TEAM DECISIONMAKING (TDM): BALANCING RISK AND PROTECTIVE FACTORS
THROUGH THE USE OF MULTIPLE PERSPECTIVES


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A dissertation submitted to the faculty of the University of North Carolina at Chapel Hill
in partial fulfillment of the requirements for the degree of Doctor of Philosophy
in the School of Social Work


Chapel Hill
2007

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ABSTRACT

THOMAS M. CREA: Team Decisionmaking (TDM): Balancing Risk and Protective Factors
Through The Use of Multiple Perspectives
(Under the direction of Charles L. Usher)

Child welfare agencies face considerable challenges in making consistent and effective

placement decisions for children coming to the attention of the child welfare system. Yet,

available evidence suggests that agency workers and supervisors may not be adequately

equipped to make these critical decisions alone. Team Decisionmaking (TDM) is an innovative

approach to decision-making in child welfare that actively seeks the input of family, community

members, and service providers in making placement decisions for children and families.

Conceptually, TDM is designed to promote effective placement decisions at key decision points

in the child welfare system by balancing consideration of families' risk factors with protective

factors that also may exist in families' community networks. As one of the four "core strategies"

of the Family to Family initiative sponsored by the Annie E. Casey Foundation, TDM has been

implemented in child welfare agencies in 17 states. This dissertation focuses on (1) variations in

scope and compliance of TDM implementation across sites; (2) the extent of implementation

fidelity across sites; and (3) the degree to which TDM characteristics may be associated with

placement recommendations for children in foster care. Findings suggest that in the study sites,

TDM meetings are being implemented on a wide systemic scale and that family and community

supports are attending a large percentage of meetings. Furthermore, a consistently strong pattern

emerged regarding the influence of caregiver attendance in reducing the likelihood of

recommendations to change foster care placements. Findings in these study sites are discussed

in light of a conceptual framework that describes how risk and protective factors could be

balanced in child welfare decision-making.

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ACKNOWLEDGEMENTS

DEDICATIONS

To Lea, Benjamin and Nicholas, who inspire me to work hard but remind me of who I am. None

of this would be possible or nearly as meaningful without your loving support and sacrifices.

You guys are my protective factors.

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# ABBREVIATIONS

AECF            Annie E. Casey Foundation

COP             Change of Placement

F2F             Family to Family

TDM             Team Decisionmaking

**CHAPTER 1**

INTRODUCTION

Team Decisionmaking (TDM) is an innovative approach to decision-making in child welfare that actively seeks the input of families and community members in making critical placement decisions for children. TDM is one of four "core strategies" within the Family to Family (F2F) initiative, funded by the Annie E. Casey Foundation (AECF), an initiative that has involved approximately 60 urban child welfare agencies in 17 states. One of the objectives of the TDM strategy is to strengthen families by placing them at the center of the decision-making process, and by connecting them to key support systems within their communities to promote the safety and permanency of children. The overall focus of the F2F initiative is on meeting the needs of families and children rather than to make the child welfare system more expedient (DeMuro & Rideout, 2002). TDM shares some commonalities with other family involvement approaches in child welfare, such as Family Group Conferencing (Crampton, 2004). Yet, TDM is unique in that it is specifically designed to promote effective decisions at *every* decision point in the child welfare system, through balancing consideration of families' risk and protective factors.

Despite extensive self-evaluation efforts within sites, no full-scale evaluation has been conducted regarding TDM's effectiveness. In many F2F sites, TDM remains in an early stage of implementation, while other sites have been conducting these meetings over a number of years. Given this stage of development, this study cannot offer definitive conclusions regarding TDM's effectiveness, as these conclusions await the results of a comprehensive evaluation of F2F to be completed in 2009. However, this study does provide an intensive examination of TDM implementation and quality, with preliminary conclusions regarding the relationship

between TDM recommendations and placement outcomes. Therefore, the purpose of this dissertation is fourfold: (1) to examine literature related to child welfare decision-making and program implementation; (2) to describe the variations in scope and compliance of TDM implementation across sites; (3) to explore the quality of implementation fidelity across sites, including the types and numbers of participants involved, and the extent to which the pattern of recommendations emerging from TDM meetings are consistent with intended F2F outcomes; and (4) to assess the degree to which team, child and site characteristics are associated with change of placement recommendations for children in foster care.

The dissertation is organized in the following manner: first, Chapter 2 introduces a conceptual framework for decision-making in child welfare that is premised on the goal of achieving an equal balance between consideration of risk and protective factors. TDM is introduced as one approach to child welfare decision-making, with a particular focus on its integration with other F2F core strategies. TDM is then assessed against the framework for balanced decision-making, and briefly compared with other approaches. In Chapter 3, a conceptual framework is introduced for measuring the fidelity and extent of TDM implementation, with the understanding that the effects of any program are largely subject to the extent to which it is implemented according to the program design.

The first study, "Implementation of TDM: Scope and Compliance with the Family to Family Practice Model," is presented in Chapter 4. It encompasses a quantitative assessment of the extent of TDM implementation using aggregate data to measure the scope and compliance of TDM implementation, and a qualitative comparison of actual TDM implementation against the conceptual model in each site. The second study, "Implementation Fidelity of Team Decisionmaking," is presented in Chapter 5. It provides a quantitative assessment of the extent of implementation fidelity at each site, with a particular focus on the number and variety of participants involved, and the extent to which group membership predicts placement recommendations. Chapter 6, "The Association of Team Composition and Meeting

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Characteristics with Placement Change Recommendations," outlines the use of binomial and

multinomial logit models to predict placement recommendations based on meeting and child

characteristics. Chapter 7 discusses the results of each chapter, describes the limitations of the

research, and outlines implications for future research.

*A Note about the Organization*

This dissertation is designed following a book-oriented format. The conceptual

frameworks introduced in Chapters 3 and 4 serve as the underpinnings for Chapters 4, 5 and 6.

Each chapter is thus designed to link to the others logically and conceptually. Yet, the analysis

chapters (Chapters 4, 5 and 6) are also designed as stand-alone journal articles. The result is that

each analysis chapter begins with a literature review that provides a framework for specific

research questions. In some cases, the language in these literature reviews closely resembles that

of the conceptual framework chapters. The reader should be aware that the duplication in

language exists because of the dual organization of this dissertation as both a book and a

collection of articles.

**CHAPTER 2**

BALANCED DECISION-MAKING IN CHILD WELFARE AND THE

POTENTIAL OF TEAM DECISIONMAKING

Research suggests that in the field of child welfare, individual caseworkers often rely on faulty reasoning when making critical decisions (DePanfilis & Girvin, 2005; Munro, 1999b). Indeed, the limitations of individual decision-makers often serve as the basis for discussions over the superior predictive validity of structured risk assessments (Shlonsky & Wagner, 2005). Yet, risk assessments typically do not include consideration of protective factors into the decision-making process (Gambrill & Shlonsky, 2000), such that a singular reliance on these assessments by individual caseworkers will probably also result in an over-reliance on risk factors. This heavy emphasis on risk in placement decision-making, in the absence of mitigating protective factors, is not likely to lead to less restrictive placements as encouraged by many state policies.

The purpose of this article is to propose a conceptual framework for balancing risk and protective factors in child welfare placement decisions by bringing a variety of perspectives to the decision-making process. This article also introduces Team Decisionmaking (TDM), an innovative approach to making placement decisions sponsored by the Annie E. Casey Foundation that currently operates in 60 sites and 17 states.

Following a discussion of TDM's structure and process, the article assesses this approach against the framework for balanced decision-making and compares and contrasts TDM with other approaches to including a variety of perspectives in child welfare decision-making.

*Introduction to Decision-Making*

Child welfare workers face considerable challenges in making consistent and effective placement decisions for children coming to the attention of the child welfare system. Workers must weigh a variety of factors in making critical decisions about substantiating reports of abuse or neglect; removing children from their homes; and, selecting appropriate services to support families and ensure the safety of children. Much of the scant research that exists on child welfare decision-making relates to investigating allegations of abuse or neglect (Wells, Lyons, Doueck, Brown, & Thomas, 2004). Even less research has been conducted on placement decisions for children once claims of abuse or neglect have been verified (Britner & Mossler, 2002). Each area of study indicates that a number of case-level, worker-level, and organizational factors are related both to substantiation and placement decisions. Without a guiding framework, however, the individual caseworker risks making inconsistent or under-informed judgments regarding the best interests of the child.

Decision-making approaches in public child welfare agencies differ mainly in the extent to which they attempt to structure decisions and the degree to which they explicitly seek to include professionals, family members and persons from the community in the decision-making process. Some approaches are driven primarily by individual caseworkers completing standardized assessments and making decisions in consultation with their supervisors. Others emphasize input from professionals, while still others promote a central role for families and community members in the decision-making process. The review presented here suggests that these approaches vary systematically in their tendency to give relatively more attention to risk factors or relatively more attention to protective factors.

*Decision-Making in Child Welfare*

The analysis of decision-making requires focus on the entity making the decision and the multifaceted processes used to make the decision:

> Decision making is a process by which a person, group, or organization identifies a choice or judgment to be made, gathers and evaluates information about alternatives, and selects from among the alternatives (Carroll & Johnson, 1990, p.19).

In the field of child welfare, the sources of influence on the decision also vary and a number of competing processes exist for gathering and sorting information, and making decisions. These processes may differ across individual child welfare workers and units, but in large part are dictated by agency policy. Perhaps an ideal situation would involve frontline social workers holding a master's degree and having clinical training. More typically, bachelor's level staff persons are required to make child welfare decisions with little or no formal training in social work. Especially in these latter cases, agencies prescribe structured protocols to reduce the inherent error involved in the decision-making of novices. Still others seek to reduce error and promote consistent decisions by including a variety of participants in the decision-making process.

In recent years, the use of risk assessments has emerged as one of the primary methods for structuring caseworker decisions. Actuarial risk assessments are used to identify the primary risk factors for future abuse and neglect, and are carefully designed by matching case outcomes to a set of predictors in a child welfare setting. In general, actuarial assessments have been found to be stronger in their predictive abilities than clinical judgment alone, although evidence of the effects of actuarial decision-making in child welfare is not extensive (Shlonsky & Wagner, 2005). Yet, risk assessments are limited to predicting future abuse and neglect and do not include information about family functioning or treatment planning; thus, a balance of actuarial findings and clinical judgment is necessary to produce an optimal decision, given the particularities of the situation (Holt, 1958, as cited in Shlonsky & Wagner, 2005). In addition,

the statistical precision of actuarial assessments is somewhat paradoxical in that clinicians must exercise a degree of subjective judgment in completing the assessment (White & Stancombe, 2003). For example, an actuarial assessment may include items regarding whether caregivers lack parenting skills or self-esteem, their motivation to improve their parenting practices, or the degree to which families appear to be stable (Children's Research Center [CRC], 1999), items which call for caseworkers to exercise clinical judgment. Finally, risk assessments do not typically include consideration of protective factors that buffer the effect of risk factors experienced by families in child welfare (Gambrill & Shlonsky, 2000).

While the predictive validity of actuarial assessments tends to be robust, these tools are limited by their narrow scope and their inherent subjectivity when completed by individual caseworkers. When examined against Carroll and Johnson's (1990) definition of decision-making, the process of actuarial assessments typically involves an individual caseworker addressing a checklist of strictly defined factors. However, this checklist cannot possibly capture the unique circumstances of each family (Shlonsky & Wagner, 2005). Moreover, the lack of clinical training among many frontline workers creates a situation in which unique problems may remain unrecognized or unexplored. The complexity and depth of issues often experienced by families involved in child welfare demands a wide *perspective* and many *sources* of information. Actuarial assessments alone cannot drive a decision–making process that balances risk and protective factors, and explores a variety of placement options. With this range of competing models of decision-making, the field of child welfare is faced with this central question: what are the best ways to gather and make use of information to encourage the most balanced, consistent and effective child welfare decisions?

A variety of strategies seek to maximize the effectiveness of child welfare decision-making in different ways. While these strategies may differ somewhat among individual units and agencies, they are usually set in place by policy of the state or local agency. Experience with these different models provides the basis for a conceptual framework for decision-making in

child welfare that draws from the strengths of these multiple approaches, and aims for an appropriate balance in considering risk and protective factors.  To provide the foundation for this framework, the following discussion outlines broad theories and associated research on decision-making that provide the basis for the proposed "balanced" model of decision-making.

### Decision-Making Research

Research on decision-making extends as far back to at least the 1950s, and can be found in widely disparate professions, ranging from business to medicine and law (Koehler & Harvey, 2004).  Some decision-making research examines cause-and-effect relationships between decision processes and outcomes, while others use mathematical formulations to predict decisions.  Still others evaluate the efficiency of certain processes, and prescribe rules for making better decisions or modifying decision-making processes (Carroll & Johnson, 1990). The following discussion outlines key theories and research concerning stages of decision-making, as well as findings regarding individual and group decision-making processes.

*Stages of Decision-Making*

To reduce the complexity of decision-making processes, Carroll and Johnson (1990) outlined a number of discrete stages through which people arrive at decisions, summarizing a large body of research.  These stages occur in a temporal sequence:  (1) *Recognition,* the realization that a decision needs to be made, including tasks undertaken to prepare for future decisions; (2) *Formulation,* exploring and classifying information about the problem and gaining some understanding of relevant objectives and values; (3) *Alternative Generation,* structuring all possible choices into a more manageable set of alternatives; (4) *Information Search,* identifying the properties or attributes of the alternatives, such that decisions are made under varying degrees of certainty and risk; (5) *Judgment or Choice,* placing a label on a single attribute (judgment) or comparing among alternatives (choice), using a series of decision rules

or heuristics; (6) *Action,* carrying out the decision itself, or "decision taking"; and, (7) *Feedback,* receiving information about the outcomes of the action to inform needed changes in decision rules and substantive knowledge (Carroll & Johnson, 1990, pp.21-24).

This temporal framework of the decision-making process is applicable to the field of child welfare. Children come to the attention of child protective services (CPS) through a report of abuse or neglect (recognition of a problem). The CPS investigator is charged with sorting through information about the report, including information the agency may already have on file, as well as service histories for the family. Often, the worker also considers information about family and community supports and the availability of services, at least in determining placement recommendations. The family's particular risk and protective factors must be weighed and assessed to determine whether the allegations are substantiated (choice), and a placement recommendation must be made (judgment). Then, the child either remains in the family setting with a recommendation to keep the case open or to close it, or is removed to an out-of-home placement (action). The appropriateness of the placement decision can be evaluated based on longer-term outcomes for the child, such as safety, permanence and well-being (feedback).

The above framework outlines the temporal process of decision-making but does not illuminate how people make decisions. The following section outlines models of generic, individual decision-making and the limitations faced by individuals when making decisions.

*Individual Decision-Making*

Decision-making theories fall into three broad categories: *Prescriptive,* describing how people *ought* to think; *Normative,* describing the *standards* of optimal thinking to maximize utility; and, *Descriptive,* describing how people *actually* think. One common normative model uses Bayes' theorem as a model of probability (Galanter & Patel, 2005). This model predicts the conditional probability of an event given the occurrence of another event, and is the

underlying model used in actuarial risk assessments in a number of fields, including child

welfare. Bayes' theorem is shown in mathematical form below, with a substantive explanation

from the field of child welfare:

$$p(H \mid D) = \frac{p(D \mid H) \times p(H)}{p(D)}$$

<div align="right">(1)</div>

Here, p(H|D) is the probability of a hypothesis (child maltreatment) given datum (evidence) of a

positive result. P(H) is the rate of child maltreatment in the population (base rate), p(D|H) is the

probability of the datum/evidence given that maltreatment occurred (sensitivity), and p(D) is the

probability of a positive result. *Sensitivity* [p(D|H)] refers to the ability of the model to correctly

identify abusive families. *Specificity* refers to the probability of a negative result if

maltreatment does not exist, or the model's ability to exclude non-abusive families (Munro,

1999a; risk assessments will be discussed in greater detail later in the paper).

Early economic research on individual decision-making focused on the interplay between

buyers and sellers in the marketplace (Galanter & Patel, 2005). Consistent with classical

economic theory, much of this work assumed that human beings use rational methods for

making decisions, maximizing the tradeoff between the probability of an outcome and the

outcome's utility, or usefulness. While classical economic theory posits that individuals adhere

to rational procedures for making decisions, research shows that people tend to diverge from

rational models (Kahneman & Tversky, 1973; Tversky & Kahneman, 1981). This divergence

may be partially explained by a lack of understanding of situations, or possessing incorrect

information about a problem. However, human beings are also limited in their ability to grasp

and make sense of large amounts of information, such that complex situations are simplified

using limited perspectives, or heuristics, for making decisions.

The use of heuristics necessarily leads to cognitive limits when compared to normative

rational models of decision-making, a concept which has been termed *bounded rationality*

(Simon, 1955).  To avoid excessive cognitive effort, individuals "satisfice," or "set a criterion

acceptance level and then use a simplifying decision strategy or heuristic to meet that level"

(Kleinmuntz, 1990, p. 298).  "Satisficing" involves making decisions under uncertain conditions

without considering the rules of statistics and probability.  Kahneman and Tversky (1973)

showed that heuristics, rather than rational models, tended to be the predominant method of

individuals' decision-making.  Heuristics also depend largely on how individuals frame

problems; individuals can vary widely in their responses depending on their perspective of the

problem (Tversky & Kahneman, 1981).  While heuristics provide an easier means of making

complex decisions, they are often skewed and incomplete, or biased.  In the above child welfare

example using Bayes' theorem, a common failed heuristic is to ignore the base rates of child

maltreatment in the population when estimating the probability of future maltreatment[1].

Normative decision-making theories model optimal decision-making processes, but

applying these processes in real-world contexts can be problematic (Falzer, 2004).  The

components of optimal processes dictate that decision-making standards are embedded within

the logic of a normative model; that optimality is a universal standard applying to all

phenomena within a domain; and that optimality is an abstract standard removed from concrete

information and real-life clinical situations.  Given the suboptimal heuristics employed by most

decision-makers as evidenced by research, Falzer asserts the concept of optimality is likely to

have little bearing on actual practice.

To address these limitations, Patel and colleagues (2002) suggest expanding the scope of

decision research to generate more adequate descriptive accounts of the decision-making

process in practice.  One of the major limitations of normative decision research is that it

ignores the practice context; thus, to improve the "ecological validity" of decision-making

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[1] See Croskerry, 2002 for a comprehensive list of heuristics and biases[0] applied to a medical setting.

research, a greater range of methodologies should be employed to understand the dynamics of real-world practice settings.   Naturalistic Decision Making (NDM) is a set of mostly qualitative research methodologies that draw from the concept of bounded rationality (Lipshitz, Klein, Orasanu, & Salas, 2001; Todd & Gigerenzer, 2001).  NDM examines the decision-making process under real-world constraints, such as time pressures, stress, and limited resources, and seeks to explain the adaptive as well as suboptimal processes employed by decision-makers (Patel et al., 2002).

Adaptive strategies may be used by individuals or teams.  Patel and colleagues (2002) advocate close scrutiny of the social and collaborative aspects of making decisions, with the recognition  "that decision makers are not solitary thinkers, but live in a social world thick with artifacts and populated by other agents who jointly determine the decision processes and outcomes" (p. 60).  While NDM offers the potential for unique insights into the practice context, detractors state that the approach is largely descriptive and does not offer a clear gold standard for evaluating the quality of decisions (Yates, 2001).  Also, as in other qualitative research, the generalizability of the findings is questionable given its focus on only a few settings.  Yet, in decision-making research, there is a need both for a close analysis of decision-making processes as well as quantitative studies of differences across settings (Patel et al., 2002).

The inherent pitfalls of normative decision-making models also apply to the field of child welfare.  First, much of the research on decision-making is predicated on the assumption that the actors are experts in their content area.  In child welfare, this assumption is rarely tenable as relates to professionals.  Few states require caseworkers to have formal clinical training in the form of graduate degrees, a situation that may lead to heavier reliance on standardized procedures to compensate for lack of training.  Second, the pressured and emotionally charged environment in which child welfare decisions are made make it highly unlikely that caseworkers will follow normative, "expected utility" decision-making processes.  In a recent content analysis of child abuse inquiries, Munro (1999b) found that child welfare workers followed a

number of failed heuristic strategies for making decisions.  Workers assessed risk based on a

small amount of evidence, ignored significant information known to other workers, and favored

evidence based on whether it was the first or last information received, or whether it aroused

emotion.  In addition, when presented with disconfirming evidence, professionals tended to be

slow in revising their initial judgments. Similarly, DePanfilis and Girvin (2005) found that

individual caseworkers experienced "perceptual blocks" in decision-making (p. 368). That is,

workers tended to resist considering the perspectives of other professionals and observers when

making an assessment of maltreatment substantiation.

That individuals diverge from rational models of decision-making, and often use failed

heuristics and biases in making decisions, is well established in the research literature.

Furthermore, an emerging body of evidence within the field of child welfare points to the

deficiencies exhibited by caseworkers in producing thorough and accurate investigations that

lead to optimal decisions for children and families (DePanfilis & Girvin, 2005; Munro, 1999b).

The following section explores the extent to which these cognitive biases are ameliorated or

improved through group processes that are often used to drive child welfare decisions.


*Group Processes and Decision-Making*

Groups are often expected to result in better-informed decisions by pooling the information

uniquely held by participants of a group.  Surprisingly, much of the early research on group

decision-making concluded that groups were equally prone to errors and inconsistencies as

individuals (Carroll & Johnson, 1990). Group discussion should also help correct inaccuracies

and inconsistencies in individuals by producing unbiased estimates of decision alternatives as a

result of individual biases being counteracted by other group members with opposite biases.

Yet, in their seminal study, Stasser and Titus (1985) found that group members tended to

withhold uniquely held information.  These group discussions were dominated by information

shared in common before the meeting, as well as by information in support of members'

existing preferences.  Other research has confirmed and added to these findings.  A summary of research by Kerr and Tindale (2004) demonstrated the following pitfalls to group decision-making, particularly groups that lack a leader or facilitator: (a) in groups seeking consensus, if group members already share the same preference for outcomes, groups may reduce the amount of information exchange and reach an early consensus; (b) people are perceived as more competent and knowledgeable when they present information already known by other group members; and, (c) group members resist changing their initial preferences, a problem that leads group members to misinterpret newly presented information that is not consistent with their preferences.

Some information is available about ways to mitigate these dysfunctional aspects of groups (Kerr & Tindale, 2004).  Unshared information tends to surface over time the longer groups engage in discussion.  Ensuring that at least one group member has access to all unshared information before convening the group will determine the degree to which this information affects group decisions.  Allowing group members access to informational records can expose hidden biases and reduced reliance on memory alone.  Training group members to explore more information may lead to a greater exchange of information.  Team leaders can facilitate the flow of unshared information.  The "preference diversity," or the degree to which members prefer different outcomes, has been shown to increase the sharing of information and the quality of decisions.  Also, dividing the group task into two components (information search, then integration and decision) has been shown to improve the sharing of uniquely held information.

Patel and colleagues' (2002) naturalistic studies of decision-making in medical critical care settings led to the conclusion that "Team Decision Making is characterized by emergent properties that cannot be captured by merely studying individual decision makers" (p. 66). These processes involve managing multiple streams of information, as well as coordination and communication among a variety of individuals and sources of data.  In this real-world decision-

making context, cognition is distributed such that individuals and technological resources do not merely add to the cognitive process, but transform it: "The combined products of a cognitively distributed system (e.g., multiple team members) cannot be accounted for by operation of its isolated components" (p. 67). Yet, each individual still brings unique knowledge, skill and professional perspective, much of which adds to the "distributed partnership" of the team.

In child welfare, not much is known regarding the process by which different professionals make decisions for children entering care. A study by Britner and Mossler (2002) evaluated how different types of professionals (judges, guardians ad litem [GALs], court appointed special advocates [CASAs], social workers, and mental health professionals) rated the importance of information in making out-of-home placement decisions. The results indicated that professional group membership was the most powerful predictor of the different types of information prioritized and used in placement decision-making. Judges and GALs emphasized the likelihood of re-abuse and the child's ability to recount the abuse. CASAs relied more heavily on information about the stability of the birth family, while social workers and mental health professionals focused on the severity and patterns of abuse, the past use of services by the family and whether the birth parents responded favorably to those services. The authors conclude that the typically low reliability and consistency of substantiation and placement decisions may be "a consequence of the *multiple perspectives* involved in this process" (p. 329, italics added).

Clearly, it would seem that *simultaneously* involving in the decision-making process as many of these perspectives as possible would increase the probability of producing unbiased decisions. Following Kerr and Tindale's review (2004), these groups would need to be characterized by a number of factors to ensure that uniquely held information was shared by professionals. Groups should be led or facilitated by a group leader who ideally should have access to all information held by individual participants. Groups ought to be composed of a variety of participants who hold different perspectives of the problem. Where possible, group

members should be provided access to written reports and evaluations during the meeting. Participants should be trained to explore information in a detailed fashion to promote a greater degree of information-sharing. Finally, groups ought to be divided into two components, the first of which is dedicated to searching and exploring information, and the second component to integrating this information and selecting a decision.

The complexity and variety of child welfare decisions make it essential to gather and review as much information as possible in a consistent manner, and in a way that maximizes a variety of perspectives within the process. Structured assessments are helpful as aids to decision-making but are dependent on the quality of the information available, and should not be used alone to prescribe decisions given the risk of ignoring unique family circumstances. Based on the theory and research of generic decision-making presented above, the following section presents a conceptual framework for effective and balanced decision-making in the real-world context of child welfare.

### *Balanced Decision-Making in Child Welfare*

All decisions and actions taken by social workers will be influenced in some degree by the context of the particular child welfare agency in which they work. Baumann and colleagues (1997) refer to this relationship as the "decision making ecology" of child welfare, in which case decisions and client outcomes interact in reciprocal relationships with factors at the individual, organizational and community levels (cited in Wells et al., 2004). For example, positive relationships between child welfare agencies and representatives from the community affect the amount of contact sustained by these two groups (Wells et al., 2004). Qualitative findings indicate that community members who attend meetings regularly are more likely to share information and cooperate with one another (Deisz, Doueck, George, & Levine, 1996), factors that directly relate to the quality of the group decision-making process (Kerr & Tindale, 2004). State laws and Federal policies also determine the process and structure of child welfare

decision-making, especially by specifying varying options for "uncertain" substantiation findings and the degree of evidence required to substantiate reports (U.S. Department of Health and Human Services [U.S. DHHS], 2003).

Finally, the relationship between the culture of the family under investigation and that of the child welfare worker may affect the decision-making process. Child welfare workers must be careful not to label behavior as "unacceptable" when it may only be a cultural variation (Hogan & Siu, 1988). This dynamic requires workers to examine the larger cultural context behind the behavior and separate these factors from acts that are truly dangerous or unacceptable across cultures (Murphy-Berman, 1994).

As previously discussed, decision-making is a temporal process that occurs in a number of discrete steps (Carroll & Johnson, 1990). In child welfare, these steps can be reduced to three main components of the decision-making process, occurring temporally: *balancing risk and protective factors, assessment,* and *placement decision.* The first component, *balancing risk and protective factors,* involves workers weighing information to make a conclusion about whether to recommend out-of-home placement after a report of abuse and neglect has been substantiated. In this framework, social workers are weighing (a) the immediate safety of the child; and (b) the probability of future maltreatment. Risk factors for repeated maltreatment may include, but are not limited to, the nature of the child abuse report and severity of the abuse or neglect; the family's previous history with child welfare services and the presence of previous substantiated or unsubstantiated reports; and, service histories for parents, including previous mental health and substance abuse treatments and evidence of compliance with treatment. Other information from which workers tend to draw includes physical evidence of harm, testimonial information, or direct observation of factors such as the condition of the home (U.S. DHHS, 2003).

An exclusive focus on risk factors as predictors of future behavior ignores the potential effects of protective influences (Newcomb & Felix-Ortiz, 1992). Protective factors also predict future outcomes, and are often conceived as modifying risk (Rutter, 1987), or compensating for risk by reducing the strength of its effects (Coie et al., 1993). Yet, no clear means exist for defining and categorizing specific protective factors. Protective factors may exist within individual and family characteristics, as well as extra-familial factors such as the presence of a supportive network of friends or place of worship (Fraser & Richman, 1999). Saleebey (1996) outlined protective factors that exist within the community that include "informal networks of individuals, families, and groups; social networks of peers; and intergenerational mentoring relationships (that) provide succor, instruction, support, and encouragement" (p. 300).

In child welfare decision-making, a balanced approach seeks to weigh families' risk factors for future maltreatment with protective factors that may exist within families' communities and with supportive relatives and friends. Recent research shows that mothers who have more informal supports experience less financial strain and fewer depressive symptoms, factors that may affect positive parenting practices (Lyons, Henly, & Scheurman, 2005). Supportive protective factors may also include the availability of services within a particular jurisdiction. Thus, this framework hypothesizes that bringing a number of *perspectives* into placement decisions augments the ability of caseworkers and supervisors to identify and utilize protective factors, for the purposes of supporting the family and achieving an appropriate placement decision to ensure the child's safety.

Following Kerr and Tindale's (2004) review of effective group processes, the group ideally should have an identifiable leader who has made contact with every participant in the group prior to the meeting. This leader should have access to all written assessments and other reports that will be discussed during the meeting, and should provide hard copies of relevant materials to all group members as soon as possible, preferably before the meeting convenes. As many different participants as possible should attend the meeting to promote maximum sharing

**Figure 1.          A Framework for Balanced Decision-Making in Child Welfare**
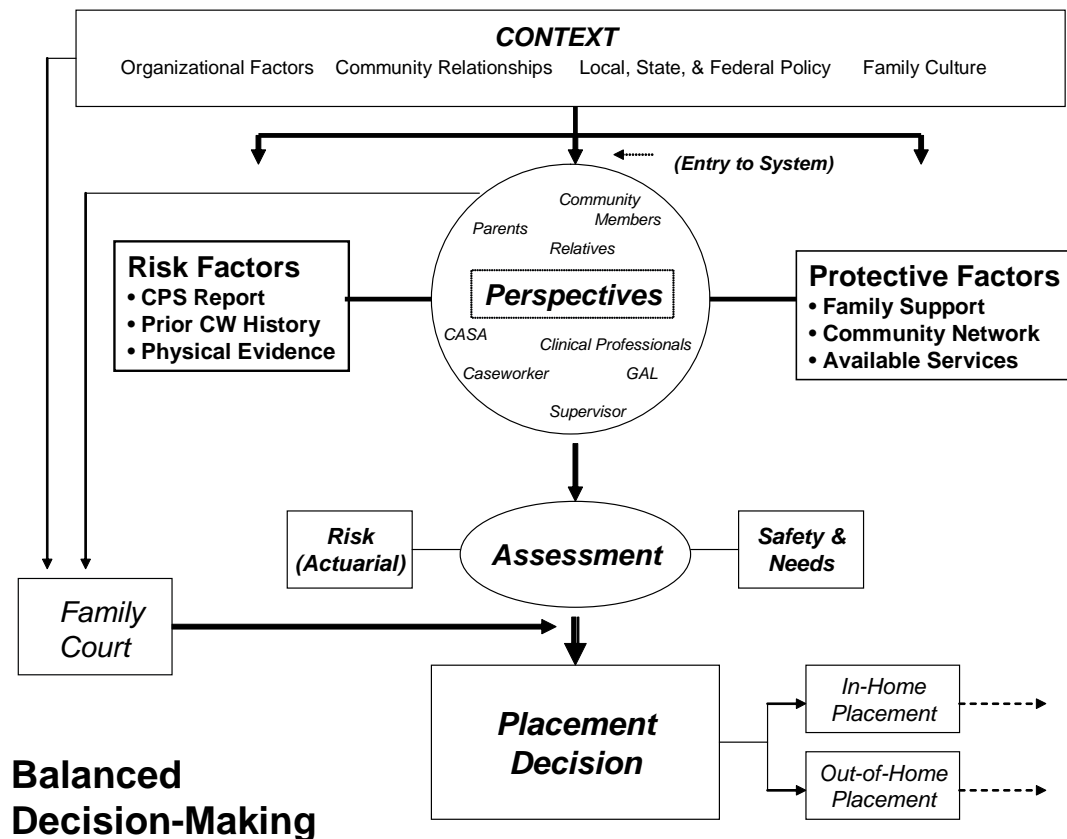


of information and to reduce bias.  Given Britner and Mosler's (2002) findings of variability

with professionals' decision-making, group participants ought to represent a wide range of

professional opinion and input, as in the Multidisciplinary Team and Team Decisionmaking

models.  In addition to caseworkers and supervisors, clinical professionals (such as mental

health and substance abuse professionals) should attend to provide their expertise to the group.

CASAs and GALs may attend to provide legal perspective and perhaps as a liaison to the family

court.

Moreover, parents, relatives and key sources of community support for the family should

be included in the process as well, as in the Team Decisionmaking model and other family

involvement approaches such as Family Group Conferencing.  The purpose of including the

latter approach is threefold: first, increasing the diversity of preferred outcomes among participants strengthens the decision-making capacity of groups (Kerr & Tindale, 2004); second, according to theories of Restorative Justice, parents who have a stake in the decision-making process are more likely to be motivated to make and maintain needed positive changes (McCold & Wachtel, 2003); and third, including families and community members may lead to the sharing of information that might otherwise be inaccessible or under-explored. Indeed, family members bring considerable expertise regarding children that may otherwise be inaccessible to other group members; parents thus play the role of "experts on their own children" (Crampton & Natarajan, 2005, p. 76). Drawing from as many possible sources of information and opinions to balance risk and protective factors, and using tools to structure information and predict future maltreatment, should lead to placement decisions that promote consistency across cases and workers and are most appropriate to the family's level of need.

Once information about the case has been gathered and sorted using multiple perspectives, *assessments* should be conducted to determine the risk of future child maltreatment and to garner a thorough understanding of the family's strengths and needs. Safety assessments should be conducted at the beginning of the investigation to ascertain the immediate risk of harm to the child. These assessments serve as a screening device to determine if immediate action is needed to protect a child during the time required to make longer-term decisions, such as placement type and the development of safety plans. Actuarial risk assessments generally are stronger in their ability to predict recurring behavior and the likelihood of long-term maltreatment than clinical judgment alone (Grove & Meehl, 1996), and thus should be used to bolster the findings of the group (Shlonsky & Wagner, 2005). Needs assessments can be used to structure workers' thinking about families' strengths and weaknesses, as well as some of the tangible ways families might need assistance. These assessments can point to specific services needed by the family, or basic needs such as money to pay bills, problems with child care, or transportation to work.

As illustrated in Figure 1, family courts also play a role in placement decision-making for children, although not much research exists outlining the exact relationship between courts and child welfare agencies. Ostensibly, agencies can offer foster care placements to families without charging them with abuse or neglect. The more likely scenario is, however, that parents charged with maltreatment will attend a judicial hearing, and in many of these cases children will be placed in foster care (Garrison, 1987). A recent observational study by Ellett and Steib (2005) describes the sometimes adversarial relationship between child welfare agencies and family courts. Court decisions often included recommendations of services with little empirical support, and tended to be more oriented to parental compliance with mandates than with measurable outcomes. Child welfare workers spent hours preparing and waiting for hearings without being sworn in as expert witnesses. The authors conclude that the goals of family courts and child welfare agencies "remain in considerable conflict" (p. 347). While beyond the scope of this paper, the authority of family courts and their impact on decision-making in child welfare is certainly a ripe area for further study. At any rate, the assumption used in this framework is that family courts have their greatest influence during the assessment phase of placement decision-making, before placement decisions are made.

*Conventional Decision-Making in Child Welfare: Caseworkers, Supervisors,*
*and Risk Assessments*

Little research exists on the differing decision-making processes employed by child welfare agencies, and by extension, workers and supervisors charged with decision-making responsibility. Yet, the research that does exist demonstrates that individuals rely frequently on failed heuristics (Munro, 1999b) that lead to biased or incomplete investigations (DePanfilis & Girvin, 2005). Many agencies use structured risk assessments to bolster caseworkers' and supervisors' capacities to make better placement decisions for children. With some exceptions, the research on actuarial risk assessments demonstrates that they more accurately predict future

**Figure 2.** **Conventional Decision-Making in Child Welfare**

**CONTEXT**

Organizational Factors   Community Relationships   Local, State, & Federal Policy   Family Culture

*(Entry to System)*

**Perspectives**

Caseworker

Supervisor

**Risk Factors**
- CPS Report
- Prior CW History
- Physical Evidence

**Protective Factors**
- Family Support
- Community Network
- Available Services

**Risk (Actuarial)**   **Assessment**   **Safety & Needs**

*Family Court*

**Placement Decision**

*In-Home Placement*

*Out-of-Home Placement*

maltreatment than individual clinical assessments (Grove & Meehl, 1996; Shlonsky & Wagner, 2005). Most researchers agree, however, that the use of risk assessment tools does not preclude the need for sound, clinical decision-making (Doueck, English, DePanfilis, & Moote, 1993; Grove & Meehl, 1996; Shlonsky & Wagner, 2005). Actuarial risk assessments alone do not assist frontline workers in developing case plans, assessing overall family functioning, or selecting therapeutic interventions; they only predict the likelihood of future child maltreatment (Shlonsky & Wagner, 2005).

Considering the conceptual framework for balanced decision-making, conventional methods tend to emphasize the risks posed to the child by the family without substantial consideration of the protective factors that buffer these effects (Gambrill & Shlonsky, 2000; see Figure 2). Related to this problem is the lack of perspective this method brings to the decision-

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making process by ignoring input from a variety of professionals, and family and community members. In discussing the predominant use of child welfare risk assessments in Britain, Munro (1999a) asserts:

> The focus on risk assessments has led to the family's needs being overlooked. Families' relationships with social workers have changed radically. Where once many families saw them as a source of assistance, most now view them with distrust (p. 120).

In addition to straining an already uncomfortable relationship between workers and families, focusing primarily on risk factors reduces the scope of the decision-making process such that family and community supports may be overlooked. This omission may have a direct effect on placement outcomes for children. For example, by bringing to the table other professionals, extended family or key members of the community, an alternative to out-of-home placement might be located for a child that would not have been discovered in a risk-driven format. Other approaches to decision-making rely on these types of collaboration, rather than rely primarily on the risk of future maltreatment.

The framework of balanced decision-making suggests that consideration of risk and protective factors is directly linked to the range of perspectives brought to bear in making placement decisions. Fewer perspectives contributing to this process leads to greater weight given to risk of future maltreatment, rather than protective factors that may exist from families' natural supports within extended relatives or their communities. An overemphasis on risk likely leads to a greater reliance on out-of-home placements, as natural supports for the family remain un-activated. Yet, to ensure that placement decisions are consistent and appropriate to the family's situation, decision-makers must seek a balance between risk and protective factors: an overemphasis on natural supports and family empowerment may ignore or downplay existing risks to the child, such that appropriate out-of-home placements may not be thoroughly considered.

A balanced approach to child welfare decision-making gives equal consideration to a family's risk and protective factors. Discussions ought to be honest and forthright, clearly targeting the problem issues but in a manner that respects the family in as non-punitive manner as possible, and gives them a high degree of support. In the child welfare context, the ability to balance strengths and needs is directly related to the variety of perspectives brought to bear on the decision-making process. In particular, having family members, extended relatives and informal community supports participate in decision-making provides a unique opportunity to identify factors in the family's context that mitigate the risk presented by an occurrence of maltreatment. Finally, given the generally strong predictive abilities of actuarial assessments, these tools should be incorporated not to make final determinations but as aids to structuring placement decisions.

*Introduction to Team Decisionmaking*

Team Decisionmaking (TDM) is one of four core strategies within the larger Family to Family child welfare reform initiative. As a whole, Family to Family is rooted in an explicit set of operating principles that include: (1) developing a network of family foster care that is culturally sensitive and based in the neighborhoods and communities where the children live; (2) ensuring that children are removed from their families only when no alternative exists; (3) reducing reliance on group care by increasing the number and quality of foster families; and, (4) reunifying children more quickly with their families when removal is necessary.

The Family to Family initiative's underlying theory of change asserts that the four core strategies are mutually reinforcing and that the greatest improvement in target outcomes will be achieved in sites that effectively implement all four strategies (Rideout, Usher, & Wildfire, 2005). These core strategies include: (1) *Building Community Partnerships*, identifying and building relationships among community members in neighborhoods with high rates of child welfare services (CWS) involvement, in order to promote a supportive environment for families

involved with CWS; (2) *Team Decisionmaking*, bringing birth families and community members into the placement decision-making process to build support networks for families and children; (3) *Resource Family Recruitment, Development, and Support (RDS)*, developing and supporting kinship and foster homes to maintain children in families in their own neighborhoods and communities; and, (4) *Self-Evaluation*, a collaboration among agency program staff, data managers, and analysts, and in partnerships with community members to monitor data on key outcomes, to monitor progress in implementing the core strategies, and to identify needed changes in policy or practice to promote the achievement of specific outcomes.

A fundamental premise of TDM is that child welfare agencies should respect families' knowledge of their children. This approach emphasizes a collaborative effort involving the agency, service providers, and supports in the extended family and community to effectively engage families in decision-making through a skillfully facilitated group process. In fact, one of TDM's purposes is to connect family members with community supports within meetings, with the hope that these community members will serve as longer-term supports for families (DeMuro & Rideout, 2002). TDM is founded on the assumption that groups can make child welfare decisions more effectively than an individual. Implicit in this assumption are the ideas that families are experts on themselves, are capable of identifying and addressing their own needs when they are treated respectfully, and that relatives and community members are families' "natural allies" and experts on the resources within the community (Rideout & Short, 2004, p. 6).

TDM consists of several components that characterize the approach: (1) *teamwork*, empowering families to be more involved in decisions affecting them, and avoiding turf battles among agencies; (2) *consensus,* wherein everyone consents to and supports the plan, even if they are not in total agreement; (3) *active family involvement,* respecting the family as experts on their children and building an alliance with them; (4) *skillful facilitation,* helping the group to focus and stay on task, while avoiding blaming attitudes; (5) *safety planning,* for all children,

and must be specific, measurable and achievable, concretely defining the responsibilities of all parties involved, tailored to the needs of the families, and should be frequently monitored and changed if necessary; (6) *strength-based assessment*, as opposed to building a case against a family; (7) *needs driven services*, recognizing the uniqueness of children's needs and tailoring service planning based on collaborative decisions; and (8) *involvement of the community into long-term support networks*, connecting families to their communities for help and support (DeMuro & Rideout, 2002).

*TDM Process*

Team Decisionmaking is designed to facilitate and improve the quality of child welfare decisions. The TDM explicitly encourages input from family and community members to inform decision-making before a child's entry to or movement within out-of-home care. As such, the quality of the TDM process is nearly as important as the placement recommendations and associated outcomes that result from the meeting. In TDM, meetings should be convened before any and all placement decisions, including the potential removal of children from their homes, changes in placement, and before recommendations to the court of reunification or any other permanency plan. Meetings ought to be convened quickly and are intended to occur before a placement decision is made. They are designed to help the agency make the best possible decision with input from family and community members.

As designed, TDM meetings should rely on highly trained facilitators to help keep the group focused and on-task. These facilitators ideally are experienced child welfare workers who are independent of the convening social worker, although facilitators may assist in the decision-making process itself to ensure a quality decision. The facilitator helps the group reach consensus regarding a decision, but the final decision rests with the child welfare agency.

At the beginning of the meeting, the facilitator asks the family and worker to present their perceptions of the problem as well as the history of the problem, including prior child welfare involvement. The caseworker may recommend a plan of action, and the family is invited to react to the plan and/or suggest their own. The facilitator leads a discussion to brainstorm potential outcomes of the proposed plan and the roles of each party involved. Clearly identifying family's strengths and needs is an important component of the meeting, and facilitators often will list these on a flip chart. If the group cannot reach consensus, agency staff meet separately; if staff cannot reach consensus the caseworker and supervisor will make a final decision. Follow-up meetings may be scheduled in certain situations, such as if the child will remain at home during implementation of the safety plan. The original caseworker and/or supervisor should attend follow-up meetings to assess whether the situation has improved (Center for the Study of Social Policy [CSSP], 2002). The overall purposes of the meeting are to solicit the family's input in decision-making, and to connect the family to key family and community members who can support them during implementation of the safety plan.

Team Decisionmaking meetings focus primarily on making the best placement decision for children. These meetings place child safety as the central consideration while providing reasonable efforts to preserve families and encourage reunification. While effective decision-making is the central goal of TDM, the approach also focuses on a number of secondary goals: (a) improving the identification of safety and risk factors for the family; (b) helping the family understand what needs to be done to address children's needs for safety and permanency; (c) where appropriate, initiating the concurrent planning process; (d) sharing all information about the family regarding the safety, permanency and well-being of children, and discussing the strengths and needs of the family; (e) improving safety assessments, promoting consensus regarding permanency plans, and pursuing more appropriate plans for in-home or out-of-home supports and interventions; and (f) offering immediate access to services to ensure safety with in-home placements (Annie E. Casey Foundation [AECF], 2001).

*An Assessment of TDM Program Theory:  Balance, Perspective, and Tools*

As part of its program design, Team Decisionmaking (TDM) offers an apparent balance in considering a family's risk and protective factors.  For each placement decision, the team conducts a thorough discussion of the current incident of maltreatment, as well as of the history of maltreatment and involvement with child welfare.  This discussion is also informed directly by the family, relatives and informal supports, and time is explicitly devoted in each meeting to discussing the family's strengths (DeMuro & Rideout, 2002).  A variety of participants contribute to a wide perspective of the family's situation; these participants include professionals similar to a multidisciplinary team model, but also include family members, relatives, and legal representatives such as CASAs and GALs, where appropriate.  The use of structured assessments in TDM is not emphasized, but integration of assessments within TDM meetings is encouraged.  Teams use existing actuarial and other assessments currently utilized in each child welfare agency in which TDM operates.

Given that TDM actively seeks family involvement in decision-making, it is tempting to categorize the approach as a form of Family Group Conferencing (FGC), and to think of TDM as a derivative of the original FGC approach.  In fact, the initial development of TDM began in the United States in the mid 1980s, before the advent of FGC in New Zealand in 1989 (Levine, 2000), and significant differences exist between these approaches.  While both approaches are geared to developing plans to ensure the safety and wellbeing of children, TDM does so within the explicit context of a child welfare placement process in which critical decisions must be made in a timely fashion.  This is rooted in the premise that it is in the interests of the child and the family for decisions to be made promptly and these decisions must be made in accordance with local, state, and federal permanency timelines, with consideration of the due process rights of parents at the front end of foster care (Rideout & Short, 2004).

*Contrasting TDM and Other Family Involvement Meetings*

The contemporaneous emergence of TDM and other family team approaches in child welfare has triggered debate over the extent to which these approaches differ in approach and purpose. In contrast to TDM meetings, family group conferences often entail several weeks of preparation time, an option not usually feasible for TDM meetings because of the need to meet legal timelines and present recommendations to the court. TDM meetings occur in a context in which the child welfare agency must make a decision about placement at the conclusion of the meeting. This basic characteristic distinguishes TDM from FGC and related approaches in that its primary objective is to support placement decision-making. While family empowerment may be a byproduct of the manner in which the decision is made, all participants understand that the agency retains responsibility and authority to make the decision with input from family, friends, community members, and other service providers (Rideout & Short, 2004). The TDM approach seeks decisions that are based on consensus with the family, and the meeting may help families develop a safety plan, but the agency must be comfortable that the plan will adequately protect the child.

At the beginning of a TDM meeting, the facilitator asks the family and worker to present their perceptions of the problem as well as the history of the problem, including prior child welfare involvement. The caseworker may recommend a plan of action, and the family is invited to react to the plan and/or suggest their own. The facilitator leads a discussion to brainstorm potential outcomes of the proposed plan and any other plans suggested by participants, as well as the roles of each party involved. Clearly identifying family's strengths and needs is an important component of the meeting, and facilitators often will list these on a flip chart. If the group cannot reach consensus the caseworker and supervisor will make a final decision.

The focus on the decision and the explicit acknowledgment of decision-making authority with the agency affect the dynamics of meetings. Caseworkers and community members are likely to engage in "straight talk" with parents, bringing issues within the discussion that are often uncomfortable. This dynamic has led some critics to argue that TDM is not a strengths-based approach; however, discussions in TDM meetings attempt to strike a balance in discussing the child's safety concerns and needs of the family as well as the family's strengths. In the end, TDM is practical in that it focuses on decision-making, but it also seeks to be fair and effective by personally involving every family in every decision. Given that placement decisions are by nature primarily focused on safety considerations, there is a heightened need within TDM meetings to balance a strengths focus with a thorough exploration of a family's needs and concerns. The process may not provide the level of nurturing and amount of time for which FGC and related models are known. Yet, TDM's primary purpose is not to empower families, but to slow down the decision-making process long enough to consider alternatives to placement or to moves that may not be in a child's or family's best interests.

### Conclusion

Evidence suggests that individual caseworkers and supervisors may not be adequately equipped to make critical placement decisions for children involved in child welfare. The underlying practice theory within TDM, the balancing of risk and protective factors, is intended to improve these placement decisions by accessing the perspectives of birth families, relatives, community partners and human service providers. These perspectives ostensibly provide crucial information to the decision-making team that can avert unnecessary placements for children. Yet, if this practice theory is not reflected in actual changes in agency practice, then TDM's ability of achieving better placement decisions for children cannot be fairly assessed. The following chapter outlines issues related to program implementation, and presents a framework for assessing the extent to which TDM has been effectively implemented within a site.

**CHAPTER 3**

PROGRAM SPECIFICATION, PRACTICE FIDELITY, AND A CONCEPTUAL

FRAMEWORK FOR MEASURING TEAM DECISIONMAKING IMPLEMENTATION


Team Decisionmaking (TDM) is an attempt to improve the gatekeeping around placement

decisions for children and families involved with child welfare agencies.  The driving force

behind TDM is the active participation of birth families, relatives, friends, and natural supports

in the decision-making process.  TDM is founded on the assumption that groups can often make

better decisions than individuals (DeMuro & Rideout, 2002). Yet, no systematic research has

been conducted to examine whether this assumption holds true, or whether it has any basis in

the decision-making literature, although sites have engaged in extensive self-evaluation efforts

to monitor their practices. Furthermore, as part of a large scale child welfare reform initiative,

Family to Family (F2F), TDM is potentially subject to dilution and local innovation such that it

might stray from the F2F conceptual framework. These two issues, the underlying theoretical

framework of TDM and the extent to which this framework is implemented in practice, are the

core issues under consideration in this chapter.

In fact, it could be stated that the effectiveness of an approach like TDM is a function both

of (a) the soundness of its program theory, and (b) the effective implementation of the approach

in day-to-day practice. Chapter 1 provided an overview of decision-making literature, and

advanced a framework for balanced decision-making in child welfare against which TDM can

be assessed.  The current chapter explores implementation analysis based on its use in a variety

of fields, but with particular attention to child welfare. It then outlines a framework for understanding and measuring TDM's effectiveness regarding placement recommendations, followed by an introduction to the particular studies undertaken in this dissertation.

*Program Implementation*

As templates and directives for change, policies and programs express intended goals, often in broad terms, and less frequently, the specific means of achieving those goals and the parties responsible for accomplishing them. Between the intended goals and the actual outcomes of a policy or program is a process generally termed "implementation." Bardach (1977) likened the implementation process to an assembly line, where an original mandate sets a blueprint by which a large machine churns out particular desired outcomes. This machine includes several components, including (but not limited to) mechanisms for administrative or financial accountability, the willing participation of clients, funding sources, innovative program designs, troubleshooters who help address routine activities and problems, and political support to protect and sustain the assembly process (Bardach, 1977, p. 2).

Yet, this process is complicated by a variety of factors, not the least of which are the number of participants responsible for, or laying claim to, the various components of the machine. The field of policy implementation documents a rich history of the failure of policies to achieve their intended outcomes, largely as the result of intervening political factors (Pressman & Wildavsky, 1973), or a failure to anticipate the behavior of practitioners and clients in the field (Derthick, 1990; Lipsky, 1980). This problem, the distance between policy or program design and practice-level implementation, prompted Elmore (1980) to conclude that "the connection between the problem and the closest point of contact is the most critical stage of analysis" (p. 612). Examining this point of contact is the study of implementation fidelity.

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In contemporary human services research, implementation fidelity refers to the extent to which practitioners conduct program activities as intended by those who developed the program (Dusenbury, Brannigan, Falco, & Hansen, 2003; McGrew, Bond, Dietzen, & Salyers, 1994). Thus, before designing a full-scale evaluation of a program or intervention, researchers frequently conduct a process or implementation study to ensure that the program is being implemented in accordance with its design (Gilliam, Zigler, & Leiter, 2000). This type of analysis is important for a number of reasons. Findings can be used for further program refinement and to provide information to funding sources regarding how resources were used. Implementation studies can also determine a program's success rates, document successful strategies for future replication, and demonstrate program activities to the public before outcomes are achieved (Substance Abuse and Mental Health Services Administration [SAMHSA], 2000). Shortcomings in implementation may lead to difficulties in determining a program's effectiveness. While full implementation should lead to the intended goals of the program, researchers should monitor agency practice to ensure that implementation is executed in close alignment with the practice model (Gilliam et al., 2000; Usher, Wildfire, & Gibbs, 1999).

*Implementation: Program Specification and Practice Fidelity*

Implementation of a policy or program "may be viewed as a process of interaction between the setting of goals and actions geared to achieving them" (Pressman & Wildavsky, 1973, p. xv). This definition is echoed by Fixsen and colleague's (2005) more recent conceptualization of implementation as "a specified set of activities designed to put into practice an activity or program of known dimensions" (Fixsen et al., 2005, p. 5). Using these definitions, program execution can be viewed as a three-tiered process, where (1) program goals pass through a set of

(2) specified activities to achieve (3) specified outcomes. An implementation study thus examines two of these three tiers: (1) the degree to which program goals are well-specified, and (2) whether the activities conducted adhere to those prescribed by the program goals.

The clear specification of a program's goals is dependent on the clarity of the theory underlying the program model (Bardach, 1977; Holden, O'Connell, Connor, Brannan, Foster, Blau, & Panciera, 2002). If the results of an evaluation do not evidence the anticipated results, it is important to distinguish a program's failure to achieve outcomes from a failure to implement the model as specified. As such, the first step in establishing implementation fidelity is a clear specification of the model's critical components. In the field of mental health, McGrew and colleagues (1994) criticized existing effectiveness research as lacking documentation of implementation, and stated, "When program models are not documented, the interpretation of individual studies becomes ambiguous, as do comparisons between studies that ostensibly examine the same model" (p. 670). Failure to document the extent of a program's implementation not only makes interpretation of outcomes different, but also limits the generalizability of the findings to other sites.

The issue of variability across sites is related to the second area addressed by implementation studies, namely the extent to which activities at a particular site adhere to the specified program model. This issue is especially pertinent in child welfare, a field often characterized by complex systems of care and wide variability of available services and approaches to practice. Given these complexities, Wind and Brooks (2002) suggest that the behavior of child welfare systems is, in part, a function of broader social influences that need to be taken into account. These influences call for a process evaluation of both the quantity of services rendered (i.e., the "dosage") as well as the quality of those services (i.e., practice fidelity), before drawing conclusions regarding program outcomes. Thus, the *context* of service provision becomes central to the consideration of child welfare outcomes, as indicators of

positive outcomes and variations across context are interdependent (Usher et al, 1999).  In other words, both the quantity and quality of services rendered are likely to vary considerably across sites.

Yet, despite the general recognition of the importance of context in social work, and particularly in child welfare, many prevailing research methodologies ignore this important source of variance.  Ortega and colleagues (2002) point to an apparent disconnection between evaluation approaches and the evaluation needs dictated by the context of practice.  These authors state that evaluation methodologies ought to be determined by particular program realities, and therefore should include multiple perspectives from a variety of stakeholders.  Wind and Brooks (2002) share this opinion, and call for the use of multidisciplinary evaluation teams that include multiple stakeholders.  The key is to isolate the particular conditions of practice within a site, in order to determine how these conditions affect outcomes above and beyond the influence of a program.  Solomon (2002) refers to this approach as the "realistic perspective":

> From the realistic perspective this assessment involves determining under what conditions the expected outcomes occur and do not occur and whether on the basis of the findings, the theory should be revised and the program modified.  The overarching question for realistic evaluation is: Will the causal model function in a given context or under a given set of conditions (p. 396)?

The repeated calls for considering context in child welfare evaluations may lead one to believe that process evaluations are largely absent in the field; however, a limited number of studies have been conducted examining contextual effects.  The next section outlines and describes some studies of program implementation and fidelity related to the field of child welfare.

*Implementation Studies Related to Child Welfare*

Central to the study of implementation studies is the ability to detect "program drift," the extent to which practice differs from the intent of the program's design. In fact, several implementation studies in child welfare document such drift. In a study of the implementation fidelity of an assertive community treatment (ACT) mental health program, McGrew, Bond, Dietzen and Salyers (1994) found that program fidelity varied considerably as the program was replicated in different sites. As the degree of fidelity decreased, so did the program's impact on the outcome of a reduction in days hospitalized. Similarly, an evaluation of a promising early intervention program, the Comprehensive Child Development Program (CCDP), demonstrated no ability to effect significant changes in clients' outcomes (Abt Associates, 1997); these findings were later used within a more general critique of federally funded programs for disadvantaged families and children (Gilliam, Ripple, Zigler, and Leiter, 2000). In a critique of the Abt outcome study, and the process study which preceded it (CSR Incorporated, 1997), Gilliam and colleagues (2000) concluded that CCDP was not implemented as intended, but rather more as a loosely organized case management program. Among other methodological and conceptual criticisms of the studies, Gilliam et al. concluded that the initial process study demonstrated that CCDP did not provide the services intended, such that a full outcome evaluation should never have been attempted.

A variety of reasons exist for a policy or program's failure to follow its intended guidelines. In a recent study of concurrent planning implementation in California, D'Andrade, Frame and Berrick (2006) found wide support among agency workers for simultaneously planning for reunification or other permanency options. Yet, despite this support, implementation of concurrent planning proved to be quite limited by the presence of mitigating factors, such as conflicting priorities for workers, confusion for children, and an emotionally

overwhelming challenge for birth families under strict timelines. Moreover, by law, California counties had wide discretion in how to implement concurrent planning, such that implementation differed greatly across counties in emphasis and intensity.

Successful implementation may also be hindered by fiscal and administrative limitations. A study of Shared Family Care demonstrated that despite some positive outcomes for the agency and community, the lack of agency administrative infrastructure lead to such inconsistencies in treatment and service structure chaos that county workers became reluctant to refer clients to the program (Simmel & Price, 2002). Such challenges are not uncommon, though agencies vary in their responses. For example, when the Commonwealth of Kentucky implemented a multidisciplinary assessment center for children entering foster care, the demand for services threatened to exceed agencies' capacity to cope effectively. Agencies responded by a variety of strategies, such as securing additional funding, developing a priority response system, and educating and developing important linkages among stakeholders. The success of the program was directly related to the degree of financial and political support it enjoyed at the state level (Sprang, Clark, Kaak, & Brenzel, 2004).

When it comes to measuring a program's impacts, the issue of implementation fidelity is not inconsequential, nor is it without some controversy. One of the highest profile outcome evaluations in child welfare, Scheurman, Rzepnicki and Littell's (1994) rigorous controlled study of Intensive Family Preservation Services (IFPS), found that IFPS had little effect on placement rates, recurring child maltreatment, or family functioning. Yet, this study has been critiqued for ignoring important variations in service delivery across sites. Among other criticisms of the evaluation, Bath and Haapala (1994) pointed to the treatment inconsistencies and differing philosophies driving practice at individual sites. As these differences were not addressed in the evaluation, Bath and Haapala called into question the study's ability to detect positive outcomes attributable to the intervention. In response, Littell (1995) stated that the researchers accepted the practice variation across sites, given that no evidence existed that one

practice model was superior to any other. Littell further argued (1997) that treatment inconsistencies are less problematic than the issue of a lack of clarity regarding which components are most effective in IFPS, and for which clients. Later analyses of subgroups receiving IFPS found that the intervention was not effective in preventing out-of-home placements or recurrence of maltreatment (Littell & Scheurman, 2002). However, it is difficult to argue that significant between-group variations in program implementation have no effect on outcomes. Fraser and colleagues cautioned that, given the wide practice variability, findings from IFPS evaluations must be interpreted carefully, and that "one cannot conclude in an unqualified fashion that FPS is an insufficient response to child maltreatment, for it is not clear that a high-quality and consistent family preservation service was provided in the two largest studies of FPS in child welfare" (Fraser, Nelson, & Rivard, 1997, p. 149).

More recently, the controversy over implementation fidelity has surfaced again, this time over the effectiveness of Multisystemic Therapy (MST). Littell (2005) used a meta-analysis of the effects of MST to draw conclusions regarding the variations across existing empirical studies of MST's effectiveness. Among her findings was the conclusion that, while studies of MST were randomized controlled trials, they often did not include important information about attrition, violations of random assignment, and intent-to-treat (ITT) analyses. These findings caused Littell to question MST's generally accepted status as an effective, empirically-supported treatment. In their rebuttal, Henggeler and colleagues (2006) claimed Littell misinterpreted the findings and methodologies of these previous MST studies, blurred the distinctions between efficacy, effectiveness, and transportability research, and ignored the importance of treatment fidelity in establishing internal validity. They further claimed that the different findings across studies and sites implementing MST "highlight the importance of examining and understanding the factors…that contribute to the success (and failure) of empirically supported practices transported to community practice settings as well as the significance of possible site and program maturity effects" (Henggeler, Schoenwald, Swenson, & Borduin, 2006, p. 452).

These controversies highlight the tensions and difficulties inherent in community-based research, particularly in child welfare. Many child welfare researchers have discussed the importance of capturing site-specific information before conducting an outcome evaluation (Ortega et al., 2002; Solomon, 2002; Wind & Brooks, 2002). Indeed, the point at which policy or program intentions meet practice-level behaviors may prove to be the fulcrum on which positive outcomes are detected or not detected. In part, this dissertation is an illustration of the degree to which one program in child welfare, Team Decisionmaking (TDM), has been implemented in compliance with the conceptual framework advanced by the Annie E. Casey Foundation (AECF) across a variety of sites. The next section of the paper introduces a conceptual framework for examining program implementation fidelity, applied specifically to TDM.

*A Framework for Assessing TDM Implementation*

The findings of implementation literature across a wide range of fields suggest that implementation is most successful when it targets multiple levels. That is, implementation strategies must take into consideration both micro- and macro-level barriers, as well as particular strengths within a site to aid successful implementation. Fixsen and colleague's (2005) broad review of implementation literature found that "implementation is synonymous with coordinated change at system, organization, program, and practice levels," and is most successful when the following conditions are met: (1) carefully selected practitioners receive coordinated training, coaching, and frequent performance assessments; (2) organizations provide the infrastructure necessary for timely training, skillful supervision and coaching, and regular process and outcome evaluations; (3) communities and consumers are fully involved in the selection and evaluation of programs and practices; and, (4) state and federal funding avenues, policies, and regulations create a hospitable environment for implementation and program operations (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005, p. vi).

These multilevel considerations also apply to the field of child welfare. In presenting a conceptual framework for child welfare reform, Usher, Wildfire and Gibbs (1995) identified these key concerns:

> ...Any given program or service is but one component of the system each community develops – deliberately or not – to respond to the needs of its families and children. Therefore, in evaluating changes in specific family and children's services and assessing their impact as part of a systemic reform effort that transcends individual programs and services, we must understand the policy, programmatic, and organizational context within which such services fit (p. 893).

The interdependence of these different levels requires program developers and evaluators to consider multiple domains, including the context and values driving public policy; the management and structure of the child welfare program; program operations, including the prevailing gatekeeping processes and available services; and the impact of the program for children, families and communities (Usher et al., 1995).

The conceptual framework depicted in this paper (see Figure 1) draws both from the conclusions of Fixsen et al. (2005) and Usher et al. (1995) that the effectiveness of a program depends largely upon the extent of its implementation across multiple levels. It is clear that the effectiveness of a program like Team Decisionmaking (TDM), which emphasizes a collaborative effort involving the agency, service providers, and supports in the extended family and community, necessarily involves targeting multiple levels (DeMuro & Rideout, 2002). In addition, the ability of TDM to be implemented effectively is also largely dependent upon the context of public policy in a site. Yet, effective implementation also involves a clear specification of the program's goals and values (Holden et al., 2002). While discussed more fully elsewhere, the goals and processes of TDM are clear: improve the quality of placement decision-making by drawing from the perspectives of family and community members, before *any* and *all* placement decisions (DeMuro & Rideout, 2002).

An evaluation of TDM's implementation fidelity also requires a close examination of the child welfare agency's program management and structure, specifically the support of TDM and Family to Family from policy-makers and senior agency administration. Other factors affecting implementation include the presence of adequate resources, the length of time TDM has been implemented at a site (e.g., the site's program maturity), and the relationship of the agency to the court system that is responsible for making final placement decisions. These programmatic factors have a direct effect on the extent of TDM practice-level implementation (i.e., implementation fidelity), such as the support of supervisors and caseworkers in adhering to the TDM process, the extent to which meetings are held before all placement decisions, and the extent of participation from birth parents, relatives and formal and informal supports from the family's neighborhood and community. Finally, these practices are hypothesized to have a direct effect on the types of placement recommendations made by groups, such that groups drawing from the perspectives of a wide variety of participants should result in a greater likelihood of family-based, least restrictive placements.

### Overview of Analysis Chapters

If the balance of risk and protective factors serves as TDM's underlying program theory, the framework for understanding TDM implementation and program fidelity forms much of the basis of this examination of TDM practice. The current section is intended as a broad overview of the topics included in the dissertation, including the title of each chapter, the research questions and methods used to answer them, the sites selected for inclusion in each study, and the types of data used.

In Chapter 4, *Implementation of Team Decisionmaking: Scope and Compliance with the Family to Family Practice Model,* the framework for implementation fidelity (see Figure 3) is used to assess the scope of implementation within three sites, and how closely TDM practice complies with the conceptual framework advanced by the Family to Family initiative (see Table

**Figure 3.**          **A Framework for Evaluating TDM Implementation Fidelity**

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┌─────────────────────────────────────────────────────────┐
│                  Public Policy Context                    │
└─────────────────────────────────────────────────────────┘

        ┌─────────────────────────────────────────┐
        │  TDM Program Specification               │
        │                                          │
        │   • Goals                                │
        │   • Values                               │
        │   • Processes                            │
        └─────────────────────────────────────────┘

        ┌─────────────────────────────────────────┐
        │  Program Management & Structure          │
        │                                          │
        │   • Support from Policy-Makers           │
        │   • Support from Senior Agency Administration │
        │   • Presence of Adequate Resources       │
        │   • Program Maturity at Site             │
        └─────────────────────────────────────────┘

 Chapter 4                                    Chapter 5

        ┌─────────────────────────────────────────┐
        │  Practice-Level Implementation           │
        │  (Implementation Fidelity)               │
        │                                          │
        │   • Support from Supervisors and Caseworkers │
        │   • Convening TDMs When Appropriate      │
        │   • Extensive Family & Community Participation │
        └─────────────────────────────────────────┘

 Chapter 6

        ┌─────────────────────────────────────────┐
        │  Placement Recommendations               │
        │                                          │
        │   • Family- and Community-Based          │
        │   • Least Restrictive                    │
        └─────────────────────────────────────────┘
```

1). Based on Figure 3, this chapter pays a close look at the *Program Management and Structure*

of individual sites, with implications for *Practice-Level Implementation,* using aggregate

quantitative data supplemented by qualitative data from interviews and focus groups. As

hypothesized in the conceptual framework, the ability of sites to implement TDM in compliance

with the Family to Family framework will in part be a function of managerial and programmatic

direction. The purposes of this chapter are to determine the extent to which sites display a strong

commitment to TDM implementation, and to explore the various factors that facilitate or hinder

implementation issues across sites. Research questions for Chapter 4 are divided into two broad

categories. The first category, *TDM Processes: Scope and Compliance,* examines system-wide

TDM implementation and how this implementation may be reflected in the placement experiences of children. Research questions include: (1) What is the relationship between agency practices and the context in which sites operate? (2) What are the types and numbers of TDM meetings held within each site? and, (3) To what extent is TDM implementation reflected in the types of placements most commonly experienced by children? These questions will be answered using aggregate TDM data collected in administrative databases, as well as aggregate longitudinal placement data, from the following sites: Louisville, KY; Cleveland, OH; and, Denver, CO. The second category, *The Relationship of Program Management with Practice-Level Implementation,* examines how programmatic influences may affect TDM implementation across sites, drawing from qualitative findings. Research questions include: (1) What is the rollout status of each of three sites implementing Family to Family? (2) What is the level of commitment expressed by agency administrators in practicing TDM meetings consistently? (3) Does the agency possess adequate resources to implement TDM effectively? (4) Do supervisors and frontline workers perceive TDM as being a valuable and critical aspect to daily practice? and, (5) What challenges to TDM implementation emerged within and across sites? These questions will be answered using qualitative data from interviews and focus groups conducted in the three aforementioned sites. Chapter 5 provides a quantitative examination of the *Implementation Fidelity of Team Decisionmaking.* This study focuses on the practice-level implementation of TDM as operationalized by key indicators of TDM implementation (see Figure 3), such as widespread use of TDM and extensive participation from family and community supports. This chapter also provides a preliminary exploration of the relationship between TDM meetings and placement outcomes for children. Research questions are divided into two categories. The first, *Extent of Implementation Fidelity,* examines the extent to which agencies' pursuit of TDM results in actual and consistent practice changes, and includes the following questions: (1) What are the numbers of children and families served within agencies, and how many meetings are held during this time period? (2) What is the proportion of meetings

**Table 1.**     **Overview of Dissertation Organization**

| Title | Questions & Methods | Sites | Data |
|---|---|---|---|
| **Chapter 4**<br><br>*Implementation of Team Decisionmaking: Scope and Compliance with the Family to Family Practice Model* | (1) *TDM Processes: Scope and Compliance*<br>-- Descriptive quantitative analysis of breadth of implementation and aggregate placement experiences<br><br>(2) *The Relationship of Program Management with Practice-Level Implementation*<br>-- Qualitative analysis of strategies and barriers to implementation | Louisville Cleveland Denver | Aggregate TDM process; Aggregate longitudinal placement; Qualitative from interviews and focus groups |
| **Chapter 5**<br><br>*Implementation Fidelity of Team Decisionmaking* | (1) *Extent of Implementation Fidelity*<br>-- Descriptive quantitative examination of key elements of implementation<br><br>(2) *Assessment of Placement Experiences Associated with TDM*<br>-- Descriptive quantitative examination of matched TDM and longitudinal placement data | Anchorage Cleveland Denver | TDM process; Longitudinal placement in Denver only |
| **Chapter 6**<br><br>*The Association Of Team Composition and Meeting Characteristics With Placement Recommendations* | (1) *Meeting Characteristics*<br>-- Descriptive quantitative examination of TDM characteristics<br><br>(2) *Likelihood of Placement Recommendation*<br>-- Binomial logit models predicting placement recommendation by meeting characteristics for each site<br><br>(3) *Likelihood of Placement Restrictiveness*<br>-- Multinomial logit models predicting restrictiveness of recommendation by meeting characteristics for each site | Anchorage Wake Co., NC Denver | TDM process |

attended by various types of participants? (3) What is the ratio of agency staff members to family members and community supports within meetings? and, (4) Among family members and community supports, what are the most common patterns of participation within meetings? The questions will be answered using TDM process data collected from administrative databases at three sites: Anchorage, AK; Cleveland, OH; and, Denver, CO. The second category, an *Assessment of Placement Experiences Associated with TDM Meetings,* is a preliminary assessment in one site of TDM's affect on the placement experiences of children. This category includes the following research questions: (1) For removal

TDM meetings, what are the most frequently made placement recommendations? (2) For custody recommendations, what percentage of children entered placement, and for non-custody recommendations, what percentage did not enter placement? (3) For custody recommendations, what are the time frames for placements, both before and after meetings are convened? and, (4) When assessed against actual placement experiences, how many TDM recommendations are successfully implemented? These questions will be answered by linking administrative TDM data with longitudinal placement data in one site, Denver, CO.

Chapter 6 moves away from a focus on implementation towards a preliminary assessment of TDM's effect on placement recommendations for children. This study, *The Association of Team Composition and Meeting Characteristics With Placement Recommendations,* examines the association of TDM characteristics with the likelihood and restrictiveness of placement recommendations for children experiencing placement change TDM meetings. This chapter focuses on the last component of implementation fidelity framework (see Figure 3), *Placement Recommendations,* which according to the Family to Family practice model should be in a family- or community-based setting (i.e., not in a shelter or congregate care setting) and should be the least restrictive option for the child (DeMuro & Rideout, 2002). This chapter posits four research questions: (1) What are the meeting and child characteristics of placement change meetings in three sites: Anchorage, AK; Wake Co., NC; and Denver, CO? (2) What is the

relationship of these characteristics with the likelihood of a child's being recommended to change placement in foster care? (3) To what extent does the presence of different types of caregivers influence placement recommendations? and, (4) To what extent are meeting characteristics related to the restrictiveness of the placement recommendation? All analyses draw from administrative TDM data in each site. Question 1 is answered using descriptive analyses, Questions 2 and 3 are answered using binomial logit models predicting placement (v. no placement) in each site, and Question 4 is answered using multinomial logit models predicting less restrictive, same level, or more restrictive recommendations, versus no change in placement.

Chapter 7 reviews the findings from these three studies and draws conclusions regarding (a) the extent to which TDM meetings are effectively implemented within sites, and (b) the potential effects of TDM on placement experiences of children and the restrictiveness of recommendations emerging from meetings. While conclusive findings of TDM's effectiveness await the results of the Family to Family evaluation concluding in 2009, this dissertation provides one of the first systematic examinations of the implementation and impact of TDM across sites.

**CHAPTER 4**

IMPLEMENTATION OF TEAM DECISIONMAKING (TDM): SCOPE AND COMPLIANCE

WITH THE FAMILY TO FAMILY PRACTICE MODEL


In contemporary human services research, full-scale evaluations of a program or

intervention often begin with an implementation or process study to ensure that the program is

being implemented in accordance with its design (Gilliam, Zigler, & Leiter, 2000). This type of

analysis is important for a number of reasons. Findings can be used for ongoing program

refinement and to provide information to funding sources regarding how resources are being

used. Implementation studies can also document successful strategies for future replication and

demonstrate program activities to the public before outcomes are achieved (Substance Abuse

and Mental Health Services Administration [SAMHSA], 2000). Shortcomings in

implementation make it impossible to determine an intervention's intrinsic effectiveness. While

full implementation *should* lead to the intended goals of a program, program staff and

researchers should monitor agency practice to ensure that implementation is executed in close

alignment with the practice model (Gilliam et al., 2000; Usher, Wildfire, & Gibbs, 1999).

A variety of reasons exist for a policy or program's failure to follow its intended

guidelines. In a recent study of concurrent planning implementation in California, D'Andrade,

Frame and Berrick (2006) found wide support among agency workers for simultaneously

planning for reunification or other permanency options. Yet, despite this support,

implementation of concurrent planning proved to be quite limited by the presence of mitigating

factors, such as conflicting priorities for workers, confusion for children, and an emotionally

overwhelming challenge for birth families under strict timelines. Moreover, by law, California counties had wide discretion in how to implement concurrent planning, such that implementation differed greatly across counties in emphasis and intensity.

Successful implementation may also be hindered by fiscal and administrative limitations. A study of Shared Family Care demonstrated that despite some positive outcomes for the agency and community, the lack of agency administrative infrastructure lead to such inconsistencies in treatment and service structure chaos that county workers became reluctant to refer clients to the program (Simmel & Price, 2002). Such challenges are not uncommon, though agencies vary in their responses. For example, when the Commonwealth of Kentucky implemented a multidisciplinary assessment center for children entering foster care, the demand for services threatened to exceed agencies' capacity to cope effectively. Agencies responded by a variety of strategies, such as securing additional funding, developing a priority response system, and educating and developing important linkages among stakeholders. The success of the program was directly related to the degree of financial and political support it enjoyed at the state level (Sprang, Clark, Kaak, & Brenzel, 2004).

The findings of implementation literature across a wide range of fields suggest that implementation is most successful when it targets multiple levels. That is, implementation strategies must take into consideration both micro- and macro-level barriers, as well as particular strengths within a site to aid successful implementation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). These multilevel considerations also apply to the field of child welfare. In presenting a conceptual framework for child welfare reform, Usher, Wildfire and Gibbs (1995) identified these key concerns:

> . . . Any given program or service is but one component of the system each community develops – deliberately or not – to respond to the needs of its families and children. Therefore, in evaluating changes in specific family and children's services and assessing their impact as part of a systemic reform effort that transcends individual programs and services, we must understand the policy, programmatic, and organizational context within which such services fit (p. 893).

The interdependence of these different levels requires program developers and evaluators to consider multiple domains, including the context and values driving public policy; the management and structure of the child welfare program; program operations, including the prevailing gatekeeping processes and available services; and the impact of the program for children, families and communities (Usher et al., 1995).

*Implementing Team Decisionmaking*

Whatever promise TDM offers in balancing risk and protective factors, its ability to produce better placement decisions is also a function of the extent to which the strategy is implemented effectively (Usher, Wildfire, & Gibbs, 1999). TDM has a clear conceptual framework for engaging family members, relatives, community partners, and service providers (DeMuro & Rideout, 2002), a necessary precondition for examining the effects of any program (Holden et al., 2002). It is also clear that the effectiveness of a program like Team Decisionmaking (TDM), which emphasizes a collaborative effort involving the agency, service providers, and supports in the extended family and community, necessarily involves targeting multiple levels.

As outlined in the conceptual framework for measuring implementation (Figure 3, Chapter 2), an examination of TDM implementation should include a close examination of the child welfare agency's program management and structure, specifically the support of TDM and Family to Family from policy-makers and senior agency administration. Other factors affecting implementation include the presence of adequate resources and the length of time TDM has been implemented at a site (e.g., the site's program maturity). These programmatic factors are

hypothesized to have a direct effect on the extent of TDM implementation fidelity, such as the support of supervisors and caseworkers in adhering to the TDM process, the extent to which meetings are held before all placement decisions, and the extent of participation from birth parents, relatives and formal and informal supports from the family's neighborhood and community.

The current study examines the scope of TDM implementation across three sites as measured by broad patterns of TDM usage, and highlights the broad placement dynamics that may be associated with this usage. Then, following the conceptual framework for measuring TDM implementation, this study focuses on the extent to which the TDM practice model is filtered through agency program management and structure to influence resource allocation and practice-level support from frontline and supervisory staff.

*Research Questions*

The research questions in this study focus on (1) the broader commitment of agencies to rolling out TDM to achieve patterns of usage that conform to the Family to Family practice model; and (2) the level of support expressed by senior administrators, and evidenced by sufficient resource allocation and support from frontline staff.

*TDM Processes:  Scope and Compliance*

The first step in examining TDM implementation issues involves measuring the broad patterns of usage and compliance with the TDM framework.  Here, the primary concern is the extent to which meetings are being implemented on a system-wide scale, and how this implementation may be reflected in the overall placement experiences of children within sites. Specific research questions include:

(1) What is the number of children entering care for the first time in each agency?

(2) What are the types and numbers of TDM meetings held within each site, and how do these numbers relate to initial placement dynamics?

(3) To what extent is TDM implementation reflected in the types of placements most commonly experienced by children?

*Strategies and Barriers to Implementation*

This set of research questions examines some of the factors that may promote or impede effective implementation of TDM in practice. Based on the conceptual framework for understanding TDM implementation (see Figure 3, Chapter 2), particular research questions include:

(1) What is the level of commitment expressed by agency administrators in practicing TDM consistently?

(2) Does the agency allocate adequate resources to implement TDM effectively?

(3) Do supervisors and frontline workers perceive TDM as being a valuable and critical aspect to daily practice?

*Site Selection*

These anchor sites were selected for more intensive support from the Annie E. Casey Foundation based on the depth of their previous commitment and their potential to implement many of the core strategies of Family to Family. In 2005, technical assistance providers for Family to Family undertook an assessment of sites' progress in implementing the four core strategies (Batterson, Crampton, Crea, Harris, Madden, Usher, & Williams, 2007). This assessment provided a basis for the Foundation to target technical assistance resources to a smaller number of sites. In 2006, prior to conducting a full outcome evaluation, the research team selected five anchor sites in which to conduct interviews and focus groups, with the

purpose of identifying challenges and strategies in implementing Family to Family. These locations were selected as examples of sites that had experienced some success in implementing the four core strategies of Family to Family (Batterson et al., 2007).

The three sites selected for the current study were among the five participating in the Family to Family implementation analysis. The five sites were Cleveland, Denver, Louisville, Orange County, California, and San Francisco. To avoid revealing confidential information through deductive disclosure, sites in this paper must remain anonymous and will be referred to as "Agency A," "Agency B," and "Agency C."

*Implementation Status of Sites*

The TDM implementation status for F2F sites refers to the stage of implementation--first implementing TDM meetings for all removals from the home, then moving to meetings for changes of placement (COP), and finally, to reunification or other permanency decisions (see Table 2). Local TDM managers and supervisors, as well as providers of technical assistance

**Table 2.** **TDM Implementation Status**

|  | Agency A | Agency B | Agency C |
|---|---|---|---|
| *Rollout Status* |  |  |  |
| Removal | March 2002 | Jan. 2003 | 1995 |
| Change of Placement | May 2003 | April 2003 | 1995 |
| Permanency | June 2005 | June 2003 | 1995 |
| *Protocol Guide* | May 2003 | Feb. 2003 | Sept. 1996 |
| *Facilitators* |  |  |  |
| Full-time | 3 | 4 | 18 |
| Part-time | 2 | 0 | 0 |
| Back-up | 6 | 4 | 0 |

from the Annie E. Casey Foundation, track each site's progress towards full implementation using progress reports. Data drawn from these reports indicate that Agency C employs significantly more facilitators than either Agency A or B. Also, one agency began implementing Family to Family in 1992, compared with 2002 and 2003 for the others. As such, one agency has significantly more experience than the others.

Agency A first implemented TDM for removals in March 2002, added COP TDM meetings in May 2003 and permanency meetings in June 2005. The site first published a set of TDM protocols for removals in May 2003, and published further protocols for COP and permanency meetings in June 2004. Agency A relies on 3 full time facilitators, as well as 2 part-time and 6 backup facilitators. The site recently began making consistent use of its TDM database, but is not yet making consistent quarterly reports to Casey Foundation technical assistants. .

Agency B first implemented TDM for removals in January 2003 and rolled out quickly to implement meetings for changes of placement in April 2003 and for permanency decisions in June 2003. TDM meetings also began for juvenile justice placements in June 2003. This site published a set of protocols for TDM in February 2003. Agency B relies on 4 full time facilitators plus 4 back-up facilitators for removals and changes of placement. The site began using TDM databases in mid-2004, has developed a user guide, and consistently produces quarterly reports.

Agency C implemented TDM meetings for removals, changes of placement, and permanency in 1995, and published a set of protocols in September of 1996. This agency relies on 18 full time facilitators for removals and COP; however, in addition to TDM, these facilitators also cover non-Family to Family cases such as semi-annual case reviews, a situation that in part accounts for the higher number of facilitators in this agency. The site has made consistent use of the TDM database, has developed a user guide, and consistently sends quarterly reports.

*Methods*

*Data Sources*

Longitudinal placement data.  In child welfare systems, the use of longitudinal data serves to build statistical case histories for children upon entry to the system.  The use of longitudinal data is important in that children with long lengths of stay are disproportionately represented by data sets that rely on "point-in-time" data (Usher, Wildfire, & Gibbs, 1995).  A longitudinal database provides data about *all* children served by a particular agency over the course of several years.  These data (1) include a series of entry cohorts for children who enter out-of-home care for the first time during a designated period of time (e.g., calendar or fiscal year); (2) track the occurrence of custody and placement events through specified periods of time; (3) represent all children who ever enter care; and (4) provide valid and reliable estimates of length of stay and other outcomes such as placement stability. For this study, aggregate data from longitudinal placement databases are used pertaining to cohorts of children initially entering care, as well as the placement experiences of children exiting care.

TDM administrative data. Agencies in each of the three sites collect process-related data for all TDM meetings held. Following each meeting, facilitators enter a variety of information about the meeting as part of agencies' self-evaluation efforts. These data allow agencies to examine the breadth of TDM use across meeting types (removal from home, change of placement, and permanency or reunification). Data are also collected on the characteristics of each TDM, including the type of placement decision under consideration, the types and variety of participants within each meeting, and the placement recommendations made by the team. These recommendations include the specific placement type as well as the restrictiveness of the placement recommendation. For this study, only aggregate data pertaining to the types and numbers of convened meetings are used.

Interviews and focus groups.  In each of the three sites, interviews and focus groups were conducted with agency staff members, legal professionals, and community partners, to capture the unique characteristics of TDM implementation with each site.  A research team visited each site to conduct interviews and focus groups[2]. Each agency organized the schedule for interviews and focus groups and invited staff members and community partners to participate.

Interviews were conducted with the following participants: (1) the TDM "champion" who most actively promoted initial implementation; (2) full-time and part-time "backup" facilitators; (3) workers in charge of scheduling meetings; (4) the director or deputy director(s); and (6) court personnel. Focus groups were conducted with: (1) initial and ongoing caseworkers; (2) initial and ongoing supervisors; and (3) members of neighborhood associations and community liaisons who attend meetings. To reduce potential contamination within focus groups, these groups were designed such that participants were of equal ranks (e.g., not combining workers and supervisors together). Each participant received an explanation regarding the purposes of the study and signed an informed consent form in adherence to IRB protocols from all three participating research universities.

In Agency A, researchers interviewed 7 individuals and conducted 5 focus groups involving 17 persons, for a total of 24 persons interviewed. In Agency B, researchers interviewed 12 persons and conducted 3 focus groups involving 17 persons, for a total of 29 persons interviewed. In Agency C, researchers interviewed 11 persons and conducted focus groups involving 25 persons, for a total of 36 persons interviewed.  Across all three sites, the sum of agency staff members, court and legal personnel, and community partners participating across 31 interviews and 13 focus groups totaled 89.

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[2] The author was one of three researchers conducting interviews and focus groups in these three sites.

The discussion guide for interviews and focus groups began with open-ended questions and narrowed into more specific issues using prompts to ensure that comments related directly to critical implementation issues (see Appendix A).  Using the questions as a guide, interviewers asked participants for their perspectives on the benefits and challenges of implementing TDM.

*Analysis*

Measuring the *scope and compliance of TDM processes* at each site required the use of both aggregate TDM data and placement outcome data.   Each year, agency analysts, technical assistants, and university-based researchers analyze placement outcome data for every site implementing Family to Family. These analyses rely on each site's longitudinal placement database, and the results are summarized in outcome profile reports submitted yearly to the Annie E. Casey Foundation (see Appendix A).  These reports include information spanning 5 years pertaining to: the number of children initially entering care; the percentage of children being placed in foster homes, relative placements, or congregate care settings; and other information pertaining to children's lengths of stay in care, the number and rate of children reunified with birth families, the number of siblings placed together, and the rates of reentry to care. These reports serve as the basis for this portion of the analysis.

First, the numbers of children entering foster care for the first time (initial entries) were plotted for each site, stratified by year of entry (entry cohort). The purpose of this analysis is to answer the first research question by providing a broad understanding of the aggregate placement dynamics operating in each site. Next, using data from administrative TDM databases from each site, the numbers of total meetings, as well as children and families involved in meetings, were generated for meetings occurring between January and December of 2005. The number of TDM meetings was further broken down by TDM type (Removal, Change of Placement, Reunification/Permanency, Non-traditional). Initial entries and the numbers of children for whom TDM meetings were convened are compared for 2005 to estimate the extent

of TDM coverage and the numbers of children diverted from entering care. Lastly, using outcome profiles, the placement settings of children exiting care were graphed over the same 5-year period to compare placement patterns within and across sites.

Assessing the *Strategies and Barriers to Implementation* across the sites is an examination of the common challenges agencies face in pursuing implementation, as well as the strategies sites have developed to address these challenges. This part of the study utilized qualitative methodologies, specifically interviews and focus groups that were conducted between May and July of 2006 for the Family to Family implementation analysis (Batterson et al., 2007). The TDM interview guide served as the tool for data collection (see Appendix B). Researchers took extensive notes during interviews and focus groups, and all interviews and focus groups were audio-taped for later cross-referencing with notes. Once qualitative data collection was completed in all three agencies, all audio-taped interviews and focus groups were downloaded onto desktop computers. Each interview and focus group was then cross-checked with notes, and researchers condensed these findings in 2-3 page summaries of each interview and focus group. These summaries included information pertaining to: (a) high-level administrative commitment to implementation; (b) the allocation of adequate resources to promote full coverage; (c) the maturity of the site as pertains to broad practice changes following the Family to Family program model; and (d) the perspectives of supervisors and frontline workers regarding the value of TDM as a decision-making process. Once summaries were completed, researchers color-coded the common themes emerging across the summaries within each category. Findings were then summarized in a final document when they emerged in 2 or more summaries.

*Results*

<u>TDM Processes:  Scope and Compliance</u>

*Initial Placements*

An examination of the pattern of first entries into foster care highlights markedly different patterns across sites (see Table 3 and Figure 4). The most striking pattern is evident in Agency C, the site having the most experience with TDM. While data are not available for FY 2000, Agency C witnessed 2,407 entries to foster care in 2001. These entries dropped by 17.4% to 1,988 entries in 2002, and this pattern continued into 2005, whose 891 entries represent only 37.0% of the overall volume experienced in 2001.

**Table 3.        Initial Entries to Care**

| | *Year of Initial Entry to Care* | | | | | |
|---|---|---|---|---|---|---|
| ***Number of Entries*** | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
| Agency A | na | 526 | 704 | 795 | 678 | 954 |
| Agency B | 733 | 649 | 769 | 707 | 467 | na |
| Agency C | na | 2407 | 1988 | 1362 | 976 | 891 |

While less dramatic in form, Agency A also appears to follow a distinct pattern in initial entries to care. Beginning in 2001, Agency A begins a slow upward trajectory that culminates in 954 entries in 2005, a 44.9% increase in initial entries over the course of 5 years. The pattern for Agency B is more difficult to discern. Agency B decreased initial entries from 2000 to 2001, but experienced an up tick in 2002 before declining further in 2003 and 2004. Yet, by comparison, Agency B experienced substantially lower rates of entry to care in 2004 than either Agency A or C.

**Figure 4.**     **Numbers of Children Initially Entering Care**
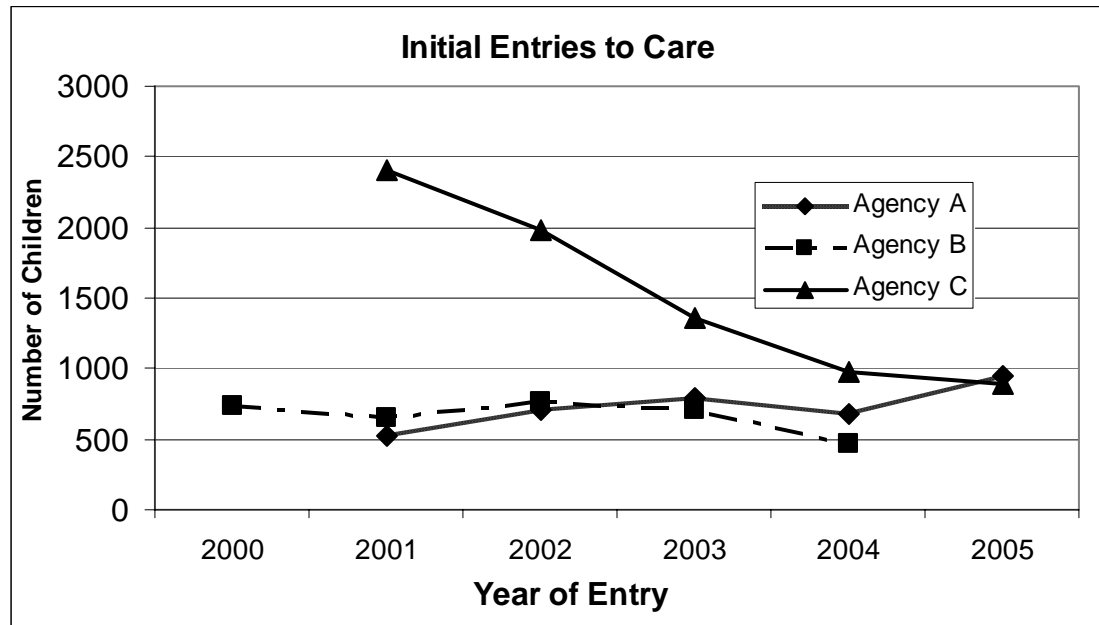


*Scope of Implementation*

Relational administrative TDM databases contain data at multiple levels, pertaining either to meeting characteristics or factors related to individual children. On a meeting level, multiple children may be involved in one meeting (e.g., sibling groups). The current analyses focus on unique meetings for each child (e.g., one child may have multiple meetings). This unit of analysis allows for a direct comparison with entry cohort data in these sites.

For Agency A, the TDM administrative database was not available to the researchers to calculate overall numbers of meetings, families and children. Using data provided by the agency in reports to the Casey Foundation, an analysis of TDM types indicates that Agency A implements slightly fewer meetings than its counterparts in this study (Table 4). In 2005, this agency convened meetings for 1,016 children pertaining to decisions regarding removals from the child's birth home and 611 involving placement change decisions for children already in foster care. Only 36 involved decisions around reunification with the child's birth family, or some other permanency option. When compared with the numbers of children entering care in

2005 (Table 3), the 1,016 children having removal meetings in 2005 represent a number that is

6% higher than the 954 children who entered care during this period. In other words, this

evidence suggests that most children entering foster care in Agency A likely have had a TDM

prior to entering care, but that few children appear to be diverted from entering care following a

TDM.

**Table 4.** **TDM Usage Across Agencies (Jan.-Dec. 2005)**

| | **Agency A** | **Agency B** | **Agency C** |
|---|---|---|---|
| *Number of:* | | | |
| TDM Meetings | n/a | 1,139 | 4,111 |
| Children | n/a | 1,473 | 4,658 |
| Families | n/a | 814 | 2,598 |
| *TDM Types[3]:* | | | |
| Removals | 1,016 | 1,226 | 3,369[4] |
| Change of Placement | 611 | 336 | 1,061 |
| Reunific./Perman. | 36 | 375 | 1,001 |
| Non-traditional | n/a | 23 | 952 |

In 2005, Agency B held 1,139 TDM meetings for 1,473 children from 814 families. Most

meetings involved removal decisions (1,226), with similar numbers pertaining to placement

change (336) and permanency decision (375). It is important to note that these aggregate

numbers do not total either the number of meetings or the number of children. This apparent

discrepancy is due to the fact that multiple children can be involved in a single meeting, and

each child potentially may have a different placement recommendation within each meeting.

Compared with the data in Table 3 that shows 707 children entering care in 2003 and 467

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[3] The unit of analysis is a unique meeting for every child (termed a meeting/child combination).

[4] In Cleveland, TDM types include an unmeasured number of re-entries to care, such that these numbers are upwardly biased by approximately 15-20% according to agency analysts.

entering in 2004, one estimate may be that around 500 children would likely enter care in 2005

(entry data are not available for Agency B in 2005). Given the validity of this assumption, the

1,226 children for whom removal meetings were held in 2005 represent a number 2.5 times that

of the children who actually enter care. In other words, meetings apparently are being convened

for the appropriate number of children and 40.8% of these children will enter foster care

following a TDM meeting. The remaining 59.2% will likely remain at home or be diverted to an

alternative placement resource.

Agency C far exceeds the other agencies in terms of the volume of children served and

meetings convened. One caveat to these data, however, is that there likely exists an unknown

number of removal meetings held for re-entries to care, with the result being a higher number of

recorded removal TDM meetings than meetings held for initial removals. In 2005, this agency

held 4,111 meetings for 4,658 children within 2,598 families. Similar to the other agencies, the

majority of children had meetings involving a placement decision (3,369), with similar numbers

of placement change and reunification/ permanency TDMs. Agency C is also distinct from the

other agencies in the number of children having non-traditional meetings (958). These meetings

include follow-up meetings and meetings pertaining specifically to safety planning. Yet, perhaps

the most striking difference is the comparison of the numbers of children entering care in

Agency C (see Table 3) with the number of children receiving removal meetings. This number

represents a proportion that is 3.78 times the number of children entering care. Thus, the 891

children who entered care in 2005 represent 26.4% of the number of children receiving removal

TDMs, such that nearly three quarters of children involved in removal TDM meetings in

Agency C are diverted from entering care. Again, some caution must be used in this

interpretation given the unknown number of reentries to care recorded in the removal TDM

category.

*Placement Settings*

As an additional means of measuring the scope of TDM implementation within sites, this

study also includes an analysis of aggregate placement outcome data. These data track the

placement settings of children entering care for the first time in each agency between 2000 and

2005 (Table 5). Possible placement outcomes for children include placement in a foster home,

placement with a relative, placement in a group home or shelter, or some other type of

placement setting. Examining these aggregate patterns will help complete our systemic

examination of TDM implementation within these sites and the extent to which implementation

may be reflected in overall placement outcomes for children.

**Table 5.        Initial Placement Settings by Year of Entry to Care**

|  |  | *Year of Initial Entry to Care* | | | | | |
|---|---|---|---|---|---|---|---|
| | *Placement Settings (%)* | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
| Agency A | Foster Home | n/a | 58 | 45 | 46 | 55 | 51 |
| | Relative | n/a | 10 | 30 | 27 | 15 | 28 |
| | Group | n/a | 31 | 25 | 27 | 29 | 21 |
| | Other | n/a | 1 | 0 | 0.8 | 0 | 1 |
| Agency B | Foster Home | 13 | 16 | 20 | 40 | 61 | n/a |
| | Relative | 10 | 5 | 11 | 13 | 20 | n/a |
| | Group | 70 | 66 | 61 | 30 | 0 | n/a |
| | Other | 7 | 12 | 8 | 16 | 19 | n/a |
| Agency C | Foster Home | n/a | 40 | 45 | 43 | 45 | 43 |
| | Relative | n/a | 47 | 41 | 40 | 36 | 38 |
| | Group | n/a | 9 | 9 | 12 | 12 | 12 |
| | Other | n/a | 4 | 5 | 5 | 7 | 7 |

Based on these aggregate data, it is difficult to discern a stable placement pattern for

children entering out-of-home care in Agency A (Figure 5). The proportion of children entering

foster homes declined from 57.9% in 2001 to 45.2% in 2002, rose again to 55.1% in 2004 and

declined to 51.1% in 2005. This pattern appears to be an inverse of the pattern of children being

placed with relatives, with decreases in foster home placements coinciding with increases in

relative placements. The proportion of children entering group care appears to be declining

overall, with 20.6% of children being placed in an initial group setting in 2005.

Of the three agencies under consideration, Agency B displays the most striking changes in

patterns of initial placements (Figure 5). The heavy use of an emergency shelter in Agency B

resulted in 70% of all children experiencing an initial placement in group care. Yet, this

percentage dropped from 61% in 2002 to 30% in 2003 (the same year as the rollout of Family to

Family), and then dropped to 0% in 2004, the last year for which aggregate placement data are

available. This pattern also coincides with a dramatic upturn in the number of children entering

family-based care during their initial placement. Initial foster placements doubled from 20% in

2002 to 40% in 2003, and tripled to 60% in 2004. A small proportion of children in Agency B

are placed with relatives, but these numbers point to a slight increase of kinship placements over

time. The closing of the shelter appeared to have such a marked impact on placement patterns

that no conclusions about the direct role of TDM on placement patterns can be ascertained.

Figure 5: Changes in Pattern of Initial Placements by Year of Implementation and Agency
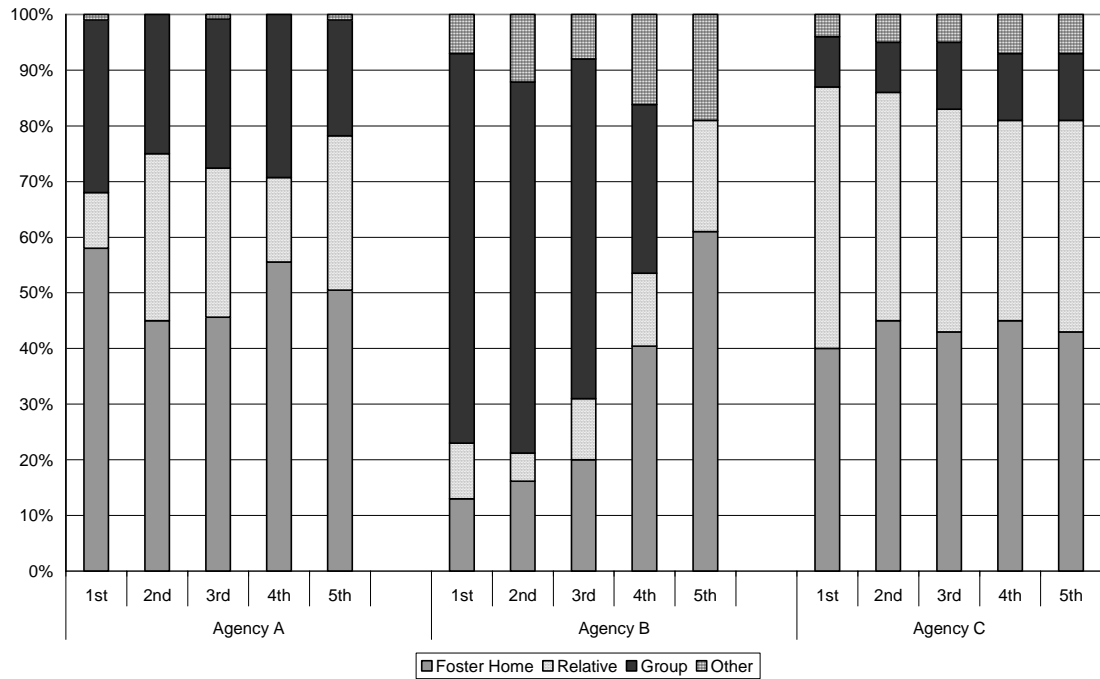


Agency C displays perhaps the most stable, aggregate placement patterns of the three sites (Figure 5). Initial placements in foster homes hover just above 40% between 2001 and 2005. Relative placements appear to decline slightly, such that the proportion of children placed with relatives has declined by 11%, comparing 2001 and 2005. However, the numbers of children placed in group homes or shelters is quite small in Agency C; only 12% of children entering care experience their first placement in a group setting in 2005, and this pattern appears to be stable over time. The stability of these aggregate placement patterns may also be a function of the maturity of Agency C in implementing TDM. Of the three sites, this agency has the most experience pursuing Family to Family, having rolled out the approach several years before the other two agencies (see Table 1).

*Administrative Commitment and Support*

Data from all three sites indicate a strong commitment from senior agency administrators to supporting TDM practice (see Table 6). These administrators expressed this support directly within interviews, and most other respondents agreed that administrators support full implementation of TDM. Agencies differed somewhat, however, in the extent to which administrators supported the practice historically. In Agency C, according to senior administrators, there was "always unwavering support from leadership," whereas Agency B experienced breaks in the implementation process with a previous change in agency administration. Despite past setbacks, each site enjoys strong TDM support from current administrators.

One of the ways in which administrators promote effective implementation is through early training and clear communication regarding the goals of TDM practice. Administrators in both Agencies A and B trained all facilitators in TDM practice as specified by the Casey Foundation, and went further to educate foster parents and community partners to maximize early buy-in to the process. These agencies likely learned lessons from TDM implementation in Agency C several years before. Agency C began TDM before the Casey Foundation had developed a curriculum. As a result, the initial trainings tended to be "hurried" and were "more of an orientation" that led to some confusion among agency staff who wondered, "How does this relate to our job here?" Based on the recollections of agency staff persons who were present during early TDM implementation, staff often tended to be skeptical and even hostile over the paradigmatic change in practice. Yet, over time, agency administrators learned that "communication from leadership is key to implementation," and adopted the strategy of speaking to individual units about the importance of TDM.

Beyond mere communication, agency administrators across all three sites also mandate TDM practice as agency policy. At each agency, leaders expect meetings to be held before any placement recommendation, placement, or change of placement. Even with this expectation, agencies undergo a significant period of adjustment transitioning to a new practice model:

> All the teams knew (about TDM), but not all the teams bought in (laughing)….It wasn't very long period before (staff) bought in because it became policy. So, there was not much room for, 'no, I'm not going to do it' type thing. (Leadership said), "You WILL do this."

One of the ways in which leadership mandates TDM practice is by instituting "firewalls," or backup methods of ensuring that meetings are held at each decision point in case normal supervisory controls fail. In one site, for example, a case-carrying worker cannot file a petition with the court to removal a child from home without holding a TDM first. The agency drafted a memorandum of understanding with the courts such that this policy would be enforced. These types of structures help ensure systemic compliance with the practice model.

Yet, workers are also rewarded by management for this participation. At each site, good TDM practice is reflected in performance appraisals, and rewarded by promotion. Managers select facilitators "from among the ranks" of caseworkers "based on whether they believe in teams." As such, pursuing effective TDM practice is "a way for workers to move up" the ranks of the agency. Similarly, facilitators are a "nice breeding ground for supervision," with the effect that facilitators "act as TDM champions" within the agency. Conversely, those who oppose TDM practice typically find little foothold. In this way, the intent is to infuse TDM within the agency culture and structure to such an extent that the practice becomes self-reinforcing over time.

*Presence of Adequate Resources*

One of the biggest challenges to effective TDM implementation is a problem perhaps endemic to many social work practice settings: an overall lack of resources related to budget constraints that limit the number of staff members an agency can hire. In this respect, Agency C

**Table 6.**　　　　　**TDM Program Management and Practice Issues**

| | Agency A | Agency B | Agency C |
|---|---|---|---|
| *Support From Upper Management* | - Strong current support<br>- Early trainings for staff and private agencies<br>- TDM mandated<br>- Firewalls established<br>- Good TDM practice reinforced by performance appraisals and promotions<br>- State-level administration change negatively affected implementation, but stronger support now | - Strong current support<br>- Steering committees to educate staff and foster parents<br>- TDM mandated<br>- Firewalls established<br>- Administration relies more on relationships than hierarchy to solve problems<br>- Breaks in implementation process with changes in leadership, currently strong | - Always strong leadership, past and present<br>- Some initial confusion, lack of curriculum<br>- TDM mandated<br>- Firewalls established<br>- Good TDM practice reinforced by performance appraisals and promotions<br>- Facilitators are breeding ground for supervision |
| *Presence of Adequate Resources* | - Budget constraints re: services provision, hiring staff<br>- Increased number of children and related increase in TDM<br>- Planning to add 4th facilitator to help maintain coverage<br>- Fewer caseworker positions than in the past<br>- Problems with scheduling logistics, screening<br>- TDM provides opportunity to access community resources<br>- Need timely training | - Increased number of children and related increase in meetings<br>- Recently hired 2 new facilitators to achieve better coverage<br>- Recent layoffs, positions eliminated<br>- Problems with scheduling logistics, screening<br>- Lack of materials (water, name tags, flip charts, etc.)<br>- TDM provides opportunity to access community resources<br>- Would like more ongoing training | - TDM and trainings are costly<br>- Adding 2 new facilitators (currently 16)<br>- Good coverage<br>- Only 2 supervisors for 18 facilitator positions<br>- Lack of flexibility re: time of day to meet families' needs<br>- 3 deployed sites in the community, more convenient for families<br>- TDM helps generate connections to community resources<br>- Room size, screening problems<br>- Need timely training |
| *Support of Practices:*<br>From Supervisors | - Some felt their authority was being questioned<br>- Perception of "one more thing to do"<br>- "Mixed bag," some value TDM more than others | - Not supportive early on, felt threatened<br>- Mostly supportive now through experiencing TDM<br>- Gradual process | - Early resistance, now mandated to attend<br>- Better support now, different agency culture |
| From Workers | - Attitudes often depend on immediate supervisor<br>- Buy-in initially a problem because of time constraints<br>- For some, TDM is "how you do business"; others value it less | - Initial reluctance to share control<br>- Some still not comfortable with groups, confrontation<br>- Good support from new workers as old workers leave<br>- Workers appreciate not being isolated | - Mostly good support, new staff do not know anything different<br>- Workers appreciate team accountability during crisis<br>- Agency must balance relationship between line workers and facilitators |

is at a more advanced stage of development than the other agencies, with 18 facilitators (see

Table 2). Agency B has 4 facilitators with plans of adding 2 more. Agency A appears to be the

agency most under strain with only 3 facilitators. The problem of few resources also appears to

be exaggerated by the fact that positions have been eliminated through state-level budget cuts,

and a perception among agency staff that the numbers of children coming to the attention of

child welfare services has increased, thereby increasing their workload.

The convergence of these two problems, a perceived increase in workload and fewer

resources to address it, appears to place considerable strain on agencies' abilities to conduct

meetings effectively at every decision point. This problem is more pronounced in settings with

fewer facilitators:

> The volume sometimes is just so difficult to keep up with, and I've seen that go up
> recently….When you have that much volume, mentally you can get exhausted sometimes
> because you're running from one meeting straight into another without any break in
> between….If we're ill or something comes up, we have to be at work.

In this particular site, facilitators perceive heavy scheduling demands that offer little flexibility

in terms of taking time off. Objectively, the Casey Foundation assists sites in determining the

number of facilitators needed based on the numbers of children and families involved with

CWS, and the related number of meetings needing to he held. Even with increased facilitators,

however, the agency is then faced with the problem of providing adequate supervision for these

facilitators. To address the workload issue, the Casey Foundation encourages sites to calculate

the number of facilitators needed based on the number of cases, recommending that facilitators

should average approximately 3 meetings per day (Patricia Rideout, personal communication,

May 16, 2007).

Another challenge that emerged across sites is related to agencies' ability to schedule

TDM meetings in advance, and provide adequate screening for special circumstances. These

circumstances include a large numbers of attendees for a particular case, or the presence of

domestic violence in the home which would require holding separate meetings for both the

victim and the perpetrator in the interest of safety. Sites varied in the extent to which they

provided thorough advance screenings. Yet, many agreed that scheduling TDM meetings proved

to be a challenge in coordinating the schedules of participants quickly:

> I think the biggest challenge sometimes is just getting the people there. It's very difficult
> sometimes, you have to schedule again and again because people don't show up….It's
> also really very difficult, and time-consuming, for workers to try and schedule TDMs
> that everybody can come at a particular time. It's a huge time issue, really, trying to get
> as many people as you can there….it's a scheduling nightmare, really, in a lot of different
> ways.

This scheduling issue is perhaps of central concern to holding an effective TDM. The

meeting is intended to promote a decision-making process resulting in a placement

recommendation, drawing from the input of various attendees, especially those close to the

family. This directive, however, is largely dependent on an agency's ability to ensure these

participants' attendance. The Casey Foundation recommends that agencies hire a full-time

scheduler, and to establish an infrastructure that accommodates emergency meetings through

adequate space and facilitator assignments. Yet, in emergency situations, meetings will be

convened even if key participants cannot attend. The alternative scenario, waiting to convene

meetings until key participants can come, creates a potential incentive for workers to avoid

meetings by not strongly encouraging these participants to attend.

Given the above-named issues, full TDM implementation places considerable demands

on an agency's resources. TDM meetings take time to schedule in advance, and place further

time demands on staffs' already tight schedules. These meetings also require hiring additional

staff to facilitate meetings and supervise facilitators' activities. Yet, even with this increased

demand on agency resources, most staff members with whom we spoke expressed their belief in

the importance of the TDM process. The reason staff members appear to believe strongly in

TDM is that "through TDMs, (community) partners get to give immediate resources to families

and be engaged in solutions." TDM meetings help promote "emotional bonding" between family members and community partners, help "plug families into community structures and supports," and "make connections with family advocates" in the community.

The central theme of respondents' comments appears to be that TDM allows agencies to move beyond their resource limitations to connect family members with resources in their neighborhoods and communities. While TDM meetings take "more time on the front end," they also "make things more efficient because all the players are at the table" and they "promote a common language" between community partners and the agency. Thus, staff members believe that taking the time to connect families to community supports, early in the life of a case, will result in an optimal placement decision that will ultimately save time and agency resources later.

*Support from Caseworkers and Supervisors*

In general, interviewees expressed their belief that caseworkers and supervisors supported TDM practice. This level of support, however, appears to be the result of a gradual process of accepting practice changes that challenge traditional approaches to child welfare casework and supervision. In contrast to upper-level administrators, who have consistently expressed their support for TDM meetings and mandated their usage, staff members closer to the frontline appear to be slower to accept the change in practice. While currently supportive as a whole, workers and supervisors appear to have undergone a process of accepting TDM as a paradigm of decision-making. As such, some workers currently appear to be very supportive of the process, while others seem to value it less.

Some interviewees, especially those who participated in the early stages of implementation, characterized supervisors as being "not at all supportive early on" during initial TDM implementation across the three sites. Much of this initial resistance resulted from an overall feeling among supervisors that TDM diminished their authority and power as decision makers. Indeed, as a model of shared decision-making, TDM promotes group discussion and

consensus as the driving factors behind determining placement recommendations. Beyond this issue of power and control, supervisors also complained that TDM meetings were "one more thing to do," and wondered "why are we doing this, we're the decision-makers, this is more complicated."  Yet, despite this resistance, and with continued TDM practice, the culture of each agency seems to have changed over time, such that facilitators and administrators feel that "most of them (supervisors) are on board" currently. Agencies appear to have experienced increased support form supervisors, but the perception among staff remains that some supervisors value TDM more than others.

Similarly, caseworkers experienced a gradual process of accepting TDM as an overall practice model. One issue behind their initial resistance is the perception of meetings taking time out of already busy schedules. Another frustration cited by caseworkers is that meetings are sometimes held after the fact, when a placement decision has already been made. This problem may be related to an inability to schedule a meetings because of booked facilitator schedules, a problem that is more apparent in sites with a lower facilitator-to-case ratio. Of course, this situation goes contrary to the TDM practice model specifying that meetings must be held prior to a child being removed, or in the case of emergencies, prior to a court hearing (DeMuro & Rideout, 2002). However, most interviewees believed that caseworkers generally support TDM as a practice model. This level of support is higher among newer workers for whom TDM has always been expected practice. In general, older workers more frequently resist the collaborative decision-making model in favor of traditional methods. Yet, this issue represents one instance in which the typical high turnover rates in child welfare agencies may work to agencies' advantage: as older workers leave, newer workers become acculturated in TDM practice more easily, as TDM is simply the practice standard.

Despite some measure of resistance on the part of caseworkers and supervisors during early implementation, these staff members eventually seemed to appreciate TDM as an effective practice model. For the most part, these workers feel strongly that families should have input

into the placement decision-making process, and that a well thought-out decision will save everyone time and energy over the long term. Yet, meetings also serve another function for caseworkers that may be equally important – workers and supervisors expressed their appreciation of having team accountability during a crisis, especially one that garners public attention. TDM involves shared decision-making but also shared accountability, such that as a caseworker, "it's nice not to be the only person on the line." In collaborative decision-making, workers must relinquish some control but also gain valuable perspectives that help mitigate the risks to children, families, and ultimately themselves:

> I think some of (the resistant workers) have been brought around by the practice itself….(Some workers) were not at all interested in doing the Team Decisionmaking model, who…interestingly enough, were very attached to the control that they had, while at the same time (they felt) out there all by themselves, and really frightened of having all of the decision-making line with the staff person and them….(TDM) is sound practice. As (workers) began to do TDMs and began to use that process, and began to see what impact that had, they really came around.

Sharing decision-making control entails sharing responsibility for the outcomes related to the decision. In this way, caseworkers and supervisors find they are not isolated by being individually responsible for families' and children's outcomes.

*Discussion*

The aggregate quantitative data presented in this study provide some preliminary evidence that not only is TDM being implemented on a wide scale, but that this implementation may be associated with changes in placement patterns for children over time. Of course, caution must be used in interpreting these findings, as causality between TDM and these placement dynamics is impossible to establish with these limited data.

One of the most interesting findings is the rapid decrease of initial entries to care in Agency C. It is unknown whether this decrease is due to TDM's ability to access community resources effectively, or whether there is another unmeasured effect in play. Anecdotal reports from administrators in Agency C suggest that the agency has experienced no surge in reports of

repeated abuse or neglect associated with this decrease in entries. At the very least, this finding points the way towards more rigorous analyses of placement dynamics in this agency, particularly regarding numbers and rates of reentries to care following a diversion.

The scope of TDM implementation varies somewhat across these three sites. Agency A appears to hold meetings for all of the children entering care in 2005, but only at a rate that is 6% higher than the number of initial entries. On the other hand, Agency B is estimated to hold 2.6 times as many meetings as children entering care and Agency C holds nearly four times the amount of meetings compared with initial entries. In these two sites, it seems that a large number of cases are being covered. Further analyses are needed to examine more directly the relationship between TDM and placement outcomes.

In examining placement settings for children in these sites, the greatest change over time is evidenced in Agency B. The drastic drop in shelter care use and the related increase in family-based care are at least contemporaneous with TDM implementation, if not directly attributable to it. Yet, these changes (e.g., closing the local shelter) are likely related to Agency B's adoption of the Family to Family approach to system reform as a whole. As agencies implement Family to Family, they commit to pursuing placements that are family-based and least restrictive. The closing of the shelter in Agency B reflects this change in administrative ideology, such that children's first placements are now in family foster care versus a congregate care setting. The placement patterns in Agency C appear stable over the five year period; this stability may be a function of the site's maturity in implementing TDM and Family to Family, such that these dynamics have reached a level of equilibrium. On the other hand, the drop in initial entries to care within this site suggests that the agency is experiencing some sort of change that cannot be accounted for in this study.

The findings from interviews and focus groups revealed that agencies face some common challenges to TDM implementation, but have also developed some similar strategies to ensure that TDM is implemented as specified by the practice model. Given the challenges faced by

each site in terms of time and resources, pursuing full scale TDM implementation appears to require an administrative vision focused on ensuring that meetings occur at each decision point. Administrators use at least three strategies to guide agency practice in this direction. First, leaders conduct systematic training to educate agency staff and community partners early during the implementation process, so that key stakeholders understand the purposes and processes of TDM practice. Second, leaders establish firewalls around each decision point to ensure that placement decisions are not made independently of a team. Third, leaders establish an incentive structure within the agency such that consistently pursuing TDM practice is rewarded by promotion.

Even with the enthusiastic leadership that is apparent among the three sites in this study, this enthusiasm appears to wane closer to the frontline of practice. Yet, caseworkers and supervisors generally express support for the *philosophy* of Team Decisionmaking. A couple of factors may help explain this apparent discrepancy. First, in each agency, most frontline workers, supervisors and facilitators perceive a heavy workload in which implementing consistent and effective TDM meetings can be difficult. In addition, these workers also perceive that their workloads are increasing as the volume of children and families increases. Thus, convening meetings for every placement decision as specified by the F2F program model places a strain on workers' and supervisors' schedules. While these workers believe that TDM promotes good decisions, and that good decisions will save time later through reduced disruptions and re-entries to care, meetings still require a significant investment of time on the front end of the decision-making process. This time constraint is especially pronounced in situations where workers perceive a shortage of agency staff in addition to an increased number of children and families.

Second, staff members appear to experience a learning curve as agencies implement TDM meetings. This learning process appears to be related to a change in the paradigm of decision-making, as the agency shifts from a process driven by individual workers and supervisors, to a

process driven by a group that includes multiple perspectives. Many workers, especially supervisors, appear to resist giving up this decision-making control in placement planning. The strength of this resistance may be buffered somewhat by the leadership strategies mentioned earlier. According to our qualitative data, this resistance may also be overcome through workers' and supervisors' participation over time in TDM, and their gradual realization that these meetings may reflect best practice. However, this resistance may also be overcome by another problem endemic to child welfare: the tendency for workers to turn over rapidly. This may promote more thorough TDM implementation if workers who are entrenched in conventional practices move on. Among new workers, TDM simply represents the manner in which the child welfare agency makes placement decisions.

Despite these barriers to implementation, most of our interviewees expressed strong support for the value of pursuing TDM, although the degree to which these participants' opinions are representative of all staff at each agency is unknown. With this caveat, one of the most commonly cited reasons for staff members' support of TDM is its perceived ability to access resources in the community for families. If this dynamic does indeed exist, then not only do families receive more support when implementing safety plans, but the agency is also able to reach beyond its resource limitations in extending help to families. Interviewees also expressed an appreciation for the group accountability inherent in TDM meetings. Thus, not only do individual workers have greater protection against liability should the decision lead to a negative outcome, but participants tend to feel more confident that the group's decision represents the best option given the problems and resources at hand.

**CHAPTER 5**

IMPLEMENTATION FIDELITY OF TEAM DECISIONMAKING


In evaluation research, implementation fidelity refers to the extent to which practitioners conduct program activities as intended by those who developed the program (Dusenbury, Brannigan, Falco, & Hansen, 2003; McGrew, Bond, Dietzen, & Salyers, 1994). The field of policy implementation documents a rich history of the failure of policies to achieve their intended outcomes, sometimes as the result of intervening political factors (Pressman & Wildavsky, 1973), but often due to the failure to anticipate the behavior of practitioners and clients in the field (Derthick, 1990; Lipsky, 1980). This problem, the distance between policy or program design and practice-level implementation, prompted Elmore (1980) to conclude that "the connection between the problem and the closest point of contact is the most critical stage of analysis" (p. 612). Examining this point of contact is the focus of studies of implementation fidelity.

Typically, before undertaking a full outcome evaluation of a program, researchers conduct a study of implementation fidelity to determine the extent to which practice-level implementation conforms to the program's specified conceptual framework and practice guidelines (Gilliam, Zigler, & Leiter, 2000). In the field of mental health, McGrew and colleagues (1994) criticized existing effectiveness research as lacking documentation of implementation, and stated, "When program models are not documented, the interpretation of individual studies becomes ambiguous, as do comparisons between studies that ostensibly

examine the same model" (p. 670). Failure to document a program's faithful implementation not only makes interpretation of outcomes difficult, but also limits the generalizability of the findings to other sites.

The issue of variability across sites is of critical importance in studies of implementation fidelity, specifically the extent to which activities at a particular site conform to the specified program model. This issue is especially pertinent in child welfare, a field often characterized by complex systems of care and wide variability of available services and approaches to practice. Given these complexities, Wind and Brooks (2002) suggest that the behavior of child welfare systems is, in part, a function of broader social influences that need to be taken into account. These influences call for a process evaluation of both the quantity of services rendered (i.e., the "dosage") as well as the quality of those services (i.e., practice fidelity), before drawing conclusions regarding program outcomes. Thus, the *context* of service provision becomes central to the consideration of child welfare outcomes, as indicators of positive outcomes and variations across context are interdependent (Usher et al, 1999). In other words, both the quantity and quality of services rendered are likely to vary considerably across sites.

*Implementation Studies Related to Child Welfare*

Central to the study of implementation studies is the ability to detect "program drift," the extent to which practice differs from the intent of the program's design, both across time within sites and across sites. In fact, several implementation studies in child welfare document such drift. In a study of the implementation fidelity of an assertive community treatment (ACT) mental health program, McGrew, Bond, Dietzen and Salyers (1994) found that program fidelity varied considerably as the program was replicated in different sites. As the degree of fidelity decreased, so did the program's impact on the outcome of a reduction in days hospitalized. Similarly, an evaluation of a promising early intervention program, the Comprehensive Child Development Program (CCDP), demonstrated no ability to effect significant changes in clients'

outcomes (Abt Associates, 1997); these findings were later used within a more general critique of federally funded programs for disadvantaged families and children (Gilliam, Ripple, Zigler, and Leiter, 2000). In a critique of the Abt outcome study, and the process study which preceded it (CSR Incorporated, 1997), Gilliam and colleagues (2000) concluded that CCDP was not implemented as intended, but rather more as a loosely organized case management program. Among other methodological and conceptual criticisms of the studies, Gilliam et al. concluded that the initial process study demonstrated that CCDP did not provide the services intended, such that a full outcome evaluation should never have been attempted.

When it comes to measuring a program's impacts, the issue of implementation fidelity is not inconsequential, nor is it without some controversy. One of the highest profile outcome evaluations in child welfare, Scheurman, Rzepnicki and Littell's (1994) rigorous controlled study of Intensive Family Preservation Services (IFPS), found that IFPS had little effect on placement rates, recurring child maltreatment, or family functioning. Yet, this study has been critiqued for ignoring important variations in service delivery across sites (Usher, 1995). Among other criticisms of the evaluation, Bath and Haapala (1994) pointed to the treatment inconsistencies and differing philosophies driving practice at individual sites. As these differences were not addressed in the evaluation, Bath and Haapala called into question the study's ability to detect positive outcomes attributable to the intervention. In response, Littell (1995) stated that the researchers accepted the practice variation across sites, given that no evidence existed that one practice model was superior to any other. Littell further argued (1997) that treatment inconsistencies are less problematic than the issue of a lack of clarity regarding which components are most effective in IFPS, and for which clients. Later analyses of subgroups receiving IFPS found that the intervention was not effective in preventing out-of-home placements or recurrence of maltreatment (Littell & Scheurman, 2002). However, it is difficult to argue that significant between-group variations in program implementation have no effect on outcomes. Fraser and colleagues cautioned that, given the wide practice variability,

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findings from IFPS evaluations must be interpreted carefully, and that "one cannot conclude in an unqualified fashion that FPS is an insufficient response to child maltreatment, for it is not clear that a high-quality and consistent family preservation service was provided in the two largest studies of FPS in child welfare" (Fraser, Nelson, & Rivard, 1997, p. 149).

More recently, the controversy over implementation fidelity has surfaced again, this time over the effectiveness of Multisystemic Therapy (MST). Littell (2005) used a meta-analysis of the effects of MST to draw conclusions regarding the variations across existing empirical studies of MST's effectiveness. Among her findings was the conclusion that, while studies of MST were randomized controlled trials, they often did not include important information about attrition, violations of random assignment, and intent-to-treat (ITT) analyses. These findings caused Littell to question MST's generally accepted status as an effective, empirically-supported treatment. In their rebuttal, Henggeler and colleagues (2006) claimed Littell misinterpreted the findings and methodologies of these previous MST studies, blurred the distinctions between efficacy, effectiveness and transportability research, and ignored the importance of treatment fidelity in establishing internal validity. These authors further claimed that the different findings across studies and sites implementing MST "highlight the importance of examining and understanding the factors…that contribute to the success (and failure) of empirically supported practices transported to community practice settings as well as the significance of possible site and program maturity effects" (Henggeler, Schoenwald, Swenson, & Borduin, 2006, p. 452).

These controversies highlight the tensions and difficulties inherent in community-based research, particularly in child welfare. Many child welfare researchers have discussed the importance of capturing site-specific information before conducting an outcome evaluation (Ortega et al., 2002; Solomon, 2002; Wind & Brooks, 2002). Indeed, the point at which policy or program intentions meet practice-level behaviors may prove to be the fulcrum on which positive outcomes are detected or not detected. The purpose of this study is to examine the extent to which

one program in child welfare, Team Decisionmaking (TDM), has been implemented in

compliance with the conceptual framework advanced by the Annie E. Casey Foundation

(AECF) across a variety of sites.

*The Team Decisionmaking Practice Model*

Team Decisionmaking (TDM) is an innovative approach to decision-making in child

welfare that actively seeks the input of families and community members in making critical

placement decisions for children.  TDM is one of four "core strategies" within the Family to

Family (F2F) initiative, funded by the Annie E. Casey Foundation (AECF), an initiative that has

involved approximately 60 urban child welfare agencies in 17 states. One of the objectives of

the TDM strategy is to strengthen families by placing them at the center of the decision-making

process, and by connecting them to key support systems within their communities to promote

the safety and permanency of children.  As a whole, Family to Family is rooted in an explicit set

of operating principles that include: (1) developing a network of family foster care that is

culturally sensitive and based in the neighborhoods and communities where the children live;

(2) ensuring that children are removed from their families only when no alternative exists;

(3) reducing reliance on group care by increasing the number and quality of foster families; and,

(4) reunifying children more quickly with their families when removal is necessary.

A fundamental premise of TDM is that child welfare agencies should respect families'

knowledge of their children.  This approach emphasizes a collaborative effort involving the

agency, service providers, and supports in the extended family and community to effectively

engage families in decision-making through a skillfully facilitated group process. In fact, one of

TDM's purposes is to connect family members with community supports within meetings, with

the hope that these community members will serve as longer-term supports for families

(DeMuro & Rideout, 2002).  TDM is founded on the assumption that groups can make child

welfare decisions more effectively than an individual.  Implicit in this assumption are the ideas that families are experts on themselves, are capable of identifying and addressing their own needs when they are treated respectfully, and that relatives and community members are families' "natural allies" and experts on the resources within the community (Rideout & Short, 2004, p. 6).

The TDM process explicitly encourages input from family and community members to inform decision-making before a child's entry to or movement within out-of-home care.  TDM is designed to achieve the best possible placement decision by respecting parents as experts on their children (Crampton & Natarajan, 2005) and by accessing sources of support in the family's community (DeMuro & Rideout, 2002). As such, the theory of change behind TDM implementation suggests that the quality of the process directly bears on the placement recommendations and associated outcomes that result from the meeting.  In TDM, meetings should be convened before any and all placement decisions, including the potential removal of children from their homes, changes in placement, and before recommendations to the court of reunification or any other permanency plan.  Meetings ought to be convened quickly and are intended to occur before a placement decision is made...Within meetings, the decision-making process ought to be informed by the perspectives of family- and community-based participants. These perspectives are intended both to highlight and expand on issues that bear on the placement decision, and to yield a clearer picture of their strengths and needs.

The current study examines TDM implementation at the level of frontline practice. Using data collected in administrative databases, this study explores whether the activities specified by the TDM practice model are borne out in practice in three sites, and the extent to which TDM placement recommendations are reflected in the actual placement experiences of children for whom TDM meetings were held in one site.

***Research Questions***

*Extent of Implementation Fidelity*

This analysis examines the extent to which agencies' commitment to the TDM practice

model results in *actual* and *consistent* practice changes, using data from administrative TDM

databases. Particular research questions include:

(1) How thorough is the TDM coverage across cases during this time period?

(2) What is the pattern of participation in TDM meetings among participants representing different perspectives—family, agency, community, and service providers?

(3) What is the ratio of agency staff members to family members and community supports within TDM meetings (i.e., a possible indicator of family empowerment)?

(4) What are the most common patterns of participation in TDM meetings with regard to attendance by family members and community supports?

If agencies are pursuing full TDM implementation, the practice dynamics emerging from

these sites ought to align closely with the TDM practice model as specified by the Annie E.

Casey Foundation. In addition, having more family and community members in the meeting

may help family members feel more empowered in a decision-making process traditionally

controlled by agency staff. Hypotheses for these research questions are that (1) TDM meetings

will be held for all children and families for whom a placement decision is needed; (2) a wide

variety of different participants should be attending, especially (3) family members and

community supports who may attend in greater, or at least equal, numbers as agency staff

participants; and, (4) the most common patterns of participation within meetings would at least

include parents and relatives most frequently.

*Assessment of Placement Experiences Associated with TDM Meetings*

After exploring the extent of implementation within three sites, the next research question

examines TDM's relationship with child placement experiences in one site. This study is a

*preliminary* assessment of the relationship between TDM implementation and the placement

experiences of children; a more definitive assessment of TDM's relationship with outcomes will

be included in a report to be submitted to the Annie E. Casey Foundation in 2009.   The analyses

will focus on children for whom meetings were held regarding removals from the birth home[5].

These initial TDM meetings are classified either as *emergency* TDMs, which typically involve

making placement decisions for children at imminent risk of harm, or *considered-removal*

TDMs, which are convened in a variety of situations, such as identifying alternatives to out-of-

home placement, or considering whether to bring a child into placement if a safety plan has not

been implemented effectively by a family.

Particular research questions for this study include:

(1)      For removal TDM meetings (including emergency TDMs and considered-removal TDMs), what are the most frequent placement recommendations made?

(2)      For custody recommendations, what percentage of children entered placement, and for non-custody recommendations, what percentage did not enter placement?

(3)      For custody recommendations, what are the time frames for placements, both before and after TDM meetings are convened?

(4)      When assessed against actual placement experiences, how many TDM recommendations are successfully implemented?

*Site Selection*

Three sites were included in this study: Denver, CO; Cleveland, OH; and Anchorage, AK.

Denver and Cleveland are termed "anchor sites," as they have been selected by the Annie E.

Casey Foundation among thirteen other sites for more intensive technical assistance efforts in

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[5] Here, the unit of analysis is termed a meeting-child combination, e.g., unique meetings held for each child.

the future. Anchorage differs from the other two sites in that it is now considered a "network site, i.e., a site that will continue to receive technical assistance but not at the same level of intensity as anchor sites.

Denver first implemented TDM for removals in January 2003 and rolled out quickly to implement TDM for changes of placement in April 2003 and for permanency decisions in June 2003. TDM also began for juvenile justice placements in June 2003. Cleveland implemented TDM for removals, changes of placement, and permanency in 1995. Anchorage began TDM implementation in September 2004 and has implemented TDM quickly to cover all decision points, including removals, changes of placement, and decisions regarding reunification or other permanency options.

*Methods*

*Data Sources*

 TDM administrative data. Agencies in each of the three sites collect process-related data for all TDM meetings. These data allow agencies to examine the breadth of TDM use across meeting types (entry to care, change of placement, and permanency or reunification). Data are also collected on the characteristics of each TDM, including the type of placement decision under consideration, the types and variety of participants within each meeting, and the placement recommendations made by the team. These recommendations include the specific placement type as well as the restrictiveness of the placement recommendation for change of placement TDM meetings. All of these data can be used to examine the quality of TDM implementation within each site.

In most Family to Family sites, TDM data are collected using relational databases that capture information about the meeting and the individual children about whom meetings are held. Data are collected on three levels, such that the unit of analysis can be unique meetings, unique children, or combinations of unique meetings for unique children (termed meeting/child

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combinations). Given that children can have multiple meetings of different types, and that unique meetings may involve multiple children, using a meeting/child combination as the unit of analysis accounts for all unique types of meetings as well as recommendations for children at different points. Thus, this unit of analysis is used for questions pertaining to TDM types, while unique meetings as the unit of analysis is used for questions pertaining to meeting characteristics, such as the proportion of meetings attended by a variety of participants.

Longitudinal placement data. In child welfare systems, the use of longitudinal data serves to build statistical case histories for children upon entry to the system. The use of longitudinal data is important in that children with long lengths of stay are disproportionately represented with estimates based on "point-in-time" data (Usher, Wildfire, & Gibbs, 1995). A longitudinal database provides data about *all* children served by a particular agency over the course of several years. These data (1) include a series of entry cohorts for children who enter out-of-home care for the first time during a designated period of time (e.g., calendar or fiscal year); (2) track the occurrence of custody and placement events through specified periods of time; (3) represent all children who ever enter care; and (4) provide valid and reliable estimates of length of stay and other outcomes such as placement stability. To measure placement outcomes related to TDM meetings requires the use of longitudinal data.

*Analysis*

The examination of the *extent of TDM implementation fidelity* within each site requires secondary data from TDM administrative databases, described earlier. In essence, this analysis is a process evaluation of TDM implementation using quantitative data. Process indicators for TDM focus both on the level and variety of participation in meetings for particular types and numbers of participants for the predominant TDM types at each of the three sites--initial entries to placement and changes of placement. Types of participants are grouped into four categories: *family members in attendance* (birth parents, adoptive parents, relatives, other relatives, children

aged 13 and over); *support persons in attendance* (friends, non-related caregivers, caregiver partners, foster parents, other neighborhood representatives); *service providers in attendance* (guardians ad litem (GALs) and court appointed special advocates (CASAs), medical staff, mental health staff, school staff, mental retardation/ developmental disabilities (MR/DD) workers, alcohol and drug treatment workers, therapeutic service providers, juvenile justice staff, residential and group home workers, and other service providers; and *child welfare agency staff in attendance* (investigators, ongoing or permanency planning workers, supervisors, and other agency staff). Tables describe the type and proportion of participants based on the two types of TDM meetings held in each site, removal and change of placement meetings.

The next component of the analysis involves calculating the ratio (R) of agency staff to family and community supports in attendance at each TDM. Participant types are divided into two categories: attendees who are either personally known to the family (i.e., family members and relatives) or serve as resource liaisons from the family's neighborhood (i.e., community support persons); and staff members from the child welfare agency (investigators, ongoing workers, supervisors, or other agency staff). Each category was summed to produce the numbers of agency-based participants (numerator) divided by the numbers of family- and community-based participants (denominator):

$$R = \frac{\sum (Agency)}{\sum (Family \ \& \ Supports)}$$

(2)

The ratio of child welfare staff members to family supports is calculated for each TDM meeting to produce distributions of these ratios by both TDM types, Removal TDM meetings and Change of Placement TDM meetings. This measure provides one indicator, among the others described, of the extent to which participation by family and community members is

being achieved in the TDM process. The rationale for this indicator is that, ideally, family- and community-based participants ought to attend in at least equal numbers as agency staff, given that meetings should be driven by family- and community-based perspectives (DeMuro & Rideout, 2002). If this condition is met, the practice hypothesis is that family members should feel more comfortable participating in a process that historically has not attempted to garner their participation. The limitation of this variable is the difficulty in interpreting values substantively for practice purposes. For example, a ratio of 1.00 represents equal numbers of agency staff and family/community participants. Yet, this ratio could describe very different meetings (i.e., one staff person and one birth parent; or, three staff persons and two birth parents and a community representative). It would be appropriate, therefore, to view the ratio in the context of the overall level of participation in a meeting (for example, any multivariate model that included the ratio indicator also should include the total number of participants).

Given this characteristic of the measure, the next analysis is an examination of the qualitative differences among meetings in terms of families' participation. This approach provides an additional perspective on patterns of participation by family- and community-based participants. Both TDM types are examined for the distribution of participants for different combinations of family and support persons. For example, each TDM type is examined for the simultaneous attendance of parents and friends (PF), parents, friends and children (PFC), and so forth. The rationale for this analysis, following the TDM practice model, is that a high percentage of meetings should include parents, relatives, and community supports.

To assess the *actual* placement experiences associated with TDM meetings for children requires (a) merging TDM data with longitudinal placement data, and (b) calculating the time period between the date on which an initial entry TDM was held and the date a child entered placement for the first time. This analysis focuses on one site, Denver, during the 2005 calendar year, and examines placements associated with two distinct types of removal TDM meetings: *emergency* TDM meetings and *considered- removal* TDM meetings, described earlier. The

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distinction between these two types of meeting is unique to Denver, but the differing dynamics

inherent in these different types of meetings necessitates separating them for analysis.

Furthermore, in Denver's TDM database, facilitators record whether removal meetings

pertained to initial placements decisions or decisions around a child's re-entry to care. This

variable is unique to Denver and allows for more accurate calculations of the relationship

between meetings and placements.

This component of the study follows a number of stages. First, by combining data from

TDM meetings with longitudinal placement data, it is possible to examine recommendations

concerning (1) the decision to remove children from their homes and place them in the custody

of the child welfare agency (custody decisions), or (2) the decision not to remove children from

birth families (non-custody decisions). For children receiving a custody recommendation, the

analysis examines the type of placement for children who enter child welfare custody,

(including placing the child with a foster family, a relative caregiver, a group home, a residential

institution, or some other setting).

Custody decisions are compared with initial placements using a table that compares

patterns of *custody* versus *non-custody* recommendations using McNemar's test for matched

pairs data (Stokes, Davis, & Koch, 2000). The resulting table measures the numbers of children

receiving a placement decision who subsequently enter care, and the numbers of children

receiving a non-custody decision who subsequently do not enter care. The results of McNemar's

test determine whether there are significantly different discrepancies in custody

recommendations and outcomes.

Next, for children receiving a custody recommendation, placement data are examined to

determine the number of days from the TDM recommendation to the actual placement (if ever).

These recommendations include placement with a relative caregiver, foster parent, unrelated

person, non-custodial parent, or residential/group home. For children within emergency-removal

TDM meetings, a custody recommendation is considered matched with a placement if the

placement occurs between five days before and at least one day after a TDM is convened. For children within considered-removal custody TDM meetings, this window ranges from at least one day after a TDM is convened to over two weeks after a TDM is convened (given that a child may be brought into placement later if a family fails to adequately follow a safety plan). In Denver, relative caregivers are considered informal resources and are not typically licensed foster parents. As a result, these placements are not recorded in the longitudinal placement database, such that a recommendation to be placed with a relative caregiver will have no recorded placement associated with it.

A final line of analysis assesses the rate at which out-of-home recommendations were successfully implemented for both emergency removals and considered removals. First, using the definitions matched recommendations and placements described above, the percentage of successfully implemented recommendations is calculated. Then, these recommendations are arranged by the level of restrictiveness of care (non-custodial parent, relative caregiver, unrelated person, foster care, residential placement) and tested for their association with the likelihood of successfully implementing these recommendations, using the Cochrane-Armitage trend test for binomial proportions (Stokes et al., 2000). This test determines whether a statistically significant trend exists in successfully achieved recommendations based on the restrictiveness of the recommendations.

### *Results*

#### <u>Extent of Implementation Fidelity</u>

To facilitate comparisons across the three sites, the analysis is restricted to TDM meetings occurring between January 3, 2005, and December 8, 2006, in Denver and Cleveland, and between October 20, 2004, and September 19, 2006, in Anchorage. The numbers of TDM meetings held, and the numbers of families and children served within TDM meetings, are much

**Table 7.**        **Frequencies and Percentages of Families, Meetings, and Children**

| | Denver | Anchorage | Cleveland |
|---|---|---|---|
| ***Number of Families*** | 1,521 | 748 | 3,750 |
| ***Number of Meetings*** | 2,382 | 1,540 | 6,659 |
| ***Number of Children*** | 2,720 | 932 | 6,543 |
| ***Meetings Per Family (%)*** | | | |
| Mean (SD) | 1.56 (1.04) | 2.06 (1.62) | 1.76 (1.10) |
| 1 | 68.4 | 54.4 | 56.9 |
| 2 | 16.8 | 19.7 | 22.6 |
| 3 | 8.7 | 10.7 | 12.1 |
| 4 | 3.7 | 6.6 | 5.4 |
| 5 | 1.2 | 4.1 | 2.1 |
| 6 or more | 1.2 | 4.5 | 0.9 |
| Total | 100.0 | 100.0 | |
| ***Meetings Per Child (%)*** | | | |
| Mean (SD) | 1.57 (0.98) | 1.66 (1.12) | 1.56 (0.91) |
| 1 | 65.4 | 63.0 | 64.3 |
| 2 | 20.8 | 21.1 | 21.8 |
| 3 | 8.1 | 7.8 | 9.3 |
| 4 or more | 5.7 | 8.1 | 4.6 |
| Total | 100.0 | 100.0 | 100.0 |
| ***Children Per Family (%)*** | | | |
| Mean (SD) | 1.92 (1.30) | 1.28 (0.63) | 1.14 (0.41) |
| 1 | 51.2 | 80.1 | 87.8 |
| 2 | 24.7 | 13.9 | 10.4 |
| 3 | 13.5 | 4.8 | 10.4 |
| 4 or more | 10.6 | 1.2 | .02 |
| Total | 100.0 | 100.0 | 100.0 |

greater in Cleveland than the other two sites (see Table 7). This contrast is likely the result of the

differing sizes of agencies' jurisdictions, but also may reflect the implementation statuses of the

three sites. In terms of time implementing TDM meetings, Cleveland is the most mature site,

followed by Denver and Anchorage. Yet, Anchorage tends to convene more meetings per family

(mean=2.06) compared with Cleveland (1.76) and Denver (1.56), and this pattern also holds true

for the number of meetings held per child across the sites. These patterns do not appear to be a function of family size, however, with Denver serving the largest family units (mean of 1.92 children per family). The reason for Anchorage's higher number of meetings per family and per child is likely the fact that in this agency, children tend to have a higher percentage of change of placement (COP) meetings than the two other sites. In addition, Cleveland does not consistently record COP meetings, a situation that artificially lowers the numbers in this agency. With the higher mean of children per family in Denver, and the roughly equivalent mean number of meetings per family and per child, these findings may reflect a tendency for Denver's child welfare agency to consider placement decisions for sibling groups simultaneously more consistently than the other sites.

In Denver and Cleveland, most TDM meetings are removal meetings (64.2% in Denver and 56.8% in Cleveland; see Table 8). Yet, in Anchorage, the majority of meetings involve decisions involving placement changes (66.2%), a situation which suggests that children may be changing placements more often in this site. While Cleveland has pursued change of placement (COP) TDM meetings since the beginning of implementation, recent information suggests that this agency does not hold meetings for placements that involve a proposal to change placements, but not to change the level of restrictiveness (particularly kinship placements). Currently, the agency now pursues these placements, but cross-site comparisons cannot be made using available, previous COP data.

Cleveland implements a significant proportion of TDM meetings for decisions relating to reunification or other permanency options, albeit at lower rates than for removals. Denver convenes similar number of COP and reunification-permanency meetings, while Anchorage implements a much smaller number of reunification-permanency TDM meetings. Overall, it is quite clear that, in absolute terms, Cleveland implements the most TDM meetings on a systemic level.

**Table 8.**         **Decision Types for Children Having TDM Meetings[6]**

| | Denver | | Anchorage | | Cleveland | |
|---|---|---|---|---|---|---|
| | **N** | **%** | **N** | **%** | **N** | **%** |
| *Removals* | 2,731 | 64.2 | 638 | 26.4 | 6,478 | 56.8 |
| *Placement Change[7]* | 721 | 17.0 | 1,601 | 66.2 | 1,996 | 17.5 |
| *Reunification-Permanency[8]* | 799 | 18.8 | 178 | 7.4 | 2931 | 25.7 |
| Total | 4,251 | 100.0 | 2,417 | 100.0 | 11,405 | 100.0 |

To examine the extent to which each site provides TDM coverage for all cases requiring a placement decision, aggregate placement data are also assessed (see Table 9). Anchorage has no data available for children's entries to care, so data from this site cannot be included in the analysis. For calendar years 2005 and 2006, Cleveland accepted a total of 27,432 referrals for investigations of incidences of alleged abuse and neglect. On average, Cleveland took 113 children into initial custody per month in 2005, and 112 per month in 2006. Using these figures, over the course of 2 calendar years, Cleveland took an average of 2,700 children into care (112.5 x 24 months). Then, using estimates of re-entry rates provided to the researchers by site analysts (15-20% re-entries over a four-year period, for an average of 17.5%), an estimated 473 children re-entering care are included among the estimated 2,700 children entering care over these two years, for a total of 2,227 estimated "initial" entries to care. Thus, the children taken into custody

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[6] Children having multiple meetings are counted each time they have a meeting.

[7] Cleveland records data for Placement Change meetings, but does not implement these meetings consistently, and thus may not reflect the same populations as in Denver and Anchorage; therefore, the remaining analyses will not take these meetings into consideration.

[8] Cleveland also uses Semi-Annual Review (SAR) meetings as forums for reunification or other permanency decision-making; SARs are included in this category.

**Table 9.**        **Referrals, Initial Entries to Care, and Removal TDM meetings**

|  | Denver (2005-2006) | Anchorage | Cleveland[9] (2005-2006) |
|---|---|---|---|
| *Referrals[10]* | 19,956 | NA | 27,432 |
| *Children Entering Placement for the 1st Time* | 1,865 | NA | 2,700 (avg.) |
| *Estimate of Children Re-entering Care* | 280 (15.0%) | NA | 473 (17.5%) |
| *Total Entries* | 1,585 | -- | 2,227 |
| *Removal TDM Meetings* | 2,538 | NA | 6,478 |
| *Entries Compared with Meetings* | 62.5% | -- | 34.4% |

represent approximately 8.1% of all children for whom the agency received a referral in 2005-2006. The average numbers of children entering care also represent approximately 34.4% of removal TDM meetings convened in Cleveland during this period. Apparently, of the 6,478 children for whom removal TDM meetings were held, only around 2,227 children actually entered care. The practice implications of these dynamics appear to be that not only are TDM meetings convened for all initial placement decisions in Cleveland, but that these decisions result in alternative placements than out-of-home care on a system-wide level.

In calendar years 2005 and 2006, Denver accepted a total of 19,956 referrals to investigate allegations of abuse or neglect (Johnson, 2006). During this period, Denver took 1,865 children into their first spell of foster care. Accounting for a re-entry rate of 15.0%, the number of initial entries during this time period is estimated to be 1,585 children, representing approximately 7.9%

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[9] Data derived from the Department of Children & Family Services, Cleveland, OH, Summary Monthly Statistical Report: December 2006.

[10] In agency reports, these data do not distinguish between child-specific referrals and referrals pertaining to groups of children. Given that other data provided in these reports focus on child-specific information, the assumption used in this analysis is that referrals are child-specific.

of received referrals. The numbers of children entering care also represent 62.5%% of children for whom removal TDM meetings were convened during this period. The practice implications appear to be that (a) Denver is convening TDM meetings for all initial entries to care, and (b) these decisions result in diversions from entering care in 37.5% of the cases, compared with 65.6% in Cleveland.

*Level and Variety of Participation*

Using unique meetings as the unit of analysis, the next analysis measures attendance at Removal and COP TDM meetings by various participants across sites (see Table 10). Birth parents attended almost all of the removal meetings in Denver (88.6%) and Anchorage (88.0%), and in somewhat lower numbers in Cleveland (71.9%). Birth parents' rates of participation were lower in COP TDM meetings than in meetings involving removals. Relatives also attended in significant numbers across the sites. Children tended to participate in more COP meetings than initial placements. Overall, service providers tended to participate at lower rates, with GALs and CASAs attending the most COP TDM meetings in Denver and Anchorage. Generally, the rates of participation among child welfare workers reflected a predictable pattern in Denver and Anchorage, with investigating workers attending most removal meetings, and ongoing/ permanency planning workers attending most COP meetings. For Cleveland's removal TDM meetings, however, investigators only attended 41.9% of meetings while supervisors attended 82.0%. Follow-up analyses determined, however, that only 12.4% of these meetings had neither an investigator nor a supervisor present. A significant percentage of meetings (36.4%) include both investigators and supervisors.

**Table 10.**  **Percentage of TDM meetings Attended by Various Participants**

| | Denver | | Anchorage | | Cleveland |
|---|---|---|---|---|---|
| | Removal N=1,438 (%) | COP N=466 (%) | Removal N=391 (%) | COP N=1,039 (%) | Removal[11] N=3,881 (%) |
| ***Family and Relatives in Attendance*** | | | | | |
| Birth Parents | 88.6 | 62.4 | 88.0 | 59.7 | 71.9 |
| Relatives | 48.9 | 38.4 | 56.8 | 32.9 | 47.2 |
| Children (age 13 or older)[12] | 13.9 | 25.1 | 11.0 | 22.9 | 7.5 |
| Adoptive Parents | 0.7 | 2.1 | 1.0 | 1.1 | -- |
| | | | | | |
| ***Support Persons in Attendance*** | | | | | |
| Caregivers (relative cg, partners) | 22.2 | 29.4 | 14.3 | 15.2 | 9.1 |
| Friends | 11.5 | 9.0 | 18.7 | 8.1 | 9.8 |
| Foster Parents | na | 35.0 | na | 38.8 | na |
| Neighborhood support | 23.5 | 15.9 | 9.7 | 9.2 | 23.0 |
| Tribal Representative | -- | -- | 18.7 | 22.2 | -- |
| | | | | | |
| ***Service Providers and Legal Staff in Attendance*** | | | | | |
| GAL, CASA, PD | 10.5 | 45.7 | 28.1 | 76.5 | 0.7 |
| Medical Staff (incl. sw) | 3.5 | 0.9 | 22.0 | 3.7 | 1.1 |
| Other Service Providers | 12.5 | 11.2 | 6.4 | 6.2 | 5.4 |
| Mental Health Staff | 6.0 | 24.5 | 7.7 | 27.9 | 7.7 |
| School Staff | 4.9 | 3.2 | 5.4 | 5.1 | 1.5 |
| MR/DD Providers | 0.7 | 0.6 | 2.0 | 2.6 | 0.7 |
| Alcohol / Drug Providers | 2.9 | 2.8 | 0.5 | 2.8 | 0.7 |
| Therapeutic Service Providers | 11.8 | 12.0 | 1.5 | 10.9 | -- |
| Juvenile Justice | -- | -- | 0.0 | 1.0 | 1.1 |
| Residential / Group home worker | 3.3 | 28.3 | 0.0 | 2.5 | 0.1 |
| | | | | | |
| ***Child Welfare Agency Staff in Attendance*** | | | | | |
| Investigator | 70.2 | 12.0 | 77.7 | 17.1 | 41.9 |
| Ongoing Worker | 27.1 | 83.3 | 23.0 | 82.0 | 47.0 |
| CW Supervisor | 29.5 | 35.2 | 38.1 | 37.4 | 82.0 |
| Other Agency Staff | 23.4 | 34.1 | 19.2 | 48.6 | 29.9 |

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[11] Cleveland does not implement change of placement (COP) TDM meetings consistently, and these meetings for Cleveland are not included in this analysis.

[12] Denver does not specify age categories of children involved with meetings.

The numbers of agency staff members relative to family members and community supports within each TDM can be expressed as a ratio (see Table 11). Results of those calculations suggest that in a majority of TDM meetings across the three sites, family members and community supports meet or exceed the number of agency staff in attendance (all investigators, ongoing workers, supervisors, or agency staff labeled "other" in the databases). Ratios between .01 and 1.00 represent conditions in which family members and community supports meet or exceed the number of agency staff, while ratios of 1.01 or higher represent agency staff members attending in greater numbers.[13] For removal TDM meetings in Denver, family members and community supports attend in greater or equal numbers in 85.2% of meetings. This percentage is higher for

**Table 11.  Ratios of Agency Staff Members to Family Members and Community Supports**

|  | Denver | | Anchorage | | Cleveland |
|---|---|---|---|---|---|
|  | **Removal** N=1,438 (%) | **COP** N=466 (%) | **Removal** N=391 (%) | **COP** N=1,039 (%) | **Removal** N=3,881 (%) |
| Median Ratio | 0.50 | 0.67 | 0.50 | 0.75 | 1.00 |
| Mean Ratio | 0.76 | 0.90 | 0.69 | 0.98 | 1.16 |
| 0.00 | 1.8 | 2.4 | 0.3 | 0.4 | 0.3 |
| 0.01 – 0.40 | 24.2 | 21.3 | 29.9 | 17.4 | 9.8 |
| 0.41 – 0.50 | 26.1 | 19.6 | 21.0 | 15.5 | 11.2 |
| 0.51 – 1.00 | 34.9 | 35.1 | 38.9 | 39.6 | 39.1 |
| 1.01 and over | 11.5 | 19.5 | 7.9 | 21.2 | 27.6 |
| Missing | 1.5 | 2.1 | 2.0 | 5.9 | 12.0 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| *Numerator* | | | | | |
| Mean # staff | 1.57 | 1.78 | 1.58 | 1.86 | 2.27 |
| *Denominator* | | | | | |
| Mean # fam. & community | 2.48 | 2.45 | 2.70 | 2.32 | 2.33 |

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[13] A ratio of "0" would result when either no agency staff or no family community supports are in attendance.  Given that TDM meetings are held by agency staff members, it is very likely that such cases represent meetings in which no family members were present.

Anchorage removal TDM meetings at 89.8% but lower for Cleveland removal TDM meetings at 60.1%. For COP TDM meetings in Denver and Anchorage, this pattern still holds true at 76.0% for Denver COP TDM meetings and 72.5% for Anchorage TDM meetings. As would be expected, the mean number of family and community supports at each meeting exceeds the number of agency staff. In Cleveland, however, these means are much closer in number, suggesting that staff members in Cleveland attend more frequently in groups during meetings than in the other two sites.

The final analysis exploring the extent of TDM implementation fidelity examines the likelihood of a variety of patterns of participation among different family-related attendees (see Table 12). Using multiple-response tables, meetings are classified according to unique combinations of birth parents (P), relatives (R), friends and community supports (F), and children and youth (C). Results suggest both similarities and differences across the sites. For removal meetings, the most common pattern of participation was the simultaneous attendance of birth parents and relatives, at 22.3% for Denver, 34.8% for Anchorage, and 22.9% for Cleveland. The next most frequent pattern was birth parents attending alone, at 18.6% for Denver, 23.8% for Anchorage, and 21.4% for Cleveland. For removal TDM meetings in Cleveland, however, a significant proportion of meetings involved no family-related participants (14.6%). One caveat in interpreting data from Cleveland is that this agency's wide systemic coverage of TDM relative to the other two sites. In Cleveland, as specified by the Family to Family practice model, every placement decision must be the result of a TDM. One implication of this wider coverage is that, at times, TDM meetings will be convened in the absence of family and community supports, in the interest of reaching an immediate placement decision. Another factor may be that the agency has experienced a number of database changes that might affect the consistency of reporting across time within this site.

**Table 12.        Family and Support Persons Attending TDM meetings**

|  | Denver | | Anchorage | | Cleveland |
|---|---|---|---|---|---|
|  | **Removal**<br>**N=1,438**<br>(%) | **COP**<br>**N=466**<br>(%) | **Removal**<br>**N=391**<br>(%) | **COP**<br>**N=1,039**<br>(%) | **Removal**<br>**N=3,881**<br>(%) |
| *Persons in Attendance* | | | | | |
| P | 18.6 | 12.5 | 23.8 | 22.4 | 21.4 |
| PR | 22.3 | 13.7 | 34.8 | 17.1 | 22.9 |
| PF | 18.5 | 13.7 | 8.2 | 4.3 | 11.2 |
| PC | 4.2 | 3.9 | 3.1 | 7.6 | 1.4 |
| PRF | 17.7 | 9.3 | 11.5 | 4.1 | 11.8 |
| PRC | 2.1 | 2.1 | 2.8 | 2.4 | 1.3 |
| PFC | 3.5 | 4.5 | 2.0 | 1.4 | 0.9 |
| PRFC | 1.6 | 2.8 | 1.8 | 0.6 | 0.9 |
| R | 2.3 | 4.1 | 4.1 | 5.3 | 6.5 |
| RF | 2.0 | 4.1 | 1.5 | 1.5 | 2.1 |
| RC | 0.2 | 1.3 | 0.0 | 1.3 | 1 |
| RFC | 0.6 | 1.1 | 0.3 | 0.4 | 0.7 |
| F | 3.1 | 6.4 | 0.8 | 2.9 | 2 |
| FC | 1.3 | 3.7 | 0.2 | 1.1 | 0.4 |
| C | 0.4 | 5.7 | 0.8 | 8.0 | 0.9 |
| none | 1.5 | 1.1 | 4.3 | 19.6 | 14.6 |
| Missing | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**NOTE:**
C = children (aged 13 and over); F = friends and community supports; P = birth parents; R = relatives

*Assessment of Placement Experiences Associated with TDM meetings*

The second broad research question pertains to the extent to which TDM placement recommendations actually translate into placement experiences for children. This analysis required linking administrative TDM data to longitudinal placement data in one site (Denver) for removal TDM meetings held for initial entries to care only. This category of TDM meetings was subdivided further into two distinct categories of removal TDM meetings, for which the distinction was described earlier: emergency removal TDM meetings; and considered removal

TDM meetings. Then, the number of days between a TDM and an initial entry to foster care was calculated within each TDM subtype, and cross-tabulated with TDM recommendations and initial placement experiences.

Between January 3 and December 30, 2005, Denver convened 431 emergency removal TDM meetings and 682 considered removal TDM meetings (see Table 13). For both types of TDM meetings, recommendations were either that a child should enter child welfare custody (Custody Recommendations in Table 13) or that a child should remain in the home or be returned home if removed on an emergency basis ( Non-Custody Recommendations in Table 13). For emergency TDM meetings, 325 (75.4%) resulted in a custody recommendation, 268 of which resulted in an actual out-of-home placement (82.5%). The 106 non-custody recommendations were evenly split between placements and no placements. Results from McNemar's test show that these placement patterns are not significantly different than the recommendations. The majority of considered

**Table 13.   DENVER – Removal TDM Custody Recommendations and Outcomes (CY 2005)**

| | | *Emergency TDM* (N=431) | | | *Considered Removal TDM†* (N=682) | |
|---|---|---|---|---|---|---|
| *TDM Recs[14]* | N | Placed n=321 | Not Placed n=110 | N | Placed n=178 | Not Placed n=504 |
| Custody | 325 | 268 | 57 | 156 | 106 | 50 |
| Non-Custody | 106 | 53 | 53 | 526 | 72 | 454 |

*† $Q_M$ = 3.967, df=1, p < .05*

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[14] Data include recommendations for each child at each initial TDM meeting (meeting/child combination).

removal TDM meetings resulted in a recommendation to remain at home (526; 77.1%), 454 of which had no subsequent placement (86.3%). Of the 156 custody recommendations, 106 (67.9%) were associated with a placement. Yet, results from McNemar's test showed a significant discrepancy between recommendations and outcomes (p < .05).

One important caveat is that placements with a relative caregiver may or may not be recorded in the longitudinal placement database. Yet, for the purpose of the analysis summarized in Table 13, recommendations for relative caregiver placements are classified as actual out-of-home placements. The underlying situation warrants some discussion. In Denver County Human Services, out-of-home placements are classified either as temporary custody (in which custody is signed over to the agency) or voluntary custody (in which parents voluntarily sign over custody). According to agency policy, temporary custody decisions should be recorded in the placement database; voluntary custody decisions should not. A further distinction is the status of relative caregivers as either licensed or un-licensed foster parents. Placements with licensed foster families will be included in the placement database, while those with unlicensed families will not.

Follow-up analyses of these data revealed inconsistencies in data entry that highlight further challenges to implementation. In emergency removal TDMs, for children recommended for temporary custody with a relative caregiver (n=72), only 42 (58.3%) had a recorded placement in the longitudinal database. On the other hand, of the 64 children recommended for voluntary custody with a relative caregiver, 39 (60.9%) had a recorded placement. Furthermore, an examination of initial placement types revealed that for relative caregiver recommendations resulting in recorded placements, approximately half were classified as a family foster home and half as a kinship or other type of placement.

The implication of these patterns may be that, as of 2005, caseworkers and administrators had yet to reach a consensus regarding which types of placements warrant entry into the placement database, although such consensus now exists. Given this problem, a further

implication is that one cannot make the assumption that a child was not placed simply because a record of placement does not exist in the placement database. In addition, relative caregivers may or may not have legal custody of the child, and may or may not be licensed; if they are licensed, their status would likely change to that of family foster home. These complications make it difficult to ascertain with certainty whether custody recommendations for relative caregivers result in placements, as outlined in the analysis for Table 13.

The remaining analyses in this study focus on custody recommendations (i.e, recommendations to enter out-of-home care) for Emergency TDM meetings (N=325) and Considered Removal TDM meetings (N=156). Children are grouped by the number of days between the TDM meeting and actual placement events according to "placement windows." These categories also include the population of children who never experienced an entry into care (126 for emergency removals, and 108 for considered removals). For each TDM type, placement recommendations were cross-tabulated with placement window categories to examine the most frequent occurrences of outcomes based on each recommendation. For both TDM types, many of these placement outcomes proved to be not entering care. The timing of the placement in relation to a TDM, and the placement type itself, are of direct practice significance to agencies implementing Family to Family. If the purpose of the TDM is to promote more effective decision-making for children and families, then the shorter amount of time between a TDM and a placement, the more likely the placement occurred in connection to that TDM. Also, placements that are more family-based and least restrictive are those types of placements that the Family to Family initiative encourages agencies to pursue on a systemic level.

Among emergency removal TDM meetings, the median number of days between a TDM and a placement was 2 days before a TDM was convened; in other words, on average, for children experiencing a placement, children tended to be placed on an emergency basis 2 days before a TDM was convened to make a placement decision. For considered removals among children experiencing a placement, children tended to be placed 9 days following a related TDM.

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**Table 14. Emergency Removal TDM Out-of-Home Care Recommendations (CY 2005)**

Number of days between TDM and placement

| TDM Recommendation[15] | N Recs | 6 or more Before (n=35) | 1 - 5 Before (n=112) | Same Day (n=24) | 1+ After (n=28) | Not Placed (n=126) | % |
|---|---|---|---|---|---|---|---|
| Relative CG | 158 | 7.0 | 26.6 | 9.5 | 13.3 | 43.6 | 100.0 |
| Foster Care | 114 | 15.0 | 49.2 | 7.0 | 5.4 | 23.4 | 100.0 |
| Residential/Group | 25 | 16.0 | 20.0 | 0.0 | 0.0 | 64.0 | 100.0 |
| Unrelated person | 15 | 13.3 | 33.3 | 0.0 | 6.7 | 46.7 | 100.0 |
| Non-cust. parent | 9 | 0.0 | 33.3 | 0.0 | 0.0 | 66.7 | 100.0 |
| missing | 4 | 25.0 | 25.0 | 25.0 | 0.0 | 25.0 | 100.0 |
| Total | 325 | | | | | | 100.0 |

Within emergency removal TDM meetings, however, a wide range of days lapsed between TDM meetings and placements (see Table 14). For recommendations to enter foster care (n=114), half entered care between 1 and 5 days before a TDM (49.2%) or the same day (7.0%) or after (5.4%) a TDM was convened. Given the emergency nature of these placements, it is not surprising that these children were removed prior to convening a TDM meeting. A significant number of children received a recommendation to be placed with a relative caregiver (n=158). Of these children, many did not enter placement (43.6%), and if they did, they entered within 5 days before to the same day as a TDM (47.1%). One issue in interpreting these placements, however, is the high likelihood of data entry inconsistencies in Denver pertaining to relative caregiver placements.

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[15] Data include recommendations for each child at each initial TDM meeting (meeting/child combination).

**Table 15. Considered Removal TDM Out-of-Home Care Recommendations (CY2005)**

| | | Number of days between TDM and placement | | | | |
|---|---|---|---|---|---|---|
| *TDM Recommendation*[16] | N Recs | Before – 1 After (n=22) | 2-14 After (n=19) | 15+ After (n=7) | Not Placed (n=108) | % |
| Relative CG | 89 | 10.1 | 16.9 | 7.9 | 65.1 | 100.0 |
| Foster Care | 29 | 34.5 | 10.3 | 0.0 | 55.2 | 100.0 |
| Residential/Group | 10 | 10.0 | 10.0 | 0.0 | 80.0 | 100.0 |
| Unrelated person | 10 | 20.0 | 0.0 | 0.0 | 80.0 | 100.0 |
| Non-cust. parent | 14 | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 |
| missing | 4 | 0.0 | 0.0 | 0.0 | 4.0 | 100.0 |
| Total | 156 | | | | | 100.0 |

The majority of considered removal TDM meetings that resulted in recommendations for out-of-home placement (see Table 15) could not be linked to subsequent placements for the children who were subjects of those meetings (108; 69.2%). The implication of this pattern may be that no additional risk factors emerged for these families while under the agency's supervision, such that no further placements were required. Of the 156 considered removal TDM meetings with out-of-home care recommendations, 29 were recommended to enter foster care, but a majority (55.2%) did not enter care according to placement data. Of the 89 children receiving a recommendation to move to a relative caregiver's home, 65.1% experienced no placement, while 17.5% experienced a placement of some kind between 2 to 14 days of having a TDM. Again, caution must be used in interpreting these patterns given the likely data entry issues around relative caregiver placement

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[16] Data include recommendations for each child at each initial TDM meeting (meeting/child combination).

The next step involved examining the extent to which placement recommendations matched the placement experiences of children within each type of TDM. This analysis also examines the number of days between recommendations and outcomes. For emergency TDM meetings (see Table 16), these outcomes involved placement in foster care (n=142), kinship care (n=41), congregate care (n=14), or no placement (n=126). The borders surrounding certain rows in Tables 14 and 15 represent recommendations that were achieved in practice. For example, in Table 14, recommendations are considered achieved if a child is placed in foster care or kinship care, and if such a placement occurred any time from 5 days before a TDM to 1 or more days after a TDM.

**Table 16.        Emergency TDM Placement Recommendations & Outcomes (CY 2005)**

*Placement Experiences*

| | Foster Care N=142 | | | | Kinship Care N= 41 | | | | Congregate Care N= 14 | | | | None N=126 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Placement Window (days) | | | | | | | | | | | | | |
| **TDM Rec**[17] | ≥ 6 Bf. | 5 -1 Bf. | 0 | 1+ Aft. | ≥6 Bf. | 5 -1 Bf. | 0 | 1+ Aft. | ≥ 6 Bf. | 5 -1 Bf. | 0 | 1+ Aft. | | |
| Rel.CG | 5 | 33 | 6 | 4 | 4 | 8 | 9 | 15 | 2 | 1 | 0 | 2 | 69 | 158 |
| Foster | 16 | 51 | 8 | 6 | 0 | 3 | 0 | 0 | 1 | 0 | 0 | 0 | 27 | 112 |
| Resid. | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 5 | 0 | 0 | 16 | 25 |
| Unrelat | 2 | 5 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 7 | 15 |
| Nc prnt | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 9 |
| miss. | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 4 |
| | | | 1 | | | | | 1 | | | | | | |
| Total | 25 | 93 | 4 | 10 | 4 | 11 | 0 | 16 | 6 | 6 | 0 | 2 | | |
| Σ Totals[18] | | | | 142 | | | | 41 | | | | 14 | 126 | 323 |

[17] Data include recommendations for each child at each emergency TDM meeting (meeting/child combination).

[18] Two children were placed in an "Other" category, such that the actual number of children for whom Emergency TDM meetings were held is N=325.

Within emergency TDM meetings (Table 16), nearly three quarters of the 112 recommendations to enter foster care were associated with a placement in foster care (n=81); 16 other children entered care 6 or more days before a TDM, 1 entered congregate care 6 or more days before a TDM, and 27 experienced no placement. For children receiving recommendations to move to a relative caregiver's home (n=158), 43 entered foster care within 5 days before and 1 or more days after a TDM, 32 entered kinship care within this time frame, and 69 (43.4%) experienced no placement. For children having a spell in foster care between 1 and 6 days in length, 30 were determined to be in care at the time of the recommendation to return home (44.1% of all children receiving this recommendation).

**Table 17.**          **Considered Removal TDM Recommendations & Outcomes (CY 2005)**

*Placement Experiences*

| TDM Rec[19] | Foster Care N= 16 | | | Kinship Care N=24 | | | Congregate Care N=6 | | | None N=108 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Placement Window (days) | | | | | | | | | | |
| | Bef. - 1 Aft. | 2-14 Aft. | 15+ Aft. | Bef. - 1 Aft. | 2-14 Aft. | 15+ Aft. | Bef. - 1 Aft. | 2-14 Aft. | 15+ Aft. | | |
| Rel. CG | 1 | 3 | 0 | 6 | 12 | 6 | 1 | 0 | 1 | 58 | 88 |
| Foster | 8 | 2 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 16 | 28 |
| Nc prnt | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 | 14 |
| Resid | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 8 | 10 |
| Unrelat | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 8 | 10 |
| missing | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 4 |
| Total | 11 | 5 | 0 | 6 | 12 | 6 | 4 | 1 | 1 | | |
| Σ Totals[20] | | | 16 | | | 24 | | | 6 | 108 | 154 |

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[19] Data include recommendations for each child at each emergency TDM meeting (meeting/child combination).

[20] Two children were placed in an "Other" category, such that the actual number of children for whom Considered Removal TDM meetings were held is N=156.

Similar analyses were conducted to measure the relationship between considered removal

TDM recommendations and placements (see Table 17). Of the 154 out-of-home placement

recommendations emerging from considered removal meetings, 16 (10.4%) children entered

foster care, 24 (15.6%) entered kinship care, and 6 (3.9%) entered congregate care; most (108;

70.1%) experienced no placement. Of the 88 children receiving a recommendation to move to a

relative caregiver's home, 58 (65.9%) experienced no placement, and 24 (27.3%) were placed in

kinship care.

A final table summarizes data concerning the percentage of Denver's TDM out-of-home

placement recommendations that are reflected in children's actual experiences in 2005 (see Table

18). These recommendations are listed in order of increasing restrictiveness, and a Cochran-

Armitage trend test (Z) is conducted to test whether these recommendations are associated with a

trend in the likelihood of successful recommendation implementation. For emergency TDM

**Table 18.**          **Custody Recommendations Successfully Implemented (CY 2005)**

| TDM Recommendation (in order of increasing restrictiveness) | _TDM Type_ | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| | _Emergency TDM*_ | | | _Considered Removal TDM†_ | | |
| | Total | Recs Imple'd. | % Imple'd. | Total | Recs Imple'd. | % Imple'd. |
| Non-cust. parent | 9 | 6 | 66.7 | 14 | 14 | 100.0 |
| Relative CG | 158 | 144 | 91.1 | 89 | 86 | 96.6 |
| Unrelated person | 15 | 5 | 33.3 | 10 | 2 | 20.0 |
| Foster Care | 114 | 68 | 59.6 | 29 | 10 | 34.5 |
| Residential | 25 | 5 | 20.0 | 10 | 2 | 20.0 |
| missing | 4 | -- | -- | 4 | -- | -- |
| Total | 325 | 228 | 70.2 | 156 | 114 | 73.1 |

* $Z = -7.587$, $p < .0001$
† $Z = -2.378$, $p < .001$

meetings, the highest number of custody recommendations involved either placement with a relative caregiver (158) or in foster care (114), for which the rates of successful implementation are 91.1% and 59.6%, respectively. Similarly, for these same recommendations among considered removal TDM meetings, the rates of successful implementation are 96.6% and 34.5%, respectively. Overall, the rates of successful implementation of custody recommendations seem relatively low for each recommendation, with the exception of relative caregiver recommendations. Yet, the overall percentage of successfully implemented recommendations is relatively high (70.2% for emergency TDMs; 73.1% for considered removal TDMs).

One issue may help explain these dynamics, at least for relative caregiver placement recommendations. In Denver, the agency instructs staff to classify relative caregiver placements as out-of-home placements. Relative caregiver placements are not licensed but children remain the legal responsibility of the agency. Given that these families are not licensed, these placements are not recorded in the placement database. In these analyses, the lack of related placements for relative caregiver recommendations is assumed to be evidence of successfully implemented recommendations. Yet, this assumption may not be valid for certain cases, such that the rates of successfully implemented recommendations may be upwardly biased. Further study is needed to explore the placement dynamics for relative caregiver recommendations in Denver.

Interestingly, for both TDM types, a strongly significant, negative trend exists between the level of recommendation restrictiveness and the likelihood of achieving that recommendation in practice.. This trend is stronger for emergency TDMs ($Z = -7.587$, $p < .0001$) than for considered removal TDMs ($Z = -2.378$, $p < .001$), but both tend in the same direction. In other words, the greater the level of restrictiveness of a recommendation, the less likely that recommendation will be successfully implemented. Again, however, these trends may be related to the high rates of successfully implemented recommendations for relative caregiver placements. Caution must be used in this interpretation as the "true" rates of success cannot be verified for these recommendations.

*Discussion*

The findings presented in this study attest to the efforts that these agencies have exerted in attempting to implement TDM. Involving family members, relatives, and formal and informal community supports in the placement decision-making process is a critical component of effective TDM implementation. Therefore, the proportion of meetings attended by these types of participants is an important indicator of whether TDM meetings are being implemented as specified. The high numbers of meetings attended by birth parents across the sites provides compelling evidence that this critical component of TDM implementation is receiving attention across sites.

The high numbers of family members and community supports in each TDM meeting, relative to agency staff, is also an encouraging indicator of family engagement and empowerment within TDM meetings. While this measurement obviously does not provide insights into the "black box" of group interactions within meetings, it does highlight an important dynamic: namely, that family members and community supports are, at the very least, attending in relatively high numbers compared with agency staff members. By numbers alone, these participants appear to be involved in the decision-making process. However, while this measure provides one basis for comparing the composition of TDM meetings across sites, it may have only limited practical application in agencies' self-evaluation efforts. Obviously, it would be a detrimental policy for agencies to encourage less involvement by agency staff to improve staff-to-family ratios.

The limitations of the ratio variable in explaining group dynamics may be offset somewhat by the analyses of participation patterns. These analyses showed that a high percentage of meetings are attended simultaneously by parents and friends, parents and relatives, or parents, relatives and friends. This finding suggests that these sites are able to access the perspectives and birth parents and relatives to a significant degree. Yet, one of the largest apparent patterns in both removal and COP TDM meetings is that of parents attending with no other family or community

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supports. This dynamic is problematic in the sense that accessing community resources for

families is a central component of TDM practice. In tracking birth parent engagement, it may be

necessary for agencies to track simultaneous engagement with relatives and community supports.

Another related issue is the relatively large percentage of meetings in one site (14.6%) that have

neither parents nor community supports in attendance. A meeting that includes no parents or

supports represents poor TDM implementation and instead resembles something like a

professional multidisciplinary team. Yet, this issue may also be related to Cleveland's wide

systemic implementation of TDM, as discussed earlier. This situation may represent a trade-off

sites must make in pursuing TDM implementation in alignment with the Family to Family

practice model: TDM meetings must be held for every placement decision, and must include

family and community supports. It may be that Cleveland ranks the former as more important,

while the other two agencies rank participation as more important than systemic coverage.

Clearly, however, more research is needed to examine these dynamics.

The comparison of initial entries to care and removal TDM coverage highlighted potential

dynamics that warrant further investigation. Both Denver and Cleveland appear to convene

meetings for all required cases prior to entering care, and to such an extent that meetings

considerably outnumber initial entries. The initial entries to care also represent a relatively small

percentage of children for whom referrals were received. These aggregate findings must be

interpreted cautiously, however, for at least two reasons. First, children entering care during a

particular calendar year may not have been *referred* during the same year. Second, children

entering care during a particular time period may or may not be the same children who received

meetings during this period. These potential inconsistencies may result in biased analyses by

comparing children who represent different populations.

The preliminary assessment of the relationship between Denver TDM recommendations and

actual placements revealed both interesting insights, and issues for further exploration. For

children receiving emergency TDM meetings, no significant discrepancy emerged between

custody recommendations and out-of-home placement outcomes. The majority of custody recommendations in emergency TDM meetings resulted in an out-of-home placement (82.5%), but non-custody recommendations were evenly split between placement and no placement. Yet, for children receiving considered removal TDM meetings, 32.1% of custody recommendations and 86.3% of non-custody recommendations yielded no placement, resulting in a significantly discrepant pattern of outcomes compared with recommendations for these children ($p < .05$). Again, the "true" relationship between recommendations and outcomes is somewhat skewed by a lack of data regarding the outcomes for children placed with relative caregivers. For children receiving emergency removal TDMs, however, these preliminary analyses provide some evidence that this agency is successfully implementing custody recommendations. For children receiving considered removal TDMs, the significant discrepancy between custody recommendations and outcomes warrants further investigation, although custody recommendations are more likely to be implemented than not.

Children with a recommendation to enter custody frequently entered placement on an emergency basis before having a TDM. Given the presumed emergency nature of these situations, children simply must be placed before a team can be convened to discuss the issue. Then, the problem emerges of determining whether the decision was made to justify the current placement, or to correct an incorrect decision by recommending that the child be returned home or to some other placement. One solution to this data problem likely lies in the development of a linked database that simultaneously collects both TDM and placement data.

The final analysis of custody recommendations demonstrated some variation in the extent to which recommendations were successfully implemented. For children within emergency TDM meetings, 70.2% of recommendations were achieved and this percentage was slightly higher for children within considered removal meetings (73.1%). Yet, for considered removals, the majority of children did not enter care regardless of the recommendation type. Furthermore, the analysis discovered significant trends for both TDM types that more restrictive placement

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recommendations were less likely to be implemented. One possible explanation for this trend is that placements in more restrictive settings (e.g., congregate care) may take an additional process to approve, such that the more restrictive placement would not be recorded as an initial placement.

Despite some similarities, the implication of the overall differences in placement patterns appears to be that considered removal TDM meetings are associated with a different dynamic than emergency TDM meetings. Considered removal TDMs appear to be more of a monitoring mechanism to track evolving safety plans, while emergency TDM meetings tend to play a more reactive role, often to make decisions after the fact. It is also important to note that this dynamic is unique to Denver; other child welfare agencies do not make such a distinction between emergency and considered removal TDM meetings, a situation that highlights the importance of capturing site-specific information (Ortega et al., 2002; Wind & Brooks, 2002).

*Conclusion*

This study of TDM implementation fidelity identifies important indicators of the degree to which sites have achieved successful TDM practice in alignment with the practice model. The good news is that, unlike other studies demonstrating low program fidelity (Gilliam et al., 2000; McGrew et al., 2004), the sites in this study appear to have achieved some measure of success in implementing key indicators of the TDM practice model, especially in encouraging participation from family and relatives. Evidence also suggests that custody recommendations are being successfully implemented, especially for children receiving emergency TDMs. Yet, the particular dynamics of these placements need further investigation, especially for relative caregiver placements.. Prior to conducting a full scale evaluation of TDM and F2F, the challenges will then be to integrate some of the practice consistencies across sites with unmeasured policy and philosophical differences that may affect the outcomes targeted by the initiative (Bath & Haapala, 1994), and to isolate those factors that impede effective implementation of TDM recommendations.

**CHAPTER 6**

THE ASSOCIATION OF TEAM COMPOSITION AND MEETING CHARACTERISTICS

WITH FOSTER CARE PLACEMENT RECOMMENDATIONS


As an approach to child welfare decision-making, Team Decisionmaking (TDM) presents an alternative to standard processes that often only involve a caseworker and a supervisor. As assessed against the conceptual framework for balanced decision-making, TDM promises a more thorough consideration of protective factors in addition to risk factors, specifically by including the perspectives of a variety of participants. The TDM approach is distinct in its explicit directive to include birth parents as well as informal and formal community supports (DeMuro & Rideout, 2002). These perspectives may add crucial information to a discussion of placement options, such that alternatives to out-of-home placement and available services and supports may be explored.

Upon full implementation at a site, TDM meetings are held at key decision points in the child welfare process: initial entry to care, change of placement, and reunification or other permanency option. This chapter focuses specifically on potential changes in placement (COP) TDMs, in which the team decides whether a child will be moved to a placement of greater, lesser, or similar level of restrictiveness. The Annie E. Casey Foundation's Family to Family initiative emphasizes the importance of family-based, least restrictive settings to ensure children's well-being (DeMuro & Rideout, 2002). Thus, this chapter speaks directly to TDM's ability to achieve an important component of the framework.

*Foster Care Placement Changes*

Child welfare literature is replete with information about the negative effects of foster care placement disruptions (Hussey & Guo, 2005; James, Landsverk, & Slymen, 2004), but researchers are less clear regarding the causes of these disruptions (Newton, Litrownik, & Landsverk, 2000) or even how to define these transitions. James (2004) explored the issue in some detail, and distinguished placement changes from planned moves. Her review of earlier placement change literature suggests that "there is a lack of definitional agreement about what constitutes a placement and a placement change" (p. 603). This dynamic may also be related to problems in the reliability of child welfare placement data, with states varying in their definitions of what constitutes a change in placement during spells in foster care (Woodruff, 2004). The result may be an underestimation of the number of placements children experience in care due to under-reporting by states, although federal measures clearly specify that a child experiences a change in placement when moving from one foster care setting to another (Children's Bureau, 2007).

With these limitations in mind, empirical evidence suggests that a large proportion of children in foster care experience a disrupted placement. In an analysis of 5,557 children entering their first spell in foster care over the course of eight years, Webster, Barth and Needell (2000) found that over half of children placed in non-relative care experienced three or more moves following their first year in care. Children placed with relatives experienced greater placement stability, but overall, children experiencing more than one placement during their first year in care were significantly more likely to change placements more frequently in long-term care. This study corroborated earlier findings that about half of children in foster care experience more than one placement (Staff & Fein, 1995).

One method of explaining foster care placement disruptions is to examine which children are most likely to change placements. Wulczyn and colleagues (2003) found that compared with younger children, adolescents were more likely to change placements, as were children placed in

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a group care setting. This study also found that most placement moves occurred within six months of entering placement, a finding also reflected in previous research showing that placements are at greatest risk of disruption early in the placement (James, 2004; Smith, Stormshak, Chamberlain, & Whaley, 2001). Children in kinship care tend to be at lower risk of placement breakdown (Chamberlain et al., 2006; James, 2004) and typically move less frequently than children in non-relative foster care (Usher, Randolph, & Gogan, 1999; Webster et al., 2000). However, findings are mixed over the question of the child's gender, with at least two studies suggesting that boys are at higher risk for changing placements (James, 2004; Palmer, 1996) and one study finding that older girls are more likely to disrupt (Smith et al., 2001). Another study determined that placement outcomes were related to specific child and family characteristics, such as the perceived attractiveness of the child, the child's desire to be fostered, and the degree to which the foster family encouraged a warm, child-centered environment (Sinclair & Wilson, 2003).

Despite some lack of clarity over the children most likely to disrupt, research points to the near universal negative effects of changing placements in foster care. Not only do disrupted placements cost agencies additional time and money (Price, 2005, cited in Chamberlain et al., 2006), they place children at higher risk of re-entering care following reunification (Courtney, 1995; Wells & Guo, 1999). Importantly, these disruptions also take a toll on children's mental and behavioral health, with placement instability being highly associated with both internalizing and externalizing behaviors (James et al., 2004; Newton et al., 2000) and an increased risk of delinquent behavior, especially for boys (Ryan & Testa, 2005). Herrenkohl and colleagues (2003) found that adolescent problem behaviors were significantly associated with earlier transitions among caretakers and homes, such that these transitions place maltreated children at an even higher risk of developing behavior problems. For children placed in treatment foster care, Hussey and Guo (2005) found that the number of previous out-of-home placements proved to be the strongest predictor of later problems, such that "each additional out-of-home placement was

predictive of increases in externalizing, internalizing, and critical pathology domains" (p. 503). Placement instability thus increases mental health problems and the costs associated with these problems (Rubin, Alessandrini, Feudtner, Mandell, Localio, & Hadley, 2004). Yet, no experimental studies have been conducted to sort out the reciprocal influences of children's behavior problems and placement changes. In the absence of such studies, researchers lack the information needed to determine whether placement changes cause, or are precipitated by, problem behaviors.

Indeed, in much of the literature, the consequences of placement instability may be confounded with the causes of disruptions. Newton and colleagues (2000) found that children's externalizing behaviors were the strongest predictor of placement disruptions, but that children initially displaying normal behavior may be particularly susceptible to later externalizing behaviors following a breakdown in placement. One of the most frequent findings, however, is that children's externalizing behaviors precede a placement change. In James' study (2004), 20% of all placement breakdowns were related to children's behavior, with externalizing behaviors being one of the strongest predictors of these disruptions, along with children's older age and the presence of emotional abuse. Leathers (2006) found that a child's integration in the foster home mediated the relationship between problem behaviors and placement disruptions. Yet, another study found a linear relationship between the number of problems a child exhibits per day and the likelihood of disruption, such that hazard of placement breakdown increased 17% for each behavior exhibited (Chamberlain et al., 2006). In addition to children's behavior problems, other predictors of placement breakdown include environmental factors, such as the foster family's undergoing stressful events or not being able to access caseworkers effectively for assistance (Farmer et al., 2005; James, 2004).

Clearly, finding an early permanent placement for children in care is crucial in promoting positive outcomes. Evidence clearly shows that children who stabilize early in care experience fewer moves overall as well as lower levels of behavior problems (James et al., 2004). Yet, the problem of disrupted placements is complex, given the role of externalizing behaviors as both a cause and consequence of changes in placement (Newton et al., 2000). This problem is further complicated by agency- and system-level factors that affect the circumstances surrounding foster care placements.

The manner in which child welfare agencies and systems differ in structure may have a direct effect on the placement experiences of children in care (Smith et al., 2001). Specifically, the rate of caseworker turnover has been found to be highly associated with multiple placements in foster care (Pardeck, 1984), longer stays in care, and a decreased likelihood of reunification (Ryan, Garnier, Zyphur, & Zhai, 2006). Private and public child placing agencies may also differ in their patterns of placement, with one study indicating that children served by private agencies changed placements more frequently than children in public agencies (Usher, Randolph, & Gogan, 1999), although this dynamic may also be related to inconsistencies across public agencies in reporting placement changes (Woodruff, 2004).

Other studies demonstrate similar agency and system-related effects. In James' study (2004), 29% of all placement changes involved the use of short-term shelters, a situation that increased the number of overall placements for children. Reliance on shelters is an issue particular to the site used for the analysis, such that another site not using shelters likely would evidence a higher proportion of behavior-related moves. In Ryan and colleagues' study (2006) of the effects of caseworker characteristics on placement outcomes, children served by MSW-level caseworkers spent less time in care overall, but were not more likely to reunify than those children served by bachelor's-level workers. Race of the caseworker had no effect on placement outcomes, although African-American children experienced longer lengths of stay in care and were less likely to reunify regardless of the caseworker's race.

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*How Team Decisionmaking Meetings Might Affect Placement Change Recommendations*

The issues outlined above suggest that placement changes arise from a variety of factors, including children's externalizing behaviors, age of the child, and systemic factors such as caseworker education and turnover. From the standpoint of disruption prevention, child welfare agencies may be limited in their ability to address directly issues related to children's behaviors coming into care, although ostensibly they might be able to use better assessments to match children's behavior problems with the appropriate level of care, or with foster parents that specialize in certain special needs (Hussey & Guo, 2005). Indeed, one of the four core strategies of Family to Family, Resource Family Development and Support, is intended to support foster families to enable them to continue caring for children who pose challenges. Yet, while assessments and increased support of foster parents might promote more stable placements, they would likely not affect systemic factors that also contribute to placement breakdowns.

It is on these systemic factors that TDM should have the strongest effect. Through distributing decision-making control to a variety of members, decisions will likely be less prone to the negative influences of caseworker turnover or lack of education. Furthermore, by introducing foster families or relative caregivers into the decision-making process, as well as these families' relatives and natural supports from the community, TDM intends to provide enhanced gatekeeping in foster care. Specifically, by drawing from a variety of perspectives, participants may identify an alternative to disruption, or depending on the best interests of the child, the group may even recommend stepping down the restrictiveness of care. The guiding framework behind TDM is that those participants closest to families in their home environments will have a greater knowledge of available formal or informal resources, such that the best decision can be made for each child.

*Methods*

This study is guided by four research questions. First, what are the meeting and child characteristics of COP TDM meetings convened in three sites implementing Family to Family: Denver, CO; Anchorage, AK; and Wake County, NC?  Second, what is the relationship of these characteristics with the likelihood of a child being recommended to change placements in foster care? Third, to what extent does the presence of different types of caregivers influence placement recommendations?  Fourth, to what extent are these characteristics related to the restrictiveness of the placement recommendation, compared with a recommendation of no change in placement?

*Data Sources*

 TDM data. In each of the three sites, agencies collect process-related data for all TDM meetings held. These data allow agencies to examine the breadth of TDM use across meeting types (entry or re-entry to placement, change of placement, permanency or reunification). Data are also collected on the characteristics of each TDM, including number of children involved, the types and variety of participants within each meeting, and the location of the meeting (public agency or community site). For each TDM, data are collected regarding the recommendations made by the team. These recommendations include the specific placement type as well as the restrictiveness of the placement recommendation.

*Analysis*

 Descriptive statistics describe TDM and participant characteristics and outcomes across all three sites. These variables include the recommended level of restrictiveness (less restrictive, more restrictive, same-level restrictiveness, and no placement); the location of the meeting (in the community versus otherwise); the number of children in the family ever having a recorded TDM; the race and gender of the child; the number of the current COP TDM experienced by each child (i.e., 1$^{st}$ meeting = 1, 2$^{nd}$ meeting = 2, etc); the child's age in years; whether a foster parent attends

the meeting; whether a relative caregiver or caregiver's partner attends the meeting; and whether either a foster parent or relative caregiver/partner attends the meeting; the number of family and relatives in attendance; and the number of friends and neighborhood supports in attendance. A one-way ANOVA analysis is conducted to test the significance of between-group differences of all variables among the three sites.

Next, binomial logistic regression models are estimated to predict a recommendation of a child's changing placement, versus experiencing no change in placement. The predictor variables are the same as outlined above, with the exception of children's age which is coded in months, rather than years. In addition, dummy variables for Anchorage and Wake County are included, using Denver as the comparison site. A generic caregiver predictor is also added to the model which includes both foster parents and relative caregivers and caregiver partners.

A further analysis selects only those cases for which a foster parent or caregiver is present (Denver, n=467; Anchorage, n=533; Wake Co., n=344; Total N=1,344). The purpose of this analysis is to identify the children whose current foster parents or caregivers attended the meeting, and to measure the effect of relative caregiver/partner compared with foster parent attendance. For this sub-sample, a binomial logistic regression model is conducted using the same predictors as before, with the exception of the indicator of caregiver attendance (v. foster parent attendance).

For the final analysis, the original intention was to conduct analyses using hierarchical linear modeling (HLM). The advantage of using this type of statistical methodology is that it accounts for the nested nature of data, and the related autocorrelation of variables (Raudenbush & Bryk, 2002). Left unaddressed, the nested structure of these data may violate the assumption of independent observations, and thus may result in biased standard errors and parameter estimates (Guo & Zhao, 2000).

In this study, the unit of analysis is termed "meeting-child," or the unique TDM meetings held for each child. These meetings are held at each site using a limited number of facilitators, so neither the meetings nor the facilitators can be assumed to be independent. The original proposed analysis thus would employ a 2-level model. Level 1 covariates would have included the meeting-level predictors previously mentioned, nested within facilitators (Level 2).

Unfortunately, upon inspection, it was discovered that one agency did not consistently record facilitator's names; rather, a number of facilitators were combined under one name, such that this name represented over 70% of the facilitators in this site, and about 25% of all the facilitators across the three sites. Further inspection discovered a similar pattern in another site. Thus, while HLM would have been preferable, the problem of disentangling facilitators precluded the usage of this analysis with these data.

Given the impossibility of conducting a multilevel analysis, and the opinion of some experts that multilevel analyses require a minimum of five sites to produce stable estimates (Snijders & Bosker, 1999), the alternative was to conduct a multinomial logistic regression for data across the three sites. These analyses used the same predictor variables as in the binomial logistic regression model, but removing the caregiver attendance variable The dependent variable of the multinomial models measured the log odds of receiving a recommendation for a less restrictive, same-level, or more restrictive placement, compared with no change in placement.

### *Results*

The restrictiveness of placement recommendations for children varied across the three sites (p<.001; see Table 19). In Denver (n = 711), the largest percentage of children received a recommendation not to change placements (36.7%), followed by recommendations for less restrictive placements (24.6%), same-level placements (18.8%), and a small number of recommendations for more restrictive placements (8.0%). The pattern in Anchorage (n = 1,039) showed that the largest percentage of children received a same-level recommendation (37.4%), as

**Table 19.    Placement Recommendations and Predictors by Site[1]**

| _Change of Placement TDMs_ (%) | **Denver** **(N=711)** | **Anchorage** **(N=1,039)** | **Wake County** **(N=916)** |
|---|---|---|---|
| _Recommendation Restrictiveness_** | | | |
| Less restrictive | 24.6 | 33.5 | 28.1 |
| More restrictive | 8.0 | 8.4 | 22.3 |
| Same level restrictiveness | 18.8 | 37.4 | 31.8 |
| No change in placement | 36.7 | 20.5 | 17.9 |
| _Meeting Location_** | | | |
| Community agency (v. other) | 4.1 | 7.5 | 2.7 |
| _Number of Children in Family_** | | | |
| 1 | 35.9 | 64.4 | 41.9 |
| 2 | 23.3 | 21.5 | 22.3 |
| 3 | 21.2 | 11.5 | 17.4 |
| 4 or more | 19.6 | 2.6 | 18.4 |
| _Race of Child_** | | | |
| Native American / Alaskan Native | 4.5 | 49.9 | 0.0 |
| African-American | 24.1 | 14.8 | 73.1 |
| Hispanic | 35.4 | 0.0 | 4.6 |
| White | 33.2 | 31.6 | 19.8 |
| Other | 0.8 | 2.9 | 2.5 |
| _Gender of Child_* | | | |
| Male | 51.2 | 52.4 | 45.9 |
| Female | 48.8 | 47.6 | 54.1 |
| _Number of Family and Relatives_** | | | |
| 0 | 23.8 | 31.7 | 63.9 |
| 1 | 35.9 | 34.6 | 25.4 |
| 2 | 29.1 | 23.8 | 5.9 |
| 3 or more | 11.3 | 9.9 | 4.8 |
| _Number of Friends and N'hood Supports_** | | | |
| 0 | 74.5 | 83.7 | 96.9 |
| 1 | 22.9 | 15.3 | 2.6 |
| 2 or more | 2.6 | 1.0 | 0.5 |
| _Number of COP Meetings Per Child_** | | | |
| 1 | 63.4 | 35.7 | 32.4 |
| 2 | 25.9 | 24.8 | 26.2 |
| 3 | 6.8 | 16.5 | 17.0 |
| 4 or more | 3.9 | 23.0 | 24.4 |
| _Child's Age in Years_** | | | |
| 0-4.99 | 30.1 | 26.2 | 18.6 |
| 5-10.99 | 29.0 | 25.9 | 16.7 |
| 11-12.99 | 10.1 | 10.9 | 10.5 |
| 13-17.99. | 29.5 | 36.2 | 52.3 |
| _Foster Parent Attends TDM_** | | | |
| Yes (v. No) | 35.3 | 38.8 | 30.3 |
| _Relative CG or Partner Attends TDM_** | | | |
| Yes (v. No) | 34.6 | 15.3 | 8.1 |
| _TDMs Attended by Foster Parents or CG_** | 65.7 | 51.3 | 37.6 |

[1] Summed percentages may not equal 100.00 because of missing data
*   p < .05
** p < .001

did the pattern in Wake County (n = 916; 31.8%). Yet, many more children received a more restrictive recommendation in Wake County (22.3%) than in Anchorage (8.4%) or Denver. There were also fewer recommendations for no change in placement than Denver in both Anchorage (20.5%) and Wake County (17.9%).

The number of meetings held in the community was small in all three sites, but ranged from 2.7% in Wake County to 7.5% in Anchorage (p < .001). Denver tended to serve larger families than the other two agencies (p <. 001), and the largest percentage of single-child families was found in Anchorage (64.4%). The racial composition of children also differed across these sites (p < .001). A large number of children served in Denver were either Hispanic (35.4%) or White (33.2%), while nearly half of children in Anchorage were of Native American/Alaskan heritage. In Wake County, 73.1% of children were African-American. The split between boys and girls was also somewhat uneven across the sites (p < .05), with more boys being served in Denver (51.2%) and Anchorage (52.4%), but fewer in Wake County (45.9%).

The number of COP TDMs experienced by children also varied by site (p < .001), with children in Denver experiencing the fewest number of meetings overall; 63.4% of meetings were the only COP meeting a child experienced. In contrast, 35.7% of COP TDMs in Anchorage, and 32.4% in Wake County, were the only COP meeting. These differences may be influenced by factors such as the amount of support foster parents receive through services like respite care. If a foster family gets connected to needed services through a TDM, it may be that future disrupted placements may be avoided, and a child will thus experience fewer COP TDMs.

Children's ages differed across the sites (p < .001). The largest percentage of meetings in Denver involved children between the ages of 0 and 4.99, while the largest percentages of children in Anchorage and Wake County were between the ages of 13 and 17.99. Foster parents attended about a third of COP TDMs, ranging from 30.3% in Wake County to 38.8% in Anchorage (p < .001). Caregivers attended 34.6% of COP TDMs in Denver, but much fewer in Anchorage (15.3%)

and Wake County (8.1%; p < .001). However, if *any* caregiver attended (relative caregivers or foster parents), these numbers were higher for Denver (65.7%), Anchorage (51.3%), and Wake County (37.6%; p < .001).

The next analysis used binomial logistic regression to predict recommendations of any type of placement change, versus no change in placement, across the three sites (see Table 20). Two models were conducted, one for all cases (N=2,545) and another for cases in which a caregiver was present (foster parent, relative caregiver or caregiver's partner; N=1,272). The first model fit the data well, with $X^2$ = 182.8863, df=14, and p < .0001. Neither the child's gender nor race significantly predicted placement change recommendations, although African-American children were marginally less likely to receive such recommendations. Meetings held in a community location were 89.8% more likely for such a recommendation (OR=1.898, p=0.013). The number of family and friends attending meetings had no statistically significant effect on recommendations. Yet, for each additional friend and neighborhood support in attendance, teams were 24.8% less likely to recommend a change of placement (OR=0.752, p=0.013). If any caregiver were present at a TDM, the team was 40.6% less likely to recommend a placement change (OR=0.594, p < .001). Compared with Denver, meetings held both in Anchorage (OR=2.493, p < .0001) and Wake County (OR=2.909, p < .0001) were much more likely to result in a placement change recommendation. For each additional child within a family having a TDM meeting, meetings were 6.0% less likely to recommend a placement change (OR=0.940, p=0.022).

**Table 20.**  **Predictors of Placement (v. No Placement)**

Binomial Logistic Regression

| Variable | All Cases[1] (N=2,545) | | | Caregivers Only[2] (N=1,272) | | |
|---|---|---|---|---|---|---|
| | OR | C.I. | *p* | OR | C.I. | *p* |
| *Gender* | | | | | | |
| Female | 1.000 | -- | -- | 1.000 | -- | -- |
| Male | 0.943 | 0.781 – 1.139 | 0.540 | 0.837 | 0.651 – 1.077 | 0.167 |
| *Race/Ethnicity* | | | | | | |
| White/Other | 1.000 | -- | -- | 1.000 | -- | -- |
| Afric. Amer. | 0.784 | 0.609 – 1.009 | 0.058 | 0.789 | 0.564 – 1.104 | 0.167 |
| Native Amer. | 1.282 | 0.950 – 1.731 | 0.104 | 1.339 | 0.897 – 1.998 | 0.153 |
| Hispanic | 0.968 | 0.693 – 1.351 | 0.848 | 1.252 | 0.832 – 1.885 | 0.281 |
| *Meeting Location* | | | | | | |
| Community | 1.898 | 1.143 – 3.151 | 0.013 | 1.765 | 0.956 -3.258 | 0.070 |
| *Any Caregiver* | 0.594 | 0.487 – 0.724 | <.001 | -- | -- | -- |
| Foster Parent | -- | -- | - | 1.000 | -- | -- |
| Relative CG or partner | -- | -- | -- | 0.809 | 0.618 – 1.060 | 0.125 |
| *Sites* | | | | | | |
| Denver | 1.000 | -- | -- | 1.000 | -- | -- |
| Anchorage | 2.493 | 1.769 – 3.514 | <.0001 | 3.947 | 2.496 – 6.241 | <.0001 |
| Wake Co. | 2.909 | 2.184 – 3.876 | <.0001 | 3.128 | 2.148 – 4.555 | <.0001 |
| *Mos. TDM implemented* | 1.010 | 0.999 – 1.022 | 0.078 | 1.022 | 1.006 – 1.038 | 0.006 |
| *# Family and Relatives Attend.* | 0.928 | 0.836 – 1.030 | 0.160 | 1.011 | 0.879 – 1.163 | 0.877 |
| *# Friends and N'hood Supports Attend.* | 0.752 | 0.601-0.941 | 0.013 | 0.748 | 0.557 – 1.005 | 0.054 |
| *Number Meetings Per Child* | 0.940 | 0.855 – 1.033 | 0.120 | 0.910 | 0.793 – 1.044 | 0.178 |
| *Number Children Per Family* | 0.940 | 0.891 -0.991 | 0.022 | 0.924 | 0.855 – 0.999 | 0.047 |
| *Child's Age in Months* | 1.001 | 0.999 – 1.003 | 0.213 | 1.001 | 0.999 – 1.003 | 0.206 |

[1]$X^2$ = 182.8863, df=14, p < .0001
[2]$X^2$ = 107.9950, df=14, p < .0001

The binomial logistic regression model for cases in which foster parents or caregivers were present fit the data well, with $X^2 = 107.9950$, df=14, p < .0001 (see Table 20). Yet, compared with foster parents, relative caregivers had no significant effect on lowering the likelihood of a placement change recommendation  For each additional friend or neighborhood support in attendance, teams were 25.2% less likely to make such a recommendation (OR=0.748, p=0.054). As in the previous model, meetings held in Anchorage (OR=3.947, p < .0001) and Wake County (OR=3.128, p < .0001) were much more likely than those held in Denver to result in a placement change recommendation. However, for every additional month for which TDM meetings have been implemented within a site, teams were 2.2% more likely to recommend a placement change (OR=1.022, p=0.006).

The remaining analysis used multinomial logistic regression to predict the restrictiveness of placement recommendations across the three sites, compared with a recommendation for no change in placement (see Table 21). The predictors in this model are the same used in the binomial models, with the exception that all relative caregivers and caregivers' partners are removed from the analysis, and the model includes the presence of foster parents in meetings. The multinomial model fit the data well with $X^2 = 356.5197$, df=42, and p < .0001.  African-American children were less likely to receive recommendations both for less restrictive (OR=0.701, p=0.032) and same-level placements (OR=0.726, p=0.052). Beyond these findings, no other child characteristics significantly predicted recommendations with the exception that for every month's increase in age, children were 5.0% more likely to be recommended for more restrictive placements (OR=1.004, p=0.001).

Some common patterns emerged between meeting characteristics and recommendation restrictiveness. A meeting's location in the community was associated with a strong likelihood of recommending less restrictive (OR=4.293, p < .0001) and more restrictive placements (OR=3.546, p=0.002), but not same-level placements.

**Table 21.**          **Predictors of Placement Restrictiveness**

**(*Comparison Group = No Change in Placement*)**

Multinomial Logistic Regression[1]

| | Less Restrictive | | | Same-Level | | | More Restrictive | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | OR | C.I. | *p* | OR | C.I. | *p* | OR | C.I. | *p* |
| *Gender* | | | | | | | | | |
| Female | 1.000 | -- | -- | 1.000 | -- | -- | 1.000 | -- | -- |
| Male | 1.039 | 0.81–1.33 | 0.760 | 0.829 | 0.65-1.06 | 0.133 | 1.024 | 0.75-1.39 | 0.882 |
| | | | | | | | | | |
| *Race/Ethn.* | | | | | | | | | |
| White/Oth | 1.000 | -- | -- | 1.000 | -- | -- | 1.000 | -- | -- |
| Afric. Amer. | 0.701 | 0.51-0.97 | 0.032 | 0.726 | 0.53-1.00 | 0.052 | 1.010 | 0.67-1.51 | 0.961 |
| Native Amer. | 1.352 | 0.92-1.98 | 0.122 | 1.304 | 0.89-1.90 | 0.169 | 1.152 | 0.66-2.01 | 0.618 |
| Hispanic | 0.741 | 0.46-1.19 | 0.213 | 0.970 | 0.59-1.59 | 0.903 | 0.552 | 0.27-1.14 | 0.107 |
| | | | | | | | | | |
| *Comm. Location* | 4.293 | 2.17-8.50 | <.001 | 1.150 | 0.54-2.48 | 0.719 | 3.546 | 1.62-7.76 | 0.002 |
| | | | | | | | | | |
| *Foster Parent* | 0.434 | 0.33-0.56 | <.001 | 0.951 | 0.74-1.22 | 0.694 | 0.576 | 0.41-0.81 | 0.001 |
| | | | | | | | | | |
| *Sites* | | | | | | | | | |
| Denver | 1.000 | -- | -- | 1.000 | -- | -- | 1.000 | -- | -- |
| Anchorage | 2.210 | 1.41-3.48 | <.001 | 2.920 | 1.83-4.67 | <.001 | 1.283 | 0.69-2.37 | 0.427 |
| Wake Co. | 1.544 | 1.06-2.26 | 0.025 | 3.858 | 2.60-5.74 | <.001 | 2.705 | 1.66-4.41 | <.001 |
| | | | | | | | | | |
| *Mos. TDM implem.* | 1.029 | 1.01-1.04 | <.001 | 1.000 | 0.99-1.01 | 0.993 | 1.011 | 0.99-1.03 | 0.206 |
| | | | | | | | | | |
| *# Family &Relatives* | 1.087 | 0.94-1.25 | 0.248 | 0.874 | 0.76-1.01 | 0.067 | 0.868 | 0.71-1.06 | 0.165 |
| | | | | | | | | | |
| *# Friends N'hood Supports* | 0.656 | 0.48-0.89 | 0.007 | 0.651 | 0.47-0.90 | 0.008 | 0.745 | 0.48-1.17 | 0.199 |
| | | | | | | | | | |
| *# Meetings /Child* | 0.908 | 0.80-1.03 | 0.120 | 1.004 | 0.89-1.13 | 0.942 | 0.979 | 0.85-1.12 | 0.762 |
| | | | | | | | | | |
| *#Children /Family* | 0.938 | 0.88-1.00 | 0.066 | 0.959 | 0.90-1.02 | 0.214 | 0.926 | 0.85-1.01 | 0.082 |
| | | | | | | | | | |
| *Child's Age (mos.)* | 1.001 | 0.99-1.00 | 0.223 | 0.999 | 0.99-1.00 | 0.167 | 1.004 | 1.002-1.007 | 0.001 |

[1]$X^2 = 356.5197$, df=42, p < .0001

If a foster parent attended the meeting, the team was 56.6% less likely to recommended changing to a less restrictive placement (OR=0.434, p < .001) and 42.4% less likely to recommended a more restrictive placement (OR=0.576, p=0.001), although no similar effect emerged for same-level placements. For every level of recommendation restrictiveness, meetings held in Anchorage and Wake County were much more likely to recommend changes than meetings held in Denver, the only exception being no significant association in Anchorage in recommending more restrictive placements. For every month's increase implementing TDM in a site, teams were 2.9% more likely to recommend a less restrictive placement (OR=1.029, p < .001), with no significant relationships with other levels of restrictiveness. For every family member and relative attending meetings, teams were marginally less likely to recommend a same-level placement(OR=0.874, p=0.067). For every friend and neighborhood support attending, however, teams were 34.4% less likely to recommend a less restrictive placement (OR=0.656, p=0.007) and 34.9% less likely to recommend a same-level placement (OR=0.651, p=0.008). For every month's increase in a child's age, the team was 4.0% more likely to recommend a change to a more restrictive placement (OR=1.004, p=0.001).

*Discussion*

The most consistent finding across the sites emerged from caregiver attendance in COP TDMs. The presence of a foster parent or relative caregiver significantly lowered the odds of an overall recommendation for a placement change. Foster parent attendance also significantly lowered the odds of the team's recommending a less restrictive or more restrictive placement, although no such effect emerged for same-level placements.

With the exception of same-level recommendations, caregiver attendance almost uniformly results in a decreased likelihood of changing placements. One reason may be that attendance by a foster parent or relative caregiver already exhibits some level of investment in keeping the child's placement intact, regardless of the reason for the threat of placement disruption. A related reason

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is the level of communication that this attendance allows between the caregiver and the agency staff and service professionals also attending the meeting. By their presence and participation in TDMs, caregivers may be able to present their perspectives of the presenting problem, and communicate to other participants what services and supports would be needed to keep the placement intact. Making these types of linkages within the TDM could mitigate the need to change placements, at least immediately, and indeed this dynamic is precisely what TDM is intended to achieve: balance the risk factors that exist with protective factors that may also exist within a family's support network.

The more friends and neighborhood supports who attend the meeting, the less likely the team will recommend changing placements, specifically less restrictive and same-level placements. Yet, the numbers of family members and relatives in attendance does not appear to be significantly associated with placement change recommendations. These findings suggest that participation from community-based participants may be associated with a better "balance" of decision-making and therefore possibly greater placement stability. At the least, there is a strong association between this participation and lowered likelihood of placement change recommendations. On the other hand, it is somewhat surprising that the numbers of parents and relatives in attendance show no such association. These patterns may reflect the knowledge of services that community-based participants bring to the decision-making process, resulting in an increased ability to support present placements.

Two of the three sites in these analyses tended to be much more likely to recommend placement changes, regardless of the level of restrictiveness. Brief explorations into the context of these agencies may illuminate some of these dynamics. Denver County Human Service (DHS)[21] operates a home based services program that "provides intensive therapeutic and casework services to families for up to eighteen months" for families at high risk of a child's being removed from the home, and for children returning home following a placement. These services

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[21] For more information on DHS, visit http://www.denvergov.org/Family _and_Children.

are for birth families as well as for kinship placements. In addition, DHS operates a Kinship

Support Unit where caseworkers with therapeutic training make weekly visits with kinship care

providers to provide therapy, parenting skills training, and connections to needed agency and

community resources.

The Office of Children's Services (OCS)[22] in Anchorage implements family preservation

services that also include post-reunification follow-up, respite care, and parent skills training.

Similarly, the Division of Social Services (DSS)[23] in Wake County, NC, provides a number of

community-based programs such as family preservation services for families at imminent and

high risk of child removal. DSS also provides services related to parent education, respite care,

reunification services, and violence prevention. Given that these three sites implement similar

programs, it is difficult to attribute difference in the likelihood of placement change

recommendations to differences in program provision. It may be that Denver's Kinship Support

Unit, a program unique to Denver, is one factor affecting the lower likelihood of

recommendations to change placements in this site. This focused service provision may provide

needed support to kinship families such that placements stabilize at a greater rate.

Beyond some programmatic differences, these sites also differ considerably in the types of

children served, the characteristics of meetings, and the patterns of placement recommendations

made for children. Follow-up analyses found that children in Wake County and Anchorage were

more frequently recommended for a placement change, but also tended to be older, than children

served in Denver. This dynamic appears to confirm the findings of Wulczyn and his associates

(2003) that older children are more likely to experience a placement disruption. Yet, children's

age had no significant effect on being recommended for placement changes overall, although

older children tended to receive recommendations for more restrictive placements. A related issue

may be that children in Denver experienced fewer COP TDMs overall than children in Anchorage

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[22] For more information on OCS, visit http://hss.state.ak.us/ocs/FamilyPreservation.
[23] For more information on DSS, visit http://www.dhhs.state.nc.us/dss/community/index.htm.

and Wake County. It would seem that the more COP TDMs children experience within a site, the more likely it will be for children to be recommended to change placements. Yet, counterintuitively, this finding did not emerge across the sites in either the binomial or multinomial logistic models. Each additional child within a family lowered the likelihood of a placement change recommendation overall; however, once caregivers were removed from the analysis, the number of children had no statistically significant effect on the restrictiveness of placement recommendations.

The gender of the child also had no statistically effect on placement recommendations of any kind. No stable pattern emerged for children's race/ethnicity except for African-American children who were at somewhat decreased risk of recommendations for an overall placement change, and specifically recommendations for less restrictive or same-level placements. The location of the meeting in the community increased the risk of receiving any type of placement recommendation, and specifically recommendations for less restrictive and more restrictive placements. Follow-up communication with site administrators in Anchorage indicated that "community location" in this site refers to the local mental health hospital, such that practically any move from this setting represents a move to a less restrictive setting. Similar, but unknown, dynamics may exist in other sites that play a role in determining the restrictiveness of recommendations.

### *Limitations*

This study has limitations. Its primary limitation is the fact the outcome variable is a TDM placement recommendation, but not an actual placement experience. Despite some evidence presented in Chapter 4 that TDM recommendations are achieved in significant numbers for removal TDM meetings, no such studies have been conducted for COP meetings. Therefore, the rate at which these recommendations are accomplished in practice is unknown. Second, given the nested nature of these meetings within a much smaller number of facilitators, it is likely that some

autocorrelation exists in these cases; yet, given the limitations of these administrative data, this study could not control for those potential effects. Also, these data are not matched with sources of information pertaining to the circumstances, and timing, of incidences of abuse and neglect. The administrative data used in this study are of unknown reliability and validity and may be subject to unknown sources of error. The relative lack of contextual information regarding the availability and intensity of services within a locale complicates the interpretation of the restrictiveness of the team's placement recommendations. Related to this limitation is an inability to distinguish, using these data, the type of placement in which the child currently resides. If a relative caregiver attends the TDM then one can safely conclude that the placement is a kinship placement. Yet, if a relative caregiver does not attend, the placement may be kinship or any other type of placement, but these data do not provide these distinctions.

*Conclusion*

The findings from this study point to two broad conclusions over the implementation and efficacy of TDM as a method of child welfare decision-making. The first conclusion pertains to the apparently strong relationship between having foster parents and relative caregivers attend meetings when a placement is at risk of disruption. Whether or not TDM meetings are implemented at a particular site, it makes sense (and is consistent with the premise of the Family to Family TDM model) that encouraging communication among foster parents or caregivers and agency staff, especially during a crisis, would help preserve the placement. Without some type of regular communication, problems in the foster home are likely to remain unknown to agency staff, until they reach a critical stage of crisis in which the placement is already at high risk of disruption.

Second, TDM's impact also appears to differ across these sites, especially regarding the likelihood of making a recommendation for the child to change placements. A related issue may be that significant variation exists across sites in terms of the types and numbers of children

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served and the placement outcomes recommended by teams. It is unclear, however, whether the differences of TDM's impact across the sites reflect differences in site and population characteristics, or whether they hint at variations in the extent and maturity of TDM and Family to Family implementation.

Future research should take into account both the particular circumstances of abuse and neglect, as well as the current and recommended placement settings for children within TDM meetings. Where possible, future research should also account for the nested nature of these data, and the potential influence TDM facilitators have on the decision-making process. If significant variation is explained by cases nested within facilitators, these findings would help illuminate both the implementation process of TDM, as well as the decision-making processes employed by skillfully facilitated groups.

**CHAPTER 7**

CONCLUSION

The studies within this dissertation are the first systematic inquiries into the implementation and effectiveness of Team Decisionmaking. As noted earlier, firm conclusions about TDM's effectiveness await the results of the full-scale evaluation of Family to Family to be completed in 2009. Yet, the results of these studies highlight some interesting dynamics in the implementation process of TDM as well as the manner in which this approach to decision-making may affect placement outcomes for children.

The purpose of this chapter is to provide a discussion of each chapter's findings viewed from the framework of measuring TDM implementation, as outlined in Chapter 3. First, findings and implications from each of the three analysis chapters are briefly reviewed and discussed. Next, the chapter presents research limitations, and concludes with a discussion of how these studies point the way towards future research.

*Overview of Findings*

The conceptual keys to this dissertation involve both the dynamics of balanced decision-making in TDM and the process child welfare agencies undergo to achieve TDM on a systemic level. The first analysis chapter, Chapter 4, provides a descriptive account of aggregate placement dynamics across 3 sites, supplemented by an exploration of common barriers and strategies to TDM implementation. Chapter 5 explores the degree to which agencies implement TDM in close alignment with the Family to Family practice model, as well as a preliminary assessment of the degree to which TDM placement recommendations are associated with the

actual placement experiences of children. Chapter 6 moves away from explorations of

implementation towards a focus on how TDM participants influence the restrictiveness of

placement recommendations for children involved with a placement change decision.


*Chapter 4: Implementation of Team Decisionmaking: Scope and Compliance with the Family to Family Practice Model*

The findings from this implementation study relate to the placement dynamics occurring

across three sites, and how these dynamics may be related to TDM and Family to Family

implementation. In two of these sites, TDM meetings are held in greater numbers than the

children entering care within these sites. This finding suggests that, within these sites, meetings

are being held on a wide systemic scale in compliance with the Family to Family practice

model, and that alternative resources are being sought to prevent unnecessary entries to care,

especially congregate care. Indeed, an exploration of aggregate placement dynamics found that

in one site, shelter use declined by a substantial degree and simultaneously with an increase in

family-based initial placements. While more descriptive than explanatory, these findings suggest

that not only are sites complying with the Family to Family directive of pursuing family-based,

least restrictive placement options (DeMuro & Rideout, 2002), but that these agencies may be

experiencing some success in this implementation.

As outlined in Chapter 3, the framework for measuring TDM implementation suggests that

the practice model will be filtered through the program management and structure of an agency

to influence the level of implementation fidelity. Previous research has documented many

barriers to successful program implementation in child welfare, especially as relates to

administrative and resource limitations (Simmel & Price, 2002; Sprang et al., 2004) that affect

practice-level implementation (D'Andrade et al., 2006). In many ways, the findings from this

study corroborate earlier research. Most of the staff members interviewed expressed

philosophical support for TDM practice, but frontline workers expressed many reservations

related to time and resource constraints. In addition, there appears to be a learning curve as agencies adopt the approach and adopt a paradigm of sharing decision-making control in placement decisions. Yet, the continued expressed enthusiasm among agency staff appears related to their perceptions that TDM provides families access to community resources beyond those the agency has to offer.

*Chapter 5: Implementation Fidelity of Team Decisionmaking*

This study of TDM implementation fidelity examines levels of participation among a variety of attendees, and the extent to which TDM recommendations are associated with placement outcomes. These two broad indicators provide an initial systematic examination of how closely agencies implement TDM in accordance with the Family to Family conceptual framework. Agencies appear to be achieving some measure of success in promoting a critical aspect of TDM implementation – high rates of family and community attendance within meetings. These participants attend a high percentage of meetings, and often in equal or greater numbers than agency staff personnel. From these findings, it appears that a central component of TDM, involving family and community members in the decision-making process, is being achieved to a significant extent in at least two of the three sites studied.

The analysis comparing TDM placement recommendations with actual placements also highlighted some interesting findings. In Denver, while nearly three quarters of emergency TDM recommendations (70.2%) and considered removal TDM recommendations (73.1%) were achieved, the placement dynamics around these different types of meetings appeared to differ. Children typically appear to be placed before an emergency TDM is convened, while considered removal TDMs show no such pattern. A high percentage of considered removal TDMs with a recommendation to remain in the home demonstrated no evidence of a placement (86.4%). These indicators suggest that, while improvements still need to be made, TDM meetings are in fact being implemented on a wide scale within sites and in substantial conformity to the Family

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to Family practice model. Yet, the discrepancies in data entry in one site, particularly in regards to placements with relative caregivers, highlight the ongoing challenges to TDM implementation. Further study is required to examine this issue and measure the extent to which TDM recommendations are successfully implemented in practice.

*Chapter 6: Team Decisionmaking: The Association of Team Composition and Meeting Characteristics With Placement Recommendations*

This final analysis chapter focused less on TDM implementation issues and more on assessing preliminary outcomes for children as measured by TDM placement recommendations. Controlling for a variety of child and meeting characteristics, a consistently strong effect emerged across sites regarding the influence that foster parents and relative caregivers have on recommending placement changes, as well as on the restrictiveness of placement recommendations. Attendance by any caregiver was associated with a lower likelihood of recommending a placement change and foster parent attendance also significantly lowered the odds of recommending less restrictive or more restrictive placements.

Despite the limitations in assessing implementation issues outlined in this chapter, these findings relate closely to the conceptual framework for balanced decision-making in child welfare outlined in Chapter 2. As stated before, this balanced approach seeks to weigh families' risk factors with protective factors that may exist within families' communities and with supportive relatives and friends. In situations related to a potential change in a foster care placement, introducing foster parents or relative caregivers into the decision-making process is intended to improve the gatekeeping around these placement decisions. By drawing on the perspectives of these crucial participants, in theory, TDM meetings should identify alternatives to a placement disruption by identifying the most appropriate resources for the child and family. Indeed, this theory seems to be supported by the finding that increased attendance by community-based

participants also lowers the odds of placement change recommendations. More research is needed into these dynamics, however, specifically related to service availability within sites that likely affect these recommendation dynamics.

### *Limitations*

This dissertation has a variety of limitations that must be considered in assessing its findings. Many of them relate to the state of TDM administrative data when the research was conducted. Sites differed in the extent to which they reliably recorded different TDM types. These differences resulted in having to select different sites across the analysis chapters. For example, Cleveland recorded data for removal meetings, but not placement change meetings; therefore, the third analysis chapter on placement change recommendations switched from Cleveland to Wake Co., a site that does not fully record data for removal TDM meetings. The inconsistencies in site selection across the analysis chapters result in an inability to draw firm conclusions across all three chapters. For example, the effect of participant attendance in Wake County cannot be interpreted in light of TDM implementation issues because the site's implementation status could not be assessed.

The result is that the analysis chapters cannot be directly linked to one another because of the changes in study context. This problem also makes it difficult to explain findings in light of the conceptual framework for measuring TDM implementation. This framework suggested that the TDM practice model would filter through program management and structure to affect practice-level implementation and ultimately placement recommendations for children. However, given the inability to make direct comparisons of all sites across the analysis chapters, this dissertation cannot fairly assess the strength of this hypothesis. Thus, the implementation conceptual framework is more of an organizing construct by which to assess implementation at multiple levels.

Problems with certain data from two sites precluded the use of HLM in the third analysis chapter. In one site, agency policy dictates that several facilitators' names should be classified under one name. The resulting lack of validity made it impossible to pursue measuring facilitator effects in a multi-level model. This problem may not be limited to one site, as the distribution of names in another site suggested a similar dynamic.

Other limitations have been mentioned in each analysis chapter but bear reiteration here. In Chapter 4, researchers had little control over participant recruitment for interviews and focus groups, making it impossible to assess the degree to which the sample was representative of overall agency staff. The measurement of implementation fidelity in Chapter 5 does not take into account the "black box" of TDM, as the quantitative data used cannot completely capture the dynamics occurring within meetings. In addition, data inconsistencies in one site make firm conclusions difficult regarding the rates of successfully implemented TDM recommendations. The outcomes measured in Chapter 6 relate to placement recommendations, but the degree to which these recommendations relate to placement outcomes is unknown. The findings in Chapter 6 are also limited somewhat by a relative lack of contextual information about sites, specifically the availability of services, which may affect placement recommendations for children.

### *Future Research*

Of the five sites selected for inclusion in this dissertation, four have been implementing TDM for five or fewer years. As such, given the challenges in implementing systemic reforms like the kind involved in Family to Family, these sites are at a relatively young stage of implementation. As sites mature in their ability to collect and analyze data, the data limitations discovered in the course of this dissertation will likely improve. It is reasonable to expect that, with experience, agency staff will record data more consistently and accurately on a systemic level such that datasets from these sites will be cleaner and more reliable.

If these data do improve, some of the analysis originally planned for this dissertation will be possible. Merging data from multiple sites for an HLM analysis will account for site- and facilitator-level effects more accurately (Raudenbush & Bryk, 2002). If TDM does in fact improve child welfare decision-making (DeMuro & Rideout, 2002), the effects of different facilitators on recommendations and outcomes should be nil. Moreover, the full scale evaluation of Family to Family will include ten anchor sites in its analysis (F2F Evaluation Team, 2007). The inclusion of these sites allows for the potential to use multilevel models across several sites to measure the consistency of TDM's effects controlling for site differences.

While the findings of this dissertation illuminate some implementation issues and preliminary assessments of outcomes, they also may assist sites in their ongoing self-evaluation efforts. The discovery of the aforementioned data limitations highlights some of the crucial areas sites will need to address to strengthen their data collection and analysis efforts. These self-evaluation activities will serve as the foundation not only for the full scale Family to Family evaluation, but also of the day-to-day practice activities pursued by sites implementing this approach to child welfare decision-making.

Placement Outcome Profile Submitted by Family to Family Sites

| Outcome Data: | Children initially entering placement in: | | | | |
|---|---|---|---|---|---|
| | 2001 | 2002 | 2003 | 2004 | 2005 |
| **Reduce number and rate of children placed away from home**<br>**Reduce disparity in placement rate by racial and ethnic group(s)** | | | | | |
| Number of initial entries | | | | | |
| Overall rate of placement per 1,000 children: | | | | | |
| Rate of placement per 1,000 white children: | | | | | |
| Rate of placement per 1,000 (racial or ethnic minority group) children: | | | | | |
| **Reduce number of children served in institutional settings (initial placements)** | | | | | |
| % Foster Homes | | | | | |
| % Relatives | | | | | |
| % Shelter/ group home/institution | | | | | |
| Other | | | | | |
| **Increase the proportion of children entering placement who are placed in their own neighborhood** | | | | | |
| % children whose first placement is in own zip code | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| % children who are currently placed in own zip code | | | | | |

**Decrease length of stay**

| | | | | | |
|---|---|---|---|---|---|
| Median length of stay (days) | | | | | |
| % children remaining in placement 1 year after initial entry | | | | | |

**Increase number and rate of children reunified with birth families**

| | | | | | |
|---|---|---|---|---|---|
| % children exiting placement who were reunified with birth parent | | | | | |
| % children exiting placement who left to live with a relative guardian | | | | | |

**Increase placement stability**

| | | | | | |
|---|---|---|---|---|---|
| % children with 1 placement during 1st year of placement | | | | | |
| % children with 2 placements during 1st year of placement | | | | | |
| % children with 3 or more placements during 1st year of placement | | | | | |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Average number of placements experienced by children who remain in placement for more than 1 year | | | | | |
| **Increase rate of siblings placed together** | | | | | |
| % children with siblings entering placement who are placed together | | | | | |
| **Decrease reentry** | | | | | |
| % children who exited placement who returned to placement within 1 year | | | | | |

Team Decisionmaking (TDM) Discussion Guide for Interviews and Focus Groups

_____

(1) ***When friends and family ask about what you do for a living, what do you say?***

(2) ***What do you see as some of the major benefits of implementing TDM/Facilitated Staffings?*** (<u>Prompts:</u> *benefits for families,* e.g., strengths and needs, opportunity for voice to be heard, families better understand expectations, etc.; *benefits for agencies,* e.g., improving coordination, providing support to worker, consistent and accountable decisions, etc.; *benefits for the community,* e.g., improving understanding, developing supports; *any other benefits?*)

(3) ***What do you see as some of the major challenges of implementing TDMs/Facilitated Staffings?*** (<u>Prompts:</u> *support from director, TDM 'champion', supervisors, and managers; resources,* e.g., sufficient staff and space, support staff for scheduling, etc.; *coverage that ensures all cases receive staffings,* e.g., training issues, supervisor support, firewalls in place and effectiveness, data usage and leadership response; *participation and attendance,* e.g., parents and relatives, community representatives, agency staff; *facilitation skills,* e.g., training and supervision; *any other challenges?*)

(4) ***Without revealing any confidential information, please tell me about a recent custody staffing you facilitated.*** (<u>Prompts:</u> *safety concerns; attendance; flow of the meeting; plan that was developed,* e.g., services in place, consensus, community involvement)

(5) ***Next I would like to ask you about the implementation of Facilitated Staffings. Based on your own observation of these events or what you have heard about them, please tell me about the rollout of TDM.*** (<u>Prompts:</u> *decision to use TDM;, team development; selection and training of facilitators; timing of TDM related to removal;, rollout status; resources; back-up facilitators; scheduling "special needs" cases involving domestic violence or large groups; other key issues?*)

(6) ***I would also like to ask you about the integration of facilitated staffings with each of the other core Family to Family strategies. What do you see as the major connections between staffings and the other strategies?*** (<u>Prompts:</u> *Resource Family Development and Support; birth parent advocate program; Community Partnerships,* e.g., community partners supporting plans; *Self Evaluation,* e.g., do they ever use or see TDM outcome data to improve practice; *any other issues?*)

(7) ***What kinds of risk, safety and needs assessments were already in place when the agency began TDM implementation?*** *(*<u>Prompts:</u>  *assessments as part of a broader model, such as Structured Decision Making? If not, how were these assessments chosen? If available, obtain information regarding effectiveness, especially predictive validity (if actuarial assessments used)*


(8) ***After implementing TDM, what adaptations needed to be made to use these assessments?*** *(*<u>Prompts:</u>  *when are the assessments completed? Before, during or after TDMs? Who completes the assessments? How do assessments inform placement decision-making in TDM?)*


(9) ***Finally, after implementing TDM, has the agency subsequently adopted the use of any type of assessments?***  (IF YES, prompts: *How did the use of these assessments emerge? How are assessments integrated within TDMs and overall agency practice?*

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