention Services.

Table A15. Confidence that family needs can be met by a local community provider, by study unit.

	Overall	YBH	CP	JP	FIS
Child care/day care	3.45 (.80)	3.44 (.92)	3.33 (.77)	3.64 (.51)	3.56 (.88)
Early childhood services	3.82 (.70)	3.72 (.68)	3.94 (.73)	3.73 (.65)	4.00 (.71)
Respite care/crisis nursery	3.45 (.91)	3.44 (1.00)	3.56 (.92)	3.36 (.67)	3.44 (1.01)
Mental health services	3.69 (.74)	3.88 (.60)	3.72 (.75)	3.00 (.63)	3.78 (.97)
Substance abuse treatment	3.57 (.86)	2.52 (1.01)	3.67 (.84)	3.45 (.69)	3.78 (.67)
Developmental disability	3.67 (.68)	3.84 (.55)	3.67 (.59)	3.18 (.75)	3.89 (.93)

services					
Medical services	4.04 (.73)	4.04 (.74)	4.06 (.64)	4.36 (.51)	4.00 (.87)
Dental services	3.15 (.99)	3.28 (.89)	2.78 (.88)	3.55 (1.21)	3.33 (1.12)
Transportation services	2.99 (.84)	3.20 (.82)	2.89 (.90)	3.00 (.78)	2.67 (.87)
Domestic violence services/shelter	3.49 (.82)	3.64 (.76)	3.33 (.84)	3.09 (.94)	3.89 (.78)
Food services/food pantry	3.64 (.73)	3.88 (.67)	3.39 (.85)	3.45 (.82)	3.56 (.53)
Housing assistance	2.76 (.99)	2.88 (.83)	2.44 (.92)	2.73 (.79)	2.89 (.60)
Utilities & other household assistance	3.01 (.84)	3.08 (.86)	2.94 (.64)	2.91 (.54)	3.00 (.50)
Employment services	3.31 (.82)	3.44 (.92)	3.06 (.80)	3.45 (.52)	3.11 (.33)
Adult education/vocational services	3.51 (.73)	3.68 (.75)	3.11 (.76)	3.64 (.51)	3.44 (.73)
Child education/vocational services	3.58 (.84)	3.76 (.72)	3.28 (.75)	3.55 (.52)	3.56 (.73)
Parenting classes, household management	3.22 (.69)	3.24 (.93)	3.17 (.86)	2.91 (.54)	3.56 (.73)
Youth recreational activities	3.33 (.76)	3.44 (.87)	3.11 (.83)	3.27 (.91)	3.44 (.53)
Legal services	3.25 (.73)	3.28 (.89)	3.11 (.76)	3.45 (.69)	3.33 (.50)
Support groups (e.g. parents anonymous)	3.15 (.70)	3.24 (.93)	3.06 (.80)	2.91 (.70)	3.11 (.60)
Mentoring	2.78 (.79)	2.88 (1.01)	2.67 (.69)	2.27 (.65)	3.00 (.50)
Tribal services	2.31 (.81)	2.48 (1.05)	2.50 (1.25)	2.00 (.63)	2.00 (.71)
Immigration services	2.85 (.77)	2.92 (1.15)	3.00 (.77)	2.45 (.69)	2.78 (.67)
Faith-based services	3.42 (.80)	3.52 (.92)	3.17 (.71)	3.45 (.82)	4.00 (1.00)
Bilingual services	3.27 (.83)	3.28 (.84)	3.17 (.92)	3.27 (.65)	3.67 (1.23)

Note. Rated on 5-point Likert scale, where 1 = Not at all confident and 5 = Completely confident. YBH: Youth Behavioral Health; CP: Child Protective Services; JP: Juvenile Probation; FIS: Family Intervention Services.

Table A16. Usefulness of Family Involvement Strategies, by study unit.

	n	Mean	SD	Median	Minimum	Maximum
Overall	67	3.28	.78	3	2	5
YBH	25	3.40	.71	4	2	4
CP	18	3.17	.92	3	2	5
Juvenile Probation	11	3.18	.60	3	2	4
FIS	9	3.67	.71	4	3	5

Appendix C: General Staff Survey Results by Unit

Note. YBH: Youth Behavioral Health; CP: Child Protective Services; FIS: Family Intervention Services.

Found, Engaged and Connected
September 2014 Focus Group Summary
(items in **bold** reflect strong themes)

FGCs

- Challenges:
  - **Lack of clarity around target population/eligibility/purpose** (particularly in YBH and JP)
    - Consistently participants stated the purpose as permanency, safety planning and building connections, but inconsistent understanding on when to refer
    - Purpose can change from time of referral and when meeting is held months later
    - Concern that without a clear purpose, FGCs aren't helpful
    - Perception that FGCs are for big decisions (but when big decisions are needed quickly FGCs are not a good option)
  - Workers are challenged to message to families effectively around purpose/process
  - **Perception that it takes up to 6 months to move from FGC referral to the conference**
    - **Concerned that length of time is too long; FGCs need to happen more rapidly**
  - Some negative perceptions of FGCs
    - Laborious
    - **Timing of FGCs is negative**
      - Evenings and weekends
      - Time from referral to meeting
    - Minimizes worker input
    - Multiple plans come out of meetings; puts agency in tough position
- Successes/Benefits:
  - **Perception that FGCs create longer-term family involvement and build supports around youth**
  - Minimizing system judgment of important family members to remain connected
- Perception that there is greater investment in FGCs for CP, than for JP or YBH
  - Feedback that FGCs are not a good fit for YBH/JP, because of crisis and voluntary nature of cases
    - Challenge: when voluntary case referrals don't go to meeting due to caregiver noncooperation
- Private Family Time:
  - Reports of family anxiety re: family dynamics and/or limited time to make serious decisions
  - Suggestion of neutral facilitator remaining with family

Follow-Up FGCs

- Perception that they are happening more, becoming understood as expectation of practice (in CP)
- **Perception that they are not always necessary but staff refer because they think they are supposed to; purpose unclear**

CPCs

- **Preferred FIS model for case planning as they are considered:**
  - Expedient (meeting length)
  - **Occur quickly (between referral and meeting)**
    - **Better suited for crisis/urgent situations than FGCs**

  - Convenient (no weekends)
  - Less intimidating/easier to sell to families
  - Task-oriented

General Practice Issues: Family Engagement

- Perception is that since the implementation of the integrated model, the new relative search law/policy, and/or family finding efforts:
  - More family participating in FIS
  - More paternal family participating in FIS
  - Viewing family as more than "placement options"
  - Increase in youth/family supports

General Practice Issues: Information Sharing/Messaging

- Successes:
  - Increase in transparency of information being shared through FIS meetings
  - FIS supports staff efficiently managing caseloads by case planning in group setting
  - **Enhanced collaboration between FIS and other units than in past (re: info sharing)**
    - Still perceived barriers here re: requests for more from FIS vs. need for "neutrality"
  - **Centralized location in case files for all relative information**, which allows for sharing between facilitators and caseworkers; staff looking forward to SSIS enhancements around this piece also
- Challenges:
  - Discrepancy between information shared with family group before and at meeting
  - Concern that family members need more information or a fuller picture before they attend FGCs
- **Inconsistency between workers and FIS staff in how FIS processes are explained to family; workers challenged to message effectively**
- Inconsistent knowledge among staff of available FIS informational resources (brochures)

Grant-specific/related issues:

- **Perceived pressure to refer**
  - Perception that 'quotas' must be met vs. referring with goal/purpose for the meeting
  - Perception that grant was done 'to' not 'with' staff in new units
- Significant differences in understanding regarding the grant/integrated model across units
  - Confusion around terminology (family finding, integrated model, follow-up FGCs, the grant)
- Challenge: lack of buy-in from GALs an ongoing issue
- Challenge: Perception that the volume of FGCs, follow-up FGCs and CPCs have increased a great deal re: FIS workload
- Success: increased staffing levels and addition of an administrative assistant to aid in scheduling

Found, Engaged and Connected
May 2016 Focus Group Summary
(items in **bold** reflect strong themes)

Family Involvement Strategies

- CPCs are most helpful
    - Timing is faster
    - Detailed planning for critical issues/crises/day to day needs
    - For YBH CPCs meet needs better than FGCs
- Family Engagement Strategies, in general, are helpful for:
    - information sharing
    - transition between workers
    - consistency
    - communication
    - decreased triangulation
- Aids with placements and prevention
- Increased family engagement, child engagement and shared responsibility
- Sets up expectation for staff to engage with family

Referrals to FGCs

- Referrals to FGCs were more consistent in CP, especially when dealing with permanency issues
- Reasons to refer to FGC:
    - Placement options
    - Permanency planning
    - Long term planning
    - Family finding and family support building
    - Information sharing
- Reasons for lack of referrals:
    - Long length of time from referral to holding meeting (up to 4 months)
    - Less effective for older youth (e.g. youth in YBH and JP)
    - Concerns about negative family dynamics

Focus of FGCs vs. CPCs

- FGC Purpose:
    - Bringing family together for planning re: permanency, placement
    - Long term planning – after case is closed
    - Build support, respite
    - Alternative care plans
    - Focus on family engagement
- CPC Purpose
    - Ongoing case planning and information sharing
    - Immediate crisis plans
    - Task/safety driven
    - Less focus on extended family, more on who is involved day-to-day
- FGC well-suited for cases in which there is:
    - Chronic mental health or neglect issues
    - When there is engaged family with protective capacities/strengths
    - Youth with maturity/capacity to be involved
- FGC ill-suited for cases in which there is:
    - Voluntary/resistant families
    - Family outnumbered by professionals
    - High conflict or negative family dynamics
    - Truancy cases
    - Severe youth mental health issues which impact youth being introduced to new family members

  - Not a major decision related to permanency/placement to be made

Follow Up Meetings

- Follow-up FGC planning/scheduling now built into initial FGC
- Families opt-in
- If the plan falls through, more important to follow up
- CPCs continue regardless – might not need a FGC
- Confusion about how decisions are followed up on after initial FGC
- Value of follow up FGC:
  - Keep family engaged
  - Information sharing
  - Helpful if plan needs to change
  - More family engaged if child is not returning home

Perceptions of FGC

- Family vs. service provider perception of FGC fidelity; why lower for families?
  - Families know less of what to expect
  - Families are more subjective than service providers
  - Trust is greater between service providers and OCCS than with family
  - Location of meetings is at OCCS – harder to coordinate/engage with remote family

- Barriers/challenges related to FGCs
  - Length of time from referral to meeting
    - Faster time frames needed for child protection cases dealing with permanency
    - Family finding takes a long time – immediate family ready to go but still waiting on other extended family members delays the process
    - Difficult to know when to stop family finding and move forward with meeting
  - FIS staff turnover
  - High caseloads for FIS workers and competing responsibilities (e.g. CPCs)
  - Lack of training in FGC
  - Family resistance to FGC
    - Youth/parents not wanting to burden/engage extended family (especially in voluntary cases (e.g. YBH))
    - FGC issues of permanency and engaging lots of family can be overwhelming.

METHODS

Detailed descriptions of the data sources can be found in the Evaluation Section of the full report. This section identifies the steps taken to utilize the data from these sources. A variety of statistical tests were used to answer questions, including t-tests, chi square analyses, ANOVAs, or paired sample t-tests. These tests enabled us to explore whether the results differed by study unit, coordinator, FEC FGC recipients (vs. FEC non-recipients), or identity of the respondent.

Meeting Log. Meeting Log data were available for all referrals to the FEC project (n = 92), whether or not an FGC occurred prior to December 31, 2015, a period of time hereinafter called the "intervention phase." Data elements discussed below that came from the Meeting Log include: the number of FGC referrals, the percent that culminated in a first and second FGC, the length of time between referral and the first FGC, time between first and second FGCs (where FGC2s were held), type and extent of remote participation in FGCs, and reasons why FGCs did not occur.

Coordinator/Facilitator Fidelity Survey. Fidelity data obtained from the Olmsted Coordinator/Facilitator Fidelity Survey reflect were available for 63 of the 65 FGCs that occurred prior to the end of the intervention phase. Data analysis commenced in late February 2016. Although additional coordinator and facilitator surveys from two meetings that occurred in late December were received in April 2016, this was after the analytic sample had been defined and dataset development was well underway, thus they were not included in the fidelity analyses.

On average, 2.19 Coordinator/Facilitator surveys, including co-facilitator surveys, were received per FGC, with a range of one to four. Depending on the question, the sample size for some coordinator/facilitator fidelity analyses varied due to missing data, the analytic approach, or to other issues. For example, in most instances, the person who coordinated the FGC also led the facilitation of it. Still, for 13 workgroups, different people coordinated and led the facilitation of the FGC. In these instances, the two people in these roles each submitted surveys but completed just those sections pertinent to the portion of the work they completed (e.g., the Coordinator completed the preparation portion and the Facilitator completed the portion of the survey asking about what happened during the FGC). Therefore, for FGC-level analytic purposes, responses from the coordinator and the lead facilitator were merged into one coordinator record. In addition, not all FGCs involved co-facilitators, some involved more than one (due to facilitators at remote locations), and for one FGC, we did not receive a coordinator survey, but did receive a co-facilitator survey. Thus the co-facilitator and overall fidelity results necessarily excluded the FGCs where the data necessary for computations were not available. Where more than one co-facilitator submitted a survey on the same FGC, the FGC-level co-facilitator fidelity score results reflect the averages of their scores. Finally, where ANOVA techniques were used to examine differences between coordinators' average scores, only those individuals who coordinated more than one FGC could be included in the analysis.

Participant Fidelity Survey. Participant Fidelity Survey data were available for 62 of the 63 FGCs included in the analytic sample. On average, 9.7 Participant Fidelity surveys were received per FGC (*SD* = 5.3, *Md = 8.5)*; the range spanned from 2 to 28. Like the Coordinator survey, the sample size for analyses

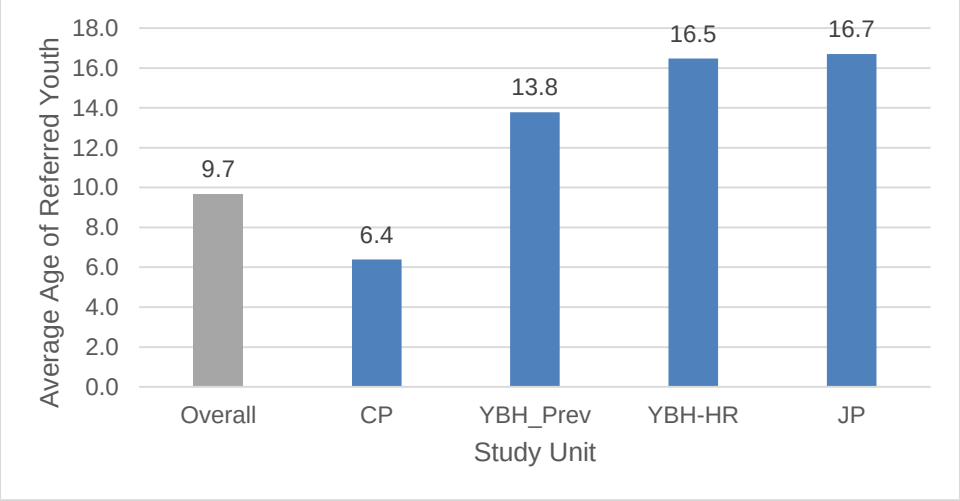
of Participant Fidelity Survey data varied depending on the question examined due to missing data and the analytic procedure employed. For example, for paired sample t-tests, a representative from both groups (e.g., agency vs non-agency service providers) had to have submitted a survey from the FGC in order for a comparison to be made. In this cases, the n was reduced to 40 since surveys from individuals representing each group at the same FGC were received for forty FGCs.

MEETING LOG RESULTS

FGC Referrals. Overall, 92 family group conference referrals were made to the Olmsted FEC project between November 15, 2013 and October 31, 2015, hereinafter called the "enrollment phase."[2] Child Protection staff referred the majority of workgroups and constituted 64% (n = 59) of the final referral sample. YBH-High Risk Placement and YBH-Prevention each referred 13% (n =12) workgroups, and Juvenile Probation referred 10% (n = 9) of the cases in the final sample.

Target Youth Demographics. To be eligible for the FEC study, staff needed to identify a particular child who was considered the primary target of the intervention. For CP this was typically the oldest youth in the household. In the end, children referred to the study ranged in age from newborns (age 0) to 19 year olds, with a mean age of 9.7 (*SD* = 6.6, *Md* =11.4,). Figure 9 presents the average age of the target child overall and by study unit. As might be expected, unit-level differences in the average age of the referral child/youth were statistically significant (*Welch's F*(3,24.6) = 53.42, *p* = .000)[3]. While the average ages of YBH-Prevention, YBH-High Risk Placement and JP unit children were statistically similar, children referred by the CP unit were at least seven years younger, on average, compared to the other units.

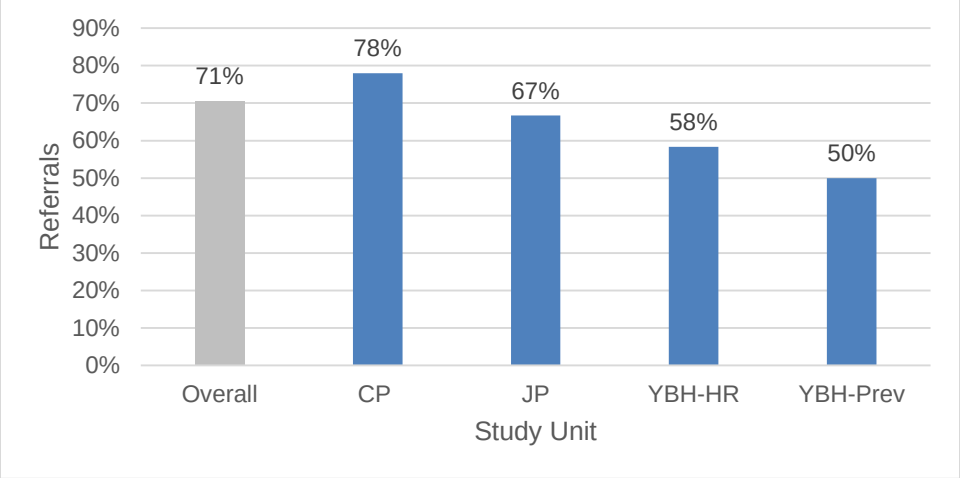
Figure 9. Mean Age of Referred Youth, Overall and by Study Unit (n = 92)



[2] Three cases with FGC referrals that predated the official study referral start date by 45 days or less were included in the study sample.
[3] Welch's statistics are more conservative and are presented when the variance between groups were not equal.

Percent of Referrals Resulting in a Family Group Conference. As of December 31, 2015, a total of 65 of the 92 referrals (71%) had culminated in a first FGC.[4] Figure 10 reflects the percent of referrals that culminated in a FGC during the study period overall and by unit. As it indicates, unit-level rates of success in referrals culminating in a FGC ranged from 50% - 78%; the CP unit held 46, JP held 6, YBH-High Risk Placement held 7 and YBH–Prevention held 6 FGC1s. Still, while the data suggest that percentages of referrals resulting in a FGC varied greatly by unit, robust tests of these differences (which take into account important elements, such as differences in the number of workgroups per unit used in the calculations) determined the differences were *not* statistically significant (*Welch's F*(3, 19.5) = 1.331, *p* = .293). This illustrates the point that in studies with small samples such as this, the difference of one or two conferences could make a large difference in the calculation of percentages and can exaggerate effects; thus identification of statistically significant differences must rely on robust analytic methods.

Figure 10. Referred Cases that had an FGC1, Overall and by Study Unit (n = 92)



Reasons Why a First FGC Did Not Occur. In any assessment of the efficacy of an intervention, it is important to understand why an intervention, such as the occurrence of an FGC, did not occur. In all, thirty percent (n = 27) of workgroups that were referred for an FEC family group conference had not had one by the end of the intervention phase. Of the 19 explanations offered, five general themes were identified:

1. Family declined (n = 7)
2. OCCS declined (n = 5)
3. Family moved/case closed (n = 4)
4. Unable to widen family circle (n = 2)

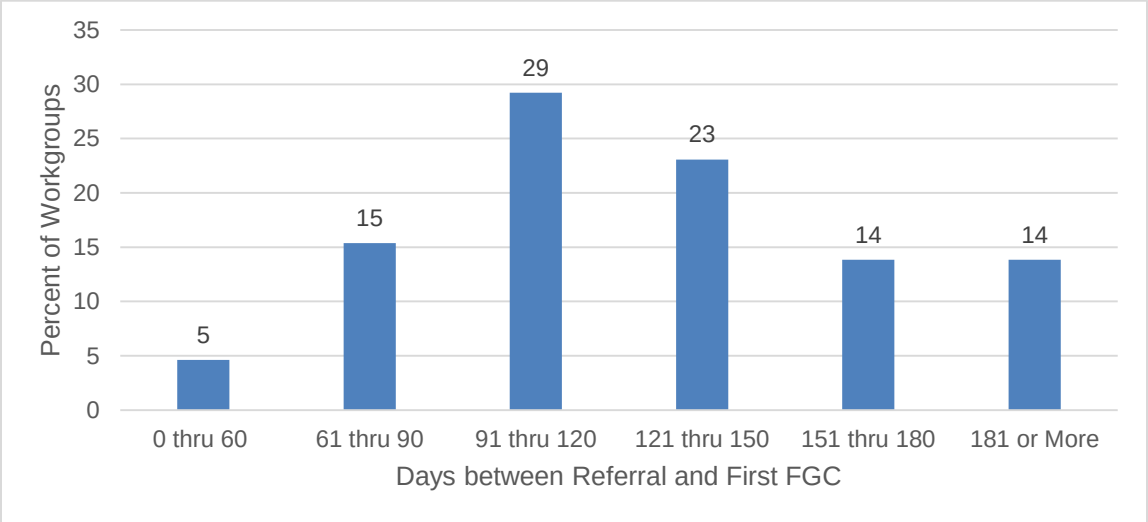
5. Joint decision by family and OCCS (n = 1)

[4] By April 2016, an additional eight meetings had taken place; five of these were CP unit referrals; two were referrals from YBH-Prevention, and one came from the JP unit. However, because these meetings took place after the project's December 31, 2015 meeting deadline, they are not included in the analysis presented here.

Although we were limited to analyzing reasons provided for just the 19 workgroups, chi-square analyses indicated that the reasons why the FGC1 did not occur did not vary significantly by study unit (*Likelihood Ratio*[5] $x^2(12) = 12.961$, $p = .372$) or identity of the coordinator (*Likelihood Ratio* $x^2(20) = 22.777$, $p = .329$). Thus, based on available data, there was no evidence that workgroups associated with a particular study unit or some coordinators were better than others at ensuring a FGC happened. Using data available from the Meeting Log to explore other reasons FGCs might have happened did not yield more insights. For example, there was no significant difference between the mean age of children in those workgroups that culminated in an FGC and those that did not ($t(82) = 1.57$, $p = .119$). In other words, workgroups involving older children were no more or less likely to have a first FGC take place compared to workgroups involving younger children.

Time between Referral and First FGC. According to the Meeting Log, for the 65 workgroups that had a FGC take place by the end of December 2015, the median number of days between the FEC referral and the date of the first FGC was 124 days ($M = 132$, $SD = 52$). Conferences took place anywhere from 38 to 389 days after the original referral.[6] Figure 11 below, presents the percent of workgroups that had a conference within specific time frames. As it indicates, fewer than 5% of workgroups had a conference within 60 days. By the end of about three months (90 days), 20% (n = 13) had had their first FGC, but 80% of the workgroups had not. For over a quarter of the workgroups (n = 18), the FGC did not take place until almost five months had passed (i.e., 151 days or more).

Figure 11. Number of days from Referral to the First FGC Meeting (n = 65)

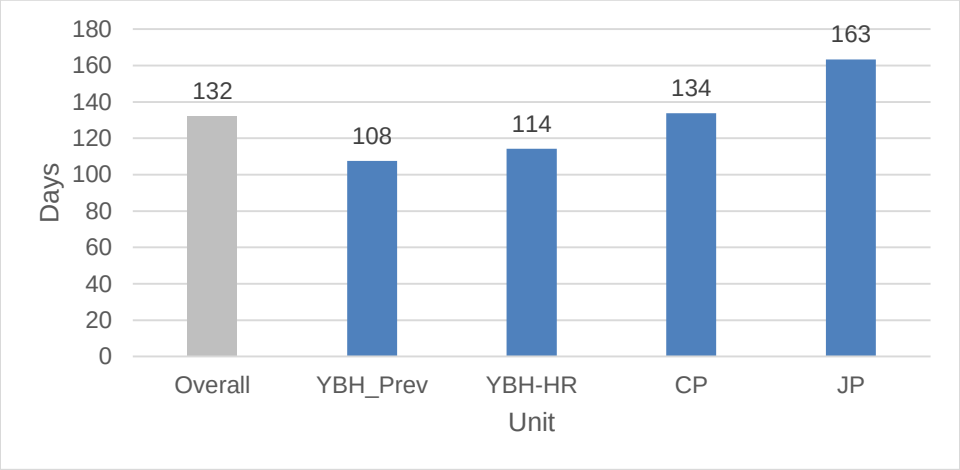


A comparison of the average (mean) number of days between referral and the first FGC by study unit was conducted and Figure 12 presents the results. While the data suggest there was some variation by unit, where, on average, YBH-Prevention unit referrals culminated in an FGC the fastest (in 108 days) and JP

[5] Likelihood ratios are conservative measures employed when sample sizes are small.
[6] The workgroup for which it took 389 days for the first FGC to occur had been put on hold as the family, youth, agency, and treatment center determined the conference would be more helpful for all closer to his exit from residential care.

referrals took the longest (163 days), the results of an ANOVA analysis indicates that these differences are *not* statistically significant (*Welch's F*(3, 11.3) = 1.672, *p* = .228).

Figure 12. Mean Number of Days from Referral to First FGC, by Study Unit (n = 65)



An expansive use of quantitative methods to examine reasons why FGCs did not occur sooner was not possible due to data limitations, however neither the identity of the coordinator (*F*(9, 54) = .356, *p* = .951), nor situations where a different person coordinated vs. facilitated the FGC (*t*(63) = -.416, *p* = .679), or even the engagement of remote participants (described further below and which arguably could add to preparation time; *t*(63) = .962, *p* = .340) appeared to have an association with differences in the average number of days between referral and the workgroup's first FGC.

Remote Participation in FGCs. FGC planning requires a lot of logistical coordination and a concerted effort to engage and facilitate participation by family, like-family, and service providers involved in the family's life. Despite efforts to hold FGCs at times and in locations that do not impose a burden on invited participants, not everyone can join the FGC in person. Thus, coordinators were trained to employ other means to foster participation, including having participants call in by phone or join by video.

Among other elements, the Meeting Log tracked the number of FGC participants who joined by phone or video conference and it is the only source of our data on these participants as they did not complete fidelity surveys. Fifty-six percent (n = 37) of the 65 FGCs involved at least one remote participant, using either phone or video technology. At least one phone participant was documented for 45% (n = 29) of FGCs and video participants were reported for 29% (n= 19) conferences. For those workgroups where remote FGC participation occurred, between one to 11 participants joined by means of phone *or* video. On average, 1.29 (*SD = 2.26)* participants joined by phone and 1.1 (*SD = 2.33)* participants joined by video conference. Figure 13 presents the type and number of participants who joined by phone and Figure 14 presents the data for video participants. As the figures indicate, for both phone and video participation, relatives and other like-family participants were more common than service providers.

Figure 13. Number of Conferences Involving Phone Participants, by Participant Type

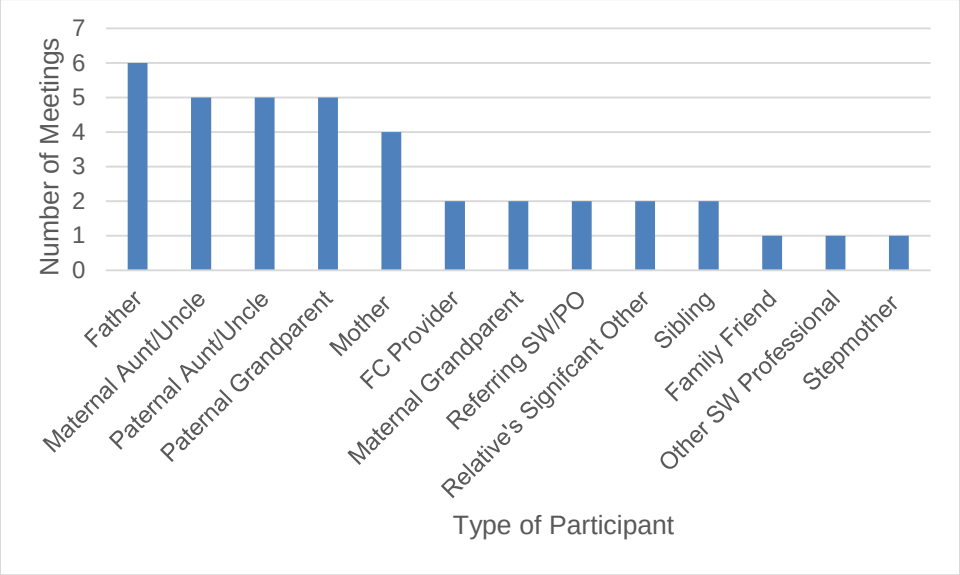
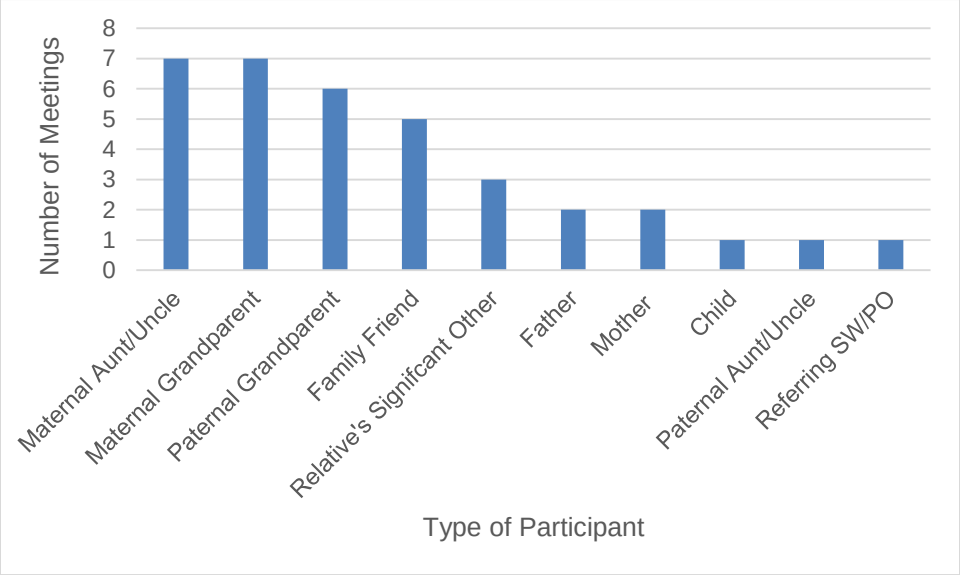


Figure 14. Number of FGCs Involving Video Participants, by Participant Type



An examination of rates of remote participation by study unit revealed that none of the YBH-Prevention workgroups reported utilizing remote participation methods during the first FGCs. When the CP, JP, and YBH-High Risk Placement groups participation rates were compared using a one-way ANOVA, no significant differences were detected with respect to the average number of participants who joined by phone ($F(2, 56) = 1.008$, $p = 0.372$) but statistically significant differences were detected for average number of people participating by video depending on the study unit (*Welch's* $F(2, 14.3) = 3.976$, $p = 0.042$). Specifically, the difference between average video participation for the CP unit's FGCs ($M = 1.13$), and the JP unit's FGC ($M = .17$) was statistically significant ($t(9) = 2.222$, $p = .034$). In other words, CP unit FGCs were more likely to have more video participants than JP unit FGCs, but the YBH-High Risk

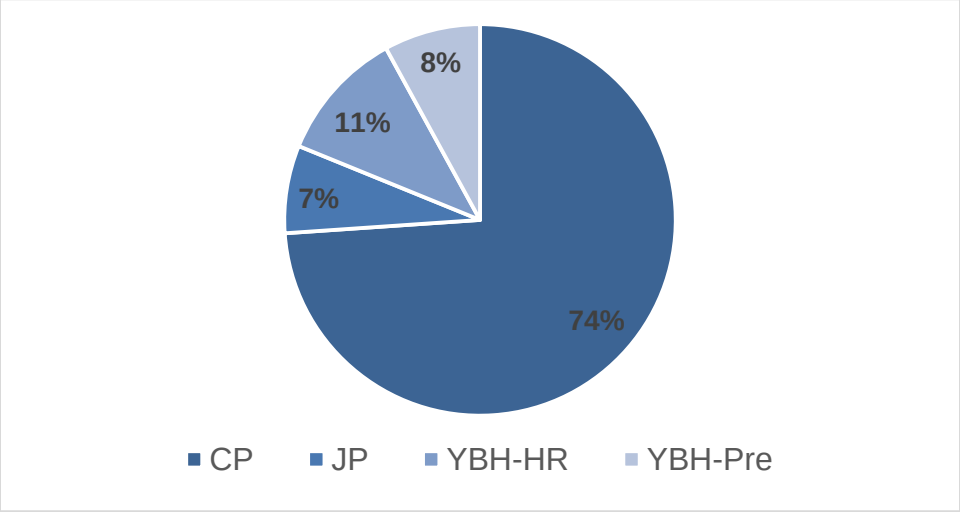
Placement group's average video participation level was not statistically different from the CP or JP unit participation levels.

In addition, chi square likelihood ratio results indicated that there was a statistically significant association between the identity of the coordinator assigned and the likelihood of that coordinator's FGCs involving any phone participants (*Likelihood Ratio* x^2 (10) = 21.34, p = .019). That said, there was no significant association between the identity of the coordinator and the likelihood of video participation (*Likelihood Ratio* x^2 (10) = 13.57, p = .194).

Coordinator and Facilitator Fidelity Results

As of February 2016, 138 surveys were received from staff who functioned as coordinators, facilitators and/or co-facilitators at one or more of 63 FGCs. The percent of surveys received by study unit are presented in Figure 15. Coordinators, facilitators, or co-facilitators associated with CP FGCs submitted the vast majority of the surveys received (74%, n = 102). Fifteen surveys (12%) were associated with YBH – High Risk Placement family FGCs, 11 surveys (8%) were associated with YBH –Prevention family FGCs, and 10 surveys (7%) were received from Juvenile Probation-related family FGCs. The imbalance favoring surveys from CP means that any summary statistics from the overall sample, presented below, should be presumed to most heavily represent what happened at CP FGCs.

Figure 15. Percent of Coordinator/Facilitator Surveys Received, by Study Unit (n = 63)



Family Finding Strategies. Coordinators were asked about which strategies they employed to find family members in an effort to engage them in the FGC process. Eighteen specific strategies were asked about and respondents could identify other approaches used not listed in those 18. Examining data for those workgroups associated with a study FGC and for which search strategy data were available (n = 60), on average, coordinators reported employing 9 strategies to find family members, though the range spanned from 0 (i.e., one respondent indicated none were used, which may have been due to staff turnover during the coordination process) to 15. Figure 16 presents the percent of staff who used 0, 4–6, 7-9, 10-12 , or 13 or more strategies to search for families. Read clockwise, for one FGC (2%) a

coordinator indicated they did not use any family finding strategies, and for 15% of the FGCs, coordinators reported using just 4- 6 strategies to find families. Still, in 84% of the FGCs (i.e., summing the highest three categories), coordinators used at least 7 or more strategies.

Figure 16. Number of Strategies used to Find Family Members, per FGC

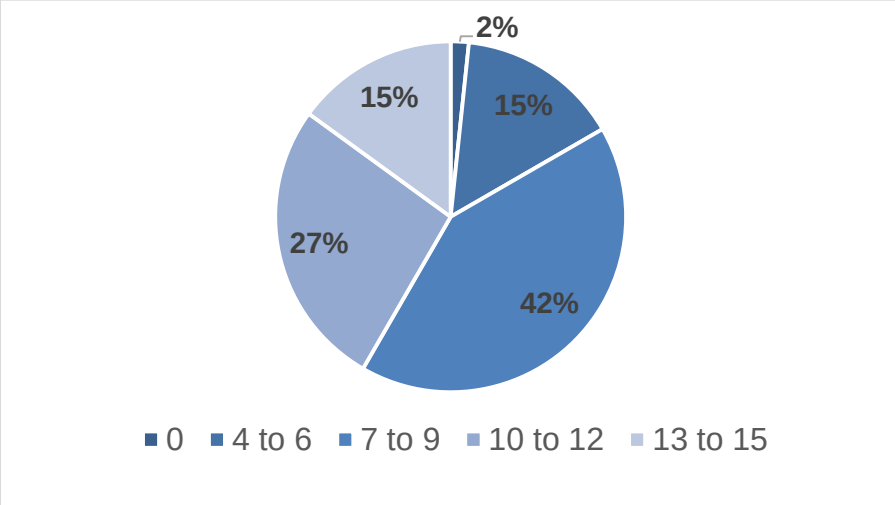
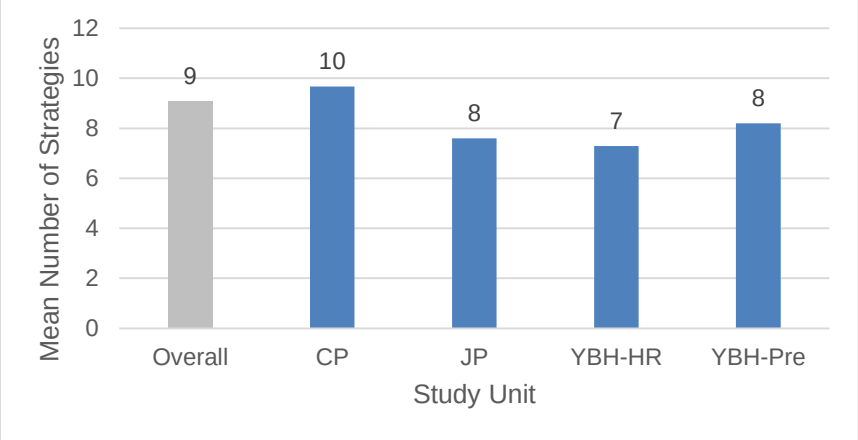


Figure 17 presents the average number of strategies employed overall and by study unit. While there appear to be differences in the average number of strategies employed according to the study unit, these differences were not statistically significant ($F(3, 56) = 2.165$, $p = .102$).

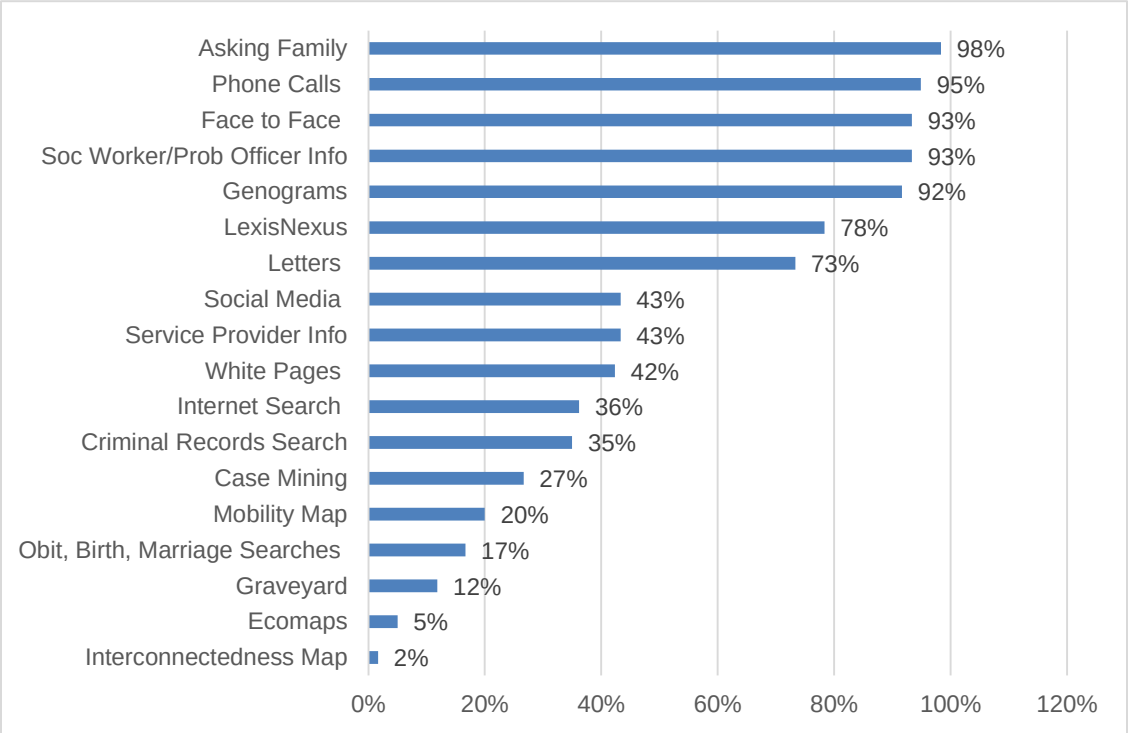
Figure 17. Mean Number of Family Search Strategies Employed, by Unit



Still, in considering ways to locate family or like family people important to the family in focus, some types of strategies were used more often than others. Figure 18 presents the types of family finding strategies employed by coordinators. Of the 18 strategies asked about, the five most common approaches (used by coordinators in over 90% of the FGCs) were: asking family, phone calls, face to face contact with family, obtaining information from the social worker or probation officers, and using genograms. Around three

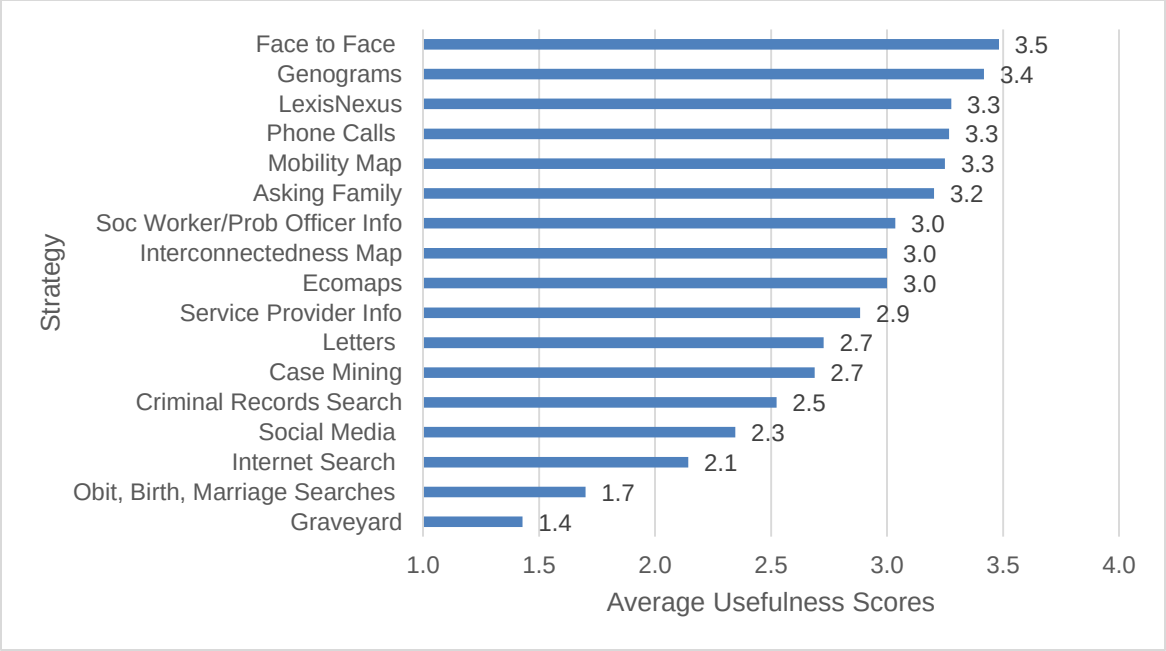
quarters of coordinators indicated they used Lexis Nexus or letters to try to reach family members. The rest of the techniques were used by fewer than 50% of the coordinators. No coordinators used concentric circles, but a few individuals indicated they employed additional methods such as driving to a possible address, employing a "Seneca search," and asking neighbors at addresses.

Figure 18. Types of Family Finding Strategies Employed



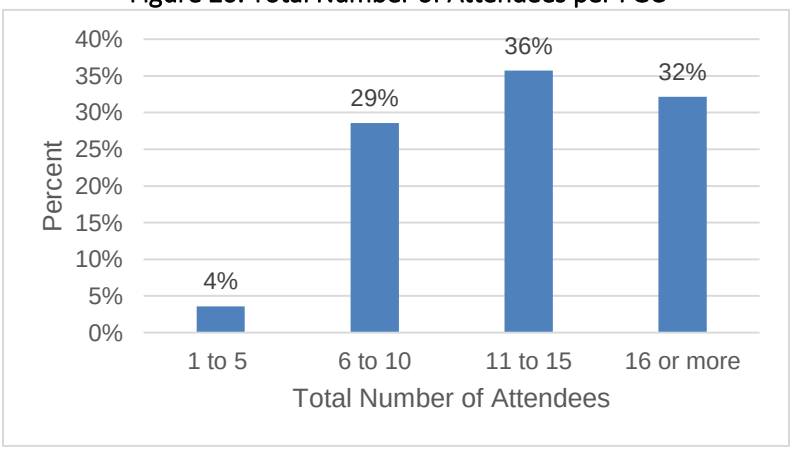
Respondents who used these strategies were asked to rate their usefulness using a four point Likert scale with response options ranging from 1 = Not at all Useful, 2 = Slightly Useful, 3 = Moderately Useful, and 4 = Very Useful. Staff perceptions of the usefulness of the strategies employed varied by strategy. Figure 19 presents the average (mean) score from those coordinators who used the method. Overall, face to face, genogram, LexisNexis, phone call and mobility map methods were associated with the strongest endorsements. Graveyard, obituary, marriage or birth, internet, social media and criminal records searches received the weakest endorsements regarding their usefulness.

Figure 19. Coordinator Perceptions of Usefulness of Family Finding Strategies



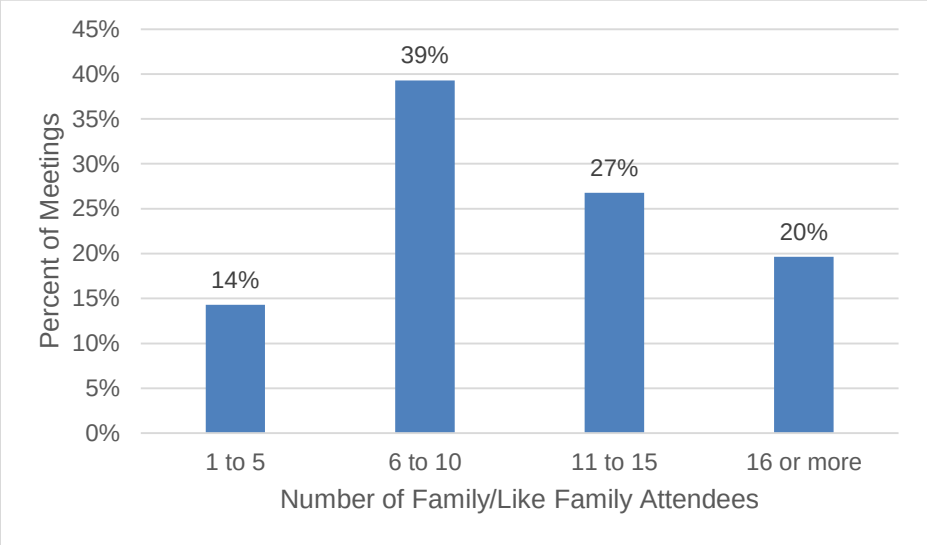
FGC Attendance. Attendance data were available for 56 FGCs where at least one person was documented. Overall, 792 people were documented as attending the FEC FGCs. The median number of attendees was 12.5 (*M* = 14.3*, SD* = 6.9), but the range spanned from four to 37. Figure 20 presents the total number of attendees per FGC in categories. Over 66% of the FGCs had 10 or more attendees present. The study units did not differ significantly on the number of total attendees at the FGCs ($F(3, 1) = 1.995$, $p = .126$).

Figure 20. Total Number of Attendees per FGC



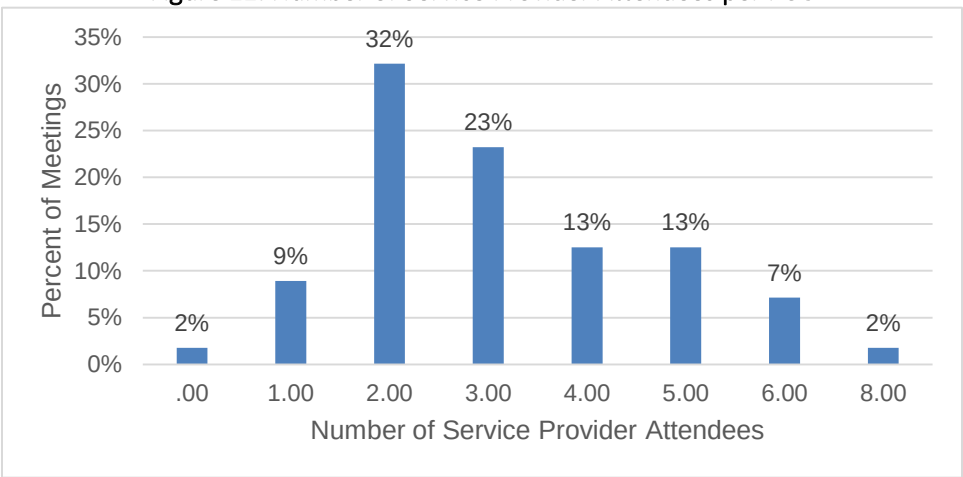
Family members constituted most of the attendees, in general, with 617 participants documented as being family or like-family. The median number of family/like family attendees was 10.0, (*M* = 11.1*, SD* = 6.5*)*, but the range spanned from two to 35 people. However, as Figure 21 suggests, over 45% of the FGCs had 11 or more family/like-family participants documented by the Coordinator/Facilitator. No differences between study unit on the average number of family/like-family participants attending were detected ($F(3, 1) = 1.065$, $p = .372$).

Figure 21. Number of Family/Like Family Attendees per FGC



In comparison, overall, 175 service providers were documented as attending the FECs; the median number of service provider attendees was 3.0, (*M* = 3.1*, SD* = 1.6*)* and the range spanned from zero (in just one FGC) to eight. As Figure 22 indicates, most FGCs had two or three service providers in attendance. Here, however, study units appeared to differ significantly on the average number of service provider attendees (*F*(3, 1) = 3.563, *p* =.020). Specifically, the difference between the JP and CP units' average number of service providers was statistically significant (*F*(3, 1) = 1.995, *p* =.126), which is expected given the differing purposes of these meetings across units.

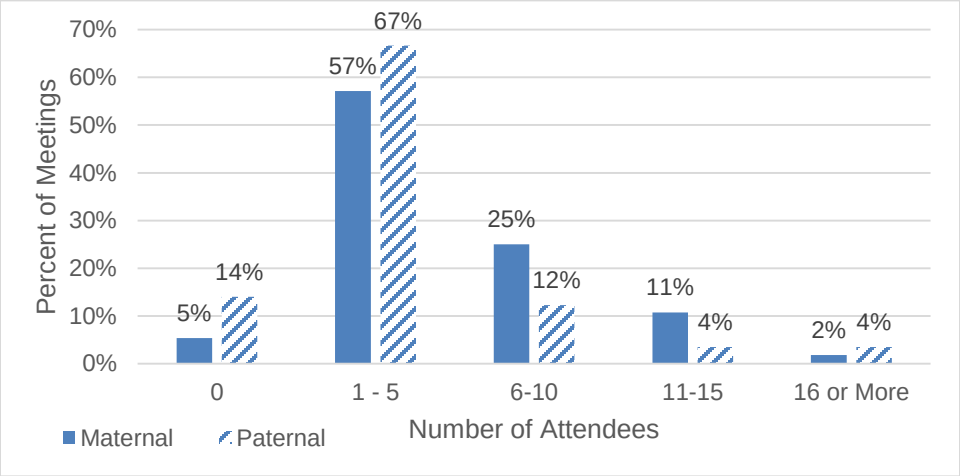
Figure 22. Number of Service Provider Attendees per FGC



Overall, the FGDM core principles goal of a 2:1 family/like family to service provider ratio was achieved in 75% (n = 42) of the 56 FGCs for which attendance data were available. There were no significant differences between coordinators (*F*(9, 1) = 0.703, *p* = .703) or the study units (*F* (3, 1) = 1.079, *p* = .366) with respect to achieving these ratios.

Examining the types of family/like-family participants in greater detail, facilitators documented 314 maternal and 206 paternal relatives attending the FGC. The median number of maternal relatives in attendance was 5.0 (*M* = 5.6, *SD* = 3.8) compared to a median of 2.0 (*M* = 3.6, *SD* = 4.6) for paternal relatives. The number of maternal relatives attending ranged from 0 – 16 while the paternal relative range was 0 – 24. Figure 23 presents the distribution of attendees in categories.

Figure 23. Number of Maternal and Paternal Family Members Attending



PARTICIPANT FIDELITY RESULTS

Demographics of Participant Survey Respondents. Coordinators and Facilitators provided a census reflecting who attended the FGC, but the Participant Fidelity Survey yielded additional detail on FGC participants, including more in depth demographic information and their perspectives on the FGC. Overall, 604 participant fidelity surveys were received by late February 2016; 33% (n = 200) of the survey respondents were male and 66% (n = 394) respondents were female. Ten respondents declined to identify their gender.

Respondents were asked to identify how they were related to the child who was the focus of the FGC. Respondents were then categorized into two types: family/like-family and service providers. Table 5 identifies the categories of respondent types and indicates which respondents were categorized as family/like-family and which were considered service providers. Of the participant surveys received, 70% (n = 422) were from respondents identified as family or like-family and 28% (n = 167) were from service providers. Respondents neglected to identify their relationship to the child in 16 (2%) of the surveys.

Table 5. Categorical Breakdown of Participant Fidelity Survey Respondent Types

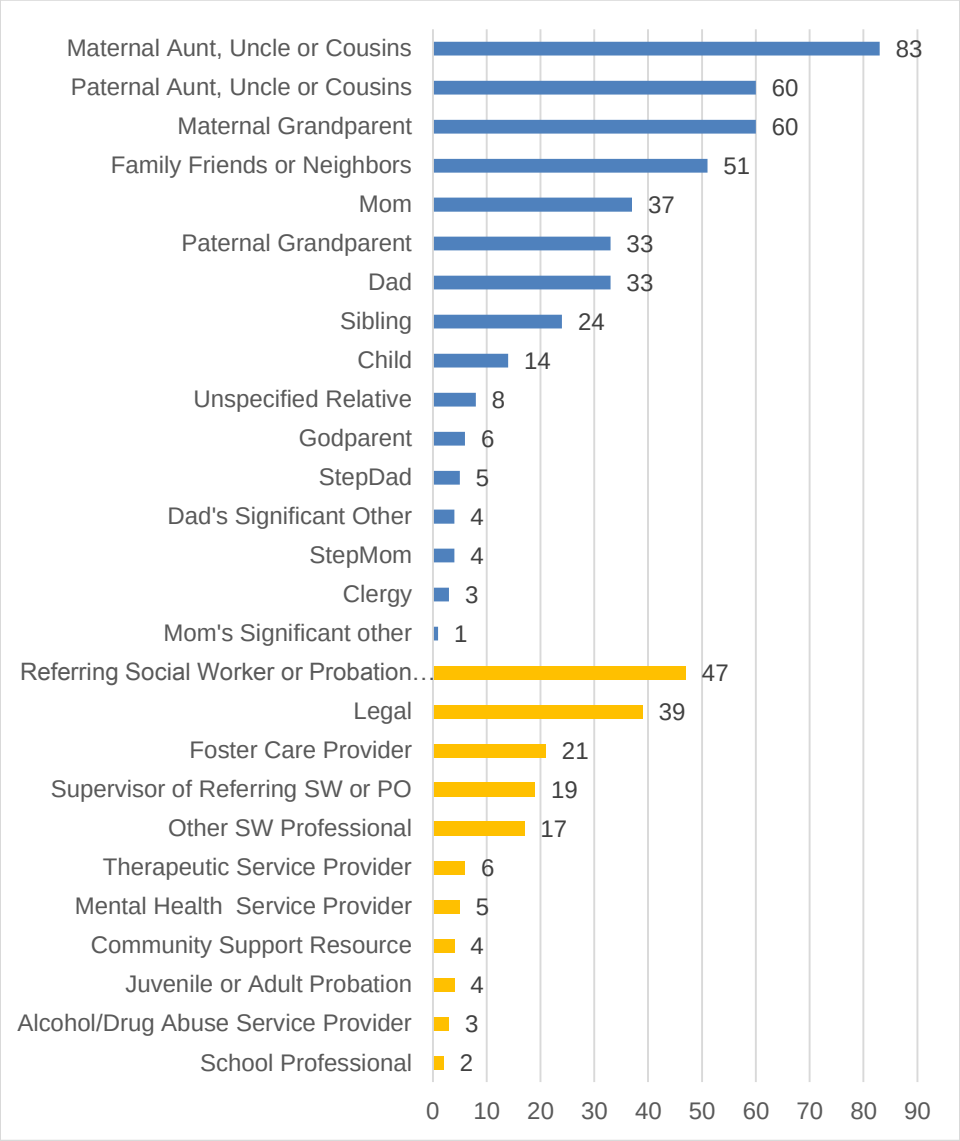
Family	Like-Family	Service Providers
Child	Mom's significant other	Referring social worker/probation officer
Mom	Dad's significant other	Supervisor of referring social worker/probation officer

Family	Like-Family	Service Providers
Dad	Neighbors	Legal (GAL, lawyer, advocate)
Stepmom	Family friends	Juvenile probation or adult probation
Stepdad	Clergy	Provider of therapeutic services
Sibling	Godmother/Godfather	Mental health service provider
Maternal aunt/uncle/cousin	Grandparent or other relative's significant other	School professional
Maternal grandparent		Community support resource
Paternal aunt/uncle/cousin		Domestic violence professional/ specialist
Paternal grandparent		Drug/alcohol service provider
Unspecified relative		Foster care provider/staff
		Substance abuse professional
		Other SW Professional

Figure 24, below, presents the number of surveys received by individual respondent types. Following the categorizations above, those respondents considered to be family and like-family respondents are identified by blue bars while service providers are identified with yellow bars.

As the figure indicates, within the family and like-family category, maternal aunts, uncles or cousins were the most highly represented in survey respondents (n = 83). Paternal aunts, uncles or cousins or maternal grandparents were tied for the next most frequently represented (n = 60 each). Some respondents did not identify to which side of the family they were connected and were therefore designated as unspecified relatives (n = 8). Overall, maternal relatives, including mom's (and step-dads), constituted a larger portion of respondents than paternal relatives, including dads (and step-moms); 31% (n = 186) of family respondents were identified with the maternal side of the child's family while 22% (n = 134) were identified as paternal relatives. In all, 40 of the workgroups (63%) had at least one maternally- and one paternally-related participant complete a fidelity survey about the same FGC.

Figure 24. Identity of Participant Survey Respondents (n = 593)



Within the service provider respondents group, referring social workers or probation officers were the most highly represented (n = 47) and legal service providers (GAL, lawyer, advocates) were the second highest respondent group (n = 39). No surveys were received from domestic violence specialists.

Table 6 presents the breakdown of the Participant Survey respondents by their self-identified racial and ethnic identity, in the total sample and by participant type. The categories presented reflect the Federal definitions, where Hispanic identity supersedes others. Therefore the other race categorizations indicate the selection of a single race as well as non-Hispanic. Where respondents indicated more than one racial identity (n = 9), they were considered multiracial. Approximately half of these respondents identified as Native American and white, non-Hispanic, the other half of the multiracial respondents identified as black and white, non-Hispanic.

Table 6. Racial and Ethnic Identities of Participant Survey Respondents

	Overall		Service Providers		Family/Like-Family	
	Percent	*n*	*Percent*	*n*	*Percent*	*n*
White	82.8	481	89.5	145	80.0	325
Black	9.8	57	3.1	5	12.6	51
Hispanic	4.8	28	3.7	6	5.2	21
Multiracial	1.5	9	2.5	4	1.2	5
Asian	0.9	5	1.2	2	0.7	3
American Indian	0.2	1	0.0	0	0.2	1

Overall, the vast majority of respondents (83%) were White, non-Hispanic. The second most common identity selected, was Black; with almost 10% (n = 57) identifying with that category. Just five percent (n = 28) of respondents indicated they identified as Hispanic, Latino or Spanish in origin. Examining the breakdown of participants in the family/like-family and service provider groups, service providers were more likely to identify as white compared to family and like-family participants.[7]

OLMSTED FGC FIDELITY SCORES

To understand whether or not an intervention may have an effect, one must ascertain whether or not the model has been implemented with fidelity to its principles and practices. To that end, four domains of FGDM fidelity were examined: *Preparedness*, *Inclusion and Respect*, *Family Leadership*, and *Transparent Planning*. These four domains mirror the core principles and practices of family group decision making as established by the National Center on Family Group Decision Making (2012). The questions from the participant and coordinator/facilitator fidelity surveys were fit into these domains and are provided in Appendix F. To produce an overall Fidelity Score, scores on all the items composing the domains were averaged. In general, response options for fidelity questions ranged from Strongly Disagree (1) to Strongly Agree (6), with an additional not applicable/don't know option. Thus, a higher score reflects a higher endorsement of fidelity.

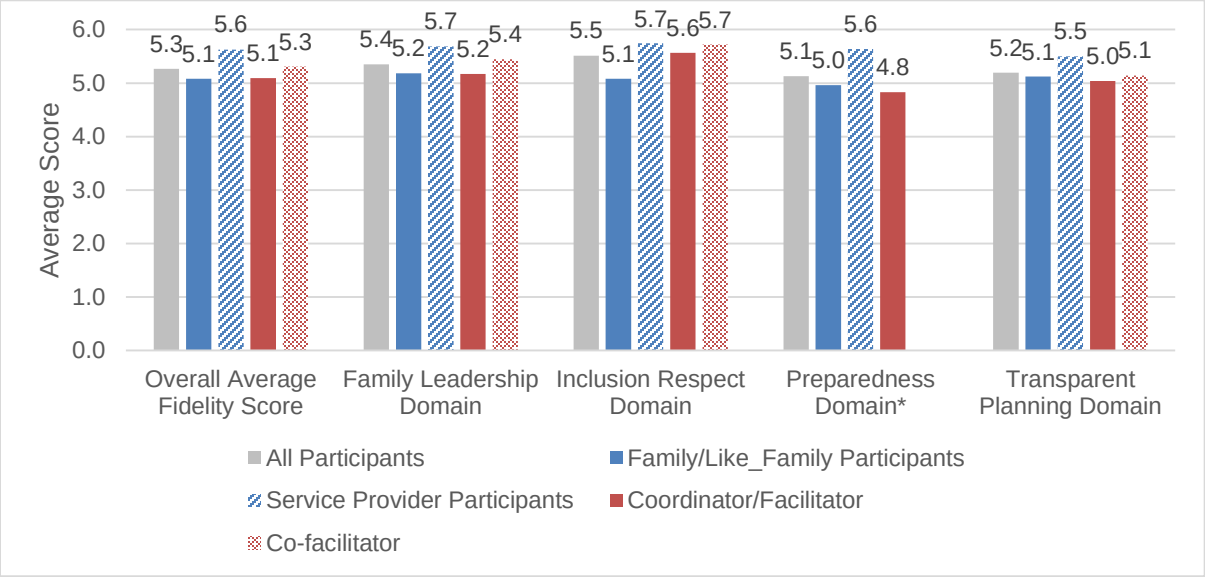
Overall and Domain-Specific Fidelity Scores by Participant Type. The FGC meeting-level scores indicated that, on average, FGCs achieved fidelity, overall and with respect to the four domains. Figure 25, below, presents the scores. With one exception, coordinator scores on preparedness, average scores across all participants and averages scores by participant type all exceeded five, indicating that

[7] Some respondents did not identify who they were in relation to the target child (e.g., aunt, therapist), but did identify their racial or Hispanic identity, thus the overall totals for race and ethnicity capture more information than the service provider or family-like family responses combined.

participants agreed that the elements assessed were in place. Still, score ranges varied depending on the construct.

Although we present the next figure with results by participant type next to each other, we strongly recommend that little weight or value be placed in the differences in scores between different types of participants. First, the number of items that were used to calculate the overall and domain-specific scores varied by participant type. For example, in the Preparedness Domain, the answers to ten questions were averaged to produce the family/like-family score, while for service providers only three items were used in the calculations, and none were answerable by co-facilitators. While this method, of using different items to construct a fidelity score depending on one's role with the workgroup, enables the family voice to be weighted more heavily, it negates the ability to make strict comparisons between different types of participants' results. On the other hand, as the results below explain, within participant type comparisons are possible.

Figure 25. FGC Fidelity Scores, Overall and by Type of Respondent (n = 63)



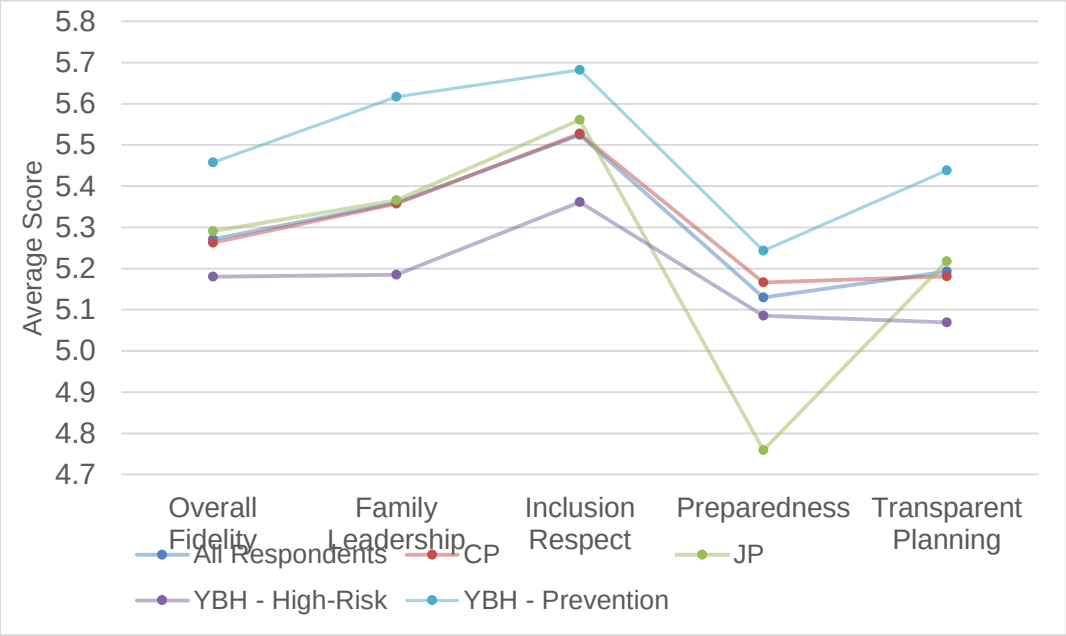
*Co-facilitator Preparedness Domain scores are not calculated as they are not involved in pre-meeting activities.

As the above figure indicates, on average, respondents of all types "agreed" that Olmsted's FGCs aligned with fidelity principles and in general, none of the domains received an overall score that was remarkably different from the others. Service providers' scores tended to average higher than others, and family/like-family members' scores were fairly similar to coordinators', but again, as the questions that constitute the respondents' scores differ according to their role, strict comparisons are not recommended.

Fidelity Scores by Study Unit. While comparisons between participant types are not appropriate, comparisons of scores associated with each study unit were possible. Figure 26 presents the score results by study unit. ANOVAs examining whether the average overall score or individual domain scores varied significantly by study unit indicated that observed differences were not statistically significant. That said,

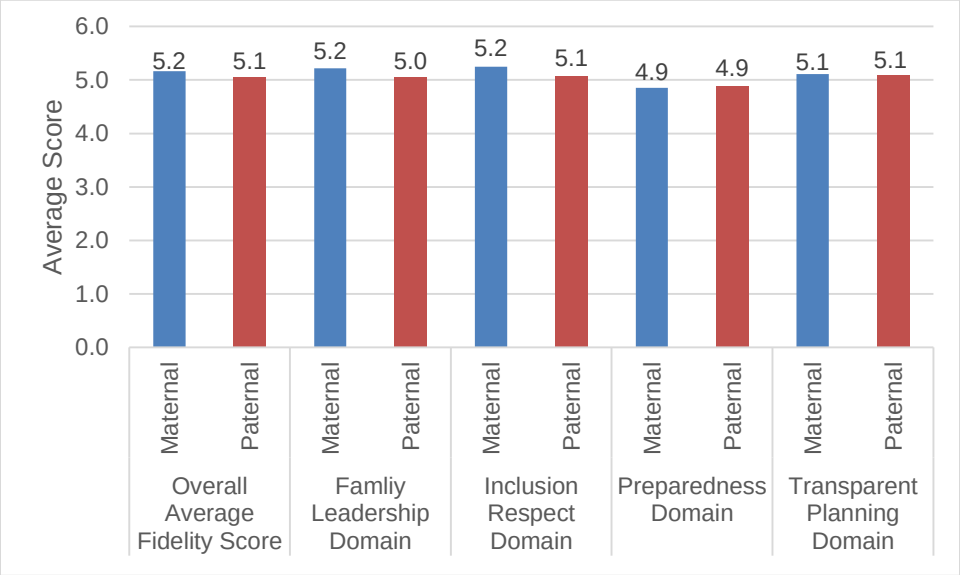
the results indicated a trend towards significance ($t(3)$, $p = .058$) when the CP vs JP units' scores on the Preparedness Domain were compared.

Figure 26. Fidelity Scores by Study Unit (n = 63)



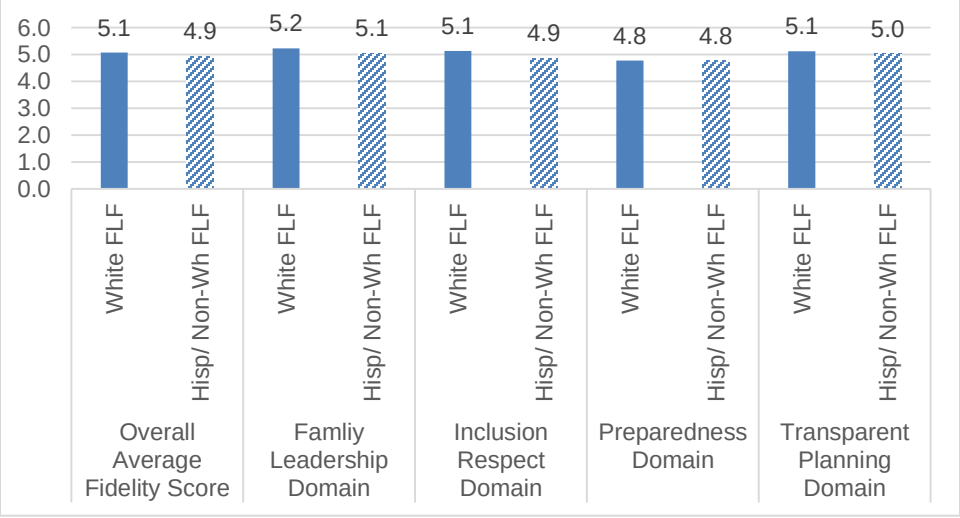
Maternal versus Paternal Respondents' Fidelity Scores. Since fidelity scores can be compared within respondent groups (i.e., family/like-family, service providers, etc.), we conducted additional analyses to determine if and how respondents differed in their perspectives. Average scores were calculated for all maternal and all paternal participants in each FGC, where a representative from both sides could be identified (n = 40, See Figure 27). Paired sample t-tests, which examine the maternal vs. paternal fidelity scores overall $t(39) = 1.190$, $p = .241$) and for each domain (Family Leadership: $t(35) = 1.714$, $p = .095$; Inclusion Respect $t(39) = 1.614$, $p = .115$; Preparedness $t(39) = .233$, $p = .817$; Transparent Planning $t(21) = 1.012$, $p = .323$), found no statistically significant differences in the scores. This suggests that, based on these data, both sides reflected similarly on the tenor, process, and dynamics of the FGC.

Figure 27. Average Maternal vs. Paternal Family/Like-Family Fidelity Scores (n = 40)



Family/Like-Family Fidelity Scores by Race and Ethnicity. In 22 workgroups, some family/like-family respondents self-identified as white, non-Hispanic while others self-identified as Hispanic or non-White. As illustrated in Figure 28 below, no significant differences were detected with respect to overall fidelity ($t(21) = 1.012$, $p = .323$) or any of the four domains (Family Leadership: $t(17) = 1.350$, $p = .195$; Inclusion Respect $t(21) = 1.9292$, $p = .067$; Preparedness $t(21) = 0.083$, $p = .935$; Transparent Planning $t(21) = 1.012$, $p = .323$) when responses from white family/like-family members and nonwhite family/like-family members were compared.

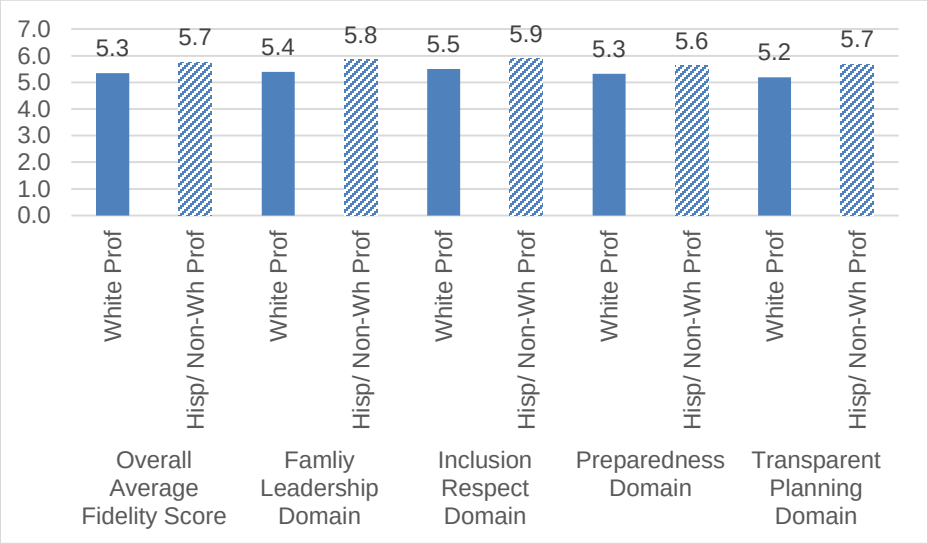
Figure 28. Average White, Non-Hispanic vs Hispanic or Non-White Family/Like Family Scores (n = 22)



In addition, as illustrated in Figure 29 below, none of the comparisons of Hispanic or non-White professionals and White professionals' results using paired sample t-tests, reached statistical

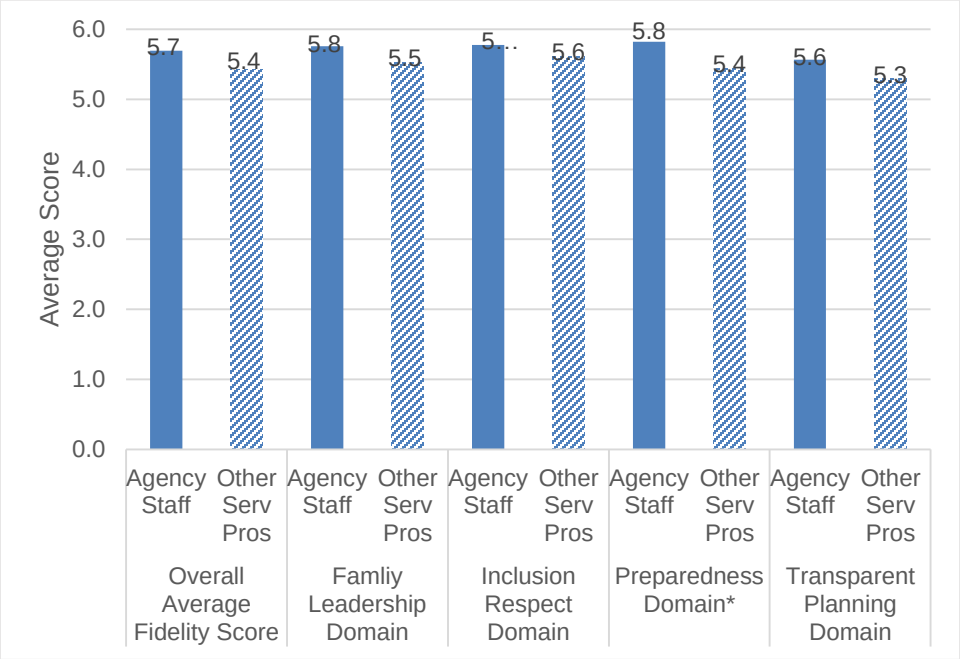
significance (Overall $t(13) = 2.020$, $p = .064$; Family Leadership: $t(11) = 1.804$, $p = .099$; Inclusion Respect $t(11) = 1.631$, $p = .131$; Preparedness $t(12) = 1.266$, $p = .230$; Transparent Planning $t(11) = 2.155$, $p = .058$).

Figure 29. White Non-Hispanic vs. Hispanic or Non-White Professionals' Fidelity Scores (n = 14)



OCCS Staff versus Other Service Provider Fidelity Scores. Additional tests were run to examine perspectives of OCCS staff compared to other service providers attending the same FGC (n = 40, See Figure 30). In all but one area, scores were statistically undistinguishable (Overall $t(39) = 1.666$, $p = .104$; Family Leadership: $t(37) = 1.329$, $p = .192$; Inclusion Respect $t(37) = 1.030$, $p = .310$; Transparent Planning $t(37) = 1.439$, $p = .158$). Still, the analysis did find that, on average, OCCS staff were more likely to score the Preparedness domain higher than other service providers ($t(38) = 2.366$, $p = .023$). While statistically significant, this result may simply reflect that those staff working at OCCS likely have greater familiarity with the FGC dynamics than providers from outside the agency, either due to FEC training or to participation in prior FGC meetings.

Figure 30. OCCS Staff vs. Other Service Providers' Fidelity Scores (n = 40)



* $p < .05$

Participant Comments on "Things that Went Well". Participants were asked to comment on things that went well in the FGC. The list below presents a summary of themes from the comments. Overall, participants most frequently commented on the fact that the family was brought together and a plan was developed as indicators of things that went well.

- The meeting enabled the identification of multiple sources of support within the family
- The introduction of maternal and paternal family who had not met each other
- The children had a voice
- The meeting enabled dialogue between family
- Engaging remotely-based family whether through technology or having them attend in person
- There was good family turnout
- The meeting helped communicate to parent issues and resources at hand
- Questions were asked and answered
- The production of a plan with details

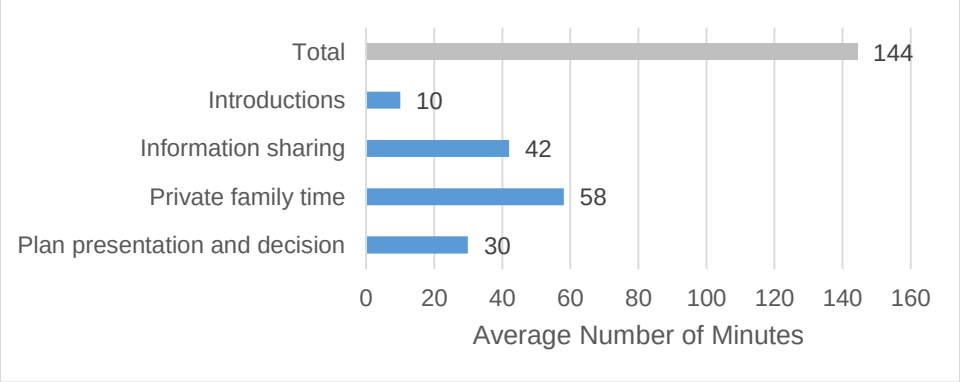
Participant Comments on "Things that Could Be Improved". Similarly, participants were asked to identify some things that could be improved. The most common challenge identified pertained to technological problems that interfered with remote participants' ability to communicate, be heard and participate effectively. Other comments regarding challenges indicated occasional issues around:

- The amount of time that passed between referral and actual meeting; meeting timing was late in the process;
- Relevant and/or opposing kin not being in attendance;
- Management of conflict between and disruptive behavior of family members;

- Inadequate details (what by whom by when) in plan, absence of contingency planning, and consequences of failure to complete plan were unclear;
- Some family/like-family would have liked more preparation for the meeting;
- Service providers were unclear about their role (i.e., were unprepared to provide information about resources for the family and did not feel privy to family's plan); and
- A need for oral or visual reminders to remind participants about the mission of the meeting and what needs to be accomplished during private family time.

Length of the FGC Meetings and Plan Acceptance. Coordinator and Facilitators Survey respondents were asked how much time it took to complete particular elements of the FGC. Figure 31 presents the average length of time overall, and by four FGC subparts: introductions; information sharing; private family time; and plan presentation and decision. On average, FGCs lasted about 144 minutes (SD = 59, Median = 130), although the range spanned from a minimum of 40 minutes to a maximum of 325. Overall, private family time had the longest average number of minutes, compared to the other portions of the FGC.

Figure 31. Length of FGC Meetings (n = 63)



Family plans were accepted in 90% (n = 47) of the 52 FGCs for which a coordinator or facilitator reported the data.

Follow-Up Family Group Conferences

For 29 (45%) of the 65 workgroups that had a first FGC, a follow-up family group conference also took place during the study period. According to the Meeting Log, these follow-ups, also called FGC2s, took place anywhere from 15 to 119 days after the first FGC and the median number of days between first and second FGC was 60 (*M* = 64, *SD* = 27). Eighty percent (n = 24) of the workgroups who had an FGC2 were originally referred by the CP unit, YBH-High Risk Placement and JP referred 10% (n= 3 and n = 2, respectively) and YBH-Prevention referred 3% (n =1). Chi-square analysis indicated that the likelihood of a second FGC taking place did not differ significantly by study unit (*Likelihood Ratio* $x^2(3) = 3.44$, $p = .329$). Further, there is no evidence that the identity of the coordinator for the first FGC influenced either the likelihood (*Likelihood Ratio* $x^2(27) = 32.20$, $p = .225$) or the timing (*Welch's* $F(4, 9.9) = .423$, $p = .789$) of a second FGC. Moreover, the average age of children associated with a second FGC was no different from

the average age of children who did not experiences a second FGC ($t(63) = .179$, $p = .859$), suggesting that the target child's age did not influence whether or not a second FGC took place.

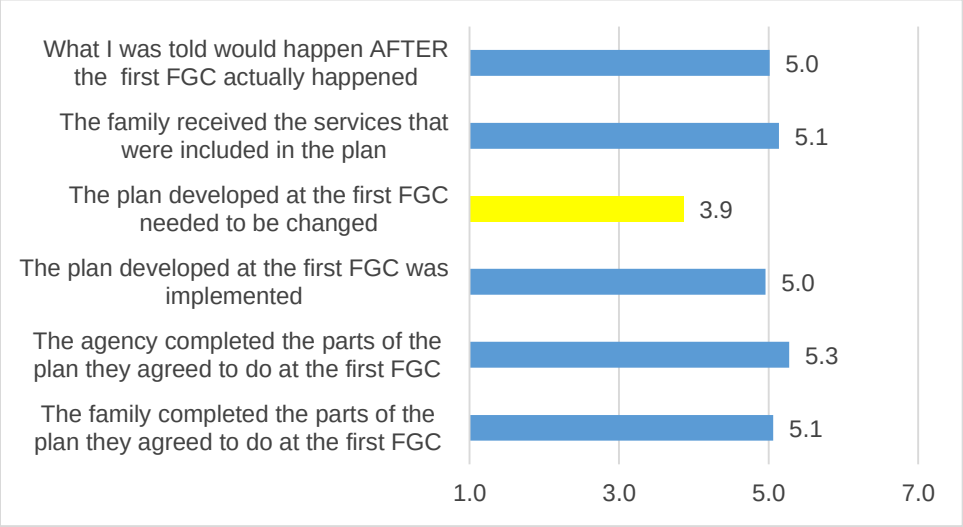
When follow-up FGC took place, coordinators again facilitated remote involvement by family, like-family or service providers via phone or video services. Overall, 63% (n = 19) of the FGC2s involved at least one remote participant. Phone participants were reported in the Meeting Log for 50% (n = 15) of the FGC2s; video participants were indicated in 27% (n= 8) of the FGC2s.

All told, 90 Follow-Up Participant Fidelity Surveys were received, reflecting on 13 FGC2s associated with 12 workgroups; one workgroup had two follow up FGC meetings eight months apart. Most respondents were family/like family, the rest were service providers. Most (83%, n = 75) of respondents had attended the prior FGC.

Participants were asked to indicate their level of agreement with a series of statements reflecting things that happened between the first and second FGC, as well as things that happened during the second FGC. Figure 32 presents the between meeting scores and Figure 24 presents the "during meeting" scores. Response options included Strongly Disagree (1), Disagree (2), Slightly Disagree (3), Slightly Agree (4) Agree (5), Strongly Agree (6) and a Don't Know/NA option, too. Items where a lower score is preferable are highlighted in yellow.

Overall and on average, scores were over five, indicating that respondents agreed that the desired activities took place. Still, a score of 3.9 shows some slight agreement that the plan developed at the first FGC had to be changed.

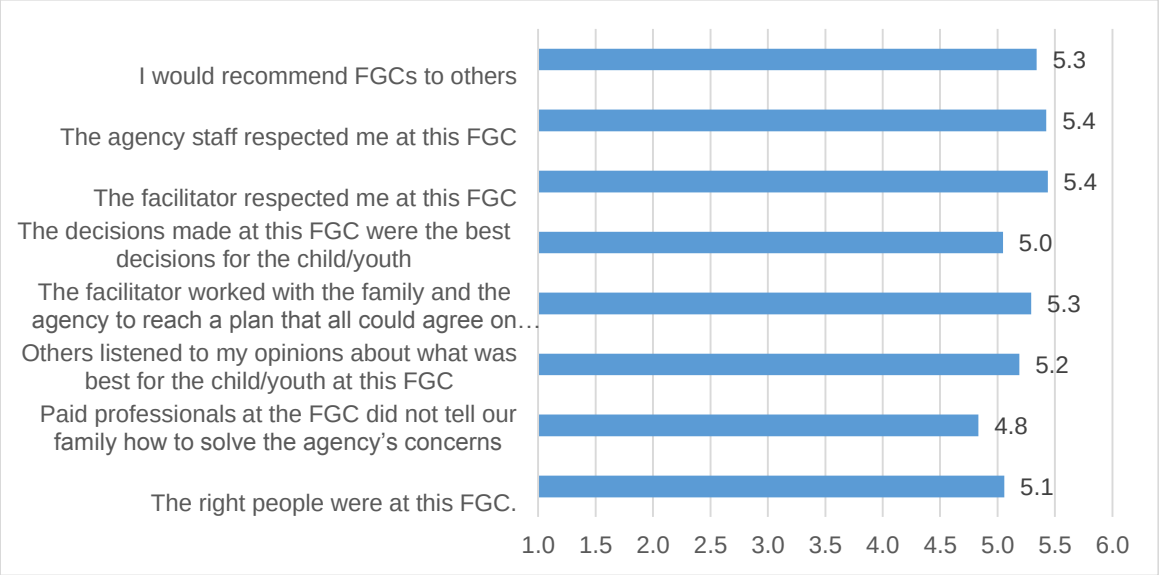
Figure 32. Activities between First and Second FGC (n = 80)



With respect to event and dynamics during the FGC2, respondents showed a little more variation, but again, largely indicated they agreed that the elements asked about had happened. Figure 33 presents the average score across respondents for these items. Respondents generally indicated agreement with items

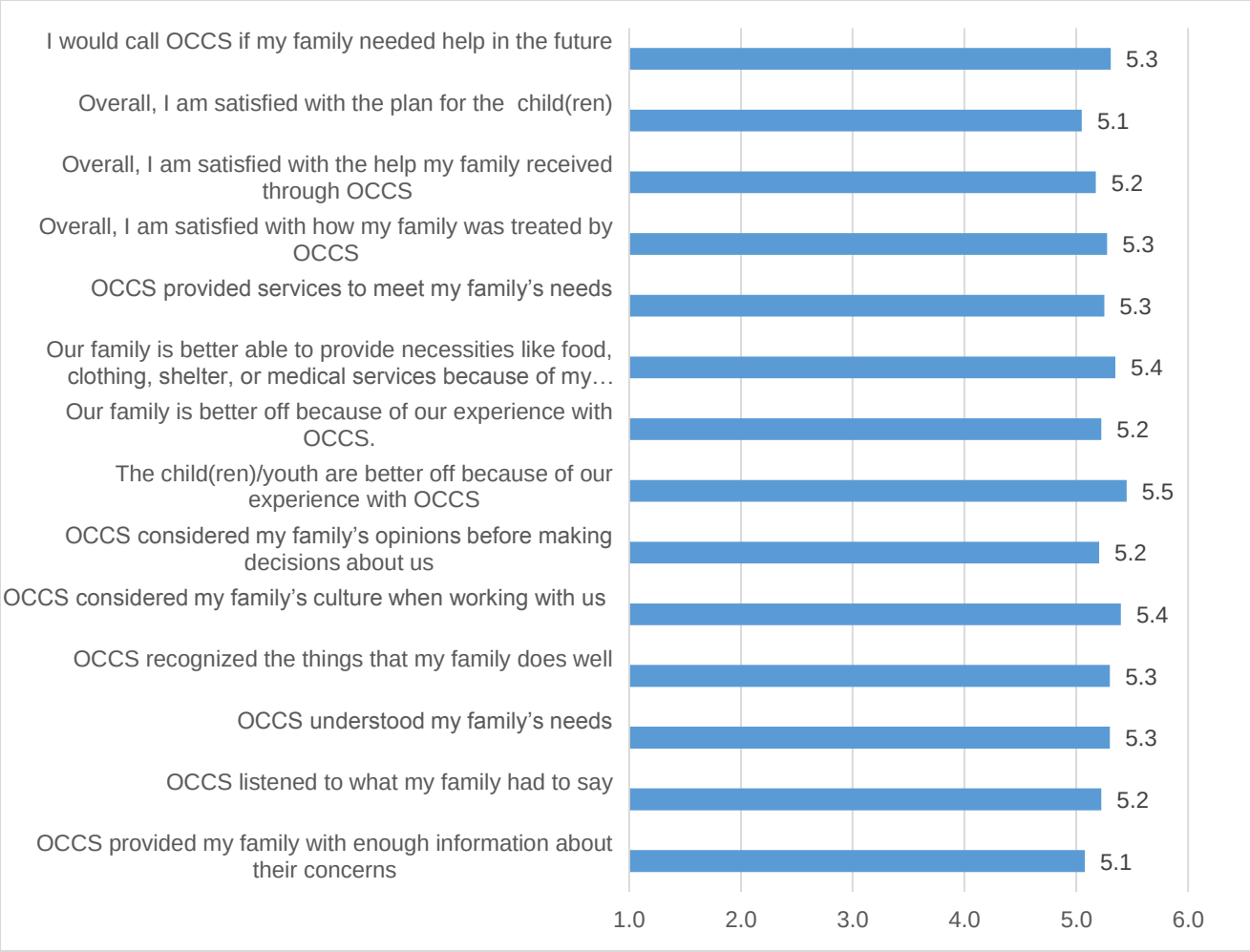
such as feeling respected, would recommend an FGC to others, felt the facilitator facilitated the case plan finalization and that people listened to their opinions. Notable, however is that the item scoring the lowest level of agreement (by a small margin), pertained to whether paid professionals told the family how to solve their concerns. Since a lower score indicates less agreement on average compared to the other statements, this is an area where respondents were slightly less positive about the meetings. Indeed, while the difference was not large, further statistical analyses indicate that the lower score for this item and the lower scores for the items pertaining to whether the right people were at the meeting, or whether the decisions made for the child were the best for the child/youth were statistically different from the scores of the other items (Mauchly's $x^2(27) = 302.6$, p=.000; Greenhouse-Geisser $F(2.728, 141.855) = 7.041$, $p = .000$). In other words, on average, while in some instances differences in scores are within a range that means they are not meaningful, in these instances, respondents felt less agreement with these items than they did with the other items.

Figure 33. Experience during Second FGCs (n = 87)



The Follow-Up FGC Fidelity Survey also invited family members to fill out section about satisfaction with their experience with OCCS. Of the 90 surveys received, 53% (n = 48) came from family members; the remaining surveys came from service providers. 40 of the potential 48 family participants completed this portion of the survey. Results are provided in Figure 34.

Figure 34. Family Participants' Satisfaction with Experience (n = 40)



Family members were asked whether they received any one of 17 services due to their involvement with OCCS. Ten family member completed this portion of the survey. Half of them indicated they had received mental health services and half indicated they received support group services. Four indicated they had received services from a youth organization, three indicated receiving school-related or legal services, two reported getting help from neighbors or alcohol or drug rehab agency services, and only one respondent indicated they had received each of the following: neighborhood organization services, child care/Head Start; domestic violence services; emergency food provider services, health care, job/employment, church-related, recreational facility services. None of the ten respondents indicated they received help from extended family as a result of their involvement with OCCS.

Family respondents were asked to indicate how effective the services had been if they had received them. Response options ranged from "Not at all effective (1)" to "Very Effective (4)." Fifteen family members answered the question and the mean score was 3.73 (*SD* = .458*)* indicating that they felt the services were between moderately to very effective.

When participants were asked if there was any help they needed but did not receive, one respondent indicated the couple had not been given fair notice about the decision to file for termination of parental rights and another simply stated “answers.”

When family participants provided comments, they centered on the following themes:

- Progress family has made was not recognized.
- Permanency decision not fair/transparent.
- Grateful for opportunity to come together; meeting moved along smoothly.
- Thankful for support of family’s needs.

Appendix F: FGC Fidelity Domain Composition

Domain	Participant Survey Questions	Coordinator/Facilitator Survey Questions
Family Leadership	Service Providers did not tell the family how to solve the agency's concerns.	I believe the agency was open to the family's ideas and decision making abilities
	There was a chance to ask questions about the information presented by the agency and other service providers.	The child's ideas or needs were considered in the plan
	Others listened to my opinions about what was best for the child.	I believe the agency staff did not have a predetermined outcome for this family meeting
	The family had private time to create a plan.	I did not share my opinion during the FGC
	My opinions were included in the plan.	
	The child's ideas or needs were considered in the plan.	
Inclusion and Respect	Members of Mom's side of the family were invited to the FGC.*	The agency staff were respectful to the family during the FGC.
	Members of Dad's family were invited to the FGC.*	In determining the time and location of the FGC, I discussed options with the family
	Service Providers were invited to the FGC.*	I felt safe at the FGC.
	Other people who feel "like family" (neighbors, friends) were invited to the FGC.*	
	I helped determine when and where the FGC would be held.*	
	I felt safe at the FGC.	
	The facilitator respected me.	
	The agency staff respected me.*	
	The facilitator was flexible in meeting the needs of participants.	
	The right people were at the FGC.*	
Preparedness	I understand the agency's concerns about the child.	I had a clear understanding of the agency's concerns about the child.
	I understand the purpose of the FGC.	I had a clear understanding of the purpose of the FGC.
	The Coordinator prepared me to participate in the FGC.	I believe that I encountered resistance from family members to participate
	I was asked if I needed any help to attend the FGC (child care, transportation).	I believe I encountered resistance from service providers to participate
		As needed, I arranged for assistance to enable family members to attend the FGC
Transparent Planning	The purpose of the FGC was clearly described.	I described the purpose of the FGC
	The child welfare agency staff told us the agency's concerns that the plan would need to address.*	The agency staff clearly told all participants the agency's concerns that the plan would need to address.

Appendix F: FGC Fidelity Domain Composition

Domain	Participant Survey Questions	Coordinator/Facilitator Survey Questions
	The plan includes things for family members to do.	I asked the family if they had any questions or needed clarification about the information presented by the service providers
	The plan includes things for the agency to do.	The plan had things for family members to do
	The plan clearly states who is doing what by when.	The plan had things for the agency to do
	The facilitator worked with the family and the agency to reach a final plan that all could agree on.	The plan clearly states who is doing what by when.
	The plan was accepted by the agency at the family meeting.	I facilitated discussions between the family and the agency for them to reach consensus on the plan
	The plan made at the FGC was best for the child.	
	A follow-up FGC was scheduled	

* Only family and like-family participant responses were used for these items

In addition to overall scores and corresponding levels of connectedness, responses to the YCS can be broken out into items within each sub-section. Section A of the YCS, Tools for Youth Connections, asked whether a genogram or Lifebook had been created with the youth. Genograms were more commonly completed (with 35.3% of youth) than Lifebooks (6.7%), although most youth had not completed either a genogram or a Lifebook. It should be noted that Lifebooks are more typically used in the adoption stage of service in Olmsted County and thus is it not surprising that this tool had been employed at such a low rate with these populations of youth.

Section B of the YCS asks youth about the number of supportive adult connections they have across a number of different categories. In the scoring of the YCS, relationships with mother(s) and father(s) are weighted more heavily, and maximum numbers of adults within each category are specified. Table 7 below, on the other hand, presents raw data from youth regarding average number of adult connections in descending order.

Table 7: Number of Supportive Adult Connections at Pretest

Adult Relationship Category	Mean # of Adult Relationships in each Category (Range)
An adult friend, mentor or sponsor	3.65 (0-30)
Other adult relatives	3.20 (0-20)
Adult siblings	2.15 (0-8)
Current/former teacher	2.05 (0-8)
Mother (birth, adoptive, step)	1.60 (0-4)
Current/former social worker	1.45 (0-8)
Current/former therapist, counselor or psychologist	1.35 (0-4)
Father (birth, adoptive, step)	0.95 (0-4)
Current foster parent	0.70 (0-2)
Other adults	0.67 (0-4)
Pastor, rabbi or other spiritual leader	0.35 (0-2)
Former foster parent	0.20 (0-2)

As described above, at the high end, youth had an average of almost 4 adult friends, mentors or sponsors, while most did not have meaningful relationships with pastors, rabbis, or other spiritual leaders, or former foster parents at the time of FEC referral.

Appendix G: Youth Connections Scale Sub-Scale Analyses

Section C, which assessed the Strength of Youth Connections, suggested that youth have the strongest connections with their siblings and with the parent with whom they have the most meaningful relationship, as well as other caring adults (Table 8). Connections were less strong with other adult relatives and with the youth's second parent.

Table 8. Strength of Youth Connections at Pretest

Adult Relationship Category	N (%)	Mean*
Parent 1		3.00
Very Strong (4)	10 (50.0%)	
Strong (3)	3 (15.0%)	
Moderate (2)	3 (15.0%)	
Weak (1)	2 (10.0%)	
Very Weak (0)	1 (5.0%)	
N/A	1 (5.0%)	
Parent 2		2.45
Very Strong (4)	6 (30.0%)	
Strong (3)	2 (10.0%)	
Moderate (2)	4 (20.0%)	
Weak (1)	1 (5.0%)	
Very Weak (0)	5 (25.0%)	
N/A	2 (10.0%)	
Siblings		3.05
Very Strong (4)	9 (45.0%)	
Strong (3)	4 (20.0%)	
Moderate (2)	5 (25.0%)	
Weak (1)	0 (0.0%)	
Very Weak (0)	1 (5.0%)	
N/A	2 (10.0%)	
Other adult relatives		2.39
Very Strong (4)	4 (20.0%)	
Strong (3)	4 (20.0%)	
Moderate (2)	7 (35.0%)	
Weak (1)	1 (5.0%)	
Very Weak (0)	2 (10.0%)	
N/A	2 (10.0%)	
Other caring adult identified by youth 1		2.80
Very Strong (4)	5 (27.8%)	
Strong (3)	3 (16.7%)	
Moderate (2)	6 (33.3%)	
Weak (1)	1 (5.6%)	
Very Weak (0)	0 (0.0%)	
N/A	3 (16.7%)	
Other caring adult identified by youth 2		3.38
Very Strong (4)	8 (53.3%)	

Adult Relationship Category	N (%)	Mean*
Strong (3)	3 (20.0%)	
Moderate (2)	1 (6.7%)	
Weak (1)	1 (6.7%)	
Very Weak (0)	0 (0.0%)	
N/A	2 (13.3%)	

*scale of 0-4, excluding those who answer 'N/A'

Section D of the YCS assessed the Number of Support Indicators that the youth endorses. Most youth reported having a majority of support indicators (Table 9). Almost all youth reported having a place to stay in case of an emergency (95%) and having someone to assist them with medical appointments (95%). Although still endorsed by most youth, the least common indicators included having a person to provide cash in times of emergency (75%), help with finding an apartment or co-signing a lease (75%), and support in civic engagement such as voting or volunteering (70%).

Table 9. Support Indicators at Pretest

Indicator	N (%)
Providing a home to go to for the holidays	
Yes	18 (90.0%)
No	2 (10.0%)
Providing an emergency place to stay	
Yes	19 (95.0%)
No	1 (5.0%)
Providing cash in times of emergency	
Yes	15 (75.0%)
No	5 (25.0%)
Help with job search assistance or career counseling, or providing a reference for youth	
Yes	18 (90.0%)
No	2 (10.0%)
Help with finding an apartment or co-signing a lease	
Yes	15 (75.0%)
No	5 (25.0%)
Help with school	
Yes	17 (85.0%)
No	3 (15.0%)
Assisting with daily living skills, such as cooking, budgeting, paying bills and housecleaning	
Yes	15 (80.0%)
No	4 (20.0%)
Providing storage space during transition times	
Yes	18 (90.0%)

Indicator	N (%)
No	2 (10.0%)
Emotional support – a caring adult to talk to	
Yes	18 (90.0%)
No	2 (10.0%)
Sharing in or supporting experiences of youth's cultural and spiritual background	
Yes	17 (85.0%)
No	3 (15.0%)
Checking in on youth regularly – to see how they are doing	
Yes	18 (90.0%)
No	2 (10.0%)
Assisting with medical appointments so youth does not have to experience that alone	
Yes	19 (95.0%)
No	1 (5.0%)
Assisting with finding and accessing community resources	
Yes	18 (90.0%)
No	2 (10.0%)
A home to go for occasional family meals	
Yes	17 (85.0%)
No	3 (15.0%)
Help providing transportation or figuring out public transportation	
Yes	18 (90.0%)
No	2 (10.0%)
Someone to send care packages at college	
Yes	16 (80.0%)
No	4 (20.0%)
Assisting with purchasing cell phone and service	
Yes	17 (85.0%)
No	3 (85.0%)
A place to do laundry	
Yes	16 (84.2%)
No	3 (15.8%)
Supporting youth in civic engagement such as voting and volunteering	
Yes	14 (70.0%)
No	6 (30.0%)

The final section of the YCS assesses the Level of Youth Connections. At pretest, most youth reported strongly agreeing or agreeing to having connected with relatives or caring adults who will be lifelong supportive connections while in foster care (70%), while several strongly disagreed (15%) (Table 10). An

even larger majority agreed or strongly agreed that an adult has made a commitment to provide a permanent, parent-like relationship to the youth (85%), with only 10% strongly disagreeing. Most youth did not report feeling disconnected from any caring adults while in placement (75%). Finally, most youth either disagreed or strongly disagreed that they were living with an adult who has or plans to adopt them (88.9%). However, this item may have been more or less applicable depending on the placement situation of the youth at the time of YCS pretest completion. For example, a youth in a residential or corrections facility would be unlikely to agree that they were living with an adult with plans to adopt; thus, this is not necessarily a negative or surprising finding given the target populations of youth completing this survey.

Table 10. Level of Youth Connections at Pretest*

Indicator	N (%)	Mean*
While in foster care, you have connected or re-connected with relatives or caring adults who will be lifelong supportive connections†		2.70
Strongly Agree (4)	6 (30.0%)	
Agree (3)	8 (40.0%)	
Neutral (2)	3 (15.0%)	
Disagree (1)	0 (0.0%)	
Strongly Disagree (0)	3 (15.0%)	
An adult has made a commitment to provide a permanent, parent-like relationship to you†		3.10
Strongly Agree (4)	9 (45.0%)	
Agree (3)	8 (40.0%)	
Neutral (2)	1 (5.0%)	
Disagree (1)	0 (0.0)	
Strongly Disagree (0)	2 (10.0%)	
You are living with an adult who has or plans to adopt you or become your legal guardian†		0.56
Strongly Agree (4)	1 (5.6%)	
Agree (3)	1 (5.6%)	
Neutral (2)	0 (0.0%)	
Disagree (1)	3 (16.7%)	
Strongly Disagree (0)	13 (72.2%)	
You feel very disconnected from any caring adults*†		0.75
Strongly Agree (4)	0 (0.0%)	
Agree (3)	1 (5.0%)	
Neutral (2)	4 (20.0%)	
Disagree (1)	4 (20.0%)	
Strongly Disagree (0)	11 (55.0%)	

*scale from 1-4

†a lower score indicates a lower level of connectedness

*†a higher score indicates a lower level of connectedness

Billed services were divided into categories of basic needs, child care services, financial services, mental health services, other services, and substance abuse services using the categorization scheme described in Table 11 below. Each youth was then coded as having either received or not received at least one of the services matching each of the categories. Services for which the fee was refunded were excluded.

Table 11. Categorization of Billed Services

Category of Interest	Billed Service Descriptions
Basic Needs	• Environmental Accessibility Adaptations, Special Supplies & Equipment • Housing Access Services / Housing Services • Housing Subsidy • Transportation • Supervised Independent Living (18 up to 21) • Health-Related Services
Child Care Services	• Other Child Care
Financial Services	• Client Flex Funds
Mental Health Services	• Family-Based Counseling Services • Other Family Community Support Services
Other Services	• Court-Related Services and Activities • Adolescent Life Skills Training • Assessment for Long-Term Services and Supports • Family-Based Services • Interpreter Services • Parent Support Outreach Services • Social and Recreational
Substance Abuse Services	• Rule 25 Assessment/Rule 24 Financial Eligibility Determination