Family Connection Discretionary Grants

2011-Funded Family Group Decision-making Grantees
Cross-site Evaluation Report – FINAL

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Cross-site Evaluation Report- FINAL

This report is organized into several key sections documenting process results for the seven Family Connection grantees that comprise the 2011-funded Family Group Decision-making (FGDM) cluster. The Background and Overview section provides contextual information on the history of Family Connection discretionary grants and program areas, as well as an overview of FGDM and implementation science literature. The Evaluation Approach details James Bell Associates (JBA)'s development of logic models, process and outcome evaluation questions, and data collection and analysis procedures. Separate sections synthesize process evaluation findings and organizational characteristics guided by various implementation science frameworks. Summary and Recommendations discusses the implications of cluster findings and offers recommendations for the public child welfare field based on findings. The report includes several appendices, such as grantee-level process and outcome syntheses, to support the core text.

Section 1: Background and Overview

In September 2011, seven grantees were awarded Family Connection Discretionary Grants: *Using Family Group Decision-making to Build Protective Factors for Children and Families;* funds were authorized by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351). These 3-year grants supported demonstration projects to test the effectiveness of family group decision-making (FGDM) as a family-centered service approach that helps prevent children and youth from entering or re-entering foster care and improves their overall well-being to achieve safety and permanency goals. Grantees conducted site-specific evaluations to improve processes and services and demonstrate linkages between project activities and improved outcomes. Grantees also participated in a national cross-site evaluation that documented the progress and outcomes of each project and the seven grantees as a whole (i.e., cluster).

Legislation Overview

In 2008, the Administration for Children and Families (ACF), Children's Bureau (CB), announced the availability of competitive grant funds authorized by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351). The Act enabled the Secretary of Health and Human Services to award competitive, matching grants of between one and three years to State, local, or Tribal child welfare agencies and private/not-for-profit organizations to help children who are in or at risk of entering into foster care reconnect with family members by developing and implementing grant programs. This legislation was authorized for a period of five years, thereby allowing for multiple rounds of awards. The first cohort included 24 Family Connection Discretionary Grants funded in September 2009 to implement Family-finding, Kinship Navigator, Residential Family Treatment, and FGDM projects. Grants were funded for three years. The 2011-funded FGDM Discretionary Grants were the second cohort of grants.

FGDM demonstration projects focused on the use of FGDM in prevention efforts aimed at serving families with children at risk of entering or re-entering foster care. FGDM programs served families through family preservation programs, family support programs, and in-home services. Grantees also served families diverted from the child welfare system through differential response/alternative response programs. Grantees used FGDM meetings to engage families in building capacity to meet children's needs by strengthening protective factors and reducing risk factors, as well as to address domestic violence, mental health, and substance abuse issues. Grantees worked toward developing these programs as identifiable sites that other States and locales seeking to implement FGDM services for similar populations can look to for guidance, insight, and possible replication.

The authorizing legislation sets aside funding for evaluation of Family Connection grantee activities. Within this charge, CB contracted with James Bell Associates, Inc. (JBA) to conduct a national, cross-site evaluation. The cross-site evaluation of the 2011-funded Family Connection Discretionary Grants: *Using Family Group Decision-Making to Build Protective Factors for Children and Families* was designed to determine the effectiveness of the seven Family Connection Discretionary Grants funded under this legislation in 2011.

In addition to participating in the national cross-site evaluation, each grantee was required to set aside funds and secure resources to conduct a local evaluation to assess its ability to reconnect children who are in or at risk of entering foster care with family members. CB set expectations for grantees to engage in a strong site-specific evaluation to improve its processes and services and demonstrate linkages between project activities and improved outcomes. JBA provided technical assistance to the Family Connection grantees toward the conduct of site-specific evaluations as required in the program announcement. Technical assistance incorporated activities to address how site-specific evaluations also contributed to the national cross-site evaluation.

FGDM Cluster Overview

FGDM engages and empowers families involved in or at risk of entering the child welfare system to take an active and leadership role in developing plans and making decisions to promote the safety, well-being, and permanency of their children. It also promotes family-centered, strength-oriented, culturally based, and community-based practice. FGDM has been utilized as a prevention approach to work with families who have not yet come into contact with Child Protective Services (CPS). The FGDM process may result in plans that can promote protective factors including nurturing and attachment, knowledge of parenting and child development, parental resilience, social connections, and concrete supports for parents. As part of preventing child abuse and neglect, such protective factors are developed and strengthened as key coping strategies, particularly in stressful situations. The emphasis on protective factors also assists service providers to develop positive relationships with parents as they encourage parents to rely on natural support networks within their families and communities.

FGDM uses a trained facilitator or coordinator from the child welfare agency or an independent, community-based organization to moderate family meetings. Key family members select participants who may be able to provide a broader view of the challenges and service needs of the family. Participants typically include immediate and extended family members, family friends, and relevant service providers. Involved community members may include representatives from local institutions such as schools, faith-based organizations, mental health, health care, or substance abuse programs.

FGDM engages community representatives in the child welfare decision-making process to facilitate agency and community collaboration.

FGDM may occur at any point during a case; however, meetings are usually initiated when children are at risk of removal from their homes or after the first emergency removal has occurred. FGDM may also be used on a regular basis to maintain family engagement and collaboration with child welfare agencies and/or service providers. FGDM often uses a trained facilitator to implement a framework of four phases:

1) Request to hold an FGDM meeting
2) Preparation and planning for an FGDM meeting
3) Participation in an FGDM meeting
4) Further planning after an FGDM meeting

During the meeting, participants identify formal and informal resources to assist in developing and implementing case plans. Formal options may consist of services from child welfare agencies, community organizations, and other service providers. Informal resources include options provided by families, friends, and community members. Several FGDM models include private family time, which refers to the time during the meeting where only family members, without input from the various service providers present, to create an initial plan, discussing available options. FGDM case plans serve as roadmaps for the family members to build upon their strengths by utilizing the necessary resources to enhance their capacity to provide a safe and healthy environment for their children.

FGDM has been used as a strategy to empower and support families experiencing domestic violence.[1] Domestic violence is an area which commonly impacts the lives of children and families who are at risk of entering or who are already involved with the child welfare system. FGDM participants for cases involving domestic violence might include advocates for domestic violence survivors or batterer intervention program staff members. In this context, FGDM supports efforts to protect and ensure the safety of victims and children through systems providing services and abuser accountability. FGDM may potentially decrease the likelihood that children are removed from the home of the non-offending parent, while increasing the possibility of reunification for children who have entered foster care.

The seven FGDM grantees funded in 2011 varied in terms of geographic location (see Table 1-1: Family Group Decision-making Grantees and Their Locations). Two grantees implemented multi-site projects. The Village Family Service Center implemented its project in multiple counties within the State of North Dakota, while Larimer County Department of Human Services (DHS) implemented its project in counties in Colorado, Texas, and South Dakota.

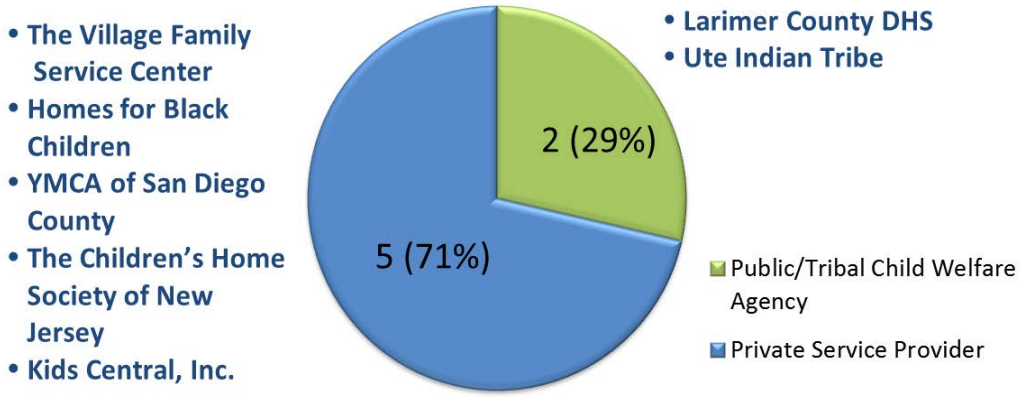
[1] Carter, L. S. (2003). *Family Team Conferences in Domestic Violence Cases, Guidelines for Practice.* Family Violence Prevention Fund and Child Welfare Policy and Practice Group. Produced by Family Violence Prevention Fund, San Francisco, CA.

Table 1-1: Family Group Decision-making Grantees and Their Locations

Grantee	Project Title	Location
The Children's Home Society of New Jersey	Kinship Connections Program of Mercer County	Trenton, New Jersey
Homes for Black Children	Nurturing the Resiliency in Wayne County Families: Rethinking the Family Decision Making Model as Community Centered Child and Family Work	Detroit, Michigan
Kids Central, Inc.	Engaging, Encouraging and Empowering Families to Succeed (FGDM-EEE) project	Ocala, Florida
Larimer County Department of Human Services (DHS)	No Place like Home: Family Group Decision-making for Children and Families Receiving In-Home Services	Fort Collins, Colorado (with two additional sites in Texas and South Dakota)
Ute Indian Tribe	Implementing Family Group Decision-making to Improve Child Well-Being and Decrease Foster Care Placements in the Ute Indian Tribe Social Service System	Fort Duchesne, Utah
The Village Family Service Center	Family Engagement for Native American Youth	Fargo, North Dakota
YMCA of San Diego County	YMCA Families United	San Diego, California

Grantees varied in the types of agencies that were funded (see Figure 1-1: FGDM Grantee Agency Types). Over half (*n*=5, 71 percent) of the grantees funded to implement FGDM projects were private service-providing agencies, while two grantees (29 percent) operated as public child welfare agencies within their county or tribe.

Figure 1-1: FGDM Grantee Agency Types



Overview of FGDM Literature

Family group decision-making (FGDM) was first introduced in the United States in 1994, with a commissioned study of New Zealand's legislatively endorsed use of "family group conferencing" (FGC)

in progressive reform of its child welfare and juvenile justice systems.[2] The initial study was conducted by the American Bar Association (ABA) Center on Children and the Law, and focused on legal and policy-related aspects of FGC. As stated by the American Humane Association, subsequent studies of FGDM in the U.S. indicated the "transformative" nature of the model when applied to child welfare decision-making. Specifically, early research on family involvement models found "that when extended families, their natural supports, and the broader community are involved in making decisions about their most precious resource – their children – everyone benefits."[3] FGDM is practiced in a variety of forms, with the most common variations on the model relating to 1) time designated for private discussion between family members, and 2) explicit consideration of family strengths.[4] Family Group Conferencing and Family Team Meetings are examples of FGDM variations.

In the 20-year period since the initial study of FGDM in the U.S., numerous studies of the model have been conducted. Much of the research provides a broader understanding of this process-intensive approach to working with families, focusing on the underlying principles and core components of FGDM, variations of the model, and key roles throughout the process. While FGDM practices have been implemented in a variety of human service settings,[5] application of the model is particularly relevant in child welfare, where its non-adversarial, family-centered, empowering approach "fits closely with some of the current philosophical changes in child welfare."[6] Most notably, recent trends in child welfare practice include increasing the use of kinship care, capitalizing on family strengths, and creating a partnership and participatory decision–making process between the family and professional. The potential impacts of FGDM are therefore important to understand at child, family, and system levels.

Some studies have focused on the implementation of FGDM and factors that facilitate and hinder effectiveness of the FGDM model. One study based on an observational analysis of meetings following the Family Group Conferencing (FGC) model noted that fidelity to the FGC process is important, given the forensic atmosphere and orientation to risk of the child protective services system.[7] This atmosphere can hinder true collaborative and participatory decision making. The study observed that a lack of thorough meeting preparation and planning, resources (particularly child care), options for the families to participate in private family time, and attention to specific needs of the family participants limited family engagement in the meetings. Factors that improved fidelity to FGC model included successful planning, meaningful family participation, and regular monitoring. The study recommended that the inherent power inequities between the system and the family could be reduced by attending to factors such as meeting location, preparing an agenda, providing a welcoming environment, and paying attention to practical issues such as access to child care and transportation. Fidelity monitoring of FGDM practice can lead to concrete steps to improve child welfare practice and can lead to needed changes to

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[2] Hardin, M. et al. (1994). *Family group conferences in child abuse and neglect cases: Learning from the experience of New Zealand.* American Bar Association, Center on Children and the Law.

[3] American Humane Association. (n.d.) *Honoring of New Zealand's progressive transformative system change.* Englewood, Colorado: National Center on Family Group Decision Making, American Humane. Retrieved from http://www.americanhumane.org/assets/pdfs/children/fgdm/timeline.pdf.

[4] Merkel-Holguin, L. (1996). Putting families back into the child protection partnership: Family group decision making. *Protecting Children 12*(3), 4-7.

[5] Schmid, J. *Using Family Group Conferencing in the Children's Mental Health Context* (American Humane Association, 2006).

[6] Merkel-Holguin, L. (1996). Putting families back into the child protection partnership: Family group decision making. *Protecting Children 12*(3), 4-7.

[7] Healy, K., Darlington, Y., & Yellowlees, J. (2012). Family participation in child protection practice: An observational study of family group meetings. *Child & Family Social Work, 17*, 1-12.

training and support of professional roles, and improvement of meeting facilitation.[8] Program model fidelity can establish the connection between FGDM services and their outcomes in terms of safety, permanency, and well-being. One study which conducted a factor analysis of FGDM fidelity items found that effective engagement of families in FGDM services focused on three core areas: 1) successful planning processes with quality family plans developed; 2) engagement of the larger family group with less emphasis on the engagement of professionals; and 3) role clarity among service providers and their respectfulness of the families' knowledge, as well as the focus of the FGDM facilitator on the conference process rather than on other tasks.[8]

The current body of literature is particularly limited regarding the outcomes of FGDM participation. As recently as 2009, FGDM specialists noted, "There [are] a limited number of studies focused specifically on outcomes for children – this reflects that many services are in a developmental stage and may not have the data to reveal mid- and long-term outcomes."[9] Some early outcome findings for FGDM implementation include promising trends in the following areas: 1) fewer children living in out-of-home care, 2) increased involvement of professionals with extended families, 3) more children living with kin, 4) fewer court proceedings, and 5) increased community involvement.[9] FGDM has been documented as an effective approach to involving paternal relatives in case planning.[10] Involving a wide network of family and supports (including fathers and/or paternal relatives) in decision-making and case planning has been shown to provide numerous benefits, including: including healthy cognitive, social, and emotional development for children; expanded placement options; increased opportunities for children to remain connected with their family members.[11] A retrospective study of families participating in FGC meetings showed positive short- and long-term outcomes for children and families.[12] The study found that FGC meetings resulted in permanent placement for 82 percent of the sample of children. Additionally, placements remained stable over time with few children returning to out-of-home care, and even fewer children had a CPS re-referral 2 years after the initial conference. While these studies show promising results, the findings need to be further substantiated using more rigorous evaluation approaches.

There have also been studies that have yielded inconclusive or contradictory findings. Quasi-experimental research findings include, for example, a reduction in indicators of child abuse and neglect (i.e., number of emergency visits, number of placements) among families 1 year after participation in Family Group Conferencing;[13] faster exits from care and increased exits to reunification particularly among Hispanic and African American children following culturally focused Family Group

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[8] Rauktis, M. E., Bishop-Fitzpatrick, L., Jung, N., & Pennell, J. (2013). Family group decision making: Measuring fidelity to practice principles in public child welfare. *Children and Youth Services Review, 35 (2),* 287-295.

[9] Burford, G., Connolly, M., Morris, K., & Pennell, J. (2009). *Annotated Bibliography – Introduction, Principles and Processes.* Englewood, CO: American Humane Association.

[10] Jenkins, M. & Kinney, E. (2009). *Dads and paternal relatives: Using family group decision making to refocus the child welfare system on the entire family constellation.* Englewood, CO: American Humane Association.

[11] Howard, M. (2009). *Quality Improvement Center for Non-Resident Fathers social worker training: Engaging non-resident fathers.* Englewood, CO: American Humane Association.

[12] Shore, N., Wirth, J., Cahn, K., Yancey, B., & Gunderson, K. (2002). Long term and immediate outcomes of family group conferencing in Washington state (June 2001). *Restorative Practices E-Forum*, September 10, 2002. International Institute of Restorative Practices. Retrieved September 9, 2014, from www.restorativepractices.org

[13] Pennell, J. & Burford, G. (2000). Family Group Decision Making: Protecting children and women. *Child Welfare, 79*(2), 131-158.

Conferencing;[14] and improved permanency outcomes (i.e., placement in relative foster care, shorter stays in care and discharge to parents or kin).[15] Contradictory results were obtained in a 2006 randomized controlled trial study using state Title IV-E Waiver funding to provide FGDM in two counties using different FGDM models with different populations. One county used the Family Unity Meeting (FUM) model, while the other blended the FUM model with Family Group Conferencing (FGC) models. Participants were randomly assigned in both counties. The study found that found that FGDM was no more effective than traditional services in improving safety, permanency stability, and permanency outcomes. In this study, no significant differences were found to impact on child maltreatment, placement stability, and permanency outcomes.[16]

Although much research and program evaluation has been done in the area of FGDM, continued effort must be made to identify and to better understand the core elements needed for successful FGDM programs.[17] Investigation of the impacts of family participation in child welfare decision making are continuing in an effort to establish an evidence-base for FGDM practice. In addition to enlisting more rigorous research designs, current research includes cost-benefit analyses[18] of the FGDM process that take into consideration the intensity of the approach.

Overview of Frameworks Used to Organize Process Findings

The national cross-site process evaluation of the 2011-funded Family Connection Discretionary Grants was designed to describe critical portions of the projects' developmental cycle, which includes design, implementation, maintenance, and sustainability. The cross-site evaluation adapted elements from the National Implementation Research Network (NIRN) Implementation Science[19] and JBA's Evidence-based Programming (EBP)[20] frameworks to facilitate the understanding the contextual factors that contribute to successful implementation of Family Connection grants.

While the NIRN framework highlights a range of stages, processes, and cycles regarding implementation, the cross-site process evaluation primarily focused on the 'intervention/innovation' and 'implementation drivers' aspects as they relate to Family Connection grant projects. The NIRN implementation science framework is based on a synthesis of implementation research findings across diverse fields. The NIRN framework assumes that implementation drivers are considered building blocks

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[14] Sheets, J., Wittenstrom, K., Fong, R., James, J., Tecci, M., Baumann, D. J., et al. (2009). Evidence-based practice in family group decision-making for Anglo, African American and Hispanic families. *Children and Youth Services Review, 31*(11), 1187-1191.

[15] Pennell, J., Edwards, M., & Burford, G. (2010). Expedited family group engagement and child permanency. *Children and Youth Services Review, 32*(7), 1012-1019.

[16] Berzin, S. C. (2006). Using sibling data to understand the impact of family group decision-making on child welfare outcomes. *Children and Youth Services Review, 28*, 1449-1458.

[17] Morris, K., & Connolly, M. (2012). Family decision making in child welfare: Challenges in developing a knowledge base for practice. *Child Abuse Review, 21*, 41-52.

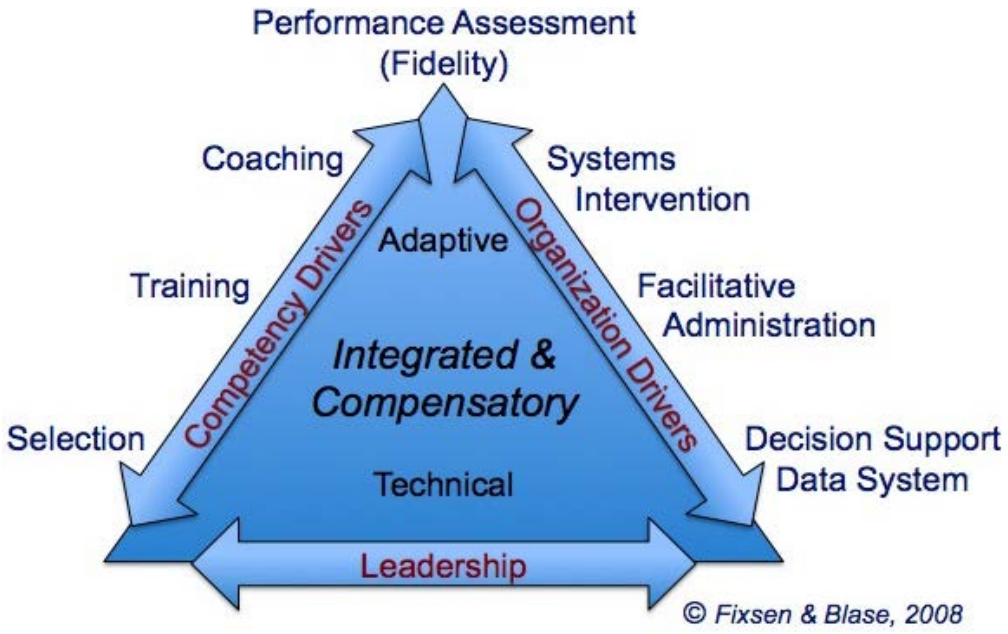
[18] Fox, D. (2008). Family group conferencing and evidence-based practice: What works? *Research, Policy and Planning, 26*(3), 157-167.

[19] Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

[20] James Bell Associates (2013). *Lessons learned through the application of implementation science concepts to Children's Bureau discretionary grant programs.* Arlington, VA: Author.

of the infrastructure required to support practice, organizational, and systems change. The framework assumes that collectively, implementation drivers contribute to the successful implementation of innovative child welfare program models and practices by ensuring program model fidelity and sustainability (see Figure 1-2: NIRN Implementation Science Framework - Implementation Drivers)[21].

Figure 1-2: NIRN Implementation Science Framework – Implementation Drivers



Implementation drivers are integrated and compensatory and organized in the following categories:

Competency Drivers

- ***Staff Selection.*** Mechanisms that grantees use to develop the competence, confidence, and capacity of staff through effective staffing practices
- ***Training.*** Opportunities for project staff and partners to learn when, how, and with whom to use new skills and practices
- ***Consultation and Coaching.*** Continuous guidance and encouragement as new skills are being used
- ***Performance Assessment.*** Evaluation of staff members' performance and fidelity to the model

Organization Drivers

- ***Decision Support Data System.*** Supporting continuous quality monitoring and improvement through evaluation
- ***Facilitative Administration.*** Addressing institutional capacity to support staff implementing practices with fidelity through a prepared and supportive administrative environment
- ***Systems Intervention.*** Collaborating and coordinating with key stakeholders

[21] Bertram, R. M., Blase, K. A., & Fixsen, D. L. (2014). Improving programs and outcomes: Implementation frameworks and organization change. *Research on Social Work Practice*. Advance online publication. doi:10.1177/1049731514537687

Leadership Drivers

- Defining and addressing adaptive and technical challenges; aligning the intervention model with the project mission, values, and vision; establishing clarity of roles, responsibilities, and communication patterns; and making informed decisions to guide and support implementation

Implementation science literature also recognizes the multi-level influences on the successful implementation of child welfare projects and practices. Core implementation components, organizational components, and influence factors work together to create implementation outcomes. Social, economic, and/or political influence factors either promote or obstruct how well core implementation components operate. As such, JBA also included a qualitative assessment of the internal and external factors influencing grantees' implementation outcomes in the cross-site evaluation to better understand the contextual factors that impacted project implementation.

Several key assumptions of the NIRN framework do not apply to these CB-funded projects, which challenges the applicability of the framework to the implementation experiences of Family Connection grantees. While the NIRN framework was developed to foster successful replication of evidence-based practices in human service practice settings, Family Connection grantees were funded to implement and evaluate 'promising practices' (i.e., FGDM) that are typically not as well established or rigorously evaluated. Additionally, while the NIRN framework assumes that programs have the resources and capacity to engage in an exploration phase (during which community stakeholders engage in a collaborative planning and problem solving process), CB grantees often operate under short timeframes for planning, adapting, implementing, and evaluating their projects.

Due to the specific funding requirements and limited start-up period given CB grantees, JBA (2013) adapted the NIRN Implementation Science framework for a set of CB discretionary grantees to help document the experiences of grantees and identify successful implementation strategies for federally funded projects. The resulting Evidence-based Programming (EBP) framework is tailored directly toward CB grant projects, and takes into account the nuances of operating under Federal guidelines and regulations. The EBP framework identifies implementation factors (which are comparable to the implementation drivers in the NIRN framework) that contribute most significantly to effective project implementation. The EBP implementation factors assessed through the cross-site process evaluation are organized by the two distinct phases within the lifespan of CB-funded projects (i.e., project planning and implementation).

Phase 1: Conceptualization and Planning. Within Phase 1, grantees develop their grant applications in response to funding announcements. This process includes documenting a clear need for proposed services, identifying project champions, developing partnerships, and creating an evaluation plan. In combination, these implementation factors should contribute to improved project plans, strengthen grant proposals, and lead to an increased readiness for implementation per the following three steps:

- Identifying, adapting, or designing a program
- Planning for program evaluation
- Building community partnerships and commitment

Phase 2: Project Implementation. Throughout Phase 2, grantees are expected to implement, adapt, and maintain their projects. In combination, the Phase 2 implementation factors are expected to contribute to improved project implementation, improved participant outcomes, and improved systems of care.

- Implementing effective participant recruitment and retention strategies
- Hiring/assigning project staff members with relevant skills and qualities
- Providing intensive initial and ongoing staff training
- Providing ongoing staff supervision, support, and evaluation
- Implementing a high-quality program evaluation
- Empowering and sustaining project champions
- Initiating a purposeful approach to change/making program changes
- Engaging in proactive sustainability efforts

Table 1-2: NIRN Implementation Science Framework and Parallel JBA Concepts illustrates the relationship between the concepts of NIRN Implementation Science and JBA's EBP framework.

Table 1-2: NIRN Implementation Science Framework and Parallel JBA Concepts

Implementation Science Component	Evidence-Based Programming Component
Intervention/Innovation	Identifying, adapting, or designing a program
	Planning for program evaluation
	Implementing effective participant recruitment and retention strategies
Selection	Identifying, adapting, or designing a program
	Involving extended family members
Training	Providing intensive initial and ongoing staff training
Coaching	Providing ongoing staff supervision, support, and evaluation
Performance Assessment (Staff Evaluation)	Implementing a high-quality program evaluation
Leadership	Empowering and sustaining project champions
Decision Support Data System (Program Evaluation)	Implementing a high-quality program evaluation
	Making program changes
Facilitative Administration	Engaging in proactive sustainability efforts
Systems Intervention	Building community partnerships and commitment
Influence Factors	No parallel JBA concept

Note: Some EBP concepts are aligned with more than one Implementation Science component.

By incorporating concepts detailed in the NIRN Implementation Science and JBA's EBP frameworks into the cross-site evaluation, JBA developed a detailed description of the key components of successful implementation, including the programmatic, organizational, and contextual factors that facilitated enhanced project performance among the seven FGDM grantees. Identifying these practices assisted in making the link between project implementation and outcomes for the grantees, and will aid future grantees in efforts to implement FGDM services effectively within Federal grant parameters.

Section 2: Evaluation Approach

An informative and rigorous cross-site evaluation addressed process and outcome questions at the parent/child/family and organizational/systems levels for all seven Family Connection grantees. JBA developed a cluster logic model as a key step in planning the evaluation design. The following sections provide details on JBA's logic model development and approach to the process and outcome evaluations.

For purposes of this cross-site evaluation, "parent" was defined broadly to include a biological parent, foster parent, adoptive parent, kinship caregiver, or other primary caregiver. "Child" included infants, children, and youth up to age 18. "Family" may have included immediate, biological family, extended family and other kin, other significant adults, and community members.

Family Group Decision-making Cluster Logic Model

A logic model was developed to reflect the Family Connection FGDM cluster. The logic model depicts common elements in project functioning and anticipated impact among all grantees, and may be found in Figure 2-1: Family Group Decision-making Cluster Logic Model. Project evaluators, directors, other interested project staff members, and CB Federal Project Officer (FPO) were provided the opportunity to review and comment on the logic model. Revisions were based on grantee and stakeholder feedback.

The logic model helped structure the cross-site evaluation, providing a map of the key project activities along with the outputs and outcomes expected as a result of these activities. It was designed to facilitate a clear understanding of what services project staff members implemented, what goals were to be achieved, what data were collected in the evaluation, and how data were used. The logic model provided a graphic representation of the inputs, activities, outputs, and outcomes listed in grantee applications, logic models, evaluation plans, and other evaluation-related documents.

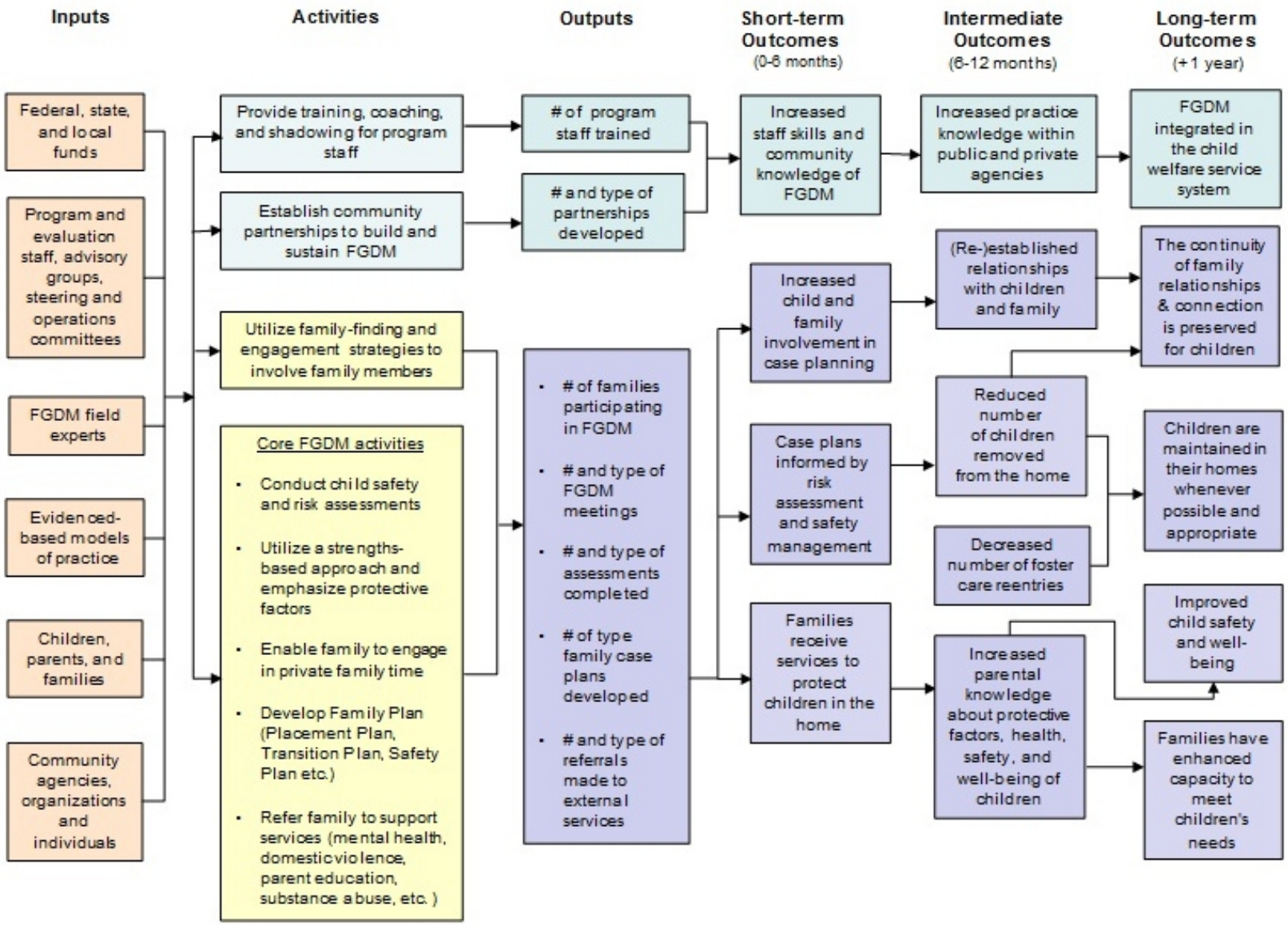
- **Inputs** fell within the categories of human (e.g., staff members), service (e.g., evidence-based and promising practices), fiscal (e.g., Federal and other funding), technical (e.g., computers, telephones), and community (e.g., community agencies and organizations, advisory boards).

- **Activities** included service models; activities for parents, children, and families; staff training and coaching activities; collaboration efforts; and FGDM services.

- **Outputs** included number of parents, children, and families served that applied throughout the cluster, along with outputs related to services, training and education, case plans, and meetings.

- **Outcomes** were divided into short-term, intermediate, and long-term outcomes. Generally, short-term outcomes could be found from 0 to 6 months; intermediate outcomes could be found from 6 to 12 months; and long-term outcomes could be found from 12 months onward. The timing of outcomes varied depending on the focus and structure of the projects. Short-term outcomes all contributed to more common intermediate and long-term outcomes related to child safety, parents maintaining custody, children avoiding foster care re-entry and multiple placements, and improved capacity of the family to meet children's needs.

Figure 2-1: Family Group Decision-making Cluster Logic Model



Cross-site Evaluation Questions

Process Evaluation Questions

JBA conducted a process evaluation designed to describe critical portions of the Family Connection-funded projects' developmental cycle related to design, implementation, maintenance, and sustainability. The following questions incorporated key CB interests and implementation science components, and were addressed for the process evaluation:

- *What are the characteristics of the children, parents, and families served by the FGDM projects?*
- *What are the service models, interventions, and activities implemented by the FGDM projects?*
- *What amount and mix of services are provided to parents, children, and families participating in FGDM meetings?*
- *What is the quality of service implementation in regard to timeliness, fidelity, and administration?*
- *How do the FGDM projects pursue continuous quality improvement as a way to improve services?*
- *To what extent do FGDM projects collaborate with key partners, particularly child welfare agencies, to serve children and families?*
- *What challenges and facilitators do FGDM projects experience in implementing services?*
- *How do FGDM project leaders promote, guide, and sustain effective project implementation?*
- *How do FGDM grantees select, develop, and sustain staff member's ability to effectively implement project services?*

Outcome Evaluation Questions

An outcome evaluation was conducted to determine the effectiveness of FGDM projects in producing outcomes related to safety, permanency, and well-being. As applicable, long-term parent, child, and family-level outcomes were labeled by Child and Family Service Review (CFSR) measures. CFSR outcomes and items were used as an organizing framework for outcomes; a CFSR was not conducted with grantees, nor were grantees expected to conduct a CFSR. The outcome evaluation also addressed several other organizational and system-level questions, including grantee impact on child welfare practice in the community and project plans for sustainability beyond the 3-year Federal funding period.

The following questions assessed parent, child, and family-level outcomes:

- *To what degree do FGDM grantees achieve short-term outcomes, such as: increased staff skills and community knowledge of FGDM; increased child and family involvement in case planning; case plans informed by risk assessment and safety management; and families receiving services to protect children in the home?*

- *To what degree do FGDM grantees achieve intermediate outcomes, such as increased practice knowledge within public and private agencies; (re)-established relationships with children and family; reduced number of children removed from the home; decreased number of foster care re-entries; and increased parental knowledge about protective factors, health, safety, and well-being of children?*

- *To what degree do FGDM grantees achieve long-term outcomes such as:*
    - *Children are safely maintained in their homes whenever possible and appropriate (CFSR Safety Outcome 2, Item 3)*
    - *Continuity of family relationships and connections preserved for children? (CFSR Permanency Outcome 2, Items 14, 15)*
    - *Families have enhanced capacity to provide for their children's needs (CFSR Well-being Outcome 1, Items 17, 8)*

The following questions addressed organizational and system-level outcomes:

- *How has the FGDM project impacted child welfare practice in the community?*

- *What new policies and procedures were developed as a result of the FGDM project?*

- *In what ways are FGDM projects sustainable beyond the federal funding period?*

- *To what extent have public child welfare agencies integrated elements of the FGDM project's service model?*

Data Collection

Primary and secondary data consisted of data collected through grantee summaries and profiles, site/ visit discussions, and grantee evaluation reports. Qualitative data consisted of descriptions of service models, service implementation processes, service challenges and facilitators, and changes in the service model and why. Qualitative data also consisted of descriptions of project staffing, continuous quality improvement, project leadership, and collaboration between the grantee and partner agencies, including local and State child welfare agencies, and how collaboration affected service delivery. Quantitative data consisted of counts of parents, children, and family members served; descriptive statistics to characterize the focus population (e.g., age, gender, race/ethnicity); counts of different types of services; other outputs; and to the degree available, short-term, intermediate, and long-term outcomes collected by grantees.

Primary and secondary data were a mixture of quantitative and qualitative data. Secondary data provided by grantees to address process and outcome evaluation questions were collected and

synthesized. Secondary data were supplemented with primary data collection to confirm information from secondary data sources and to elicit additional information not readily available from these secondary sources.

Secondary Data

Secondary data sources consisted of grantee-generated documents and JBA-generated documents. Grantee-generated documents included grant applications, logic models, evaluation plans, semi-annual project and evaluation reports, and other documents describing project and evaluation activities. Grantees were required to provide applications, logic models, evaluation plans, and semi-annual project and evaluation reports to CB. These documents were reviewed and incorporated, as they were made available.

Grantee Summaries. JBA-generated documents included grantee summaries created for the Kickoff Meeting in November 2011 and updated in January 2012. Summaries chronicled in narrative format: each grantee's key project interventions and activities, evaluation design and data collection activities, and expected outcomes. An accompanying matrix incorporated detailed information on grantees' services, outcomes, and evaluation design and measures. Grantee summaries may be found in Appendix A: Grantee Summaries.

Grantee Profiles. Summaries and grantee-generated documents were used to create a detailed profile for each grantee that organized information into the following categories: 1) needs and available resources, 2) goals and desired outcomes, 3) best practices and evidence-based models, 4) organizational capabilities and capacities, 5) project plans, 6) process and outcome evaluation plans, 7) continuous quality improvement strategies, and 8) sustainability strategies. Profiles were considered working documents and updated throughout the first half of the grantees' funding period per information from grantees' semi-annual reports, other documents, and conversations with grantees. The profile template can be found in Appendix B: Grantee Profile Template.

Evaluation Reports. An evaluation report template was designed for grantees to report the results of local process and outcome evaluations as part of semi-annual reports delivered to CB. The templates were designed to capture national cross-site evaluation information, yet provide grantees the flexibility to report results consistent with local data collection procedures. Grantees used primary and secondary data sources to capture local data elements of interest. Grantees' primary data sources included copyrighted, author-owned, or team-designed instruments; programmatic forms that captured administrative and intake data; assessments; and interviews and focus groups with project staff members and service recipients. Grantees' secondary data sources included management information systems (MIS) at the agency, county, or State level that contained information on child welfare history, education, employment and income, juvenile or adult justice history, etc. For example, six grantees accessed the Statewide Child Welfare Information System (SACWIS) for data on child-level outcomes, while one grantee (the Ute Indian Tribe) accessed tribal social services data.

All grantees completed a common reporting template, and accompanying reporting instructions provided guidance on how each section of the report should be completed. Instructions further specified that evaluation reports should be consistent with information captured in grantee profiles, semi-annual and annual reports to CB, and other local reports to project staff members and stakeholders. Grantees determined how to use text and/or tables to report information on progress and changes, process and outcome results, and conclusions. The report instructions and templates, which

may be found in Appendix C: Evaluation Semi-Annual Report Templates and Instructions, organized information into the following categories: evaluation progress and modifications; process evaluation (including information on participant unit of analysis, participants served, demographics, type of service by participant, additional FGDM outputs, model fidelity, and cost studies); outcome evaluation (including information on data source changes, treatment and comparison group data, and data analysis timelines); and discussion.

Grantees were encouraged, but not required, to address the following CFSR outcomes and accompanying items listed in the program announcement and documented in Table 2-1: CFSR Outcomes and Items from Program Announcement.

Table 1-1: CFSR Outcomes and Items from Program Announcement

CFSR Outcome	CFSR Item
Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.	Item 3: Services to families to maintain the child or youth safely in home to prevent entry or re-entry into foster care Item 4: Assessment of risks and safety management
Permanency Outcome 1: Children have permanency and stability in their living situations.	Item 5: Foster care re-entry rates of children and youth served by the program
Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs.	Item 17: Assessment of needs and provision of services to children, parents and foster parents Item 18: Engagement of children, youth and family members in case planning to enhance family capacity to provide for children's needs, including educational, physical and mental health needs, (as defined by CFSR Well-being Outcome 1, Item 18; and Well-being Outcomes 2 and 3, Items 21, 22, and 23)

Drawing upon JBA's previous experience conducting a cross-site evaluation of 24 Family Connection grantees funded in 2009, a proactive approach was taken to ensure that grantees' semi-annual evaluation reports provided accurate and uniform data across grantees for the cross-site evaluation. In order to guide the evaluation semi-annual report review process and ensure consistency in evaluation reporting, a quality assurance checklist was developed for evaluation of semi-annual reports. The evaluation TA liaison used the checklist to identify areas in the reports that required additional information or clarification. This quality assurance review was conducted on a semi-annual basis as grantees submitted their reports, and the evaluation TA liaison provided feedback on the reports to grantees and the cluster FPO. For this cross-site evaluation report, reported information was cumulatively incorporated from semi-annual reports covering September 30, 2011 through September 29, 2014.

Final Report. JBA developed a suggested outline for the Final Progress Report for CB to disseminate to grantees as suggested guidance to organize their reports. The report outline included eight sections: 1) Executive Summary; 2) Overview of the Community, Population, and Needs; 3) Overview of the Program (Service) Model; 4) Collaboration; 5) Sustainability; 6) Evaluation; 7) Conclusions; and 8) Recommendations. The evaluation section requested details on evaluation methodology by process and outcome evaluation methods, results, and discussion. The suggested Final Progress Report outline may be found in Appendix D: Grantee Suggested Final Progress Report Outline.

Final Progress Reports were submitted on December 31, 2014. However, only grantees not pursuing a no-cost extension were required to submit a final report at this time; final reports for grantees granted a no-cost extension were submitted 90 days after the end of the extension. Grantees pursuing a no-cost extension were asked to provide evaluation results by December 31, 2014 for the cross-site evaluation, though only one of the two grantees with a no-cost extension submitted preliminary data. JBA focused data synthesis on a combination of the Final Progress Reports submitted on December 31, 2014 and final semi-annual Performance Progress Reports submitted on October 31, 2014.

Primary Data

The aforementioned secondary data sources were supplemented with primary data collection, consisting of customized discussion guides to confirm secondary data and solicit primary data on process constructs not readily available from existing grantee information. JBA engaged in discussions with grantee leadership, project and evaluation staff members, and collaborating partners, including the child welfare agency director or managers. Discussions, conducted in Year 3 of grantee funding, addressed multiple aspects of implementation and impact.

Discussion protocols were created for a cross-section of grantee participants: project leadership, service providers, child welfare and other project partners, and the evaluation team. Protocols were organized by categories that corresponded to cross-site evaluation questions and implementation drivers/factors from the Implementation Science and EBP frameworks. Some similar questions were asked across various discussion participants to assess consistency in responses.

Key discussion topics included the following:

- Participant background
- Project planning
- Project implementation and modifications
- Project referral process, service flow, and service provision
- Collaboration with project partners
- Collaboration with evaluation team
- Trends and benefits from service use
- Project achievements and challenges
- Project sustainability
- Evaluation process
- Assessing FGDM model fidelity
- Evaluation report highlights

Site visits lasted from 1½ to 2 days and incorporated discussions with project directors, other project leadership, service providers, the evaluation team, and community partners (including child welfare agency representatives). Discussions occurred individually and in small groups. If a specific participant was not available on site, telephone or videoconferences were arranged. All information was confidential and not shared with the grantee project team.

Two members of the JBA project team, consisting of the evaluation TA liaison assigned to the cluster and an additional staff member, attended each site visit. During discussions, the additional staff member captured detailed notes true to the conversation via laptop. In cleaning the notes, the note-taker matched participant responses to protocol items, regardless of where in the protocol the participant addressed the question. This process was critical for later coding of notes. The evaluation TA liaison

reviewed the notes for accuracy, added their own notes, and made further revisions as needed; the evaluation TA liaison and note-taker discussed the notes as needed during this process.

A discussion overview document provided to interview participants while on site is located in Appendix E: Site Visit Discussion Overview. A brief summary of each site visit was submitted and included a list of JBA staff members, site visit dates and locations, grantee participants, and a brief synopsis of the combined discussions to CB as addendums to monthly project reports. The site visit addendum template is also included in Appendix F: Site Visit Discussion Addendum Template. A sample of discussion protocols by respondent type may be found in Appendix G: Sample Discussion Templates by Respondent Role.

Data Analysis

Multiple sources were used to extract data that were indicative of process and outcome questions, including outcome questions related to safety, permanency, and well-being. Data sources included site visit discussion data, grantee profiles, and grantee semi-annual evaluation reports. For site visit discussion data, selective coding, matching parent, child, family, organization, and system-relevant data elements, from grantee-generated and JBA-generated secondary and primary data sources to address each evaluation question were used. A taxonomy-based template was also created for process and outcome reports to address proposed evaluation questions. The data provided by grantees in their semi-annual evaluation reports were aggregated across all seven projects to summarize cluster-level process and outcome findings. In order to ensure accuracy of reporting, grantees were provided an opportunity to review and provide feedback on the synthesized evaluation findings. These methods are further detailed below.

Qualitative Analysis

Qualitative analysis was guided by the exploratory process evaluation questions developed for the cross-site evaluation. Qualitative data was analyzed from site visits in several steps that included identifying, coding, and categorizing primary patterns in the data. Four key stages of JBA's analytic approach, adapted from Pandit's five-phase diagram of building grounded theory[22] are described in the four sections: primary data collection, data organization, qualitative coding process, and literature comparison.

Primary Data Collection. A standard site visit discussion/data collection protocol was developed and based on the exploratory cross-site evaluation questions. This ensured that key issues relevant to each evaluation question were explored. For each evaluation question, JBA sub-questions were generated to gather further information from grantees. To test the relevance of discussion protocol questions, a pilot site visit was conducted with one grantee in December 2013. The pilot test resulted in revised protocols that were used for the remaining six grantees. Protocol questions that elicited minimal or unclear responses were modified or discarded.

Data Organization. To facilitate data analysis, a two-phase coding process was applied to organize discussion notes for each project. In Coding Phase 1, the data were organized by applying a code to each

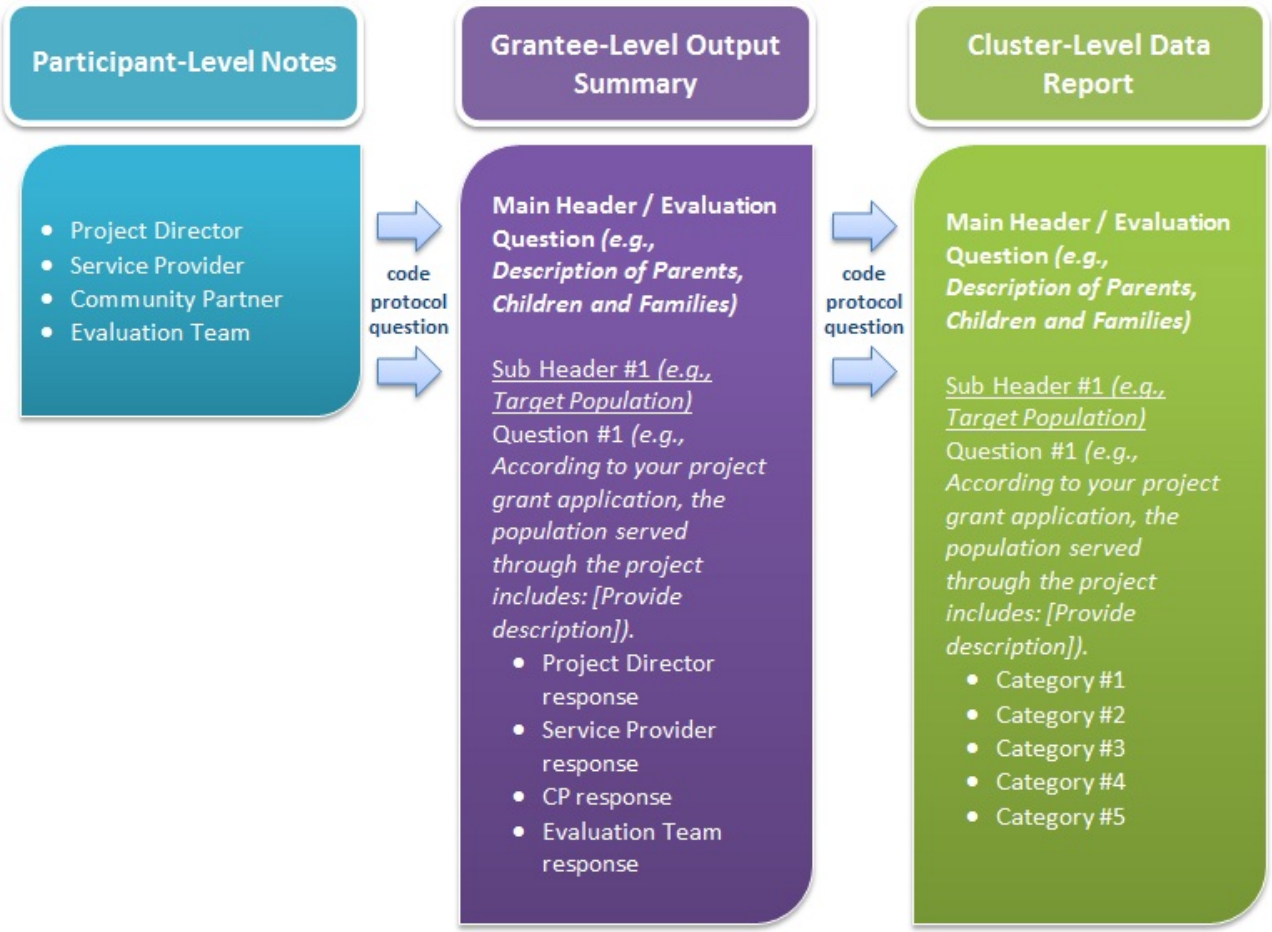
[22] Pandit, N. (1996). The Creation of Theory: A Recent Application of the Grounded Theory Method (The Qualitative Report, Volume 2, Number 4, December, 1996). Retrieved March 28, 2013 from NOVA Southeastern University website: http://www.nova.edu/ssss/QR/QR2-4/pandit.html/pandit.html

protocol question. In Coding Phase 2, responses were coded to each protocol question. All coded responses were entered into Atlas.ti, a qualitative software package used to support organizing and producing reports at multiple levels – by grantee/project and as a cluster.

The first of two grantee-level Atlas.ti output summaries was generated, both of which are illustrated in Figure 2-2: Family Connection Cross-site Evaluation – Coding Process. Grantee-level output summaries for each grantee provided organized responses by participant to each protocol question. Output summaries were generated using Atlas.ti coded questions and responses from Coding Phase 1. Consistent with the format of the codebook and organization of protocols, grantee-level output summaries were organized as follows:

1. Evaluation question / header (e.g., Description of Parents, Children and Families)
2. Applicable evaluation sub-header (e.g., Target Population)
3. Protocol question
4. Responses for each participant that responded to the protocol question

Figure 2-2: Family Connection Cross-site Evaluation – Coding Process



From the grantee-level output, cluster-level data reports were created for each grantee that provided a coded summary of responses for targeted site visit questions. During the initial open coding process (Coding Phase 2), data reports for cluster-level output were created using the coding software. Coding

Phase 2 is further detailed in the next section: Qualitative Coding Process. Consistent with the format of the codebook, organization of protocols, and grantee-level output summaries, cluster-level data reports were organized as follows:

1. Evaluation question / header (e.g., Description of Parents, Children and Families)
2. Applicable evaluation sub-header (e.g., Target Population, Target Population Observations)
3. Protocol question
4. Summary of key responses to the protocol question by grantee/project

Additional cluster-level data reports were conducted to address selected questions.

Qualitative Coding Process. Data were systematically analyzed at the cluster level via qualitative analysis to identify commonalities, relationships and themes; identify clusters and categories; partition variables as needed; and analyze and incorporate patterns and variations. During Coding Phase 2, each primary coder began analyzing the qualitative data in Atlas.ti using an open coding approach to identify emerging categories for each project, followed by axial coding to identify similarities and relationships among various categories within and among other projects. This process required multiple reviews of the discussion notes to compare categories and make appropriate classifications. Primary coders also used analytic and conceptual memos to highlight salient patterns and themes that warranted further explanation, and to elaborate on themes that emerged from the data. As categories emerged for each process evaluation sub-question, they were continually tested by reviewing data across FGDM projects.

The codebook generated for the 2009 Family Connection Cross-site Evaluation Report was used to categorize qualitative data for this report, validating the categories identified by the primary coders during the initial coding process. The codebook was modified as patterns and themes emerged from the initial coding process. All codes were captured in a new data codebook organized by 1) cross-site evaluation question; 2) discussion protocol question; 3) response categories; and 4) applicable code, with an additional reference to the type of grantee participant (e.g., project directors, service providers, the evaluators, and key community partners) that responded to each question. Additional codes were added during analysis to further capture grantee processes and outcomes that emerged in the final year of operation under Family Connection funding. The codebook may be found in Appendix H: Discussion Codebook.

Table 2-2: Sample Codebook Question, Categories, and Codes provide a sample discussion protocol question with associated response categories, and applicable codes from the data codebook. Each discussion protocol question was grouped within a series of larger evaluation questions. The discussion protocol question, “According to your project grant application, the population served through the project includes… (Provide description),” addresses the cross-site evaluation process question, “Who are the parents, children, and families served by the projects?” As noted in the Participant column, this discussion question was asked of project directors (PD), service providers (SP), and evaluation team members (Eval).

During later stages of coding, secondary coders reviewed the categories created by primary coders and re-categorized concepts where needed. This multi-coder process strengthened coding reliability and helped unify categories already identified into core categories. The secondary coders were the primary interviewers during site visit discussions. Due to their direct experience working with the grantees, they had the contextual knowledge and experience to identify and interpret core categories. Incorporating secondary coders into the process also provided an opportunity for collaborative analysis and helped

elicit more thorough, descriptive detail and explanations for variations between categories and key themes that emerged. For instances when there were discrepancies or outliers, secondary coders provided examples of grantee strategies and success stories that varied from the norm. These outliers are documented in the grantee evaluation findings.

Table 2-2: Sample Codebook Question, Categories, and Codes

Protocol Question	Response Categories	Code	Participant[1]
Description of Parents, Children and Families (Evaluation Question) According to your project grant application, the population served through the project includes…(Provide description).	African-American families	Demographic1	PD, SP, Eval
	Families at risk of entering or re-entering foster care	Demographic2	PD, SP, Eval
	Families receiving in-home services	Demographic3	PD, SP, Eval
	Families with a minimum of 2 family members to contact	Demographic4	PD, SP, Eval
	Formal CW cases	Demographic5	PD, SP, Eval
	Informal involvement in CW system	Demographic6	PD, SP, Eval
	Kinship families	Demographic7	PD, SP, Eval
	New child welfare cases in the system	Demographic8	PD, SP, Eval
	Native American families	Demographic9	PD, SP, Eval
	Families with children in out-of-home placement where reunification within 6 months has been deemed likely	Demographic10	PD, SP, Eval
	Families who are subjects of an abuse call	Demographic11	PD, SP, Eval

[1]PD= Project Director; SP= Service Provider; Eval=Evaluation Team

During later stages of coding, secondary coders reviewed the categories created by primary coders and re-categorized concepts where needed. This multi-coder process strengthened coding reliability and helped unify categories already identified into core categories. The secondary coders were the primary interviewers during site visit discussions. Due to their direct experience working with the grantees, they had the contextual knowledge and experience to identify and interpret core categories. Incorporating secondary coders into the process also provided an opportunity for collaborative analysis and helped elicit more thorough, descriptive details and explanations for variations between categories and key themes that emerged. For instances when there were discrepancies or outliers, secondary coders provided examples of grantee strategies and success stories that varied from the norm. These outliers are documented in the grantee evaluation findings. Throughout the report, various quotations from the perspective of FGDM project representatives were selected to illustrate key themes as well as outliers that emerged during site visit discussions. These quotations represent the perceptions and observations of key stakeholders involved in Family Connection funded projects. Quotations were lightly edited in some instances to remove speech idioms or to correct minor/grammatical errors which did not alter the ideas expressed.

Literature Comparison. Once final analytic decisions were established to help answer key process evaluation questions, the findings were compared with existing literature on implementation science. In a description of theory development using qualitative approaches, Eisenhardt stated, "tying the emergent theory to existing literature enhances the internal validity, generalisability, and theoretical level of the theory building from case study research . . . because the findings often rest on a very limited number of cases."[23] Implementation science literature is used to validate process evaluation findings, and found that many implementation "facilitators" reflected implementation science drivers identified in various reports, including JBA's implementation science report.[24]

Quantitative Synthesis

Quantitative data provided by grantees was synthesized in semi-annual evaluation reports and final reports submitted to CB. The cluster logic models and the cross-site outcome evaluation questions, guided the quantitative synthesis of grantee outcomes. Data were organized in the report by categories of safety, permanency, and well-being, as well as by child, family, and organizational-level outcomes. Due to the diversity in outcomes reported, data indicative of these concepts were synthesized when provided by a majority of grantees within the cluster. Table 2-3: Common Grantee Data Sources and Instruments provide an overview of common data sources and measures used by grantees across the cluster.

Table 2-3: Common Grantee Data Sources and Instruments

Grantee	Family Needs Scale (FNS)	Parenting Stress Index, short form (PSI)	FRIENDS Protective Factors Survey (PFS)	North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R)	State/Tribal Social Services data (SACWIS)
The Children's Home Society of New Jersey	●	●			●
Homes for Black Children	●	●	●		●
Kids Central, Inc.	●		●		●
Larimer County DHS (CO, SD, and TX sites)			●		●
Ute Indian Tribe		●	●	●	●
The Village Family Service Center	●		●		●
YMCA of San Diego County	●		●	●	●

[23] Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of Management Review, 14*, 532-550.

[24] James Bell Associates (2013). *Lessons learned through the application of implementation science concepts to Children's Bureau discretionary grant programs*. Arlington, VA: Author.

Report Review

This report was submitted to CB and Family Connection grantees for review as a strategy for testing and confirming findings, consistent with recommendations from Miles & Huberman in regard to qualitative analysis.[25] Family Connection grantees included those participants who supplied discussion data for this report. Concerns and questions were discussed with CB and grantees, and findings and conclusions were revised as appropriate.

Limitations of the Evaluation

The cross-site evaluation of the Family Connection discretionary grants provided a unique opportunity to assess the degree to which grantees made concerted efforts to use the FGDM process to engage family members effectively in planning and decision-making, and to identify, provide and arrange appropriate services that resulted in improved evidence of child safety, permanent and stable living situations, continued family relationships, and enhanced capacity of families to care for their children's needs. This opportunity also came with significant limitations and constraints.

In designing the evaluation, JBA researched what FGDM grantees were already doing for site-specific evaluations, determined commonalities, and designed a report process to obtain as much common data as possible while respecting the resources grantees had already allocated to local evaluations. Despite efforts to capture a common data set, there continued to be considerable variation in reporting and analyses across grantees as local evaluations were tailored to meet the needs of their respective interventions. These limitations should be considered when reading and interpreting process and outcome results for the FGDM cluster.

Outcome Variability

There was a high degree of heterogeneity among grantees in regard to outcome-level data collection. While grantees measured similar or the same behaviors, attitudes, and knowledge, there were differences in how those outcomes were operationalized. Although initial discussions were conducted with grantees to identify common instruments to measure FGDM outcomes, grantees were not required to use these instruments. While most grantees were open to incorporating the FRIENDS Protective Factors Survey and Family Needs Scale into their evaluation design, these were the few outcome data elements collected across the projects that were common to more than one grantee. As a result, JBA was able to synthesize and describe this data but was limited in the ability to conduct quantitative analyses that would represent a common result across grantees.

Low Sample Sizes

Several FGDM grantees reported low sample sizes and unequal numbers of participants in the experimental and comparison groups by the time of the semi-annual evaluation report addressing processes and outcomes through December 31, 2014. Some grantees experienced challenges obtaining referrals to the projects and engaging families in FGDM services. Grantees also reported low follow-up rates for survey instruments. Families often declined to complete supplemental measures due to

[25] Miles, M. B., & Huberman, A. Michael. (1994). *Qualitative data analysis: An expanded source book.* Thousand Oaks, CA: Sage Publications.

fatigue, termination of service, and/or perceptions that they improved functioning so instruments were no longer used. As a result, several grantees had less data from fewer clients than they originally projected in their evaluation designs. This has implications for the generalizability of results.

Different Evaluation Designs

Family Connection grantees varied in evaluation designs. As a result, some grantees reported results for treatment and control or comparison groups, sometimes at baseline and follow-up, while others reported results only for a treatment group at baseline, and depending on data availability, at follow-up. A table of grantee evaluation designs may be found in Appendix I: Grantee Local Outcome Evaluation Design.

Multiple Models of FGDM

Because the 2011 Family Connection funding announcement did not specify a particular FGDM model to be used by grantees, various FGDM models were implemented based on grantee service models, target populations, and community needs. As a result, interpretations of findings must take into account the different models used by grantees. For instance, meetings held for long-term permanency planning involved significantly more preparation than meetings for short-term placement planning requiring the development of an immediate family plan. Consequently, the type of meeting held also impacted the costs and outcomes associated with FGDM meetings. A table of grantees' FGDM models may be found in Table 3-3: FGDM Grantee Service Model Descriptions of Section 3: Process Evaluation Findings.

Section 3: Process Evaluation Findings

This section describes process evaluation findings for the Family Group Decision-making (FGDM) cluster. Process evaluation findings include a description of the target populations served by the grantees, the number of children, adults, and families served, key demographic characteristics, and observations by grantee staff members about target population trends. Service models and key activities implemented by FGDM grantees are described, along with strategies to effectively meet the needs of families served. Process outcomes related to service provision are also highlighted. The report subsections address the following cross-site evaluation research questions:

- *What are the characteristics of the children, parents, and families served by the FGDM projects?*
- *What are the service models, interventions, and activities implemented by the FGDM projects?*
- *What amount and mix of services are provided to parents, children, and families participating in FGDM meetings?*

Summary of Family Group Decision-making Process Evaluation Findings

FGDM grantees engaged and empowered families to take an active and sometimes leadership role in developing plans and making decisions to promote the safety, permanency, and well-being of their children. FGDM projects primarily served families with children who were in or at risk of entering the child welfare system. Families either received voluntary in-home support services or out-of-home services from the public child welfare agency and/or private/not-for-profit service-providing agency. FGDM grantees used a trained facilitator from the public child welfare agency or an independent, community-based organization to moderate family meetings. The timing of FGDM meetings varied across grantees, and largely depended on the model of FGDM used and the purpose of the meeting. Grantees described common service model activities across projects, which included referral to the project, meeting preparation and coordination, FGDM meeting facilitation, follow-up services, and service model adaptation.

The number of children served by FGDM grantees from September 30, 2011 to December 31, 2014 ranged from 21 to 606. The total number of adults served during that period ranged from 50 to 373, while the total number of families served during that period ranged from 15 to 488. FGDM grantees provided quantitative demographic information on the children and families served. While one half of the families served had a history of child welfare involvement, less than one half of families had a history of substance abuse, domestic violence issues, and legal system involvement.

The number of FGDM meetings conducted ranged from 16 to 323. Output data provided by grantees showed that grantees engaged a combination of formal and informal family supports in FGDM meetings. Key family members selected participants to participate in FGDM meetings. Meeting participants typically included immediate and extended family members, family friends, and relevant service providers. Community members involved in FGDM included representatives from the public child welfare agencies; local institutions such as schools, mental health, and health care; domestic violence

advocates; and/or substance abuse programs. Supporting data for process evaluation findings may be found in Appendix J: Process Evaluation Data.

Description of Target Population

This section describes the target populations for FGDM grantees. Key demographic characteristics of adults and their children are provided along with grantee leadership and staff member observations about target population trends. Grantees served families that were identified through screening protocols or referrals as at-risk of child abuse and neglect. Families either received in-home support services or out-of-home services from the public child welfare agency or privatized child welfare service agencies. Key characteristics of grantee target populations across the cluster can be seen in Table 3-1: Key Characteristics of Grantee Target Populations below.

Table 3-1: Key Characteristics of Grantee Target Populations

	The Children's Home Society of New Jersey	Homes for Black Children	Kids Central, Inc.	Larimer County DHS	Ute Indian Tribe	The Village Family Service Center	YMCA of San Diego County
No involvement in child welfare system	●[1]	●				●	
In-home services		●	●	●		●	●
Out of home services				●	●	●	●
New (first-time) child welfare cases				●	●		
Kinship families	●						●
Native American families				●	●	●	
African American families		●		●			

Note: Larimer County DHS' SD site intended to target Native American families, while their TX site intended to target African American families.
[1] CHSofNJ served families who had no current involvement in child welfare system at intake.

Five grantees targeted services toward families receiving in-home child welfare services (i.e., diversion of family preservation services for families with unsubstantiated Child Protective Services [CPS] investigations). Four grantees served families that were formally involved in the public child welfare system (i.e., court-dependent families, families with a substantiated maltreatment investigation, families in which the child/children have been removed but are in the process of returning to the home). The two public and tribal child welfare agency grantees specifically targeted services to families who were involved in the child welfare system for the first time (i.e., new child welfare cases). Another two grantees aimed to serve kinship families. Due to disproportionality among racial/ethnic groups in their service areas, three grantees used their cultural expertise to serve Native American families, while two grantees targeted families of African American children to receive FGDM and supplemental services.

FGDM grantees broadly defined "families" as the parent or caregiver (e.g., biological mother and/or father, guardian, legal guardian, adoptive parents, or foster parents) and "children" from birth to age 18. Grantees also included informal and formal supports to families as FGDM meeting participants. Informal supports consisted of extended family members (e.g., aunts, cousins, uncles, and grandparents), family friends, and family advocates. Formal supports included service professionals in the areas of substance abuse, domestic violence, and mental health.

Children, Adults, and Families Served. Table 3-2: Number of Children, Adults, and Families Served documents the total number of children, adults, and families served by FGDM grantees from September 30, 2011 through December 31, 2014. The seven grantees served a combined total of 1,441 children, 893 adults/caregivers, and 1,143 families throughout the funding period. These numbers represent the total number of children, adults, and families that projects were able to reach through FGDM and/or other supplemental services and activities funded by the grant. The numbers served varied significantly across projects due to differences in the originally projected numbers of children and families intended to be served, as well as the geographic scope and organizational capacity of the Family Connection grantees.

- ***Children:*** The total number of children served throughout the project period ranged from 21 at the Ute Indian Tribe to 606 at Homes for Black Children.
- ***Adults:*** The total number of adults served throughout the project period ranged from 50 adults at YMCA of San Diego County to 373 adults at The Children's Home Society of New Jersey.
- ***Families:*** The total number of families served throughout the project period ranged from 15 families at the Ute Indian Tribe to 488 families at Kids Central, Inc.

Table 3-2: Number of Children, Adults, and Families Served

Grantee	Children	Adults	Families
The Children's Home Society of New Jersey[1]	587 total (80 FGDM)	373 total (47 FGDM)	Data not collected
Homes for Black Children[1]	606 total (44 FGDM)	262 total (83 FGDM)	222 (18 FGDM)
Kids Central, Inc.	Data not collected	Data not collected	488
Larimer County DHS			
Colorado site[2]	-	-	-
South Dakota site	Data not collected	Data not collected	15
Texas site	Data not collected	Data not collected	274
Ute Indian Tribe	21	55	15
The Village Family Service Center	227	153	129
YMCA of San Diego County	Data not collected	50	Data not collected
Total	**1,441**	**893**	**1,143**

Note: Adults include the parent or caregiver (e.g., biological mother and/or father, guardian, legal guardian, adoptive parents, or foster parents)

[1] The grantees used a phased model approach to engage and recruit FGDM participants, and thus provided more supplemental services to a higher number of families.

[2] The Larimer County DHS' Colorado site served a combined total of 488 control and treatment families. The grantee was not able to determine treatment and control group designation for this site until the conclusion of its no-cost extension.

Child and Family Demographics. All FGDM grantees provided demographic data on the children, adults, and families served through FGDM projects. All seven grantees provided data on average age, gender, and race/ethnicity; several grantees provided additional data on the children, adults, and families served through their projects.

Age of Children and Adults Served. Although grantees offered services to children from birth to age 18, grantees tended to serve younger children. The average age of children receiving FGDM services across all grantees was 7.3 years (range of average child age = 4.2 to 11 years). YMCA of San Diego County served younger children than other grantees (average age = 4.2 years), while most other grantees primarily served children between the ages of 6 and 11. The average age for adults or caregivers receiving FGDM services was 36.3 years (range= 27.6 to 58 years). The high spread was largely due to the fact that one grantee, The Children's Home Society of New Jersey, primarily served older kinship caregivers.

Gender of Children and Adults Served. Across all seven grantees, the average percentage of children served was similar for males (53 percent) and females (47 percent). A majority of grantees (The Children's Home Society of New Jersey, Homes for Black Children, Larimer County DHS (CO and TX sites), Ute Indian Tribe, and YMCA of San Diego County) provided FGDM services to slightly more male children, while The Village Family Service Center served slightly more female children. Kids Central, Inc. served an even number of male and female children. All seven grantees provided gender data for primary caregivers receiving project services (which include FGDM and supplemental support services provided by grantees using Family Connection funding). On average, primary caregivers served through Family Connection funding across all grantees were female (82.6 percent). The low percentage of males as the primary caregiver of the child (16.9 percent) supports findings from the literature which assert that mothers tend to be more involved than fathers when their families become involved with child welfare agencies.[26] The 2011 Family Connection funding announcement sought to address this issue by encouraging grantees to focus on engaging fathers and/or paternal relatives to develop more comprehensive case plans.

Race/Ethnicity of Children and Adults Served. Most children and primary caregivers served through the FGDM projects were reported within five main race/ethnicity categories: White/Caucasian, Black/African American, Hispanic, Native American, Asian, and Multi-Racial. The Children's Bureau (CB) has found that African American and Native American children have the highest rates of child abuse and neglect.[27] Four grantees primarily served children and their caregivers from these race/ethnicity categories through their FGDM projects. Three grantees (Larimer County DHS (South Dakota site), Ute Indian Tribe and The Village Family Service Center) specifically targeted and primarily served Native American children and families, while another two grantees (The Children's Home Society of New Jersey and Homes for Black Children) primarily served Black/African American children and adults. YMCA of San Diego County served mainly Hispanic clients, while Kids Central, Inc. and Larimer County DHS (CO and TX sites) predominantly served White/Caucasian clients.

Additional Demographics. On average, a majority of primary caregivers across the seven projects were unmarried (66.4 percent) at the time project services were procured (documented by grantees as

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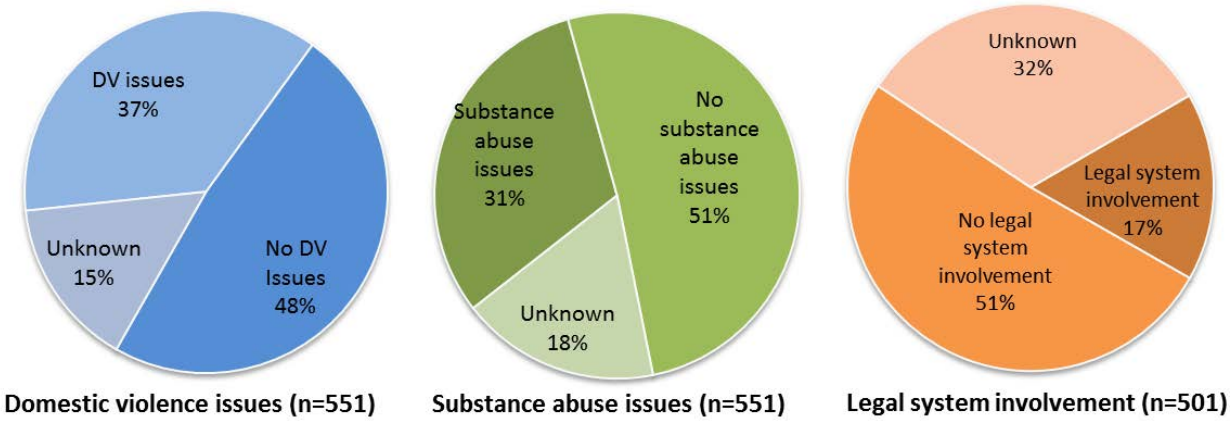
[26] Cameron, G., Coady, N., & Hoy, S. (2012). Perspectives on being a father from men involved with child welfare services. *Child & Family Social Work, 19*(1).

[27] Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. (2012). Child Maltreatment 2012. (Contract Order HHSP233201200657G). Washington, DC: U.S. Government Printing Office. Chapter 3: 20, 23, 37.

single, never married, separated, divorced, or widowed). A minority of adult caregivers across the sample reported being married or living with a partner (33.7 percent). This pattern also occurred within individual projects except for the Ute Indian Tribe, where a majority (60 percent) of adults receiving FGDM services were married or partnered.

Six grantees provided data on their history of domestic violence and substance abuse, and five grantees provided data on the primary caregiver's history of involvement in the legal system. Across these grantees, over a third of the families served (37 percent) experienced a history of domestic violence within the household. About one third (31 percent) of the families also experienced drug and alcohol issues within the household. A small percentage (17 percent) of families receiving FGDM services had prior legal system involvement. Figure 3-1: Legal, Substance Abuse, and Domestic Violence Issues among Families provides detailed findings on the prevalence of these issues among families served by grantees.

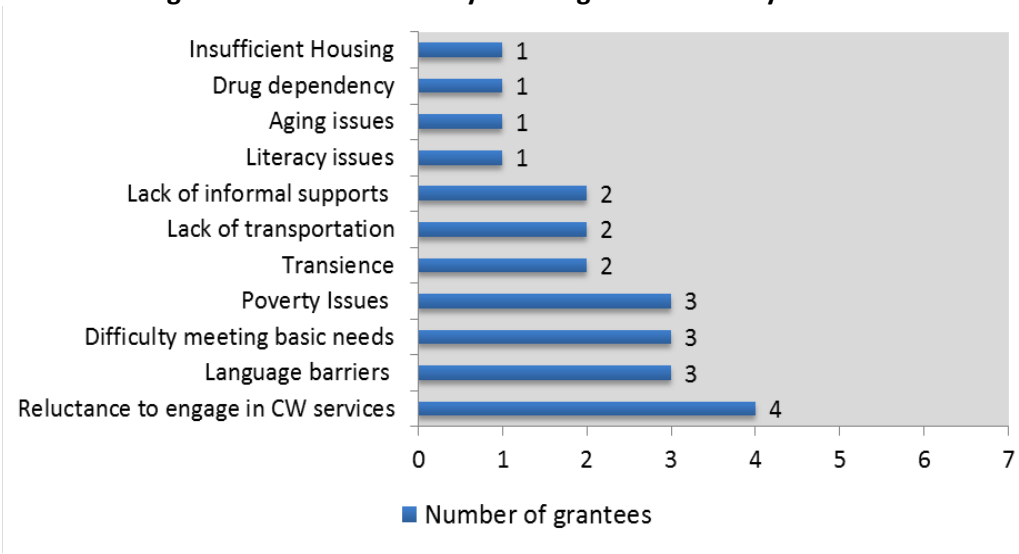
Figure 3-1: Domestic Violence, Substance Abuse, and Legal Issues among Families Served



All seven grantees provided data on the families' prior involvement with child welfare. Half of the children served by the projects had no prior involvement with the child welfare system (51 percent). Larimer County DHS (CO, SD, and TX sites) and the Ute Indian Tribe originally intended to serve families who were new to the public child welfare system with no history of child welfare involvement, though the Ute Indian Tribe reported that 26.7 percent (*n*=4) of adults participating in their project's intervention group had prior involvement with CPS. Larimer County DHS (CO, SD, and TX sites) opted not to implement this eligibility criterion across sites due to lower-than-expected referral rates, and thus did not screen families with prior CPS involvement out of the study.

Through site visit discussions with project staff members, FGDM grantees highlighted several challenges that families enrolled in their projects faced, including reluctance to engage in FGDM or other child welfare services (most often due to lack of trust in the child welfare system or lack of motivation to participate in services because of the voluntary nature of Family Connection funded FGDM services); difficulty meeting basic needs (i.e., food, shelter, clothing); language barriers (some grantees required interpreters for FGDM services); poverty/financial issues; transience/highly mobile population; lack of transportation; and lack of informal supports to participate in FGDM meetings (e.g., immediate or extended family and friends). Figure 3-2: Common Family Challenges Identified by Grantees illustrates these challenges.

Figure 3-2: Common Family Challenges Identified by Grantees



Description of Service Models and Key Activities

This section describes the service model and key activities implemented by FGDM grantees, including the general flow of services for each project. Documentation of best practices chosen and/or adapted for each project is included, along with strategies used by grantees to address critical needs of the target populations. The section concludes with a discussion of key characteristics, skills, and experiences needed to effectively facilitate FGDM meetings.

FGDM is a family-focused intervention approach that brings together children, parents, foster parents, service providers, child welfare professionals, advocates, and community partners to make decisions that support the safety, well-being, and permanency of children. Grantees implemented projects that reflected the wide variety of existing FGDM models as documented in Table 3-3: FGDM Grantee Service Model Descriptions. Larimer County DHS (CO, SD, and TX sites) and The Village Family Service Center evaluated two different models of FGDM through grant funding. For the purpose of this report, all service models will be referred to as FGDM as reflected by the 2011 Family Connection funding announcement.

Table 3-3: FGDM Grantee Service Model Descriptions

Grantee	Service Model Description
The Children's Home Society of New Jersey	***Family Success Conferencing (FSC)*** is based on the Annie E. Casey Foundation's "Family Teaming: Comparing Approaches" model of FGDM, which brings families together to solve issues that they have identified. When possible, coordinators try to ensure that at least 50 percent of FSC participants are family members or other informal supports. Families share information about available resources within their families and the community to help address concerns, and private family time is provided.

Grantee	Service Model Description
Homes for Black Children	***Family Group Conferencing (FGC)*** is based on the model researched by the American Humane Society: Family Group Conference Model. It focuses on the development of a plan with collaborative support to achieve the family's goals and allows participants to identify their needs, and discuss child safety issues within the context of family strengths. It also helps identify formal community resources and the resources the family has to offer. A key distinction of this model is that the FGC coordinator gathers supporting participants together and a member of the family is appointed to lead the meeting.
Kids Central, Inc.	***Family Team Conferencing (FTC)*** is a non-threatening environment where a family can come together with identified supports and develop a plan to improve skills and access resources, which allow for the safety, permanency, and well-being of children. The FTC approach encourages convening a child and family team to address major child welfare decisions from safety planning to case closure.
Larimer County DHS (CO, SD, and TX sites)	***Family Unity Meetings (FUM)*** are held when families experience crises during interventions. It allows the family to gather additional supports and develop relationships with service agencies. This model requires minimal preparation of families prior to the meeting, and private family time is only provided if needed. Only the project staff members at the Colorado site used this model. ***Family Group Conferencing (FGC)*** is a model focused on expanding a family's support network during crises. The preparation phase involves speaking with all participants in person prior to the meeting. Networks are strengthened through enhancing connections within the family group and through education that may take place through the FGC preparation phase. Families plan for the safety, well-being, and permanency of the children during FGCs. FGCs also incorporate private family time. All three Larimer County DHS sites implemented FGCs.
Ute Indian Tribe	***Family Team Meeting (FTM)*** is based on the Family Group Decision-making (FGDM) in Child Welfare Model developed by the American Humane Association and the FGDM Guidelines Committee. The coordinator makes face-to-face contact with families and assesses child safety and domestic violence or physical/sexual abuse. During FTMs, referrals are provided and families plan for the safety, well-being, and permanency of the children and utilize private family time.
The Village Family Service Center	***Family Team Decision-making (FTDM)*** The goal of FTDM is to plan for the immediate placement or safety of children following an emergency removal from the home. ***Family Group Decision-making (FGDM)*** The process of FGDM brings together family members, the children (when appropriate), service providers, and other community support participants to create a plan to safeguard children and other family members. There can be many different purposes for holding an FGDM, as long as the goal of the meeting is to develop a plan to support the long-term safety, permanency, and well-being of children.
YMCA of San Diego County	***Family Group Conferencing (FGC)*** is focused on expanding a family's support network during crises. Networks are strengthened through enhancing connections within the family group and through the education that may take place through the FGC preparation process. During FGCs, families plan for the safety, well-being, and permanency of the children and utilize private family time.

Although the 2011-funded FGDM grantees adopted various FGDM models, they all placed family strengths, family engagement, and informed family decision-making as core values in approaches to working with children and families. FGDM grantees considered their chosen service models as a best practice approach to serving the needs of children and families in or at risk for entering the child welfare system.

Referrals. Grantees relied heavily on referrals to reach their target population. Table 3-4: FGDM Project Referral Sources identifies grantees' key sources of FGDM project referrals. Referrals to FGDM projects occurred due to an imminent risk of placement; prior to removal from home; at the times of a change of placement and change of permanency plan; or when key decisions needed to be made regarding the child or family. Most grantees (*n*=6) received service referrals from the public child welfare agency (primarily through CPS investigators). Projects administered by public and tribal child welfare agencies received referrals from CPS staff members within their agencies. Three grantees also obtained referrals from internal programs/departments within their agencies. For example, The Children's Home Society of New Jersey received referrals from the agency's GrandFamily Success Center, which provides linkages to community services, supportive education groups, and individual support to kinship caregivers in the county.

Table 3-4: FGDM Project Referral Sources

Referral Source	The Children's Home Society of New Jersey	Homes for Black Children	Kids Central, Inc.	Larimer County DHS	Ute Indian Tribe	The Village Family Service Center	YMCA of San Diego County
External Public Child Welfare Agency		●	●			●	●
Internal Public Child Welfare Agency				●	●		
Internal Private/Not-for-Profit Service Provider	●	●					●
External Private/Not-for-Profit Service Provider			●			●	

Preparation and Coordination. A staff coordinator or facilitator typically organized the initial FGDM meeting by inviting participants identified by key family members and coordinating schedules. In order to ensure that families were prepared to engage in FGDM, project staff members communicated with families, service providers, and other meeting participants to provide information on the purpose of the meeting, clarify roles and expectations, and address all questions. Staff members also inquired about safety concerns, family conflict, scheduling preferences, and special accommodations. The preparation phase varied across grantees and depended on the model of FGDM used and the number of participants invited. Meetings held for long-term planning required significantly more preparation (ranging from 15 hours up to 7 months) compared to meetings for short-term planning, which required developing a more immediate family plan.

Meeting Facilitation. Six grantees used a trained facilitator from the child welfare agency or an independent, community-based organization to moderate family meetings. One grantee (Homes for

Black Children) did not have a facilitator present at meetings. Meeting coordinators prepared the family members to lead their own discussions and develop their own family plans during the meeting. Key activities included a discussion of family strengths, service needs, resources available, and development of a case plan or family plan. For projects using models based on long-term planning, private family time was a critical component of the meeting. Policy often allowed for more preparation and facilitation time for FGDM models. Meetings ranged from 2 to 6 hours for grantees using FGDM service models to expand the support circle of families and plan for the long-term safety, permanency, and well-being of children. Meetings were shorter, averaging 1 to 2 hours, for the grantee that implemented the FTDM model. Families served through this model needed to identify immediate placement or plan for the safety of children following an emergency removal from the home. Referrals for FTDM services often resulted in a meeting scheduled for the next day, which allowed minimal preparation time and often did not include private family time during the meeting.

Private Family Time and Development of Family Plans. All seven grantees included private family time as part of their FGDM models, which is a component of FGDM that has been found to help facilitate family engagement in the process.[28] Private family time was described by grantees as an integral part of the meeting during which the facilitator and service providers leave the room and allow the family to make decisions for the children. A common purpose of private family time is to allow the family to discuss options and develop a resultant family plan to increase the safety, permanency, and well-being of its child(ren) without agency influence. One public child welfare agency representative noted, "We are giving families that authority to come up with their own plan as long as it meets our safety requirements. We try to avoid the cooker cutter plan child welfare has been used to." One grantee, Kids Central, Inc., noted that additional safety plans were developed during the meeting with service providers present for children in households where domestic violence was an issue.

Supplemental and/or Follow-Up Services. Six grantees incorporated additional follow-up meetings into their service models to 1) support continued family participation in decision-making and feedback and 2) provide opportunities for the child welfare agencies, service providers, and families to remain updated regarding the progress of services, family visits, and permanency plans. While Homes for Black Children did not include follow-up FGDM meetings as part of the service model, it provided supplemental services to families (e.g., counseling, parenting groups) and assigned a parent mentor/advocate to work closely with families to track their progress on achieving goals from their family plans developed during FGDM meetings. Kids Central, Inc. assigned Diversion Care Coordinators to provide in-home support to families for 30-90 days as they worked on their action plans developed during FGDM meetings. This provided continuity of services and ensured that families remained focused on their action plans following the meetings. Children's Home Society of New Jersey's FGDM facilitators hosted classes and groups for kinship caregivers and children to provide resources and education and families targeted to receive FGDM services.

Service Model Modifications/Adaptations. Five grantees reported that they made changes to their service models and key activities over the course of the grant period. Grantees viewed this as an adaptive capacity that helped them remain responsive to the dynamics of the project. During discussions, grantees described the following modifications to the FGDM model or other key services:

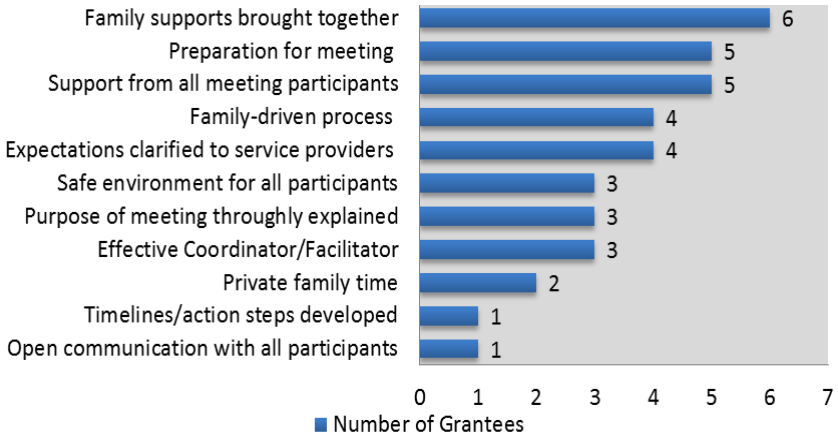
[28] Healy, K., Darlington, Y., & Yellowlees, J. (2012). Family participation in child protection practice: An observational study of family group meetings. *Child & Family Social Work, 17*, 1-12.

- Implementing a second Family Team Conference as an opportunity to follow up on the progress of the family and bring other family members into the process (The Children's Home Society of New Jersey)
- Adding supplemental services and activities (e.g., birth parent orientation, in-home services, assigning Parent Advocate, Project Resiliency Coordinator serving as a case manager) to help strengthen families and prepare them for Family Group Conferences (Homes for Black Children)
- Family Team Conference facilitators joining Diversion staff at the first meeting with their assigned families if Diversion staff members were not able to attend the meeting to ensure continuity of the family plan (Kids Central, Inc.)
- Re-assigning data collection responsibilities so that case managers, who work directly with the family, administer family assessments rather than CPS workers (Ute Indian Tribe)
- Shortening the duration of meetings, developing more specific safety plans, and revising the data collection process to include a 6-month follow-up interview not only with families, but also with their referral workers (due to transience of families) (The Village Family Service Center)

Key Characteristics of Effective FGDM Meetings. While grantees implemented varying models of FGDM, they identified a common group of facilitating factors that they believed impacted the effectiveness of FGDM meetings. The characteristic most often cited across grantees as a key factor in implementing meetings was bringing family supports to the table to participate in the meetings. Families often began with a small number of supports, but in working with grantees they were able to identify and engage a wider circle of support for the meetings. Grantees perceived that having a stronger support system present at the meetings greatly increased family engagement in FGDM.

Other commonly cited characteristics included obtaining support for the FGDM process from meeting participants, thoroughly preparing for the meetings in advance, clearly explaining and articulating goals and expectations to service providers, and ensuring that FGDM is a family-driven process. Additional factors mentioned were ensuring that the FGDM coordinators or facilitators have undergone FGDM training and have strong skills in communication, planning, and facilitation; providing a safe and neutral environment for participants; ensuring that families have private family time to discuss goals and plans; openly communicating with all participants; and developing timelines and concrete action steps to help the family achieve their goals. Figure 3-3: Characteristics of an Effective FGDM Meeting documents the ingredients identified by grantees as essential to successfully providing FGDM services.

Figure 3-3: Characteristics of an Effective FGDM Meeting



Meeting Target Population Needs. FGDM grantees incorporated a variety of strategies to address the needs of children and families. Through discussions with grantee staff members, the following themes emerged as key components of a quality service delivery system: utilizing a tailored approach, adopting effective family engagement strategies, and addressing domestic violence issues.

Tailored Approach to Service Provision. All FGDM grantees recognized the uniqueness of each family and the importance of tailoring services to meet special needs, including institutionalizing the practice of understanding what works with one family may not necessarily work with another. FGDM grantees met families where they were most comfortable (based on discussions with families prior to the meetings)—for some families this was at the office, while others preferred their homes. Grantees perceived that the most effective approach to service tailoring was to have early conversations with the families during the preparation phase and allow them to decide how they would like to proceed with the meetings (e.g., meals that might be provided, using prayer/religion as an opener, having tribal representatives at the meetings, etc.).

Three grantees (The Children's Home Society of New Jersey, Kids Central, Inc., and Larimer County DHS (CO and TS sites)) addressed language barriers by using interpreters and/or sign language to communicate with families who had non-English language speakers and/or special needs. Though grantees found that using an interpreter significantly lengthened FGDM meetings, it greatly increased family engagement in the process. The three grantees who specifically worked with Native American families (Larimer County DHS (South Dakota site), Ute Indian Tribe, and The Village Family Service Center) expressed the importance of tailoring FGDM services to meet the cultural needs of this population. Project staff members discussed Tribal customs and traditions with families during the preparation phase, and incorporated special prayers and smudging ceremonies into the meetings.

Grantees also recognized that families' basic needs must be met before they could fully engage in FGDM. Two grantees (The Children's Home Society of New Jersey and Homes for Black Children) partnered with other internal programs or external agencies to connect families to supplemental services that could address underlying issues that often intensify family issues (e.g., poverty and health issues). For instance, Homes for Black Children continuously recruited new community service agency representatives to their coalition of service providers working together to provide referrals and resources to families (referred to as their Well-Being Cluster) because these organizations provided basic needs items for families.

Family Engagement. Meaningful family engagement was considered a cornerstone of FGDM service models and key to achieving positive outcomes. Practice models involving clear, honest communication, a strengths-based approach, motivation and empowerment, and shared decision-making and planning reflected a strong commitment to the values and goals of FGDM. Grantees identified several key challenges to family engagement, including a lack of understanding of the purpose of FGDM, difficulty bringing family supports to the table (either because they were difficult to find/reach, or because the family did not feel comfortable involving others), and families' lack of trust (due to negative past experiences with child protective services). Despite these challenges, grantees developed family engagement strategies that promoted full participation in the FGDM process. The most commonly cited engagement practices included empowering the family to lead the process/be in control of the meeting (n=4 grantees), followed by maintaining flexibility in planning meeting logistics (n=3 grantees), and fully preparing the family for the meeting (n=3 grantees). Other, less commonly cited practices included addressing the family's immediate needs (e.g., basic needs) (n=2 grantees), including children and youth in the process (n=2 grantees), maintaining a balance of family and service providers present at the

meeting (*n*=2 grantees), engaging the family in other supportive services (e.g., support groups) (*n*=2 grantees), and assisting the family with family-finding (*n*=1 grantee).

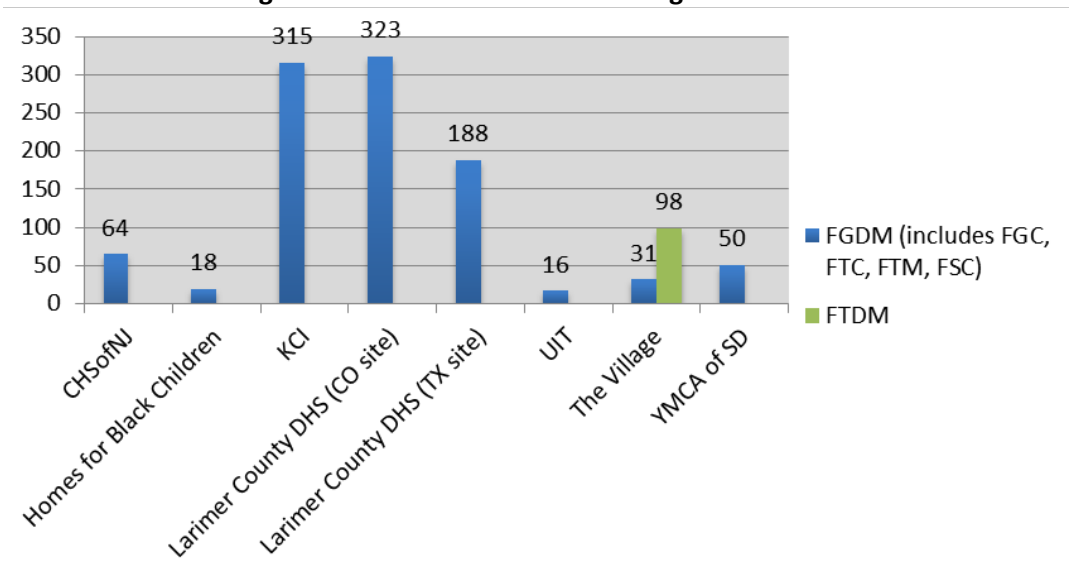
Addressing Domestic Violence. Domestic violence was considered a significant challenge for many families receiving FGDM services as it created safety issues and concerns. All seven grantees encountered domestic violence issues while providing services to families. Grantees acknowledged that the presence of domestic violence or a potential concern of violence occurring required grantees to put safeguards in place for families. The following were the most commonly cited strategies grantees used to address domestic violence issues during the FGDM process.

- ***Pre-screen for domestic violence issues.*** Families were most often screened for domestic violence issues during the preparation phase. Four grantees (Kids Central, Inc., Larimer County DHS (CO, SD, and TX sites), The Village Family Service Center, and YMCA of San Diego County) communicated with referring workers/service providers and families prior to the FGDM meeting to discuss safety concerns and court-mandated orders (e.g., criminal order, restraining order, and no negative contact order).
- ***Make alternative arrangement to include both maternal and paternal families.*** When safety concerns arose, grantees made alternative arrangements based on the dynamics of the parents/caregivers. Four grantees (Kids Central, Inc., Larimer County DHS (CO, SD, and TX sites), The Village Family Service Center, and YMCA of San Diego County) held separate meetings with both sides of the family, engaged the perpetrator via written communication or telephone conference, and/or brought in the perpetrator's relatives to engage in the meetings.
- ***Provide referrals to other services.*** Three grantees (The Children's Home Society of New Jersey, Homes for Black Children, and Ute Indian Tribe) did not have a formal protocol in place for addressing domestic violence, but supplied referrals to local community and Tribal agencies specializing in services to individuals and families impacted by domestic and sexual violence.
- ***Engage supports for maternal and paternal sides.*** Three grantees (Kids Central, Inc., Larimer County DHS (CO, SD, and TX sites), and YMCA of San Diego) stressed the importance of involving both sides of the families in the FGDM process. Grantees brought together informal supports for both the victim and the perpetrator to build a safe environment for all parties.

Service Provision

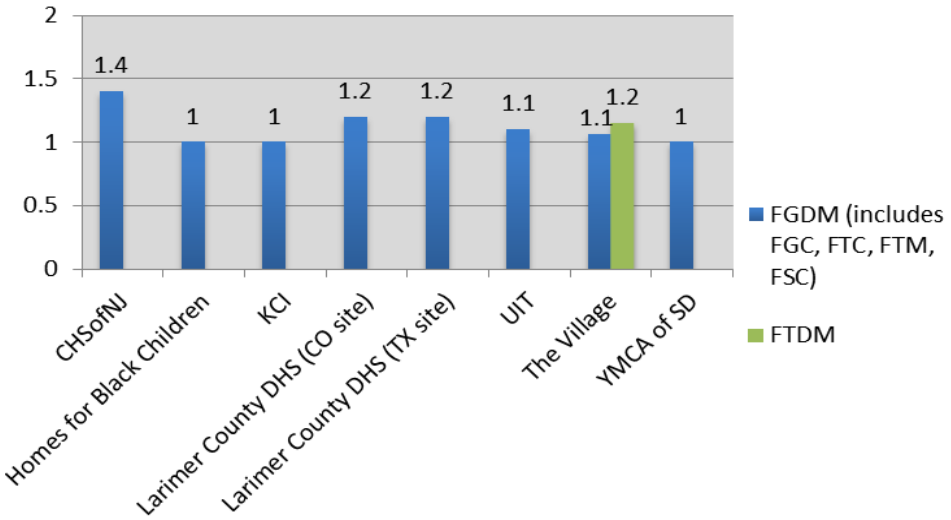
Grantees provided data on family and child-level outputs regarding FGDM service provision. Key measures reported include the number of FGDM meetings conducted, stakeholder involvement, timing of FGDM, and the type of services received by children and families. Figure 3-4: Total Number of Meetings Conducted documents the number of FGDM meetings conducted by each grantee from September 30, 2011, to December 31, 2014, and Figure 3-5: Average Number of Meetings per Family depicts the average number of FGDM meetings provided for each family. The number of FGDM meetings held ranged from 16 at the Ute Indian Tribe to 323 at Larimer County DHS (CO site).

Figure 3-4: Total Number of Meetings Conducted



* Due to data quality issues at the Larimer County DHS Colorado site, meeting service numbers only reflect data from the TX and SD sites.

Figure 3-5: Average Number of Meetings per Family



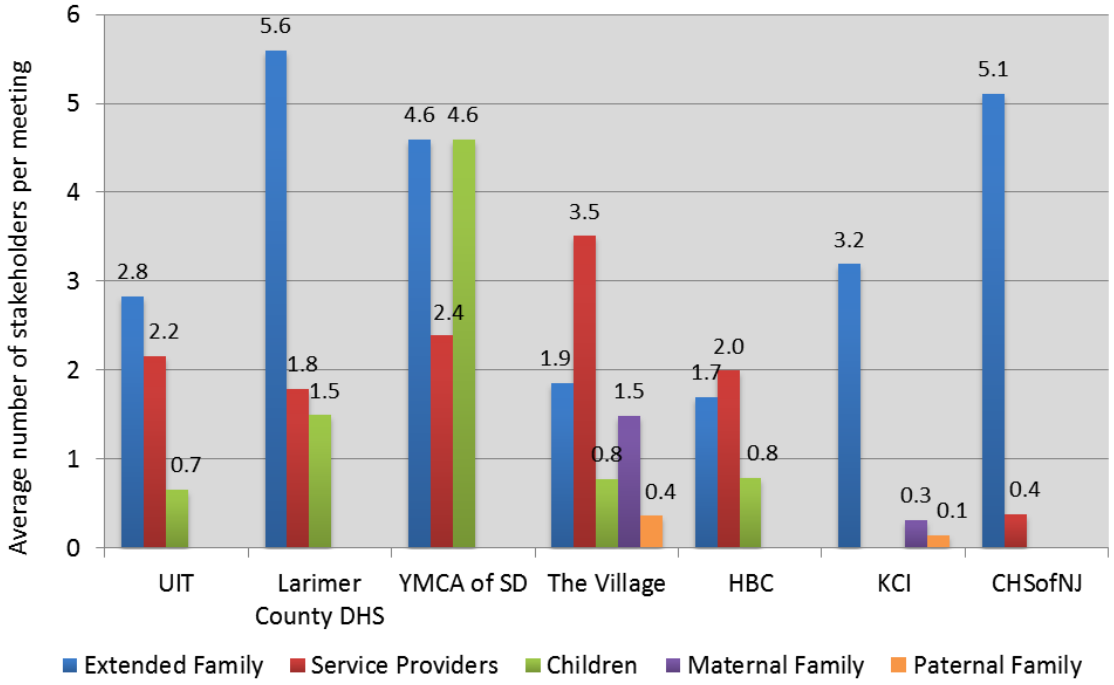
* Due to data quality issues at the Larimer County DHS Colorado site, current meeting service numbers only reflect data from the TX and SD sites.

On average, families served across the Family Connection projects engaged in one to two meetings throughout their time receiving FGDM services. However, grantees varied significantly in the total number of FGDM meetings conducted due to the service models, geographic scope of the Family Connection grants, and differences in the projected number of families intended to be served. Larimer County DHS sites and the Village Family Service Center, who had already been implementing some form of FGDM prior to the grant, were able to conduct more meetings than other grantees who were implementing FGDM for the first time, or who were re-introducing FGDM into their service system. Kids Central, Inc. was in a unique position of facilitating service provider meetings with the public child welfare system and was able to refer families to the project as soon as they became involved in the

system. While the Ute Indian Tribe's project was part of the tribal social service agency, the project provided FGDM services to a narrow target population (i.e., children involved in Ute Social Services who had substantiated child maltreatment investigations), and thus conducted fewer meetings.

Stakeholder Involvement. Stakeholders invited to the FGDM meetings across the projects included extended family, children, maternal and paternal family, and service providers. Grantees engaged a combination of formal and informal family supports in FGDM, involving more family members (informal supports) than service providers (formal supports) in FGDM meetings (see Figure 3-6: Average Number of Stakeholders per Meeting). Across the seven grantees, the average number of extended family members that participated in FGDM meetings was 3.6 per meeting (average range of extended family per meeting = 1.7 to 5.6). Larimer County DHS (CO and TX sites) and The Children's Home Society of New Jersey involved the most extended family members per FGDM. Five grantees (Homes for Black Children, Larimer County DHS (CO and TX sites), Ute Indian Tribe, The Village Family Service Center, and YMCA of San Diego County) tracked the number of children that participated in FGDM meetings. Among these grantees, an average of at least one of more children ($\bar{X}$= 1.7) participated in each meeting (average range of children per meeting = 0.7 to 4.6). Two grantees (Kids Central, Inc., The Village Family Service Center) provided the number of maternal and paternal family members involved in the meetings. These grantees made an effort to involve the family informal supports in decision making, though maternal and paternal family members were not present for every meeting. On average, more maternal relatives ($\bar{X}$= 0.9) participated in each meeting than paternal relatives ($\bar{X}$= 0.3). Six grantees (The Children's Home Society of New Jersey, Homes for Black Children, Larimer County DHS (CO and TX sites), Ute Indian Tribe, The Village Family Service Center, and YMCA of San Diego) documented the number of service providers that participated in FGDM meetings. Among these grantees, an average of 1.7 service providers participated in each meeting (average range of service providers per meeting= 0.4 to 3.5).

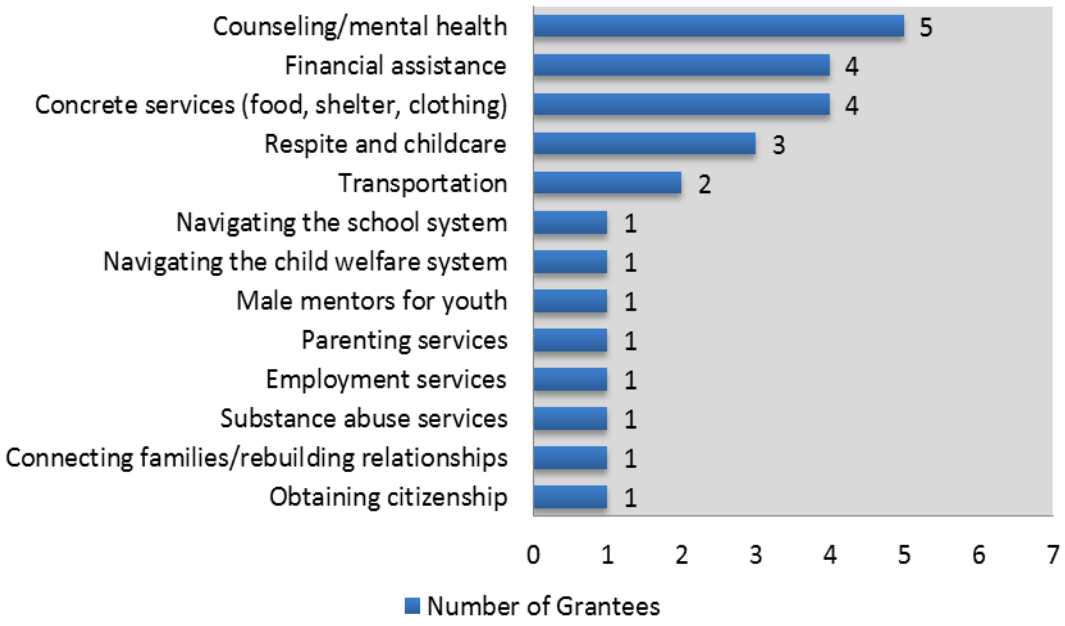
Figure 3-6: Average Number of Stakeholders per Meeting



Timing of FGDM. The timing of FGDM meetings largely depended on the model of FGDM used and the purpose of the meeting. The Village Family Service Center used the Family Team Decision-making (FTDM) model, which must be conducted within 24-72 hours of a report/removal. The timing of the meeting was less critical for grantees that used Family Group Decision-making (FGDM), Family Group Conferencing (FGC), Family Team Conferencing (FTC), Family Team Meeting (FTM), Family Unity Meeting (FUM), and Family Success Conferencing (FSC) models for long-term planning of the child's well-being, as these models required significantly more preparation and engagement of family supports (ranging from 15 hours up to 7 months). Two grantees used a more fluid, phased approach to engaging families in FGDM, as many of the families they served had needs that needed to be addressed prior to engaging in FGDM. The Children's Home Society of New Jersey engaged kinship caregivers in a recruitment and service provision phase prior to introducing FGDM as a service, while Homes for Black Children applied a "standard of care" model (which offered solution-focused family counseling, parent advocate/mentor services, Family Well-Being Cluster, and life enrichment activities) to strengthen families and prepare them for FGDM.

Type of Services Requested by Families. During site visit discussions, project staff members identified the services most frequently requested based on their experiences working with families, as documented in Figure 3-7: Most Commonly Requested Services across FGDM Projects. Grantees most commonly cited counseling/mental health, concrete services (i.e., food, clothing, affordable housing), financial assistance, and respite and childcare as the most requested needs. Other service requests included transportation, obtaining citizenship, connecting families together/rebuilding relationships, providing male mentors for young boys, help navigating the school and child welfare systems, and providing substance abuse, parenting, and employment services.

Figure 3-7: Most Commonly Requested Services Across FGDM Projects



Three grantees (The Children's Home Society of New Jersey, Homes for Black Children, and Kids Central, Inc.) collected and reported data regarding the type of services children and families were referred to and received. While the types of services that staff members referred families to varied across grantees, all three reported providing referrals for parenting education (e.g., teen parenting, parenting classes, and services to improve family interactions, communication, and activities). Families served by The Children's Home Society of New Jersey were most often referred to and received parenting (*n*=93) and household management services (*n*=66). At Kids Central, Inc., domestic violence counseling was the most commonly referred service (*n*=112). A comparison of the services families typically requested and the services actually received by families suggests that while the most common services requested by families across the projects were mental health services, financial assistance, and concrete services, these were not the most common services referred by the three grantees. This may be due to a lack of services in the community to which grantees could refer families, or due to project staff members helping families recognize and address deeper, underlying issues to improve family functioning and decrease welfare dependence.

Section 4: Implementation Components

As mentioned in Section 1: Background and Overview, this report includes a detailed description of the organizational characteristics, activities, and processes that facilitated the successful implementation of FGDM as a promising practice within grantee organizations. The following report subsections are organized using the National Implementation Research Network (NIRN) implementation science framework[29] and JBA's Evidence-based Programming (EBP) framework[30] to help address the following cross-site evaluation research questions:

- *How do FGDM grantees select, develop, and sustain staff member's ability to effectively implement project services?*
- *What is the quality of service implementation in regard to timeliness, fidelity, and administration?*
- *How do the FGDM programs pursue continuous quality improvement as a way to improve services?*
- *How do FGDM project leaders promote, guide, and sustain effective project implementation?*
- *To what extent do FGDM programs collaborate with key partners, particularly child welfare agencies, to serve children and families?*

Characteristics of Implementation Components across Family Group Decision-making Projects

The Implementation Components section begins with an overview of the processes grantees underwent to select staff members to implement FGDM project activities and services, followed by the ways in which grantees provided information, instruction, and skill development to key staff members, and the support and feedback that supervisors or coaches provided as they worked with families. A summary of quality assurance processes and model/project fidelity results is provided. The last two subsections describe leadership involvement in the projects and the ways in which grantees developed new partnerships or strengthened existing partnerships to implement their FGDM projects. The section concludes with a discussion of the contextual factors influencing project implementation and evaluation. Key findings from the review of grantee's implementation components include the following:

- Staff tenure was stable across FGDM projects. Seventy-seven percent of project stakeholders interviewed had been in their role for at least 2 years.
- Staff turnover was an issue for grantees, particularly in smaller projects with less staff members to carry out project activities. Training new staff on the service model and evaluation component of the projects caused delays in implementation.

[29] The National Implementation Research Network (NIRN) (2011). Available at: http://www.fpg.unc.edu/~nirn/
[30] James Bell Associates (2013). *Lessons learned through the application of implementation science concepts to Children's Bureau discretionary grant programs.* Arlington, VA: Author.

- All grantees reported that ongoing training or professional development activities related to the FGDM project were provided to staff members. Stakeholders from four projects reported that increased training efforts improved their commitment to practicing the model with fidelity.

- Grantees used fidelity data to improve the quality of project implementation. Five grantees indicated that they developed new policies and procedures in response to fidelity findings.

- Providing project updates to staff and partners was critical for FGDM grantee leadership to sustain the momentum of the FGDM projects. The most frequently used strategy by leadership to obtain and sustain support for the FGDM project was regular communication with staff members regarding project progress (*n*=6). Representatives from two projects expressed dissatisfaction with their project leadership due to lack of information sharing regarding the evaluation component of the project and how it impacted their work.

- All grantees worked with the public child welfare agency as a primary collaborative partner (*n*=3) or as a secondary partner (*n*=4) to provide referrals and coordinate services as part of implementing their FGDM projects.

- Four grantees reported that collaboration helped address service gaps and expand FGDM services. Project partners assisted grantees by providing resources and services the grantee did not have the ability to provide.

- The most common challenges to collaborating with partners were working with different organizational processes and conflicting service goals in working with children and families (*n*=5).

Staffing of FGDM Projects

This section describes general staffing and knowledge development efforts among FGDM grantees. Key implementation components addressed in this section include FGDM staff selection, FGDM project training, and FGDM staff coaching.

FGDM Staff Selection. Successful implementation of FGDM requires a comprehensive team of project leaders, staff members, and partnering agencies. Previous reviews of CB-funded projects suggest that the most important factor in ensuring effective project implementation involves hiring or assigning the right project personnel.[31] Key contributors to the FGDM process included project leadership, case managers and supervisors, service coordinators, and facilitators. Internal and external partners included referring child welfare caseworkers and service providers (e.g., family preservation workers and county child welfare staff). Implementation and delivery of FGDM services required the participation of staff members in the following categories: 1) executive leaders, 2) project managers, 3) direct service supervisors, 4) service providers, 5) project partners, 6) data administrators, and 7) evaluators. The diverse roles and responsibilities of these individuals are summarized in Appendix J: Process Evaluation Data.

[31] Ibid.

Four grantees reported that they strategically selected staff members to conduct the work of the FGDM projects, which is in line with the NIRN framework's criterion that staff members must be specially recruited and selected to be the practitioners using the intervention.[32] Project leaders identified the required qualifications for FGDM project staff members and determined whether new or existing staff members would fill the positions. Of these four grantees, three planned to fill the position with new and existing staff members as long as the candidates had the desired qualifications and/or experience and were "the best fit." While staffing the grantees' projects was strategically planned, nearly half (*n*=3) indicated that they modified their staffing plans over time for various reasons, including increasing the number of staff members (*n*=1), decreasing the number of staff members (*n*=2), adding staff members to fulfill evaluation tasks or hiring data collectors matching the culture of the population (*n*=2), and changing the funding sources for the positions (*n*=1).

Critical Role of the FGDM Team. The implementation of direct project services was the responsibility of FGDM coordinators and facilitators with the guidance of their supervisors. The ability of these staff members to engage, inform, and support families throughout the FGDM process was essential for successful implementation of the intervention. All of the grantees indicated that a successful FGDM facilitator must have strong knowledge of and experience working with families. Other required characteristics identified by grantees included (in order of frequency): effective people skills (e.g., compassion) (*n*=6), group management/leadership (*n*=5), good communication skills (e.g., active listening) (*n*=4), passion for serving and advocating for families (*n*=2), and ability to work on a team (*n*=1).

FGDM Staff Tenure and Turnover. Length of service and rate of staff turnover were particularly important in the context of FGDM. As described earlier in this report, FGDM required commitment from meeting facilitators as well as the families served. The relationship between the FGDM facilitators and families also required time to develop and sustain. Information from site visit discussions indicated that the majority of FGDM project staff members had been in their roles since the inception of the grant in fiscal year 2012 or longer. Of the 66 agency and partner staff for whom the length of time in their role was reported, 77 percent (*n*=51) had been in their current role for 2 or more years.

Six grantees experienced turnover in staff members since the beginning of the grant. The remaining grantee (YMCA of San Diego County) reported no turnover from initial hiring to the time of the site visit. The most frequently cited reason for staff attrition was promotion or an opportunity for advancement (*n*=3). Other reasons for staff turnover included career change (*n*=2), retirement (*n*=2), moving (*n*=1), performance issues (*n*=1), burnout (*n*=1), and illness (*n*=1). Three grantees indicated that the turnover substantially disrupted implementation of the FGDM project due to the low number of staff members in place to carry out key project services. As described by project leadership at one grantee site, "When you have only two to three coordinators, turnover makes a huge impact." Project implementation was delayed as replacement staff were hired and trained.

FGDM Project Training. According to the NIRN framework, new practices require staff members to develop new knowledge, skills, and abilities.[33] Consequently, JBA's EBP framework found that initial and ongoing staff member training was key to enhancing a project's positive impact, and provides

[32] The National Implementation Research Network (NIRN) (2011). Available at: http://www.fpg.unc.edu/~nirn/
[33] Ibid.

opportunities for staff members to improve work-related skills and knowledge.[34] Preparation of staff members for implementation of the FGDM intervention models was a critical component of the FGDM grantees' projects as well. All of the grantees reported that they provided training prior to or within the first months of receiving the grant in order to ensure that staff members and partners in the process (e.g., referring child protective service caseworkers) had appropriate knowledge and skills about the FGDM model. Training recipients included project leadership (*n*=3), FGDM facilitators (*n*=4), caseworkers (*n*=2), evaluators (*n*=2), and project partners (*n*=1).

The focus of the trainings was on understanding FGDM principles and processes, using a specific FGDM model, and relevant topical training, such as trauma, substance abuse, and domestic violence. The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect provided FGDM training for the majority of grantees (*n*=6). The length and format of trainings varied by grantee, and depended on the program model and staff members' previous experience with FGDM. For example, initial trainings ranged from 3 hours to 1 week in length.

All grantees reported that ongoing training or professional development activities related to the FGDM project were provided to staff members. Most of the grantees (*n*=5) engaged staff in ongoing professional development through special in-service trainings on FGDM and related topics such as trauma-informed parenting training (Homes for Black Children), personal safety training (The Children's Home Society of New Jersey), and the nuances of coordinating family meetings (Larimer County DHS (CO, SD, and TX sites)). Recognizing the importance of evaluating FGDM projects, three grantees provided training to project staff and partners on the evaluation objectives and processes, as well as staff members' roles in the evaluation. As part of these trainings, the evaluators provided instruction on data tracking systems and corresponding data collection materials and forms. Exposure to this additional training broadened staff members' understanding not only of the evaluation, but also of their own practices.

> "Seeing the data, along with training and observation, has helped [me] understand what does and does not work with families."
>
> - **Perspective of an FGDM Project Staff Member**

Four grantees reported that their staff members attended FGDM conferences or workshops. Four grantees included skills practice (e.g., role-playing) in regularly scheduled staff meetings. Ongoing staff trainings were provided in various formats, including onsite trainings, webinars, videos, and observations of FGDM meetings. For example, Kids Central, Inc. and its community partner, Devereux Kids, collaborated with a community volunteer to videotape an FTC, which provided training material to professionals learning the FTC process.

Participants in initial and ongoing grantee trainings identified several training strategies that were most useful; these strategies included role playing different scenarios working with a family (*n*=3), having an FGDM expert present the training (*n*=2), engaging in discussions with one another and their trainers (*n*=2), and observing or attending an actual FGDM meeting (*n*=1). Additional strategies noted

[34] James Bell Associates (2013). *Lessons learned through the application of implementation science concepts to Children's Bureau discretionary grant programs.* Arlington, VA: Author.

by three grantees included receiving immediate feedback from practice sessions (Homes for Black Children), shadowing facilitators (The Children's Home Society of New Jersey), and participating in trainings that were solution-focused and addressed engagement of hard to reach populations (Kids Central, Inc.).

Project Staff Coaching. On-the-job coaching and supervision during the performance of key project activities were common forms of staff training that have been suggested in other studies as an important implementation component.[35] Five FGDM grantees reported that they provided regular coaching and supervision to project staff members. These activities were directed toward FGDM coordinators and facilitators under the supervision of project managers and/or supervisors. FGDM model developers were also involved in coaching and supervision through regularly scheduled consultations with supervisory staff members to ensure quality of services and fidelity to the FGDM model. For example, YMCA of San Diego County held monthly case consultations with the Family Engagement Liaison at Casey Family Programs, a community partner, to address quality assurance and fidelity to the model. Among the grantees that practiced coaching and supervision, all provided this guidance in individual and group settings (e.g., individual supervision sessions or case staffing meetings). This practice provided staff members an ongoing source of support and the opportunity to receive input and feedback on specific family issues and challenges. Other methods used to provide continuing instruction and support included mentoring and coaching staff (*n*=3) and enlisting a consultant to meet as needed with facilitators (*n*=1).

Impact of Staff Training, Coaching, and Supervision. The cumulative effect of training, coaching, and supervision was addressed in discussions with FGDM project evaluators. The impacts were determined in two ways: 1) impact on fidelity to the FGDM models and 2) impact on the project evaluations. In general, the reported impacts were positive. The most frequently cited impact on fidelity was improvement in staff member's ability to comply with the model. Evaluators from more than half of the projects (*n*=4) reported that increased training efforts improved their commitments to practicing the models with fidelity. Larimer County DHS' evaluation team noted that project staff members achieved a level of pride and investment in the FGDM process as a result of the additional knowledge provided by the training. Less frequently reported impacts of training on fidelity included increased discussion with staff about FGDM objectives and best practices (*n*=2) and provision of additional supervision (*n*=1). Fewer training impacts were reported on the projects' evaluations. Impacts cited included clarification of project staff's roles and responsibilities related to the evaluation (*n*=2), additional time allowed for training staff on data collection and specific instruments (*n*=2), and increased support for the evaluation from project staff members (*n*=1). One evaluator noted that they encountered resistance from project staff members to coaching on the evaluation instrument.

Quality of FGDM Implementation

Continuous quality improvement (CQI) is both a process and approach that "ensures programs are systematically and intentionally improving services and increasing positive outcomes for the families they serve."[36] CQI was particularly important in the grantees' implementation of FGDM models and enhanced their ability to provide data-informed, responsive, and effective services. FGDM grantees engaged in continuous quality improvement through 1) assessing fidelity to the FGDM model and 2)

[35] The National Implementation Research Network (NIRN) (2011). Available at: http://www.fpg.unc.edu/~nirn/
[36] FRIENDS National Resource Center for Community-Based Child Abuse Prevention (2010), Continuous Quality Improvement. Chapel Hill, NC. Retrieved from: http://friendsnrc.org/continuous-quality-improvement

applying fidelity findings to project practices. During the first year of the projects, grantees collectively agreed that it was important to capture local evaluation data on whether FGDM models and practices were delivered by project staff members consistently and accurately, as they were intended to be implemented. This section provides an overview of the fidelity instruments used and findings across the cluster. Project fidelity has been described as "the extent to which an intervention is implemented as intended by its designers. It refers not only to whether or not all the intervention components and activities were actually implemented, but also to whether they were implemented properly."[37] Project fidelity enhances the reliability and validity of the impact of FGDM services on child and family outcomes.

Fidelity Instruments and Data Sources. Because grantees implemented various models of FGDM, they also selected their own fidelity instruments to maintain quality control of project services. Since fidelity measures are specifically tied to project components, most grantees developed their own instruments in collaboration with their evaluators. Four grantees adapted existing FGDM fidelity instruments to the project. A list of the instruments and approaches used by grantees to measure FGDM project model fidelity can be found in Appendix J: Process Evaluation Data. While all seven grantees used instruments that obtained FGDM project staff/facilitator feedback, three grantees also reported participant and observer feedback through satisfaction surveys. Five grantees administered fidelity surveys at the end of each FGDM meeting, while one grantee (Kids Central, Inc.) conducted a 10 percent random sampling of FGDM cases per quarter from which to collect survey data.

Fidelity Findings. Grantees focused on different areas for fidelity assessments. Six grantees focused their fidelity assessments on the specific FGDM model used, and two grantees assessed their project's general service models (i.e., the combination of service components implemented by each grantee). Fidelity results for all seven grantees through December 31, 2014 are summarized in Table 4-1: Grantee Fidelity Results and are further discussed below. Across grantees, fidelity results were either provided as overall percentages (i.e., the percentage of meetings conducted with fidelity) or as average means (based on Likert scale fidelity questions).

Table 4-1: Grantee Fidelity Results

Grantee	Focus of Assessment	Findings	Overall Fidelity (September 30, 2011 to December 31, 2014)
The Children's Home Society of New Jersey	FGDM model	As reported by the caregiver and other participants, compliance was very high with the principles of FGDM.	Average Participant Score (*n*=249): 96% fidelity Average Facilitator Score (*n*=64): 98.5% fidelity
Homes for Black Children	FGDM model	Facilitator fidelity surveys resulted in an average score of 87%, which is moderately high adherence to the project FGDM model.	Average Facilitator Score (*n*=9): 87% fidelity

[37] Daro, D., Hart, B., Boller, K., & Bradley, M.C. (2012). Replicating home visiting programs with fidelity: Baseline data and preliminary findings. Chicago, IL: Chapin Hall; Princeton, NJ: Mathematica Policy Research.

Grantee	Focus of Assessment	Findings	Overall Fidelity (September 30, 2011 to December 31, 2014)
Kids Central, Inc.	FGDM model and Project service model	Overall improvement in fidelity across reporting periods (from 88% fidelity in the first reporting period to 95% fidelity in the final reporting period) for staff survey. High fidelity from the family perspective.	Average Participant Score (*n*=77): 1.5[1] Average Staff Score (*n*=80): 90.8% fidelity[2]
Larimer County DHS (CO, SD, and TX sites)	FGDM model	Participant and Facilitator/Coordinator survey scores indicate that there is agreement that the meeting process adhered to the various fidelity components of the FGC model for both the pre-meeting and post-meeting portions of the fidelity pre-test survey. Post-test fidelity data were not available for the cross-site analysis.	Participant Fidelity Pre-Test: TX site (*n*=844): Pre-Meeting Average[3]: 5.1; Post-Meeting Average: 5.3 CO Site (*n*=652): Pre-Meeting Average: 5.1; Post-Meeting Average: 5.4 Facilitator/Coordinator Fidelity Test: TX site (*n*=153): Pre-Meeting Average: 4.5; Post-Meeting Average: 5.4 CO site (*n*=155): Pre-Meeting Average: 4.4; Post-Meeting Average: 5.5
Ute Indian Tribe	FGDM model	Twenty-one of the twenty-two Participant Fidelity questions showed a cumulative of 80% or greater in marking the highest two responses of "strongly agree" or "agree."	Average Participant Score[4] (*n*=55): 4.0 Average Facilitator Score (*n*=10): 4.3
The Village Family Service Center	FGDM model	Facilitators and meeting participants rated the facilitation high (agree to strongly agree) on items vital to the fidelity of the model.	Combined Participant, Facilitator, and Observer Satisfaction Score[5] (*n*=not specified): 3.7 FGDM, 3.7 FTDM Combined Participant, Facilitator, and Observer Fidelity Score (*n*=not specified): 3.7 FGDM, 3.6 FTDM

Grantee	Focus of Assessment	Findings	Overall Fidelity (September 30, 2011 to December 31, 2014)
YMCA of San Diego County	Project service model	There was consistently high fidelity across reporting periods (from 99.7% fidelity in the first reporting period to 100% fidelity in the latest reporting period).	Average Fidelity Score (*n*=50): 99.9% fidelity

[1] For Kids Central, Inc. FTC Participant Survey, 1= Strongly Agree, 2=Agree, 3=Somewhat Agree, 4=Disagree, 5=Strongly Disagree
[2] For Kids Central, Inc. Staff Survey, 1= Strongly Agree, 2=Agree, 3=Somewhat Agree, 4=Disagree, 5=Strongly Disagree
[3] For Larimer County DHS Participant and Facilitator Fidelity Survey, 4=Slightly Agree, 5=Agree, 6=Strongly Agree
[4] For the Ute Indian Tribe Participant and Facilitator Fidelity Survey, 0=NA, 1= Strongly Disagree, 2=Disagree, 3=Unsure, 4=Agree, 5=Strongly Agree
[5] For the Village Family Service Center Participant, Facilitator, and Observer Satisfaction Survey, 1= Strongly Disagree, 2=Disagree, 2.5=Unsure/NA, 3=Agree, 4=Strongly Agree

FGDM Model Fidelity. Though fidelity assessment data were reported differently across projects (i.e., mean scores and percentages), overall findings of fidelity assessments to date were positive. As indicated in Table 4-1, participants and facilitator fidelity ratings were high across all of the projects. While this suggests that high-quality FGDM meetings were conducted for these sites, grantees also acknowledged potential ceiling effects, which means that fidelity scores may have clustered toward the high end of fidelity survey ratings due to a lack of sufficient response options in the scales used. For two grantee projects, FGDM facilitator ratings were compared across reporting periods. Though the evaluators for both projects observed improvements in fidelity to the model between the first and second data collection periods, it was noted that the ratings had begun high (i.e., 88 percent fidelity or above). Similar ceiling effects were indicated in the remaining grantees' assessments. In response, at least three of the evaluators modified their data collection instruments or analyses. For example, open-ended items were added to The Village Family Service Center's facilitator survey, which yielded more informative data. The evaluators for Larimer County DHS planned to conduct more complex analyses, cross-walking facilitator fidelity data to participant fidelity data.

Items included in YMCA of San Diego County's FGC program model fidelity checklist:

- Follow recruitment protocol
- Follow randomization protocol
- Notify families of control or intervention assignment
- Home visits to conduct baseline assessments (NCFAS-GR, genogram)
- Family finding for FGC meetings
- Plan logistics
- Conduct Meeting
- Provide FGC Satisfaction Tool to family
- Monitor family plan progress
- Monitor for case closure

Grantees also found differing trends in perception of fidelity based on the respondent. For instance, while facilitators rated fidelity higher than participants at The Children's Home Society of New Jersey and the Ute Indian Tribe, Larimer County DHS (CO and TX sites) found that facilitators rated pre-meeting fidelity lower than participants, but rated post-meeting fidelity higher than participants. Despite these

initial challenges, fidelity assessments helped yield useful information, such as disparities in facilitator and family perceptions of the family's role in the process. These factors might inhibit facilitator adherence to the model, and highlight the need to balance process adherence and responsiveness to families in FGDM meetings.

Project Service Model Fidelity. Results for the two grantees that assessed the fidelity of their project service models show that the projects closely adhered to the processes detailed in their service models. While YMCA of San Diego had consistently high fidelity across all reporting periods in all areas of their service models (e.g., adherence to recruitment and randomization protocol, home visits, monitoring family progress), Kids Central, Inc. showed an overall improvement in fidelity across reporting periods. While the agency experienced an increase in fidelity for most components of their service models (e.g., developing family plans, comprehensive services, cases successfully closed), there were two areas where fidelity was lower (i.e., pre-planning activities completed, strengthened informal support system for families), which the grantee addressed through training and additional quality assurance procedures.

Sharing Fidelity Data. Evaluators from five projects reported that they shared the findings of their fidelity assessments with project leadership, staff members, and other stakeholders. Across the projects, fidelity findings were shared with the grantees' executive leadership (*n*=2 grantees), project managers (*n*=3 grantees), project staff members (*n*=3 grantees), and other project stakeholders (*n*=1 grantee). Grantees shared quantitative and qualitative information. In addition to descriptive data (e.g., number of participants, services provided), evaluators shared information regarding participant responses to the FGDM process, and the extent to which meeting facilitators consistently adhered to their chosen FGDM and service models with fidelity. Three evaluators described the frequency with which they shared fidelity data and how they provided the data to the projects. Frequencies reported included monthly (*n*=1), semi-annually (*n*=1), and annually (*n*=1). Despite this difference, the manner in which the data were shared was consistent across these evaluators. All evaluators reported that fidelity information was discussed during formal meetings with the grantees. Two grantees indicated that they had also presented the information in seminars and webinars.

Use of Fidelity Data for Continuous Quality Improvement. Evaluators and project leaders of four grantees reported that fidelity data had been used in two ways to improve the quality of their FGDM projects: 1) to assess the extent to which facilitators adhered to the models during the meetings and 2) to identify areas in which the FGDM models could be made more efficient. For example, one project leader expressed concern that the length of time between obtaining consent and conducting the meeting was too long when the process was completed with full fidelity to the model. The grantee planned to conduct further analyses to identify whether the length of meeting preparation was correlated with family outcomes. Five grantees indicated that they had developed new policies and procedures in response to fidelity findings. Procedural changes included 1) modifying or implementing new referral practices (*n*=3 grantees), 2) expanding or implementing new training materials (*n*=3 grantees), 3) implementing an updated FGDM model (*n*=2 grantees), and 4) changing enrollment protocols and practices (*n*=1 grantee).

Other changes made in response to fidelity scores included 1) providing additional staff training, 2) increasing case supervision, and 3) modifying the project's outreach to potential participants. Evaluation data in general (i.e., not necessarily related to fidelity) were also used to inform the grantees' decisions about potential project improvements. For example, findings were used by two projects to identify practical factors that could affect child and family outcomes. These factors included 1) the timing of

when families were asked to participate in an FGDM, 2) the characteristics of families that were served using the FGDM model, and 3) project practices that required improvement.

Staff Performance Monitoring and Feedback. A final way in which fidelity data were used was for staff performance monitoring and feedback. Data obtained through facilitator fidelity measures and participant ratings of meeting facilitation were a valuable source of information on the performance of individual staff members. Additional means cited for providing performance feedback to FGDM facilitators included semi-annual or annual performance reviews; debriefing staff following observations or shadowing; sharing quantitative fidelity, evaluation data, and audit of case files with staff members; feedback during unit and individual coaching and supervision meetings; and immediate feedback during family meeting observations.

Other Strategies for Continuous Quality Improvement. Additional strategies developed by project leadership in two projects to support continuous quality improvement included providing ongoing staff training opportunities (e.g., during regularly scheduled staff meetings or conference calls); developing technical assistance resources and materials (e.g., electronic manuals); creating venues for ongoing guidance (e.g., FAQ blogs); and mentoring, coaching, or shadowing FGDM facilitators. Less frequently considered approaches included conducting focus groups with families to obtain their feedback, conducting an annual review of progress towards outcomes, and establishing an Advisory Board with whom to discuss project issues.

Leadership

This section describes the extent to which FGDM project leaders promoted, guided, and sustained effective project implementation. The critical role of project leaders in guiding implementation and successful outcomes has been documented in the implementation science literature.[38,39] Commonly referred to as project 'champions,' these individuals develop project priorities, establish consensus among key stakeholders, provide incentives, and manage the overall process of implementation. Project champions have organizational clout or administrative authority, play a role in project conceptualization, and build relationships with potential organizational partners. In addition, they are trusted and respected by staff members, provide support to staff, advocate and maintain support for the innovative practice models, address challenges, secure necessary resources, and lead sustainability efforts.[40]

NIRN suggests that leadership needs within an organization may change as implementation progresses and project goals evolve. For example, adaptive leadership styles are needed to 'champion change' in the beginning of a grant. Adaptive leadership is characterized by the ability to align practices with the mission, values, and philosophy of the organization, convene groups and build consensus, establish clear and frequent communication channels, actively and regularly seek feedback from staff members and partners, and facilitate training and professional development. To manage continuing implementation

[38] Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S., & Stall, R. (2007). Implementing evidence-based interventions in health care: Application of the replicating effective programs framework. *Implementation Science, 2,* 42.
[39] Gold, M., & Taylor, E. F. (2007). Moving research into practice: Lessons from the US Agency for Healthcare Research and Quality's IDSRN program. *Implementation Science, 2,* 9.
[40] Durlak, J.A., & DuPre, E.P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*, 327-350.

supports over time, technical leadership styles are required. Technical leadership consists of providing specific guidance on technical issues; providing rationale for changes in policies, procedures, or staffing; actively engaging in problem solving; focusing on priority areas; and maintaining a fair, respective, considerate, and inclusive management style. FGDM grantee leadership used both adaptive and technical leadership styles to achieve project goals and objectives.

FGDM Leadership Characteristics. Strong leadership support and effective management styles are often viewed as facilitators to implementing FGDM projects. Leadership played a key role in project management and delivering FGDM services. During site visit discussions, all seven grantees reported having a *'project champion'* who was actively involved in developing the Family Connection grant proposal. Each grantee organization was led by individuals who played a significant role in conceptualizing the project to ensure a good fit with the organizational mission and the needs of the service population. Nearly all grantees (*n=6*) indicated that project leaders supported staff members and openly worked with them to achieve implementation goals. The next section elaborates on the specific ways in which leadership obtained and maintained support for the FGDM projects.

Leadership Strategies to Build and Sustain Support. FGDM grantee leadership and project staff members described adaptive and technical leadership strategies used to obtain and sustain support for FGDM projects. Commonly identified strategies across projects were communicating regularly with staff members regarding project progress (*n*=6), providing evaluation support (*n*=6), conducting outreach to community stakeholders (*n*=5), and providing staff member training opportunities (*n*=4). Less frequent strategies included supporting staff members in the FGDM process (*n*=2) and building capacity among project leaders (*n*=2).

- ***Regular Communication Regarding Project Progress.*** The majority of FGDM grantees reported that project leaders made consistent efforts to share information with staff members regarding implementation progress, successes, and challenges. Project leaders communicated with staff members about their visions and goals for the FGDM projects, which staff members found helpful to foster support for the FGDM practice models. Grantees appreciated that project leaders discussed the Family Connection-funded FGDM project at a high level, as well as how the grant impacts their daily work. One grantee representative mentioned that their project leader often speaks "openly" with staff members about challenges. As a result, staff members felt that they were kept abreast of important project matters. Through regularly scheduled staff meetings via conference calls, video conferencing, or in-person, staff members were updated on the status of the project. Project leaders also convened advisory groups to communicate with staff members and stakeholders, as well as to solicit feedback.

> *"We held kick-off meetings for different levels of staff to inform them of what is going on, and why we want to do this, and what this means to them. We still encounter challenges as we work through the trainings, but that was a big help for us."*
>
> - **Perspective of an FGDM Project Leader**

- ***Provided Evaluation Support.*** By supporting evaluation efforts, project leaders demonstrated the value of assessing the project's impact. Strong collaborative relationships with grantee

evaluators allowed project leaders to develop an in-depth understanding of the evaluation component of the grant and its impact on families, staff members, and sustainability efforts. Subsequently, project leaders were able to communicate the importance of a high quality evaluation to staff members and ultimately gain their support. Project leaders supported and improved staff members' compliance with evaluation requirements (*n*=2), influenced the scope and/or quality of the evaluation (*n*=2), and altered the evaluator's perspective and approach to the evaluation (*n*=1). One grantee evaluator noted the role of leadership involvement and support motivated them to review the research protocols and the evaluation more often: "From leadership we get questions like, 'How many families do we need for a certain effect size?' It forces us to be on top of our game." Project leaders' ability to support evaluation encouraged staff members to develop a better understanding of the relationship between the quality of FGDM service delivery and obtaining positive evaluation outcomes.

- ***Conducted Community Outreach****.* Leadership played an important role in increasing awareness regarding the FGDM project. Project leaders often allocated time and resources to build rapport, establish relationships, and conduct outreach. One grantee representative reported that their project leader has a "great reputation" in their state, which is leveraged to successfully interact, both virtually, and in-person, with external stakeholders. This staff member commented, "Leadership knows how to work with the people. They feel good about the decisions. [Leadership staff member] is a fearless leader and will back us up. [Leadership staff member] is still able to change and is a real visionary." The project leader met with directors of each region participating in the FGDM project to garner support during the early implementation stage. Three grantees also reported that project leaders reached out to families, church organizations, and project partners to educate them about the FGDM project. Another grantee held a community event to orient stakeholders to their project's services.

- ***Provided Staff Member Training Opportunities.*** Four grantees reported that project leaders dedicated time and resources to formally train project staff members, child welfare agency staff members, and project partners regarding the FGDM practice model. Through training, project leaders hoped to increase staff members' knowledge about FGDM services while fostering excitement and motivation about the opportunity to positively impact families. Project staff members and key stakeholders learned about the Family Connection-funded FGDM intervention, and how it differed from previous practice models. Trained staff members were encouraged to provide training to child welfare caseworkers and other staff members as well (i.e., using the train-the-trainer model). Project staff members were satisfied with the level of training received.

- ***Supported Staff Members in the FGDM Process.*** FGDM project leaders provided a significant level of personal and professional support for staff members. One grantee representative discussed how their supervisor provided support for a challenging experience during an FGDM meeting, "Our supervisor is great. I wouldn't be able to do what I do without the support of the leadership." Project leaders were responsive to staff members' requests for more resources. For instance, one grantee requested more phone calls, face-to-face meetings, and trainings for project staff members, and leadership immediately accommodated the request. Project leaders conducted case consultation meetings with staff members who needed additional guidance and support. They also provided staff members with their personal phone numbers so that they could contact them regarding cases and follow up with important issues.

- ***Leadership Capacity Building.*** Project leaders were highly invested in building and strengthening their personal and professional capacity to effectively lead the FGDM projects. Two grantees shared that project leaders engaged in weekly leadership meetings to discuss what was working well for the project, what was not working, and specific cases that needed further attention. After gaining an understanding of the successes and challenges, project leaders spent time developing strategies to increase program effectiveness. For example, one grantee representative highlighted how their project leaders addressed programmatic challenges: "It can be hard to keep motivation going for the projects when there have been so many barriers. We've always identified the challenge, the strategy, and how to move forward. If we stopped trying we would have stayed with the voluntary population and been status quo. We came together and brainstormed."

> *"Leadership drove a lot of key meetings for us to push forward. It created an authority level to promote involvement. It gave a sense of how committed we were for our partners to see."*
>
> - **Perspective of an FGDM Project Staff Member**

While most FGDM grantees reported positive perceptions of leadership support, representatives from two projects expressed dissatisfaction with their project leadership, specifically the lack of engagement of leadership and executive staff members. One grantee representative reported, "One of the things that might have helped us maintain a high level of motivation is feedback to staff and facilitators around our outcomes. But staff has no information. We have logistical numbers of response rates but no analysis of information. We haven't received any information. Feedback will help keep people incentivized." This grantee would have appreciated more information regarding the evaluation component of the project and how it impacted their work. Another grantee representative described how executive leadership's lack of involvement at the beginning of the project led to a lack of understanding of the FGDM service model; the representative noted that when leadership makes changes to practice without understanding the model, it has a negative impact on fidelity. Nonetheless, most grantees identified strong leadership support, guidance, and communication as critical factors in understanding the FGDM practice models and achieving implementation and evaluation goals.

Collaboration

This section begins with a brief review of collaboration literature and describes collaboration among FGDM grantees, public child welfare agencies, and other key project partners throughout the Family Connection funding period. The perspectives of the grantees and the various partners are included. Key topics addressed in this section include the following: 1) Collaboration and coordination, 2) Advantages to working with project partners, 3) Contributing factors to positive collaborative relationships, 4) Challenges in partnerships, and 5) Private/not-for-profit service provision versus public child welfare agency service provision.

Collaboration is an integral aspect of FGDM service delivery since it plays a critical role in providing knowledge and expertise, strengthening outreach and referral efforts, providing services, and measuring process and outcome goals. Within the implementation science framework, collaboration is closely aligned with the concept of systems interventions. Systems interventions include organizational

strategies to work with external partners to ensure the availability of financial, organizational, and human resources required to support implementation goals. Aligning and coordinating these external partners is an important component of systems interventions in which stakeholder perspectives are included and roles are clearly defined. System interventions are designed to help create a supportive context in which effective services can be provided, maintained, and improved over time.

JBA's EBP framework also highlights the important role of collaboration for successful project implementation.[41] JBA's 2013 study on implementation science components as it applies to time-limited CB discretionary grants found that collaboration facilitated the development of grant proposals that incorporated a variety of ideas and demonstrated community support for the project. Partnering organizations played a critical role in recruiting participants and providing access to material resources that grantee agencies were unable to obtain themselves. Success in referring and enrolling project participants was partly based on pre-existing formal and informal organizational relationships, as well as believing in the goals and effectiveness of a grantee's project.

Organizational theory literature has identified various models of collaboration.[42,43,44,45] These models focus on stages of collaboration through which project services and initiatives progress. One of the most common approaches is based on the work of the School Program Evaluation and Research Team which developed the *Levels of Collaboration* scale.[46,47] This scale is based on the work of other collaboration researchers to measure progress over the levels of collaboration among grant partners. According to this scale, the five stages of collaboration are 1) Networking, 2) Cooperation, 3) Coordination, 4) Collaboration, and 5) Coalition (see Figure 4-1: Levels of Collaboration).

Grantees may progress across the different stages at different times and in various ways, depending on the type of organization, stage of implementation, leadership and management style, staff and organizational culture, and nature of project partners. Grantees may also demonstrate components of multiple stages simultaneously. While the final stage in the collaboration process is typically characterized by members belonging to one system, frequent communication and mutual trust, and consensus on all decisions, FGDM grantees also described components of collaborative relationships and facilitators to successful collaboration at the coalition, coordination, cooperation, and networking stages. The section below discusses the extent to which FGDM grantees collaborated with internal and external key partners to provide FGDM services to children and families.

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[41] James Bell Associates (2013). *Lessons learned through the application of implementation science concepts to Children's Bureau discretionary grant programs.* Arlington, VA: Author.

[42] Bailey, D., and Koney, K. (2000). *Strategic alliances among health and human services organizations: From affiliations to consolidations.* Thousand Oaks, CA: Sage.

[43] Gajda, R., (2004) Utilizing collaboration theory to evaluate strategic alliances. American Journal of Evaluation, 25(1), 65-77.

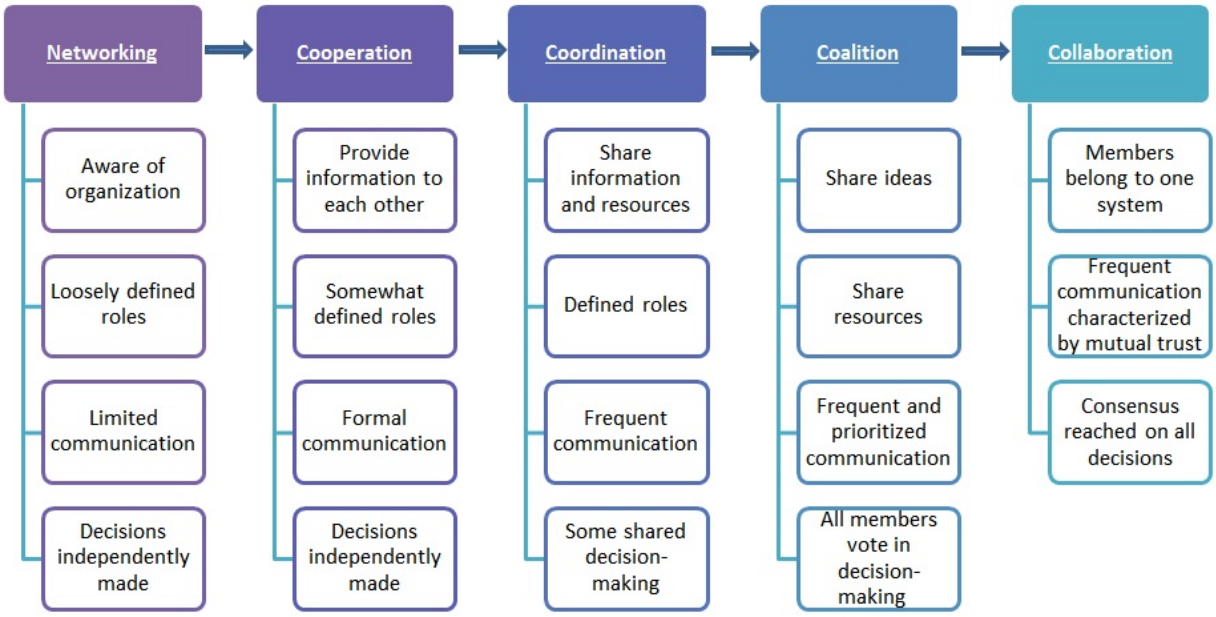
[44] Hogue, T. (1993). *Community-based collaboration: Community wellness multiplied*. Bend, OR: Chandler Center for Community Leadership. Retrieved April 21, 2004, from http://crs.uvm.edu/nnco/collab/wellness.html

[45] Peterson, N.L. (1991). Interagency collaboration under Part H: The key to comprehensive, multidisciplinary, coordinated infant/toddler intervention services. *Journal of Early Intervention,* 15(1), 89-105.

[46] Borden, L., & Perkins, D. (1998). Evaluating your collaborative effort. *Program Evaluation Newsletter*, *1*, 5.

[47] Borden, L., & Perkins, D. (1999). Assessing your collaboration: A self-evaluation tool. *Journal of Extension*, *37*(2), 67-72.

Figure 4-1: Levels of Collaboration



Collaboration and Coordination. Interagency collaboration was noted by grantees as one of the greatest facilitators of FGDM project implementation. Through formal and informal partnerships, grantees utilized external service providers, local community organizations, public child welfare agencies, and organizations providing evaluation and other technical assistance to address the needs of children and families. FGDM project partners contributed expertise, provided training and consultation, offered substance abuse, mental health, and domestic violence services and resources. They also facilitated exposure to the broader community. Five FGDM grantees reported having pre-established working relationships with their partners prior to implementing FGDM projects.

The level of collaboration between FGDM grantees and partners varied within and among projects. Table 4-2: Summary of Grantee Partnerships and Partner Roles in FGDM Projects depicts the various roles that public child welfare agencies, external non-profit service providing agencies, internal service providing agencies and departments, and evaluation partners had in FGDM projects.

- ***Primary project partners*** engaged in collaborative partnerships with grantees to implement key project services/activities, engage in regular communication regarding the projects, and share information with one another. At the primary partner level, all seven grantees collaborated with evaluation partners. Three grantees collaborated with the public child welfare agency as primary partners, and another three grantees collaborated with external service providing agencies.

Table 4-2: Summary of Grantee Partnerships and Partner Roles in FGDM Projects

Partner Role Description	Public Child Welfare Agency	External Private/Not-for-Profit Service Providing Agency	Internal Agency or Department	Evaluation Partner
Primary Partner (Highly involved in project, implements key project services/activities, provides/shares resources with grantee, regular communication about project, shared decision-making)	3 Grantees	3 Grantees		7 Grantees
Secondary Partner (Provides referrals, shares information and data, occasional communication about project)	4 Grantees	2 Grantees	1 Grantee	
Tertiary Partner (Grantee refers clients to partner, little communication about project)		7 Grantees	1 Grantee	
Advisory Board (Provides input, reviews project successes and challenges)	3 Grantees	3 Grantees		3 Grantees

- ***Secondary project partners*** coordinated their services with grantees to provide referrals, share information, and communicate occasionally regarding project status. Within this level of partnership, over half of the grantees (*n*=4) worked with the public child welfare agency, two grantees coordinated services with external non-profit service providing agencies, and one grantee coordinated with an internal department within the agency to provide services to families enrolled in the project.

- ***Tertiary project partners*** had cooperative but less formal relationships with grantees. Grantees referred families to these organizations to receive supplemental or additional services not provided through FGDM funding. All seven grantees cooperated with external non-profit service agencies to provide referrals to clients, and one grantee referred families to services provided by a department within its own agency. Tertiary partners were aware of the project, but for the most part they did not provide referrals to the project.

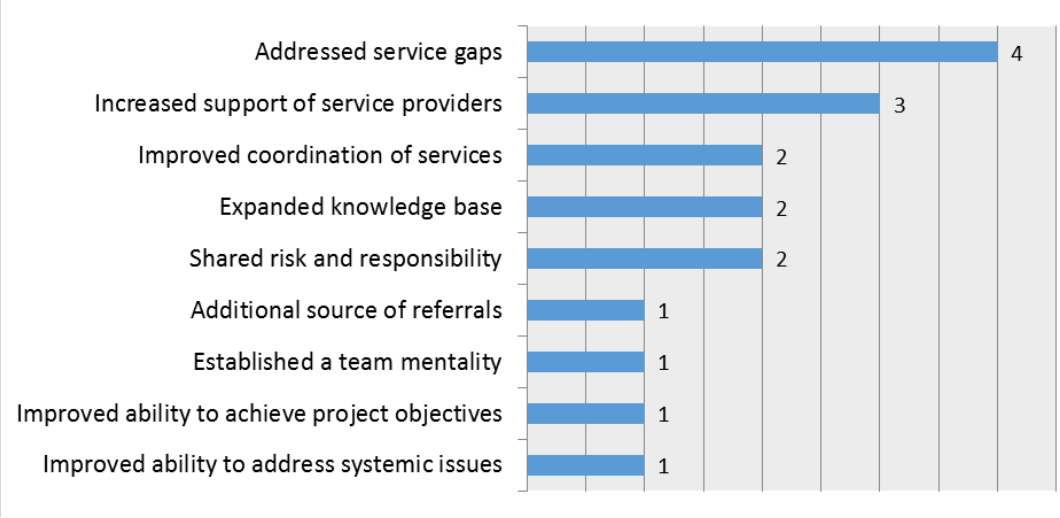
- ***Advisory boards*** or coalitions were also developed by grantees to engage partners and other community stakeholders in FGDM project decision-making. Three grantees included the public child welfare agency, external non-profit service providing agency, and evaluators on their advisory boards to review project progress and provide input on project implementation.

Although four grantees reported that their proposed relationships with project partners worked out as originally planned, three grantees discussed partnership changes that occurred throughout the Family

Connection funding period. One grantee (YMCA of San Diego County) experienced multiple changes within the public child welfare agency that impacted their partnership. Changes included eligibility screening modifications for families, new policies regarding co-location of project and child welfare staff members, and an expansion of the project's service population to include court-ordered families. One grantee (Ute Indian Tribe) obtained an additional domestic violence partner (the Ute Victim Advocacy Program), while another grantee (Kids Central, Inc.) lost a key project partner (Child and Family Connections of West Palm, Florida) due to contractual issues. Kids Central, Inc. reported a new partnership with a community volunteer to videotape an FTC for training purposes.

Advantages to Working with Project Partners. All FGDM grantees addressed the advantages of working with project partners, documented in Figure 4-2: Advantages to Working with Project Partners. The greatest advantage to collaboration was the ability to address gaps in services via the increased support of service providers. Grantees and project partners also cited other collaboration benefits including shared risk and responsibility, expanded knowledge base, and improved service coordination. Less commonly mentioned advantages included the ability to address system issues, achieve project goals, foster a team mentality, and provide additional referral sources.

Figure 4-2: Advantages to Working with Project Partners



- ***Addressed Service Gaps.*** Four grantees reported that a significant benefit of working with partners was their ability to expand FGDM services and address service gaps. Project partners assisted grantees by providing resources and services the grantee did not have the ability to provide. Partners filled gaps in services by locating and making referrals to community resources, providing additional funding, and strengthening recruitment efforts. One grantee representative commented on the ability to leverage resources through collaboration: "One partner's limitations are another partner's strength. [Partner name] comes with resources."

- ***Increased Support of Service Providers.*** In addition to addressing service gap issues, three grantees indicated that collaborating with other agencies also facilitated support for the FGDM projects. For example, grantees who were private, non-profit organizations reported that partnering with the public child welfare agencies helped the public agency caseworkers become more comfortable with allowing families to participate in FGDM services and engage with FGDM facilitators. One grantee representative shared, "There is a lot more engagement when you

work together collaboratively. Helps CWS buy into the process. It then becomes more confident about involving FGDM facilitators with the families."

- ***Shared Risk and Responsibility***. Having multiple project partners helped distribute FGDM project responsibilities among partners (*n*=2). Each partner played a role in implementing a particular component or providing a key service. For instance, Kids Central, Inc. contracted with its long-time community partner, Devereux Kids, to facilitate Family Team Conferences (due to the agency's history and experience facilitating meetings), while the staff of Kids Central, Inc. provided diversion coordination services for families following the meetings. Within these partnerships, stakeholders had a vested interest in the successful implementation of the project. Grantees valued partnering with engaged stakeholders who collectively shared perspectives on project achievements, challenges, and strategies.

- ***Expanded Knowledge Base*.** Two grantees cited the importance of collaborating with partners in expanding their knowledge regarding FGDM services. Sharing information and knowledge regarding evidence-based practices positively impacted project leaders and staff members' abilities to provide effective services to meet the needs of children and families. One grantee representative noted, **"**We learned about other things, such as how their agency services families. They educated us on permanency roundtables and helped to share knowledge in the field about innovative strategies or demonstrations. If another RFP (Request for Proposals) comes up, we have our partners."

- ***Improved Service Coordination*.** Working with multiple partnering agencies allowed two grantees to provide multiple services to address the complex needs of families. Grantees worked with partners to identify social, health, emotional, or educational services for children and families through regular communication and service referrals. One grantee representative shared, "Families often have multiple needs and need to be able to access more than one service provider."

Fostering Collaborative Relationships. FGDM grantees also provided strategies on fostering and strengthening collaborative relationships. Grantees and project partners responded to questions on the overall characterization of ongoing collaborative relationships with one another. All grantees described the relationships as positive and elaborated on specific factors that contributed to these positive relationships, listed in Figure 4-3: Grantee and Partner Relationship Facilitators. Details on key relationship facilitators are summarized.

- ***Regular and Open Communication.*** Grantees and partner organizations appreciated ongoing and open communication regarding roles and responsibilities, implementation efforts, and project services. Representatives from each grantee reported that there was sufficient communication between partners regarding the FGDM project. Six grantee partners responded to questions regarding clarity of roles and indicated that they were aware of their responsibilities. Grantees reported sharing information through community meetings (*n*=2), reports (*n*=2), informal conversations (*n*=1), advisory board meetings (*n*=1), conference calls (*n*=1), and staff meetings (*n*=1).

Figure 4-3: Grantee and Partner Relationship Facilitators

- ***Common Goals.*** Four grantees reported that having a common vision and similar goals for children and families to achieve positive outcomes helped foster strong, favorable relationships. Project partners had a common interest in helping families increase their capacity to take care of their children, and ultimately improve their general well-being. Partnering with agencies with similar goals supported successful implementation.

- ***Co-location of Staff Members***. Co-located staff members facilitated information sharing and decision-making at the case level and formal and informal training on key service issues (*n*=2). One grantee's staff members obtained an e-mail address sponsored by the public child welfare agency that allowed the easy, quick transfer of confidential information. One grantee representative commented on the importance of visibility: "If you will be partnering on specific services you need staff [members] integrated into their service. It doesn't work if you're not there. Out of sight, out of mind."

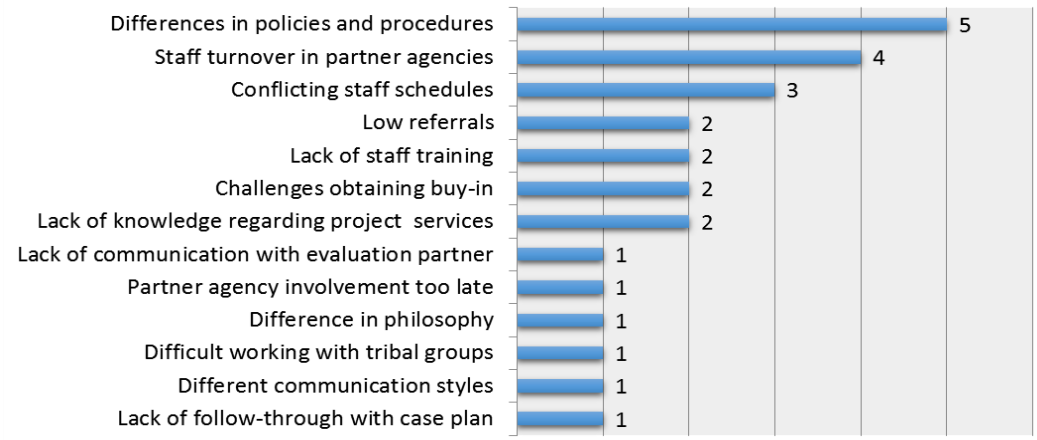
- ***Face-to-Face Contact.*** Two grantees considered their attendance at partner agency staff meetings helpful in establishing and strengthening rapport. Grantees reported that having project staff members attend child welfare agency meetings and case consultations was instrumental in developing strong partnerships with child welfare caseworkers and supervisors. The in-person contact fostered a sense of transparency, respect, and consideration.

- ***Enter into a Formal Agreement.*** Formal agreements with partners, such as Memorandums of Agreement (MOAs) or Memorandums of Understanding (MOUs) supported strong collaborative relationships (*n*=2). Formal agreements fostered a sense of ownership among partners for key project components. Through formal agreements grantees were able to secure designated staff, contribute time, and cash match which provided the infrastructure required to effectively implement FGDM services.

Challenges Working With Project Partners. Despite the benefits of partnerships and ongoing efforts to enhance them, grantees identified challenges in developing and maintaining partnerships. The challenges focused on differences in organizational policy and procedures, scheduling conflicts, staffing issues, and lack of knowledge regarding project services. To a lesser degree, grantees noted lack of follow-through with case plans, different communication styles, difficult relationships with Tribal organizations, differences in missions and philosophy, late involvement in the process, and lack of

communication with evaluation partners. Figure 4-4: Collaboration Challenges from Grantees lists the collaboration challenges identified by grantees.

Figure 4-4: Collaboration Challenges from Grantees



- ***Differences in Policies and Procedures.*** Five grantees expressed frustration with the lengthy processes within public child welfare agencies to approve grant-related documents. One grantee representative commented, "When we were designing, we thought it would be fast to sign a document, but it took up to 1 year to sign one document. Modifications may take six months to 1 year. We can't implement anything until it is signed, which is hard for a 3-year grant." Grantees also highlighted the differences in procedures between private and public child welfare agencies during FGDM meetings. While the FGDM facilitator attempted to empower families toward a specific case plan goal, some child welfare workers focused on departmental policies which could ultimately disempower a family. Conflicting service goals in working with children and families may potentially create discord between partnering agencies.

- ***Staff Member Turnover.*** Four grantees discussed the impact of staff member turnover in their partnering agencies, particularly with the public child welfare agencies. Frequent staff member turnover required grantees to rapidly train and orient new staff members to the FGDM practice models. Grantees were also required to constantly market services to new staff members, which required substantial effort and time.

- ***Conflicting Staff Member Schedules.*** Providing the full spectrum of FGDM services required coordinating the schedules of several people (e.g., families, FGDM facilitators, and service providers), which was often challenging. Three grantees described differences in work schedules with private/not-for-profit agency staff members and public child welfare agency workers. Partner agency staff members were often confined to a 40-hour workweek and lacked flexibility in their work schedules. Project partners were sometimes unwilling to work later hours or on weekends to participate in FGDM meetings.

Private/Not-for-Profit Agency and Public Child Welfare Agency Service Provision. With the exception of two grantees (Larimer County DHS and the Ute Indian Tribe), FGDM grantees were private/not-for-profit organizations. According to site visit discussions with grantees, having either public or private not-for-profit child welfare agencies providing services to children and families had advantages and disadvantages. Each type of agency brought strengths and challenges to the table.

Advantages and Challenges to Private/Not-for-Profit Agency Service Provision. During site visit discussions, grantees explained the primary advantages of private/not-for-profit agency service provision. There was a wide range of responses across grantees, and advantages included maintaining neutrality, which made families more receptive to engaging in services since these agencies were not attempting to remove children from their homes (*n*=2); having more flexibility to allocate resources to evaluate the effectiveness of project services (*n*=1); working within a decentralized system where there is a culture of shared responsibility and decision-making between partnering agencies (*n*=1); using a customer service approach that supports feedback on project services (*n*=1); addressing service gaps by providing comprehensive services to children and families and accessing local and widespread networks of community resources (*n*=1); and providing services and access resources in a timelier manner due to private agencies often having fewer regulations, required requests for permissions, and less "red tape to work through to address service needs (*n*=1).

Although grantees found many benefits to private/not-for-profit agencies providing services to children and families, some also noted several challenges. Challenges to effectively providing FGDM services included: lack of understanding of the public child welfare system (project representatives suggested that project staff members shadow caseworkers to learn more about the child welfare system) (*n*=2); issues with communication and information sharing (e.g., confidentiality, exchanging data, and obtaining accurate and complete information regarding the family)(*n*=2); lack of resources (i.e., understaffing and unreliable funding) (*n*=2); difficulties connecting with caseworkers due to organizational differences in location, culture, goals, and processes (*n*=1); and the unclear chain of command with private/not-for-profit organizations, particularly regarding resolving implementation or service delivery issues (*n*=1).

Advantages and Challenges to Public Child Welfare Agency Service Provision. FGDM grantees also discussed the advantages of having public child welfare agencies provide services. Representatives from three projects reported that public child welfare agencies are able to easily share data and experience less communication challenges among staff members. A grantee representative from a private organization explained that having staff members in different locations and offices often impeded staff communication, while another grantee discussed how information does not always filter down to staff members in private/not-for-profit organizations. Having staff members located in centralized areas was perceived to help increase internal communication about referrals and service delivery. Grantee representatives also noted that coordinating the engagement of the family seemed to be easier for child welfare caseworkers and would be more time efficient since they are the ones who carry the case (*n*=2). According to one grantee representative: "The coordination of everything is harder when you're removed from the system. If you are working in the [public child welfare system] it's a bit easier. Coordinating services with other system partners can be difficult."

Two private/not-for-profit agency staff members responded to questions regarding the challenges public child welfare agencies face in providing services. One grantee representative discussed the lack of trauma-informed services within child welfare. Another grantee representative reported that public child welfare agencies are not perceived as neutral and stated that "establishing trust and rapport with the family will be a lot harder." This concept is aligned with other grantee representatives who indicated that a significant benefit of private/not-for-profit service provision is the ability to be perceived as neutral. One way that FGDM projects administered by public child welfare agencies addressed this issue was by assigning a separate staff member to coordinate/facilitate the FGDM meeting, which established a neutral environment for families to develop their plans and allowed child welfare caseworkers to fully engage in the meetings.

Contextual Factors Influencing Project Implementation and Evaluation

The following subsections discuss factors that impacted project implementation and evaluation. Supporting documentation of findings may be found in Appendix J: Process Evaluation Data. Each subsection addresses the cross-site evaluation question:

- *What challenges and facilitators do FGDM programs experience in implementing services?*

Organizational and Community–Level Factors

In addition to implementation components, which are organizational characteristics that can be strengthened with the appropriate resources, there were various social, economic, and political contextual factors, which also influenced project implementation for FGDM grantees. These contextual factors included community readiness, project alignment with organizational beliefs and practices, experience using FGDM principles prior to project implementation, and community needs.

Community Readiness for FGDM Projects. Four grantees indicated during site visit discussions that they were only somewhat ready to implement the project when they received funding. Grantees described having support at all levels (i.e., leadership, staff, partner agency, and family) as an instrumental factor in ensuring that the system was ready for the implementation of the FGDM project. Examples of supportive leadership included providing space and staff to conduct FGDM meetings and developing policies to ensure agency-wide adoption of project practices. For both public and private child welfare grantees, gaining the support of child welfare agency leadership and staff members was particularly important. Several grantees relied upon child welfare workers (CPS workers, case managers) to help refer and engage families in the FGDM process. Lack of support from child welfare staff was seen as a major challenge for many grantees (*n*=4). Without leadership's enforcement of referral processes, grantees struggled to meet their targeted service numbers.

FGDM Alignment with Organizational Philosophy. Four grantees indicated that the primary reason the organization thought it was necessary to incorporate FGDM into organizational practice was because FGDM was viewed as a good organizational fit that aligned with their current work and their agency's philosophy. For instance, representatives from the Ute Indian Tribe stated that the FGDM model "resonated with Ute Tribal culture of family and responsibility" and saw Family Connection funding as an opportunity to provide a new service to families. Staff members at Homes for Black Children indicated that the American Humane Association's model of FGDM provided "a further application of the 'nothing about me without me' philosophy."

Experience with FGDM. Most grantees (*n*=6) indicated that FGDM was not a new practice for their organizations. Grantees either had some form of FGDM currently being practiced within their agencies (*n*=3), had used FGDM in the past within the agency (*n*=3), and/or staff members had already been trained on FGDM (*n*=3). However, grantees saw the 2011 Family Connection FGDM funding as an opportunity to introduce more family-centered FGDM models to staff, partners, and families than the models used in the past. YMCA of San Diego County had prior exposure to FGDM through its primary community partner (Casey Family Programs), though the agency itself had not practiced FGDM as a part of service delivery.

Adequacy of Community Resources and Services. During site visits, five grantees discussed the adequacy of their available service array to meet the needs of potential clients in the community. Three grantees noted that the service array within their communities was inadequate. One grantee indicated that while many services were available for families, they were not tailored enough to truly impact them. For example, services such as parenting education lacked a practice component to help parents practice what they learned. Another grantee serving a more rural population described resource shortages (particularly culturally-based services) across the state. Two grantees responded that the service array was adequate, describing a wide variety of holistic services (e.g., mental/behavioral health, family preservation, diversion, home visiting, etc.) provided by public and private child welfare agencies. Four grantees stated that their FGDM projects were not the only FGDM services offered to families in their communities; some form of FGDM was also used by other agencies within their communities. However, these services did not compete with Family Connection-funded FGDM projects because they used different FGDM models and served different target populations. In several cases, grantees noted that other agencies used models that were less family-focused such as FTDM, which is intended for families that have interfaced with child welfare systems.

Facilitators and Challenges to Project Implementation

Grantees provided examples of several factors that helped leverage support for project implementation and evaluation, as well as challenges that threatened to impede the success of FGDM projects. FGDM implementation was facilitated by several factors, including supportive leadership, project planning during the start-up period, staff members who were invested in the work, and the strengths-based and empowering focus of the FGDM models. While some challenges were unique to the project start-up period, others were experienced by grantees at later points or throughout the course of the projects. In general, implementation issues were related to the processes that the grantees had originally planned for the projects (e.g., recruitment and referral, project model, service provision). Common facilitators and challenges to project implementation are summarized below. Supporting documentation may be found in Appendix J: Process Evaluation Data.

Facilitators to Project Implementation.

Supportive Leadership. Successful implementation of FGDM services required leadership support within each grantee organization. Early involvement of leadership in the implementation of FGDM resulted in the formation of positive working relationships between all contributors to the FGDM project and set the tone for the later stages of the project. This effect is reflected in the statement of one grantee's evaluator, "There has been good communication between people. Everyone wants to do what benefits the family. Everyone is interested in supporting engaged family practice." Grantees also reported that it was important that executive leadership understood FGDM and acknowledged its value in serving families. This was achieved by including project leadership in early planning for the grant, informing them about the FGDM process, and providing information on the validity of including FGDM in case work practice. FGDM project managers included their local evaluators in this process. For example, a representative from The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect participated in meetings with Larimer County DHS leadership at all three sites (CO, SD, and TX) to explain the practice model and help leaders understand how FGDM improves casework and outcomes. These activities provided grantees with the necessary organizational support to implement their projects.

Dedicated Project Staff. The intensive nature of FGDM and family casework in general requires a unique set of skills from service providers. All seven grantees noted that the commitment of FGDM coordinators and facilitators to the families served had the greatest impact on implementing FGDM services. Most importantly, the team members who carry out FGDM services with families must be motivated to guide and empower families to address their problems and develop solutions. As part of this commitment, strong FGDM service providers demonstrated "an openness to learning new things" and interest in engaging in ongoing training, case consultations, and peer-to-peer learning opportunities. In addition to being knowledgeable and skilled in FGDM, coordinators and facilitators were described by leadership, management, evaluators, and partnering providers as possessing the following characteristics: "a single-mindedness in focusing on the needs of families," "being non-demanding, neutral, flexible," and able to "understand what the family is going through."

Effective Use of the Project Start-up Period. Several grantees reported that activities during the first year of the grant contributed to FGDM implementation. Critical processes included implementing the project work plan, selecting and training staff members, reviewing the evaluation plan and activities, documenting FGDM policies, procedures, and logistics, and recruiting families. Grantees that implemented FGDM in the past noted that it was particularly helpful for them to have processes already in place (e.g., knowing the setting where they would conduct family meetings).

Strengths-based Approach. Family engagement in the FGDM process is fundamental. Grantees reported that the manner in which the families are informed about FGDM and their role substantially impacts whether families participate in and benefit from FGDM services. Achieving these goals is facilitated by the strengths-based and solution-focused nature of the intervention. All grantees identified the family-empowering nature of the FGDM process as one of the greatest contributors to the intervention's successful engagement of families. Grantees noted that in addition to requiring engagement and rapport building with families, FGDM enabled staff members to interact with families in new, non-directive ways to strengthen families' ability to identify solutions to their problems. When successfully conducted, FGDM enabled the meeting facilitators to "take their lead from the families." One project leader saw the impact of FGDM preparation on families and their ability to make better decisions: "The strength of FGDM is that it takes families back to their roots. FGDM is about families taking care of families. When families are empowered to make their own decisions, they make great decisions, especially if they are educated. They are personally invested."

Challenges to Project Implementation.

Delays in Service Implementation. The FGDM grantees reported that services were implemented later than anticipated. The most common challenges to full service implementation included lack of referrals to the FGDM project, resistance to FGDM on the part of key staff members or project partners, and lack of qualified individuals to hire. Low referral rates, particularly from CPS workers, have been documented in previous FGDM studies as well, and it has been speculated that referral issues may be due to: families being less interested in participating in FGDM earlier in their involvement in child welfare; inadequate training and awareness of FGDM services on the part of CPS workers; and/or potential child welfare system disincentives to participating in services.[48] Other less common challenges encountered during the start-up phase included unanticipated turnover in project leadership and the

[48] Shore, N., Wirth, J., Cahn, K., Yancey, B., & Gunderson, K. (2002). Long term and immediate outcomes of family group conferencing in Washington state (June 2001). *Restorative Practices E-Forum*, September 10, 2002. International Institute of Restorative Practices. Retrieved September 9, 2014, from www.restorativepractices.org

need for staff members in projects with previous FGDM experience to adjust to different processes, terminology, and staff roles associated with a new FGDM model. However, grantees continued project planning, staff training, and marketing the project within the community while they were experiencing other project delays.

Difficulty Reaching Service Goals. Most of the grantees reported that they overestimated the number of families that would be referred by internal (cross-departmental) and external agency partners. Fewer than anticipated referrals from child welfare partners were often due to a lack of understanding of the project and distrust of FGDM (despite participation in training). As noted by one project leader, "The intended flow of referrals to the project was hindered because the referring service providers did not truly understand the value of FGDM." Although formal memorandums of understanding (MOU) were in place between the grantee and referring providers, distrust between the service areas reportedly created a barrier to the flow of families into FGDM services. This challenge was addressed with some success by one grantee by co-locating child welfare and project staff members. Other grantees marketed the project-to-project partners to increase participation.

Challenges Serving the Target Population. FGDM grantees identified numerous characteristics of their target populations that made delivering FGDM services particularly challenging. The most frequently cited challenge was family resistance to the FGDM process. This lack of engagement was attributed in part to the fact that members of the target population were unaware of or unaccustomed to accessing the formal and informal supports available in their communities. While empowering families is a core principle and benefit of FGDM, most families from the target populations had not participated in services in which they were central to the process (e.g., accepting the lead in identifying problems, problem solving, etc.). As a result of this, retaining families was a significant challenge. Additional factors hindering implementation were related to limited resources available to serve difficult-to-reach populations. Grantees also recognized that it was not possible to begin FGDM with families while they were experiencing a crisis and/or attempting to meet basic needs (e.g., food, housing, transportation). One project leader explained, "Many families have basic needs or experienced immediate crises that need to be met prior to engaging in FGDM. … [We] help stabilize families. We need to focus on the crisis at hand and meet immediate needs first."

> *"There is a disconnect between what caseworkers believe about families and FGDM, and so coordinators have to be marketers of this as a service even though [project partners] have policies that mandate that FGDM occurs."*
>
> - **Perspective of an FGDM Project Leader**

Facilitators and Challenges to Project Evaluation

Grantees were required to conduct rigorous project evaluations, as stated in the Family Connection program announcement. Grantees' experimental or quasi-experimental evaluation designs required support and cooperation from multiple stakeholders including families, project staff members, and partner agencies. The most frequently identified facilitators to project evaluation included collaboration between project staff and evaluators; the use of effective, reliable assessment instruments; data management systems tailored to project activities; and staff preparation and training. Challenges to the

grantees' evaluations differed from implementation issues, but were often interrelated. For example, recruitment, or lack thereof, directly impacted sampling and data collection for the evaluation. Common facilitators and barriers to project evaluation are outlined in Appendix J: Process Evaluation Data and detailed below.

Facilitators to Project Evaluation.

Collaboration between Project and Evaluation Team Members. Effective working relationships between grantees and their project evaluators were essential for successful implementation of the FGDM projects. While the roles of the project staff members and evaluators were very different, it was important that individuals from both teams worked together in order to track the project activities and progress and to determine the effect of the intervention on families served. Positive relationships required understanding each other's responsibilities, open communication, and information sharing. Six of the grantees' evaluators reported that they had a strong, positive working relationship with project leadership and staff members. The relationships between evaluators and project staff members were most successful for grantees that enlisted a collaborative approach. Common practices included evaluator participation in project planning meetings, ongoing communication, training project staff members on the evaluation and their role in data collection, and sharing evaluation findings with project leadership, managers, and FGDM service providers. As described earlier in this report, periodic presentation of evaluation findings to project staff members also assisted grantees in identifying areas in which services could be modified or improved.

Effective Instruments. Evaluators expressed substantial confidence in the effectiveness of the projects' evaluation instruments to capture process and outcome data. The evaluators used numerous instruments to assess project outcomes. An evaluation team representative noted that the Parenting Stress Index (PSI) was particularly useful because it helped the service provider understand the caregiver's stress level as well as the relationship between the caregiver and the child. Confidence was also expressed in the Family Needs Scale (FNS), which one evaluator strongly encouraged service providers to use to better understand their clients' needs. Evaluators considered statewide Automated Child Welfare Information System (SACWIS) data as a source of strong outcome data. According to an evaluation team representative, "We are looking at post-service comparisons. In looking at deliverables, are there reoccurrences and removals? It was a gain for [project staff] to have child welfare data."

Data Systems to Improve Services. FGDM evaluation was further facilitated by the use of effective data management systems. Six grantees either developed a project database specifically for the FGDM project or modified an existing one for the project. Most grantees used professional software (e.g., Mindshare, Efforts to Outcomes) or developed their system internally. One grantee did not have a data management system, but maintained project data using spreadsheet software. Grantees identified several ways in which having a data management system impacted their project, including: improved reporting (n=6); more effective project management (n=5); improved ability to track progress on outcomes and conduct analyses (n=3); and improved staff supervision (n=2).

Adequate Preparation and Staff Training. Recognizing the importance of evaluation in the FGDM projects, grantees provided initial and ongoing evaluation training to project staff members and partners. The purpose of the trainings was to inform project staff members about the evaluation objectives and process and to explain staff members' roles in the evaluation. As part of these trainings, the evaluators provided instruction on data tracking systems that was accompanied by corresponding data collection materials and forms. Exposure to evaluation training broadened the staff members'

understanding not only of the evaluation, but of their own work. Ongoing evaluation training over the course of the projects provided opportunities for the evaluators and project staff members to discuss processes and any changes that had been made in the evaluation (e.g., form modifications, database changes). Project evaluators also remained available on an ongoing basis to provide technical assistance to staff as needed.

Challenges to Project Evaluation. Similar to evaluation facilitators, implementation and evaluation challenges were interrelated in most areas, particularly in regard to the number of families served. At the time of site visits in December 2013 to March 2014, five projects had partially met their projections for families served, with each project having met 50 percent or less of their targets. One project had exceeded projections by approximately one third, while the remaining project did not have data available. All grantees noted that they had overestimated the number of families the projects would serve and modified their projections or evaluation approach (e.g., eliminating randomization of families to control and intervention groups) in response. The majority of evaluators noted low referral rates from project partners and small sample sizes. These factors, in combination with low survey/instrument response rates among those families that did participate in FGDM, were substantial challenges to demonstrating project effects. A final challenge expressed by the projects' evaluators was the limited duration of the grants, which allowed for short-term outcomes at a maximum to be addressed.

Section 5: Outcome Evaluation Findings

This section describes grantees' outcome evaluation findings, which are organized by child, adult, family, and organizational and systems-level outcomes. Child, adult, and family-level outcomes address the areas of safety, permanency, and well-being, and address the cross-site evaluation question, *To what degree do FGDM grantees achieve short, intermediate, and long-term outcomes?* Grantees also provided examples of organization and systems-level changes regarding policies and procedures, service model integration by the public child welfare agency and other key agencies, and impacts on child welfare practice in the community that occurred due to the FGDM projects in their semi-annual reports and during site visit discussions. These data, along with grantees' cost study findings, were synthesized in this section and directly address the following cross-site evaluation questions:

- *How has the FGDM project impacted child welfare practice in the community?*
- *What new policies and procedures were developed as a result of the FGDM project?*
- *In what ways are FGDM projects sustainable beyond the Federal funding period?*
- *To what extent have public child welfare agencies integrated elements of the FGDM project's service model?*

A summary of key outcome findings are described below. Supporting data for this section may be found in Appendix K: FGDM Outcome Evaluation Findings.

Summary of Family Group Decision-making Outcome Evaluation Findings

The primary safety, permanency, and well-being outcomes identified in the 2011 Family Connection funding announcement included 1) Safety – Children are safely maintained in their homes whenever possible and appropriate; 2) Permanency – Children have permanency and stability in their living situations; and 3) Well-being – Families have enhanced capacity to provide for their children's needs (which include physical and mental health, and developmental and educational needs). The funding announcement required that grantees' outcome evaluations assess these and any other relevant child welfare outcomes identified in CFSRs.

- ***Safety.*** Public child welfare data showed primarily positive child safety trends over time for families receiving FGDM services; compared to control group families, a lower percentage of FGDM families had subsequent CPS referrals and substantiated reports after case closure. Grantees also noted positive trends in risk reduction from pre- to post-test for families receiving FGDM services. Safety assessments conducted by grantees provided additional evidence to support the effectiveness of FGDM.

- ***Permanency.*** Public child welfare data showed that after 3, 6, and 12-month follow-up periods, children receiving FGDM services tended to have lower child welfare system involvement than those who did not receive services. Compared to control group families, families who received FGDM tended to have lower rates of child removals and foster care entries and higher rates of case closures.

- ***Well-being.*** Six key areas were used to measure well-being among the grantees: protective factors, family functioning, social support, family needs, parenting stress, and child well-being. Grantees found data suggesting that FGDM may be associated with positive outcomes related to family functioning and resiliency (a key protective factor), child health, and youth relationships. While grantees documented mixed results in terms of FGDM's impact on protective factors, family needs, and parenting stress, trends were mainly in the positive direction.

- ***Organizational and Systems Impact.*** Grantees addressed organizational and system-level outcomes that were achieved through the implementation of their FGDM projects. Grantees impacted child welfare practice through improving child welfare staff attitudes and practices related to increasing support and advocacy for FGDM, strengthening service planning, increasing family engagement, and improving working relationship with Tribal Indian Child Welfare (ICW) workers. Grantees made several efforts toward sustaining components of their FGDM projects, including the integration of FGDM service models into agency or child welfare partner practice the development of new policies and procedures around referral processes, and manualizing FGDM practices.

- ***Project Costs.*** Grantees' cost study findings showed that while costs varied dramatically based on the specific program models adopted by each site, there may be cost savings associated with providing FGDM services as a strategy to prevent children from entering or re-entering foster care, as compared to foster care services. While this has implications for cost savings for the child welfare system, more rigorous outcome and cost evaluations could be conducted to determine whether FGDM is truly more effective than current interventions.

Limitations of Outcome Findings

While all seven grantees provided evaluation data, not all data collection and analyses were completed at the time of data synthesis. Two grantees (Larimer County DHS and Ute Indian Tribe) received no-cost extensions to continue their projects beyond the third year of the project, though the Ute Indian Tribe provided preliminary outcomes for the cross-site evaluation. Inclusion and exclusion criteria were developed for reporting outcome data for the cross-site evaluation. The criteria included projects for which data were complete. Data were not reported for projects with missing data components (e.g., pre-post designs that were missing follow-up data) or if surveys were improperly scored. Based on these criteria, findings were synthesized from a total of six FGDM grantees (The Children's Home Society of New Jersey, Homes for Black Children, Kids Central, Inc., Ute Indian Tribe, The Village Family Service Center, and YMCA of San Diego County) addressing child and family-level outcomes related to safety, permanency, and well-being. Another limitation of the findings is the limited sample size across projects, which impacts the generalizability of results. Throughout this section, results are identified as trends (i.e., results that have a tendency to fall in a particular direction) or statistically significant findings. While Family Connection projects produced several trends and results that supported FGDM as a promising intervention, rigorous evaluations with larger sample sizes are suggested to increase the validity and reliability of findings.

Child and Family-Level Outcomes

This section describes the child and family-level outcomes most commonly reported by FGDM grantees in regard to safety, permanency, and well-being.

Safety Outcomes

Safety is defined in CFSR Safety Outcome 1 as protecting children from abuse and neglect (i.e., no subsequent substantiated or indicated maltreatment allegations). Four grantees obtained child welfare data (i.e., SACWIS) from local public child welfare agencies to track the number of subsequent CPS referrals and substantiated reports following FGDM service provision. The data are presented in Table 5-1: Child Safety and Maltreatment Recurrences at Follow-Up. Grantees noted primarily positive child safety trends over time for families receiving FGDM services, with a lower percentage of FGDM families having subsequent CPS referrals and substantiated reports than control group families. Kids Central, Inc. validated these trends with statistically significant findings. While a majority of grantees noted positive safety trends, one grantee (YMCA of San Diego County) reported negative trends in the number of child welfare recurrences at 12 months when comparing intervention and control groups, though this may have been due in part to their limited sample size (*n*=24).

Table 5-1: Child Safety and Maltreatment Recurrences at Follow-Up

Grantee	Follow-up Time Period	Level of Child Welfare Involvement	Results in Percentage	Trend
The Children's Home Society of New Jersey	3 months after service completion for a sample of 85 children in the FGDM and control group	Number of CPS referrals	FGDM: 0.04% Control: 0.08%	Positive
		Number of substantiated CPS reports	FGDM: 0.02% Control: 0.02%	No Trend
Homes for Black Children	October 2014 follow-up data collection for 293 families referred to HBC services between April 2012- Sept 2014 (includes both FGDM and services as usual)	Number of substantiated CPS reports	FGDM: 0.00% Control: 3.40%	Positive
Kids Central, Inc.	6 and 12 months following successful case closure of FGDM cases (*n*=371) compared to control cases (*n*=2,174)	Number of substantiated CPS reports	6 months* FGDM: 3.20% Control: 8.90% 12 months* FGDM: 4.10% Control: 14.20%	Positive
YMCA of San Diego County	12 months following case closure for children in the FGDM group (*n*=24) compared to the control group (*n*=50)	Number of CW recurrences	FGDM: 12.50% Control: 6.00%	Negative

* *Difference in mean score between intervention and control group is statistically significant (p<.01).*

Safety and Risk Assessments. Safety (as defined by CFSR Safety Outcome 2, Items 3 and 4) further includes providing services to families to maintain the child or youth safely in the home to prevent entry or re-entry into foster care and conducting assessments of risks and safety management. Two grantees conducted risk assessments (developed internally for their FGDM projects or using risk assessment data collected by CPS workers) to identify threats to family safety and risk factors. Risk assessments helped determine the likelihood of future maltreatment to a child or adolescent. While the Village Family Service Center collected baseline and follow-up data for the intervention group only, Kids Central, Inc. collected baseline and follow-up data for both intervention and control groups. Both grantees found positive trends in risk reduction from pre- to post-test for families receiving FGDM services, though findings were not statistically significant. Key findings from these grantees are explained below and in Table 5-2: Safety and Risk Assessment Outcomes.

Table 5-2: Safety and Risk Assessment Outcomes

Grantee	Number of Risk/Safety Assessments Completed	Pre-Test Risk in Percentage	Post-Test Risk in Percentage	Trend
Kids Central, Inc.	Total Risk Assessments: 523 FGDM: 117 Control: 406	FGDM (case opening) Low Risk: 21.4% Medium Risk: 75.2% High Risk: 3.4%	FGDM (case closing) Low Risk: 68.4% Medium Risk: 29.1% High Risk: 2.6%	Positive
		Control (case opening) Low Risk: 17.5% Medium Risk: 66.0% High Risk: 16.5%	Control (case closing) Low Risk: 62.6% Medium Risk: 33.0% High Risk: 4.4%	Positive
The Village Family Service Center	Child Welfare Placement Risk Assessment: 129	FGDM/FTDM Intake Imminent Risk: 50.4% High Risk: 22.2% Moderate Risk: 7.0% Low Risk: 0.8% Missing Data: 20.2%		
	Maltreatment Risk Data (SACWIS): 99 families	6 months prior to FGDM 104 incidents regarding 78% families	6 months post-FGDM 43 incidents for 27% of families	Positive

- Kids Central, Inc. conducted risk assessments for 523 cases (117 FGDM cases and 406 non-FGDM cases) at intake and case closure. Results demonstrated a positive trend in safety risk reduction over time for both the intervention and control groups, though there were no significant differences between groups. The FGDM group showed greater decreases in risk level for low and medium risk families over time, though control group families receiving non-FGDM diversion services exhibited a much larger 12.1 percent reduction in high-risk cases at case closure.

- The Village Family Service Center received 129 child removal risk assessments for FGDM and FTDM cases for programmatic use at intake only. These assessments were conducted by referring child welfare workers. Risk assessment data were used for programmatic purposes. At intake, half of the families (50.4 percent) were at imminent risk of child removal from the home,

22.2 percent of families were at high risk, and 7 percent of families were at moderate risk. A minimal percentage of families (0.8 percent) were at low risk of child welfare placement. This suggests that the Village provided FGDM/FTDM to the highest risk families. Additional data from referring child welfare workers indicated that the most common risk factors identified by workers were child abuse/neglect (*n*=73, 50 percent) and substance abuse (*n*=52, 35.6 percent).

- The Village Family Service Center also received SACWIS data for 99 families related to maltreatment risks in the 6 months prior to and 6 months following their first family meeting. In the 6 months post-FGDM/FTDM, families on average experienced a decrease in the number of child welfare referrals due to maltreatment risk (from 104 incidents pre-meeting to 43 incidents post-meeting). Among these cases, neglect was the most common reason for referral. Of the 43 incidents, only 10 referrals actually resulted in a 'services required' disposition.

Family Safety. The Ute Indian Tribe and YMCA of San Diego County assessed family safety using the Family Safety subscale of the North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R). This subscale relies on workers' clinical judgments to assess the presence of domestic violence between parents/caregivers, family conflict, and physical abuse of children in the home. See Table 5-3: Family Safety Ratings Pre- and Post-FGDM Intervention (Using the NCFAS-G+R Family Safety Subscale) for detailed findings.

Table 5-3: Family Safety Ratings Pre- and Post-FGDM Intervention (Using the NCFAS-G+R Family Safety Subscale)[1]

NCFAS-G+R Domain	Group Assignment	Ute Indian Tribe Pre-Test Mean	Ute Indian Tribe Post-Test Mean	YMCA of San Diego Pre-Test Mean	YMCA of San Diego Post-Test Mean	Trend
Family Safety	FGDM	0.1 (*n*=12)	1.4** (*n*=12)	-2.4 (*n*=49)	2.0** (*n*=49)	Positive
	Control	0.6 (*n*=10)	0.4 (*n*=10)			Negative

[1] Higher scores on subscales represent higher safety.
** *Difference in mean score between pre- and post-test is statistically significant (p<.01).*

- YMCA of San Diego County found statistically significant improvements in family safety ratings from intake to case closure for families receiving the FGDM intervention. The data presented in Table 5-3 indicate that on average, families entered FGDM services with moderate family safety issues ($\bar{X}$= -2.4). The mean family safety rating greatly improved for families by the time of case closure ($\bar{X}$= 2.0), which suggests that families receiving the intervention were seen by workers as having protective strategies or plans in place that were clear strengths.

- The Ute Indian Tribe found similar improvements in family safety ratings over time. For the FGDM group, the improvement in family safety scores from baseline to the 3-month follow-up period was statistically significant. The Ute Indian Tribe administered the NCFAS-G+R to control group families as well, though the difference in family safety scores from baseline to 3-month follow-up period were not statistically significant for this group. Findings suggest that FGDM helped improve family safety more than general case management services at the Ute Indian Tribe.

Permanency Outcomes

Most grantees served voluntary child welfare populations who were at risk for removal; therefore, a key goal for grantees was to safely maintain children in their homes and prevent child removals or foster care entries. Five grantees (Children's Home Society of New Jersey, Homes for Black Children, Kids Central, Inc., The Village Family Service Center, and YMCA of San Diego County) reported outcomes regarding child welfare involvement and permanency for families participating in FGDM as well as families in the control group. All five grantees documented positive trends for FGDM services maintaining intermediate (3 and 6 months) and long-term (12 months) stability in children's living situations (see Table 5-4: Child Welfare Involvement at Follow-Up). One grantee (Kids Central, Inc.) found statistically significant differences between the FGDM and control groups regarding permanency outcomes.

Table 5-4: Child Welfare Involvement at Follow-Up

Grantee	Follow-up Time Period	Level of Child Welfare Involvement	Results in Percentage	Trend
Children's Home Society of New Jersey	3 months after service completion for a sample of 85 children in the FGDM and control group	Placement status (All children were in kinship care at baseline)	FGDM: Biological Parent: 0.0% Foster Care: 0.0% Control: Biological Parent: 0.0%	Positive
Homes for Black Children	October 2014 follow-up data collection for 293 families referred to HBC services between April 2012-September 2014 (includes both FGDM and services as usual)	Number of foster care re-entries	FGDM: 0.0% Control: 8.8%	Positive
Kids Central, Inc.	6 and 12 months following successful case closure of FGDM cases (*n*=371) compared to control cases (*n*=2,174)	Number of child removals	6 months* FGDM: 0.0% Control: 2.7% 12 months* FGDM: 1.7% Control: 4.9%	Positive
The Village Family Service Center	6 months following the family's first FGDM/FTDM meeting (*n*=110)	Placement status	Baseline Foster Care: 66% Relative Care: 10% In-Home: 19% 6 months Foster Care: 54% Relative Care: 32% In-Home: 32%	Positive

Grantee	Follow-up Time Period	Level of Child Welfare Involvement	Results in Percentage	Trend
YMCA of San Diego County	12 months following case closure for children in the FGDM group (*n*=24) compared to the control group (*n*=50)	Number of closed CW voluntary cases due to the family being stabilized	FGDM: 75% Control: 72%	Positive

[*] *Difference in mean score between intervention and control group is statistically significant (p<.01).*
[1] The Village Family Service Center served both voluntary and court-dependent families.

- The Children's Home Society of New Jersey collected data on permanency and subsequent changes in placement through a follow-up telephone survey, which was conducted three months after case closure for control and FGDM families. The grantee noted that less than 1% of children experienced placement changes following both the family engagement (i.e., control) and FGDM phases of their intervention.
- At the end of the project (October 2014), an analysis of county public child welfare records indicated that only 26 (8.8 percent) of the 293 families referred to Homes for Black Children between April 2012 and September 2014 had a CPS referral substantiation. Of those 26 families, only 10 (3.4 percent) had been by served by Homes for Black Children. None of these families were in the FGDM condition (i.e., the families received control group or other agency services). The public child welfare agency also generated a quarterly count of children placed in foster care, as well as a count of foster care re-entries within 12 months. None of the children involved in the FGDM intervention entered or re-entered foster care during the 3-year grant period.
- Kids Central, Inc. found promising findings for the FGDM intervention in terms of permanency. Child welfare data indicated a lower number of substantiated subsequent CPS referrals for the FGDM group at both 6 and 12 months post-intervention. The data also showed a lower number of child removals for the FGDM group at 12 months compared to the control group. The difference between FGDM and control group scores was statistically significant for both of these findings.
- The Village Family Service Center used SACWIS data provided by the child welfare agency to compare pre- and post-meeting placement status. The grantee noted a reduction in the number of children placed in foster care 6 months following the intervention, and an increase in parent and relative placement for families who received FGDM/FTDM services.
- YMCA of San Diego County used SACWIS data to compare case closure rates for FGDM and control group families. The data showed that both FGDM and control group families had high case closure rates 1 year post-services due to the family being stabilized (75 percent for the FGDM group, and 72 percent of control group cases).

Well-being Outcomes

FGDM grantees measured several indicators of well-being, including protective factors, family needs, caregiver/parent stress, and family functioning. Results for the various measures of well-being are described below.

Protective Factors. Six of the seven grantees administered the Protective Factors Survey (PFS), developed by the FRIENDS Network and University of Kansas Institute for Education Research and Public Service. The self-administered survey measures protective factors in five areas: Family Functioning/Resiliency, Social Support, Concrete Support, Nurturing and Attachment, and Knowledge of Parenting/Child Development. While a majority of grantees used this instrument, only three grantees

(Homes for Black Children, Kids Central, Inc., and Ute Indian Tribe) provided both baseline and follow-up data for this instrument. Overall, PFS subscale scores resulted in mixed trends across the grantees. Grantees found strong evidence supporting FGDM's impact on Family Functioning and Resiliency, though the impact of FGDM on other protective factors remains unclear. Table 5-5: Mean Baseline and Follow-up Scores on the Protective Factors Survey provides the mean baseline and follow-up scores on the Protective Factors subscales.

Table 5-5: Mean Baseline and Follow-Up Scores on the Protective Factors Survey[1]

		Protective Factors				
Grantee	**Group Assignment**	**Family Functioning and Resiliency**	**Social and Emotional Support**	**Concrete Support**	**Nurturing and Attachment**	**Trend**
Homes for Black Children	FGDM (*n*=13)	Pre-test: 5.1 Post-test: 6.3	Pre-test: 5.3 Post-test: 6.2	Pre-test: 4.9 Post-test: 6.0	Pre-test: 6.2 Post-test: 5.9	Mixed
	Control					
Kids Central, Inc.[2]	FGDM (*n*=not specified)	Pre-test: 4.7 Post-test: 5.5[t]**	Pre-test: 5.5 Post-test: 5.7	Pre-test: 5.1 Post-test: 5.6	Pre-test: 6.4 Post-test: 6.5	Positive
	Control					
Ute Indian Tribe	FGDM (*n*=12)	Pre-test: 5.7 Post-test: 5.8[t]*	Pre-test: 6.5[F]* 3 months: 6.2	Pre-test: 3.6 3 months: 2.5	Pre-test: 6.1 3 months: 6.1	Mixed
	Control (*n*=12)	Pre-test: 4.9 Post-test: 5.0	Pre-test: 4.7 3 months: 5.2	Pre-test: 2.3 3 months: 2.3	Pre-test: 6.0 3 months: 6.4	Positive

[t]* *Statistically significant differences between baseline and follow-up means (p<.05).*
[t]** *Statistically significant differences between baseline and follow-up means (p<.01).*
[F]* *Statistically significant differences between the FGDM and control group (p<.05).*
[1] Higher scores on subscales represent more positive family functioning.
[2] FGDM case closures were based on PFS scores; scores during follow-up were used to validate or delay case closures. Successful case closures occurred once participants made improvements in two or more domains of the PFS.

- Homes for Black Children administered 13 surveys pre- and post-intervention (at baseline and 12 months) for families receiving FGDM services. The grantee reported positive trends from baseline to the 12-month follow-up period for a majority of the subscales (i.e., Concrete Support, Social Support, and Family Functioning and Resiliency). Scores for the Nurturing and Attachment subscale tended to decrease from pre- to post-test.
- Kids Central, Inc. administered a survey at case opening and case closure for families receiving FGDM services, though the final number of surveys completed was not specified. Findings revealed a statistically significant change in Family Functioning and Resiliency subscale scores from pre- to post-test. The grantee also reported positive trends for the Social Support, Concrete Support, and Nurturing and Attachment subscales. The grantee administered the Knowledge of Parenting/Child Development subscale (which is an additional PFS subscale) and noted mixed trends in mean scores from case opening to case closure on subscale items. One subscale item ("*There are many times when I don't know what to do as a parent.*") had a statistically significant mean increase from pre- to post-test, which suggests that FGDM families showed an improvement in general parenting knowledge, or "knowing what to do as a parent,"

from case opening to case closure (see Table 5-6: Kids Central Mean Scores on Child Development / Knowledge of Parenting).

Table 5-6: Kids Central Mean Scores on Child Development / Knowledge of Parenting

Subscale Item	Time of Assessment	
	Pre-Test Mean (*n*=unspecified)	Post-Test Mean (*n*=unspecified)
There are many times when I don't know what to do as a parent. (score reversed)	4.33	5.67*
I know how to help my child learn.	6.02	5.93
My child misbehaves just to upset me. (score reversed)	4.77	4.84
I praise my child when he/she behaves well.	6.35	6.37
When I discipline my child, I love control. (score reversed)	6.37	6.37

** Change in mean score is statistically significant from pre- to post-test (p<.05).*

- The Ute Indian Tribe administered 12 surveys at baseline and 3-months after case closure for the intervention and control groups. Mean scores between FGDM and control group families for the Family Functioning and Resiliency subscale were statistically significant at the 3-month follow-up periods. This indicates that the FGDM group had higher family functioning than control group families post-services. The grantee noted negative trends over time for FGDM families on the Social Support and Concrete Support subscales, and a repeated measures ANOVA revealed significant differences between FGDM and control group families at intake in terms of the level of social support. At baseline, FGDM families typically had higher levels of social support, and largely maintained a stable level of social support from pre- to post-test.

Social Support. The Children's Home Society of New Jersey measured caregiver social support using the Social Support Questionnaire-Short Form. Caregivers were asked to identify people that they can count on in various situations and to express how satisfied they were with the support. There was no significant change in the number of people identified as social supports from pre-test (intake) to post-test (case closure) for the intervention or control group. On average, satisfaction with supports improved over time for both groups, but this was not statistically significant. See Table 5-9: Social Support Questionnaire-Short Form Results for detailed findings.

Table 5-9: Social Support Questionnaire-Short Form Results

	Group Assignment	Pre-Test	Post-Test	Trend
Average Number of Supports	FGDM (*n*=47)	2.6	2.6	No trend
	Control (*n*=132)	2.9	2.9	No trend
Average Satisfaction with Supports[1]	FGDM (*n*=47)	5.7	5.8	Positive
	Control (*n*=132)	5.9	6.0	Positive

[1] Satisfaction scores range from 1 (Very dissatisfied) to 6 (Satisfied).

Family Functioning. The Ute Indian Tribe and YMCA of San Diego County captured family functioning using the NCFAS-G+R, which is based on project staff member assessments of family strengths, issues, and behaviors that underlie child maltreatment. FGDM staff observed families and

provided ratings in the following domains: 1) Overall Environment, 2) Parental Capabilities, 3) Family Interactions, 4) Family Safety, 5) Child Well-being, 6) Social/Community Life, 7) Self-Sufficiency; and 8) Family Health. Results provided promising support in favor of the FGDM intervention. Both grantees found positive improvements over time in most to all scale domains for families receiving FGDM. Detailed findings are reported in Table 5-7: Mean NCFAS-G+R Rating Comparisons.

Table 5-7: Mean NCFAS-G+R Rating Comparisons[1]

		Ute Indian Tribe		YMCA of San Diego		
NCFAS-G+R Domain	Group Assignment	Pre-Test Mean	Post-Test Mean	Pre-Test Mean	Post-Test Mean	Trend
Overall Environment	FGDM	0.4 (*n*=11)	1.5 (*n*=11)	-0.9 (*n*=49)	2.7 [t]** (*n*=49)	Positive
	Control	1.5 (*n*=10)	1.2 (*n*=10)			Negative
Family Health	FGDM	0.2 (*n*=12)	1.5 [t]* (*n*=12)	-0.6 (*n*=49)	1.0 [t]** (*n*=49)	Positive
	Control	0.8 (*n*=10)	0.7 (*n*=10)			Negative
Family Interactions	FGDM	0.4 (*n*=12)	1.5 [t]*, [F]** (*n*=12)	-2.9 (*n*=49)	0.8 [t]** (*n*=49)	Positive
	Control	0.8 (*n*=10)	0.6 (*n*=10)			Negative
Family Safety	FGDM	0.1 (*n*=12)	1.4 [t]** (*n*=12)	-2.4 (*n*=49)	2.0 [t]** (*n*=49)	Positive
	Control	0.6 (*n*=10)	0.4 (*n*=10)			Negative
Parental Capabilities	FGDM	0.0 (*n*=12)	1.5 [t]*, [F]* (*n*=12)	-1.2 (*n*=49)	2.4 [t]** (*n*=49)	Positive
	Control	0.6 (*n*=10)	0.7 (*n*=10)			Positive
Self-Sufficiency	FGDM	0.4 (*n*=12)	1.7 [t]*, [F]** (*n*=12)	0.1 (*n*=49)	1.1 [t]** (*n*=49)	Positive
	Control	1.0 (*n*=10)	0.3 (*n*=10)			Negative
Social/Community Life	FGDM	0.3 (*n*=12)	1.3 [F]* (*n*=12)	0.1 (*n*=49)	1.1 [t]** (*n*=49)	Positive
	Control	0.8 (*n*=10)	0.6 (*n*=10)			Negative
Child Well-being	FGDM	0.2 (*n*=12)	1.4 [t]*, [F]* (*n*=12)	-0.9 (*n*=49)	0.8 [t]** (*n*=49)	Positive
	Control	0.8 (*n*=10)	0.5 (*n*=10)			Negative

[1] Higher scores on subscales represent stronger family strengths.
[t]* *Statistically significant differences between baseline and follow-up means (p<.05).*
[t]** *Statistically significant differences between baseline and follow-up means (p<.01).*
[F]* *Statistically significant differences between the FGDM and control group (p<.05).*
[F]** *Statistically significant differences between the FGDM and control group (p<.01).*

- The Ute Indian Tribe's child welfare caseworkers completed the NCFAS-G+R for 21 FGDM and control group families at baseline and at 3 months. While all subscales showed positive trends, data analysis further provided strong evidence in support of the intervention. For the FGDM group only, differences in mean scores from intake to 3 months following case closure were statistically significant for the following subscales: Parental Capabilities, Family Interactions, Child Well-being, Social/Community Life, and Self-Sufficiency. This suggests that families improved in the aforementioned areas after receiving FGDM services. Additional analyses showed statistically significant differences between the FGDM and control group mean scores at the 3-month follow-up period (and not at intake) in the domains of Parental Capabilities, Family Interactions, Family Safety, Child Well-being, Social/Community Life, and Self-Sufficiency. This suggests that FGDM families fared better than control group families in these domains at follow-up.

- YMCA of San Diego County's FGC facilitators conducted 49 NCFAS-G+R assessments at intake and case closure for the FGDM group only. Similar to the Ute Indian Tribe's findings, the YMCA of San Diego County's NCFAS-G+R results showed statistically significant improvements in all subscale domains from pre-test to case closure, which suggests that family progress, strengths, and resources improved after families received FGDM services.

- The Ute Indian Tribe used the Family Assessment Device (FAD) to assess seven domains of family functioning from the parent/caregiver's perspective: 1) Problem Solving, 2) Communication, 3) Roles, 4) Affective Responsiveness, 5) Affective Involvement, 6) Behavior Control, and 7) General Functioning. Preliminary trends were mainly positive, with improvements in family functioning for nearly all domains (excluding Affective Involvement) from baseline to the 3-month follow-up period. The grantee found statistically significant differences between the FGDM and control group mean scores at the follow-up period in the domains of Affective Responsiveness and General Functioning (which measures the overall health/pathology of the family).[49] This provides support that FGDM families fared better than control group families in these domains at follow-up. The control group showed mainly negative trends in family functioning over time. Findings are reported in Table 5-8: Ute Indian Tribe Mean Scores on the Family Assessment Device (FAD).

[49] Epstein, N.B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. *Journal of Marital and Family Therapy, 9*(2), 171-180.

Table 5-8: Ute Indian Tribe Mean Scores on the Family Assessment Device (FAD)[1]

FAD Domain	Group Assignment	Pre-Test Mean	Post-Test Mean
Problem Solving	FGDM (*n*=12)	10.4	10.1
	Control (*n*=12)	11.3	11.8
Communication	FGDM (*n*=12)	17.4	16.3
	Control (*n*=12)	17.8	18.0
Roles	FGDM (*n*=12)	17.4	16.3
	Control (*n*=12)	17.8	18.0
Affective Responsiveness	FGDM (*n*=12)	10.8	9.8*
	Control (*n*=12)	11.8	12.3
Affective Involvement	FGDM (*n*=12)	12.7	13.1
	Control (*n*=12)	13.0	14.0
Behavior Control	FGDM (*n*=12)	14.1	13.1
	Control (*n*=12)	13.7	15.8
General Functioning	FGDM (*n*=12)	18.2	17.8*
	Control (*n*=12)	20.3	22.1

[1] Lower scores on subscales represent higher family functioning.

* *Statistically significant differences between the FGDM and control group (p<.05).*

Family Needs. Five FGDM grantees administered the Family Needs Scale (FNS) one or more times to parents/caregivers while receiving FGDM services. The self-report scale consists of 41 items intended to help identify the areas in a family's support network that need to be strengthened to better meet the family needs. Grantees used the FNS for different purposes (e.g., screening or service planning, assessing family progress, and/or evaluating the effectiveness of the project) and reported results in varying ways. Due to the inconsistency in survey administration and reporting, outcome data could not be directly compared across grantee projects. However, there were common trends across projects in the types of needs that FGDM families faced. Across the five grantee projects, the following FNS items were commonly reported as high needs by FGDM participants at baseline/intake:

- Getting a place to live (*n*=4 grantees)
- Exploring future educational options for my child (*n*=4 grantees)
- Having money to buy necessities and pay bills (*n*=3 grantees)
- Caring for my child during work hours (*n*=3 grantees)
- Doing things with my family (*n*=3 grantees)

A comprehensive list of the most pressing family needs at each site (as reported using the FNS) can be found in Appendix K: FGDM Outcome Evaluation Findings. Findings for which baseline and follow-up FNS results were collected are summarized in the following section. Mixed trends were reported across grantees, with two grantees observing positive trends in the reduction of serious needs over time, while one grantee noted that trends in family needs remained consistent over time.

- The Children's Home Society of New Jersey collected baseline and follow-up data from intervention (*n*=47) and control groups (*n*=104) and noted a reduction in the mean number of serious needs (identified by families as needs requiring help "often" or "almost always") for both groups from baseline to case closure (Table 5-10: Children's Home Society of New Jersey Family Needs Scale Results). The grantee attributed positive trends in reducing family needs to

the work completed by grantee staff members, who provided supplemental and support services for the control and intervention groups.

Table 5-10: Children's Home Society of New Jersey Family Needs Scale Results

	Mean Number of Serious Needs	
Group Assignment	**Pre-Test Needs**	**Post-Test Needs**
FGDM (*n*=47)	7.0	3.2
Control (*n*=104)	6.3	2.2

- Homes for Black Children reported pre- and post-test data for intervention families only. The grantee did not observe any trends in reporting family needs at both time periods. This is because on average, families tended to report needing the 41 survey items less than "sometimes." At both intake and case closure, the items reported most frequently as "almost always" needing help were "having medical and dental care for my family" and "getting where I need to go."

- The Ute Indian Tribe reported FNS data at baseline and at three months after case closure. Though the grantee administered the full 41-item assessment, the local evaluation only focused on ten scale items that the grantee perceived to be most relevant to the goals of the project (see Table 5-11: Ute Indian Tribe Family Needs Scale Results). The grantee reported a reduction in the number of families with serious needs (identified by families as needs requiring help "often" or "almost always") for both groups from baseline to three months.

Table 5-11: Ute Indian Tribe Family Needs Scale Results

FNS Scale Item	Group Assignment	Number of Families that Reported Item as a Serious Need	
		Pre-Test (*n*=14)	Post-Test (*n*=11)
Having money to buy necessities and pay bills	FGDM	4	2
	Control	4	1
Feeding my child	FGDM	6	2
	Control	2	0
Getting a place to live	FGDM	6	2
	Control	3	0
Having plumbing, lighting, and heat	FGDM	6	2
	Control	3	0
Getting furniture, clothes, and toys	FGDM	7	2
	Control	2	0
Managing the daily needs of my child at home	FGDM	6	2
	Control	2	0
Caring for my child during work hours	FGDM	4	2
	Control	4	1
Expanding my education, skills, and interests	FGDM	4	2
	Control	4	1
Doing things that I enjoy	FGDM	4	2
	Control	3	1
Doing things with my family	FGDM	5	2
	Control	2	1

Parenting Stress. Three grantees (The Children's Home Society of New Jersey, Homes for Black Children, and the Ute Indian Tribe) measured parent/caregiver perceptions of children's behaviors and the stress of caring for children through the Parenting Stress Index (PSI), which assesses Parental Distress, Parent-Child Dysfunctional Interaction, Difficult Child, and Total Stress. There are two versions of the PSI: a parent/caregiver-administered version used by the Children's Home Society of New Jersey and Homes for Black Children and the youth-administered version used by the Ute Indian Tribe. While grantees reported mixed trends, the direction of change for PSI subscales was mainly positive. A notable trend across all three grantees was the overall reduction in Total Stress from intake to case closure for FGDM families (see Table 5-12: Parenting Stress Index Results).

Table 5-12: Parenting Stress Index Results[1]

Grantee	Group Assignment	Parental Distress	Parent-Child Dysfunctional Interaction	Difficult Child	Total Stress	Trend
The Children's Home Society of New Jersey	FGDM	Pre-test (*n*=47): 28.6 Post-test (*n*=45): 25.2	Pre-test (*n*=47): 25.4 Post-test (*n*=45): 23.8	Pre-test (*n*=47): 30.5 Post-test (*n*=45): 28.0	Pre-test (*n*=47): 84.5 Post-test (*n*=45): 77.0	Positive
	Control (*n*=84)	Pre-test: 26.5 Post-test: 24.4	Pre-test: 21.9 Post-test: 21.5	Pre-test: 26.5 Post-test: 26.7	Pre-test: 74.9 Post-test: 72.6	Mixed
Homes for Black Children	FGDM (*n*=8)	Pre-test: 31.8 Post-test: 25.1	Pre-test: 42.8 Post-test: 33.1	Pre-test: 53.9 Post-test: 30.2	Pre-test: 128.5 Post-test: 88.4	Positive
	Control					
Ute Indian Tribe	FGDM (*n*=16)	Pre-test: 24.7 Post-test: 22.6*	Pre-test: 22.4 Post-test: 22.8	Pre-test: 24.3 Post-test: 27.2*	Pre-test: 71.4 Post-test: 70.2*	Mixed
	Control (*n*=13)	Pre-test: 30.0 Post-test: 28.2	Pre-test: 29.7 Post-test: 27.1	Pre-test: 27.2 Post-test: 29.4	Pre-test: 88.2 Post-test: 85.8	Mixed

[1]Lower scores indicate less parenting stress.

* *Statistically significant differences between the FGDM and control group (p<.05).*

- The Children's Home Society of New Jersey observed mean PSI Total Stress pre-test scores above the 80th percentile for parent/caregiver stress for both intervention and control groups (scores which fall between the 15th to 80th percentile are considered typical; high scores are those at or above the 85th percentile). The above average pre-test scores were not surprising since the grantee targeted kinship caregivers with high needs for control and FGDM services. The grantee observed positive trends in all PSI subscales as well as the Total Stress score over time for the intervention group. Subscale scores were also lower at case closure for the control group, with the exception of the Difficult Child subscale.

- Homes for Black Children's FGDM group experienced high stress above the 85th percentile at pre-test on all PSI subscales. The highest area of stress at pre-test was the Difficult Child subscale ($\bar{X}$= 53.9). This indicated that prior to receiving FGDM, parents experienced high stress related to gaining their children's cooperation and/or managing their children's behavior. Though mean subscale scores decreased at the 12-month follow-up period, scores were still above the 80th percentile for all subscales with the exception of Parental Distress ($\bar{X}$= 25.1, 50th percentile). Positive Parental Distress scores suggest that parents tended to perceive themselves as having a higher sense of parenting competence and social support 12 months after receiving FGDM and supplemental standard of care services. The grantee explained that other stressors

may reflect structural factors beyond the ability of the program to impact within a short period of time.

- The Ute Indian Tribe reported positive trends for nearly all PSI domains for the intervention and control groups (excluding Difficult Child). The grantee found statistically significant differences between FGDM and control group mean scores at the 3-month follow-up period in the domains of Parental Distress, Difficult Child, and Total Stress. This suggests that families receiving FGDM services tended to perceive a higher reduction in stress than control group families after case closure. Although the grantee reported an increase in Difficult Child scores from pre- to post-test, the analysis indicated that FGDM families felt less stressed related to managing their children's behavior than control group families at follow-up.

Child Well-being. The Ute Indian Tribe and The Children's Home Society of New Jersey administered instruments to assess child and youth outcomes associated with receiving FGDM services. Overall, results were positive. One grantee documented improvements in child health at case closure, and another found improvements in youth functioning 3 months after service.

- The Children's Home Society of New Jersey staff members administered the Child Well-being Scale, which represents the following areas: 1) Physical and Environmental, 2) Child Behavior, 3) Education, 4) Community Engagement, 5) Child and Family Relationships, 6) Family Functioning/Resiliency, 7) Child Development/Knowledge of Parenting, 8) Nurturing and Attachment, and 9) Health Care. Pre- and post-test comparisons for the intervention group demonstrated greater and more consistently positive gains than the control group on all eight subscales from intake to case closure (see Table 5-13: Child Well-being Scale Results). The Health Care subscale was the only measure that had a statistically significant improvement over time for intervention families compared to control group families. The Health Care subscale included questions regarding the child's routine medical care, health insurance coverage, vaccination status, dental care, chronic health issues, and overall physical health.

Table 5-13: Child Well-Being Scale Results

Child Well-being Domain	Control		FGDM	
	Pre-Test (*n*=84)	Post-Test (*n*=75)	Pre-Test (*n*=47)	Post-Test (*n*=45)
Health Care	22.0	22.5	20.0	22.2**
Physical and Environmental	15.8	16.6	15.5	16.3
Child's Behavior	34.6	35.3	31.7	33.7
Education	18.3	18.1	17.0	17.6
Nurturing and Attachment	18.1	17.7	16.9	17.3
Community Engagement	11.9	12.0	11.3	11.8
Child/Family Relationships	6.9	7.1	6.4	6.6
Family Functioning/Resiliency	20.0	20.4	18.3	18.9
Child Development/Knowledge of Parenting	25.3	25.5	23.7	24.7

*** Change in mean score statistically significant (p<.01).*

- The Ute Indian Tribe administered the Youth Outcomes Questionnaire (YOQ) to parents and caregivers of youth receiving FGDM services. The survey consists of six domains: Interpersonal Distress, Somatic, Interpersonal Relations, Critical Items, Social Problems, and Behavioral Dysfunction. The grantee reported positive trends in nearly all domains of the YOQ for both the FGDM and control group. Youth in the control group had statistically significant improvements in Somatic (e.g., physical and/or somatic concerns such as headaches and stomach problems) and Social Problems domains from baseline to the 3-month follow-up period. This suggests that FGDM involvement may be associated with improvements in behavioral issues and physical health. The grantee also found statistically significant differences between FGDM and control group mean Interpersonal Relations scores at the 3-month follow-up period. This provides support that youth who received FGDM services experienced considerably less interpersonal difficulty (e.g., verbal aggression, defiance, arguing) with family, adults, and/or peers than comparison group youth. Table 5-14: Ute Indian Tribe Average Scores on the Youth Outcomes Questionnaire provides detailed YOQ results.

Table 5-14: Ute Indian Tribe Average Scores on the Youth Outcomes Questionnaire (YOQ)[1]

YOQ Domain	Control		FGDM	
	Pre-Test (*n*=14)	Post-Test (*n*=14)	Pre-Test (*n*=17)	Post-Test (*n*=17)
Interpersonal Distress	9.2	8.6	6.2	3.9
Somatic	3.4	1.8 [t]*	2.6	2.5
Interpersonal Relations	3.4	3.4	-0.1	-1.5 [F]**
Critical Items	3.4	2.6	1.9	1.4
Social Problems	2.9	1.1 [t]*	0.6	1.4
Behavioral Dysfunction	10.9	8.2	5.2	3.9
YOQ Total Score	33.2	25.6	16.5	11.5

[1] Lower scores on subscales represent higher youth functioning.

[F]** *Statistically significant differences between the FGDM and control group (p<.01).*

[t]* *Statistically significant differences between baseline and follow-up means (p<.05).*

Organizational and Systems-Level Outcomes

This section describes organizational and systems-level outcomes found for FGDM grantees. Policies and procedures prompted by Family Connection funding are described. FGDM project impact on the system of child welfare services in the community is documented, along with public child welfare integration of the grantees' service models and activities and sustainability efforts.

Impact on Child Welfare Practice

FGDM projects impacted the child welfare system in a variety of ways. Grantees described improvements in child welfare attitudes and practices, increased child welfare staff support and advocacy for FGDM, strengthened service planning, and increased family engagement. These impacts are described in detail below.

Improvement in Child Welfare Attitudes and Practices. Over half of the grantees (*n*=4) found that child welfare caseworkers adopted a more family-centered approach. A shift in the attitudes of professional staff members was noted. The family unit became the focus of attention rather than the child or parent alone. For instance, representatives from Kids Central, Inc. observed that the Florida Department of Children and Families (DCF) moved from a punitive model with many child removals toward a more supportive model of working with families to strengthen their capacity to function independently. Similarly, staff members at The Village Family Service Center noted that several county-administered child welfare agencies involved in the project began using a more strengths-based approach to services that involved families in all aspects of the service delivery system and linked them to a continuum of community-based supports. Qualitative interviews that the YMCA of San Diego County conducted with child welfare staff found that child welfare workers had a positive view of the FGDM intervention and were supportive of the availability of the service.

> "One of the areas we were lacking in was family involvement. Identifying placement options and locating absent parents was a huge tool for us to increase work in that area. It was a boost for us and helped us grow."
>
> – **Perspective of an FGDM Project Representative**

Increased Child Welfare Support and Advocacy for FGDM. A majority of private non-for-profit grantees (*n*=4) also described how projects helped raise awareness and support for FGDM among child welfare workers. Kids Central, Inc. staff members noted that CPS investigators appreciated that FTC facilitators provided support and continuity of service providers for the families. Representatives from the Ute Indian Tribe and YMCA of San Diego County described how child welfare workers who participated in FGDM often became the greatest supporters of their project. Grantee representatives perceived that child welfare caseworkers who had experienced the process were enthusiastic about the positive benefits and were more willing to refer families for FGDM services. The Village Family Service Center further described how FGDM was incorporated into new county caseworker trainings; facilitators from The Village were asked to provide FGDM training to all new child welfare workers in various counties in North Dakota. Counties also saw FGDM as a practice that could be used to address key areas for improvement based on their Child and Family Service Reviews (CFSR).

Strengthened Service Planning. FGDM strengthened the service planning process by engaging families and their support systems in planning for safe and permanent living arrangements for children and youth. FGDM project staff members from three projects perceived that FGDM allowed for more tailored service plans that were focused on the family's needs and reflected the family's input, rather than a caseworker's agenda. A representative from Kids Central, Inc. noted that while facilitators were able to help meeting participants see the big picture with the families, they were also able to help the families identify underlying needs and refer families to services beyond the FGDM meeting.

Increased Engagement of Families. Two grantees reported increased family engagement in the case planning process. Larimer County DHS (Colorado and South Dakota sites) project staff members expressed that they were able to get family members involved in FGDM planning early on in the case, which increased the opportunity to build rapport with families. Project staff members noted that the process felt less adversarial once rapport had been built with families. Partnering with The Village Family Service Center, the county child welfare workers reported that the project educated the families about

the child welfare system and provided them with information to make decisions for themselves. Additionally, the project gave children a voice and engaged children and youth in their own case planning by discussing the strengths, weaknesses, needs, and wants of the child during FGDM.

Improved Relationship with Tribes. While The Village Family Service Center was the only non-tribal agency that served Native American families, it is noteworthy that the FGDM project helped the agency establish a positive working relationship with local Tribes. Staff members noted that these relationships improved largely due to The Village staff's diligence in reaching out to the Tribes and inviting them to FGDM meetings. As one project staff member explained, "The Tribes are always invited. Initially, they thought that something would be done to them in this FGDM process, but more trust was built when they realized they had a voice in decision making."

Service Model Integration

Four grantees reported that public child welfare agencies had partially or fully integrated FGDM services into casework practice at the time of site visits. Larimer County DHS (CO, SD, and TX sites) formalized policies and procedures supporting FGDM, though meetings were already a core part of child welfare practice, and were required and written into policy prior to the FGDM projects. For Larimer County DHS (CO, SD, and TX sites), the project findings provided further justification for this policy and helped identify ways to adapt existing FGDM programs. One representative noted, "Leadership is supportive about making accommodations to make meetings happen. If we need to fly people in or fly out there or if we need to have food or transportation, we can do so. There is a lot of positive talk from the top down about how successful the meetings are." As previously mentioned, The Village Family Service Center's FGDM model was incorporated into county caseworker trainings to ensure that all new child welfare staff members would learn the model. Kids Central, Inc. facilitated all mandatory staffing meetings for child welfare investigators and contracted service providers, and thus was able to include FGDM project staff members at the table for each case to advocate for FGDM services. The grantee's Community-Based Services staffing model eliminated the project's need to rely on referrals from other agencies or departments, which was a key challenge for other grantees. The Ute Indian Tribe described plans to continue using the FGDM model as a culturally sensitive model to serve Native American families in crisis.

Sustainability

The maintenance of all or core components of FGDM projects was viewed as critical by all grantees, as they all felt a pressing need for FGDM services for their target populations within their community. This section of the report documents grantees' efforts toward project sustainability, particularly in terms of grantees' sustainability plans, policies, and procedures in place to support their program models.

Sustainability Plans and Strategies. Grantees began planning for sustainability during the second year of their projects. During this time, five grantees planned to sustain components of their FGDM projects through State/Tribal funding. Two of these grantees were State/Tribal child welfare agencies (all three Larimer County DHS sites and the Ute Indian Tribe) and had already budgeted to continue FGDM services beyond the life of the grant using existing funding streams. The Children's Home Society of New Jersey and The Village Family Service Center had previously received funding from the State for kinship services, and thus planned to continue working with the public child welfare agency to maintain resources for their Family Success Conferences. Three grantees planned to sustain FGDM services by expanding or changing their target populations. For example, the Ute Indian Tribe planned to facilitate

meetings for families in the Tribe's Victim Advocate (domestic violence) program. Homes for Black Children planned to incorporate FGDM into aftercare services in order to obtain State funding to conduct meetings. Less commonly cited plans for sustainability included manualizing the FGDM model and using a 'train-the-trainer' approach to ensure knowledge transfer within the organization.

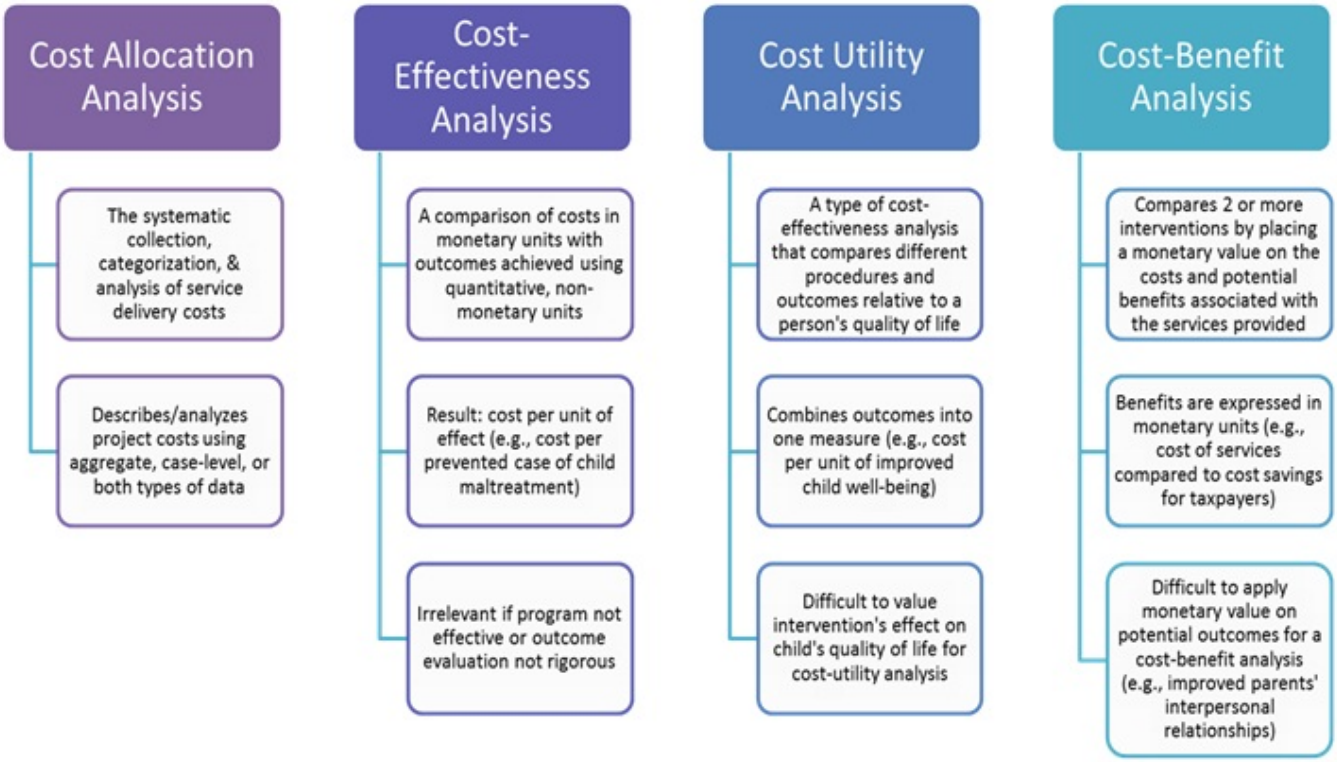
Policies and Procedures. FGDM projects developed a variety of new policies and procedures to ensure that key aspects would be sustained within their agencies with six grantees reporting formal policy and practice developments. The FGDM projects helped three grantees improve collaboration through the development of new procedures for both inter- and intra-agency referral processes. Another two grantees manualized their FGDM practices, and one grantee implemented a policy to strengthen its service model. Examples of policies and procedures developed to promote sustainability include the following:

- Referrals to another organization for continued services for families who choose not to participate in the FGDM project (The Children's Home Society of New Jersey)
- Integrating/adapting of a more family-focused component of FGDM into previous family meeting practice models (Larimer County DHS (CO, SD, and TX sites))
- Developing a systematic, refined process of tracking referrals from other agencies to the project (Ute Indian Tribe)
- Developing an online FGDM facilitator manual, consisting of forms, references, and resources to enhance facilitation skills and engage families (The Village Family Service Center)
- Developing a Child Welfare outreach protocol that required staff members to refer all voluntary child welfare cases to the FGDM project (YMCA of San Diego County)
- Developing an FGDM practice manual (Kids Central, Inc., YMCA of San Diego County)

Cost Study Methodology and Results

The 2011 Family Connection funding announcement required grantees to present a plan to conduct a cost analysis, stating that projects funded under this FOA were expected to "conduct a cost analysis that will provide State, local and Tribal policy makers with the information they need to make more thoughtful decisions about resource allocation in their communities." During the 3-year funding period, grantees developed and implemented cost study plans focused on providing expenditure data for use by local project administrators, key project partners, and future partners and funders. Projects varied in the types of cost studies conducted because studies were tailored to the needs of local stakeholders. Figure 5-1: Cost Study Designs provides examples of the most common cost study approaches and the types of inferences that can be drawn from each method.

Figure 5-1: Cost Study Designs



Grantee Cost Study Designs

All seven grantees developed plans to assess the basic cost of providing FGDM services at either the project-level or case/family-level (or both for some grantees), which is a form of cost allocation analysis. Data generated from these analyses provide information such as the cost per adult, child, and family served. This type of cost study has been described as the critical first step in any economic evaluation and provides the essential foundation for all other types of analysis.[50] Grantees' detailed cost study plans are located in Appendix K.

Three grantees (Homes for Black Children, Kids Central, Inc., and The Village Family Service Center) also conducted a comparison of the costs of their FGDM projects with the costs associated with other child welfare programs/services, such as the cost for the control group or the cost of child welfare involvement. For instance, Homes for Black Children planned to conduct a comparison between project costs and social costs prevented due to project participation, while Kids Central, Inc. compared FGDM costs to other interventions such as Family Behavioral Therapy. This level of analysis required grantees to collaborate with local community partners such as public child welfare agencies to obtain data for comparison.

[50] Foster, E. M., Porter, M. M., Ayers, T. S., Kaplan, D. L., & Sandler, I. (2007). Estimating the costs of preventive interventions. *Evaluation Review*, 31, 261–286.

Cost Study Data Sources

Grantees used multiple sources to obtain cost data, including project tracking databases and spreadsheets; administrative and cost data provided by fiscal, project and administrative staff; time tracking logs; time tracking surveys; and expenditure estimates provided by the public child welfare agency. While most cost studies required project staff members to track their time for key activities, grantees varied in the timing of cost data collection. For instance, while The Children's Home Society of New Jersey required FGDM coordinators to track their time in monthly logs, Kids Central, Inc. conducted a brief time study over two different 1-week periods to identify staff time commitment to various FGDM-related activities.

Project Services Included in Cost Study

Grantees' cost studies were comprised of project expenditure data for both direct and indirect services that were key components of their FGDM projects. The types of project services tracked were specific to local projects, though grantees tracked some services that were common across the grants cluster for the cost study.

Direct Services. Direct service activities require project staff members to have contact with and engage with their clients face-to-face, over the telephone, or by e-mail. The direct service activities tracked by grantees for the cost study included FGDM meetings with families; meeting preparation and coordination (e.g., preparing family members and service providers for meetings); follow-up conference activities (e.g., conducting home visits, monitoring families prior to case closure); case management services; and family recruitment/enrollment in the project.

Indirect Services. Indirect service activities can be conducted on behalf of the client without the client or family present and include activities related to implementing services such as prep-work, case documentation, and reading about the family's background prior to meeting them. Indirect service activities tracked by grantees for the cost study included transportation and travel for meetings or training; meeting preparation and coordination (e.g., scheduling meetings, making childcare arrangements); follow-up conference activities (e.g., completing surveys, documenting case notes); staff management/supervision; training and consultation; collaboration (e.g., participating in community committees); outreach; developing and preparing project materials; screening and receiving referrals to the project; and reporting/documenting case notes.

Cost Study Results

Four grantees provided cost study data in their final evaluation reports. Two grantees (Larimer County DHS and Ute Indian Tribe) received no-cost extensions beyond the third year, and thus did not provide cost data by December 31, 2014. Grantees' cost study findings showed that the cost of implementing FGDM services ranged across the projects based on the specific FGDM service models adopted by grantees. While facilitating the FGDM meeting itself was a low-cost activity, preparing for the meeting and providing supplemental services (such as mentoring and advocacy) was a significant cost driver. Key findings are documented in Table 5-15: Key Cost Study Findings across Grantees. Despite the variance in costs, grantees found that overall, conducting FGDM services for the purpose of maintaining children in their homes was less costly than foster care services. While this suggests potential for cost savings to the child welfare system, more rigorous outcome and cost evaluations would provide stronger evidence to

support the effectiveness (both in terms of cost and impact) of the FGDM intervention. Individual grantee cost study findings are detailed below.

Table 5-15: Key Cost Study Findings across Grantees

Grantee	Cost Study Timeframe	Project Cost Findings
The Children's Home Society of New Jersey	3 years	• Direct Cost Project Rate[1]: $33.39/hour • Average cost of FGDM per family[2]: $552 • All project costs [3]: $7,709/family; $156.25/hour
Homes for Black Children	72 weeks	• Average direct costs[4] for FGDM and Standard of Care (control) services per family: $364.29; $10.41/hour • Average direct costs for FGDM and Standard of Care services per adult: $364.81; $11.23/hour • Average direct costs for FGDM and Standard of Care services per child: $349.27; $13.67/hour
Kids Central, Inc.	12 months	• Cost per referral per family[5]: $2,905.49 • Cost per successful case closure per family: $7,230.70 • Cost per day in project: $31.01
The Village Family Service Center	12 months	• Direct and Indirect FTDM/FGDM Cost Rate[6]: $528.13/hour • Average cost per FTDM: $3,873; $435.73/hour • Average cost per FGDM: $9,394; $435.73/hour

[1] The direct cost project rate for CHSofNJ is provided for both Phase 2 and Phase 3, and was determined using the hours of service per family plus group work, the average staff member's hourly rate (including fringe benefits), and the number of client families served.
[2] This number represents the cost of FGDM activities (staff costs only).
[3] All project costs at CHSofNJ include a combination of direct services costs along with staff support services such as outreach, training and consultation, overhead, evaluation, and administrative costs.
[4] The direct cost project rate for HBC is for the costs associated with work with both the Standard of Care (control) and FGDM families, and includes staff time for the Case manager, Counselors, Parent Advocates, and Life Enrichments activities.
[5] Costs for Kids Central, Inc. are intervention-specific (e.g., excluding the cost of grant-specific activities such as training, evaluation, and travel).
[6] The direct and indirect cost project rate for The Village includes FGDM/FTDM staff time for preparation, conference, private time, reporting, post-conference, and travel.

The Children's Home Society of New Jersey. The grantee conducted a cost allocation analysis by calculating the overall cost of implementing services for Phase 2 (the Trust Building/Service Provision stage of services which all families receive) and Phase 3 (Family Success Conferencing/FGDM services for families who elect to participate) of the project. These phases were used as the control and intervention group for the evaluation, respectively. The grantees also calculated the cost per family for each phase, and specific costs associated with the FGDM. The grantee collected salary and cost data (provided by the agency CFO) and data logged by project staff members. On a monthly basis throughout the 3-year project, staff members classified their activities using established categories and recorded the length of time of each activity. Hence, the cost study data represent project costs for the entire duration of the project. The grantee's key findings are documented in Table 5-16: The Children's Home Society of New Jersey 3-Year Project Expenses.

Table 5-16: The Children's Home Society of New Jersey 3-Year Project Expenses

Project Expense	Project Phase	Per Hour Rate in Dollars	Total Staff Hours	Average cost per Family in Dollars
Direct Services (Personnel Costs)[1]	Phase 2 (control)	$33.39	2,335	$886.00
	Phase 3 (FGDM)	$33.39	2,875	$2,042.00
Total Project Cost[2]	All Phases	$156.25	6,661	$7,709.00
Family Group Conference Costs[3]	Phase 3 (FGDM)	$33.39	1,009	$552.00

[1] The hours of service per family plus group work
[2] The cost per family for the total program, including staff support services (e.g., outreach, training and consultation) as well as the agency's standard overhead, evaluation and administrative costs
[3] Family Group Conference costs were based on staff time spent on the following activities: preparation for the conference; preparation with the family for the conference; facilitating the conference; providing supports such as child care; and post-conference updates.

Based on a combination of the hours of service per family and group work logged by staff on a daily basis, the average staff member's hourly rate ($33.39 per staff hour, which includes fringe benefits), and the number of clients served, the grantee determined that the cost per family for direct services was $886 per family for families completing Phase 2 of the project and $2,042 per family for families completing Phase 3. Total project cost was further calculated by converting the direct service costs, all other project costs, and the agency's standard overhead, evaluation, and administrative costs into an hourly rate of $156.25 per hour for all project costs (a total project cost of $7,709.00 per family). The grantee determined the specific costs (based on staff time) associated with the FGDM conference, which was the focus of the intervention. Based on the average staff member's rate of $33.39 and a total of 1,009 hours of services, the cost of providing FGDM conferencing activities was $552 per family.

The grantee's analysis reveals that the cost of solely conducting FGDM activities was relatively low (about $552 per family), considering the potential cost savings. While preparing families for FGDM requires additional staff time and costs compared to standard service provision, the combination of providing supportive services and FGDM could help reduce costs for the public child welfare agency by preventing disruption of placement of children in these kinship homes and preventing additional children from entering the child welfare system.

Homes for Black Children. The grantee determined the direct costs associated with providing FGDM meetings and supplemental standard of care services (which all families receive, regardless of being randomized into the intervention group or not). Standard of care services included learning resources, Parent Club Facilitator, Life Enrichment Activities Coordinator, and parent education. The grantee's cost data provided an overview of project expenses (from April 1, 2013 to September 30, 2014). The grantee's cost data are documented in Table 5-17: Homes for Black Children 72-Week Direct Cost Expenses.

Table 5-17: Homes for Black Children 72-Week Direct Cost Expenses

Unit	Per Hour Rate in Dollars	Total Staff Hours	Average Cost in Dollars
Adult (*n*=195)	$11.23	6,334.7	$364.81
Child (*n*=26)	$13.67	664.3	$349.27
Family (*n*=200)	$10.41	6,998.9	$364.29

Based on the number of hours staff worked with adults/children/families, salaries, FTE, and hourly staff rates, the grantee determined the dollar value of staff's direct service hours during the 72-week timeframe. Factoring direct costs only, which included coordinating and being involved in the FGDM meeting with families (an average of 4 hours per family), follow-up home visits (an average of 10 hours per family), and staff, the average per adult served (*n*=195) was $11.23 per hour; the average cost per child (*n*=26) was $13.67 per hour; and the average cost per family (*n*=200) was $10.41 per hour. Project staff spent the most amount of time working at the family-level (a total of 6,998.9 hours during the 72-week timeframe), followed by the adult-level (a total of 6,334.7 hours), and finally at the child-level (a total of 664.3 hours). Parent Advocates (mentors assigned to conduct weekly home visits with the family, invite family members to FGDM meetings, and support families as they execute the Family Resiliency [FGDM] service plan) provided the majority of direct services, averaging 60 percent of all costs.

The grantee obtained estimates for the annual cost for placing one youth in foster care from the National Resource Center for Permanency and Family Connections.[51] The center's report determined that the annual costs for placing one youth in foster care in the United States ranges from $27,000-42,000. Based on this information, data suggest that if the project is able to prevent the removal of a child (or children) from the home or maintain the child safely within the home, then FGDM would provide cost savings for the public child welfare agency.

Kids Central, Inc. Using program-level costing, the grantee determined the full cost of implementing the project, including training, evaluation, and dissemination expenditures for a 12-month grant period. (See Table 5-18: Kids Central, Inc. 12-Month Project Expenses for a detailed description of items included in the total cost.) Taking into account the project's total cost for an average year ($812,647.11, which included both intervention-specific and grantee-specific costs), it was determined that the cost per referral (*n*=219) into the project was $3,710.72, and the cost per successful case closure (*n*=88) was $9,234.63. The cost per day in the project (given that the average case duration was 93.7 days) was calculated to be $39.60 per family.

[51] Grantee retrieved national foster care cost information from the Measuring the Costs of Foster Care and the Return of Investment for the "Great Expectations" Initiative (2011), extracted from http://www.nrcpfc.org/education_summit/meeting_materials/day1/Workshop%20G_Measuring%20the%20Costs%20of%20FC_Great%20Expectations%20Initiative.pdf

Table 5-18: Kids Central, Inc. 12-Month Project Expenses

Cost Category	Cost Elements	Actual Project Expenditures Total in Dollars
Intervention-related costs	Project oversight and administration salary	$636,301.44
	Fringe	
	Deveraux Foundation (Service Provision and Supervision)	
	Administrative overhead	
	Match: Cash and cost sharing	
Non-intervention costs (grant-specific)	Training	$176,345.68
	Publication/Printing	
	Dissemination	
	Evaluation	
	Travel	
	Match: Cash and cost sharing	
	TOTAL COST	**$812,647.11**

The grantee also provided cost estimates for the project without grant-specific activities included (i.e., intervention-specific costs only), which resulted in lower cost estimates. The grantee determined that the cost of FGDM staff for one year of service provision, administration, and supervision was $322,133.08. The total intervention-related costs amounted to $636,301.44. The cost per referral (*n*=219) into the project was $2,905.49, and the cost per successful case closure (*n*=88) was $7,230.70. The cost per day in the project (given that the average case duration was 93.7 days) was calculated to be $31.01 per family.

Intervention-specific costs were compared to two other diversion service provided by Kids Central, Inc. (See Table 5-19: Cost Comparison with Other Kids Central, Inc. Diversion Services.) Family Behavioral Therapy was implemented by the grantee in 2013 as a diversion service, and a cost comparison indicates a similar cost as the FGDM intervention. The grantee also compared FGDM costs with other (non-evidence based) diversion programs. Compared to FGDM, the programs were offered at a lower cost ($2,040.00 per referral) but with shorter, less intensive service duration (which increased the cost to $68.01 per day).

Table 5-19: Cost Comparison with Other Kids Central, Inc. Diversion Services

Intervention	Cost Per Day in Dollars	Average Total Cost Per Referral in Dollars
FGDM	$31.01	$2,905.49
Family Behavioral Therapy	$27.31	$2,731.00
Other Diversion programs	$68.01	$2,040.00

Kids Central, Inc. reviewed recidivism data and obtained data on the average cost of out-of-home care to conduct a cost avoidance analysis. On average, the grantee found that it costs $9,000 per child for

out-of-home care. Grantee data indicated that families served by the agency had an average of two children per case, which led to a potential cost of $18,360 per family for foster care entry. Because the grantee was able to find statistical evidence to support the effectiveness of FGDM in reducing the rate of recidivism for diversion families, the data support FGDM as a cost-effective service for diversion cases.

The Village Family Service Center. The grantee used program-level costing to determine costs for FTDM and FGDM meetings. Per The Village's service model, FGDM meetings take significantly more time for meeting preparation and facilitation than FTDM. The grantee's cost data provided a 12-month overview of project expenses (September 30, 2013 to September 29, 2014). Taking into account the project's total cost for an average year ($812,647.11, which included both intervention-specific costs and non-intervention [grant-specific] costs), it was determined that the cost per project referral (*n*=219) had an average cost of $3,710.72 per family. The cost per successful case closure had an average cost of $11,386.48 per meeting.

The grantee also provided cost estimates for the project without infrastructure support (i.e., facilitator and personnel costs only), which resulted in a lower hourly cost of $435.73, with an average cost of $3,873 per FTDM meeting and $9,394 per FGDM meeting. The grantee's key findings are documented in Table 5-20: The Village Family Service Center 12-Month Project Expenses.

Table 5-20: The Village Family Service Center 12-Month Project Expenses

Intervention Model	Total Staff Hours	Average Staff Hours Per Meeting	Average Cost Per Meeting in Dollars (Direct and Indirect Costs)[1]	Average Cost Per Meeting in Dollars (Direct Costs Only)[2]
FTDM	259.9	8.89 hours	$4,689.07	$3,873.00
FGDM	489.0	21.56 hours	$11,386.48	$9,394.00

[1] This calculation also includes support for infrastructure (rent, supplies, etc.).
[2] This calculation only includes facilitator personnel and benefits expenses.

The Village obtained cost-of-care information from the public child welfare agency to determine the cost of maintaining a child in foster care for 6 months. Findings showed that the cost of an emergency FTDM meeting has potential for cost savings to the child welfare system ($3,873 per FTDM meeting or $9,394 per FGDM meeting, compared to $13,701 for 6 months in foster care per child). Further, the cost-of-care figure for foster care does not include tertiary expenses such as the costs of social service personnel and infrastructure. The data suggest that if the intervention is able to prevent the removal of a child (or children) from the home or if it can reduce time in care, then FGDM and FTDM would provide thousands of dollars in cost savings to the State of North Dakota.

Section 6: Project and Evaluation Lessons Learned from Grantees

The 2011 FGDM grantees gained a great deal of knowledge over the course of their 3-year projects. Lessons learned from implementation and evaluation of the FGDM projects were of benefit to current grantees, and may be applicable to future grantees and other stakeholders interested in applying FGDM to similar target populations served by grantees to prevent entry/re-entry into foster care. Information regarding lessons learned was collected from the grantees' executive leadership and project management, project staff members, service providers, community partners (e.g., referring child welfare caseworkers), and evaluators. Their insights on the project and its evaluation can be found in Appendix L: Grantee Lessons Learned and are summarized below.

Lessons Learned from a Project Implementation Perspective

Grantees' own lessons learned and recommendations to other organizations in regard to the successful planning, implementation, and maintenance of similar projects addressed serving families, collaborating with partners, achieving positive outcomes, and evaluating project services. Several recurring themes were identified in the grantees' responses to questions about successfully implementing FGDM, including project planning, communication, staffing, and training.

Thoughtful and Thorough Project Planning. All seven grantees noted the substantial amount of time and effort required to bring the necessary people together, think through grant objectives, and develop effective plans for incorporating FGDM into their continuum of services. Grantees emphasized the importance of engaging leadership and service providers early in the planning process. This increased the likelihood that the project achieved the intended outcomes because the plan had the necessary supports, and front-line staff members who ultimately carried out the plans made the decisions. Respondents at all levels also emphasized the importance of proceeding slowly when implementing FGDM services in order to ensure that all appropriate factors had been taken into consideration.

Clear and Ongoing Communication Among Key Project Stakeholders. Implementing the FGDM projects required effective communication among staff members at all levels within the project: between the grantee and partnering service providers; referring community organizations and their project evaluators; and most importantly, between family group coordinators and facilitators and the families they served. Grantees noted that a lack of communication or miscommunication was often directly related to aspects of the project identified by grantees as not working as well as planned. At an organizational level, it was particularly important that all individuals contributing to the FGDM process understood the intent of the model, in addition to their roles in the process in order to achieve optimal outcomes.

Staffing Projects with Qualified, Skilled Facilitators. Coordinators and facilitators played a pivotal role in engaging, educating, and supporting families as they progressed through the FGDM process. Grantees noted that the objectives of the intervention were substantially impacted by the manner in which the facilitator approached and interacted with the family, the extent to which he/she could engage and empower the family, and how effectively the facilitator could prompt the family into taking the lead in addressing and identifying solutions to their problems.

Informing and Training all Project Stakeholders on the FGDM Process. FGDM grantees recognized that educating executive leadership, partner organizations, and all staff members involved in the FGDM process (including staff involved in the recruiting and referring families to the project) was critical to successful implementation. Informing individuals about FGDM helped reduce concerns among staff members that were not as familiar with the purpose or intended outcomes of the process, and helped project managers obtain the necessary staff member support to implement the interventions. Training staff members who were directly engaged in the process was essential to maximize knowledge and skills of staff members, and to ensure that FGDM meetings were conducted with fidelity to the models.

Lessons Learned from an Evaluation Perspective

Perspectives on the evaluation were obtained from the evaluators of the grantees' projects and other project stakeholders. Six of the seven project evaluators noted that in hindsight, they might have made changes in communication, evaluation instruments, and evaluation design.

Frequent and Open Communication between Project Staff and Evaluators. Grantees described the importance of developing a collaborative relationship between project and evaluation staff members. Conducting regular meetings contributed to keeping all projects and evaluation staff members informed on project and evaluation modifications and builds understanding of the purpose of evaluation among service providers. For grantees whose evaluations and project staff members collaborated as a team, project personnel were seen as being more invested in the evaluations and participated in making evaluation-related decisions. Additionally, evaluators who regularly shared evaluation findings with project staff members found that staff members were more engaged and active in the evaluation process.

Assess the Appropriateness of Evaluation Instruments and Forms. Evaluators had several factors to consider when selecting and designing evaluation instruments for their FGDM projects. It was necessary for the evaluators to consider the amount of time required to administer instruments and other service documentation required for the evaluations (e.g., meeting logs) in order to avoid participant and staff burden. Additionally, evaluation staff members described the importance of conducting preliminary analyses on instruments to test for reliability, sensitivity, and ceiling effects. Evaluators advocated addressing these issues early in the evaluations to ensure that the outcome results are valid.

Select Project Outcomes That Can Be Demonstrated Within a 3-Year Time Period. The limited funding period for Family Connection grants required evaluators and project leaders to select safety, permanency, and well-being outcomes that could feasibly be demonstrated within the 3 years of the project. While many safety and permanency outcomes were considered short- and/or intermediate-term outcomes that were impacted by FGDM services, grantees required more time to assess the well-being impact of the projects on children and families. Several grantees found that due to start-up delays during the first year (primarily caused by IRB, staff selection and training, and project partner issues), projects had limited time to fully implement project services and assess outcomes before they had to begin closing out their projects. This, in turn, had a substantial impact on the evaluation sample sizes for these grantees. Grantees noted that having additional time to fully implement the FGDM projects would allow for more rigorous evaluation approaches.

Section 7: Conclusions and Recommendations

This section summarizes key process and selected outcome evaluation findings of the FGDM projects and poses observations about the overall 2011 FGDM cluster. Limitations of the cross-site evaluation are described. The section concludes with recommendations for the child welfare field based on overall report findings.

Key Family Group Decision-making Observations

This cross-site evaluation explored the implementation and evaluation efforts of FGDM services involving voluntary populations at-risk of child abuse or neglect through qualitative and quantitative research methods. Semi-annual report reviews and in-depth discussions with representatives from all seven 2011 Family Connection grantees provided insight into how grantees executed their FGDM projects, accounting for local-level context and exploring cross-site trends and variations. Implementation science literature guided a review of grantees' organizational characteristics to determine the extent to which grantees addressed challenges to implementing and evaluating project activities and services. Process and outcome data provided detailed information on FGDM service models and general characteristics of grantee projects, collaboration with key partners, project leadership and staffing characteristics, challenges and facilitators to project implementation and evaluation, and organizational and systems-level impact of the projects. A summary of key cross-site evaluation findings, provided below, is organized and presented under the corresponding cross-site evaluation research question.

➢ ***What are the characteristics of the children, parents, and families served by the FGDM projects?***

- Although services were open to children between the ages of birth and age 18, grantees tended to serve younger children between the ages of 4.2 to 11 years. This had implications for the types of services caregivers needed assistance obtaining, and the types of services and resources FGDM service providers should have familiarity with in their communities (e.g., parenting classes, respite/childcare, and early childhood education).

- Fifty-three percent of adult caregivers served across the projects were male. While past research suggests that service provider gender bias can alienate fathers from case planning,[52] FGDM grantee practices made proactive attempts to promote paternal involvement in FGDM meetings. Grantees included fathers in the FGDM whenever possible (without compromising the safety of those involved in the meetings), and made arrangements to include maternal and paternal families in the FGDM process.

- Findings suggest that families who voluntarily participated in FGDM services may also be involved in multiple systems. While only 17 percent of adults served had prior legal system involvement, 31 percent of families had a history of drug and alcohol issues and 37 percent had domestic violence issues. Half of the children served across the projects had prior involvement with the child welfare system.

[52] Franck, E. J. (2001). Outreach to Birthfathers of Children in Out-of-Home Care. *Child Welfare, 80*(3), 381–99.

- Domestic violence was a prevalent issue across FGDM projects. One third of the adult caregivers served (37 percent) had a history of domestic violence, either as a victim or abuse or the perpetrator. Grantees addressed domestic violence in a variety of ways, including screening for these issues prior to the FGDM meetings, making alternative arrangements to include both maternal and paternal families when safety issues arose, providing referrals to local community and Tribal agencies specializing in services to individuals and families impacted by domestic and sexual violence, and bringing together supports for both the victim and the perpetrator to build a safe environment for all parties.

- Four grantees sought to reduce disproportionality in their child welfare system (i.e., the overrepresentation of specific populations) by targeting African American or Native American children and their families to receive project services. These populations have been demonstrated to have the highest rates of child abuse and neglect.[53] The implementation and evaluation of FGDM services provided to these populations may help identify culturally appropriate practices and enhance effectiveness in working with African American and Native American families.

➢ ***What are the service models, interventions, and activities implemented by the FGDM projects?***

- All grantees implemented and evaluated FGDM models for long-term planning, which required time for preparing and engaging family supports. The timing for these meetings was flexible, as preparing stakeholders and coordinating meeting logistics required many hours of planning, often over several months. Two grantees implemented additional short-term planning meetings for high-risk cases in which emergency planning of the child's safety and well-being was necessary. For these cases, the timing of the meetings was critical and meetings were required to be conducted within 24 to 72 hours of a report/removal.

- Although grantees adopted various FGDM models, they all placed family strengths, family engagement, and informed family decision-making as core values in approaches to working with children and families. Key service model characteristics across the projects included heavy reliance on referrals from internal or external partners to reach their target populations; a built-in preparation phase to fully explain the FGDM process to families, children, service providers, and other stakeholders invited to participate in the meeting; resources (i.e., space, time, staff members) for FGDM meeting facilitation; and follow-up meetings to support the family and track family progress.

- Adapting project service models was a common practice for a majority of grantees. Five grantees made changes to their service models and key activities (including FGDM practices) over the course of the grant period. These changes were made in response to project evaluation findings and stakeholder feedback. Grantees viewed this as an adaptive capacity that helped them remain responsive to the dynamics of the project and to provide a cultural match with their target populations.

[53] Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. (2012). Child Maltreatment 2012. (Contract Order HHSP233201200657G). Washington, DC: U.S. Government Printing Office. Chapter 3: 20, 23, 37.

- Family engagement was also critical to the success of FGDM, though grantees identified several key challenges that impeded family participation in meetings. These included a lack of understanding of the purpose of FGDM, difficulty bringing family supports to the table (either because they were difficult to find/reach, or because of family discomfort in involving others), and families' lack of trust (due to negative past experiences with CPS). Despite these challenges, grantees developed family engagement strategies that promoted family participation in the FGDM process. The most commonly cited engagement practices included empowering the family to lead the process, maintaining flexibility in planning meeting logistics, and fully preparing the family for the meeting.

- Grantees engaged a combination of formal and informal family supports in FGDM. Across the projects, stakeholders invited to the FGDM meetings included extended families, children, maternal and paternal families, and service providers. Grantees involved more informal supports (e.g. extended family, kin, friends and non-professional services) than formal supports (e.g., service providers) in FGDM meetings. This finding is aligned with FGDM practices suggested by FGDM experts and training consultants.

➢ ***What amount and mix of services are provided to parents, children, and families participating in FGDM meetings?***

- In combination, the seven FGDM grantees served 1,441 children, 893 adults/caregivers, and 1,143 families throughout the 3-year funding period. These numbers represent the total number of children, adults, and families that projects were able to reach through FGDM and/or other supplemental services and activities funded by the grants.

- The total number of children, adults, and families served throughout the project period varied across grantees due to several factors, including differences in grantee FGDM service models, geographic scope of the Family Connection grant, organizational capacity of grantees, and the projected numbers of families intended to be served. A majority of grantees reported that they overestimated the number of families that would be referred to their projects by internal and external partners. Subsequently, the total number of FGDM meetings held ranged from 16 to 323 across FGDM projects.

➢ ***What is the quality of service implementation in regard to timeliness, fidelity, and administration?***

- FGDM model fidelity assessments yielded information regarding disparities in facilitator and family perceptions of the family's role in the process, factors that might inhibit facilitators' adherence to the models, and the need to balance process adherence and responsiveness to families in FGDM meetings. Findings of the fidelity assessments across the projects were positive, and indicated that high-quality FGDM meetings were conducted. Results for grantees that assessed the fidelity of their project service models showed that the projects closely adhered to the processes detailed in their service models.

- ***How do the FGDM projects pursue continuous quality improvement as a way to improve services?***

  - FGDM grantees engaged in continuous quality improvement by assessing fidelity to the FGDM models and applying the findings to their projects' practices. All seven grantees conducted fidelity assessments to assess compliance with their FGDM models or overall project service model.

  - The majority of project evaluators shared fidelity assessment findings with key staff members and project stakeholders. Fidelity findings were shared with the grantees' executive leadership, project managers, project staff members, and other project partners. In addition to providing updates on project outputs (e.g., numbers served, services provided), the evaluators shared information regarding participant responses to the FGDM process, and the extent to which meeting facilitators consistently adhered to their chosen FGDM and service model with fidelity.

  - Across the projects, leadership was responsive to fidelity assessment results. A majority of the grantees developed new policies and procedures to improve the quality of service provision. Procedural changes included modifying or implementing new referral practices, expanding or implementing new training materials, modifying their FGDM models, and changing enrollment protocols and practices.

- ***How do FGDM grantees select, develop, and sustain staff member's ability to effectively implement project services?***

  - Successfully implementing FGDM requires a comprehensive team of project leaders, staff, and partnering agencies. Key contributors to the FGDM process included project leadership, case managers and supervisors, service coordinators, and facilitators. Internal and external partners included referring caseworkers and service providers (e.g., family preservation workers and county child welfare staff). Implementing and delivering FGDM services required participation from the following categories of staff: executive leadership, project management, direct service supervisors, service providers, project partners, data administrators, and evaluators.

  - Implementing direct project services was the responsibility of FGDM coordinators and facilitators with the guidance of their supervisors. All grantees indicated that a successful FGDM facilitator must have strong knowledge of and experience working with families. Other required characteristics identified by grantees included (in order of frequency) people skills, group management/leadership skills, good communication skills, passion for serving and advocating for families, and an ability to work on a team. The ability of staff members to engage, inform, and support families throughout the FGDM process was essential for successful implementation of the intervention.

  - Six FGDM projects experienced staff member turnover throughout the course of the Family Connection grant. The most frequently cited reason for staff attrition was promotion or an opportunity for advancement. Other reasons for staff turnover included career change, retirement, relocation, performance issues, burnout, and illness. Three grantees indicated that the turnover substantially disrupted implementation of the FGDM projects due to the low number of staff members available to provide services. However, tenure was high for staff

members who remained in their positions. Seventy-seven percent of project stakeholders had been in their roles for 2 or more years.

- All grantees reported that ongoing training and professional development activities related to the FGDM projects was provided to staff members. Training topics included FGDM principles and processes; use of a specific FGDM model; and trauma, substance abuse, and domestic violence services. Most grantees received training from the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect at the University of Colorado. In general, grantees identified several training strategies that were most useful, which included role-playing, presentations conducted by FGDM experts, informal peer-to-peer discussions, and observing or attending an FGDM meeting. Additional strategies noted as useful by grantees included receiving immediate feedback from practice sessions, shadowing facilitators, and solution-focused training on engaging hard to reach populations. Stakeholders from over half of the projects reported that increased training efforts improved their commitment to practicing the FGDM models with fidelity.

- The majority of FGDM grantees reported that they provided regular coaching and supervision to project staff members, particularly FGDM coordinators and facilitators. FGDM model developers were often involved in coaching and supervision through regularly scheduled consultations with supervisory staff members. The overall objectives of the projects' coaching and supervision activities included ensuring quality of services and fidelity to the FGDM models. All grantees who provided coaching and supervision provided this guidance in individual and group settings (e.g., individual supervision sessions or case staffing meetings). This practice provided staff members with an ongoing source of support and the opportunity to receive feedback on specific family issues and challenges. Other methods used to provide continuing instruction and support included mentoring and coaching staff members and enlisting a consultant to meet with facilitators on an as-needed basis.

➢ ***How do FGDM project leaders promote, guide, and sustain effective project implementation?***

- Strong leaders played a key role in project management and delivering FGDM services. All grantees reported having a 'project champion' who was actively involved in developing the Family Connection grant proposals. Each grantee organization was led by individuals who played a significant role in conceptualizing the project to ensure a good fit with the organizational mission and the needs of the service population. Nearly all grantees indicated that project leaders supported staff members and openly worked with them to achieve implementation goals.

- FGDM grantee leadership and project staff members described adaptive and technical leadership strategies used to obtain and maintain support for the FGDM project. The most frequently identified strategy was regular communication with staff members regarding project progress. Providing project updates to staff members and partners was critical for FGDM grantee leadership to sustain the momentum of the FGDM projects. Strategies that were mentioned less frequently included supporting staff members in the FGDM process, providing staff member training opportunities, building capacity among project leaders, conducting outreach to stakeholders, and providing evaluation support. Dissatisfaction with project leadership was due to a lack of information sharing regarding the evaluation component of the project and how it impacted their work.

- ***To what extent do FGDM projects collaborate with key partners, particularly child welfare agencies, to serve children and families?***

  - Interagency collaboration was noted by grantees as one of the greatest facilitators of FGDM project implementation. Through formal and informal partnerships, grantees utilized external service providers, local community organizations, public child welfare agencies, and organizations providing evaluation and other technical assistance to address the needs of children and families. All grantees worked with the public child welfare agency to implement their FGDM projects as a primary collaborative partner or as a secondary partner to provide referrals and coordinate services. Five FGDM grantees reported having pre-established working relationships with their partnering agencies prior to implementing their FGDM projects.

  - Over half of the grantees reported that collaboration helped address service gaps and expand FGDM services. Project partners assisted grantees by providing resources and services the grantees did not have the ability to provide. Collaboration also increased the overall support of FGDM projects and established shared risk and responsibility among partnering agencies. The majority of grantees cited regular and open communication and common goals as important factors in establishing and maintaining positive collaborative relationships. Despite the benefits of partnerships and efforts to enhance them, grantees identified collaboration challenges regarding different organizational policy and procedures, opposing service goals, staff turnover issues within partner departments/agencies (particularly with child welfare workers), and conflicting service provider schedules.

  - Grantees listed benefits for both private/not-for-profit and public child welfare agencies providing FGDM services to prevent foster care entry/re-entry. Grantees' perceived advantages to private/not-for-profit FGDM service provision included the ability to maintain neutrality, flexibility to allocate resources to project evaluation, promoting shared responsibility and decision-making among partnering agencies, providing comprehensive services, and leveraging community resources to address service gaps. Grantees also identified several benefits to public child welfare agencies providing services. Having child welfare staff members in centralized locations was seen as a facilitator to internal communication and service delivery. Communication regarding project progress and updates was easier when staff members were located within the same agency. It also greatly reduced confidentiality issues related to data and information sharing. Additionally, child welfare caseworkers were seen by grantees as having a better understanding of the child welfare system and were in a strong position to coordinate family engagement in FGDM since they are the ones who work with families and carry the cases.

- ***What facilitators and challenges do FGDM projects experience in implementing and evaluating services?***

  - Facilitators to project implementation included supportive leadership, project planning during the start-up period, dedicated project staff, and the strengths-based and empowerment focus of the FGDM model.

    - Early involvement of leadership resulted in positive working relationships between project staff members and set the tone for later stages of the project. Critical processes developed during the start-up period included implementing the work plans, selecting

and training staff members, reviewing evaluation plan activities, documenting FGDM policies, procedures, and logistics, and recruiting families.

  - The strengths-based and solution-focused nature of the FGDM interventions motivated project staff members to provide services in non-directive ways aimed at strengthening families' abilities to identify solutions to their problems.

- Facilitators to project evaluation included collaboration between project staff members and evaluators, reliable assessment instruments, data management systems used to improve services, and staff members' preparation and training.

  - The relationship between evaluators and project staff members was most successful for grantees that used collaborative approaches such as including evaluator participation in project planning meetings, ongoing communication, training project staff members on evaluation and their roles in data collection, and sharing evaluation findings with project staff members and partners.

  - Evaluators were confident in the effectiveness of projects' evaluation instruments to capture process and outcome data, particularly for the Parenting Stress Index (PSI) and Family Needs Scale (FNS). These instruments helped project staff members better understand families' needs, and also helped measure outcomes for local evaluations.

  - Developing or tailoring data management systems to capture key reporting elements specific to the project impacted grantees in several ways, including improved reporting, more effective project management, improved ability to track progress on outcomes, facilitated data analysis, and improved staff supervision.

  - Grantees provided initial and ongoing evaluation training to project staff members and partners to inform staff members about evaluation objectives and processes, as well as explain their roles in the evaluation.

- Challenges to project implementation included service implementation delays, challenges reaching service goals, and difficulty serving the target populations. The common obstacles to full service implementation included lack of referrals to the FGDM projects, resistance to FGDM on the part of key staff members or project partners, and lack of qualified individuals to hire. Five grantees reported that they overestimated the number of families that would be referred by internal and external partners; therefore they were not able to serve the projected number of families. Project staff members also experienced difficulty in delivering services to families who were resistant to the FGDM process. This lack of engagement was attributed in part to families' unawareness or unfamiliarity with accessing formal and informal supports available in their communities.

- Challenges to grantees' evaluations were related to implementation issues and included low referral rates from project partners and small sample sizes. These factors, in combination with low survey/instrument response rates among families receiving FGDM services and the limited duration of the grants, were substantial challenges to demonstrating project impact.

- ***To what degree do FGDM grantees achieve short-term, intermediate, and long-term outcomes such as:***
    - ***Children are safely maintained in their homes whenever possible and appropriate (CFSR Safety Outcome 2, Item 3)***
    - ***Continuity of family relationships and connections preserved for children (CFSR Permanency Outcome 2, Items 14, 15)***
    - ***Families have enhanced capacity to provide for their children's needs (CFSR Well-being Outcome 1, Items 17, 8)***

- Grantees' use of cross-site evaluation instruments and common measures greatly facilitated the synthesis of data across projects and helped build support for short-term, intermediate, and long-term outcomes related to safety, permanency, and well-being. Grantees found positive child safety trends for families receiving FGDM services, such as lower rates of subsequent CPS referrals and substantiated reports, compared to control group families. Positive trends in intermediate and long-term permanency (3, 6, and 12 months) post-FGDM were also reported. Children who received FGDM tended to have lower subsequent child welfare system involvement than those who did not receive services. In terms of child and family well-being, results across projects suggested that FGDM was associated with positive outcomes related to family functioning and resiliency, child health and behavior, and youth relationships. Finally, grantee cost studies highlighted the cost savings that these demonstrated outcomes may provide for the child welfare system.

- ***How has the FGDM project impacted child welfare practice in the community?***

- FGDM projects impacted the child welfare system in a number of ways, including improving child welfare staff attitudes and practices related to advocating and supporting FGDM, strengthening service planning, and increasing family engagement in case planning. The most notable impact across projects was the shift in attitudes of child welfare workers so that the family unit became the focus of attention rather than the child or parent alone, and child welfare agencies involved in the projects began using more strengths-based approaches to services that involved families in all aspects of the service delivery system.

- ***To what extent have public child welfare agencies integrated elements of the FGDM project's service model?***

- Over half of the grantees reported that child welfare agencies had partially or fully integrated FGDM services into casework practices by the end of the projects. Projects run by Tribal/public child welfare agencies integrated FGDM into practice through formalizing policies and procedures supporting FGDM or modifying their practice models to include FGDM as a culturally sensitive model to serving families in crisis. Service model integration strategies used by private/non-profit agencies included providing FGDM training to public child welfare agency staff members and including project staff at all case staffing meetings to advocate for FGDM services.

- ***What new policies and procedures were developed as a result of the FGDM project?***

- In addition to developing new departmental policies and procedures based on fidelity assessments (as mentioned previously), a majority of grantees developed additional policies to

ensure that key aspects of the FGDM project would be sustained within their agency. New policies focused on improving collaboration and referral processes, documenting and manualizing FGDM practice, and adding a family-focused component to existing FGDM models.

➢ ***In what ways are FGDM projects sustainable beyond the federal funding period?***

- All grantees began planning to sustain FGDM services by the second year of the FGDM projects. A majority of grantees planned to sustain components of their projects through State/Tribal funding. Projects run by State/Tribal child welfare agencies budgeted to continue FGDM services beyond the life of the grants using existing funding streams. Other plans for sustainability included expanding the projects' target populations to serve families in other departments or programs that could financially support FGDM services, manualizing the FGDM model to preserve institutional knowledge, and using a train-the-trainer approach to ensure knowledge transfer of key FGDM practices within the organization.

Cross-site Evaluation Considerations

The cross-site evaluation of the Family Connection discretionary grants provided a unique opportunity to assess the degree to which grantees made concerted efforts to use the FGDM process to engage family members effectively in planning and decision-making, and to identify, provide, and arrange appropriate services that addressed child safety, permanent and stable living situations, continued family relationships, and enhanced capacity of families to care for their children's needs. This opportunity also came with significant challenges, the most critical being the substantial diversity of project activities within the Family Group Decision-making cluster. Among the seven projects in the cluster, grantees implemented seven different models/adaptations of FGDM, with two grantees evaluating two different types of FGDM models.

A construct-level, cross-site evaluation of the seven FGDM grantees was designed. A rigorous process evaluation resulted in detailed descriptions of grantee target populations and service models, and an assessment of cross-site themes regarding project staffing, continuous quality improvement, leadership, collaboration, facilitators and challenges to implementation, and sustainability. The cross-site evaluation was designed to include a synthesis of the impacts of all seven 2011 Family Connection FGDM projects implemented within a 3-year project period. JBA used grantees' last semi-annual evaluation reports (submitted by grantees to CB in October 31, 2014) and final reports (submitted by grantees to CB in December 31, 2014) for the final synthesis of outcome data across the projects.

While the cross-site evaluation allowed for the rich, descriptive data obtained, trends in outcome data support the need for further evaluation using more rigorous methodology (i.e., pre-post designs, comparison groups, and random assignment). Additionally, using common evaluation measures and instruments across sites will allow for stronger evidence to be built, supporting the impacts of FGDM on children and families.

Recommendations to the Child Welfare Field

Recommendations to the child welfare field address the successful implementation of FGDM services funded through Family Connection grants. The child welfare field is defined broadly and includes public and private/not-for-profit organizations. The recommendations are based on process evaluation report findings. Key areas covered in this section include FGDM service models; staff member selection, training, and supervision; continuous quality improvement; leadership; collaboration; and sustainability. Recommendations also provide suggestions to strengthen local evaluation design and methodology.

FGDM Service Models. Grantees across the FGDM cluster implemented different models to provide FGDM services. For the purpose of long-term planning, which required additional time for preparation and included private family time, grantees used Family Group Decision-making (FGDM), Family Group Conferencing (FGC), Family Team Conferencing (FTC), Family Team Meeting (FTM), and Family Success Conferencing (FSC) models. For short-term, emergency placement decisions, one grantee used the Family Team Decision-making (FTDM) model. Model adaptation was common across grantees; grantees adapted their FGDM models in response to the needs of their target populations, evaluation findings, and stakeholder feedback. Family engagement in FGDM was critical to successfully implementing services. Grantees also identified challenges to engaging families, including a lack of understanding of the purpose of FGDM, difficulty bringing family supports to the table, and families' lack of trust in the child welfare system.

Recommendations:

- Due to the wide array of existing FGDM models, there are several considerations for child welfare organizations in selecting an FGDM model to serve families. Considerations include intended target populations, purpose of conducting meetings, case characteristics, and the agency's staffing resources. These factors may have implications for the type of FGDM meetings that should be conducted. For instance, families receiving voluntary in-home services may require time to build rapport with FGDM coordinators before agreeing to participate in an FGDM meeting. These populations would benefit from FGDM and other similar models, which provide ample time for service providers to engage families. However, families in which a child has been recently removed may require more immediate coordination; emergency/crisis-oriented models such as FTDM may better suit these situations. Many organizations implement more than one FGDM model, based on case characteristics. Child welfare organizations interested in implementing multiple models of FGDM may consider providing separate trainings for each model to ensure that core components of the models are fully understood by service providers.

- While FGDM model adaptation may allow for more culturally sensitive service provision, child welfare organizations implementing FGDM may want to consider consulting with program developers and/or experts before adapting to the model. The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect provided FGDM training to a majority of the grantees and is a resource to consider when contemplating model adaptations. This will ensure that key components are not omitted from the model, which could reduce the effectiveness of the intervention. All changes made to the original model should be documented for future replication.

- Child welfare organizations serving voluntary populations will likely work with families that are new to and unfamiliar with the child welfare system. FGDM service providers have an opportunity to engage families and child welfare workers to participate in service planning using a positive, strengths-based, empowering approach that can help families understand that the common goal among FGDM participants and stakeholders is to ensure the safety, permanency, and well-being of children. To help build families' understanding of and level of comfort in disclosing issues with child welfare workers, FGDM coordinators have an opportunity to thoroughly prepare participating child welfare staff members for the meetings, and explain their roles in addressing the agency's bottom line requirements to ensure the safety of children in the homes.

Staff Member Selection, Training, and Supervision. Staffing structures among FGDM projects included project leadership, case managers and supervisors, service coordinators, and facilitators. Nearly all grantees experienced turnover in staff members at some point in their projects, and for projects with a low number of staff members in place to conduct FGDM activities, turnover substantially disrupted project implementation. Preparing staff members to implement of the FGDM intervention models was a critical component of the FGDM grantees' projects; all grantees provided initial and ongoing training on FGDM and related professional development topics to staff members. The most useful training strategies included role-playing, presentations conducted by FGDM experts, informal peer-to-peer discussions, and observing or attending an FGDM meeting. In addition to training, grantees provided coaching and supervision to ensure quality of services and fidelity to the FGDM model.

Recommendations:

- Child welfare organizations may want to consider ways to ensure that institutional knowledge of the FGDM model and related practices remain within the organization even when key staff members leave the project. Strategies for maintaining project continuity even in the event of staff turnover include manualizing practices to document key FGDM components and using a train-the-trainer approach to develop a pool of internal staff expertise on FGDM. These methods can be used to efficiently and effectively transfer knowledge to new staff members.

- Child welfare organizations may consider incorporating structured coaching opportunities in combination with hands-on, interactive FGDM training to ensure that staff members acquire the necessary skills to work effectively with families. Providing ongoing supervision and support to meeting facilitators ensures that fidelity to the FGDM and project service models remains strong, and further helps service providers engage in meaningful discussions on how to improve practice.

Continuous Quality Improvement. FGDM grantees engaged in continuous quality improvement by assessing fidelity to the FGDM models and applying the findings to their projects' practices. Overall findings of FGDM fidelity assessments to date were positive, indicating that FGDM staff members delivered quality FGDM services. Project leadership was responsive to fidelity assessment findings, with a majority of grantees developing new policies and procedures in response to the findings. Project leadership aimed to enhance staff performance by providing ongoing staff training, developing technical assistance resources and materials, creating venues for ongoing guidance (e.g., FAQ blogs), and mentoring or shadowing FGDM facilitators.

Recommendation:

- Child welfare organizations are encouraged to ensure that project leadership and staff members are committed to project fidelity. Decisions made about FGDM model selection, implementation, and evaluation should include project leadership and staff members who are responsible for providing key services as well because project fidelity relies upon the commitment of service providers to execute services as intended. Obtaining feedback from service providers on a regular basis (through supervision and fidelity assessments) helps identify and correct fidelity issues as they arise.

FGDM Project Leadership. Leadership played a key role in managing and delivering FGDM services. Each grantee had at least one 'project champion' who played a significant role in conceptualizing the project to ensure a good fit with the organizational mission and the needs of the service population. Project leaders used several strategies to build support for the project, including regular communication with staff members regarding project progress, providing personal and professional support for staff members, providing staff member training opportunities, engaging in leadership development activities, conducting outreach to stakeholders, and supporting evaluation efforts. While staff members identified strong leadership support, guidance, and communication as critical factors in understanding the FGDM practice model and achieving implementation and outcome goals, lack of information sharing regarding the evaluation component of the project and how it impacted staff member's work was seen as a challenge to effective leadership. Several grantees relied upon child welfare workers to refer families to the project, though a lack of support from child welfare staff and of leadership enforcement of referral processes was seen as a challenge to meeting targeted service numbers.

Recommendations:

- Project leaders and evaluators may enhance support for project activities by regularly providing feedback to FGDM staff members and referring workers. Sharing success stories and preliminary findings (e.g., process, fidelity, and outcome data) with service providers helps them see the impact of their work and motivates them to continue providing quality services. Feedback can be provided in several ways, including written reports, presentations at staff meetings, data briefs, or newsletters. Sharing preliminary findings with service providers also helps elicit feedback from staff members who work directly with families. Their insight can be helpful in explaining data trends and can help resolve implementation challenges, such as low referral rates and low family engagement.

- Organizational leadership plays a strong role in implementing and enforcing new practices. Service providers (particularly those playing a less direct role in FGDM service delivery, such as screening/referral workers) are less likely to implement services when they are voluntary or when they are considered "additional" tasks. Child welfare organizations implementing FGDM as a new practice may consider involving high-level leadership in the early stages of project planning and startup to ensure that key practices are institutionalized into the work through policy development. All new policies can be followed by additional information demonstrating how the FGDM service models and activities can complement the work, and include clear guidelines describing new/modified practices.

Collaboration with Key Partners. Relationships and collaboration among grantees and project partners were critical to project implementation. Through formal and informal partnerships, grantees utilized external service providers, local community organizations, public child welfare agencies, and organizations providing evaluation and other technical assistance to address the needs of children and

families. Collaboration had numerous benefits, including helping grantees address service gaps, distributing responsibility among multiple agencies, sharing knowledge and expertise, and improving service coordination. However, grantees also noted that differences in organizational policy and procedures, scheduling conflicts, staffing issues, and lack of knowledge regarding project services often made collaboration difficult.

Recommendations:

- Child welfare organizations may consider involving key project partners early in the planning process to thoroughly discuss the service model and evaluation design. Engaging in conversations about the roles that project partners play (e.g., data sharing, providing referrals, and implementing key services) helps clarify how they can impact the implementation of the project and highlights their contributions to project goals and successes. Strategies to communicate with partners include clarifying key terminology, as many organizations (and even departments within the same organization) understandings of similar terms differently; building an understanding of each agency's philosophy and general practice model in order to avoid challenges to project implementation and duplication of work; and sharing project progress with partners on a regular basis to discuss interpretations of preliminary findings together.

- Most FGDM grantees relied heavily upon child welfare workers to provide referrals to the projects. Child welfare organizations may consider including referring partners (particularly child welfare caseworkers and CPS workers) in FGDM training to help increase their understanding of the FGDM model and to strengthen support for the project. Without strong staff member support from referring agencies/departments, families may lose opportunities to participate in potentially beneficial services.

Sustainability of FGDM Services. Common grantee plans to sustain services included using existing State/Tribal funding streams to continue FGDM services beyond the life of the grant, expanding their target population to serve families in other departments, and collaborating with programs that could financially support FGDM services. Four grantees found ways to integrate some or all parts of their FGDM service models into the public child welfare system. Tribal/public child welfare agency grantees were able to seamlessly integrate FGDM into casework practice. Private/non-profit agency grantees sustained key components of their model, such as integrating the family-centered, strengths-based philosophy of FGDM into child welfare practice through caseworker trainings to ensure that all new child welfare workers were familiar with the model.

Recommendations:

- Cost study data may be collected, analyzed, and leveraged to provide potential stakeholders/funders with information on the cost of implementing key components of the FGDM service model. Conducting cost studies for FGDM services can also provide a comparison between project costs and social costs prevented (e.g., preventing entry/re-entry of children into the child welfare system) as a result of project participation. Combined with a strong outcome evaluation, cost studies are a tool that potential funders and decision-makers can use to invest in the most cost effective interventions, which provide maximum benefits for children and families.

- Child welfare organizations may benefit from beginning sustainability planning in the early stages of project implementation. Sustainability planning begins with identifying potential stakeholders (e.g., State or county child welfare system, education system, domestic violence

programs, mental health agencies, etc.) and engaging them in discussions regarding the community-level impact of FGDM services. Including potential stakeholders in project advisory boards can help build their investments in the project. While they may not necessarily have the financial resources to fund FGDM services, they may be able to provide other important resources to help sustain practice, such as staff, space, or equipment.