Clarifying the outcomes of family involvement interventions: An evaluative research proposal

Families are circles within other circles- relatives, community, and government. Economic change, community decline, and family relocation are all constricting or severing the connections among these circles. As a result families become isolated and their interactions secretive and often abusive. Struggling on their own, families turn inward and place impossible expectations on children for maturity, women for caring, and men for provision. Cut off from outside support and scrutiny, families implode into violence (Pennell & Buford, 1994, p.1)

In partial fulfillment of Olivia Lindly's 2008 MPH Capstone Requirement

Table of Contents

Executive Summary **5**

Introduction **6**

Child maltreatment in the United States 6

Child maltreatment consequences 7

Bridging the gap between public health and child welfare outcomes 8

A common thread: Child maltreatment, social support, and engagement 9

Family involvement interventions: Mobilizing social support and engaging families 11

Conceptual framework 14

Team decision-making 16

Research plan 19

Methodology **20**

Design 20

Setting 20

Sample 20

Measures 21

Procedures **23**

Human subjects protection 23

Recruitment 24

Informed consent 24

Data collection 25

Data analysis plan 26

Conclusions **27**

Limitations 27

Implications 29

Appendices

Appendix A: Family Involvement Interventions Evidence 31

Appendix B: What happens once child maltreatment has been reported? 43

Appendix C: Universal Fidelity Tool 44

Appendix D: Demographic Information Questionnaire 58

Appendix E: Multidimensional Scale of Perceived Social Support Items 59

Appendix F: Client Engagement in Child Protective Services Questionnaire 60

Appendix G: Family Compliance/ Follow through Questionnaire 61

Appendix H: Family Member Informed Consent Form 62

Works Cited **63**

List of Tables and Figures

Figures

Figure 1	Conceptual Framework for Family Involvement Interventions	15
Figure 2	Quasi-Experimental Nonequivalent Control Group Design	20
Figure 3	What happens once child maltreatment has been reported? (Appendix B)	43

Tables

Table 1	Supportive Functions	10
Table 2	Essential Elements of Family Involvement Interventions	12
Table 3	Family Involvement Interventions Evidence (Appendix A)	31
Table 4	Characteristics of Family Meetings	17
Table 5	Covariates of Interest	27

Executive Summary

Family involvement interventions, such as family group conferencing, family group decision-making, and team decision-making, have been increasingly implemented by child welfare agencies across the U.S. and other developed countries since the early 1990's. Legislation authorizing universal implementation of these interventions for children and families in the child welfare system has been enacted in several developed countries and some U.S. states. These interventions are generally theorized to empower families by collaboratively involving them with child welfare professionals in the decision-making process concerning child placement and custody issues; thereby eliciting more favorable, long-term child welfare outcomes. However, the descriptive causation of these outcomes remains largely unstudied. Moreover, the limited empirical research that has sought to determine the efficacy and effectiveness of these interventions in relationship to child welfare outcomes, such as length of stay in out-of-home care, placement stability, recurrence of child maltreatment, and permanency, has yielded mixed results. Therefore, as advocates, child welfare professionals, and policy makers march forward to enact legislation requiring that U.S. child welfare agencies universally implement family involvement interventions, it is integral to clarify the program theory by which these interventions may be beneficial, and then utilize rigorous evaluation methods to study whether relevant outcomes ensue. This proposal draws upon existing theory related to family involvement interventions as well as child maltreatment more broadly to posit one theory whereby these interventions may affect positive outcomes for children and families in the U.S. child welfare system. This theory is the basis for the proposed evaluative research, which focuses on the present utilization of team decision-making at several Maryland child welfare agencies. Proposed research methodology and procedures as well as potential limitations and implications are discussed.

Introduction

Child maltreatment is a public health problem in the United States.

During 2006, an estimated 905,000 children in the U.S. were victims of maltreatment (12.1 child maltreatment victims per 1,000 children) (U.S. Department of Health and Human Services, 2008). Under the Federal Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Keeping Children and Families Safe Act of 2003, child maltreatment is recognized as:

> Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act of failure to act which presents an imminent risk of serious harm.

Every state is required to use these criteria as the basis of its state specific child maltreatment definition. Most states recognize four main types of child maltreatment, including neglect, physical abuse, sexual abuse, and emotional maltreatment (U.S. Department of Health and Human Services, 2008). In addition, many states differentiate between "other" types of child maltreatment, most commonly citing abandonment, threats of harm to the child, congenital/perinatal drug exposure, medical and educational neglect as "other" types of child maltreatment in Child Protective Services (CPS) reports (Wulcyzn, F., 2005; U.S. Department of Health and Human Services, 2008).

Since the Department of Health and Human Services (DHHS) published the first child maltreatment report in 1992, child neglect has remained the leading type of child maltreatment in the U.S. In 2006, 64.1% of child maltreatment victims experienced neglect compared to 16.0% that were physically abused, 8.8% who were sexually abused, 6.6% that were psychologically maltreated, 2.0% that were medically neglected, and 14.3% that experienced other types of child maltreatment[1]. Most of these children (75.3% or 676,947 children) were first time child maltreatment victims with no prior history of victimization (U.S. DHHS, 2008).

Several other, persistent child maltreatment trends are also important to briefly note. First, a graded relationship exists between child age and incidence of child maltreatment. Children younger than four years old have the highest maltreatment incidence rate (24.4 child maltreatment victims per 1,000 children) compared to older children. Similarly, the largest proportion of child maltreatment related mortality in the U.S. occurs among children younger than four. In 2006, 78% of child maltreatment occurred among children younger than four (U.S. DHHS, 2008). Race and ethnicity are also related to child maltreatment trends in the U.S. African American children generally experience the highest maltreatment rate (19.5 maltreatment victims per 1,000 children) compared to American Indian (16.5 maltreatment victims per 1,000 children), Pacific Islander (16.1 maltreatment victims per 1,000 children), White (10.8 maltreatment victims per 1,000 children), Hispanic (10.7 maltreatment victims per 1,000 children), and Asian (2.5 maltreatment victims per 1,000 children). Overall, nearly half (48.8%) of all child maltreatment victims were White, 22.8% were African American, and 18.4% were Hispanic in 2006 (U.S. DHHS, 2008).

[1] These proportions do not add up to 100%, because children and youth that experienced multiple forms of maltreatment were counted under each type of maltreatment that they experienced.

Although these statistics primarily reflect child maltreatment data from 2006, these trends have remained relatively constant throughout the past decade (Wulzcyn, 2005; U.S. DHHS, 2008). In addition, both child maltreatment incidence and related fatality rates have not significantly declined during the past five years in the U.S.

Child maltreatment consequences

An estimated 1,530 child fatalities resulted from maltreatment in 2006 (U.S. Department of Health and Human Services, 2008). Although the vast majority of child maltreatment victims do not suffer this tragic fate, those that survive become increasingly susceptible to a wide range of adverse health outcomes. To date, few studies have examined the effects of child maltreatment on health outcomes among victims that remain placed with their parents[2]. However, an increasing number of studies have assessed the health status and functioning of child maltreatment victims in out-of-home placements[3] (Hansen et al., 2004; Lawrence, Carlson, Egeland, 2006; Leslie et al. 2005; U.S. Department of Health and Human Services, 2001). The most recent estimate from the Adoption and Foster Care Analysis and Reporting System (AFCARS) indicates that approximately 513,000 U.S. children were in out-of-home placements as of September 2005. Approximately half of these children (46%) were placed in non-relative foster family homes, 26% were placed in relative foster family homes, 10% were placed in institutions or residential care facilities, and 8% were placed in group homes.

In 2003, the Children's Bureau published the first wave of data from a nationally representative sample of children in foster care for one year. This study was conducted as part of the National Survey of Child and Adolescent Well-Being (NSCAW), and included more than 5,500 children ages 14 and younger that had been subject to child maltreatment investigations between 1999 and 2000. Health status, functioning, and social and cognitive development were measured among those children who were placed in out-of-home placements one year following the child maltreatment investigations (n = 727). Data was collected through standardized questionnaires and structured interviews, which were administered to caseworkers, caregivers, and/or children[4].

The prevalence of chronic health conditions, such as asthma, epilepsy, severe allergies, and skin disease, among child maltreatment victims in out-of-home care did not differ significantly from estimates of chronic health condition prevalence among all U.S. children. However, child maltreatment victims in out-of-home care demonstrated significant deficits in cognitive capacities, language development, behavioral problems, and academic achievement compared to the general population of children in the U.S. Overall, 19-28% of child maltreatment victims in out-of-home care were reported to have special needs (i.e., those considered relevant for special education services)[5], within the 36 months following their initial maltreatment investigations, compared to the 12% of all U.S. children that received special education services in 2005 (U.S. Department of Education, 2005). Moreover, a higher prevalence of

[2] According to the *2006 Child Maltreatment* report, 79.4% of child maltreatment perpetrators were parents (U.S. Department of Health and Human Services, 2008).
[3] The U.S. Department of Health and Human Services, Administration for Children, Youth, and Families defines out-of-home placements for victims of child maltreatment as non-kin foster homes, kinship foster homes, group homes, and residential placements (2001).
[4] In cases with older children, the questionnaires and interviews were administered directly to the children. However, in cases with infants and young children, surveys and questionnaires were administered to their caregivers or caseworkers.
[5] The Administration for Children and families includes autism, deafness, emotional disturbance/behavioral disorder, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, specific learning disability, speech or language impairment, traumatic brain injury, visual impairment (including blindness) as special needs (2007).

delinquent behavior, including running away, property damage, theft, aggravated assault, and attempted rape, was found among child maltreatment victims in out-of-home care compared to the estimated prevalence of delinquent behaviors among all U.S. children (Fang & Corso, 2007), a finding that has been confirmed across other studies (Maas, Herrenkohl, & Sousa, 2008).

Similarly, results from a multi-site, prospective study of emotional and behavioral disorder prevalence among American youth placed in residential treatment facilities and therapeutic foster homes, upon entering the child welfare system, revealed that more than half (53.9%) of the total sample had emotional and/or behavioral disorders (Baker et al. 2007). This is a shockingly high proportion of youth with emotional and/or behavioral disorders in comparison to the 2.3% of all American youth with behavioral and/or emotional disorders.

In terms of more distal outcomes, several retrospective studies have established that graded associations exist between self-reported exposure to adverse childhood experiences, such as child maltreatment, and health risk behaviors (e.g., smoking, illicit drug use, alcoholism, attempted suicide), mental health status, and the likelihood of chronic health conditions (e.g., lung disease, skeletal fractures, liver disease, cancer, cardiovascular disease) among adults (Anda et al., 1999; Dube et al., 2001; Dube et al., 2003; Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1998). In general, this research indicates that exposure to adverse childhood experiences is associated with an increased likelihood of health risk behaviors, chronic health conditions, and/or poorer mental health status among American adults.

On the whole, child maltreatment consequences affect victims throughout the life span. Throughout adolescence, maltreatment victims are more likely to be removed from their homes and placed in foster care, have special needs, and engage in delinquent behaviors compared to children that have not experienced maltreatment. Into adulthood, child maltreatment victims have a higher likelihood of engaging in health risk behaviors, experiencing chronic health conditions and/or poorer mental health status in comparison to adults that did not experience child maltreatment.

Bridging the gap between public health and child welfare outcomes

In conceptualizing child maltreatment as a public health problem, it is necessary to identify risk and protective factors relevant to the problem and interventions designed to ameliorate the adverse consequences previously described. However, given that one type of family oriented intervention is the subject of this paper, the subsequent discussion of risk and protective factors related to child maltreatment will focus primarily on family-level factors related to child maltreatment. Nevertheless, it is important to recognize that both individual (i.e., child-level) and community level risk and protective factors have also been associated with child maltreatment and child welfare interventions.

Further, in the following discussion regarding family-level child maltreatment risk and protective factors, it is essential to frame the consequences of child maltreatment from the lens of child welfare practice and research. In child welfare, case-level outcomes related to recurrent child maltreatment, placement stability, length of stay for children in out-of-home care, and permanency (i.e., the child is reunified with his/her family, legal adoption is finalized, or the child is discharged from foster care to the care of a legal guardian)[6] are typically utilized rather than child-level outcomes (e.g., child health and well-being) as indicators of both effective child welfare practice and/or the severity of the child maltreatment case.

[6] Permanency is referred to according to the DHHS' definition in the *Child Welfare Outcomes 2003: Annual Report*.

In a recent study on family involvement interventions, Crampton and Jackson (2007) describe favorable short-term child welfare outcomes, in terms of the initial child maltreatment response by CPS, as least restrictive placement (i.e., that the child remains placed with caregivers or kin) and least intrusive custody (i.e., the family of the child retains legal custody of the child while typically entering a voluntary service agreement with the child welfare agency). The authors additionally cite child's length of stay in an out-of-home placement, placement stability (i.e., how many times the child's placement changed), and permanency as longer-term child welfare outcomes. Therefore, since child welfare workers consider the child's safety as paramount throughout the case duration, the child's health and well being are most commonly viewed as one facet within the broader case, rather than the main outcomes of interest (Crosson-Tower, 2005).

Crampton and Jackson (2007) emphasize that such child welfare outcomes are "crude measures of safety and permanency that cannot speak to the well-being of the children served" (p. 64). Nevertheless, given the present state of U.S. child welfare legislation, these are the types of outcomes that policy makers, child welfare administrators, and caseworkers are the most concerned with regarding child welfare intervention efficacy and effectiveness (U.S. DHHS, 2003). Thus, the following section will discuss family-level factors related to child maltreatment with respect to child welfare outcomes, such as recurrent child maltreatment and permanency, which are to some extent indicative of child and family health and well-being.

A common thread: Child maltreatment, poverty, social support, and engagement

Poverty, across family, neighborhood, and community levels, has consistently been identified as a risk factor for child maltreatment (Connell et al. 2007; Coulton et al., 2007; Theodore, Bunyan, & Chang, 2007). In addition, poverty has been associated with social support deficits among families with child maltreatment, such that low-income families have been found to perceive less social support through their social networks (Coohey, 1996). That is, the social networks of low-income families are more likely to consist of other low-income families, which possess limited emotional and instrumental resources. In turn, low income families with less perceived social support have been found to have an increased risk of child maltreatment compared to middle and high income families with relatively more perceived social support (DePanfilis, 1996; Zuravin, 1989). In both retrospective and prospective research, which has controlled for family income, deficits in family members' perceived social support have been independently associated with increased child maltreatment risk. Therefore, poverty in addition to lack of perceived social support among families has been associated with increased likelihood child maltreatment and maltreatment recurrence (Budde & Schene, 2004; Coohey, 1996; DePanfilis, 1996; DePanfilis & Zuravin, 1999; DePanfilis & Zuravin, 2002).

In further describing the relationship between social support and child maltreatment, it is first useful to differentiate between perceived and received social support as well as the main functions of social support. Wills & Shinar (2000) define perceived social support as "supportive functions that are perceived to be available if needed" in contrast to received social support as "[supportive] functions that are reported to be recently provided" (p.87). These definitions assume that social relationships serve supportive functions for individuals by providing resources to them that promote adaptive coping responses to acute or chronic stressors. Table 1 summarizes the main supportive functions of both perceived and received social support as well as the related theoretical benefits (i.e., how these functions promote adaptive coping).

Table 1. Supportive Functions (Adapted from Wills & Shinar, 2000)

Function	Definition	Theoretical Benefit
Emotional support	The availability of one or more persons who can listen sympathetically when an individual is having problems and can provide indications of caring and acceptance.	Alters threat appraisal of life events, enhances self-esteem, reduces anxiety/depression, motivates coping.
Instrumental support	Involves practical support when necessary, such as assisting with transportation, helping with household chores and childcare, providing tangible aid, such as bringing tools or lending money.	Solves practical problems, allows increased time for rest and relaxation, other coping efforts.
Informational support	Providing knowledge that is useful to solving problems, such as providing information about community resources or providing advice and guidance about alternative courses of action.	Increases the amount of useful information available to the individual, helps obtain needed services, leads to more effective coping.
Companionship support	Availability of persons with whom one can participate in social and leisure activities or recreational activities.	Produces positive affect, allows for release and recuperation from demands, and provides positive distraction from rumination about problems.
Validation support	Information provided through social relationships about the appropriateness or normativeness of behavior	Decreases perceived deviancy, allows acceptance of feelings, provides favorable comparisons.

Although most research related to child maltreatment and social support has failed to differentiate between social support types and functions, through the application of the social support definitions provided in Table 1, it is evident that this body of research has primarily assessed family members' perceived social support in terms of emotional, instrumental, and informational support functions (Coohey, 1996; DePanfilis, 1996; Polasky, Gaudin, Ammons, & Davis, 1985). Despite the identification of perceived social support as a risk factor for child maltreatment, the pathways through which perceived social support may affect child maltreatment remain largely unstudied (Budde & Schene, 2004).

However, several studies suggest that levels of perceived social support among family members are related to family member engagement in child welfare services, and that engagement with services affects long-term child welfare outcomes for families (DePanfilis & Zuravin, 1999; DePanfilis & Zuravin, 2002). More specifically, DePanfilis & Zuravin (2002) found that low levels of perceived social support and "attendance at services" were significantly correlated with increased risk of recurrent child maltreatment among families with previously substantiated child physical abuse or neglect. Although, family member engagement with services continues to be differentially defined in the child welfare field, attendance at services has been one operational variable frequently used to measure client compliance, one construct of engagement (Dawson & Berry, 2002).

However, attendance at services or client compliance more broadly does not reflect client collaboration, which is also considered a main construct of family engagement in child welfare services (Littell & Tajima, 2000; Yatchmenoff, 2005, Yatchmenoff, in press). Rather, client collaboration is defined as the involvement and agreement of clients in the treatment planning process (Dawson & Berry, 2002). Similar to client compliance, client collaboration in child welfare services has also been associated with child welfare outcomes. However, client collaboration has been conceptualized more as a psychosocial outcome whereas, client compliancy most commonly measured as a behavioral outcome.

In one of the first empirical studies to investigate the multi-dimensional nature of engagement among parents involved in non-voluntary child welfare services, Yatchmenoff (2001) characterized engagement as a feeling state that reflects "positive involvement in a helping process," a definition more reflective of client collaboration (p. 46). Yatchmenoff (2001) found different engagement concepts, such as "buy-in" (i.e., investment in the helping process with the expectation that this process will fulfill self-interest), receptivity (i.e., the recognition that help is needed), and mistrust (i.e., belief that the agency and/or worker is working against the client), to be correlated with client compliancy. More specifically, low levels of mistrust in conjunction with high levels of buy-in and receptivity were significantly associated with increased compliancy among parents. As a result of this study, Yatchmenoff developed the Client Engagement in Child Protective Services Scale, which has become an increasingly popular standardized instrument used to assess client collaboration among family members in child welfare services as a multi-faceted construct. It is also important to recognize that in light of Yatchmenoff's findings that client collaboration may precede client compliancy, such that more positive client collaboration elicits greater levels of client compliancy among families in the child welfare system.

Therefore, child welfare interventions that enhance family members' perceived social support and engage them in a positive helping process, may elicit greater compliancy with child welfare services over time. As such, the likelihood of more favorable long-term, child welfare outcomes for children and families may increase (Dawson & Berry, 2002).

Family involvement interventions: Mobilizing social support and engaging families

Budde & Schene (2004) define informal social support (ISS) interventions as "systematic activities designed to change the existing quality, level, or function of an individual's personal social network" (p.342). The authors identify family involvement interventions as one type of ISS intervention. Similar to other types of ISS interventions, family involvement interventions mobilize existing supporters, including extended family members, friends, and community members, to bolster social support among families with child maltreatment histories.

Family involvement interventions originally grew out of New Zealand's family group conferencing (FGC) practice. FGC was developed by the Maori people in response to European or expert-driven child welfare practice models, which were viewed as discriminatory towards families and their tribes (Hassall, 1996; Mirsky, 2003; Pennell & Burford, 1994). In 1989, family group conferencing was legislated for all families in New Zealand's child welfare and/or youth justice systems through the enactment of the Children, Young Persons and Their Families Act. That is, FGC was subsequently required for all families entering the child welfare systems because of substantiated child maltreatment.

Family group conferences involve immediate and extended family members as well as friends, community members, and professionals (e.g., social workers, teachers, mental health providers). Skilled individuals, which have not previously served as child welfare workers for the families receiving the

FGC intervention, generally facilitate family group conferences. During the FGCs, facilitators guide family members and professionals in constructively discussing both the strengths and challenges that families are presently facing. Families are then given "private family time," during which the professionals and facilitators leave the conference space, providing families with opportunities to independently create their own plans to improve the situations that necessitated the FGCs. Once the plan is complete, the families present their plans to the professionals and facilitators. The professionals and families must then reach consensus regarding the plans, with the assistance of the facilitators. After consensus about the family plans has been achieved, facilitators conclude the FGCs by summarizing the plan components and next steps for plan follow-through. Mirsky (2003) and others have summarized the key features of the New Zealand FGC model as "preparation, information giving, private family time, agreeing on the plan, monitoring and review" (p. 1) (Macgowen & Pennell, 2001).

Although certain adaptations of the New Zealand FGC model, such as family group decision-making (FGDM), have maintained these key features, other adaptations, such as team decision-making (TDM) and the family unity model, have modified these features. As Crampton (2007) asserts, "more than 150 communities worldwide are *experimenting* with family group decision making (FGDM) in child welfare practice" (p. 202). Given the likely variation that is occurring in the application of these interventions, the following table distills the fundamental philosophies and goals of family involvement interventions.

Table 2. Essential Elements of Family Involvement Interventions
(Adapted from Berzin, Thomas, & Cohen, 2007)

Philosophies of Family Involvement Interventions
• Families have a responsibility to provide for the care and protection of their children. • Families have the most complete information about themselves to make decisions. • Children have the right to safety, knowledge of their heritage, and a voice in the decisions. • Child safety plans are most effective when developed out of the strengths of their culture and community. • The long-term protection and welfare of children are best served through collaboration between families and community and agency supports.
Family Involvement Intervention Goals
• Recognition and respect for families, their communities, and their cultures. • Increased support, including mobilizing extended family and community resources. • Increased family, community, and agency collaboration in child welfare decision-making and service provision. • The inclusion of children in the process. • Empowerment of families to form their own plans that protect their children.

Although the primary goals of family involvement interventions, presented in Table 2, largely reflect the initial psychosocial outcomes elicited through the actual intervention's conferencing component, child

welfare researchers have attempted to study the relationships between family involvement interventions and long-term child welfare outcomes (e.g., maltreatment recurrence, length of stay in out-of-home care, placement stability, permanency). Unsurprisingly, this research has yielded mixed results, which indicate marginal associations between family involvement interventions and long-term child welfare outcomes (Berzin, 2006; Crampton & Jackson, 2007; Sundell & Vinnerljung, 2004). As Berzin (2006) suggests (p. 1456):

> FGDM may not be a strong enough intervention to effectively improve child welfare outcomes or may be just one step in improving these larger outcomes. Perhaps more intermediate outcome measures (e.g., family engagement, improved relationship between county and family, and improved family communication) would be better at assessing the impact of FGDM than these broader child welfare outcomes.

However, few studies have measured the initial, intended outcomes of family involvement interventions. One evaluative study of a family group conferencing program in Washington State found that most family members accessed both formal and informal support services to address personal problems (e.g., anger management issues, mental health disorders) at family group conferences (Veneski & Kemp, 2000). Additionally, 78% of children experienced "no moves" (i.e., the children remained in their current placements), and 86% of children were either placed with kin (43.6%) or parents (38.9%) as a result of the family group conferences. Although this study lacked a control group, the high proportion of family members that received support as evidenced by their access to various services in addition to the use of relative foster or kinship care suggests that family group conferences were effective at mobilizing social support in terms of emotional, instrumental, and informational functions among those families that received the intervention.

A more recent study conducted by Berzin, Thomas, & Cohen (2007) assessed both family member and facilitator perceptions of family and community support mobilization as a result of family involvement interventions. In this study, nearly half of all family members reported that family and community supports were not addressed at FDGM or family unity meetings. Additionally, a large proportion of the family plans generated at these meetings were not completed within 12 months of the meetings. Child welfare workers primarily attributed plan incompletion to family members' lack of follow-through. In contrast to the Washington State study, these findings indicate that the implementation of family involvement interventions may not always ensure the basic activities are completed, such as attempting to mobilize extended family and community supports. Such a lack of fidelity to the model naturally could not be expected to achieve improved compliance by families with service plans.

Despite the increasing use of these family involvement interventions in states such as Oregon, Maryland, Ohio, Pennsylvania, and North Carolina (Keys & Rockhill, 2000; Batterson et al., 2007), a very limited body of empirical research exists with respect to intervention implementation as well as the spectrum of related outcomes among families. Table 3 (see Appendix A) summarizes all peer-reviewed empirical research related to family involvement interventions from a literature search conducted with PsychInfo, Social Sciences Citation Index, and Social Work Abstracts using the terms 'Family Group Decision Making,' 'Family Group Conferencing,' and 'Team Decision-Making'. In reviewing this research, it is apparent that these studies have focused on either process or long-term outcomes, but have not assessed the psychosocial and behavioral outcomes among families with child maltreatment that have been exposed to these interventions in comparison to those families that receive traditional child welfare services. Consequently, there is a pressing need for further research to better elucidate the descriptive causation of these interventions.

Conceptual framework

The conceptual framework (see Figure 1) proposes one pathway through which family involvement interventions may result in more favorable outcomes for children and families in the child welfare system. This framework serves as the basis for the following evaluative research proposal.

This framework presents some of the family-level factors that have been associated with child maltreatment. Certain factors, such as family mental health/substance abuse issues and parenting skills, are not explicitly discussed in this proposal, since these are factors that have not been explicitly associated with family involvement interventions (i.e., services for parenting skills and substance abuse may be established through the utilization of FII, but thus far these factors have not been the focus of these interventions). Nevertheless, these factors have been the basis of other child welfare interventions for maltreating families (Corcoran, 2000). Over time, the distribution and intensity of these factors among families may heighten child maltreatment risk, eventually leading to child maltreatment. Once child maltreatment has occurred, it may be reported[7]. Figure 3 (see Appendix B) describes in greater detail what the Child Protective Services (CPS) response to child maltreatment allegations has traditionally been. Generally though, CPS either "screens-in" or "screens-out" child maltreatment allegations, whereby those screened-in allegations are further investigated. During 2006, maltreatment was substantiated approximately 26% of all those maltreatment reports screened in (U.S. Department of Health and Human Services, 2008). The conceptual framework solely depicts child maltreatment cases in which substantiated dispositions are made, indicating that the maltreatment occurred.

In many cases of substantiated maltreatment, children are at risk of removal from their homes, because of safety concerns. Traditionally, it has been the assigned CPS worker's responsibility to determine whether the child(ren)'s home environment is safe enough to remain placed there. In an ideal situation, a shelter hearing, at which time the juvenile court becomes involved in the child welfare case, would be held to grant temporary custody of the children to the agency prior to the removal. However, in severe cases of child maltreatment, it is often not feasible to hold a court hearing prior to removal due to the eminent risk of harm.

As the conceptual framework illustrates, it is at this point that a family involvement intervention may be implemented by the child welfare agency. As previously discussed, the implementation of these interventions requires involving families in the decisions that must be made regarding children's placement, methods to ensure safety, and accountability for plan components. This process theoretically promotes engagement between the family and agency in addition to mobilizing informal social supports and ensuring that the children are initially placed in the safest, least restrictive, and least intrusive environment. Successful implementation of family involvement interventions is expected to produce family members' perceptions of enhanced social support, engagement in terms of their feelings of being involved in a positive helping process with the agency, and in the process of determining the placement of the children.

Behavioral outcomes are also expected, specifically that family members will be compliant with non-voluntary child welfare services. Such evidence is in the form of behaviors and actions (e.g., attendance at services, follow through with service plan elements, number of services accessed). Moreover, as previously mentioned, family member compliance with child welfare services has been associated with

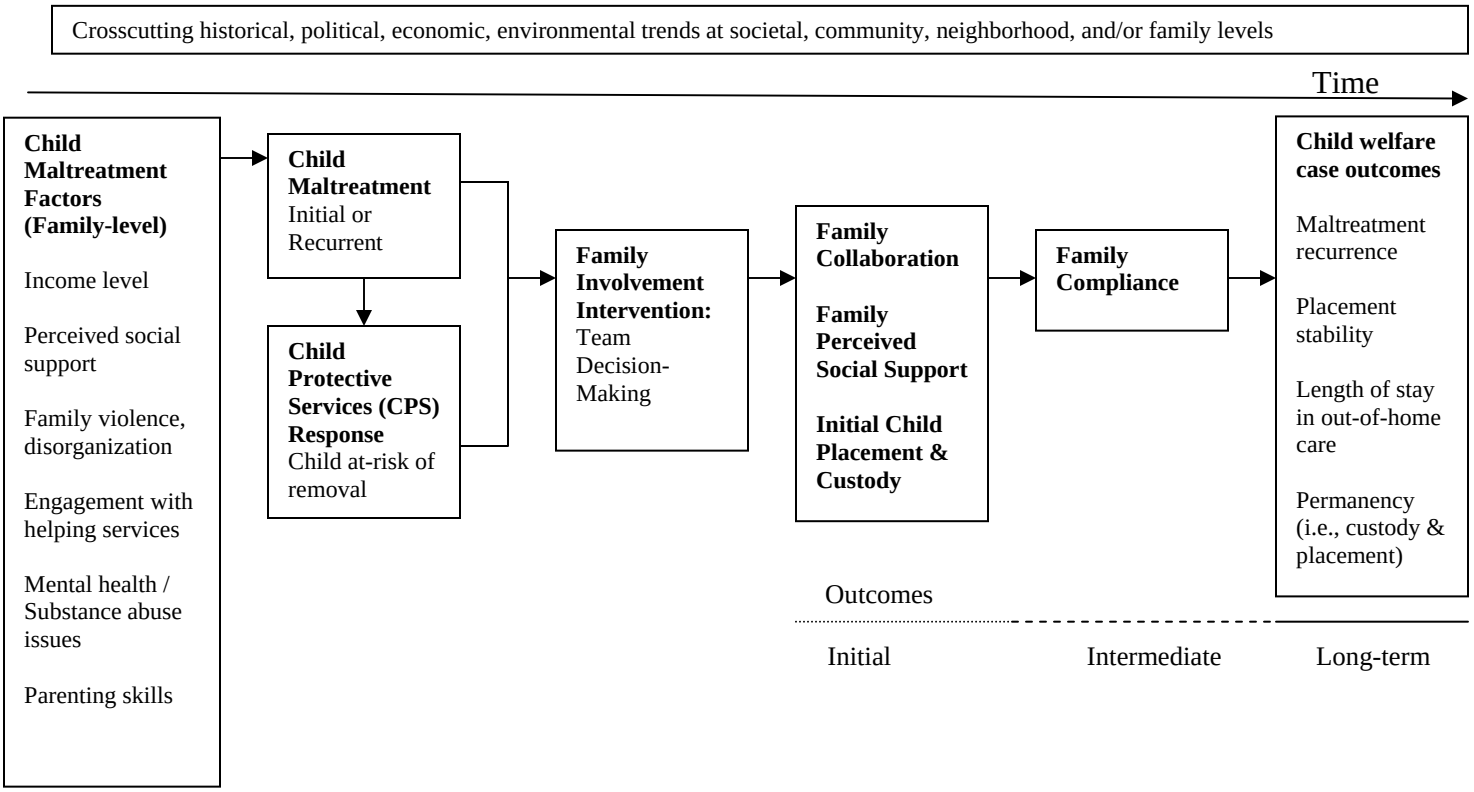
[7] According to the *Child Maltreatment 2006* report, professionals, such as teachers, law enforcement, clinicians, and social workers, most frequently reported child maltreatment (U.S. Department of Health and Human Services, 2008).

both client collaboration and perceived social support as well as long-term child welfare outcomes, such as recurrent maltreatment and reunification. Based on other behavior change theories (e.g., social cognitive theory, the transtheorectical model), this framework assumes that the psychosocial outcomes precede behavioral outcomes.

Finally, child welfare outcomes, including maltreatment recurrence, length of stay in foster care, placement stability, and permanency are presented as long-term outcomes. These outcomes were selected as the long-term outcomes related to the intervention primarily because these are the child welfare outcomes that federal, state, and local child welfare agencies are presently using to determine whether interventions are worthwhile. Further, some of these outcomes, such as permanency, can be evaluated only once a case has been opened for 12 months. That is, under the Adoption and Safe Families Act (ASFA) of 1997, child welfare workers are required to determine whether a child can be safely reunited with his/her parents or relatives within 12 months of maltreatment substantiation. If this determination cannot be made (i.e, the caseworker does not believe the child can be safely placed back with his/her family), then a concurrent plan must be initiated by the agency, which typically involves filing for adoption, terminating parental rights, and/or seeking subsidized guardianship for the child(ren) with relative or non-relative caregivers.

It is also important to note that contextual factors across different levels may potentially mediate or modify outcomes. Examples of such factors are listed at the top of the conceptual framework.

Figure 1. Conceptual Framework for Family Involvement Interventions (Family-level)



Team decision-making

Team decision-making (TDM) will be the focus of the proposed research, since it is a newer model of family involvement intervention that is being widely implemented in the U.S. Moreover, TDM is often a critical component of family-centered child welfare practice reform, which has received increasing attention by child welfare advocates and policy makers seeking to decrease the number of children placed in out-of-home care and rates of recurrent maltreatment. Although research regarding several statewide child welfare reform initiatives that have include TDM implementation, suggest that TDM may reduce the number of children entering out-of-home care (Usher, Wildfire, & Gibbs, 1999), there has been no empirical research conducted on the range of outcomes that TDM exposure may elicit among family members.

Although team decision-making is one family involvement intervention model (Crampton, 2004; Crampton & Natarajan, 2005; DeMuro, 1997), there are several distinctive ways in which it differs from other family involvement interventions models, such as FGC and FGDM. In further describing the unique elements of the TDM model, it is first important to consider the broader context of team decision-making within the Family to Family Initiative launched by the Annie E. Casey Foundation in 1993.

In essence, the Family to Family Initiative was a response by the Annie E. Casey Foundation to the increasing number of children being placed in non-relative out-of-home care. The ultimate goal of this initiative was to help neighborhoods establish effective responses to families at-risk of child maltreatment. At state and local levels, this initiative was intended to assist child welfare agencies in redesigning their foster care systems to develop family foster care networks in neighborhoods and communities, ensure that neighborhood-based family foster care is available to children that must be removed from their homes, decrease reliance of congregate care by placing more children in family foster care (i.e., kinship care), reduce children's length of stay in out-of-home placements, and decrease the overall number of children entering out-of-home care. Team decision-making is promoted as one of several interventions or "strategies" through which state and local child welfare agencies may achieve these goals.

The main component of the TDM intervention is the team decision-making meeting, which the Annie E. Casey Foundation defines as:

> multi-disciplinary meetings with families, extended families, community members, providers of services, and child welfare staff that are held when [out-of-home] placement is contemplated, when a change in placement may occur, or when reunification is imminent. The goal [of TDM] is to reach consensus about a plan which protects the children and preserves or reunifies the family (DeMuro, 1997, p. 11).

TDM is differentiated from other family involvement interventions (i.e., "the New Zealand model") as an intervention in which public child welfare agencies share the responsibility of placement decisions with families as opposed to "hand[ing] off its responsibility for critical placement decisions." Table 4, adapted from Crampton & Natarajan (2005), summarizes of the key differences between TDM and FGDM models with respect to the actual meeting process.

Table 4. Characteristics of Family Meetings (Adapted from Crampton & Natarajan, 2005)

	Team Decision Making	**Family Group Decision Making**
Purpose	To make an immediate decision regarding a child's placement, including providing services and support.	To develop a plan for the care and protection of a child.
Distinctive Elements	Held for every placement-related decision faced by every family served by the public child welfare system. If a child must be removed prior to TDM, then the TDM must convene by the next business day. It is recommended that TDM meetings occur prior to court hearings if possible.	Held when a family agrees to try using an extended family meeting, which must include private family time to create a family plan.
Preparation Time	Meeting arrangements are typically made quickly by the assigned child welfare worker in consultation with his/her supervisor and/or the TDM program supervisor/coordinator.	Preparation time may range from 20-30 hours per week over a 3-4 week period.
Participants	On average, TDM meetings have five participants, including a facilitator, parent, relative, the assigned social worker, and a community representative or neighbor. Children may attend if determined to be mature enough (i.e., typically 12 year or older) and if it is appropriate that s/he should be at the meeting.	The average number of FGDM participants is 10-12, including the facilitator, parent(s), other family members, service providers, and anyone else that the family may have identified as a potential support. Children may also attend if determined to be mature enough.
Meeting Location	Meetings are usually held at the child welfare agency's office in private conference rooms.	Facilitators and child welfare workers are encouraged to schedule meetings in community locations (e.g., churches, schools, recreation centers) or family homes.
Length of Meeting	1-2 hours	3-5 hours
Therapeutic Factors	Primary focus is on placement decisions, not services, although service planning is a secondary focus.	May be a concern depending on the family's concerns.
Facilitation Skills	Experienced staff that have demonstrated excellent communication skills are encouraged to become facilitators, and then once selected receive specialized facilitation training.	Facilitation is de-emphasized; staff should intervene in the family's decision making process as little as possible.
Group Decision Making	The public agency shares, but does not delegate its responsibility to make critical placement decisions.	Ideally, the family develops a plan on their own, but agency staff can veto plans they believe are not safe.

During TDM meetings, facilitators are expected to follow certain protocol developed by the Annie E. Casey Foundation to positively reach group consensus and develop a plan that addresses both the family's strengths and growth areas. The Annie E. Casey Foundation has identified the following elements as essential parts of team decision-making meetings (DeMuro, 1997):

- Introductions: The facilitator greets the meeting participants, explains the purpose of the meeting, and lays the ground rules concerning confidentiality and respect. The facilitator then allows each participant to introduce him/herself and explain his/her relationship to the case.

- The caseworker presents the case (i.e., what happened to necessitate the meeting) as well as any pertinent family history, previous case plans, prior referrals, investigations, and/or dispositions.

- Family members and other team members are encouraged to provide their perspectives on the case.

- The caseworker recommends a plan of action.

- The family and other team members are provided with an opportunity to express their reactions to the plan and provide suggestions and/or revisions.

- The facilitator leads a discussion regarding the expected outcome(s) of the proposed plan, and allows the team members to assume or reject roles in carrying out the plan.

- The facilitator ensures that the team discusses the family strengths as well as the risk to the children.

- Action steps are clearly articulated as part of the plan, such that who is to do what by when is stated and written into the plan.

- The team will ideally reach consensus around the primary meeting decision (e.g., where the child is to be placed, where the child will be changing placements to, what the plan for reunification will be). However, if the team cannot achieve consensus, then the agency staff will attempt to reach agreement. If the agency staff cannot agree on a plan, then the caseworker will make the decision.

- At the meeting's end, the facilitator verbally and in writing summarizes the team's decision, including the family plan and subsequent action steps. All team members receive a copy of the plan.

Figure 3 (see Appendix B) illustrates how traditional case practice generally progresses, independent of the TDM intervention, once child maltreatment has been reported. Typically, the TDM intervention for initial placement decisions related to risk of removal is administered following child maltreatment substantiation, regardless of whether or not the court becomes involved. It is also important to recognize, that family involvement interventions are often implemented by child welfare agencies for any placement related decision. That is, these interventions may be administered throughout the life of a case, whenever a child's placement and/or permanency plan may be changed. Nevertheless, for the purposes of this study, the relationship between TDM exposure and the initial outcomes of interest will only being measured when this intervention is first utilized, once child maltreatment has been substantiated.

Research plan

The main purpose of the proposed research is to assess whether team decision-making exposure is related to changes in perceived social support and engagement, two of the intended initial outcomes of family involvement interventions like TDM. The proposed research will measure both perceived social support and engagement (i.e., a feeling state of being involved in a positive helping process) among family members with child maltreatment that are exposed to team decision-making (TDM) in comparison to family members with child maltreatment that are exposed to traditional child welfare case practice. The initial placements of children, after Child Protective Services (CPS) has substantiated maltreatment, will be compared between families receiving the TDM intervention and those families receiving traditional case practice. In addition, family compliancy and follow-through with services will be measured to determine whether intervention exposure and/or change in perceived social support and/or engagement (post-pre) is related to family member compliancy with child welfare services. Lastly, long-term child welfare outcomes will be assessed, specifically maltreatment recurrence, length of stay in out-of-home care, placement stability (i.e., # of placement changes), and permanency (e.g., child placement and custody 12 months following maltreatment substantiation).

The proposed research will attempt to better discern the mechanism by which TDM is beneficial to maltreating families by answering the following questions:

1. Does team decision-making intervention (TDM) exposure significantly change family members' self-reported ratings of engagement in comparison to family members exposed to traditional case practice?

2. Does TDM exposure significantly change family members' self-reported ratings of perceived social support compared to families exposed to traditional case practice?

3. Are initial placement decisions for children whose families receive the TDM intervention less restrictive than the initial placement decisions made for children whose families receive traditional case practice?

4. Does family member compliancy with child welfare services from the perspective of the family members, and as evidenced by their access to and attendance at child welfare services, differ between the comparison and experimental groups?

5. Do child welfare outcomes, specifically maltreatment recurrence, length of stay in out-of-home care, placement stability, and permanency (i.e., child placement and custody), at six and 12 months following child maltreatment substantiation differ significantly between the comparison and experimental groups?

6. Is the fidelity of the team decision-making intervention (high or low) at the experimental study sites associated with family members' self-reported engagement and perceived social support?

7. Are perceived social support and engagement among maltreating families correlated?

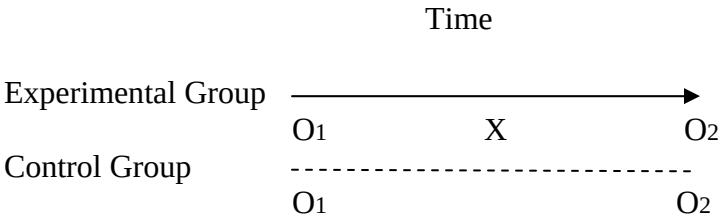
8. Are changes in perceived social support and engagement among maltreating families associated with family compliancy and/or long-term outcomes?

Methodology

Design

The proposed research will use a quasi-experimental non-equivalent control group design (Figure 2), as described by Fisher & Foreit (2002). The experimental group(s) will consist of adult family members with substantiated child maltreatment cases that are exposed to the TDM intervention. The control group will be composed of adult family members with substantiated child maltreatment cases are not exposed to the TDM intervention (i.e., they receive traditional case practice). This design allows for data collection at an earlier time (O_1) as well as data collection at a later time (O_2), such that comparisons related to changes in the dependent variables can be measured over time between the experimental group that received the intervention (X) and the control group that did not receive the intervention.

Figure 2. Quasi-Experimental Nonequivalent Control Group Design



Setting

This research will be conducted at the Baltimore City Department of Social Services (BCDSS), which is presently implementing the TDM intervention *only* for families living in East Baltimore. Families living in West Baltimore that become involved with BCDSS because of substantiated child maltreatment are exposed to traditional case practice (described in Figure 3).

In 2005, Baltimore City had an estimated 636,000 residents (65% African-American, 32% White, 2.2% Hispanic), according to the Maryland Department of Human Resources (DHR). Approximately 19.6% of the city's population was living in poverty as of 2005, and the city had an unemployment rate of 6.4%. During 2005, Baltimore City had the highest incidence of substantiated child maltreatment (11.2 child maltreatment victims per 1,000 children) compared to all other Maryland jurisdictions (Maryland Governor's Office for Children, 2008). Moreover, Baltimore City had the highest out-of-home placement rate for Maryland children (28.9 Baltimore City children per 1,000 Maryland children placed in out-of-home care by DHR) in 2006 (Maryland Governor's Office for Children, 2008).

Sample

For the experimental group, primary caregivers with substantiated child maltreatment, as determined by BCDSS Child Protective Services (CPS), that have been referred for TDM services by child welfare staff because their children are at-risk of removal, will be recruited as a nonprobability convenience sample (Fisher & Foreit, 2002). An additional, nonprobability, convenience sample of primary caregivers with substantiated maltreatment, as determined by BCDSS CPS, who are not designated to receive the TDM intervention, will be recruited as the control group. Primary caregivers will be

recruited from BCDSS for both experimental and control groups on an ongoing basis throughout the study period, which is expected to last approximately 12 months.
To ensure that an adequate number of participants are recruited for the experimental and control groups at BCDSS, a priori estimates of the mean change scores (.5) and standard deviations (1.5) on the two dependent variables between the experimental and control groups were used to compute the minimum sample size required, with the assumptions of power = .8 and significance level = .05 (two-sided). This computation indicates that a minimum sample size of 67 participants for each group (i.e., 134 participants total) will be required to detect statistically significant differences between the experimental and control groups.

Measures

Demographic Information

To analyze the affects of potentially confounding demographic variables, such as age, gender, and race/ethnicity, a brief questionnaire adapted from Yatchmenoff (2001) (see Appendix D) will also be administered to participants with the other pretest questionnaires.

Fidelity of the Intervention

Presently, no standardized instruments exist to measure TDM model fidelity. It is unclear what adaptations the study site has made to the TDM intervention or may make during the study period. Therefore, to assess the fidelity of the TDM intervention as it is being implemented at the study site in comparison to the TDM model originally proposed by the Annie E. Casey Foundation, TDM program staff from each study site will complete the universal fidelity tool (see Appendix C) developed by Education Development Center (EDC) (Cummins, Goddard, Formica, Cohen, & Harding, 2003). This tool measures intervention adaptations in terms of the nature of each intervention component, how each component is delivered, to whom each component is delivered, where each intervention component is delivered, and who delivers each intervention component.

It is important to recognize that the study site has been implementing TDM for approximately 24 months. Consequently, it is not feasible to track all the adaptations that may have been made since the sites began implementing the intervention, prior to this study. However, it will be possible to assess the present TDM model fidelity at the study site in comparison to the original TDM model proposed by the Annie E. Casey Foundation at the beginning of this study. Further, by additionally assessing TDM model fidelity towards the end of data collection period (i.e., six to eight months later), it will be possible to determine whether any additional adaptations were made to the TDM model at the site during the study period.

Initial outcomes: Family member collaboration, perceived social support, & initial child placement

To measure the effects of TDM intervention exposure on client collaboration and perceived social support, three previously validated, structured questionnaires will be administered to primary caregivers directly before TDM meetings and within two months following TDM intervention exposure. To measure perceived social support and client engagement among parents in the control group, the same structured questionnaires will be provided to parents during the intake process (i.e., soon after CPS has substantiated child maltreatment) and then again within two months.

To assess family members' perceived social support the Multidimensional Scale of Perceived Social Support (MSPSS) will be utilized. Zimet, Dahlem, Zimet, & Farley (1988) developed the MSPSS to concisely measure individuals' perceived social support from three support sources, including family, friends, and significant other. The authors recommend that this 12-item scale (see Appendix E) be used with a 7-point Likert type scale. The initial test of the MSPSS revealed sound psychometric properties. The internal reliability for the total scale was .88, and the test-retest reliability was.85. Additionally, strong factorial validity was found between the three subscales. Although this initial study was conducted among a sample of co-ed undergraduate students, subsequent studies of the MSPSS in other diverse samples (e.g., urban African-American adolescents, Hispanic/Latino youth, pregnant women, pediatric residents, adult psychiatric outpatients) have consistently demonstrated high internal reliability, test-retest reliability, and factorial validity (Canty-Mitchell & Zimet, 2000; Cecil, Stanley, Carrion, & Swann, 1995; Clara, Cox, Enns, Murray, & Torgrudc, 2003; Dahlem, Zimet, & Walker, 1991; Edwards, 2004; Zimet, Powell, Farley, Werkman, & Berkoff, 1990). Therefore, it is expected that the MSPSS will maintain relatively high internal and test-retest reliability among family members in Maryland's child welfare system.

It is important to note that the MSPSS does not differentiate between support functions (e.g., emotional, instrumental, informational). Therefore, the structured Social Support Behaviors (SS-B) instrument, which measures five perceived or available support functions from family and friends including emotional, socializing, practical assistance (i.e., tangible), financial (i.e., tangible), and advice/guidance (i.e., informational) will also be utilized (Vaux, Riedel, & Stewart, 1987). Similar to the MSPSS, this instrument has been previously validated, with relatively high internal consistency ($\alpha > .80$) (Wills & Shinar, 2000).

To measure family member collaboration, as the feeling state of being involved in a positive helping process, the Client Engagement in Child Protective Services Scale, a 15-item structured questionnaire will be utilized (see Appendix F) (Yatchmenoff, 2005). This scale measures the four dimensions of engagement previously discussed, including receptivity, buy-in, working relationship, and mistrust. This scale was originally tested among 298 child protective services clients in Oregon. Participants were primarily the biological mothers of children that were named in the child protective services cases (87%), with about 15% African American, 68% European American, 4% Hispanic, 4% "mixed racial heritage, 2% Asian, and 2% Native American. Over half (60%) of cases had been open for less than four months, and nearly all (93%) had been open for less than 24 months. Participant ages ranged from 16-52 years, with a mean age of 31 years. More than half (69%) of participants reported that one or more of their children had been removed as a result of the most recent maltreatment allegation. Internal reliability for the four subscales ranged between .81 and .91. The internal reliability for all 15-items was similarly high ($\alpha = .95$). In addition, the four dimensions of engagement as well as the summary measure were significantly correlated with other, previously validated measures of engagement, indicating strong construct validity.

To determine initial placement types of children within one month of maltreatment substantiation, data from the Maryland Children's Electronic Social Services Information Exchange (MD CHESSIE) will be accessed. If information regarding the children's initial placement type is not documented in MD CHESSIE, then the family's caseworker and/or supervisor will be contacted by telephone to verbally obtain this information.

Intermediate outcomes: Family member compliancy and follow-through with services

To measure family member compliancy with child welfare services following child maltreatment substantiation, one previously validated, structured questionnaire will be utilized. This questionnaire is intended to measure family member compliancy or follow through with child welfare services from the family member's perspective (see Appendix G). This instrument was developed by the Regional Research Institute (1998) to measure child welfare outcomes for the Oregon Title IV-E Waiver Demonstration Project from 1997-2002. Yatchmenoff (2002) used the family member perspective compliancy scale to test the construct validity of the family member engagement questionnaire. This study revealed good internal consistency reliability ($\alpha = .78$) for the compliancy items as well as a significant positive correlation with the engagement summary measure ($p < .05$). Family member compliancy will additionally be measured with child welfare agency administrative data regarding the number of services accessed and attended by primary caregivers during the four months following child maltreatment substantiation. If this data is unclear, then the family's assigned caseworker will be contacted by telephone.

Long-term case-level outcomes

The MD CHESSIE will again be accessed eight and 12 months following child maltreatment substantiation for control and experimental group participants. Data collected will include case outcomes related to maltreatment recurrence (i.e., substantiated maltreatment), length of stay for those children placed in out-of-home care, placement stability, and permanency (i.e., placement and custodial status).

Procedures

Human subjects protection

Family members involved in the child welfare system are undoubtedly a vulnerable population. Therefore, safeguards to ensure that family members are not coerced or unduly influenced to participate in this study will be established prior to any participant recruitment efforts. Participation in this study will be entirely voluntary throughout the research period. No monetary incentives will be provided to family members for their participation, given that a large proportion of families in the child welfare system are low income and may be unduly influenced by such incentives.

With respect to the equitable selection of participants, TDM facilitators will be encouraged to make reasonable efforts to recruit all families that have been referred for initial placement TDM meetings because of substantiated maltreatment. To this end, TDM facilitators will be provided with forms to document their recruitment efforts (e.g., how many family members they were referred for TDM services, their reasons for not attempting to recruit certain families for study participation). Research team members will analyze TDM facilitator recruitment records at the end of each month during which participant recruitment occurs, in order to promptly address any reasons for apparent selection bias in recruitment processes. Similar measures will be taken with child welfare workers recruiting family members for the control group, such that assigned caseworkers will also document their initial attempts to recruit family members to the control group, and the research team will subsequently review recruitment documentation.

In terms of the risk/benefit that this research may pose to family members, it is not anticipated that any risks or harm beyond what family members ordinarily experience in their daily lives will result from

participation in this study. Family members may gain some satisfaction from their participation in this study by knowing that they are providing input, which may contribute to the state of knowledge regarding the helpfulness of different child welfare practices.
To maintain the security of the study data, all questionnaires, recorded MD CHESSIE and administrative data will be stored in a locked filing cabinet. This information will be linked together with participants' first names, contact information, and Department of Human Resources (DHR) case file numbers entered into a password protected excel sheet that will only be accessible to the study's primary investigator. All analyses of the data will only identify participants by their assigned numerical codes. All data files will be password protected and only accessible to research team members. Pretest and posttest questionnaires will be destroyed once participants' scores have been entered into the database. In addition, all data will be deleted upon the study's completion.

Recruitment

Primary caregivers recruited for the experimental group at the BCDSS study site will be initially approached about the study by TDM facilitators, since TDM facilitators are bound to maintain confidential relations with families in the child welfare system, but should not have any pre-existing ties to the families' cases. If for some reason, a TDM facilitator has been previously assigned as a child welfare caseworker for a given case, then a different TDM facilitator will approach the family members about study participation. All TDM facilitators at the study site will undergo a brief training led by the research team, concerning the ethical recruitment of families for the study. Through this training, it is expected that during all recruitment efforts that families will understand their participation is entirely voluntary and that they will not be penalized for declining to participate. Since the TDM facilitators are also responsible for scheduling the TDM meetings with the families, the TDM facilitators ask the those family members interested in participating if they will come to meeting approximately one hour before the meeting is scheduled to begin. If the family members agree to this scheduling, the TDM facilitators will subsequently contact the research team, such that the research team can meet these family members at the scheduled time to administer the informed consent forms and questionnaires to family members that have expressed interest in participating.

Similarly, primary caregivers recruited for the control group will be approached during the intake process (i.e., once the substantiated maltreatment disposition has been made) about the study by child welfare workers that are not directly assigned to their cases. If families express interest in participating, then the child welfare worker will have them sign a permission to contact form, indicating that the research team may contact them via telephone. The child welfare worker will subsequently forward the permission to contact forms to the research team, and the research team can proceed to directly contact families about participating in the study. If the families do not express interest in participating in the study after talking with the child welfare workers, then no further recruitment efforts will be made. by such incentives.

Since completion of the universal fidelity tool is intended to be a collaborative effort among program staff (Cummins, Goddard, Formica, Cohen, & Harding, 2003), this component of the study may involve the participation of TDM program coordinators, TDM facilitators, and/or other child welfare agency staff. Thus, recruitment of child welfare personnel at study sites will be conducted through administrative and supervisory staff members that have previously met with the research team regarding the study.

Informed consent

Informed consent will be obtained from all participants in this study, including family members and child welfare staff. Informed consent from family members will be obtained using the family member informed consent form (see Appendix H). Informed consent forms will be administered to family members by research team members. The research team member that administers the informed consent form will be required to read the form text aloud to all family members. Family members will then be given an opportunity to ask any questions they may have or express any concerns related to the study. Family members will indicate either their agreement to participate in the study by signing the informed consent form or may decline their participation in the study at this time. All family members that agree to participate in the study will be given a copy of the informed consent form.

Informed consent from child welfare staff completing the universal fidelity tool will also be obtained. Members of the research team will obtain written informed consent from child welfare staff prior to the administration of the universal fidelity tool. All child welfare staff participants will also receive a copy of the informed consent form.

Data collection

The universal fidelity tool is recommended for use every six months in order to track intervention adaptations over time (Cummins, Goddard, Formica, Cohen, & Harding, 2003). Therefore, this tool will be administered to TDM program staff at each study site at the beginning of the study period and then again six months later, towards the end.

For participants in the experimental groups, data regarding family members' perceived social support, collaboration, and demographic information will be collected prior to TDM meetings and then again within two months following the TDM meetings by research team members. Completion of the pretest questionnaires is estimated to take family members 20-25 minutes. Family members will be provided with envelopes to secure their questionnaires in following completion. All questionnaires will be numerically coded to maintain participants' anonymity. Within two months of pretest questionnaire completion, the research team will attempt to contact family members in order to arrange times for posttest questionnaire completion. Posttest questionnaire administration may likely coincide with family members' other child welfare service related appointments (e.g., parenting classes, substance abuse counseling). Therefore, if posttest data collection is to occur at the child welfare agency, the research team will reserve a private room for the participants to complete their posttest questionnaires in. Members of the research team will administer the posttest questionnaires to family members with similar protocol to that used for the administration of pretest questionnaires. Participants will again receive an envelope to secure their posttest questionnaires in following completion. Upon posttest completion, research team members will attempt to schedule a time with family members during the next several months to complete the compliancy questionnaire. If this is not feasible, then research team members will remind family members that they will be touch with them about setting up a time to complete the compliancy questionnaire during the next month.

Although child welfare workers will initially recruit family members for the control group during the intake process, research team members will obtain informed consent and administer the pretest questionnaires. The same informed consent form and pretest questionnaires will be used with control group participants as will be used with experimental group participants. It is anticipated that control group participants will complete the pretest within two weeks of the substantiated child maltreatment disposition made by CPS workers. Within the two months following pretest completion, the research

team will contact family members to schedule times for completion of the posttest questionnaires. Research team members will subsequently administer posttest questionnaires during the scheduled times. Again, if posttest questionnaire completion is to occur at the child welfare agency office, then the research team will secure a private room where participants can complete the posttest questionnaires. Following participants' posttest completion, research team members will attempt to schedule a time with them during the following two months to complete the compliancy questionnaire. If this is not feasible, then the research team members will remind participants that they will be in contact with them to schedule an final questionnaire completion time.

Approximately four months following administration of pretest questionnaires, participants from both control and experimental groups will complete the compliancy scale. The research team will schedule compliancy questionnaire completion times with participants. It is expected that this questionnaire should take participants five minutes or less to complete. Again, participants will be provided with an envelope for their questionnaires.

Eight and 12 months following the substantiation of child maltreatment for participants in the control and experimental groups, data from the MD CHESSIE will be collected regarding participants' case level outcomes. Specifically, data regarding maltreatment recurrence (i.e., substantiated, not substantiated, indicated), children's length of stay in out-of home care (i.e., if placed in out-of-home care), and children's permanency as reflected by the children's placement and custodial status will be collected. If this data is not recorded in the MD CHESSIE, then the child welfare caseworker and his/her supervisor listed as assigned to the case at the time of data collected will be contacted directly by the research team via telephone and email.

Data analysis plan

The null hypothesis for all dependent variables measured in the proposed research is that there are no differences between the experimental and control groups. The alternative hypothesis is that differences in the dependent variables exist between the experimental and control groups. In the proposed research the main independent variable of interest is whether or not participants were exposed to the TDM intervention. However, other potentially confounding variables, such as gender, ethnicity, income-level, and maltreatment case type, may also be predictive of participants' scores on the dependent variables. Dependent variables that will be measured in the proposed research include perceived social support, client collaboration, initial child placement (i.e., following the TDM meeting), and client compliance with child welfare services, recurrent maltreatment, and case permanency outcomes.

To determine if the null hypothesis can be rejected with respect each of the dependent variables, the assistance of an expert statistician will be sought. However, it is expected that the fundamental analyses utilized will include multivariate analysis of variance (MANOVA), since multiple dependent variables will be measured between the experimental and control groups (Altman, 1991). In addition, multiple linear regression analyses will be employed to determine whether potentially confounding variables (see Table 5) account for more of the variance in the model of best fit compared to the main independent variable (i.e., TDM exposure). Kendall's rank correlation test may also be to determine whether statistically significant correlations exist between the dependent variables of interest. For all analyses, 95% confidence intervals for differences in means and p-values will be computed, with the alpha level set at .05 to determine statistical significance.

Table 5. Covariates of Interest

Potentially Confounding Variables
• Age • Gender • Case type (e.g., physical abuse, neglect, domestic violence, substance abuse) • Race/Ethnicity • Education level • Case age (i.e., length of time that participant that participant has had a child welfare case) • Children removed as result of allegations that caused child welfare case • Income level

Conclusions

Limitations

Fisher & Foreit (2002) indicate several threats to validity that may bias the findings of studies with quasi-experimental nonequivalent control group designs. These threats include selection bias, testing, regression to the mean, and contamination. Since the proposed research employs this design, these threats will be briefly described in addition to ways in which these potential effects may be detected.

Likely types of selection bias that may affect this study's results include self-selection and experimenter biases. Self-selection bias may occur due to the voluntary nature of family member's participation in this study, such that those family members that choose to participate in the study may have certain underlying characteristics that those family members that decline participation may not have. Similarly, child welfare staff that initially recruit family members for the study may act in biased ways towards potential participants, thereby affecting the study sample. In addition, the intra-agency referral processes of child welfare workers with respect to the East Baltimore families actually referred to the TDM program may also influence the characteristics of the study sample.

However, as previously mentioned in the recruitment section, by systematically tracking the recruitment efforts of child welfare staff it is anticipated that experimenter bias will become apparent to the study team. Moreover, through the comparison of demographic characteristics as well as pretest scores between the experimental and control groups it will be possible to deduce to what extent selection bias differentially affected participants' responses between groups. That is, if the distribution of participants' demographic characteristics between experimental and control groups appears to be very different (e.g., there are a larger number of African-Americans in the control group versus the experimental group, a

larger proportion of families in the experimental group are low-income), then it is probable that selection biases may have influenced results. Likewise, by comparing experimental and control group participants' pretest scores, obvious discrepancies between the two groups in terms of dependent variable scores may indicate underlying differences, unrelated to intervention exposure, that affect findings between the two groups. In a similar vein, regression to the mean effects, whereby participants pretest scores are higher or lower than their posttest scores independent of treatment, may be recognized through the comparison of control and experimental groups' magnitude and direction of mean change scores (post-pre) on the dependent variables.

Testing effects may also influence results, such that pretest measurements may affect participants' post-test results. However, it is important to recognize that both of the instruments, which will be utilized to measure perceived social support and engagement among family members, have been previously tested and determined to have sound test-retest reliability.

Contamination, whereby the practice of child welfare workers serving West Baltimore families may be influenced by the implementation of TDM for East Baltimore families within the same social service agency is possible. However, given the long-established CPS protocols for responding to families with substantiated maltreatment using traditional case practice, it is unlikely that child welfare workers will alter their practice while serving West Baltimore families during the study period. It is also important to recognize that BCDSS CPS workers do not facilitate TDM meetings; instead, designated child welfare workers that are solely assigned to the TDM program facilitate TDM meetings. Further, several studies of family involvement intervention pilot programs suggest that CPS workers are often resistant to referring families to and/or participating in family involvement interventions, because they perceive the intervention as more time-consuming and threatening to their expertise as child welfare professionals (Crampton, 2007; Sundell, Vinnerljung, & Ryburn, 2001).

An additional limitation of this research is the relatively limited process evaluation component. Although fidelity of the TDM intervention will be assessed through the utilization of the Universal Fidelity Tool, more comprehensive process evaluation efforts are not within the scope of the proposed research. This is in part a feasibility issue related to the time and resource availability of the research team and child welfare staff. Nevertheless, some inferences regarding the adequacy of the TDM intervention may be made from model fidelity data. Additionally, it is expected that through the recruitment of participants for the study that data related to the reach of the intervention (i.e., how many children and families receive the intervention in East Baltimore) may be obtained.

It is also necessary to note one final limitation of the proposed research, specifically regarding the generalizability of findings. This study will be conducted with family members from Baltimore City that are involved in the child welfare system. Baltimore City is a predominately African American, urban area. Therefore, although certain characteristics of families involved in the child welfare system have been found to be similar throughout the nation, the generalizability of the study findings will be limited, especially with respect to urban and rural child welfare settings (Barth, Wildfire, & Green, 2006).

In considering these limitations of this study design, it is imperative to consider the feasibility of the proposed study design given the research setting. That is, this evaluative research will occur at a public child welfare agency with internal policies based on federal, state and local level government laws related to child welfare practice. In light of these circumstances, it is the most pragmatic to employ a study design that minimally alters the delivery of services that is presently occurring. Consequently,

although a randomized control trial of the TDM intervention at the study sites would yield the greatest potential for causal inferences regarding the effectiveness of this family involvement intervention; this is not a viable design both politically and logistically. Therefore, the quasi-experimental nonequivalent control group design proposed for this research, while subject to more threats to validity than a randomized control trial, is likely to elicit the least amount of resistance from the child welfare agency and staff in addition to providing the greatest potential for plausibility inferences that support the proposed change theory regarding the effectiveness of this intervention.

Implications

At this point in time, family involvement interventions should not be considered an evidence-based child welfare practice. "*Evidence-based* refers to practices for which verifiable information exists to support their adoption and sustained use," according to Sugai and Horner (2006, p. 247). Rather, family involvement interventions are a promising practice in need of further research. Moreover, as Crampton asserts, the development of family involvement intervention program theory is critical to both implementing and evaluating the efficacy and effectiveness of these interventions (2007).

The proposed research is a step in this direction, insofar as a program theory (i.e., the conceptual framework) is presented, with an emphasis on the initial outcomes that family involvement interventions are intended to elicit among family members. Clarification of the theoretical underpinnings and the initial outcomes of family involvement interventions are fundamental to the basis of further research efforts aimed at measuring the impact that these interventions may have on both family members' behaviors as well as the long-term child welfare case outcomes. Thus far, research efforts have failed to clearly articulate a change theory regarding *how* family involvement interventions positively affect children and families in the child welfare system. As such, previous research has generally yielded inconclusive evidence that does not support the widespread utilization of these interventions.

This has extremely important implications in an era where most domestic human services agencies, especially public child welfare agencies, are held increasingly accountable for their service delivery and related outcomes. Over the past several decades, the U.S. child welfare system has undergone substantial reforms with an influx of laws, consent decrees, and administration changes. Together these changes have required that child welfare agencies track their outcomes more carefully, modify service delivery, reshape practices, and constantly adapt to funding inconsistencies.

Under these mounting pressures, child welfare agencies have sought out innovative case practices and interventions to reduce the number of children entering out-of-home care, maltreatment recidivism rates, and length of stay in out-of-home placements for children that have been maltreated. However, the child welfare field is relatively new, and generally only exists in developed countries. Furthermore, given the vulnerable nature of the population served by the child welfare system, empirical research efforts have been somewhat limited as of yet. Nonetheless, the child welfare field has begun to adapt and apply research strategies and techniques from other more established fields, such as public health, to build an evidence base of practices and interventions that most benefit children and families in the system (Usher & Wildfire, 2003).

However, in all fields, theory should always be the foundation of research. Maltreatment recurrence, length of stay in out-of-home placements, and reunification will and *should* not change for children that are victims of maltreatment without some change in the knowledge, attitudes, and behaviors of parents that have been the perpetrators of maltreatment. Therefore, in determining the efficacy and effectiveness

of family involvement interventions, it is essential to measure both the psychosocial and behavioral outcomes that are expected among family members as a result of intervention exposure, which should precede the longer-term child welfare case outcomes. Given that both the child welfare and juvenile court systems primarily base their placement and custodial determinations for child maltreatment victims on the behaviors of pertinent family members, change in family members' attitudes and behaviors should be reflected by these determinations.

Moreover, as Habicht, Victora, and Vaughan (1999) suggest, the purpose of evaluative research is to influence decisions. With respect to family involvement interventions, American policy makers are presently focused on both the adequacy (i.e., how well the program has met the expected objectives) and plausibility (i.e., whether the program has an effect above and beyond the impact of non-program influences) of these interventions. This orientation is indicated by the federal emphasis placed on quasi-experimental evaluative research designs for Title IV-E waiver demonstration projects as opposed to randomized control trials (Family to Family Evaluation Team, 2007; Testa, 2002). For despite the causal evidence that RCT designs may provide, they are extremely resource intensive and often difficult to initiate, especially in public agencies that are often under significant fiscal and political constraints related to service provision.

The proposed research will test one program theory related to family involvement interventions. In essence, the proposed research is intended to add to the existing body of research as well as future research efforts regarding family involvement interventions through the elucidation of one pathway by which these interventions may be advantageous for exposed families. If this pathway can be substantiated, such that family member engagement and compliance with child welfare services are plausibly related to family involvement intervention exposure, then these outcomes alone may be sufficient to warrant the continued utilization of such interventions by child welfare agencies. However, if neither positive psychosocial and behavioral nor favorable long-term case outcomes can be plausibly related to these interventions, then the theoretical basis and implementation of such interventions should be questioned. For, although there is an undeniable need for more evidence-based child welfare practices to enhance child and family safety and well-being, a finite amount of resources exists to support the implementation of such interventions. Therefore, research that provides political and administrative decision-makers with more evidence regarding the efficacy family involvement as well as other innovative child welfare interventions is integral to ensuring that child welfare funds are appropriately allocated and reform initiatives actually achieve expected outcomes.

Appendix A

Table 3. Family Involvement Interventions Evidence

Family-level Interventions: Child & Family Focused						
Author(s)	**Study Question(s)**	**Intervention**	**Sample & Setting**	**Number**	**Measures**	**Main Findings**
Berzin (2006)	Do child welfare outcomes, including child maltreatment, placement stability, and permanency, differ between families exposed to family group decision making interventions and those that receive traditional child welfare services?	*Design* RCT (part of a Title IV-E Waiver Demonstration Project) *Intervention* Family Unity Model, Family Group Conferencing + Family Unity Model	Children (ages 0-18) living in Fresno County (CA), assessed to be at moderate-high risk of recurrent maltreatment & eligible for voluntary in-home services. Children (ages 2-12) living in Riverside County (CA), in non-relative or relative foster care and at-risk of placement change.	Fresno (n = 164) Riverside (n = 163)	Administrative data from the California Children's Services Archive related to: • Safety: # substantiated maltreatment reports, and removal from caregiver during study period. • Placement: # placement moves and steps up in placement restrictiveness • Permanency: Case closure & exit type	• Safety: No significant differences found between treatment and control group children in # substantiated child maltreatment reports and removal from caregiver. • Placement: No significant differences between treatment and control groups in # placement changes and steps up in placement restrictiveness. • Permanency: No significant differences between treatment and control groups in case closure and exit type.
Berzin, Thomas, & Cohen (2007)	(1) Does the implementation of FGDM programs in Fresno and Riverside Counties follow the	*Design* RCT (part of a Title IV-E Waiver Demonstration Project)	Children (ages 0-18, mean age = 4.6 years), in Fresno County (CA), assessed as at moderate to high risk of recurrent	Fresno = 76 children (49 treatment group & 27 control group)	Original instruments to extract the prescribed structural components, goals, and philosophies of FII. These	• Plan Participation & Endorsement: In Fresno, 95%

	structures, goals, and philosophies as shown in the literature? (2) What aspects of the FGDM model are most and least effectively adhered to in these counties?	*Intervention* Family Unity Model (Fresno), Family Group Conferencing + Family Unity Model (Riverside)	maltreatment & eligible for voluntary in-home services Children (ages 2-12, mean age = 5.5 years), in Riverside County (CA), in non-relative or relative foster care and at-risk of placement change.	Riverside = 63 children (41 treatment group & 22 control group)	instruments included: • Conference Participants Questionnaire (CPQ) • Conference Characteristics Survey (CCS) • Framework for Observing a Family Conference • Child Welfare Worker (CWW) Follow-Up Survey	of conference participants endorsed the family plans developed at meetings. In Riverside, 81% of conference participants felt equal deliberation between family members and professionals had occurred regarding the plan. • Plan Development: 96% of Fresno participants felt a clear plan was developed, and 99% Riverside felt a clear plan was developed. • Plan Completeness (six months after meeting): Fresno and Riverside child welfare workers mean rating of plan completeness was 2=mostly completed. In Riverside and Fresno, child welfare workers mainly

						attributed plan completeness to lack of follow-through on the part of family members. • Collaboration: Fresno meeting attendants included 65% family members, 14% friends, and 21% professionals. Riverside meeting attendants included: 67% family members, 14% friends, and 21% professionals. 79% of Fresno and 83% of Riverside meeting participants felt they expressed what they wanted to at the meetings. • Support: Family support was not consistently discussed as a conference topic according to family participants

						(69% Fresno, 49% Riverside). Only 33% of Fresno and 17% of Riverside family participants reported that community resources were discussed at meetings. • Satisfaction: 83% of Fresno and 91% of Riverside family community participants felt the meetings were helpful. 96% and 92% of Fresno and Riverside participants, respectively, were satisfied with the plans.
Crampton, & Jackson (2007)	How do the child welfare outcomes differ between groups, specifically those families that create a diversion plan during FGDM intervention and those families that are not able to create diversion plans as a result of FGDM intervention?	*Design* Multiple nonequivalent control group *Intervention* Family Group Decision-Making (FGDM)	Minority group families with substantiated child maltreatment (excluding sex abuse) with out-of-home placement removal petition referred for FGDM from 1996-1998 in Kent County, Michigan.	Comparison groups: Removal petition withdrawn (n = 51) Professionals did not agree case was appropriate for FGDM	CPS & Family Court data was used to determine additional contact with CPS, # out-of-home placements, long-term placements with parents or relatives, general permanency.	• No significant intergroup differences in additional CPS contact following initial maltreatment substantiation. Both diversion and no-diversion groups had the

				(*n* = 53) Families declined FGDM (*n* = 59) Families exposed to FGDM + developed diversion plan (*n* = 61) Families exposed to FGDM + *did not* develop diversion plan (*n* = 33)		same proportion (12%) of substantiated recurrent child maltreatment. • Families that developed a diversion plan through FGDM intervention were significantly less likely than families in other comparison groups to have children with three or more placements. • A significantly higher proportion (65%) of children in the diversion FGDM group experienced guardianship (i.e., a relative or non-relative foster parent maintained legal custody of the child) as a permanency outcome than the other groups.
Pennell & Burford (2000)	1) Does FGDM implementation reduce violence against child	*Design* Quasi-experimental nonequivalent control	Three culturally distinct regions in the Newfoundland and	Treatment group: 32 families, with	Two main measures: 1. Progress reports: structured and	• Safety: Families in the treatment

	and adult family members and promote their well-being across different cultural milieus?	group *Intervention* Family Group Decision-Making (FGDM)	Labrador Provinces of Canada, including Nain, Port au Port Peninsula, and St. Johns	91 children under 18, & 384 family members Control group: 31 families (not randomly selected) from same area, selected during same time period	unstructured questions posed to treatment group family members regarding family violence and well-being. 2. Child protection events: A checklist with 31 indicators of child abuse and adult abuse	group demonstrated declines in events indicative of maltreatment (pre = 233 total & post = 117 total) Families in the control group showed an increase in events indicative of maltreatment (pre = 129 total & post = 165 total). • CPS Activity: Maltreatment reports decreased for treatment group families (pre =120 & post = 69); whereas, CPS reports increased for families in the comparison group (pre=71 & post=94). • Wife/mother abuse: Decreased among families in treatment group (pre = 84 reports, post = 34 reports) and increased in the comparison

						group (pre = 45 reports & post = 52 reports).
Sieppert, Hudson, & Unrau (2000)	What were the FGC outcomes, in terms of care plan, plan monitoring, and participants' conference appraisal, of a FGC pilot program designed for child welfare clients?	*Design* Non-experimental post-test only/ Process evaluation *Intervention* Family Group Conferencing (FGC)	Calgary, Alberta, Canada, February to December 1997, families involved in child welfare system	23 families (51 children)	• Care plans produced at the end of FGC • Care plan goal completion by families • FGC participant satisfaction	• Care plans were produced for each family (n = 23) • The average number of goals specified in FGC care plans was four. • Families that participated in follow-up meetings completed on average half of the FGC care plan goals. • 80% of FGC participants were highly satisfied with conference location, 70% were highly satisfied with FGC preparation and people invited. 76% felt strongly involved in the decision-making process, 62% expressed high degree of satisfaction with FGC decisions, and 72% expressed

						high degree of satisfaction with care plan.
Sundell, & Vinnerljung (2004)	1) Will Family Group Conferencing (FGC) exposure decrease child maltreatment referrals? 2) Will FGC exposure reduce the likelihood of repeated neglect and abuse? 3) Will FGC exposure increase child maltreatment reports by extended family? 4) Will kinship/relative foster care increase among families that receive FGC? 5) Will FGC exposure increase the likelihood of closing child welfare cases?	*Design*: Concurrent prospective study with nonequivalent control group *Intervention* Family Group Conferencing (FGC)	Treatment Group: Children whose families received "first-time" FGC from November 1996 – October 1997 in 10 local, Swedish authorities Control Group: Children randomly sampled from families being assessed in traditional Swedish CPS-procedures in the same local authorities during the study period	Treatment Group *n* = 99 Comparison Group *n* = 149 Family members participating in FGC *n* = 413	• FGC process evaluation instruments adapted from previous FGC study • Short survey regarding FGC participants' feelings of empowerment, relation to the child, their assessment of the family plan and the child's future situation • Child welfare administrative data	• Selection bias: Families referred for FGC were significantly more likely to have been previously investigated by CPS and children in families referred for FGC reported as having significantly more severe problems than those children whose families received traditional CPS process • Social Support: In 86% of FGC plans extended family members volunteered to assist the child and parents. 51% of services suggested in the FGC plans were to be provided by extended family, 32% by social services,

						and 17% by the school. Children in treatment group received on average more services than children in the control group. • Initial Placement: Children in treatment group were significantly more likely to be placed in foster or residential care following FGC. • Maltreatment Recurrence: Treatment group children were significantly more likely to have substantiated maltreatment allegations than control group children three years following their initial investigations. No significant differences were found between the groups with

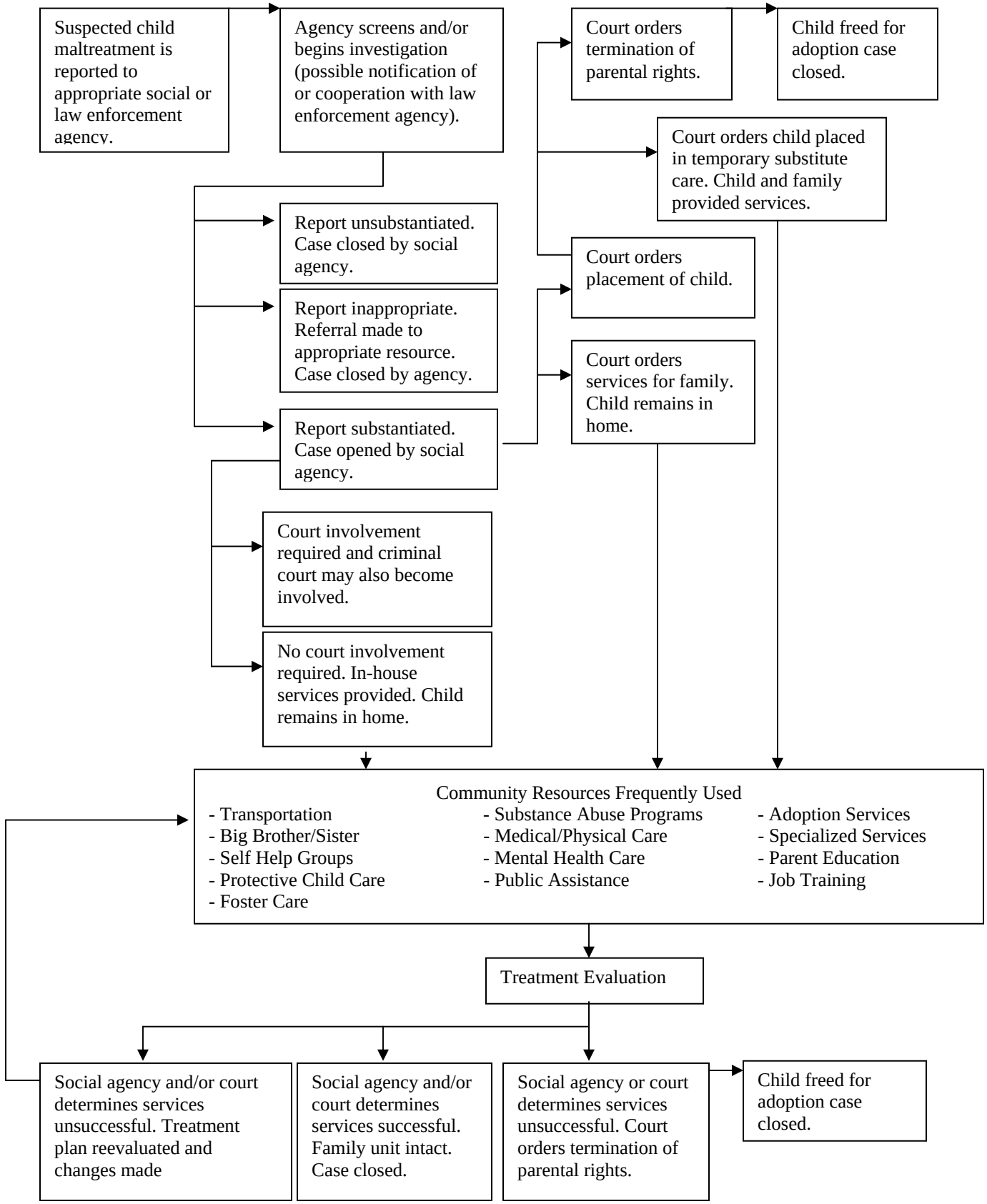
						respect to child maltreatment allegations made by extended family. • Permanency: Treatment group children were significantly more likely to be placed in out-of-home care during the three years following FGC than control group children. Treatment group children were also significantly more likely to experience longer lengths of stay in out-of-home care than children in comparison group. A significantly larger proportion of treatment group children placed in out-of-home care during three years following initial allegation were placed with

						extended family members in comparison to control group children.
Sundell, Vinnerljung, & Ryburn (2001)	What are social workers' attitudes regarding family group conferencing, and do these attitudes relate to their referral behaviors?	*Design* Cross-sectional, non-experimental *Intervention* FGC	Social workers from 18 local authorities: eight UK & 10 Swedish authorities	Swedish Social Workers *n* = 110 UK Social Workers *n* = 109	• 11-item structured questionnaire regarding FGC • 8-item structured questionnaire child maltreatment investigations in general • Administrative data regarding referral of families for FGC	• Overall, workers from the UK and Sweden expressed positive attitudes regarding FGC. • Only 42% of workers had initiated at least one FGC over an 18 month period.
Veneski, & Kemp (2000)	1. Who was served by the FGC project? 2. What were the outcomes for children and families participating in the project? 3. Does conferencing engage families in the delivery of child welfare services?	*Design* Non-experimental post-test only *Intervention* FGC	Families involved in Washington State's child welfare system from October 1996 – March 1998 (71% involved in Juvenile Court System as well) that were referred for FGC (no specific referral criteria stated)	*n* = 229 children	• Descriptive data from conferences • Two structured surveys of child welfare workers involved with the FGC project • Analysis of family plans using grounded theory • Case plan data	• Placement: 78% of children experienced no placement changes, 11% were moved from non-relative to relative foster care, 6 % were moved from relative care to parental care. • Of the children that did not change placements, 39% remained in parental care, 44%

						remained in relative care, 17% remained in foster care, & <1% remained in group care.

Appendix B

Figure 3. What happens once child maltreatment has been reported? (Adapted from the Ohio Department of Public Welfare, Children's Protective Services, as cited in Crosson-Tower, 2005)



Appendix C

Universal Fidelity Tool

Report on Program Fidelity and Adaptations

PURPOSE AND INSTRUCTIONS

The purpose of this document is to assess any changes to your program. Tracking changes is important because
modifications may lead to different outcomes than those that would be expected if the program were implemented as originally designed.

Fill out information on the cover page; then complete one set of the attached forms for each of your major program
components/interventions. For example, if the two main aspects of your program were a TDM worker training component and a TDM meeting component, you would complete one set of forms for each of these two components. We have left room for one change under each heading; in an instance when you have more than one change, you can photocopy that particular page.

ADMINISTRATIVE INFORMATION (write in)

Program Name	
(if applicable, include name of model/promising program)	
Administrative Organization Name	
Name of Person Completing the Form (contact person)	
Address of Person Completing the Form	
Phone Number of Person Completing the Form	
E-mail Address of Person Completing the Form	
Date Form Completed	

Created by Social Science Research and Evaluation, Inc. and Health and Human Development Programs, EDC

GOALS AND OBJECTIVES

1. List the current goals and objectives of your program.

2. Were any changes (additions/deletions/modifications) made to these goals and objectives during the past six months?

   ☐ *No* ☐ *Yes*

   a. If you answered "Yes," identify each goal or objective that was changed, explain the change, and explain the rationale for the change.

EVALUATION

3. Provide a summary of your evaluation design for this program. Include a description of your process evaluation and outcome evaluation activities, instruments, and measures.

4. Were any changes (additions/deletions/modifications) made to the evaluation design during the past six months?
   ☐ *No* ☐ *Yes*

   a. If you answered "Yes," identify each change, explain the change, and explain the rationale for the change.

PROGRAM COMPONENTS

5. Describe each of the major program components of your project. We have left room for information on three components. If you need more room, reproduce this sheet and attach it to the packet.

Program Component Description:

Type(s): ☐ Universal (general population) ☐ Selected (high risk group) ☐ Indicated (diagnosed or apparent risks in participant referred)

Target(s) – Domain: ☐ Youth ☐ Family ☐ School ☐ Community ☐ Workplace ☐ Healthcare ☐ Other ______________

Target(s) – Age: ☐ No distinction ☐ Early Childhood (0-4) ☐ School Age (5-11) ☐ Early Adolescent (12-14) ☐ Teenagers (15-17)
☐ Young Adults (18-24) ☐ Adults (25-54) ☐ Seniors (55+)

Target(s) – Race/Ethnicity: ☐ No distinction ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ______________

Target(s) – Gender: ☐ No distinction ☐ Female ☐ Male

Purpose(s): ☐ Improve knowledge/awareness ☐ Improve skills ☐ Increase involvement in healthy alternatives ☐ Change norms
☐ Change policies ☐ Change laws ☐ Improve enforcement ☐ Mobilize community ☐ Build collaboration
☐ Improve problem identification and referral ☐ Improve access to/quality of care ☐ Other ______________

Program Component Description:

Type(s): ☐ Universal (general population) ☐ Selected (high risk group) ☐ Indicated (diagnosed or apparent risks in participant referred)

Target(s) – Domain: ☐ Youth ☐ Family ☐ School ☐ Community ☐ Workplace ☐ Healthcare ☐ Other ______________

Target(s) – Age: ☐ No distinction ☐ Early Childhood (0-4) ☐ School Age (5-11) ☐ Early Adolescent (12-14) ☐ Teenagers (15-17)
☐ Young Adults (18-24) ☐ Adults (25-54) ☐ Seniors (55+)

Target(s) – Race/Ethnicity: ☐ No distinction ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ______________

Target(s) – Gender: ☐ No distinction ☐ Female ☐ Male

Purpose(s): ☐ Improve knowledge/awareness ☐ Improve skills ☐ Increase involvement in healthy alternatives ☐ Change norms
☐ Change policies ☐ Change laws ☐ Improve enforcement ☐ Mobilize community ☐ Build collaboration
☐ Improve problem identification and referral ☐ Improve access to/quality of care ☐ Other ______________

Program Component Description:

Type(s): ☐ Universal (general population) ☐ Selected (high risk group) ☐ Indicated (diagnosed or apparent risks in participant referred)

Target(s) – Domain: ☐ Youth ☐ Family ☐ School ☐ Community ☐ Workplace ☐ Healthcare ☐ Other ______________

Target(s) – Age: ☐ No distinction ☐ Early Childhood (0-4) ☐ School Age (5-11) ☐ Early Adolescent (12-14) ☐ Teenagers (15-17)
☐ Young Adults (18-24) ☐ Adults (25-54) ☐ Seniors (55+)

Target(s) – Race/Ethnicity: ☐ No distinction ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ______________

Target(s) – Gender: ☐ No distinction ☐ Female ☐ Male

Purpose(s): ☐ Improve knowledge/awareness ☐ Improve skills ☐ Increase involvement in healthy alternatives ☐ Change norms
☐ Change policies ☐ Change laws ☐ Improve enforcement ☐ Mobilize community ☐ Build collaboration
☐ Improve problem identification and referral ☐ Improve access to/quality of care ☐ Other ______________

REPORT OF PROGRAM CHANGES

Complete one set of the attached forms for each of your major program components/interventions (identified in the previous section). For example, if the two main aspects of your program were a TDM worker training component and a TDM meeting component, you would complete one set of forms for each of these two components.

Write in the name of the individual component at the bottom of each page of the corresponding set of forms.

You should complete the forms as follows:

- Identify whether you made a change to the specific programmatic aspect listed, such as "Duration of intervention" under "HOW is the component/intervention delivered?". The aspects being examined are:

  1. WHAT is the nature of the component/intervention?
     a. Content of sessions

  2. HOW is the component/intervention delivered?
     a. Duration of intervention
     b. Delivery method of intervention
     c. Number of sessions
     d. Length of sessions
     e. Order of sessions
     f. Frequency of sessions
     g. Materials

  3. TO WHOM is the component/intervention delivered?
     a. Target Population – Number of participants
     b. Target Population – Characteristics (age, gender, ethnicity, risk level, geography, etc.)
     c. Target Population – Recruitment/retention methods

  4. WHERE is the component/intervention delivered?
     a. Setting/location (class setting, after-school setting, home, community center, etc.)

  5. WHO delivers the component/intervention?
     a. Delivery Agents – Number of staff/volunteers
     b. Delivery Agents – Training required/provided
     c. Delivery Agents – Characteristics (age, gender, ethnicity, experience, role, etc.)
     d. Delivery Agents – Recruitment/retention method

If you report that a change has taken place, you are asked to provide the following additional information.

- *Date that the change occurred* – Provide your best assessment.

- *The primary reason for the change* – Involves an appraisal of the primary reason for a program modification using six categories: recipient issues, program provider issues, community issues, setting issues, evaluation issues, and sustainability. The categories, along with some examples, are listed below.

1. Recipient Issues (cultural norms, demographics, etc.)
    - •Parents were unwilling to attend TDM meetings.
    - •We were able to provide translation services for some parents that did not speak English.

2. Program Provider Issues (staff recruitment/retention issues, costs, etc.)
    - •We didn't have the necessary number of TDM facilitators for the number of families referred for TDM.
    - •Our agency did not have enough funds to hire additional TDM facilitators and program staff.

3. Community Issues (political climate, traumatic incident, community norms, etc.)
    - •We hired cultural liasons to research community resources for family members.
    - •Families from certain communities that our agency serves were unwilling to participate in TDM.

4. Setting Issues (policies, scheduling, facilities, etc.)
    - •It has been difficult to schedule TDM meetings, because of conference room availability at the agency.
    - •We have been trying to schedule more TDM meetings in community locations.

5. Evaluation Issues (sample size requirements, resources, reporting schedule, etc.)
    - •We have been unable to track our TDM data in a centralized database that other agencies may access.
    - •We have started measuring TDM participant satisfaction.

6. Sustainability Issues (potential funding leverage, community buy-in, etc.)
    - •CPS workers have not been referring their cases for TDM.
    - •We were able to rollout the next phase of our TDM program because of increased funding.

- *A description of the programmatic change and why it occurred* – This narrative provides qualitative information on the cause and nature of adaptations and provides a valuable record for funders, researchers, and implementers.

- *Report of resulting changes to the evaluation* – This includes both (1) an assessment of whether any modifications were made to the evaluation design to accommodate the programmatic change and (2) a description of changes to the evaluation design or a rationale for why such changes were not necessary.

We have left room for one change under each heading; in an instance when you have more than one change, you can photocopy that particular page.

1. WHAT is the nature of the component/intervention?

1a. Content of Sessions

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•***Primary*** Reason (check one) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

2. HOW is the component/intervention delivered?

2a. Overall Duration of the Intervention

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•***Primary*** Reason (check one) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

2b. Delivery Method

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

2c. Number of Sessions

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

2d. Length of Sessions

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

2e. Order of Sessions

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

2f. Frequency of Sessions	☐ *Does not apply* ☐ *No changes* ☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

2g. Materials	☐ *Does not apply* ☐ *No changes* ☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

3. TO WHOM is the component/intervention delivered?

3a. Target Population – Number of Participants

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

3b. Target Population – Characteristics (age, gender, ethnicity, risk level, geography, etc.)

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

3c. Target Population – Recruitment/Retention Methods	☐ *Does not apply* ☐ *No changes* ☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

4. WHERE is the component/intervention delivered?

4a. Setting/Location (class setting, after-school setting, home, community center, etc.)	☐ *Does not apply* ☐ *No changes* ☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

5. WHO delivers the component/intervention?

5a. Delivery Agents – Number of Staff/Volunteers

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

5b. Delivery Agents – Training Required/Provided

☐ *Does not apply*
☐ *No changes*
☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

5c. Delivery Agents – Characteristics (age, gender, ethnicity, experience, role, etc.)	☐ *Does not apply* ☐ *No changes* ☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

5d. Delivery Agents – Recruitment/Retention Method	☐ *Does not apply* ☐ *No changes* ☐ *Yes, there were changes* – Complete the information below for each change in this area during the reporting period.

•Date of Change _____/_____/_____

•*Primary* Reason (check *one*) ☐ *Recipient Issues* ☐ *Program Provider Issues* ☐ *Community Issues* ☐ *Setting Issues* ☐ *Evaluation Issues* ☐ *Sustainability Issues*

•Describe the change and your rationale for making it. Essentially, explain (1) what the aspect used to be, (2) what it is now, and (3) why it changed.

•Was it (or will it be) necessary to modify your evaluation design to accommodate this programmatic change? ☐ *No* ☐ *Yes*

•If "No," describe why no changes are necessary. If "Yes," describe what evaluation change(s) have been or will be made.

Appendix D

Demographic Information Questionnaire

This is a survey to find out how family members like you feel about child welfare. The questions on the survey ask you about how you feel about your case right now. There are no right of wrong answers. The survey is completely voluntary. You don't have to take it if you don't want to. It is absolutely confidential. No one but the researchers will see you answers. When you are done, please place your survey in the envelope provided and then seal the envelope to make sure no one else sees your answers if you don't want them to. Please give the sealed envelope to the researcher once you have finished. Thank you for your participation.

1. Do you have an open case with child welfare? Yes_____ No _____

2. About how long have you had a case with child welfare?

_____1-2 months _____3-6 months _____6-12 months _____longer than 12 months

3. How old are you? _____

4. Are you _____Female _____Male

5. Why was your case opened and/or the reason for the meeting today [You can check more than one reason]

_____physical abuse _____neglect _____domestic violence _____substance abuse

_____failure to protect your child(ren) from harm _____other _____don't know

6. Were any of your children placed in care because of these allegations?
   Yes _____ No _____

7. Is this the first time that you have had a case opened by child welfare?
   Yes _____ No _____

8. Do you think of yourself as:
   African American? _____ Hispanic/Latino? _____ European American? _____

   Asian Pacific Islander?_____ Native American?_____ Mixed race/ethnicity? _____

9. Please indicate the highest level of education you have completed.

   Elementary School _____ Junior High School _____ Some High School _____

   High School_____ Some College_____ Bachelors Degree_____ Advanced Degree _____

10. How many people live in your household? _____

11. Please indicate what your household income typically is each year?
    Less than $10,000 per year _____ $10,000-$20,000 per year _____ $21,000-$31,000 per year _____

    $32,000 -$42,000 per year _____ $43,000-$53,000 per year _____ More than $54,000 per year_____

Appendix E

Multidimensional Scale of Perceived Social Support Scale

MSPSS Items
1. There is a special person around when I am in need.
2. There is a special person with whom I can share my joys and sorrows.
3. My family really tries to help me.
4. I get the emotional help and support I need from my family.
5. I have a special person who is a real source of comfort to me.
6. My friends really try to help me.
7. I can count on my friends when things go wrong.
8. I can talk about my problems with my family.
9. I have friends with whom I can share my joys and sorrows.
10. There is a special person in my life who cares about my feelings.
11. My family is willing to help me make decisions.
12. I can talk about my problems with my friends.

Appendix F

Client Engagement in Child Protective Services Questionnaire

These questions are about how you feel.

Please select the answer that is closest to how you feel right now about working with Child Welfare.

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. There were definitely some problems in my family that child welfare saw.	5	4	3	2	1.
2. My child welfare worker and I agree about what's best for my child(ren).	5	4	3	2	1
3. I need some help to make sure my kids have what they need.	5	4	3	2	1
4. I can trust my child welfare worker to be fair and see my side of things.	5	4	3	2	1
5. My caseworker understands my point of view.	5	4	3	2	1
6. Child welfare is helping me to take care of the problems in my life.	5	4	3	2	1
7. What child welfare want me to do is the same as what I want.	5	4	3	2	1
8. Child welfare wants to help families- not hurt them.	5	4	3	2	1
9. There's a good reason why CPS is involved with my family.	5	4	3	2	1
10. I'm only doing what child welfare wants so they'll get out of our lives.	5	4	3	2	1
11. Things will get better for my child(ren) now that child welfare is involved.	5	4	3	2	1
12. My child welfare worker and I respect each other.	5	4	3	2	1
13. I'm making changes in my life to keep my kid(s) safe.	5	4	3	2	1
14. Child welfare is helping my family get stronger.	5	4	3	2	1
15. I can tell my worker I'm afraid to get my kids back.	5	4	3	2	1

Appendix G

Family Compliance/ Follow through Questionnaire

The following statements refer to the expectations that [child welfare] may have for you and your family – that is, what your worker wants you to do. We are interested in your honest report of how well you feel you are meeting those expectations. **Remember that your answers are absolutely confidential. Your name is not on this questionnaire, and your answers will not be seen by anyone except the researchers.**

Over the past one-two months...

1. I have been able to follow through on the things my worker and I agreed I would do...

5 All or nearly all of the time

4 Most of the time

3 Some of the time

2 A little of the time

1 None of the time

2. I have followed up on service referrals (or have attended services) suggested by my worker...

5 All or nearly all of the time

4 Most of the time

3 Some of the time

2 A little of the time

1 None of the time

3. I have shown up for scheduled meetings with my worker (in my home or at the agency) and/or returned my worker's phone calls...

5 All or nearly all of the time

4 Most of the time

3 Some of the time

2 A little of the time

1 None of the time

4. I believe I am meeting the expectations of my service agreement (or what my child welfare worker) wants me to do.

5 All or nearly all of the time

4 Most of the time

3 Some of the time

2 A little of the time

1 None of the time

Appendix H

Family Member Informed Consent Form

You are invited to participate in a study being conducted by Olivia Lindly, a Masters of Public Health student at Johns Hopkins University. Your participation in this study is entirely voluntary. This study is intended to determine whether family team decision meetings are helpful for family members that become involved in Maryland's child welfare system. You will be asked to complete several questionnaires before the team decision-making meeting and again two and four months following the meeting. These questionnaires should take you 20-25 minutes to finish.

It is not expected that you will experience any discomfort as a result of your participation in this study beyond that you would ordinarily encounter in your day-to-day life. You may decline to participate or withdraw from the study at any time. Your questionnaire responses will be anonymous. Your questionnaires will be separated from this consent form and stored separately. Your name will not appear anywhere on the questionnaire; instead the questionnaires will be identified with a number from which individual persons cannot be identified. This consent form will be stored in a secured location, and your participation will not be reported to your caseworker or any other child welfare staff member through which you were recruited. In written reports of this research, only responses averaged across groups of participants will be examined.

If you have any other questions or comments about this study, you may contact the primary investigator by email at: olindly@jhsph.edu. Other concerns about this study may also be referred to Dr. Anne Riley at: ariley@jhsph.edu or (410) 955-1058.

I have read and understand the information provided above, and I voluntarily consent to participate in this study. In signing this form, I affirm that I am 18 years of age or older.

_____ _____

Participant's Signature Date

_____ _____

Investigator's Signature Date

Works Cited

Altman, D. G. (1991). *Practical Statistics For Medical Research*. London: Chapman & Hall.

Anda, R. F., Croft, J. B., Felitti, V. J., Nordenberg, D., Giles, W. H., Williamson, D. F., Giovino, G. A. (1999). Adverse childhood experiences and smoking during adolescence and adulthood. *Journal of the American Medical Association, 282(17),* 1652-1658.

Baker, A. J., Kurland, D., Curtis, P., Akexander, G., & Papa-Lentini, C. (2007). Mental health and behavioral problems in the child welfare system: Residential treatment centers compared to therapeutic foster care in the odyssey project population. *Child Welfare, 86(3),* 97-123.

Barrera, M., Sandler, I., & Ramsay, T. (1981). Preliminary development of a scale of social support: Studies on college students. *American Journal of Community Psychology, 9,* 435-447.

Barth, R. P., Wildfire, J., & Green, R. L. (2006). Placement into foster care and the interplay of urbanicity, child behavior problems, and poverty. *American Journal of Orthopsychiatry, 76(3),* 358-366.

Batterson, M., Crampton, D., Crea, T., Harris, F., Madden, A., Usher, L. & Williams, J. (2007). *Implementing Family to Family*. Chapel Hill, NC: The University of North Carolina at Chapel Hill.

Berzin, S. (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.

Berzin, S. C., Thomas, K. L., & Cohen, E. (2007). Assessing model fidelity in two family group decision-making programs: Is this child welfare intervention being implemented as intended? *Journal of Social Service Research, 34(2),* 55-71.

Budde, S., & Schene, P. (2004). Informal social support interventions and their role in violence prevention: An agenda for future evaluation. *Journal of Interpersonal Violence, 19(3),* 341-355.

Canty-Mitchell, J., & Zimet, G. D. (2000). Psychometric properties of the multidimensional scale of perceived social support in urban adolescents. *American Journal of Community Psychology, 28(3),* 391-400.

Cecil, H., Stanley, M. A., Carrion, P. G., & Swann, A. (1995). Psychometric properties of the MSPSS and NOS in psychiatric outpatients. *Journal of Clinical Psychology, 51(5),* 593-602.

Clara, I. P., Cox, B. J., Enns, M. W., Murray, L. T., & Torgrudc, L. J. (2003). Confirmatory factor analysis of the multidimensional scale of perceived social support in clinically distressed and student samples. *Journal of Personality Assessment, 81(3),* 265-270.

Connell, C. M., Bergeron, N., Katz, K. H., Saunders, L., & Tebes, J. K. (2007). Re-referral to child protective services: The influence of child, family, and case characteristics on risk status. *Child Abuse & Neglect, 31,* 573-588.

Coohey, C. (1996). Child maltreatment: Testing the social isolation hypothesis. *Child Abuse & Neglect, 20(3),* 241-254.

Corcoran, J. (2000). Family interventions with child physical abuse and neglect: A critical review. *Children and Youth Services Review, 22(7),* 563-591.

Coulton, C. J., Crampton, D. S., Irwin, M., Spilsbury, J. C., & Korbin, J. E. (2007). How neighborhoods influence child maltreatment: A review of literature and alternative pathways. *Child Abuse & Neglect, 31,* 1117-1142.

Crampton, D. (2003). Family group decision making in Kent County, Michigan: The family and community compact. *Protecting Children, 18,* 81-83.

Crampton, D. (2007). Research review: Family group decision-making: A promising practice in need of more programme theory and research. *Child and Family Social Work, 12,* 202-209.

Crampton, D. S. (2004). Family involvement interventions in child protection: Learning from contextual integrated strategies. *Journal of Sociology and Welfare, 26(1),* 175-195.

Crampton, D., & Lewis, W. L. (2007). Family group decision making and disproportionality in foster care: A case study. *Child Welfare, 86(3),* 51-69.

Crampton, D., & Natarajan, A. (2005). Connection between group work and family meetings in child welfare practice: What can we learn from each other? *Social Work with Groups, 28(1),* 65-79.

Crosson-Tower, C. (2005). *Understanding Child Abuse and Neglect* (6th ed.). Boston: Allyn & Bacon.

Cummins, M., Goddard, C., Formica, S., Cohen, D., & Harding, W. (2003). *Assessing program fidelity and adaptations toolkit*. Newton, MA: Education Development Center, Inc.

Dahlem, N. W., Zimet, G. D., & Walker, R. R. (1991). The multidimensional scale of perceived social support: A confirmation study. *Journal of Clinical Psychology, 47(6),* 756-761.

Dawson, K., & Berry, M. (2002). Engaging families in child welfare services: An evidence-based approach to best practice. *Child Welfare, 81(2),* 293-317.

DeMuro, P. (1997). Team decision-making: Involving the family and community in child welfare decisions. Building Community Partnerships in Child Welfare, Part Two. Family to Family: Tools for Rebuilding Foster Care. Annie E. Casey Foundation, Baltimore, MD.

DePanfilis, D., & Zuravin, S. J. (2002). The effect of services on the recurrence of child maltreatment. *Child Abuse & Neglect, 26*, 187-205.

DePanfilis, D., & Zuravin, S. J. (1999). Predicting child maltreatment recurrences during treatment. *Child Abuse & Neglect, 23 (8)*, 729-743.

DePanfilis, D. (1996). Social isolation of neglectful families: A review of social support assessment and intervention models. *Child Maltreatment, 1 (1)*, 37-52.

Drake, B., & Pandey, S. (1996). Understanding the relationship between neighborhood poverty and specific types of child maltreatment. *Child Abuse & Neglect, 20*, 1003-1018.

Dube, S. R., Felitti, V. J., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111(3)*, 564-572.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from he adverse childhood experiences study. *Journal of the American Medical Association, 286(24)*, 3089-3096.

Edwards, L. M. (2004). Measuring perceived social support in Mexican American youth: Psychometric properties of the multidimensional scale of perceived social support. *Hispanic Journal of Behavioral Sciences, 26(2)*, 187-194.

Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results form the adverse childhood experiences study. *American Journal of Psychiatry, 160*, 1453-1460.

Family to Family Evaluation Team (2007). Evaluation plan for family to family. Baltimore, MD: The Annie E. Casey Foundation.

Fang, X., & Corso, P. S. (2007). Child maltreatment, youth violence, and intimate partner violence: Developmental relationships. *American Journal of Preventative Medicine, 33(4)*, 281-290.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of child abuse and household dysfunction to many of the leading causes of deaths in adults. *American Journal of Preventative Medicine, 14(4)*, 245-258.

Fisher, A. A., & Foreit, J. R. (2002). Designing HIV/AIDS intervention studies: An operations research handbook. New York, NY: The Population Council Inc.

Habicht, J. P., Victora, C. G., & Vaughan, J. P. (1999). Evaluation designs for adequacy, plausibility, and probability of public health programme performance and impact. *International Journal of Epidemiology, 28,* 10-18.

Hansen, R. L., Mawjee, F. L., Barton, K., Metcalf, M. B., & Joey, N. R., (2004). Comparing the health status of low-income children in and out of foster care. *Child Welfare, 33(4),* 367-380.

Hassall, I. (1996). Origin and development of family group conferences. In J. Hudson, A. Morris, G, Maxwell, & B. Galaway (Eds.), *Family group conferences: Perspectives on policy and practice* (pp. 17-36). Monsey, NY: Willow Tree Press.

Keys, T., & Rockhill, A. (2000). Family group decision-making in Oregon. In *Family group conferencing; new directions in community-centered child and family practice* (pp. 271-277). New York: Aldine de Gruyter.

Lawrence, C. R., Carlson, E. A., & Egeland, B. (2006). The impact of foster care on development. *Developmental Psychopathology, 18(1),* 57-76.

Leslie, L. K., Gordon, J. N., Mencken, L., Premix, K., Michel more, K. L., & Ganger, W. (2005). The physical, developmental, and mental health needs of young children in child welfare by initial placement type. *Journal of Developmental and Behavioral Pediatrics, 26,* 177-179.

Littell, J. H., & Tajima, E. A. (2000). A multilevel model of client participation in intensive family preservation services. *Social Services Review, 74*, 405-435.

Macgowen, M. J., & Pennell, J. (2001). Building social responsibility through family group conferencing. *Social Work with Groups, 24(3/4),* 67-87.

Maas, C., Herrenkohl, T. I., & Sousa, C. (2008). A review of research on child maltreatment and violence in youth. *Trauma Violence Abuse, 9(1),* 56-67.

Maryland Department of Human Resources (2008). DHR Snap Shot 2005: Baltimore City. Retrieved on April 26, 2008, from http://www.dhr.state.md.us/baltocity.htm

Maryland Governor's Office for Children (2008). Research, evaluation, and data collection: Children safe in their families and communities. Retrieved on April 26, 2008, from http://www.ocyf.state.md.us/

Mirsky, L. (2003). Family group conferencing worldwide: Part one in a series. *International Institute for Restorative Practices*: *EFORUM.* Retrieved on April 26, 2008, from www.restorativepractices.org

Pennell, J. (2003). Are we following the key FGC practices? Views of conference participants. *Protecting Children, 18(1&2),* 16-21.

Pennell, J., & Burford, G. (2000). Family group decision making: Protecting children and women. *Child Welfare, 24(2),* 131-158.

Pennell, J., & Burford, G. (1994). Widening the circle: Family group decision making. *Journal of Child and Youth Care, 9(1),* 1-11.

Polansky, N. A., Gaudin, J. M., Ammons, P. W., & Davis, K. B. (1985). The psychological ecology of the neglectful mother. *Child Abuse & Neglect, 9,* 265-275.

Regional Research Institute (1998). Strengths/Needs Based Services Evaluation (Interim Report). Portland, OR: Portland State University.

Sieppert, J. D., Hudson, J., & Unrau, Y. (2000). Family group conferencing in child welfare: Lessons from a demonstration project. *Families in Society: The Journal of Contemporary Human Services, 81(4),* 382-391.

Sugai, G., & Horner, D. (2006). A promising approach for expanding and sustaining school-wide positive behavior support. *School Psychology Review, 35(2),* 245-259.

Sundell, K., & Vinnerljung, B. (2004). Outcomes of family group conferencing in Sweden: A 3-year follow-up. *Child Abuse & Neglect, 28,* 267-287.

Sundell, K., Vinnerljung, B. & Ryburn, M. (2001). Social workers' attitudes towards family group conferences in Sweden and the UK. *Child and Family Social Work, 6,* 327–336.

Testa, M. F. (2002). Subsidized guardianship: Testing an idea whose time has finally come. *Social Work Research, 26(3),* 145-158.

Theodore, A., Bunyan, D., & Chang, J. J. (2007). Measuring the risk of physical neglect in a population-based sample. *Child Maltreatment, 12(1),* 96-105.

Wills, T. A., & Shiner, O. (2000). Measuring perceived and received social support. In S. Cohen, L. G. Underwood, & B. H. Gottlieb (Eds.), *Social support measurement and intervention* (pp. 86-135). New York, NY: Oxford University Press.

Wulcyzn, F. (2005). The epidemiology of reported child maltreatment. In F. Wulczyn, R. P. Barth, Y. T. Yuan, B. J., Harden, & J. Landsverk (Eds.), *Beyond Common Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform* (pp. 59-90). New Brunswick: Aldine Transaction.

U.S. Department of Education (2005). 25th Annual (2003) Report to Congress on the implementation of the Individuals with Disabilities Act (Vol. 1): U.S. Department of Education.

U.S. Department of Health and Human Services, Administration for Children, Youth and Families (November 2001). National survey of child and adolescent well-being: One year in foster care report. Washington, D.C.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children Youth and Families, Children's Bureau (2003). *Child Welfare Outcomes 2003: Annual Report*. Washington, D.C.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children Youth and Families, Children's Bureau. *AFCARS Report-Preliminary Estimates for FY 2005*. Retrieved on April 5, 2008, from the Administration for Children and Families Web site: http://www.acf.hhs.gov/programs/cb

U.S. Department of Health and Human Services, Administration for Children, Youth and Families. *Child Maltreatment 2006* (Washington, DC: U.S. Government Printing Office, 2008).

Usher, C. L., & Wildfire, J. B. (2003). Evidence-based practice in community-based child welfare systems. *Child Welfare, 32(5),* 597-614.

Usher, C. L., Wildfire, J. B., & Gibbs, D. A. (1999). Measuring performance in child welfare: Secondary effects of success. *Child Welfare, 28(1),* 31-51.

Vaux, A., Riedel, S., & Stewart, D. (1987). Modes of social support: The social support behaviors (SS-B) scale. *American Journal of Community Psychology, 15(2),* 209- 237.

Veneski, W., & Kemp, S. (2000). Families as resources: The Washington State family group conference project. In G. Burford, & J. Hudson (Eds.), *Family group conferencing: New directions in community-centered child and family practice.* New York: Aldine DeGruyter.

Yatchmenoff, D. (in press). A closer look at client engagement: Understanding and assessing client engagement from the perspectives of workers and clients in non-voluntary child protective services. In M. Calder (Ed.), *The carrot or the stick? Towards effective practice with involuntary clients*. Dorset, England: Russell House Publishing.

Yatchmenoff, D. K. (2005). Measuring client engagement from the client's perspective in non-voluntary child protective services. *Research on Social Work Practice, 15(2),* 84-96.

Yatchmenoff, D. K. (2001). Measuring client engagement in non-voluntary child protective services. Unpublished doctoral dissertation, Portland State University; Portland, Oregon.

Zimet, G. D., Powell, S. S., Farley, G.K., Werkman, S., & Berkoff, K. A. (1990). Psychometric characteristics of the multidimensional scale of perceived social support. *Journal of Personality Assessment, 55(3-4),* 610-617.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52(1),* 30-41.

Zuravin, S. (1989). The ecology of child abuse and neglect: Review of the literature and presentation of data. *Violence and Victims, 4,* 101-120.