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Final Report

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Program Name: Found, Engaged and Connected: Innovating for Olmsted County's Most Vulnerable Children & Youth

City and State: Rochester, Minnesota

Reporting Period: September 29, 2012 to September 30, 2016

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I. Executive Summary

Summary

Found, Engaged and Connected: Innovating for Olmsted County's Most Vulnerable Children & Youth is a project that combines the expertise and tenured experience of Olmsted County Community Services, Family Service Rochester with the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, The National Institute for Permanent Family Connectedness (NIPFC) and National Council on Crime and Delinquency (CRC/NCCD), to test the effectiveness of an integrated family finding and family group decision making (FGDM) model to increase connections and improve social and emotional well-being for a highly vulnerable group of children and youth. The Found, Engaged and Connected (FEC) project's main emphasis was to integrate family finding/FGDM model in Olmsted County that would:

- Expand the practice both within and beyond the child protection population into these populations where FGC was previously under-utilized within OCCS.
- Incorporate the more advanced approaches to discovery and initial engagement embodied by Family Finding to bring more family members to the table.
- Strengthen and emphasize the ongoing work done with families via the Family Finding model in order to maintain the continuity and momentum created at the FGC.
- Give preference to the plan developed by the family over any other plan as long as the agency's concerns are addressed.
- Shift from an event-driven family meeting culture to one in which families continued their decision-making involvement until permanency was achieved and/or ongoing network was established and supported.

Project Overview

The project model was organized and approached as three significant areas: 1.) Community Engagement, 2.) Imbed FF/FGDM philosophy into the fabric of Olmsted County's child welfare & juvenile corrections practice, and 3.) Develop and implement an integrated FF/FGDM process. The integration of Family Finding and FGDM required the attention to fidelity and best practices of both models grounded in culturally-based practice. Strategies were utilized to engage community partners through the development of the Think Family Stakeholder Committee that allowed the opportunity to build community stakeholder engagement with the project and to provide a venue for project updates. Additionally, the culture of the child welfare and juvenile corrections practice needed to support on-going family involvement in planning for children/youth. The establishment of the Peer Networking Group (PNG) comprising of cross-agency representatives who championed family engagement and involvement in planning for youth within their respective teams became an effective tool in building organizational culture.

Evaluation

Regarding the evaluation, challenges in data collection and low referral rates precluded the ability of the evaluation team to conduct the planned outcome analysis utilizing a historical comparison group. However, process analyses yielded findings around implementation, including barriers and challenges particularly as it related to expanding the use of the integrated model outside of the traditional CPS setting. Fidelity findings demonstrated that fidelity was achieved in the majority of meetings held, across populations, and that perception was shared across participant types. Staff survey findings showed the variation in perceptions of FGC and FIS across OCCS units. Youth Connections Scale findings are descriptive in nature given the low sample size for this survey, and especially for the posttest but demonstrate that target youth had, on average, a moderate level of adult connections at the time of referral to the study. The cost analysis was limited to a cost allocation which found the average cost to provide an FGC, including staff time, agency overhead costs, and direct costs to be approximately $2,700.

Key Lessons Learned

In summary, the agency's capacity to provide a continuum of family conference models allowed the system and the family to come together early in their work with one another. A rigorous integrated FF/FGDM process requires intensive family finding and engagement. In order to assure fidelity to the model, the scheduling of the FF/FGDM conference needed to occur within the context of the child's *entire* family's (maternal & paternal) readiness to come to the table. The integration of FIS meeting models early and throughout the case work with families further enhanced family finding and achieved ongoing engagement of the family in decision-making throughout the process.

Additionally, engagement of new target population served in Youth Behavioral Health and Juvenile Corrections required strategies within project implementation to embrace in the purpose and benefit of the engagement of a wider "family" network. The establishment of the Peer Network Group (PNG) and Think Family group assisted in supporting an organizational culture shift. Organizational capacity to recognize and have confidence in the family group to be key decision-making partners in planning for child safety, permanency, and well-being is fundamental to successfully implement an integrated FF/FGDM.

II. Overview of Community, Population and Needs

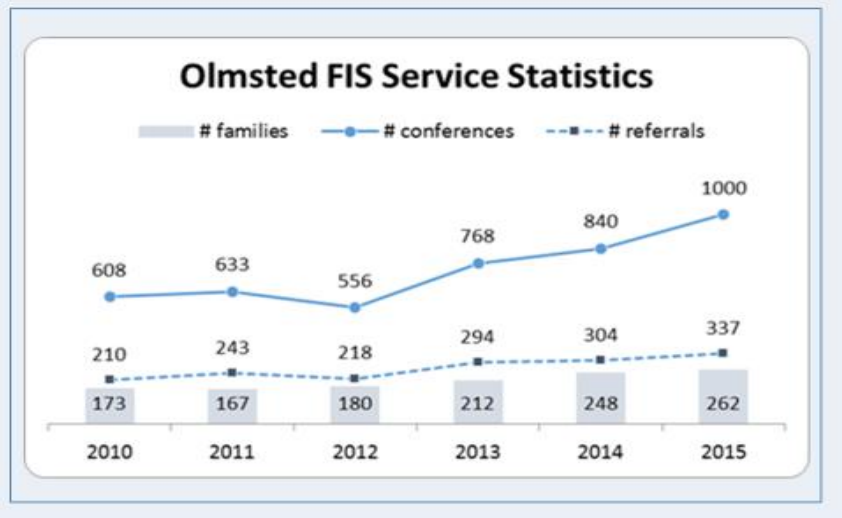
Description of Olmsted County Community Services

Olmsted County Community Services is a public county organization with a vision to be a safe, thriving, and inclusive community. Olmsted County Community Services has four divisions: Adult & Family Services Division; Child & Family Services Division; Community Corrections; and Family Support & Assistance Division (Appendix A-1). Through direct service delivery, as well as contractual partnerships with community agencies, Olmsted County Community Services delivers a wide array of services targeted to support child safety, well-being, and permanency. Over the past 15 years the agency has focused on a practice model that is family-centered and builds upon partnerships and collaboration.

Olmsted County Community Services provides a comprehensive training schedule for social workers and other department staff regarding early identification of mental health diagnoses and referral procedures. Social workers and probation officers are trained to complete regular mental health screenings on all children served and regularly consult with internal and local experts on behavioral health issues for adults, adolescents and children. These relationships also apply to the Family Group Decision Making (FGDM) coordinators who call upon community providers to participate in a family meeting and share their specific knowledge, allowing family to have accurate information to develop their family plan. FGDM is provided by Family Service Rochester through their Family Involvement Strategies (FIS) team and embedded within Olmsted County Community Services. These services are critical to positive outcomes for children – including safety, stability, and timely establishment of permanency. Recognizing the inherent imbalance of power between the statutory agency and the family, FGDM conferences are facilitated by independent, non-case carrying coordinators/facilitators. Early identification and engagement of family members assist in keeping children safe while maintaining family connections. FGDM addresses over representation of children of color in the child welfare system and

the disparate outcomes for these children by finding and engaging their "family" network to actively participate in making critical decisions regarding the safety, permanency and well-being needs of the child(ren) within the context of their culture. Through embracing FIS/FGDM values, Olmsted County commits to anti oppressive and culturally respectful practices that are fair, equitable and ensure child safety, permanency and well-being.

Figure 1: FIS Statistics



# Unduplicated Youth Served	
2008	290
2009	310
2010	293
2011	304
2012	295
2013	311
2014	355
2015	439

Description of Family Service Rochester

Family Service Rochester (FSR) is a private non-profit organization that has served Olmsted County, Minnesota residents since 1965. For the past 19 years, FSR's focus has been working with families with serious child welfare and/or family violence concerns. Major areas of work are in: counseling, case management, educational programming, supervised visitation, and a 17-year delivery of FIS/FGDM and family finding.

Family Service Rochester Family Involvement Strategies are described as both an evidence-informed practice and a transformational strategy, with the fundamental goal of engaging the family in a decision-making process when their children come to the attention of the child welfare and/or juvenile corrections system. Originating from an anti-racist, anti-oppressive framework, Family Service Rochester

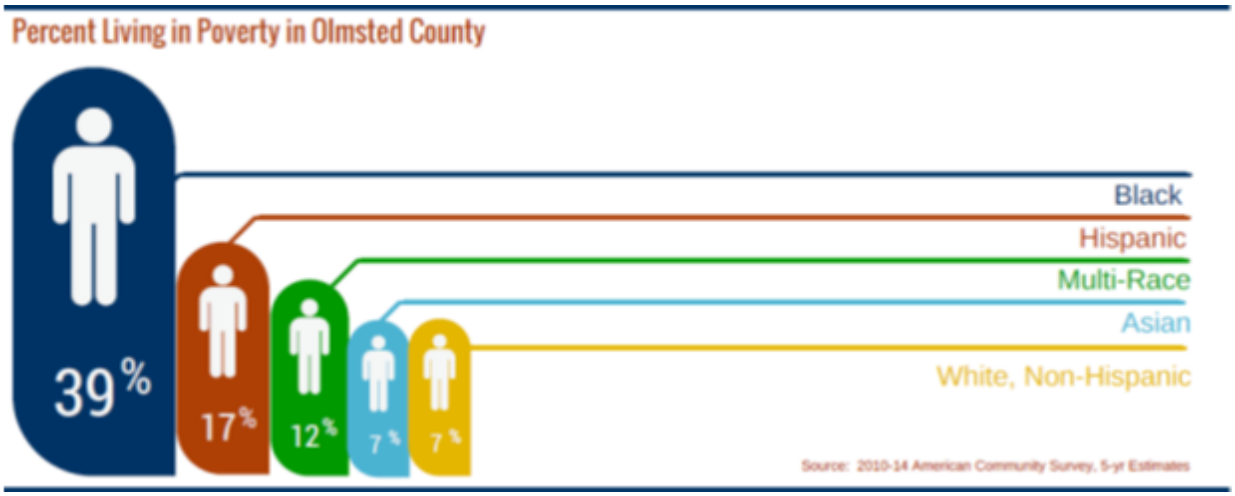
FIS facilitates an integrative planning process where family systems, community members and child welfare agency professionals partner to develop a plan for the safety, permanency and well-being of children (See Figure 2). Family Service Rochester partners with Olmsted County Community Services to provide a trained coordinator, independent of the case, to bring together the family group and the service providers to create and carry out a plan to safeguard children and other family members. This approach recognizes that families are embedded within an ecological context of extended relations, friendships, neighborhoods and communities, and that long-term solutions are more effective when they are constructed by the families within their own social network.

Figure 2: Description of Conference Models

Description of Olmsted County

Olmsted is a mid-sized county located in southeastern Minnesota, approximately 90 minutes southeast of Minneapolis-St. Paul. The county hub is Rochester, which is known as a center for Medicine, Technology and Biosciences, most notably the home of the Mayo Clinic. In 2014, the population of Olmsted County was estimated at 150,287, approximately a 20% increase since 2000. About one-quarter of the population is under age 18, and 18.3% are minorities (including Hispanic or Latino). The overall poverty rate in Olmsted County is 9.8% for individuals. Of children age 0-17, 12.9% live in poverty as compared to 15% statewide. Source: U.S. Census, 2014 Quick Facts, Olmsted County, Kids Count 2016 Fact Sheet.

Figure 3: 2015 Poverty Data in Olmsted County



Olmsted Population Change by Race/Ethnicity

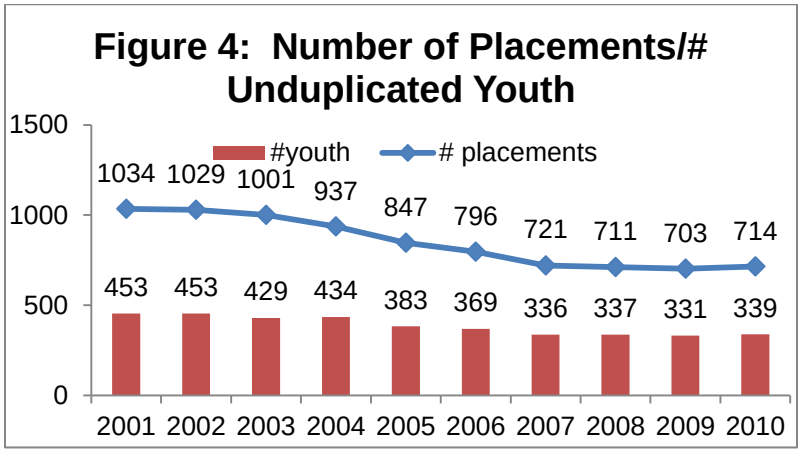
American Community Survey (ACS), 5-Year Estimates

	2006	2014	Increase
Multi-race	2,397	3,681	+54%
Black	6,397	7,497	+17%
Hispanic	5,624	6,501	+16%
Asian	7,516	8,271	+10%
White, Non-Hispanic	119,097	121,524	+2%

Olmsted County has experienced significant population growth among minority groups. This growth has resulted in expanded diversity, and an increased number in poverty, especially Black and Latino community members.

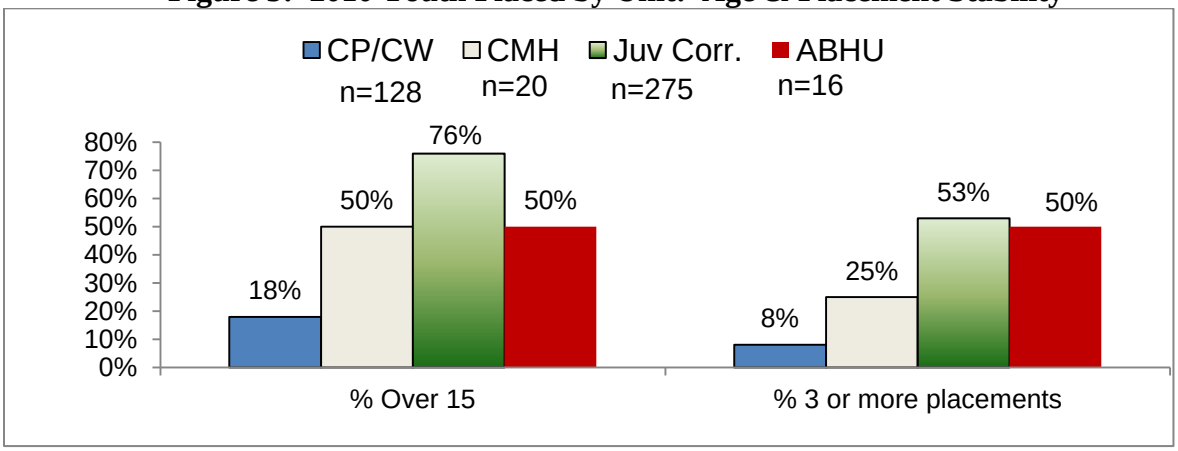
Description of Primary Issues

Overall in Olmsted County, the number of unduplicated youth and the number of placements made by Child and Family Services and Juvenile Corrections has decreased over the past ten years; youth by 25% and number of placements by 31%. However, trend data with regard to cost, which relates to type and length of placement, has not been as clear cut.



Out-of-home placements are a much more expensive option than other solutions. Of the children placed in out-of-home care, data demonstrates that there is significant variation in children's age, number and type of placements, and average cost per youth based on referral unit. Figure 5 below illustrates the correlation between age and placement stability across units.

Figure 5: 2010 Youth Placed by Unit: Age & Placement Stability



Note: ABHU and CMH merged in 2012 to create Youth Behavioral Health (YBH)

Description of Population to Be Served

In 2010, Olmsted County Child and Family Services served approximately 3,800 children; 2,800 in Child Protection/Child Welfare unit, 375 in Adolescent and Behavioral Health, 230 in Children's Mental Health, and 400 in Developmental Disabilities. During that same year, Juvenile Corrections served 581 youth on supervised probation, 281 youth on administrative probation and 524 youth in the diversion program. Building on the positive outcomes achieved for children and families in Olmsted county's CPS population through the use of FGDM and the family findings models, this project intends to install a more rigorous Family Finding model, combining it with the County's existing FGC model (for an integrated approach) to meet the needs of the children and youth who are served by CPS, Youth Behavioral Health, and Juvenile Corrections. In expanding its family finding and FGC practice into these additional units, Olmsted County seeks to demonstrate its quest for excellence of outcomes for all children and youth, independent of which door they enter our system.

The Found, Engaged, Connected project looked to implement the integrated FF/FGC with the following target populations.

Figure 6: Target Populations

Target Population	Eligibility Criteria	Proposed Number of FF/FGDM Conferences Provided Annually During Project	Number of FF/FGDM Referral Made During Project	Number of FF/FGDM Conferences Provided During Entire Project
Child Protective Services	• On-going Services being provided • Child(ren) in Out of Home Placement • SDM Safety Assessment = Unsafe • Child In Need of Protection or Services (CHIPS) petition filed with the court	60	59	46
Youth Behavioral Health: Prevention	• Child/Youth age 14 or under • YBH services initiated • Child/Youth receiving community based interventions • Child/Youth meet residential level of care needs	20	12	6

Youth Behavioral Health: High Risk	• Youth age 15 or older • Youth approved for 60+ days of Out of Home Placement	10	12	7
Juvenile Corrections	• Youth age 15 or older • Youth approved for 60+ days of Out of Home Placement	10	9	6

Throughout the project adjustments were made to eligibility criteria to assist in meeting the projected goal of youth served by the project. The age criterion was eliminated allowing for any age youth/child from the YBH: Prevention target population to be eligible for a FF/FGDM conference referral.

III. Overview of the Program Model

Description of Project Goals

To date, there is insufficient rigorous research on the effects of implementation of integrated family finding/FGDM models on child safety, permanency and well-being outcomes, particularly through trauma-informed and protective factors lenses, within the child welfare field. In addition, there is a sub-population of families in Olmsted County whose children have mental health and behavioral health concerns and who have committed offenses, that are not afforded—at the same rate—the opportunity to come together to create long-lasting solutions for their children as are those within the child welfare population. These children experience negative outcomes, which can persist into adulthood and which ultimately have a detrimental effect on the community as a whole. Our vision, therefore, was to install an integrated family finding/FGDM approach for this marginalized group of vulnerable children and youth in Olmsted County: (1) to increase the combined approach with CPS families; (2) research the effects; (3) to broadly disseminate and weave the findings into the agency's continuous quality improvement processes; (4) to ultimately improve the outcomes of all children and families.

FIGURE 7: PROJECT GOALS AND OBJECTIVES

Goal 1. Improve permanency outcomes for children and youth at-risk of coming into care and those in care
Objective 1.a. Increase the number of connections identified and engaged for the target population of children and youth through enhanced search mechanisms/engagement strategies. *Objective 1.b.* Better measure the notion of "youth connectedness" through the perspective of the youth, and embed their perspectives into planning efforts.
Goal 2. Improve the well-being outcomes for children and youth
Objective 2.a. Continue to conduct trauma assessments, and integrate those assessments into the integrated family finding/FGDM model at all stages. *Objective 2.b.* Embed a protective factors lens into the integrated family finding/FGDM model.
Goal 3. Further institutionalize an evidence-based integrated family finding/FGDM model for the most at-risk youth, served by Children's Mental Health, Adolescent Behavioral Health and Juvenile Corrections
Objective 3.a. Create synergy in Olmsted County among all the different agencies, professionals and stakeholders, to embrace a philosophical and programmatic shift that places the extended family group and their social network at the center of planning and decision making. *Objective 3.b*. Create various networks and Committees in Olmsted County to create and adapt the integrated family finding/FGDM model, to provide guidance to the evaluation, and to secure buy-in with the community's direction.

Objective 3.c. Demonstrate the effectiveness of an integrated family finding/FGDM model, using the evaluation results to support resource allocation decisions and possible expansion efforts.
Goal 4. Leverage results from rigorous evaluation and product development to impact the local, State and national landscape for child welfare
Objective 4.a. Leverage the national dissemination channels of the Children's Bureau T/TA network, the National Center on FGDM, and the National Institute for Permanent Family Connectedness, as well as the local and State networks to broadcast the results, in varying formats and products, to interested audiences. *Objective 4.b*. Building from existing tools created by the Kempe Center and NIPFC, develop a combined family finding/FGDM fidelity tool that can be used nationwide to assess for best practices.

This project installed a more rigorous Family Finding model, combining it with the County's existing FIS strategies (for an integrated approach) to meet the needs of the children and youth who are served by CPS, Youth Behavioral Health, and Juvenile Corrections.

Program Logic Model

The logic model reiterates the project's vision, goals, target population, needs, inputs, outputs, activities and outcomes that guide this project's approach. The project's design flows from the Logic Model (Appendix B-1) which, at the center, has the following theory of change:

> *Families that are engaged in a partnership based collaborative practice can build safety, enhance well-being and secure permanency for children. Family Finding/FGDM facilitate the marshaling of family strengths/protective factors, by identifying and calling upon extended family and community social networks to remove barriers to effective parenting, increase enduring family connections, and address trauma. Safety, permanency and well-being are achieved through implementation, program enhancement, and rigorous evaluation of Family Finding/FGDM to impact local and national child welfare practice/policy and disproportionality of placement rates of African American, Latino and multi-racial children.*

Description of Project Service Model- Historical Context

Olmsted County was well-positioned to yield significant results to impact not only our local community and the State of Minnesota, but also the nation for the following reasons: 1) From an implementation science standpoint, Olmsted embedded FGDM models, and to a lesser extent, formalized family finding processes, into the fabric of everyday child welfare practice; 2) the target population of children and youth who were served by CPS, Youth Behavioral Health, and Juvenile Corrections allowed

for a unique and innovative opportunity for enhanced implementation of an integrated family finding/FGDM model; 3) The staff expertise and competency in FGDM and family finding positioned the project with a highly skilled workforce who were able to quickly deploy family finding and FGDM, make mid-course corrections, continuously improve their practices, and place the evaluation results in context; 4) Olmsted County has sophisticated data systems, 5) Olmsted has experience with implementing multiple FGDM models at specific points in time in the case process, for different purposes, and with varying populations; 6) Olmsted and partner agencies have foundational training in FGDM; and 7) the project partners have a productive, multi-year working relationship.

FGDM and family finding programmatic maturity greatly benefited this project and the evaluation, allowing us to: have greater confidence in the fidelity of the FGDM models being implemented; tailor training and technical assistance efforts to specialized areas, such as integrating a trauma-informed lens into the integrated model and domestic violence; have more seamless implementation of an integrated family finding/FGDM model, with referral sources and processes already established; expedite the installation of the evaluation, allowing for a longer-follow up period which is essential for measurement of permanency and well-being outcomes; and target the evaluation to answer some of the more advanced questions being generated by the child welfare field about a highly vulnerable population.

Description of Project Service Model

The Found, Engaged, and Connected (FEC) project's main emphasis was to enhance the existing family finding/FGDM model (Appendix C-1) and also create a practice model in Olmsted County that would:

- Expand the practice both within and beyond the child protection population into those populations where FGC was previously under-utilized within OCCS.
- Incorporate the more advanced approaches to discovery and initial engagement embodied by Family Finding to bring more family members to the table.

- Strengthen and emphasize the ongoing work done with families via the Family Finding model in order to maintain the continuity and momentum created at the FGC.
- Give preference to the plan developed by the family over any other plan as long as the agency's concerns are addressed.
- Shift from an event-driven family meeting culture to one in which families continued their decision-making involvement until permanency was achieved and/or ongoing network was established and supported.

The project's logic model, as noted above, formed the basis for the goals and vision of the project. The service project model was organized and approached as three significant areas: 1.) Community Engagement, 2.) FF/FGDM philosophy embedded into the fabric of Olmsted County's child welfare & juvenile corrections practice, and 3.) Development and implementation of an integrated FF/FGDM process.

1. Community Engagement. Inasmuch as Olmsted County had an 18 year history of implementing multiple family involvement strategies within Child and Family Services and Juvenile Corrections, Olmsted County recognized that fully embedding an integrated family finding/FGDM model into the daily fabric of its structure, operations and service provision was a long-term proposition. With workforce and leadership changes at political and agency levels, it was essential to constantly engage the internal and external stakeholders in the vision of this work, and specifically, this project. Therefore, this project had community engagement activities woven throughout the three-year grant period. Specifically, the project: 1) Developed a *Think Family* Stakeholders Committee, consisting representatives from the various Child and Family Services Units (CPS, CMH, ABHU), Juvenile Corrections, a judge, and guardian ad litem, and convened this Committee quarterly; (See Full Description in section IV Collaboration); 2)Held

community forums with various stakeholders for a multitude of purposes (e.g. introduce the project in the context of the agency's vision and philosophy, review the community's experiences, and showcase and elicit feedback on evaluation findings); 3) Conducted project briefings with various groups in Minnesota that had a vested interest in the project, including the Minnesota Supreme Court, Children's Justice Initiative, and other entities; and 4) Conducted strategic planning activities whereby more internal and external stakeholders were engaged in Olmsted County's vision, and family finding/FGDM was better integrated within the County's organizational structures and culture. These were facilitated by the National Institute of Permanent Family Connectedness and the Kempe Center, two entities with experience in engaging stakeholders with diverse perspectives.

2. FF/FGDM philosophy was embedded into the fabric of Olmsted County's child welfare & juvenile corrections practice. The philosophical tenants of Family Finding and Family Group Decision Making go beyond that of a meeting model. The culture of the child welfare and juvenile corrections practice needs to support on-going family involvement in planning for children/youth.

The establishment of the Peer Networking Group (PNG) comprised of cross-agency representatives who championed family engagement and involvement in planning for youth within their respective teams. The PNG developed processes and procedures to assist in embedding the philosophy of FF and FGDM in the social work practice (i.e. relative rights notification, tips for engaging relatives, and centralized electronic documentation of relative contact information). PNG members also solicited feedback from peers to inform practice, advocated for extended family engagement and honoring family driven decisions, and mentored, coached and trained team members.

Olmsted County leveraged the organization's practice of group decision making from the point of case entry into the system to exit from the system, through embedding an intentional lens specific to engagement of extended family network.

3. Development and implementation of an integrated FF/FGDM process.

Develop: A Stakeholder Workgroup of people who had experience with OCCS current Family Group Conference (FGC) process was convened to 1) review the fidelity and effectiveness of the current FGC process; 2) understand the Family Finding Model; 3) enhance the FGC model by incorporating FF elements to develop an integrated Family Finding/Family Group Decision Making (FF/FGDM) meeting model. Primary focus of the integrated model included discovery and engagement of the family/support network for children and youth, child specific needs/information sharing at the conference and follow-up conference utilization to ensure on-going involvement of the wider family support network in planning for children.

Implement: Initial training was provided by Kempe and NIPFC on the importance of kin/family connections and family driven planning for leadership, social workers, system stakeholders and FIS coordinator/facilitators. Specialized training was delivered to social workers on the integrated FF/FGDM meeting model specific to their role in the process. Specialized training and regular consultation with FIS team, FIS supervisors and technical assistance providers (Kempe & NIPFC) for FIS coordinator/facilitators assisting in model fidelity, discovery tools and engagement skills (i.e. mobility mapping, engaging paternal family members, working with referring social workers). Assessment of implementation facilitators and barriers was ongoing. Through a rapid cycle feedback structure, coaching, mentoring and additional training was provided.

Evidenced Based Practice. The integration of Family Finding and FGDM required the attention to fidelity of both models. The California Evidenced Base Clearinghouse (CEBC) does not designate a scientific rating of Family Finding. However, the Child Welfare System Relevance of Family Finding is rated as High. The CEBC designated a scientific rating of 3 of Family Group Decision Making and a Child Welfare System Relevance Level of High. Integration of Family Finding and FGDM included careful attention to the integration of best practices of Family Finding and the fidelity of FGDM.

Evidence based practice is reflected in Olmsted County's core training requirements of all child welfare staff. Training curriculum incorporates child welfare theory, research pertaining to protective and risk factors, child development, trauma, domestic violence and diversity (Appendix D-1). This project leveraged partnership with NIPFC to conduct a rigorous literature review pertaining to kinship care. The findings of the review were disseminated and continue to be integrated into system policy and day to day practice (Appendix E-1).

Culturally Based Practice. The above focus sought to enhance Olmsted County's best practices approach with families knowing that the elements and values of Family Finding and FGDM parallel those of Olmsted County's practice values based on Andrew Turnell and Steve Edwards, "Practice Principles." These practice principles/values have been imbedded and woven into the fabric of Olmsted County's practice culture since 1999. The origins of FGDM are based on an anti-oppressive practice:

> *"FGDM was first legislated in New Zealand in recognition that the existing Child Welfare system was affected by institutional racism and paternalistic organizational and professional practices. In other countries implementing FGDM, it is designed that if referral bias is controlled, that FGDM will hopefully impact the disparate outcomes of families of color. FGDM is highly attendant to the family group's culture." (CBC)*

FGDM is culturally-relevant in that extended family, cultural brokers, kinship navigators and others, partner to make FGDM reflect traditions, values and styles of cultural groups. This expectation and cultural awareness is imbedded into everyday social work practice.

Olmsted County, specifically with regard to Family Finding, also wanted to bring more advanced/enhanced efforts to include more family members (emphasis on paternal family members) in children's lives and impact decisions regarding their children as soon as possible. The idea of family finding is to help establish a lifetime network of support for children and youth who are disconnected or

at risk of disconnection through placement outside of their home and community. The process identifies family members and other supportive adults, estranged from or unknown to the child, especially those who are willing to become permanent connections for him/her. It should be stated that as a part of best practices, Family Finding begins in Olmsted County as soon as a call comes into the agency. As with FGDM, Family Finding also addresses racial disparities in the child welfare system through prioritizing permanent connectedness with families and the inclusion of the family throughout the process. This prioritization hopes to reduce the disproportional representation of families of color in the child welfare system by employing the social capital particularly present within communities of color as a valuable resource for establishing permanency.

IV. Collaboration

Key Partners

The key partners critical for providing program services, training and evaluation services etc. in the project were: 1.) Family Service Rochester (FSR), trained independent coordinator/facilitators; 2.) Kempe Center for Prevention and Treatment of Child Abuse and Neglect, project evaluation and training, technical assistance and consultation on FGDM; 3.) The National Institute for Permanent Family Connectedness (NIPFC), training, technical assistance and consultation on Family Finding; and 4.) National Council on Crime and Delinquency (CRC/NCCD) consultation on integrating a trauma-informed lens into training.

Family Service Rochester (FSR) *is* a private non-profit organization that has served Olmsted County, Minnesota residents since 1965. The agency's vision is a safe, vital community that fosters strong, healthy families and capable children. A wide variety of programs and services are provided to support child safety, well-being and family stability. Family Service Rochester is committed to ensuring all in need may receive the help, regardless of income. For the past 19 years, FSR's focus, in collaboration with Olmsted County Community Services, has been working with families with serious child welfare and/or family violence concerns. Major areas of work are in: counseling, case management, educational programming, supervised visitation, and a 16-year delivery of FGDM and family finding. The Family Service Rochester FIS independent coordinators/facilitators are integrated into Olmsted County Community Services. Olmsted County leveraged its long-lasting partnership with Family Service Rochester (FSR), to partner in building an integrated family finding/FGDM model. To support this relationship, the *Olmsted County Child & Family Services and Family Service Rochester Teaming Agreement* was in place and continued to work under an active *Business Associate Addendum for Confidentiality.* This legal document includes clauses

regarding privacy of protected health information, compliance with standard transactions, individual rights and breach of privacy obligations. Unlike most FGDM programs, FSR's FIS coordinators are integrated within the Olmsted County Child & Family Services structure. This long-standing contractual and Business Agreement relationship between Olmsted County Community Services and Family Service Rochester supports the following:

- Co-location of FIS independent coordinators/facilitators with Olmsted County Community Services child welfare programs
- Shared data access including case documentation of FIS activities into the child welfare case file management system
- Shared program evaluation and data management
- Access and participation in training and staff development provided by Olmsted County Community Services

Kempe Center for Prevention and Treatment of Child Abuse and Neglect at the University of Colorado, Denver treats abused children, trains professionals and conducts research to ensure a healthy and hopeful future for vulnerable children and families. Under the direction of Professor John Fluke, the Kempe Center is the lead evaluator for a multi-site, rigorous evaluation of FGDM in three States, funded in 2011. In July 2011, at the request of American Humane, the Kempe Center assumed leadership and the staff of the National Center on Family Group Decision Making. The National Center on FGDM, established in 1999, has supported over 300 U.S. communities in the implementation of FGDM, providing training, technical assistance, consultation and coaching, as well as conducting research. With the transfer, the Kempe Center also assumes multiple avenues for dissemination including a dedicated website on FGDM (www.fgdm.org); an annual Conference; webinar technology and an e-list of almost 7,000 individuals with interest in FGDM. Olmsted County Community Services entered into a contract with the Kempe Center to

provide the following activities to support the integration of family finding/FGDM model into Olmsted County:

- Training of child welfare staff
- Training of community stakeholders including judicial system
- Training and Technical Assistance to FIS team
- Research Design and Evaluation of the Family Finding/FGDM model

National Council on Crime and Delinquency (NCCD) is a national, private, nonprofit research and consulting firm specializing in child welfare, juvenile justice, and adult criminal justice issues. NCCD creates just and innovative solutions to complex social problems, and works to improve the lives of all people through research, public policy, and practice. The Children's Research Center (CRC), a division of NCCD, conducts research and data analysis and creates assessment models to improve child welfare decision making and practice. CRC is also well-regarded for providing training on safety-organized practice. Olmsted County Community Services has a long-standing relationship with NCCD, in particular, The Children's Research Center (CRC) in our use of Structured Decision-Making (SDM) tool in child protection and child welfare practice. Olmsted County entered into a contract with NCCD/CRC to support efforts in building a trauma-informed family finding/FGDM integrated model including the following activities:

- Curriculum development that embeds a trauma lens in the use of SDM (Appendix F-1)
- Training of all child welfare staff utilizing the trauma-informed curriculum
- Technical assistance to support agency integration of a trauma lens in the use of SDM

National Institute for Permanent Family Connectedness (NIPFC) offers an evidence-informed, systematic approach to the dissemination and implementation of the Family Finding practice approach, which reconnects foster children with extended family members (and/or fictive kin) and encourages them to provide emotional support or even a permanent home for these vulnerable children and youth. NIPFC

trainers provide child welfare organizations, practitioners and caregivers with the tools and ongoing support they need to sustain the ongoing implementation of family finding and other permanency best practices, so that every child has the opportunity to grow up and flourish in a safe and loving family. Olmsted County entered into a contract with NIPFC to support efforts to integrate family finding/FGDM including the following:

- Training of all child welfare staff on the Family Finding practice approach
- Training and Technical Assistance of the FIS in the integration of the Family Finding practice with FGDM

Advisory Groups

In order to facilitate organization-wide input and buy-in to the development of the integrated model, Olmsted County deliberately sought the ongoing involvement of various internal and external stakeholders in the drafting and implementation of the model. The first group convened in *The Found, Engaged, and Connected Project* was a **"Stakeholder Group."** This group, who had experience and knowledge of OCCS's family group conferencing efforts, consisted primarily of FIS staff as well as representatives from other social work units within OCCS and agency leadership. This group was tasked with conceptualizing the integrated model and sharing/soliciting feedback with the greater agency. The group began with the elements and values that were crucial to good practice and built upon the existing FIS processes and procedures with enhanced family finding elements to arrive at the conceptualized model.

The "Stakeholder Group" was designed to be time-limited and consisted of champions of family engagement work solicited from each unit by the project leaders. The" Stakeholder Group" was chartered with the focused task of model conceptualization, following with a larger constellation of agency staff and stakeholders that began the task of developing the model's implementation plan. The latter group was termed the **"Peer Networking Group"** (PNG) and met monthly throughout the life of the

FEC grant. In addition to clarifying the next steps of model implementation, this group, comprised of cross-agency representatives, was also tasked to message back to and solicit feedback from their respective units. It was further hoped that they would learn from each other through the PNG as well as serve as models for good practice within their units. The PNG group continues to meet even as the grant has expired maintaining the focus of supporting an integrated family finding/FGDM model.

In addition to the Stakeholder and PNG groups, OCCS recruited external stakeholders to form a "Think Family" group. Their purpose was to provide guidance on FEC program implementation and input on FEC program evaluation findings, aid in the problem-solving process around practice issues identified by practitioners, and champion objectivity. Members of this group were solicited from partner organizations who worked closely with OCCS cases, particularly in the realm of permanency, and would have insight into how the model could be improved toward that goal. Representatives of the group included a local judge, guardian ad litem, county attorney, juvenile family court attorney and public defenders, Community Services Advisory Board member, former service recipient, foster care/kinship program manager and other community representatives including members of the clergy. In addition, participation of leadership from each of the target OCCS population units was also solicited. This group met quarterly to receive updates and provide input on the project. Many of the members on the Think Family group were also members of the Children's Justice Initiative (CJI). Therefore, at the end of this project this group was dissolved and responsibilities pertaining to cross systems issues regarding family finding/FGDM would be brought to the CJI (Children's Justice Initiative) committee.

Collaboration in Implementation and Sustainability Planning

Effective collaboration was demonstrated at the county leadership level and from a multi-systems perspective, which had a direct impact on grant activities. The Director of Child and Family Services (CPS, CMH, ABHU), and Director of Corrections (Juvenile Corrections), demonstrated commitment to collaborate in order to address the prevention of out-of-home placements, active agency

efforts to support rigorous family finding and prevention of placement re-entry of children and youth. All units agreed to work together to address the needs of high-risk adolescents and children with significant mental health needs. This partnership was demonstrated further through a commitment between child and family services and juvenile corrections in their joint initiative to improve outcomes of "crossover youth" that encompasses the development of a crossover workgroup representative of child and family and juvenile corrections to improve outcomes for high-risk adolescents. These are ongoing partnerships and collaborations across systems in Olmsted County that have incorporated the family finding/FGDM as an integral part of the practice model.

Olmsted County Children's Justice Initiative (CJI) is a local partnership of judges, attorneys for parents, Guardian Ad Litems, County Attorneys, Court Administration, and Child and Family Services. CJI provided an ideal venue to build, expand and strengthen best practices to support improved outcomes of safety, permanency and well-being for children. Community partners were integral in effectively implementing Family Finding and FGDM model to assist in further widening the circle of enduring supports for children and families. This CJI also became the ideal venue to support cross system collaboration post the FEC grant activities.

V. Sustainability

Sustainability Planning Worksheet for Children's Bureau Discretionary Grantees v.5
Olmsted County FF and FGDM Project

FIGURE 8: SUSTAINABILITY PLANNING

1. WHAT to sustain? What is your vision for 5 years from now?	*Your best response to this question at this point*	*Next steps? Who'll do them? When?*
Keep all or part of the project going (as is or modified), e.g., services, staff salaries, training, infrastructure, data collection, evaluation, CQI, fidelity monitoring	Maintain capacity for current level of FGC's and Follow-up Conferences. Funding was obtained through new child protection State grant dollars to fully sustain family finding/FGDM post grant funding. Data collection evaluation, CQI, fidelity monitoring: Olmsted County has an internal Evaluation and Analysis unit. Olmsted County will work with the CQI team to incorporate family finding/FGDM grant measures into the division's data dashboard and into the FIS annual report. Training: An annual training plan is developed that addresses core practice, skills and fundamental elements of our work with children and families. Family Group Conferencing is a critical service and will be incorporated into an annual training plan that includes training provided from internal and external content experts.	Next steps: a. Evaluation – obtain framework of evaluation structure and transition to internal evaluation team. b. Fidelity- obtain framework and transition to internal CQI process.
Integrate the project's activities into your ongoing practices - institutionalizing necessary program strategies and activities into organizational policy and infrastructure	The projects and activities connected with FGDM/FF model are part of the Child Protection Teams practice. We will continue to expand our efforts and focus in serving children and families in Juvenile Probation and Youth Behavioral Health.	Leadership including administration, staff and community stakeholder's will continue to engage stakeholders including utilization of Peer Network Group as well as reaching out to targeted programs to further institutionalize FGCs across department.
Embed the key elements of the project in the broader system	Key elements: Family Finding: Early and rigorous Follow-up Conference: Building a culture and capacity	Continue with framework with all staff and community stakeholders of how to work with families that includes: Implement paradigm shift from a Child-

	with family for on-going follow-up conferences post agency/system involvement.	Centered focus in traditional Child-Centered programs (i.e. Juvenile Probation and Youth Behavioral Health) to an Ecological Perspective that is better able to leverage family and support networks (formal and informal) to achieve improved Child-Centered outcomes.
Expand, take to scale- e.g., replicate in other communities, statewide, nationally	Our intention is to sustain current staffing capacity to support Integrated FGDM/FF Model for children and families served in Olmsted County.	Continue to disseminate the positive attributes and research findings at conferences, other local counties in Minnesota, the Department of Human Services and distribution of annual reports via the County website.
Leave a legacy of knowledge that informs the field and which can be used by others who wish to replicate your project or implement something similar	Olmsted County will continue to evaluate the effectiveness of the current practice and will change and enhance as needed.	Continue to disseminate the positive attributes and research findings at conferences, other local counties in Minnesota, the Department of Human Services and distribution of annual reports via the County website.
2. WHY sustain? Why do you believe part or all of your project should be sustained?		
What are early indicators that program elements should or should not be sustained?	Why Sustain? Promising data: We have seen an increase in relative care rate. This is most prevalent for Child Protection with a shift from 35 - 40% relative care rate to approximately 60% relative care rate. Additionally, promising data is reflecting increased relative identification and engagement by agency (i.e. increased number of family members contacted and participating in conferences). Aligns with Agency Core Practice Principles: Supports agency goal to build capacity within families to reduce reliance upon the formal system of care. Reduces Risk to Youth: National, State and local data informs us of the negative impact of long term care. Strategies to build connections and placements with families provide a better solution to address the long-term permanency needs of youth. Earlier permanency planning is occurring for youth as well, shortening length of placement due to the ability to build a transition plan.	Olmsted County evaluation team will continue provide ongoing data collection, analysis and distribution to support ongoing program evaluation.

	Worker and Family Satisfaction: Family and social workers have reported an increase in engagement. Families have shared that, over time, they have more input and decision making with regard to the youth. The relationship between social worker and family has been strengthened and better reflects one of genuine partnership.	
When will you know "for sure"? How will you know?	Quarterly evaluation of performance benchmarks. Benchmarks will include sustained level of referrals from CP and increased number of referrals by juvenile probation and youth behavioral health. Achievement of relative care targets that are sustainable over time. Continuing ongoing support of youth including widening of their network of support. Decrease in the length of placements for youth. Greater family involvement and input in the planning for the youth which reflects a family centered partnership with the agency.	The data and the discussions with each unit and respective supervisors will impact decisions for Olmsted County. The data will be provided by the CQI team and the Peer Network Group will be a key conduit to review data and provide agency guidance on best practices.
How will you assess and gather evidence to identify the particular strategies and activities initiated under this grant that should be sustained after the grant ends?	Ongoing data collection and evaluation by Evaluation unit. Ongoing data distribution to program managers/supervisors (quarterly dashboards) Ongoing data analytics by internal Continuous Quality Improvement Team. (CQI	Data analytics will remain post grant to support ongoing program evaluation and planning.
Are there other sources of evidence for sustainment (e.g., cross cluster findings or findings from other similar initiatives)? What are they and how will you gain access to and use this evidence to build your case?	Minnesota provides FGDM grants to counties that include data gathering requirements. Partnership with the State affords the opportunity to do the following: Improved data analytics and cross program comparisons Leveraging of expansion of State level funding to support sustainability	Continual discussion and dissemination of information in our systems about the value-add of this strategy with Olmsted County, Department of Human Services, and other State FGDM stakeholders

	Dissemination of project data and outcomes to expand practice model throughout the state. (Olmsted County, Department of Human Services and other State FGDM stakeholders)	
3. HOW to sustain?		
What changes will be required in order to sustain program benefits? What systems, legislation, policy, procedures, training and funding sources would need to change? What are the barriers to these changes happening? What are the opportunities (e.g., how do your sustainment goals fit with other current systems change initiatives)?	Systems, legislation, policy, procedures, training and funding sources: Legislation: Ambiguity in statutory language regarding relative notification in non CP related court cases (i.e. Delinquency, Behavioral Health Placements). Policy/Procedures: Policies and procedures that balance the rights of parents as well as the rights of youth to build family connections. Training: Agency and staff need to receive ongoing evidenced- based training that incorporate research based findings on the role of family and kinship connections and to embed a deep organizational culture that values family involvement and decision-making in a youth's life. Barriers: A system shift that involves influencing not only practice but the legislation and the systems policies and procedures that drive the practice Opportunities: The FF/FGDM model has allowed the following: • In Juvenile Probation there is a push to utilize evidence based practices to support and engage families to build capacity to shorten the length of out of home placements and return the youth to the community. • In Child and Family there are opportunities to support state and federal efforts to increase kinship care and father engagement.	Ongoing effort by Administration and leadership on a state and local level.

	• In Youth Behavioral Health there is a paradigm shift from a Child-Centered focus in traditional Child-Centered programs (i.e. Juvenile Probation and Youth Behavioral Health) to an Ecological Perspective that is better able to leverage family and support networks (formal and informal) to achieve improved Child-Centered outcomes.	
How much will it cost to sustain key program elements? If you don't know, how can you find out? How will you secure funding and other resources that will be needed to sustain program benefits?	Funding to fully sustain current Family Finding/FGDM has been leveraged in the amount of $307,000 (CY 2017) through the use of new Child Protection dollars available to the agency.	
4. WHO can help? Can you succeed by your efforts alone or will you need help?		
Who are the key individuals and organizations whose support will be required?	The FGDM/FIS processes have received support for almost 15 years. Its track record within the agency and agency partners/ community systems has been consistent and continues to be well received. Other areas of the system are now in a position to see the value that it may add to their area. Key Individuals and organizations are: Family Service Rochester, Juvenile Probation, Court System, social work and probation staff, and Department of Human Services)	Leadership including administration, staff and community stakeholders. To continue to engage stakeholders including utilization of Peer Network Group as well as reaching to targeted programs to further institutionalize FGC's across department.
How and when to engage partners to develop and implement your sustainability plan?	All above partners have been part of this project and continue to be engaged and have voiced their on-going support to continue the FGDM/FIS processes.	It has been continuous.
What support is needed from each of them?	Continued funding from Olmsted County, and the Department of Human Services. Consistent and continual Olmsted County FGC/FF practice implementation.	
What evidence would convince them that they should provide this support?	Data analytics that have been and continue to be collected and distributed. Satisfaction relayed to partners by organizations, staff and families.	Provide Evaluation through internal evaluation team. Deliver Fidelity information that will be provided by Olmsted County's internal CQI process. (Additionally, the state and federal CQI processes.)
How will you maintain the involvement	Regular and continued meetings with	Through forums and specifically scheduled

of key project partners on an ongoing basis in the planning and operation of your program, during and after the grant project?	administration, key partners, staff etc.	meetings with: Administrative, Supervisors, Peer Networking Group, and Human Services FIS grants and programs.
5. TRANSITION - If there are parts of your project that will NOT be sustained, how will you manage the transition?		
Which parts will NOT be sustained? Why?	All parts of project will be sustained.	
Who needs to know? How will you tell them? When?		
How will you manage this transition to minimize impact on service recipients, your organization and staff, and your partners?		
6. DISSEMINATION & COMMUNICATION - How can effective dissemination help you achieve your sustainment goals?		
• For each sustainment goal, identify: How can dissemination help us achieve this goal? Who to target? When? What are the key messages? How to communicate them most effectively?	Dissemination and communication is effective through the well formulated meeting forums with the partners and staff in the organization.	This will and does have many forums for regular discussion and strategic planning. Administrative meetings with the criminal justice committee, administration regarding financial support, CQI, Supervisor meetings, Human Services, staff consult and peer network groups etc. (FIS provider is imbedded into all meeting forums).

Products developed and disseminated: (See Appendix D-1 through J-1)

VI. Evaluation

A. Process Evaluation Methodology

Process evaluations focus on how something happened rather than the results obtained. These evaluations are particularly useful for dissemination and replication of interventions because practice factors may help explain how and why an intervention is effective, and for whom, in ways that a purely outcome-focused evaluation cannot. The purpose of this process evaluation was to shed light on the mechanisms underlying any hypothesized effects as well as to provide helpful information to Olmsted County and other jurisdictions about implementation of an integrated Family Finding and Family Group Decision Making (FF-FGDM) model, termed the Found, Engaged and Connected (FEC) project, in three units of Olmsted County Community Services (OCCS). Ultimately, based on data sources, the following process-oriented questions (as well as others) were addressed through this evaluation: the characteristics of families who participate in the integrated model; what barriers to implementation and uptake of the model exist in the agency or community and how are those addressed in developing and maintaining the model; the relationship between worker characteristics (demographics, background, years of experiences, attitudes) and their perceptions on the effectiveness of FGCs; the length of time between referral and the actual FGC; a description of who is invited and who attends FGCs; and, the extent of fidelity to the models' core components based on type of respondent.

Figure 9. Process Evaluation Questions

Research Question 1: What are the characteristics of the children, youth and family members involved in an integrated FF-FGDM model?
a) What are the characteristics of the target children/youth referred for the integrated model?
b) How are family members engaged in the intervention?
c) How are youth engaged in planning and participating in the intervention?
Research Question 2: What are the essential elements of the integrated FF-FGDM model being put into practice and what activities and services are being implemented?
a) Do the essential elements vary based on the referring unit (CP, YBH, JP)?
Research Question 3: Is the integrated FF-FGDM model being practiced with fidelity (e.g., appropriate

dosage, adherence to model, high quality)?
a) Are the implementation activities occurring as planned and how well are they being completed?
b) What are the challenges of implementation of each component of the intervention? What are the strengths of implementation? How are challenges to implementation addressed?
c) What contextual factors may have affected program implementation? Which factors impeded and which facilitated implementation of services? How were the factors that impeded implementation of services addressed?
Research Question 4: How is the FF-FGDM model impacting overall practice or "culture" in OCCS (e.g., changes in rules and regulations, policies, procedures, changes in practice knowledge and beliefs)?
a) Did Olmsted County and collaborating agency staff's knowledge, understanding, and implementation of the FF-FGDM model increase over time?
Research Question 5: How did the key stakeholders assess FEC program quality?
a) What are Olmsted County and collaborating agency staff perceptions of the demonstration project?
Research Question 6: What processes guided program changes over time? What processes were developed to ensure program sustainability—both fiscal and policy and program-related?
a) What resources are employed to support implementation? How are these resources being used?
b) Are elements being implemented in established timeframes?

The process evaluation design included two features, which were closely linked to the research questions. First, a global or agency-level assessment of how the integrated FF-FGDM model was designed and implemented by the agency. This assessment included the barriers and strategies for model uptake, and how these have changed over time as the project progressed, with a strong focus on fidelity. Second, a more detailed view of processes at the case-level in conjunction with the outcome evaluation were planned to understand how other factors contribute to the success of the integrated model. Key to the process evaluation was determining how the agency- and case-level views are actually integrated, the degree to which policy is consistent with practice, and how agencies identify and resolve implementation problems. The process evaluation involved a combination of qualitative (focus groups and interviews) and quantitative (staff, youth, and fidelity surveys; Meeting Log) data, which are described in "Data Sources and Collection."

B. Outcome Evaluation Methodology

The planned outcome evaluation methodology for the study consisted of a Propensity Score Matching (PSM) longitudinal design, using a historical data set for the comparison group, covering a maximum of 6

months of potential follow-up. However, upon receiving the final dataset, and after multiple conversations between the external evaluation team and Olmsted County leadership and their data team, it was determined that a meaningful and reliable comparison between treatment and historical comparison groups was not possible. As a result, a within-groups analysis of the treatment group was the focus of the final outcome analysis (for more detailed information please see section "Evaluation Changes.") The within-group comparison of the target intervention population consisted of children/youth who were referred to the integrated FF-FGDM model during the study period.

Children/youth (hereafter referred to as youth, ranging in age from infants to teenagers) from four target populations were referred to the Found, Engaged, and Connected (FEC) study from three units within Olmsted County Community Services (OCCS) – Child Protection (CP), Youth Behavior Health (YBH) High-Risk Placement and YBH Prevention, (formerly Adolescent Behavioral Health and Children's Mental Health units, respectively), and Juvenile Probation (JP) when specific eligibility criteria were met (see Appendix A for an eligibility flow chart). These analyses focus on the 65 'treatment' youth who received an FGC before December 31, 2015, and the 26 'comparison' youth who were referred to receive an FGC but did not receive an FGC (n = 18) or received an FGC after December 31, 2015 (n = 8).

It should be noted that the comparison youth cannot serve as a 'pure' control sample, given that they were selected after, rather than prior, to data collection, and the assumption of sameness between groups cannot be assured. As such, the comparison youth may differ in important ways from treatment youth in ways unknown to the evaluation team (please see Section VIII.F. Evaluation Discussion). Further, follow-up data was limited for cases who received an FGC after December 31, 2015 given the minimum 6-month follow-up timeframe required by the evaluation. This is a limitation of the study.

The data collection period for the treatment group began in November 2013 and referrals to the project ceased in September 2015 with the cut-off for FGCs being December 31, 2015 to allow for a minimum of six months of follow-up through June 2016. A no-cost extension was sought and approved to allow for the

maximum data collection period as well as to allow for data analysis. The final set of administrative data (e.g. SACWIS data) was pulled in July 2016. During the ~24 month data collection period, interim results were used for formative work with the sites and to inform technical assistance and training efforts. The final months of the no cost extension project period were used to consolidate data, complete the analysis, and prepare the evaluation report.

The core research questions of the FEC outcome evaluation were:

1. How does participation in the integrated FF-FGDM model impact service provision?
2. Does use of the integrated FF-FGDM model result in expanded or stronger community and family connections, including fathers and paternal relatives?
3. Does use of the integrated FF-FGDM model result in fewer episodes of OCCS involvement?
4. Are children in the target populations who experience a placement and participate in the integrated FF-FGDM model more likely to experience placements with relatives, lower levels of care, fewer placement changes, and more permanent connections?

Key outcomes for the study such as re-involvement and placements were derived from administrative data sources. Where administrative data were not used, surveys were utilized and linked to the administrative data sources. Such instrumentation (discussed below) was used to obtain data on possible moderators and mediator variables as well as outcomes such as participant satisfaction.

Evaluation Participants

The target population for the FEC project were children or youth in care or at high risk of entering care within the CP, YBH, and JP units within Olmsted County. Please see Appendix A “Evaluation Case Flow and Eligibility Triggers” for a flow chart indicating how eligibility for FEC participation was determined for each sub-population. Members of the target population were included in the process

evaluation in addition to referring OCCS workers, FIS facilitator, supervisors of both groups, and OCCS managers and administrators.

Data Sources and Collection

Data for the evaluation were derived from multiple sources including focus groups, interviews, administrative data, and surveys. Local evaluation support was used to aid in evaluation implementation and data quality assurance processes. The text below describes the data sources that were collected, the instruments or data collection approach, and the timing.

Focus Groups and Key Stakeholder Interviews

Semi-structured focus groups with caseworker and FIS staff were conducted in all three years of the project to understand aspects and/or strategies for FGC preparation and family engagement as well as to understand how agencies handled barriers to implementing the integrated model across the OCCS units. Key information was extracted from transcribed focus group audio recordings and included herein to provide contextual information to support conclusions and findings.

Surveys

A range of survey data were collected from various study participants to answer process and outcome evaluation research questions. For any survey administered, there were two key principles that were followed to ensure high data quality. The first was that the survey data must be linkable to the administrative data. The second was that, to the extent possible, any survey administered would not be overly burdensome to agency staff study participants. To this end, the determination of what survey instruments to utilize for the project was done through conversations with OCCS to ensure that the data obtained via any given proposed survey could not be obtained by other means to minimize respondent burden and avoid duplicative documentation.

General Staff Survey

The General Staff Survey was administered to referring case workers, FIS staff, and supervisors of both at the time that staff received the mandatory FEC Evaluation Training prior to the beginning of data collection. It was used to obtain demographic information for those staff that were expected to have any involvement with FEC integrated model. This instrument was adapted from one already in use in a prior Family Connection evaluation. Many of the items and scales were validated based on studies of worker and supervisory decision making and disparities conducted in a Texas evaluation. Scales pertaining to skills, tenure, perceptions of FIS usefulness and effectiveness were included. In addition, an organizational climate and culture scale was included to better understand how attitudes, beliefs, and experiences may influence relations between the intervention and the outcomes. Finally, questions about job satisfaction and the relationship between it and experience with FIS were also included.

Youth Connections Scale

The Youth Connections Scale (YCS) is designed to measure youth relational permanence (lifelong connections to caring adults, including at least one adult who will provide a permanent, parent-like connection for the youth) while the youth is in out-of-home placement.[1] Pilot testing of the tool by its developers indicated that the scale has both strong test-retest reliability, and strong concurrent validity with an instrument measuring a similar construct. This tool was developed for, and validated with, foster youth populations. This survey was be administered as a pre- and post-test for youth at the point of referral for integrated model. This tool was intended for use as a measure of program evaluation for cross-population analyses among the intervention groups.

Participant and Facilitator Fidelity Surveys

To better understand the conditions under which the integrated FF-FGDM model affects child outcomes, it was important to examine the characteristics of the model and the degree to which fidelity was achieved. To this end, three versions of a fidelity tool were developed which incorporated

[1] Semanchin, J. A. & LaLiberte, T. (2013). Measuring youth connections: A component of relational permanence for foster youth. *Children and Youth Services Review*, *35*(3):509-17.

components of family finding to previously developed FGC fidelity domains. The four versions are: 1) Facilitator Fidelity, 2) Participant Fidelity, and 3) Follow-Up Participant Fidelity, and 4) Follow-Up Facilitator Fidelity. Satisfaction questions were included in the participant follow-up version of this survey to assess family members' degree of satisfaction with OCCS services, in addition to their retrospective reflections of their experiences with their first FGC.

The Participant Fidelity survey was introduced by FIS facilitators at the start of each FGC, and all participants in attendance were asked to complete the first page which captured their experiences with the preparation process and some basic demographic information. At the conclusion of the FGC, all participants were asked to complete the second page of the survey. A large envelope was available for participants to securely place their surveys. The envelope was sealed and mailed to the Kempe Center by the case aid. Coordinators were asked to complete their version of the survey within 2 business days of the FGC and to turn them into the case aid for bulk mailing. This fidelity data collection protocol was mimicked for the follow-up FGCs that were part of the FEC program model. It should be noted that while remote participation (e.g. via phone or video conference) was a common phenomenon, fidelity surveys were not obtained from remote participants. While their perspectives could match those of people physically present of the FGCs, they may have had a different qualitative experience and thus our fidelity results do not necessarily reflect their experience.

Meeting Log

The FEC Meeting Log was an Excel spreadsheet, housed on a secure SharePoint site hosted by the evaluation team that was designed to provide live tracking of case assignment to the FEC project, FGC occurrence, and data collection. This document allowed for real-time communication between the evaluation team and FIS program staff about who was being referred to and receiving the enhanced-dosage FF-FGDM model and aided in data tracking and QA efforts.

Administrative Data

Administrative data from the Minnesota SACWIS system, SSIS, were used to answer many of the questions related to the outcome evaluation. In addition, the administrative data were used for the propensity score matching process. The evaluation team worked with designated Continuous Improvement and Analysis staff in Olmsted County to define the specifications for the extract files which included re-involvement with OCCS, out-of-home placements, and services as well as demographic information.

Cost Data

Cost data were collected via an MS Excel spreadsheet that was completed by OCCS staff. Costs were computed primarily based on a functional analysis of staffing resources and an estimation of indirect (non-personnel) costs. Agency staff costs were estimated based on the agency budgeting model and represent the average cost per position type including fringe benefits. Other overhead specific to the FGC program was obtained from the site budgetary models or drawing from existing research, where needed. Additional time for various agency staff participating in the conferences was included; agency staff costs were assigned based on the position of the participating staff and the average staff cost per position as determined from the site's budget model.

Data Collection Targets and Response Rates

Based on preliminary discussions with the site project leads, targets for referrals to the project were determined based on the size of the OCCS units and their capacity to provide FF-FGDM services to the target populations. Table 2, below, indicates the referral and response rates for each piece of survey data collected for each of the OCCS target populations. It should be noted that depending on the survey, the denominator for the response rate varied. For YCS, response rates were calculated using the number of eligible cases (the YCS is validated for youth 12 and over only) as the denominator for the pretest calculation and number of pretests received for the posttest calculation. For Fidelity data, the total number of FGC1 or FGC2 meetings held was used, depending on the survey.

TABLE 1. FEC REFERRALS AND RESPONSE RATES

Data Source	N level	Overall	CP	YBH-Prevention	YBH-High-Risk	Juvenile Probation
Referrals	Workgroup-level *n*	92	59	12	12	9
FGC1 Meetings	Workgroup-level *n*	65 (71%)	46 (78%)	6 (50%)	7 (58%)	6 (67%)
Participant Fidelity	Meeting-level *n* (response rate)	62 (87%)	45 (98%)	5 (83%)	7 (100%)	5 (83%)
Facilitator Fidelity	Meeting-level *n* (response rate)	63 (97%)	46 (100%)	5 (83%)	7 (100%)	5 (83%)
FGC2 Meetings	Workgroup-level *n*	29 (45%)	24 (41%)	1 (8.3%)	3 (25%)	2 (22%)
Participant Follow-Up Fidelity	Meeting-level *n* (response rate)	13 (36%)	11 (46%)	0 (0%)	1 (33%)	1 (50%)
Facilitator Follow-Up Fidelity	Meeting-level *n* (response rate)	27 (93%)	21 (88%)	1 (100%)	3 (100%)	2 (100%)
Youth Connections Scale Pretest	Workgroup-level *n* (response rate)	20	3	0	11	6
Youth Connections Scale Posttest	Workgroup-level *n* (response rate)	8	2 (67%)	0 (n/a)	4 (36%)	2 (33%)

Evaluation Changes

A number of changes were made to the evaluation plan and design throughout the project to accommodate practice changes occurring in OCCS or data collection issues. One of the persistent challenges related to the evaluation was lower than anticipated referrals to the FEC project from all target populations. In an effort to maximize the sample, the referral period was extended from the original date of April 31, 2015 to July 30, 2015 and then again through October 2015. This, in turn pushed out the data collection cut-off to December 31, 2015 and the follow-up period through June 2016 to maximize data collection for all survey instruments and administrative data. In addition, shortly after referrals to the project began, the Children's Mental Health (CMH) and Adolescent Behavior Health Unity (ABHU) merged into one Youth Behavioral Health (YBH) unit. The evaluation reframed its target populations to YBH-Prevention (formerly CMH) and High-Risk Placement (formerly ABHU). In addition, as of September 2014

the age cut-off criteria of youth younger than 14 for the YBH-Prevention population was removed in hopes of increasing referrals.

Risk assessment scores for the various target populations were slated to be used as part of the propensity score matching process under the original evaluation plan whereby the PSM would be conducted separately for each of the 4 target populations. However, it became clear that there weren't sufficient numbers of target youths in the non-CP units to conduct a rigorous match at a unit level and so the match was conducted at the cross-site level using the unit as a matching variable. While this enabled CP youth to be matched against other CP youth, it precluded the use of the assessment scores as the assessment tools varied across units and PSM analysis does not allow for missing matching variables. This was a limitation of the evaluation in that, although the match statistics were positive – indicating sufficient quality matches on the variables available – they may not have matched target youth to appropriate comparison youth given the high risk nature of the target sample and the inability to match for that risk amongst the historical comparison group.

Ultimately, the most significant change to the evaluation plan and design was the shift from a between groups outcome analysis (treatment *vs*. historical comparison group) to a within-groups analysis (treatment youth who had a FGC vs. those who did not). This decision was reached after consultation between the evaluation team and the Olmsted project team and data staff once it became clear that the planned analysis between groups would not be meaningful given the limitations of the historical comparison group dataset.

There were a couple of factors that influenced this change. First, the original historical comparison group sample was proposed to be of youth in the target populations who had intakes between January 2009 and December 2010. The data pull for the treatment and historical control groups was scheduled for July 2016 (to pull outcome data through June 2016). However, the evaluation team was notified by the data staff in OCCS that, per Minnesota statute, a purge of SSIS data older than 5 years

impacted the data pull for the historical control group such that the full time period of data was no longer available. As such, the PSM process had to be run again on a different set of youth (with intakes between August 2011 and July 2013 and allowing for follow-up through January 2014) to avoid the data purge issue and to apply comparable timeframes as those experienced by the treatment group. Upon receiving the new outcomes dataset for the historical comparison group, it was discovered that there were discrepancies in the outcomes of interest between the two files. Second, OCCS alerted the evaluation team that certain outcomes were tracked differently in the administrative data system between 2011 and 2016 which appears to have impacted the ability to compare outcomes between the treatment and comparison groups. As such, the between groups analysis were abandoned in favor of a more reliable and meaningful within-groups analysis of treatment cases with a focus on descriptions of the trajectory through the OCCS system of youth in each target unit as well as those who were referred but did not have a conference to those that did.

Evaluation Training

Leading up to the launch of the evaluation in late Fall 2013, webinars were conducted with each of the 4 referring OCCS units as well as FIS staff to provide evaluation training for all referring workers, facilitators, and supervisors. These trainings covered a project overview, goals of the evaluation and the specific tasks required of any staff member who might be touched by the project, namely referring caseworkers and FIS coordinators/facilitators. At this time, the General Staff Survey was administered to all staff in attendance as well.

C. Process Evaluation Results

For the 93 target youth referred for the Found, Engaged and Connected project, demographics are indicated in Table 3 below. The average age of youth referred for the FEC study was approximately 9 years of age. There was a roughly even split between male (55%) and female (45%) youth while the

majority of target youth were identified as Caucasian (64%), which is consistent with the overall demographics of the county as a whole. Finally, and as aforementioned, the majority of referrals came from the CP unit while fewer came from the other three target populations (JP, YBH – Prevention, YBH – High Risk Placement) though all units fell short of targets.

Table 2. FEC Youth Demographics (*n*=92)

Demographic	N (%)
Age	Average age: 9.3 years
Gender	Male: 51 (55%) Female: 41 (45%)
Race/ethnicity	Caucasian: 59 (64.1%) African American: 15 (16.3%) Hispanic: 2 (1.6%) American Indian/Alaskan Native: 1 (1.1%) Multi: 15 (16.1%)
Sub-population	Child Protective Services: 59 (64.1%) Juvenile Probation: 9 (9.8%) Youth Behavioral Health – Prevention: 12 (13.0%) Youth Behavioral Health – High-Risk Placement: 12 (13.0%)

Note: Some totals do not equal 100% due to rounding.

General Staff Survey

The successful implementation of an intervention in human services often depends on agency ownership, confidence in intervention effectiveness, and the ability to implement with fidelity. Because referring worker attitudes can impact referral rates to and participation in FGCs, results from the General Staff Survey (GSS) were used to assess staff perspectives about the effectiveness of this intervention. Staff involved with the FEC project included OCCS case workers, supervisors, and managers from the various OCCS units, subcontracted staff from Family Service Rochester (e.g. FIS staff, supervisors, and management), as well as Zumbro Valley Health Center, another local community provider who employs many of the YBH staff. These staff perceptions are important because, beyond referral and participation, they also reflect organizational support of FGCs. Further, the GSS was used to assess staff orientation toward family preservation or child safety, which may have implications for decision-making within an

agency. The sample of staff surveyed consisted of any staff who had a role in the FEC evaluation, their supervisors, and FGC coordinators who participated in Evaluation Trainings held in Fall 2013. In all, 67 staff members responded to the survey. Full descriptive results from the GSS are available in Appendices B and C.

Focus Groups and Interviews

Focus groups were conducted at two points in time – prior to implementation in September 2014 and following the end of the project in May 2016 – to access OCCS staff perceptions of FIS practice generally and the integrated FF-FGDM model specifically, including barriers and challenges to implementation and uptake. At both points in time workers, supervisors and leadership from all target units as well as FIS were solicited for participation. The first focus group focused on perceptions of practice and readiness to implement. The second focus group re-assessed staff perceptions to identify any shifts over the life of the project as well as provided a context for certain preliminary findings (including low referral rates). A summary of themes for both sets of focus groups can be found in Appendix D. In general, the long time period between referral and FGC (which was also confirmed by the data) was identified as a persistent barrier to effective practice across time periods and did not appear to be successfully mitigated throughout the project period. In addition, for the three non-CP units, staff and managers alike expressed concerns and lack of clarity around the value or purpose of the intervention for their target populations. This finding is particularly relevant for future work spreading interventions traditionally implemented in CP to other child and youth serving areas both in terms of engaging and soliciting stakeholders early on.

Fidelity Results

This section of the report summarizes findings from three key data sources: the Olmsted FEC Meeting Log, the Coordinator and Facilitator Fidelity Survey and the Participant Fidelity Survey. It

describes the incidence, timing, and characteristics of, and perspectives on the FGCs overall, by study unit, and where pertinent and feasible, at the coordinator/facilitator level. A summary of findings follows while detailed findings can be found in Appendix E.

Across the study units, the median age of the target youth at the date of study referral was 11.4 (*M* = 9.7, *SD* = 6.6). Seventy-one percent (*n* = 65) of the 92 referrals culminated in a FGC during the study, and the most common reason why a FGC didn't happen was the family declining the opportunity to participate. The median number of days between referral to the study (as opposed to eligibility) and the first FGC was 124 (*M* = 132, *SD* = 52) and after 90 days, only 20% of the sample had had their first FGC. Average number of days between referral and FGC did not vary significantly by coordinator, or in situations where a person other than the coordinator facilitated the FGC. On average, coordinators reported using nine out of 18 listed strategies to find family members. Five family finding strategies were used by over 90% of the coordinators, including: asking family, phone calls, face to face contact with family, obtaining information from the social worker or probation officers, and using genograms. Coordinators did vary significantly on whether or not they incorporated any remote participants, but within the group that did, the average number of remote participants did not vary significantly. At least one phone participant was documented for 45% (*n* = 29) of FGCs and video participants were reported for 29% (*n*= 19) FGCs.

Differences between study units were found with respect to: the average age of the target youth (Child Protection-referred youth were significantly younger; *Welch's F*(3,24.6) = 53.42, *p* = .000); whether or not remote participation methods were used (CP unit FGCs used them more than JP; *Likelihood Ratio* $X^2(3) = 13.405$, *p* = .004), the average number of FGC1 video participants (CP engaged more than JP; *Welch's F*(3,14.306) = 3.976, *p* = .042); and the average number of service providers attending (more attended CP FGCs compared to JP FGCs; *F*(3,52) = 3.458, *p* = .023).

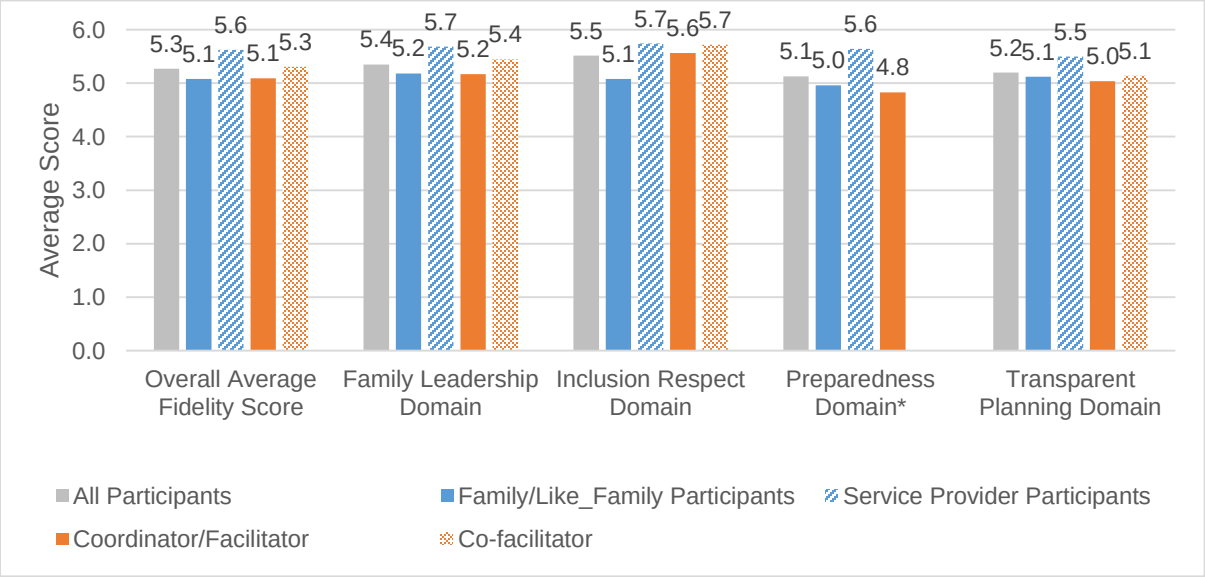
No differences between study units were detected with respect to: the percent of referrals culminating in an FGC during the study period, reasons why FGCs were not held, average number of days between

referral and the first FGC, the average number of FGC1 phone participants, the average number of search strategies employed, average number of FGC1 attendees, average number of FGC1 family/like family participants attending, whether or not the FGC achieved the goal of a 2:1 family/like family to service provider ratio, and FGC level overall fidelity or fidelity domain scores.

When performance of coordinators was considered, no statistically significant differences emerged with respect to the average number of days between referral and the occurrence of the FGC1 occurred (and whether or not the same person ultimately facilitated the FGC). No differences were found between coordinators with respect to the reasons FGCs were not held, the likelihood of video participants at the FGC1; reaching the 2:1 family/like-family to service provider ratio; the likelihood of an FGC2 occurring; the number of days between the FGC1 and FGC2. Based on the analyses conducted, coordinators differed from each other in one area only: the likelihood of engaging any participants in the meeting by phone (*Likelihood Ratio* $X^2(10) = 21.34$, $p = .019$).

The overall profile of fidelity, as reported by Olmsted Coordinators and/or Facilitators, co-facilitators, family/like family, and service provider participants is presented in Figure 10, below.

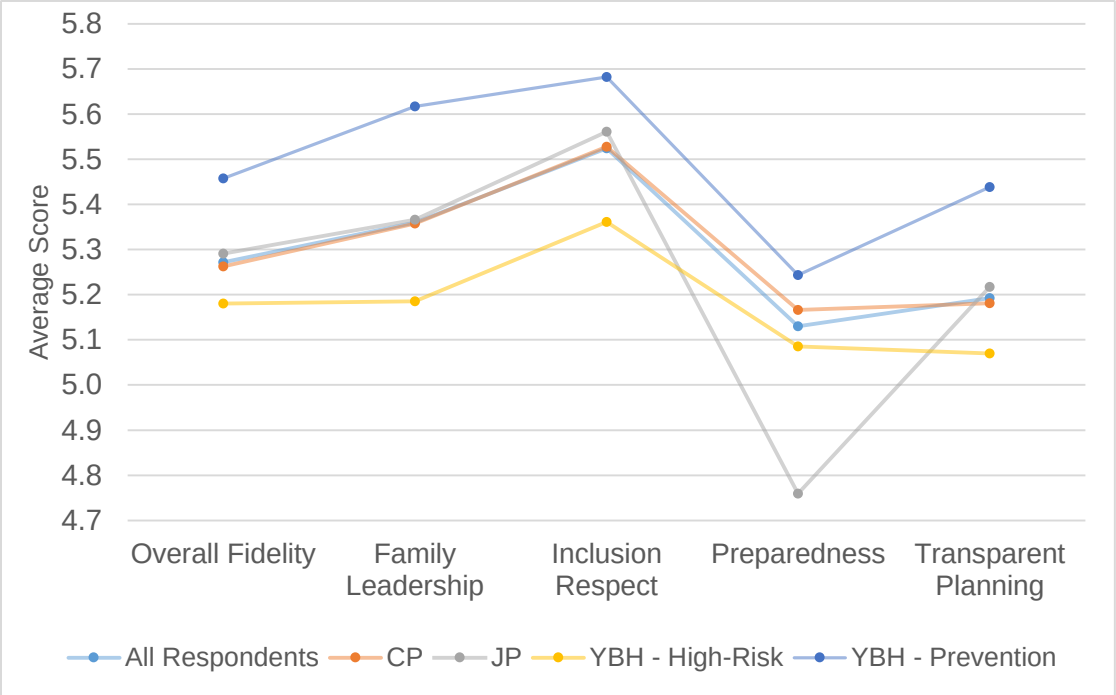
Figure 10. FGC Fidelity Scores, Overall and by Type of Respondent (*n* = 63)



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.

While it may be tempting to compare across respondent types, the basis for calculating the scores varies according to whether one is a coordinator and/or Facilitator, co-facilitator, family/like family, or service provider participant. Therefore, we do not recommend comparing at this level. Still, we examined fidelity scores by study unit and conducted within respondent type comparative analyses, however. Figure 11 presents the study unit findings. ANOVAs examining whether the average overall score or individual domain scores varied significantly by study unit indicated that any observed differences were *not* statistically significant.

Figure 11. Fidelity Scores by Study Unit (*n* = 63)



Finally, we conducted paired sample t-tests to determine if similar groups of respondents attending the same FGC scored the FGC differently. Our analysis did not identify significant differences between: maternal and paternal family/like-family scores; white, non-Hispanic family members and non-White

and/or Hispanic family members' scores; white, non-Hispanic service providers and non-White and/or Hispanic service providers' scores, and, with one exception, agency staff vs other service providers' scores. In this last instance, agency staff reported higher scores for the Preparedness Domain compared to other service providers attending the same FGC ($t(38) = 2.366$, $p = .023$).

Youth Connections Scale

Background

The YCS is divided into five sections, representing: (A) Tools for Youth Connections, (B) Number of Supportive Adult Connections, (C) Strength of Youth Connections, (D) Support Indicators, and (E) Level of Youth Connections. The Tools for Youth Connections section measures whether genograms or Lifebooks were created with the child. The Number of Supportive Adult Connections section measures the number of meaningful relationships that the youth has with various groups of adults (i.e., parents, professionals, spiritual leaders, adult friends) who can be counted on for some type of support. In the Strength of Connections section, the youth reports the strength of their relationship with parents, siblings, other adult relatives, and other caring adults identified by the youth on a scale from very weak to very strong. The Support Indicators section provides a list of 19 support indicators (i.e., a home to go to for the holidays, someone to provide emergency cash in times of emergency, a place to do laundry, etc.), and asks the youth whether they have an adult in their life whom could be counted on to provide those things after leaving foster care. Finally, the Level of Youth Connections section measures the degree to which youth feel a) connected to caring adults and relatives while in foster care, and b) feel that an adult has made a lifelong commitment to provide a parent-like relationship to them. An overall score is calculated to assess overall relational permanence, encompassing all five sections and ranging from 0-100. Scores of 80-100 can be interpreted as a 'Very High' level of connectedness, with lower scores representing 'High' (60-79), 'Moderate' (40-59), 'Low' (20-39) or 'Very Low' (0-19) levels of connectedness.

Youth Connections Scale Pretest

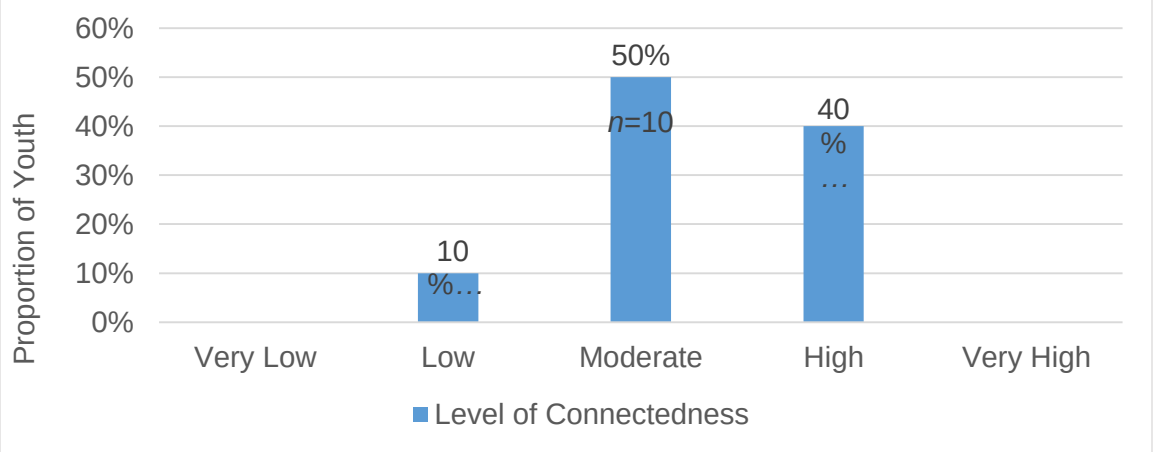
Table 3 below displays mean overall scores for each subsection and the total scale score for the 20 youth who completed the YCS at pretest. The average total score for youth completing the YCS pretest was 55.6, which indicating a 'Moderate' overall level of connectedness. Support indicators of connectedness (section D) were particularly high, with youth reporting an average of 16.2 indicators out of a possible 19. This indicates that youth felt that, after leaving foster care, they would have an adult in their life who could support them in most indicators included in the survey.

Table 3: Mean scores overall and by section for youth completing the YCS at Pretest (*n*=20)

Sub-Section	Possible Range	Mean (Observed Range)
A: Tools for Youth Connections	0-2	0.4 (0-2)
B: Number of Connections	0-39	15.4 (6-25)
C: Strength of Connections	0-24	14.2 (7-22)
D: Support Indicators	0-19	16.2 (0-19)
E: Permanent Connections	0-16	9.6 (1-16)
Total Score	**0-100**	**55.6 (31-70)**

Using the scores presented above, Figure 12 categorizes each youth who completed the YCS at pretest into a Level of Connectedness, very high to very low, based on the scoring criteria provided previously.

Figure 12: Overall level of connectedness for youth completing the YCS at Pretest (*n*=20)



At the time of YCS pretest completion, half of youth had scores placing them in the 'Moderate' level of connectedness category (50%), with another 40% falling into the 'High' level of connectedness category and 10% falling into the 'Low' level of connectedness category. Taken together, the results of Table 4 and

Figure 1 suggest that youth completing the YCS had moderate to high levels of relational permanency at baseline (e.g. time of FEC referral). Scores for each subsection of the YCS can be found in Appendix G.

Pre-Post Youth Connections Scale Comparison

A total of 8 youth completed both a pre- and post-test. Of these 8 youth, 6 had an FGC and 2 did not. The results below reflect pre-post comparisons for 6 youth, as 2 youth did not complete all sub-sections which precluded overall Level of Connectedness score calculations.

For the 6 youth for whom total YCS scores could be calculated at both pretest and posttest, average scores rose from 60.3 to 64.8 (Table 4). A test of significance was not calculated due to the small sample size.

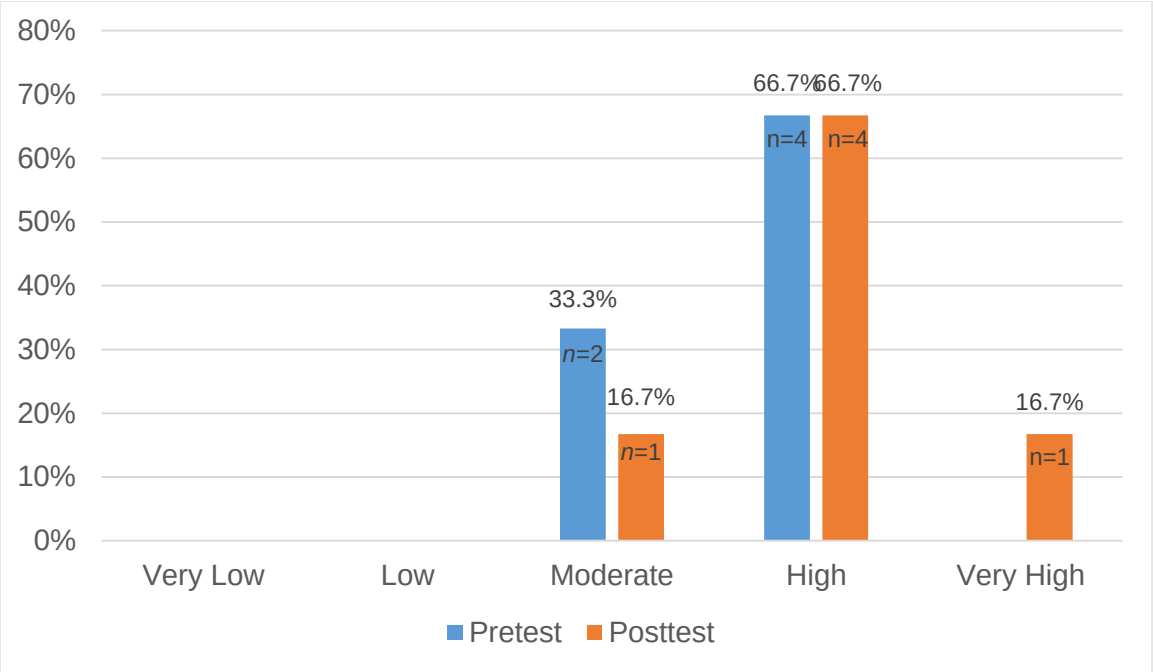
Table 4: Mean scores by section and overall for youth completing the YCS at Pretest* (*n*=6)

Sub-Section	Mean Pretest	Mean Posttest	Mean Change
A: Tools for Connectedness	0.2	0.7	+0.5
B: Number of Connections	16.5	16.8	+0.3
C: Strength of Connections	15.5	18.0	+2.5
D: Support Indicators	18.2	18.2	-
E: Permanent Connections	10.0	11.2	+1.2
Total Score	**60.3**	**64.8**	**+4.5**

*Includes only those with both a pretest and a posttest and for whom enough data was available for a score to be calculated.

Figure 13 displays the overall level of connectedness for youth in the pretest and posttest period. One youth moved from a high level of connectedness at pretest to a very high level of connectedness at posttest, while another youth moved from a moderate level of connectedness to a high level of connectedness. The remaining 4 youth did not change categories (1 remained in the moderate level category while 3 remained in the high-level category). A test of significance was not calculated due to the small sample size. In addition, due to the small sample size, item-specific responses are not further described in comparing YCS Pretests and Posttests.

Figure 13: Overall level of connectedness for youth completing the YCS at Pretest and Posttest* (*n*=6)



*Includes only those with both a pretest and a posttest and for whom enough data was available for a score to be calculated.

Services Received

Administrative data provided by the OCCS was used to compare service provision in six different categories between target youth who received an FGC as well as those that did not receive an FGC. It should be noted that this analysis of services only captures services paid for by OCCS and, as such, is not an exhaustive list of all services potentially received by a youth. Within the treatment sample of 65 youth who received an FGC before December 31, 2015, families participated in an FGC, on average, 110 days following referral to the study. We applied this 110-day window, or grace period, to the 18 comparison cases who were referred for, but did not have an FGC, as well as the 8 cases who received an FGC after December 31, 2015. This was done to preserve the maximum number of FEC cases in the sample while still allowing for adequate follow-up timeframes (e.g. six months' minimum from when an FGC was held).. Billed services were assigned to 6 different categories, including basic needs, child care services, financial services, mental health services, substance abuse services, and other services (a detailed categorization

of all billed services accounted for can be found in Appendix H). We also compared the mean number of categories in which at least one service was received between the treatment and comparison group.

Table 5: Description of Services Received following (estimated)* FGC Date

Service Category	Treatment Group (*n*=65) N (%)	Comparison Group (*n*=26) N (%)	p-value
Basic Needs	42 (64.6%)	12 (46.2%)	0.11
Child Care Services	22 (33.9%)	6 (23.1%)	0.31
Financial Services	0 (0.0%)	1 (3.7%)	0.29
Mental Health Services	13 (20.0%)	5 (19.2%)	0.94
Other Services	8 (12.3%)	2 (7.7%)	0.72
Substance Abuse Services	2 (3.1%)	0 (0.0%)	>0.99

*For the treatment group, any services with a start date after FGC meeting date. For the control group, any services with a start date after the estimated FGC meeting date.

In most service categories, a higher proportion of youth receiving an FGC received services than those who did not receive an FGC, although these differences were not statistically significant (partially reflecting the small sample size) (Table 5). Those who had an FGC received services in an average of 1.34 out of 6 categories, while those who did not have an FGC received services in an average of 1.00 out of 6 categories. This difference was not statistically significant (p=0.09). A limitation of this analysis, however, is the lack of services data for other individuals within the family unit. As the FGC is a family-level intervention we would want to have a greater understanding of services provided to the family unit as a whole, not just the target youth.

D. Outcome Evaluation Results

Administrative data from Olmsted County were used to analyze effects of this model on re-involvement with the OCCS system and placements throughout the life of a case for those youths referred to the FEC project – from the time of initial intake to the FGC referral, the FGC, and in the follow-up period after the FGC occurred. We defined *re-involvement* in terms of whether a case was accepted for either a compulsory CP assessment or voluntary/service needs/non-CP intake. We defined *placements*

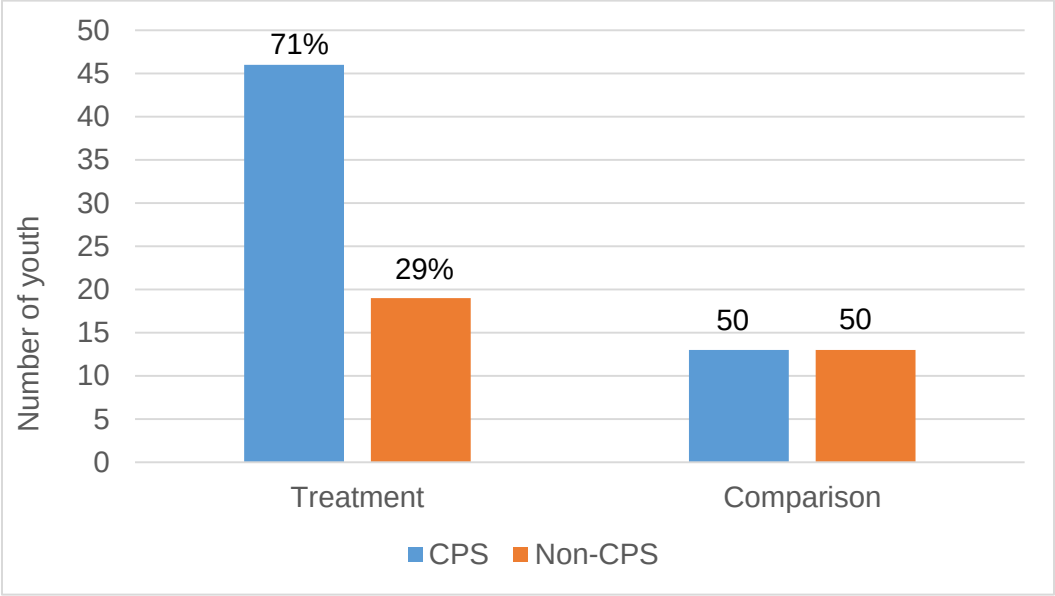
in terms of whether the child experienced an out-of-home placement. We examined both the number of placements and the level of placement (from least to most restrictive).

Mirroring the approach taken in the services analysis we counted any intake to Olmsted OCCS or removal of a child from his/her home after an FGC or after the 110-day window as an affirmative outcome in these analyses. Thus, the total sample available for the outcome analyses was 91 cases, of whom 65 received an FGC before December 31, 2015 (e.g. the treatment group), and 26 cases who did not (e.g. the comparison group).

It should be noted that the numbers of prior and subsequent intakes and removals are only partially known. Minnesota data privacy statute dictates an automatic purging of its SSIS system for certain types of data collected more than 5 years before the current date; it is conceivable that some early assessments, intakes or removals were missing because of these purging controls. Similarly, subsequent intakes or removals may have been underestimated because some intakes and removals likely occurred after the study had ended.

For both outcomes of interest, we were interested in the average numbers of assessments/intakes and removals that occurred, as well as whether these averages differed across by group (treatment *vs*. comparison) and study unit (CP *vs*. non-CP). Non-CP units included both JP and YBH which JP and YBH cases were combined due to low referrals in both units which precluded the ability to analyze by each individual study unit. As shown in Figure 5, the treatment group of those referrals that received an FGC consisted primarily of CP cases (n = 46, vs. n = 19 control cases). In contrast, CP and non-CP cases were evenly split within the comparison group of those referrals that did not receive an FGC (13 CP cases and 13 non-CP cases). We tested mean differences between treatment and comparison groups using independent *t*-tests. Because splitting the treatment and comparison groups into CP and non-CP cases resulted in reduced sample sizes (and therefore reduced statistical power), we did not test for significant differences when we looked at results by both group and study unit.

Figure 14. Number/Percent of youth in the treatment and comparison group by study unit (CP versus non-CP)



OCCS Re-Involvement

As aforementioned the definition of OCCS re-involvement is any CP assessment or YBH/JP intake experienced by a target youth during any of the timeframes of interest. To understand the effects of involvement in the FEC study on OCCS re-involvement, we considered (1) *number of prior intakes/assessments* defined as those that preceded the youth's referral to the FEC study; (2) *number of intakes/assessments during the youth's involvement in the FEC study,* defined as the intake/assessment that led to the youth's referral in the FEC study plus any intakes/assessments that occurred up to the FGC, and (3) *number of subsequent intakes/assessments*, defined as intakes/assessments that occurred after the study FGC. Referral was defined as the date on which the youth was referred or deemed eligible to participate in the FEC study (whichever came later). For each time period, we distinguished between compulsory, CP assessments and non-CP intakes. Non-CP intakes refer to intakes to non-child protection units including: adoption/guardianship, adult mental health, adult protective services, chemical dependence, general child welfare, children's mental health, developmental disabilities, and parent support outreach.

Average number of intakes/assessments

We examined the average (mean) number of CP assessments and non-CP intakes prior to, during, and after the study for the treatment and comparison groups and by study unit (CP versus non-CP). Full descriptive statistics are provided in Table 7. The average numbers of both CP assessments and non-CP intakes were low for all groups at each time point, with means less than 1 for all outcomes except prior CP assessments and CP assessments during study in the CP treatment group, which is to be expected given that the index assessment (e.g. the assessment that resulted in FEC eligibility) is included in the latter. This finding indicates that, on average, cases did not have an intake before, during, or after the study, except for CP treatment group cases, who had on average 1 prior CP assessment and 1 CP assessment during the study. For all outcomes, however, the standard deviation (SD) was greater than 0, indicating that there was variability around the means. That is, while, on average, cases did not have an intake before, during, or after the study, some cases did have one or more intakes. This variability is also shown by the minimum and maximum values for the intakes; although the minimum number of intakes was 0 in all cases, the maximum number of intakes ranged from 1 to 9 (non-CP treatment group, prior CP assessments).

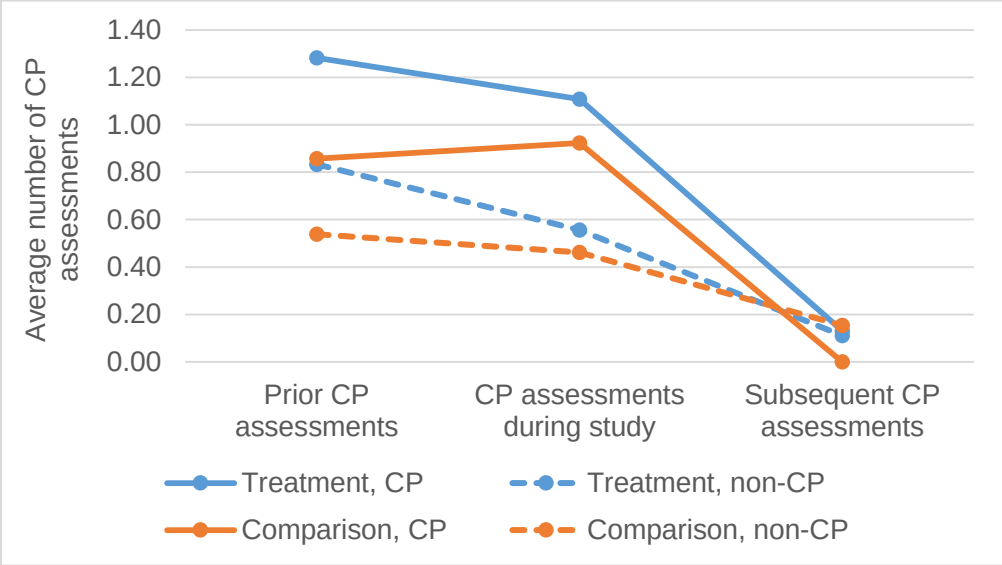
Table 6. Descriptive statistics for assessments/intakes by group (treatment *vs*. comparison) and study unit (CP *vs*. non-CP)

	N	Mean	*SD*	Median	Minimum	Maximum
Treatment group - CP						
Prior CP assessments	46	1.28	2.07	0	0	8
Prior non-CP intakes	46	.28	.46	0	0	1
CP assessments during study	46	1.11	.57	1	0	3
Non-CP intakes during study	46	.74	.44	1	0	1
Subsequent CP assessments	46	.13	.40	0	0	2
Subsequent non-CP intakes	46	.33	.47	0	0	1
Comparison group - CP						
Prior CP assessments	14	.86	1.17	.50	0	4
Prior service intakes	14	.36	.50	0	0	1
CP assessments during study	13	.92	.49	1	0	2
Non-CP intakes during study	13	.69	.48	1	0	1
Subsequent CP assessments	14	.00	.00	0	0	0
Subsequent non-CP intakes	14	.57	.51	1	0	1
Treatment group – non-CP						

	N	Mean	*SD*	Median	Minimum	Maximum
Prior CP assessments	18	.83	2.15	0	0	9
Prior non-CP intakes	18	.17	.38	0	0	1
CP assessments during study	18	.56	.78	0	0	2
Non-CP intakes during study	18	.00	.00	0	0	0
Subsequent CP assessments	18	.11	.32	0	0	1
Subsequent non-CP intakes	18	.56	.51	1	0	1
Comparison group – non-CP						
Prior CP assessments	13	.54	.52	1	0	1
Prior non-CP intakes	13	.23	.44	0	0	1
CP assessments during study	13	.46	.66	0	0	2
Non-CP intakes during study	13	.08	.28	0	0	1
Subsequent CP assessments	13	.15	.38	0	0	1
Subsequent non-CP intakes	13	.62	.51	1	0	1

Figure 15 shows the average number of CP assessments before, during and after the study by group and study unit. CP cases within both the treatment and comparison group had a higher average number of prior CP assessments and CP assessments during the study compared with non-CP cases. By the end of the study, all groups had very low levels of CP assessments

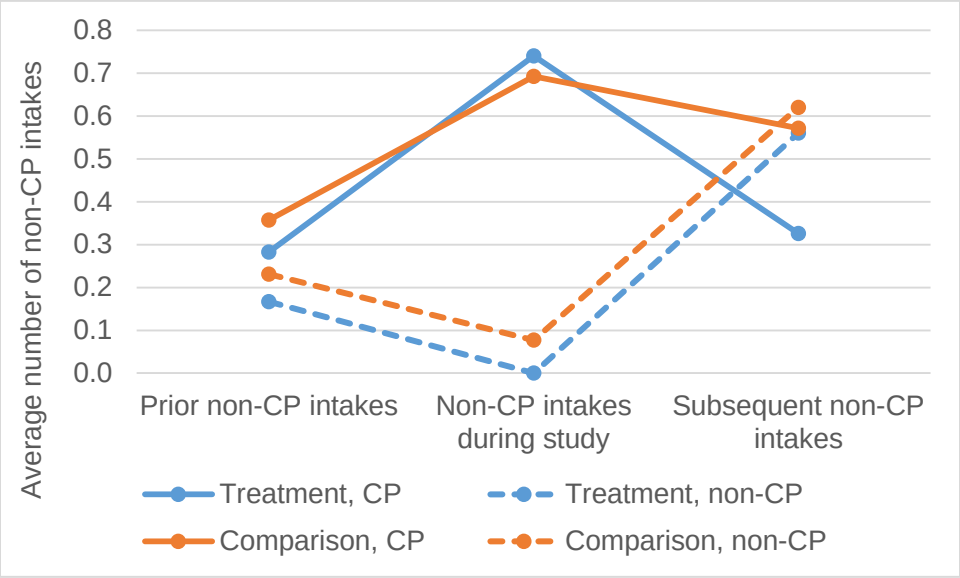
Figure 15. Average number of CP assessments by group (treatment *vs*. comparison) and study unit (CP *vs*. non-CP)



Finally, Figure 16 depicts the average number of non-CP intakes before, during and after the study by group and study unit. The average number of non-CP intakes before the study was relatively low in all four groups. During the study, however, there were relatively high levels of non-CP intakes among CP cases within both the treatment and comparison group, and very low levels among non-CP cases within

both groups. There were relatively high levels of non-CP intakes after the study in all groups except for CP treatment cases.

Figure 16. Average number of non-CP intakes by group (treatment *vs*. comparison) and study unit (CP *vs*. non-CP)



Both figures above appear to demonstrate a more consistent pattern of re-involvement by target population (CP versus non-CP), more so than study group (treatment versus control). However, as aforementioned these findings were not tested for statistical significance due to low numbers of target youth in each group and are presented as descriptive findings only.

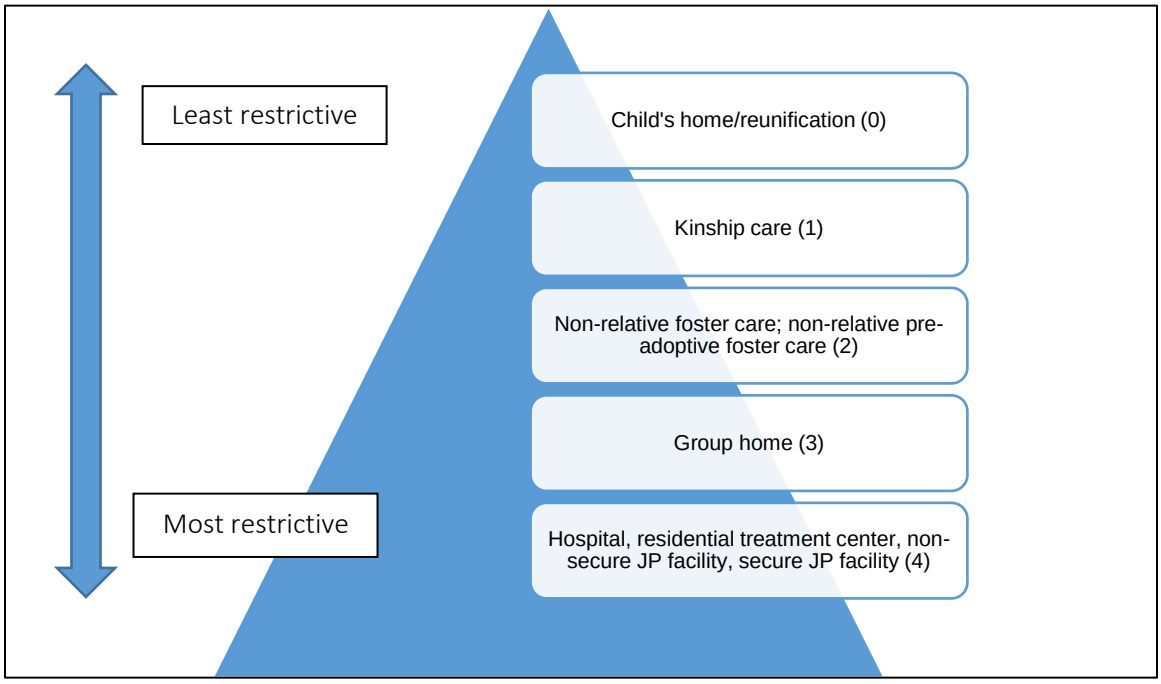
Out-of-Home Placements (Removals)

A total of 84 cases experienced at least one out-of-home placement over the analysis period. This sample included 60 treatment youth (46 CP, 14 non-CP) and 24 comparison youth (13 CP, 11 non-CP). We categorized the timing of placements in terms of five key time periods of interest: (1) *before the study*, defined as a placement that occurred prior to intake to the study; (2) *intake date*, defined as a placement that occurred between the intake date and the FEC referral date, (3) *referral date*, defined as a placement that occurred between the referral date and the date of the FGC, (4) *FGC date,* defined as a placement that occurred within 30 days following the date of the FGC (or date corresponding to the 110-day window

in the comparison group), and (5) *after the study*, defined as a placement that occurred more than 30 days after the FGC. The 30-day window was chosen to understand placements that occurred immediately following, and presumably triggered by, the FGC. Mirroring our approach for intakes, *referral* was defined as the date on which the youth was referred or deemed eligible to participate in the FEC study (whichever came later).

We were interested in both the *average number* of placements at each of the five time points and the *average restrictiveness* of placement. We examined average placement restrictiveness to evaluate whether youth were more likely to be placed in less restrictive placements after as a result of participating in the FGC process. We identified five levels of placement restrictiveness, ranging from the least restrictive, most family-like environment, to the most restrictive placement. These levels were: not in placement/reunification (coded 0), kinship placement (coded 1), somewhat restrictive (coded 2; e.g. non-relative foster care), moderately restrictive (group home; coded 3), and most restrictive (coded 4; e.g., residential treatment or correctional facility). Figure 17 shows which placement types comprised each of these three categories.

Figure 17. Placement Categories by Levels of Restrictiveness



Where multiple placements had occurred during any of the five key time periods, we took the average level of placement restrictiveness across the placements for that period. For example, if a youth had been in a secure JP facility, group home, and then to a non-secure JP facility prior to the study (i.e., 3 placements), placement restrictiveness for prior placement was coded as 3.66 (calculated as 4+3+4/3).

Average number of placements

Figure 18 depicts the average number of placements at each of the five study points by group and study unit. Full descriptive statistics are provided in Table 8. Before the study, average number of placements was higher for non-CP cases compared with CP cases within both groups. After referral to the study, both treatment groups saw an increase in average number of placements, followed by a plateau after the FGC meeting date or date of the 110-day window. The non-CP treatment group saw a substantial decline in the average number of placements over the course of the study; the average number of placements for 5.3 before the study compared with an average of 2 placements after the

study. In contrast, the average number of placements in the CP treatment group was around the same before and after the study (3.3 and 3 placements, respectively).

The average number of placements in the CP comparison group was relatively low across the course of the study, ranging from 1.00 (at the date of the 110-day window) to 2.2 (intake date). The average number of placements in non-CP comparison group, by contrast, fluctuated considerably, with a sharp decline at intake (from an average of 4.8 to 2.3 placements), but increasing again at referral (3 placements, on average) and after the study (4.9 placements, on average).

It should be noted that these average numbers sometimes conceal considerable variation. As shown in Table 7, for example, the minimum number of placements after the study for CP treatment cases was 1, whereas the maximum number was 12. The median number of placements provides a less skewed picture of the trends over time. For example, the median number of placements after the study for CP treatment cases was 1.5. Prior to the study, the median number of placements for this group was 3. Non-CP treatment cases also saw a decline in the median number of placements, from 6 placements before the study to 2 placements after the study. The median number of placements declined in the non-CP comparison group (from 5 placements before the study to 3.5 placements after the study), but stayed the same in the CP comparison group (1.5 placements before and after the study).

Figure 18. Average number of placements at five study time points by group (treatment *vs*. comparison) and study unit (CP *vs*. non-CP)

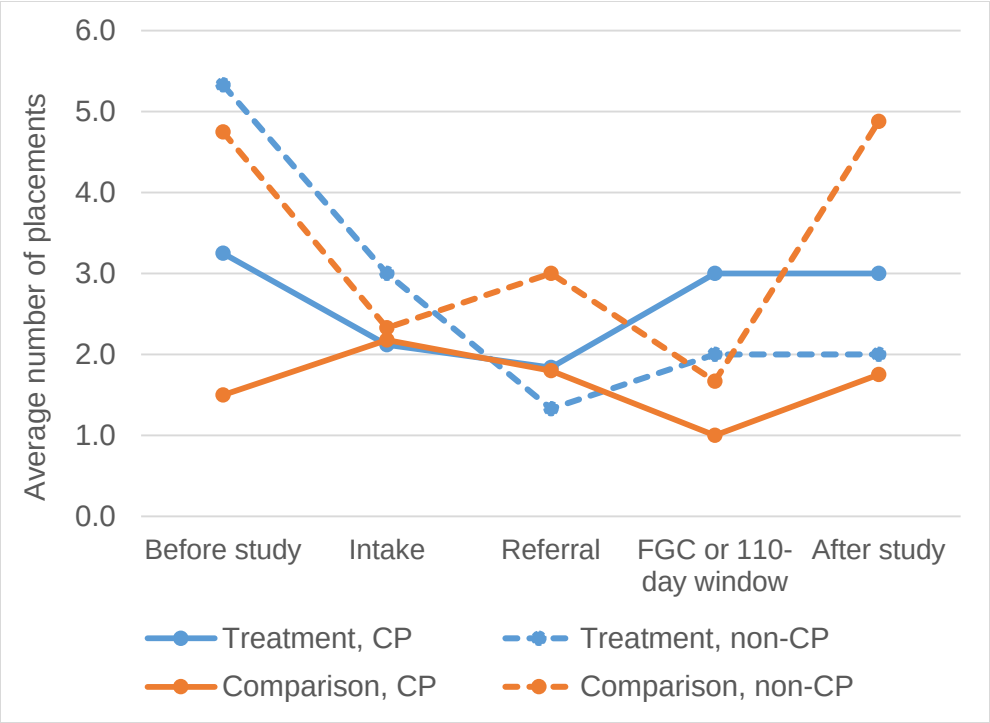


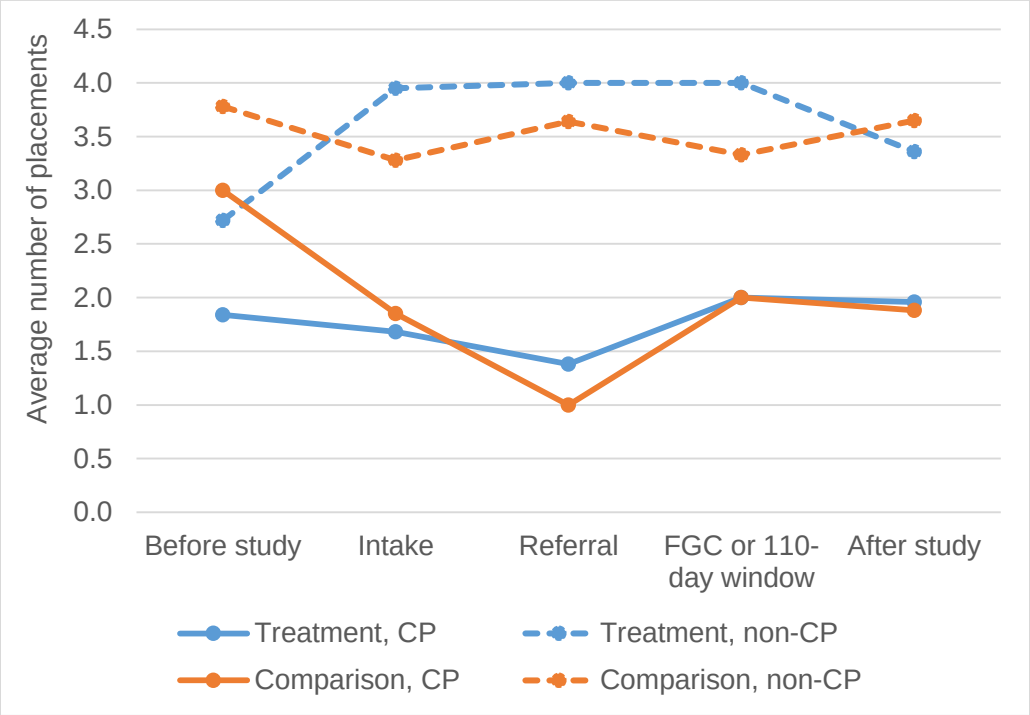
Table 7. Descriptive statistics for average number of placements by group (treatment *vs.* comparison) and study unit (CP *vs.* non-CP)

	N	Mean	*SD*	Median	Minimum	Maximum
Treatment group – CP						
Prior placements	4	3.25	1.26	3.00	2.00	5.00
Intake placements	26	2.12	1.21	2.00	1.00	6.00
Referral placements	25	1.84	.99	1.00	1.00	4.00
FGC or 110-day placements	2	3.00	.00	3.00	3.00	3.00
Subsequent placements	18	3.00	3.22	1.50	1.00	12.00
Comparison group – CP						
Prior placements	2	1.50	.71	1.50	1.00	2.00
Intake placements	11	2.18	1.08	2.00	1.00	4.00
Referral placements	5	1.80	.84	2.00	1.00	3.00
FGC or 110-day placements	1	1.00	-	1.00	1.00	1.00
Subsequent placements	4	1.75	.96	1.50	1.00	3.00
Treatment group – non-CP						
Prior placements	3	5.33	3.06	6.00	2.00	8.00
Intake placements	10	3.00	1.94	2.50	1.00	6.00
Referral placements	3	1.33	.58	1.00	1.00	2.00
FGC or 110-day placements	1	2.00	-	2.00	2.00	2.00
Subsequent placements	7	2.00	1.60	2.00	1.00	5.00
Comparison group – non-CP						
Prior placements	4	4.75	2.22	5.00	2.00	7.00
Intake placements	6	2.33	1.97	1.50	1.00	6.00
Referral placements	5	3.00	1.23	3.00	2.00	5.00
FGC or 110-day placements	3	1.67	1.16	1.00	1.00	3.00
Subsequent placements	8	4.88	4.39	3.50	1.00	15.00

Average restrictiveness of placements over time.

As described above, placement restrictiveness was rated on a 0-4 scale: reunification/not in placement (coded 0), kinship placement (coded 1), somewhat restrictive (coded 2; e.g. non-relative foster care), moderately restrictive (group home; coded 3), and most restrictive (coded 4; e.g., residential treatment center). Figure 19, shows average placement restrictiveness at each of the five study points by group and study unit for youth who had experienced a placement at any of the five study time points. Full descriptive statistics are provided in Table 8.

Figure 19. Average placement restrictiveness by group (treatment *vs*. comparison) and study unit (CP *vs*. non-CP)



Mirroring the finding for average number of placements, average placement restrictiveness was generally higher for non-CP cases compared with CP cases within both groups. This finding is not surprising given that a much higher proportion of the comparison group relative to the treatment group were in non-CP units, which included JP; by definition, youth in JP are placed in the most restrictive placements (e.g., secure or non-secure JP facility). Within both CP groups, there was a decrease in

average placement restrictiveness followed by an increase after referral. After the date of the FGC meeting or 110-day window, placement restrictiveness was low and relatively stable. Within the non-CP treatment group average placement restrictiveness increased at intake and was high and stable until the FGC meeting date, at which point average placement restrictiveness declined. Within the non-CP comparison group, average placement restrictiveness was high and relatively stable across all five study points. In contrast to the average number of placements, there was much less variation in average placement restrictiveness; that is, mean and median levels of placement restrictiveness were generally similar.

Table 8. Descriptive statistics for average placement restrictiveness by group (treatment *vs.* comparison) and study unit (CP *vs.* non-CP)

	N	Mean	*SD*	Median	Minimum	Maximum
Treatment group - CP						
Prior placements	4	1.84	.94	2.10	.50	2.67
Intake placements	26	1.68	.96	1.13	1.00	4.00
Referral placements	25	1.38	.55	1.00	0	2.00
FGC or 110-day placements	2	2.00	.00	2.00	2.00	2.00
Subsequent placements	16	1.96	1.29	1.29	1.00	4.00
Comparison group - CP						
Prior placements	2	3.00	1.41	3.00	2.00	4.00
Intake placements	11	1.85	.67	2.00	1.00	3.33
Referral placements	5	1.00	.71	1.00	0	2.00
FGC or 110-day placements	1	2.00	-	2.00	2.00	2.00
Subsequent placements	4	1.88	.85	1.75	1.00	3.00
Treatment group – non-CP						
Prior placements	3	2.72	.75	2.67	2.00	3.50
Intake placements	10	3.95	.16	4.00	3.50	4.00
Referral placements	3	4.00	.00	4.00	4.00	4.00
FGC or 110-day placements	1	4.00	-	4.00	4.00	4.00
Subsequent placements	7	3.36	1.18	4.00	3.50	4.00
Comparison group – non-CP						
Prior placements	4	3.78	.28	3.84	3.43	4.00
Intake placements	6	3.28	1.00	3.84	2.00	4.00
Referral placements	5	3.64	.50	4.00	3.00	4.00
FGC or 110-day placements	3	3.33	1.15	4.00	2.00	4.00
Subsequent placements	8	3.65	.34	3.74	3.00	4.00

Finally, it is of interest to examine in more detail the types of placements received by group and study unit over the course of the study. Figure 20 depicts the proportion of placement types experienced by each group and study unit at each of the five study points. Each bar shows when a given placement

type occurred over the course of the study. Thus, for example, cases in the CP treatment group were classed as 'not in placement' at three study points: before the study, at the referral date, and after the study. A higher number of children were not in placement after the study, however, which is why the bar is predominantly dark blue. In contrast, unauthorized absences only occurred after the study within this group. It should be noted that the proportion of placement types at any study point does not provide direct information on the *number* of cases. For example, 100% of unauthorized absences in the CP treatment group occurred at the end of the study; however, this represented only one case within this group. The numbers and proportions are shown in full in Table 9.

Figure 20 reveals several trends. CP and non-CP treatment cases were most likely to have no placement (i.e., to be reunified) after the study compared with any other time in the study. CP cases in both treatment and comparison groups had kinship placements at several stages of the study, notably at intake and referral. In contrast, kinship placement in the non-CP treatment group did not occur until the end of the study. Within the non-CP treatment group, cases were most likely to be in the most restrictive placement types at the time of intake. No non-CP comparison cases experienced reunification or a kinship placement over the course of the study. Overall, these findings point to a picture in which treatment cases moved to less restrictive placements over the course of the study, with the caveat, as described above, that this is perhaps not surprising given that a much higher proportion of the comparison group relative to the treatment group were in non-CP units, and therefore more restrictive placements.

Figure 20. Types of placement (%) at each study period by group (treatment *vs*. comparison) and study unit (CP *vs*. non-CP)

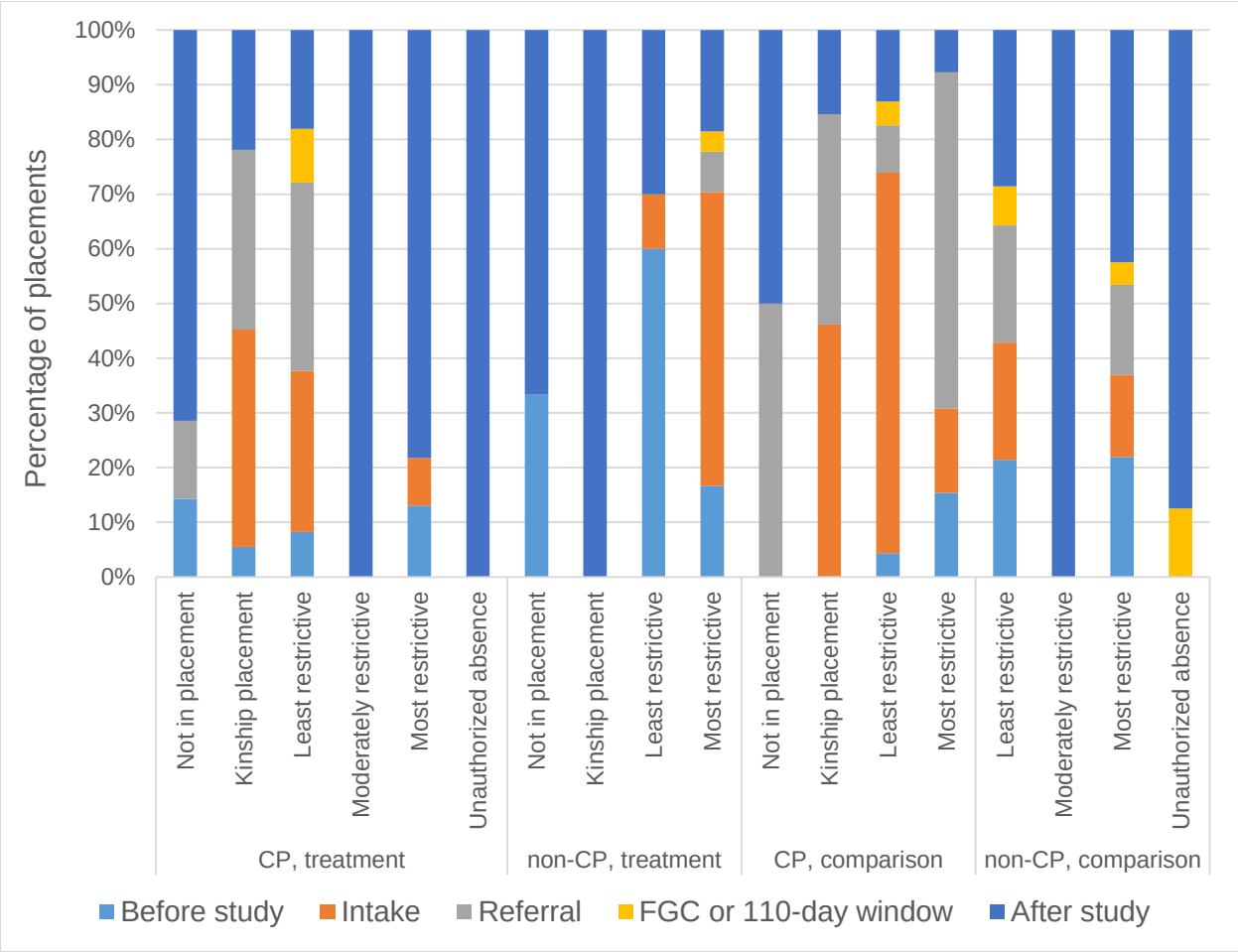


Table 9. Types of placement (number and %) at each study period by group (treatment *vs*. comparison) and study unit (CP *vs*. non-CP)

Study unit, Group	Placement type	Before study	Intake	Referral	FGC or 110-day window	After study
CP, treatment	Not in placement	1 (14%)		1 (14%)		5 (71%)
	Kinship placement	4 (5%)	29 (40%)	24 (33%)		16 (22%)
	Least restrictive	5 (8%)	18 (30%)	21 (34%)	6 (10%)	11 (18%)
	Moderately restrictive					2 (100%)
	Most restrictive	5 (20%)	2 (8%)			18 (72%)
	Unauthorized absence					1 (100%)
Non-CP, treatment	Not in placement	1 (50%)				1 (50%)
	Kinship placement					2 (100%)
	Least restrictive	6 (60%)	1 (10%)			3 (30%)
	Most restrictive	9 (17%)	29 (54%)	4 (7%)	2 (4%)	10 (18%)
CP, comparison	Not in placement			1 (50%)		1 (50%)
	Kinship placement		6 (47%)	5 (37%)		2 (16%)
	Least restrictive	1 (4%)	16 (70%)	2 (9%)	1 (4%)	3 (13%)
	Most restrictive	2 (15%)	2 (15%)	8 (62%)		1 (8%)

Study unit, Group	Placement type	Before study	Intake	Referral	FGC or 110-day window	After study
Non-CP, comparison	Least restrictive	3 (21%)	3 (21%)	3 (21%)	1 (7%)	4 (30%)
	Moderately restrictive					3 (100%)
	Most restrictive	16 (22%)	11 (15%)	12 (16%)	3 (4%)	31 (43%)
	Unauthorized absence				1 (12%)	7 (88%)

E. Cost Study Results

The following cost analyses utilize information on the salaries, fringe benefits, and time allotment of personnel involved in the administration of FGCs. This *cost allocation* is distinct from a cost-benefit or cost-effectiveness analysis as it only calculates the total annual cost of FGC provision (and the subsequent cost per meeting); this analysis cannot, by design, assess cost-effectiveness because the marginal increase in cost to provide FGCs over services as usual has not been measured and the lack of inability to test for meaningful differences between treatment and control groups regarding re-referrals and out-of-home placements make it impossible to generate cost savings estimates resulting from the intervention. This cost estimate represents the cost to OCCS and does not differentiate between units nor does it and include the cost of participating in FGCs to other systems (e.g., mental health counselors invited to participate in the meetings).

Table 10 presents the estimated personnel and non-personnel overhead costs for FGCs in OCCS.[2] Costs were calculated for all personnel involved in the delivery of FGCs, including FGC coordinators, caseworkers, administrative staff, and their supervisors in the year 2014; the only full calendar year of FEC implementation. The cost of FGC coordinators' time was calculated using their hourly rate multiplied by the average number of hours worked per FGC and the number of FGCs held in 2014. It should be noted that some FGCs held during that year were outside of the purview of the FEC project; however,

[2] Only the costs of FGCs are considered. The costs of *other* family meeting types (e.g., Case Planning Conferences) are excluded.

system-wide practice changes were implemented in OCCS as a result of the training received such that the cost of an FGC within the purview of the project is expected to be the same as those outside of it. The cost of caseworkers' time was calculated using their hourly rate multiplied by the average time spent on FGCs (in the meeting and preparation time) multiplied by the number of FGCs held in 2014. The cost of supervisors' time was calculated using their annual salary multiplied by the FTE (full-time equivalent) allotted for supervising FIS coordinators multiplied by the percentage of FGCs held in 2014 versus other meeting types. And, the cost of administrative (clerical) staff was calculated using their annual salary multiplied by the FTE allotted to supporting FGCs under the purview of the FEC project.

Fringe benefits and non-personnel costs were included to represent the entire cost of FGC delivery. Fringe benefit costs were calculated using the payroll rates used to budget benefit costs based on employment classifications. Non-personnel costs, which typically include contracted services, supplies and materials, durable equipment, rent and facilities, training, other direct costs, and indirect overhead, were estimated at 25% because not all of the non-personnel costs could be itemized. Twenty-five percent was derived from two seminal cost studies (Burwick et al., 2014; Corso & Filene, 2009) that demonstrated these costs average between 24-28% (though non-personnel cost estimates have been shown to range from 11% to 46%).

Table 10. Total Estimated Annual Cost of FGCs in OCCS

Cost Category	Amount
Personnel Salary	$103,469
Personnel Fringe Benefits	$35,992
Direct Costs	$23,378
Non-Personnel Costs/Overhead	$40,710
Total:	$203,549
Number of FGCs Held (2014)	73
Estimated Cost per FGC:	$2,788

F. Evaluation Discussion

As discussed in the Evaluation Changes section, the number of referrals (both for the project generally, and each of the sub-populations in particular) were much lower than anticipated; this was a persistent challenge related to the evaluation which resulted in substantial limitations to the rigor of the final analyses. Small samples make it difficult to identify statistically significant effects or differences between groups, especially if an intervention had a small effect. In order to increase samples for the units with relatively few referrals, the JP, YBH-Prevention, and YBH-High-Risk Placement sub-populations were merged to form a non-CP analytic group that was used for the outcome analysis. However, because of this, any meaningful differences between the three non-CP populations (JP, YBH – Prevention and YBH – High-Risk Placement) could not be assessed in our analyses; for example, the inability to isolate the effect of being in the comparison group on average placement restrictiveness from the effect of being in non-CP units, which was associated with higher average placement restrictiveness.

The inability to conduct an outcome analysis comparing the influence of the integrated model on treatment youth trajectories through to those of their historical counterparts is an additional limitation of the evaluation. Since we did not have adequate data for the PSM control group cases for use as a reference, we were unable to explore how the integrated FF-FGDM model benefits families differently from practices employed in the past. Further, since the comparison group was composed of those FEC workgroups where a family was referred for an FGC but did not receive one by the end of the study period, we cannot control for differences in this sample of workgroups that may have influenced the findings. For example, it may be that the FEC workgroups that did not experience a meeting within the study period represented families with more complex needs or dynamics that may affect their performance on the outcomes examined. Further, there were other factors, unknown to the evaluation team that may have impacted whether a meeting occurred or not, and thus whether participants

ultimately ended up in the treatment or comparison group. As a result, it is possible that selection biases may be present.

While the analytic framework employed represents the best available option given the impact of data purges on the original plan to use a PSM historical control group, the use of only data from FEC referred families means the final analyses lacks the rigor of the originally proposed analysis. Indeed, the results point to a greater impact of target population (e.g. CP versus non-CP youth) on outcomes over treatment versus comparison group assignment indicating that the integrated model may not be the most salient factor in impacting outcomes for youth in OCCS. Moreover, the small sample size (overall and by unit) and high degree of specificity of Olmsted's integrated model mean generalizations of findings to other jurisdictions would not be advisable.

Therefore, while differences between groups may not have been identified in the above analyses, this should not suggest that the integrated model had no impact on target youth outcomes. It simply means that the impact may not have been large enough to be detected or that the limitations of the evaluation precluded our ability to detect them. As a result, many of the results contained in this report are purely descriptive, which is not to say they do not have value or provide insight into practice, but they are not the rigorous findings that the project and evaluation team hoped to generate.

That said, it is a tremendous endeavor for an agency such as OCCS to engage in research such as this. The agency and staff who implemented the FEC project should be commended for the dedication, time and effort it took to produce the information reflected in this report. We appreciate their efforts to build knowledge about family group decision making and family finding.

VII. Conclusions

FIGURE 21: PROJECT GOALS AND OBJECTIVES

Goal 1. Improve permanency outcomes for children and youth at-risk of coming into care and those in care	Outcomes
Objective 1.a. Increase the number of connections identified and engaged for the target population of children and youth through enhanced search mechanisms/engagement strategies.	• Relative foster care rate went from 35% in CY 2011 to 47% in CY 2015 • In CY 2015, 54% of children placed in foster due to child protection concerns were placed in relative foster care
Objective 1.b. Better measure the notion of "youth connectedness" through the perspective of the youth, and embed their perspectives into planning efforts.	• Social Worker training on importance of connections for youth • Youth Connections Scale utilized to facilitate a conversation about connections with youth – youth completing this scale score on upper end of moderate support ◦ Many social workers used this tool with youth not involved in the project • Use of mobility mapping and other tools to engage youth in planning for the FF/FGC – 20% of meetings utilized mobility mapping as a strategy • Of the total 94 FF/FGC, 89 youth participated with an average of 1.3 youth in attendance per family meeting
Goal 2. Improve the well-being outcomes for children and youth	
Objective 2.a. Continue to conduct trauma assessments, and integrate those assessments into the integrated family finding/FGDM model at all stages.	• Minnesota Pilot participant to embed trauma assessment into SDM (Structured Decision Making) - CY 2016 and CY 2017 • Staff received training on trauma assessment and have integrated a trauma focus into the consultation framework • FIS coordinators integrate trauma assessment information into preparing participants prior to, during and post conference
Objective 2.b. Embed a protective factors lens into the integrated family finding/FGDM model.	• Staff received research based training on the identification and utilization of strengths and protective factors • Family strength and protective factors are integrated into the consultation framework • FIS coordinators integrate protective factors into preparing participants prior to, during and post conference
Goal 3. Further institutionalize an evidence-based integrated family finding/FGDM model for the most at-risk youth, served by Children's Mental Health, Adolescent Behavioral Health and	

<table>
<tr><th>Juvenile Corrections</th><th></th></tr>
<tr><td>Objective 3.a. Create synergy in Olmsted County among all the different agencies, professionals and stakeholders, to embrace a philosophical and programmatic shift that places the extended family group and their social network at the center of planning and decision making.</td><td>
80% increase in overall utilization of FIS from 2012 to 2015
<table>
<tr><th></th><th>2012</th><th>2015</th><th>% increase</th></tr>
<tr><td>YBH</td><td>145</td><td>239</td><td>65%</td></tr>
<tr><td>JC</td><td>33</td><td>66</td><td>100%</td></tr>
<tr><td>CP</td><td>301</td><td>596</td><td>98%</td></tr>
</table>
153% increase in overall utilization of FF/FGC*, the most family driven FIS process, from 2012 to 2015
<table>
<tr><th></th><th>2012</th><th>2015</th><th>% increase</th></tr>
<tr><td>YBH</td><td>3</td><td>12</td><td>300%</td></tr>
<tr><td>JC</td><td>0</td><td>6</td><td>600%</td></tr>
<tr><td>CP</td><td>27</td><td>60</td><td>120%</td></tr>
</table>
*Includes FF/FGCs that occurred outside of the project
</td></tr>
<tr><td>Objective 3.b. Create various networks and Committees in Olmsted County to create and adapt the integrated family finding/FGDM model, to provide guidance to the evaluation, and to secure buy-in with the community's direction.</td><td>

Established Stakeholder Workgroup to develop the integrated FF/FGC model
Established Peer Network Group to support agency operationalization of an integrated FF/FGC model
Established Think Family to leverage cross system support and guidance of the project

</td></tr>
<tr><td>Objective 3.c. Demonstrate the effectiveness of an integrated family finding/FGDM model, using the evaluation results to support resource allocation decisions and possible expansion efforts.</td><td>
See Sustainability Chart which reflects full sustainability of the project post grant period.
</td></tr>
<tr><td>Objective 4.a. Leverage the national dissemination channels of the Children's Bureau T/TA network, the National Center on FGDM, and the National Institute for Permanent Family Connectedness, as well as the local and State networks to broadcast the results, in varying formats and products, to interested audiences.</td><td>
Dissemination activities included: 1) presenting at state, and international conferences, 2) developed a paper speaking to Olmsted's County's journey developing the FF/FGDM model, 3) funding a written brief focusing on research based information regarding kinship care and utilizing that information for training within the systems, 4) creation of a host of tools to assist social workers and systems for best practices implementation of model. (See Section V Sustainability for list of key products developed for dissemination)
</td></tr>
<tr><td>Objective 4.b. Building from existing tools created by the Kempe Center and NIPFC, develop a combined family finding/FGDM fidelity tool that can be used nationwide to assess for best practices.</td><td>

Developed fidelity tool in conjunction with Kempe Center and NIPFC
Implemented fidelity tool in research design
Integrated fidelity tool into the on-going evaluation of FIS program

</td></tr>
</table>

Project Facilitators Related to Project Implementation

Peer Network Group (PNG) was one of the most essential and valuable strategies developed for implementation of the model. Members of the Peer Network Group represented the "boots on the ground" that provided rapid cycle feedback to the direction of the project and were mentors to their respective peers regarding the FF/FGDM process. This membership was representative of all the three respective targeted groups and also included Guardian Ad Litems (GAL's) that represented the court system. The Peer Network Group had leadership responsibility in the development of tools to support implementation. (See Appendix Sustainability Products)

System stakeholders and families came together sooner and began building shared agreement within the context of the family's voice. System stakeholders were able to share non-negotiables and concerns which allowed the family to obtain clarity and create a plan in a manner that could be supported by all stakeholders. This process of consensus on the plan for the children had a direct impact in reducing the number of contested permanency cases in the court system.

The continuum of FIS Strategies allowed the system and the family to come to the table early in their work with one another. Data reflects that families received an average of 4.3 Case Planning Conferences (CPC's) which provided a venue to address immediate and day to day case planning for children. This further enhanced the capacity for the FF/FGDM integrated model to focus on finding, engaging, and mobilizing the family's network in long-term planning for the children.

Minnesota Relative Search Statute (MS 260C.221) was modified early in this grant process clarifying the requirements of notification of family and continual rigorous relative search throughout the involvement with the agency. The requirement of reasonable efforts to conduct a comprehensive relative search provided a conduit to engage stakeholders, including the Court system, to participate and support the development and the implementation of the FF/FGDM integrated model.

Project Barriers Related to Project Implementation

Time from referral of FF/FGDM to the actual conference was on average more than 110 days. A rigorous integrated FF/FGDM requires intensive family finding and engagement. In order to assure fidelity to the model, the scheduling of the FF/FGDM conference needed to occur within the context of the child's *entire* family's (maternal & paternal) readiness to come to the table. The integration of FIS meeting models early and throughout the case work with families further enhanced family finding and achieved ongoing engagement of the family in decision-making throughout the process.

Engagement of new target population served in Youth Behavioral Health and Juvenile Corrections created challenges in the ability for families and social workers to understand the purpose and benefit of the engagement of a wider "family" network. Specialized training was provided for social workers and FIS staff regarding advanced engagement skills specific to the target population's needs (i.e. mental health stigma, past family fractured relationships for older youth). Additionally, regular meetings occurred with Youth Behavioral Health and Juvenile Correction teams to further explain the process. Peer Mentors were partnered with new staff, FIS Coordinators were deployed to assist with family engagement to build a better understanding of the purpose and benefit of FF/FGDM, and development of TIP Sheets for social workers.

Project Impact on Parents, Children and Families

Family Involvement: A median of 10 family/like family members were present at the FF/FGDM conferences, with 45% of the conferences reporting more than 11 family/like family members present. Paternal family members were present in over 86% of the conferences. The variety of search/engagement strategies utilized by the conference coordinator (average 9 strategies utilized) and the use of technology (45% telephone participation and 29% video participation) allowed for the involvement of both sides of the family to participate in planning for the child/youth.

Family Plan Implemented: Family members who participated in a Follow-up FF/FGDM conference agreed that the family plan developed at the initial FF/FGDM conference was implemented. Family member fidelity scores reflected the following: (1) the family received the services that were included in the family plan; (2) the agency followed through with agreements that were made in the family plan; (3) and family members completed the parts of the plan they agreed to at the first conference.

Placements: There was not a significant difference between treatment and control children/youth in the average number of placements; however the treatment group experienced a lesser level of restrictiveness in placements.

Access to Services: The FF/FGDM process facilitated identification of service needs for the treatment group, evidenced by an increase of Non-Child Protection intakes upon referral. Subsequent Non-Child Protection intakes declined, demonstrating effectiveness of the FF/FGDM conference in identifying services needs for youth and families. A decline in Non-Child Protection intakes indicates promising results regarding the effectiveness in increasing the "family" network to reduce reliance on formal systems. In contrast, the comparison group experienced an increase in Non-Child Protection intakes throughout the study. Child Protection intakes declined for both treatment and comparison children/youth demonstrating the agency's attention to child/youth safety across all target populations.

Project Impact on Partner Organizations

The average number of service providers in attendance at the FF/FGDM conference was 3.5 for Child Protection referrals. The purpose of these FF/FGDM conferences was to develop family driven alternative permanency plans for children who have been placed outside of their homes. In an effort to ensure families have accurate information to develop plans pertaining to permanency, an adoption/foster care social worker, in addition to the referring social worker, is in attendance. This allows for an immediate response to questions, empowering the family to develop an informed family plan. Bringing family and service providers to the table at the same time to discuss the long term plan for the child

allowed for system support of the family's decision eliminating the need to utilize the court system to negotiate a permanency plan for the child. (90% of conferences had agreement on the plan at closure of the conference)

Project Impact in the Child Welfare Community

The integrated FF/FGDM process provides a strategy to meet Minnesota child welfare statute specific to active efforts throughout the case work for relative search, notification and engagement. The project provides promising practice in the areas of engagement of non-custodial parent/family, reduced reliance on the already burdened court system to negotiate permanency plans, and increased placement stability and reduction in the level of placement restrictiveness.

VIII. RECOMMENDATIONS

Recommendations to Administrators

Budget/Fiscal

The Kempe Center for Prevention and Treatment of Child Abuse and Neglect provided external project research. Olmsted County Community Services Continuous Improvement and Analysis (CIA) unit provided data mining of the agency information system to support Kempe research and analysis. The CIA unit had intimate knowledge of Olmsted County's IT system, data and practice which was a critical liaison for the Kempe Center. ***Recommendation:*** Future projects consider adequately resourcing agency level data analytics capacity including the leveraging of grant dollars to support the addition of staffing.

Staffing of the FF/FGC team to position the organization well for project roll-out and implementation also needs to be considered. ***Recommendation:*** In organizations with a continuum of family conferencing models, a targeted FF/FGC team allows for the FGC team to provide full focus on timely family finding and engagement. Additionally, embedding administrative staff within the FF/FGC team provides support of administrative functions including grant tracking and reporting requirements.

Practice

Organizational understanding and support of the project at a leadership level is instrumental in assuring timely and effective rollout and operationalization of project goals. ***Recommendation***: Leverage agency leadership serving the target groups to: (1) build program level ownership and understanding of project and project goals for target populations; (2) quickly address project barriers; (3) enhance capacity and structure for rapid data feedback of project inputs and outputs.

Recommendations to Project Funders

Budget/Fiscal

Fiscal resources were utilized for direct practice through the hiring of additional family meeting coordinators, training and technical assistance to support organization culture shift, and required external

research. Funding limitations prevented agency ability to increase internal data analytics and coordination capacity with external researcher. Additionally, funding was insufficient to allow an opportunity to engage another jurisdiction in establishing an external control group. ***Recommendation:*** (1) Provide targeted funding to enhance internal agency capacity for data analytics and coordination with external researcher; (2) Provide funding for data analytics and coordination expenses to obtain participation by another jurisdiction for the external control group comparison.

Project development encompassed a significant portion of first year grant activities included: (1) project model development; (2) training of workforce; (3) finalization of evaluation design. ***Recommendation:*** 1.) Allow for a development year to frame up the evaluation with the project team and their internal data analytic staff; 2.) Stagger research and evaluation to enhance project ability to measure outcomes one year post intervention.

Practice Considerations

Identification of a comparison group creates multiple ethical dilemmas for an organization including: (1) project model implementation included an intentional focus for a sustainable organizational culture shift with all system stakeholders, therefore, all families served by the agency were positively impacted; (2) decision-making as to whether to include or not include families in the intervention is counter to the philosophical framework that all children deserve rigorous family finding and a lifelong "family" support network. ***Recommendation:*** Partnership with a different jurisdiction to identify a control group not receiving the project model intervention.

Recommendations to Child Welfare Field

Budget/Fiscal

In order to support "family" networks to fully participate in family meetings, it is critical that the agency is attentive to reducing barriers impacting their involvement. ***Recommendation:*** (1) Designate funds to assist family networks in addressing barriers and maximizing participation including child care, travel expenses and ancillary expenses; (2) Enhance technology capacity to allow for flexibility in

engagement through the use of conference phones, secure video conference software and voice activated web cameras.

Training and technical assistance is essential in supporting organizational culture shift and building a workforce with the skills needed to mobilize "family" networks in building plans for the child(ren). ***Recommendation:*** Resource quality foundation and on-going training and technical assistance specific to theory, evidence based practice and skill development for leadership, social workers and coordinators of family meetings.

Practice

The culture of the child welfare practice needed to support on-going family involvement in planning for children including the recognition and confidence in the family group to be key decision-making partners in planning for child safety, permanency, and well-being. ***Recommendation:*** (1) Assessment of the agency's culture to ensure social work practice principles are built on the foundation of partnership with families; (2) Ongoing assessment and strategies to integrate the agency's social work practices principles and values with FF/FGDM principles and values.

Direct service staff engagement in project development and implementation is critical in assuring buy-in and timely feedback on project goals. ***Recommendation:*** Create structures to engage direct service staff to: (1) develop the FF/FGDM model; (2) provide rapid feedback loop for model adjustments; (3) identify and deliver training and technical support specific to needs of target groups.

An independent family meeting coordinator creates an environment in which transparent, honest and respectful dialogues can occur between agency personnel and family networks signifying the agency's commitment to empowering and non-oppressive practice. ***Recommendation:*** Provide an independent, non-case carrying coordinator who is charged with finding, engaging and involving family networks in planning for children.

Community

It is critical to engage key community stakeholders, including family and youth representation, in the development of an advisory group to provide guidance on project implementation, aid in problem-solving around practice issues, and champion objectivity, accountability and transparency throughout the life of the project. ***Recommendations:*** (1) Establish a community stakeholder advisory group; (2) Disseminate regular data to the community stakeholder advisory group to assist with engagement and increase ownership of project model.