2010-2011

Family Centered Practice
In Three Florida Innovation Sites
Evaluation Brief – Years 1 and 2

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Table of Contents

Evaluation Brief: Family Centered Practice Evaluation In Three Florida Innovation Sites

Introduction

Serving Florida's families in a way that is "family centered" improves efforts to ensure positive outcomes for children. As a practice that has gained prominence nationally, Family Centered Practice (FCP) is beneficial for children in the child welfare system, their families and the communities in which they live. A basic premise of FCP is respectful and inclusive engagement of each family in decisions that affect the well-being of their child(ren). The ultimate objective is to improve a family's ability to care safely for their child(ren) beyond the time services are available.

Florida's level of interest in and commitment to FCP gained momentum after the most recent federal Child and Family Services Review (CFSR) in 2008. The purpose of these reviews is to assess the performance of each state's child welfare agencies in achieving positive outcomes for children and families. Florida's 2009 Quality Improvement Plan (QIP) presented goals and strategies for addressing the findings and recommendations of the CFSR. The implementation of FCP was one of five goals, with the participation of several innovation sites presented as a key strategy. In addition, evaluating Florida's progress in reaching this goal was included in the set of recommendations. Responding to the need for an evaluation and a continuing collaboration among several key agencies, Casey Family Programs stepped up to fund and facilitate these endeavors.

This *Brief* documents two phases of the evaluation of FCP in three Innovation Sites. Phase 1 began in August of 2010 and ended in January of 2011. Phase 2 started at the end of Phase 1 and continued through December 2011. The scope of the evaluation in Phase 2 expanded to include the judiciary, but several data collection methods remained the same. There were six measurement constructs used and these were consistent across the two phases. However, tools used in surveys and questions posed in focus groups were modified to capture more specific responses across child welfare staff positions and follow-up on issues that surfaced during the first year.

In planning the evaluation, consideration was given to the *Family Centered Practice Framework* developed by the Florida Department of Children and Families (DCF). This framework listed "core beliefs" or principles of FCP. These are listed below:

- FCP focuses on the family as a whole and not just the individual child, and supports the family in the context of their own culture, networks and community.

- Families are seen as partners in the change process, helping to define problems and identifying solutions based on their own experiences.

- Engagement with the family by investigators, case managers and other service providers includes trust, genuineness, respect and empathy.

- The child and the family are involved in the assessment, planning, decision-making and participation in services when the safety and the best interest of the child are ensured.

Figure 1 below illustrates the expectation of integrating FCP in all practice activities and related policy or procedural steps when serving families in the child welfare system. In addition, this figure illustrates that this evaluation developed six constructs for FCP, all of which are important when interacting with families. These constructs are described in greater detail in a subsequent section of this *Brief,* but they address family inclusion and accommodation, family engagement, flexible and individualized services, being strengths and needs-based, family empowerment, and family bonding. All of them are essential from the initial contact through assessment, case planning, the provision of services to address identified needs and the formal end of the case. All child welfare staff serving the families, including the Department of Children and Families child protection investigators (CPI), case managers in community-based care agencies, service providers in the communities, and the judiciary should be aware of and implement child welfare services in a manner consistent with the FCP principles and strategies identified in these six constructs.

Figure 1: Integrating Family Centered Constructs into a Practice Model Framework
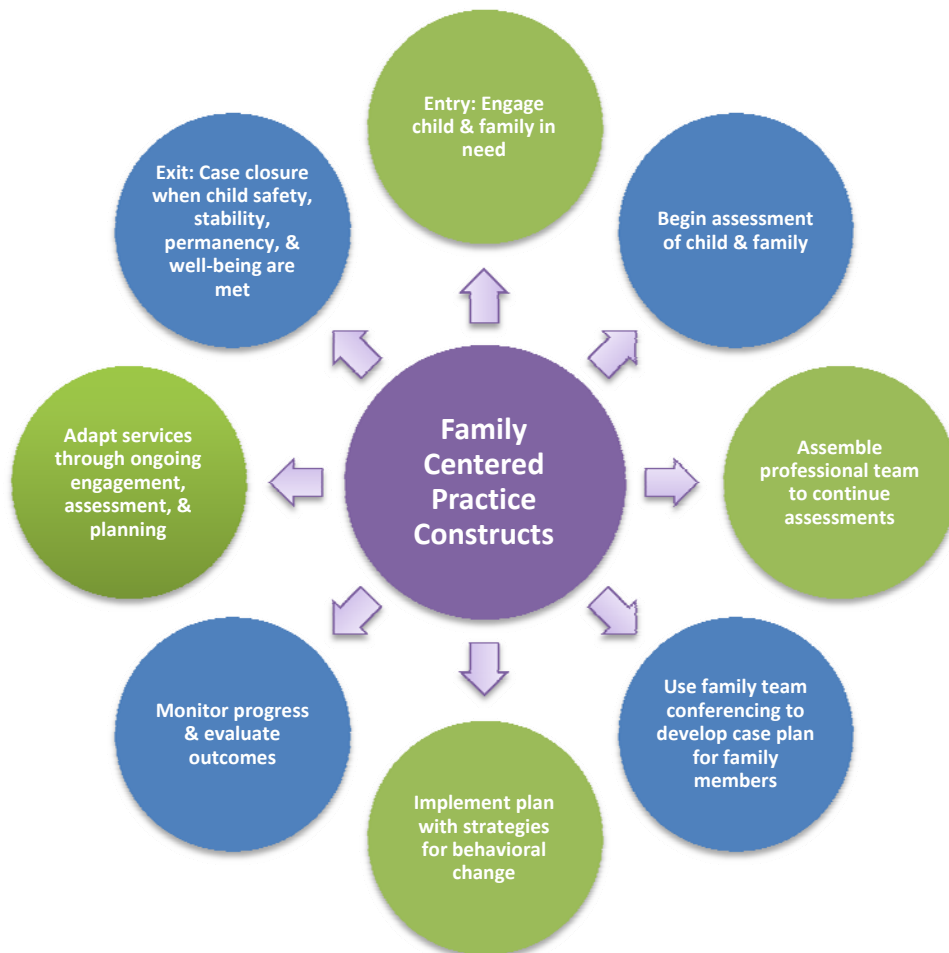
The evaluation innovation sites included the following circuits and counties:

Family Centered Practice Innovation Sites

Circuit 1   Escambia, Okaloosa, Santa Rosa and Walton

Circuits 3/8   Alachua, Baker, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Madison, Suwannee, Taylor and Union

Circuit 11   Miami-Dade

Using a participatory or utilization-focused approach, a Leadership Team convened by Casey Family Programs provided guidance to the evaluators. The members of the Leadership Team were from the Department of Children and Families in Tallahassee, the Department of Children and Families and community-based care agencies at each innovation site, the Office of the State Courts Administrator, and Casey Family Programs. In Phase 1, the emphasis was on collecting evidence about the level of knowledge and degree of implementation of FCP across six constructs. In Phase 2, the emphasis in Phase 1 was continued but expanded to include the judiciary. In addition, Phase 2 encompassed a review of options for calculating FCP outcomes, documenting efficiency in FCP implementation, and adding to our inventory of challenges and lessons learned.

The justification for and movement to FCP in each innovation site had similar origins but the implementation path differed across the sites. In addition to ensuring the safety of children, the primary focus that brought FCP to the forefront in child welfare at each innovation site was a desire to achieve a safe reduction in the number of children in foster care. Related to this primary focus were two additional concerns; preserving families, and when that was not possible, achieving timely permanency for children in out-of home care. Each innovation site took a different path in their planning approach, training and technical assistance, service delivery protocols and case management strategies (e.g., solution-based casework, structured decision making). An historical account of how FCP emerged and the procedures and practices at each innovation site were documented in site chronicles. These chronicles serve as important references for future replication of FCP across Florida.

Evaluation Methods

The FCP evaluation included quantitative and qualitative data collection methods in Phases 1 and 2. The first method conducted was a ***Web-based survey.*** The survey solicited responses that were appropriate for measuring and developing benchmarks for FCP based on knowledge, implementation activities and techniques, and satisfaction. The target population in the first FCP online survey (Phase 1) was a wide range of Department of Children and Families and community-based care staff serving families at each site, including service providers. The target population for the second FCP online survey (Phase 2) was more selective and included only case managers, CPIs, case manager supervisors and CPI supervisors.

This evaluation also included a wide selection of qualitative methods. ***Case file reviews*** were conducted during Phase 1, as well as ***semi-structured interviews with child welfare staff*** (CPIs, case managers and service providers) who worked with the families in the selected case files. The number of case files reviewed was 20 with between six and seven reviewed at each site. The total number of interviews with child welfare staff was 41. These interviews were with CPIs, case managers, service

providers and supervisors. ***Interviews with judges, Children's Legal Services (CLS) attorneys and Guardian ad Litem (GAL) volunteers*** were conducted during Phase 2. During Phases 1 and 2, ***focus groups*** were conducted at each innovation site. In Phase 1, these focus group sessions were with CPIs, case managers, supervisors and service providers. They served as an important opportunity to obtain views on training, implementation challenges, benefits to families, and the essential steps, activities, approaches, or services that contribute to successful FCP implementation. In Phase 2, the focus groups were conducted with case manager supervisors and CPI supervisors. The theme for the second round of focus groups was challenges implementing FCP, including those identified during Phase 1, as well as those that surfaced during Phase 2. A final method used was 22 ***semi-structured interviews with families served.*** Some of the families interviewed were in the case files reviewed. These interviews occurred during Phase 1, and each innovation site was represented in this set of interviews**.** The family interviews provided confirmation of some evidence shared by child welfare staff and additional perspectives on FCP implementation.

The selection of multiple methods allowed a "mixed methods" approach in order to compare and triangulate findings across innovation sites and across qualitative and quantitative methods. The assistance of members of the Leadership Team and child welfare staff at each innovation site was essential in the completion of each method. The methods, target populations, sample sizes and dissemination approaches are displayed in Figures 2 and 3 for Phases I and 2 below.

Figure 2: Phase 1 – Data Collection Methods, Target Population/Samples, and Dissemination Approaches

Methods (Three Innovation Sites)	Target Populations and Sample Sizes	Dissemination Approaches	Documents
First FCP Online Survey (September/October, 2010)	Child Welfare Staff (CWS) Circuit 1 (121); Circuits 3/8(126); Circuit 11(84); 331 total respondents	Webinar	Evaluation Brief: Phase I, Materials for Summits, Innovation Site Chronicles, and Executive Summary for the Evaluation Brief
Case File Review (October/November, 2010)	Child Welfare Clients (20 cases) Circuit 1(6); Circuit 3/8(7); Circuit 11(7)	Webinar	
Semi-Structured Interviews (October/November, 2010)	CPIs (13), CMs(16), Supervisors/Other(5), and Service Providers(7)	Webinar	
Focus Groups (November/December, 2010)	CPIs, CMs, Supervisors, and Service Providers	Webinar	
Document Review	Each Innovation Site	Chronicles	
Secondary Data Analysis	QA Standards/Analysis of FSFN Extract	Ongoing	
Semi-Structured Interviews (January, 2011)	Families in Selected Cases Circuit 1 (8); Circuits 3/8(3); Circuit 11 (11); 22 total interviews	Webinar	

Figure 3: Phase 2 – Data Collection Methods, Target Population/Samples, and Dissemination Approaches

Methods (Three Innovation Sites)	Target Populations and Sample Sizes	Dissemination Approaches	Documents
Semi-Structured Interviews (April 2011)	Guardian ad Litem Volunteers (19), CLS Attorneys (21), and Judges/Magistrates (10) in the Dependency Courts; 50 total interviews	Webinar Journal Article DCF Pathways to Independence Summit 2011 Florida Coalition for Children Conference 2011 (FCFC)	Evaluation Brief: Phases 1 and 2 Executive Summary for the Evaluation Brief
Second FCP Online Survey (September/October 2011)	Child Welfare Staff--Case Managers (95), CPIs (71), CM Supervisors (27) and CPI Supervisors (23); 230 total respondents (includes "other" category)	Conference Call Summit (FCFC)	
Second Round of Focus Groups (September/October 2011)	CPI Supervisors and CM Supervisors	Conference Call Summit (FCFC)	
Review of Child Welfare Measures and Secondary FSFN Data Analysis	FCP Outcomes: Measures available on the website for the Center for the Advancement of Child Welfare Practice using FSFN; Measures calculated using FSFN Data Extract for a Cohort	Conference Call	
Document Review and Conference Calls	Family Centered Practice Efficiencies	Conference Call	

Family Centered Practice Constructs

In addition to the compilation of responses to all questions in the online survey, posed during interviews and focus groups, and documented in the case files, measurement of the implementation of FCP encompassed six constructs. These constructs stem from the principles in Florida's *Framework for Family Centered Practice* and a review of the literature. They also relied on a "wide lens" in order to ensure comprehensive coverage of this practice. Figure 4 displays the six constructs with measurement criteria used for each.

Figure 4: Family Centered Practice Constructs

Family Inclusion, Accommodation and Participation
- Family, support system members, caregivers and older children invited to and actively participated in meetings/hearings
- Family and collateral contacts interviewed
- Accommodated family schedules for meetings
- Parent provided information about possible relative placements
- Efforts made to prevent disruption of education and placements
- Involved parents in daily life of child in out-of-home care (co-parenting)

Family Engagement
- Honesty and transparency
- Respect and cultural-sensitivity
- Trust-based relationships
- Responsiveness
- Genuine care and concern
- Cooperation and compromise
- Encouragement, support and positive reinforcement
- Active listening
- Positive communication
- Engaged all involved with the child

Flexible, Adaptable and Individualized Services
- Individualized services/plans
- All major needs addressed
- Services provided to ensure the child(ren)'s academic success, as needed
- Additions or changes made to services or plans when needed based on the family s needs, strengths or circumstances

Strengths and Needs Based
- Acknowledged family strengths
- Identified family and individual strengths and needs during assessments
- Developed service plans based on strengths and needs

Family Bonding and Strengthening
- Efforts made to prevent child removal
- Focus on improving all relationships in support system
- Increased visitation rights and responsibilities, when safe
- Provided and encouraged visitation (parent & sibling)
- Clear preference for...
  - Child placements that facilitate normalized visitation with parents/siblings
  - Child placements that preserved family member connections
- Placing children with a relative or non-relative caregiver based on child(ren)'s needs or if no relative caregiver is available

Family Empowerment and Autonomy
- Made efforts to empower, encourage and support parents
- Provided opportunities for parents to expand parenting knowledge, competencies and skills
- Parents and support system members took responsibility for child(ren s) physical, medical, mental health and educational needs
- Parents assumed and maintained responsibility for self-sufficiency and their needed treatment, recovery, rehabilitation and skill building

Family Centered Practice Knowledge, Utilization, Perceptions and Other Evidence

During October/November of 2010 and September/October of 2011, online surveys of a broad range of child welfare staff were conducted in each innovation site. The survey responses addressing *knowledge* of FCP generated the first set of findings summarized below. The second set of findings refers to the *use* of FCP. *Perceptions* of FCP are addressed in the next set of findings. Responses to a question regarding Family Team Conferences as a demonstration of FCP are summarized in the final set of findings in this section of the *Brief*.

Knowledge of Family Centered Practice

In the first online survey during Phase 1, a high percentage of the survey respondents agreed that they know what FCP is with 87.7 percent of the CPIs agreeing with this statement and 86.8 percent of the case managers agreeing. In Phase 2, the response percentages indicating knowledge of FCP were higher, between 90 percent and 100 percent. See Table 1 below. Even though survey respondents were not asked to address each FCP construct, they were asked to describe what FCP means to them. The responses to this question were analyzed with corresponding percentages calculated. In addition to the percentages of respondents agreeing that they know what FCP is, two others sets of percentages are displayed in Figure 6. These percentages refer to voluntary and unprompted coverage of FCP constructs in the respondents' descriptions of what FCP means to them. While there is variation in the percentages across the four positions in Figure 5, reference to at least one or two FCP constructs occurred at relatively high levels and is promising as an indication of FCP knowledge.

Table 1: Responses indicating whether they know what FCP is
(FCP Online Survey, Phase 2, 2011, All Innovation Sites)

Response Item	Case Managers	Child Protection Investigators (CPI)	Case Manager Supervisors	CPI Supervisors
No	1.1%(1)	2.8%(2)		
Unsure	3.2%(3)	2.8%(2)		4.3(1)
Yes	95.8%(91)	94.4%(67)	100.0%(27)	95.7%(22)
Total	100.0%(95)	100.0%(71)	100.0%(27)	100.0%(23)

Figure 5: Knowledge of Family Centered Practice by Staff Position at All Innovation Sites
(FCP Online Survey, Phase 2, 2011)
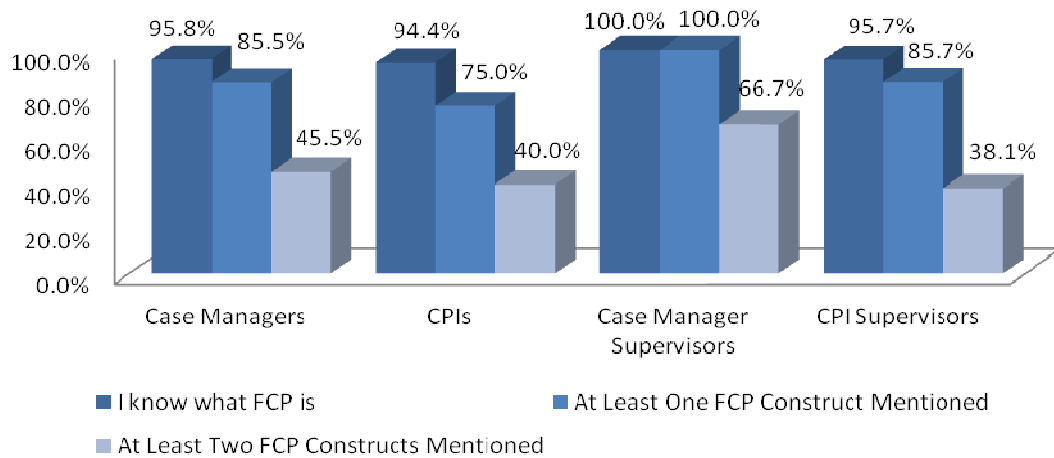
Based on responses in the Phase 2 FCP online survey, several child welfare staff positions within each innovation site had 100 percent of the respondents indicating that they know what FCP is. These positions within each innovation site were case managers, case manager supervisors and CPI supervisors in Circuit 1, case manager supervisors and CPI supervisors in Circuits 3/8 and case manager supervisors in Circuit 11.

As indicated earlier in an explanation of Figure 5, open-ended responses referring to knowledge of FCP were requested in both the first and second online surveys. Among a number of benefits that enrich our understanding of whether respondents have an accurate and comprehensive knowledge of FCP, the qualitative data allow evaluators to identify the extent of the coverage of the FCP measurement constructs. The responses include descriptions of FCP or what it means to them and what they think are good demonstrations of FCP. Some of the responses in the second FCP online survey are highlighted below. Among the 95 case manager survey respondents, 90 or 94.7 percent provided a description of what FCP means to them. A few of these responses are below (bold highlighting of terms and phrases that are FCP construct specific):

▸ *Establishing a **partnership with families** in an effort to actively **engage** them in the process of **identifying strengths**, then **building on those strengths** by **working with the family to develop a plan of action** that can help them keep their children safe.*

▸ *Family centered practice involves **empowering families to make decisions** that will have an impact on their lives and **be a part of the decision making process** for the problems that the family is facing.*

▸ *It means that **keeping the family safe and together** is the most important goal I have for all my families. It means **placing kids with relatives and keeping siblings together**. It means that I understand addiction and **how to help parents overcome** this. It does NOT mean that parents should have 101 chances making it harder for the children before their rights are terminated. Important difference!*

▸ *The family is included in some of the day to day decisions* you make. It is *not always taking the authoritarian stance,* but instead *looking at where the family is coming from and the progress they made with empathetic eyes.* Empathy is defined by me as *putting yourself in your client's shoes,* so you can *get a better perspective of where they have been and where they are going* with your help.

▸ *Families are allowed to be involved in decision making* about their issues and desired outcomes *instead of just telling them what they should do.*

Among 71 CPI survey respondents, 60 or 85 percent included entries in response to the same question. Examples of CPI descriptions of what FCP means to them were (bold font highlighting terms and phrases that are FCP construct specific):

▸ *Family Centered Practice means to **include the family** in the child protection process. The **family can help assist with identifying problems and solutions**. This way **the family feels that they have some say in what happens in their lives**. If the **family can recognize their strengths and weakness instead of an outsider telling them what's wrong** they would be **more willing to cooperate with services**.*

▸ *Family Centered Practice means: 1**. Engaging and treating a family like you would like to be treated (Treating with respect and empathy)**; 2. **Allowing families to make decisions** as to what **their needs are** and what they want. **(Nothing about me without me)**; 3. Provide what the family asks for if possible. **(Be honest and fair)***

▸ *Family Centered Practice is an approach of working with families in a manner which **maximizes the strengths of the family**. It incorporates **the team approach to making decisions with the family**, employing **persuasion in the form of encouragement, rather than coercion**. It helps the family to grasp the big picture of taking care of the small items before they become big challenges; it **empowers the family** to take the necessary steps to have their **needs met with assistance/support from a case manager** as an advocate.*

Summary measures of the extent of the coverage of the six FCP constructs across staff positions and all innovation sites also were developed in analyses of the FCP online survey qualitative data. See Table 2 and Figure 6 below. The percentages displayed in Table 2 for each FCP construct were based on the number of times an FCP construct was mentioned in the responses indicating what FCP means. They are average response percentages across all four staff positions for each FCP construct. Similar to qualifications mentioned earlier when interpreting the percentages in Figure 6, it is important to note that the survey question did not specifically request the respondent to address FCP constructs. Despite the absence of a specific FCP construct prompt, the percentages in Figure 6 are impressive and provide an indication of the familiarity with and emphasis on each FCP construct across all positions and all innovation sites.

Table 2: Coverage of FCP Constructs in Open-Ended Responses to the Question, What does Family Centered Practice Mean to You? by Staff Position at All Innovation Sites (FCP Online Survey, Phase 2, 2011)

Family Centered Practice Constructs	Case Managers (% of 90 Responses)	CPIs (% of 60 Responses)	Case Manager Supervisors (% of 21 Responses)	CPI Supervisors (% of 21 Responses)
Family Inclusion, Accommodation, and Participation	56(62.2%)	31(51.6%)	13(61.9%)	13(61.9%)
Family Engagement	9(10%)	6(10%)	7(33.3%)	2(9.5%)
Flexible, Adaptable, and Individualized Services	23(25.5%)	11(18.3%)	6(28.5%)	4(19%)
Strengths and Needs Based	30(33%)	17(28.3%)	8(38.1%)	7(33.3%)
Family Empowerment and Autonomy	9(10%)	6(10%)	4(19%)	2(9.5%)
Family Bonding and Strengthening	10(11.1%)	4(6.6%)	0	0

Figure 6: Family Centered Practice Construct Coverage for All Positions and Innovation Sites: Percent of Respondents Reporting Each Construct (FCP Online Survey, Phase 2, 2011)
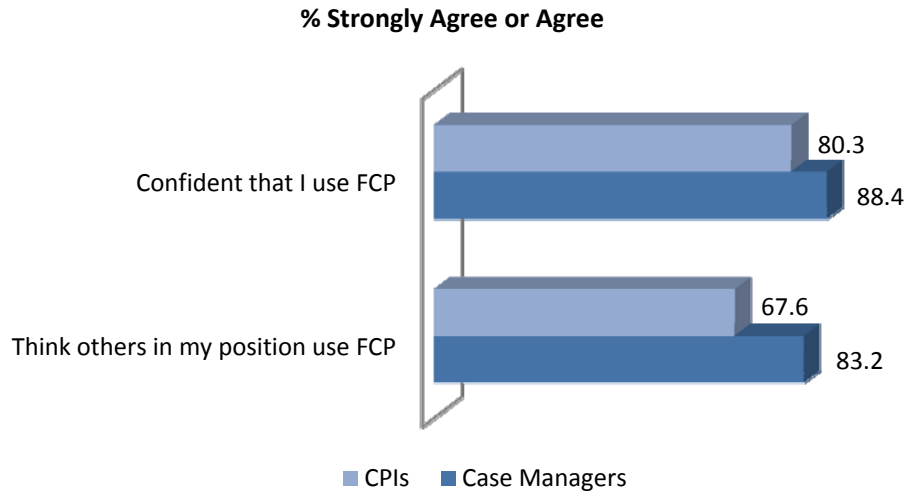

Average % All Positions
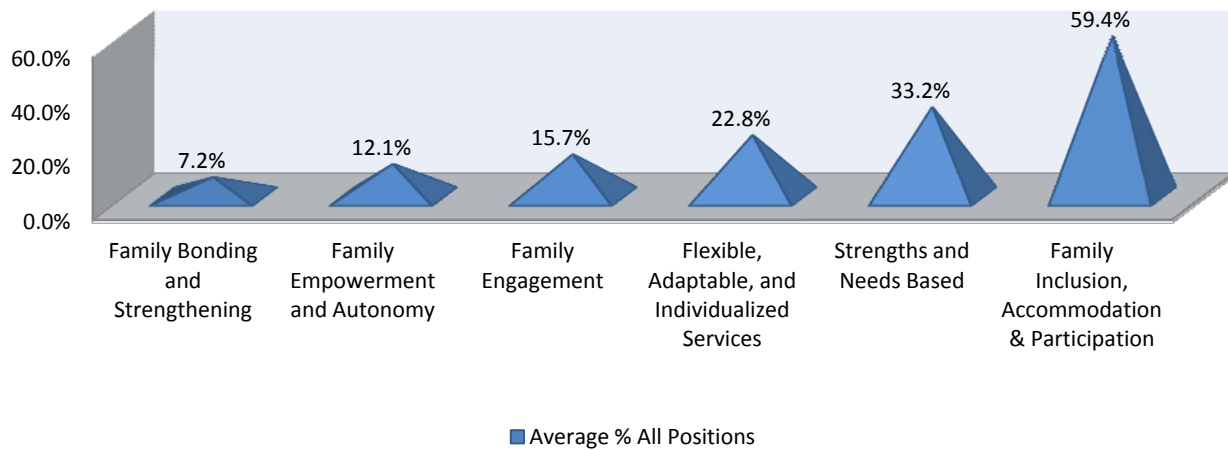
A new series of questions addressing knowledge of FCP was included in the second (Phase 2) online FCP survey. These questions asked the respondents to rate others in their position as well as counterparts in other positions on their knowledge of FCP. When given the opportunity to rate themselves and others on knowledge of FCP, there were substantial differences. Only 76.8 percent of case managers agreed that CPIs are very knowledgeable about FCP. However, 90 percent of CPIs agreed that CPIs are very knowledgeable about FCP. Case managers also rated others in their position higher.

Among case managers, 95 percent agreed that case managers are very knowledgeable about FCP, but only 86 percent of CPIs agreed that case managers are very knowledgeable about FCP. When rating service providers, CLS attorneys and GAL volunteers on their knowledge of FCP, CPI supervisors had the lowest percentages strongly agreeing that these counterparts were knowledgeable about FCP. CPI supervisor response percentages ranged from 4.3 percent for CLS attorneys to 13 percent for GAL volunteers.

Utilization of Family Centered Practice

In addition to knowledge of FCP, this evaluation was interested in the use of FCP. A relatively high percentage of survey respondents in Phase 1, 76.4 percent, agreed that they used FCP. However, when asked to indicate whether most or all of the staff they work with used FCP, this percentage dropped to 66.2 percent. In Phase 2, the percentages of case managers and CPIs agreeing to a similar question on the online survey were higher (88.4% and 80.3%, respectively). When rating others in their position on whether they practiced FCP, the percentages dropped again, but the decreases varied across the CPIs and the case managers. Refer to Figure 7.

**Figure 7: Family Centered Practice Utilization by Case Managers and CPIs
(FCP Online Survey, Phase 2, 2011)**

% Strongly Agree or Agree

	CPIs	Case Managers
Confident that I use FCP	80.3	88.4
Think others in my position use FCP	67.6	83.2

Perceptions of Family Centered Practice

During Phase 1 and Phase 2, perceptions of FCP were measured in a variety of ways. Benefits for families and job satisfaction using FCP were of interest in both phases. Agreement that there are benefits to the families when FCP is used was firmly established among the survey respondents in both Phases 1 and 2. Among all survey respondents in Phase 1, 83.7 percent thought that FCP benefits families. In Phase 2, the percentages for case managers and CPIs were also high for this item, over 85 percent. Job satisfaction improvement when using FCP remained at a moderate level across both phases, around 50 percent. However, there were differences between case managers and CPIs observed when comparing responses across the two surveys. The percentage of case managers agreeing that FCP improved their satisfaction with their job jumped from 47.2 percent in Phase 1 to 57.8 percent in Phase 2. The satisfaction percentages for CPIs remained at 53 percent. An additional survey item asked about whether families appreciated their assistance when practicing FCP and provided another measure of staff perception of FCP. Percentages measuring strongly agree or agree responses to several items that address perceptions of FCP in Phase 2 are displayed in Figure 8 below.

**Figure 8: Perceptions of Family Centered Practice by Case Managers and CPIs
(FCP Online Survey, Phase 2, 2011)**
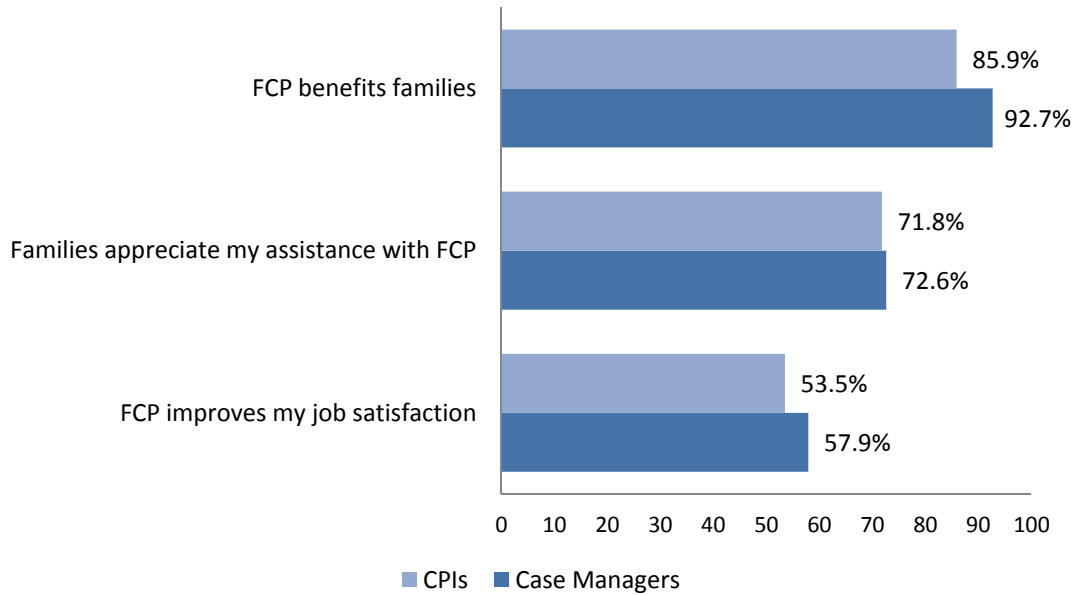
The perception of staff regarding FCP and the achievement of goals for cases offers another indication of its strengths. The goals listed in the online survey tool included family preservation, family reunification, timely permanency, prevention of child abuse and neglect, child safety and child well-being. The respondents were asked which goals were "more likely" to be achieved with FCP. Table 3 below displays the percentages of respondents in each staff position with all innovation sites combined. While most of the percentages are relatively high (> 75%), the percentages indicating the highest endorsement of FCP in achieving goals referred to family preservation, child safety, family reunification and child-well-being. Case manager supervisors had the highest percentages for all but one of the goals.

**Table 3: Percentage of Respondents Identifying Goals More Likely to be Achieved
with Family Centered Practice by Staff Position, All Innovation Sites
(FCP Online Survey, Phase 2, 2011)**

Goals Achieved with Family Centered Practice	Case Managers	CPIs	Case Manager Supervisors	CPI Supervisors
Family Preservation	78.9%	83.1%	92.6%	91.3%
Family Reunification	86.3%	63.4%	92.6%	78.3%
Timely Permanency	80.0%	50.7%	92.6%	60.9%
Prevention of Child Abuse and/or Neglect	74.7%	67.6%	70.4%	65.2%
Child Safety	77.9%	76.1%	88.9%	82.6%
Child Well-Being	78.9%	73.2%	85.2%	78.3%

Staff opinions of several FCP practices were of particular interest in the second FCP online survey. The objective was to identify which FCP practices had a high level of agreement and/or support among case managers, CPIs, case manager supervisors and CPI supervisors. This set of responses was considered valuable feedback for each site in identifying where subsequent emphasis might be needed and for replication of FCP in other circuits. While 19 FCP practice statements were included in the survey, not all of them are displayed in Table 4 below. The innovation sites are combined in this table.

Table 4: Perceptions/Opinions of Family Centered Practices by Position
(FCP Online Survey, Phase 2, 2011, All Innovation Sites)

Opinion of FCP Practices Survey Statements	Strongly Agree/Disagree or Agree/Disagree	Case Managers	Child Protective Investigators	Case Manager Supervisors	CPI Supervisors
It is NOT important for family members to be involved in making decisions about their family and their case.	Strongly Disagree	72.6%(69)	64.8%(46)	70.4%(19)	69.6%(16)
	Disagree	24.2%(23)	25.4%(18)	22.2%(6)	21.7%(5)
	Strongly Disagree or Disagree	96.8%	90.2%	92.6%	91.3%
In out of home cases, it is important for the caregiver(s) (foster parent or relative/non-relative caregiver) and the biological parent(s) to work together.	Strongly Agree	47.4%(45)	38.0%(27)	63.0%(17)	47.8%(11)
	Agree	37.9%(36)	45.1%(32)	33.3%(9)	39.1%(9)
	Strongly Agree or Agree	85.3%	83.1%	96.3%	87.0%
Using Family Centered Practice does NOT increase the amount of positive communication and trust between me and the members of the family.	Strongly Disagree	42.1%(40)	42.3%(30)	51.9%(14)	39.1%(9)
	Disagree	33.7%(32)	29.6%(21)	37.0%(10)	39.1%(9)
	Strongly Disagree or Disagree	75.8%	71.9%	88.9%	78.2%
Cases are more successful if I sufficiently engage the family.	Strongly Agree	50.5%(48)	39.4%(28)	66.7%(18)	60.9%(14)
	Agree	30.5%(29)	49.3%(35)	29.6%(8)	34.8%(8)
	Strongly Agree or Agree	81.0%	88.7%	96.3%	95.7%
It is important for me to be aware of and sensitive to cultural differences between the family and me.	Strongly Agree	72.6%(69)	53.5%(38)	55.6%(15)	73.9%(17)
	Agree	23.2%(22)	40.8%(29)	40.7%(11)	26.1%(6)
	Strongly Agree or Agree	95.8%	94.4%	96.3%	100%
The services provided to the family should address the specific needs of that particular family.	Strongly Agree	74.7%(71)	56.3%(40)	74.1%(20)	60.9%(14)
	Agree	24.2%(23)	38.0%(27)	25.9%(7)	30.4%(7)
	Strongly Agree or Agree	98.9%	94.4%	100%	91.3%

Opinion of FCP Practices Survey Statements	Strongly Agree/Disagree or Agree/Disagree	Case Managers	Child Protective Investigators	Case Manager Supervisors	CPI Supervisors
I look for strengths in each individual and family I work with.	Strongly Agree	69.5%(66)	52.1%(37)	70.4%(19)	47.8%(11)
	Agree	28.4%(27)	38.0%(27)	29.6%(8)	47.8%(11)
	Strongly Agree or Agree	97.9%	90%	100%	95.7%
In my work with families, the members of the family are given opportunities to make decisions and provide input about their family.	Strongly Agree	50.5%(48)	40.8%(29)	51.9%(14)	34.8%(8)
	Agree	44.2%(48)	47.9%(34)	37.0%(10)	43.5%(10)
	Strongly Agree or Agree	94.7%	88.7%	88.9%	78.3%
The relationship between a family and their extended family and/or support system members can be an important factor in their success.	Strongly Agree	56.8%(54)	53.5%(38)	70.4%(19)	52.2%(12)
	Agree	33.7%(32)	40.8%(29)	22.2%(6)	39.1%(9)
	Strongly Agree or Agree	90.5%	94.4%	92.6%	91.3%
In out of home cases, it is preferable for children to be placed with a relative or non-relative caregiver the children know, preferably one who lives in the same area as the parent(s).	Strongly Agree	60.0%(57)	52.1%(37)	66.7%(18)	60.9%(14)
	Agree	34.7%(33)	39.4%(28)	25.9%(7)	21.7%(5)
	Strongly Agree or Agree	94.7%	91.5%	92.6%	82.6%
It is important for all parties serving and involved with the family to work together.	Strongly Agree	74.7%(71)	62.0%(44)	77.8%(21)	73.9%(17)
	Agree	23.2%(22)	35.2%(25)	22.2%(6)	21.7%(5)
	Strongly Agree or Agree	97.9%	97.2%	100%	95.7%

Differences were expected across staff positions in the responses to the statements listed in Table 4 above due to variations in responsibilities and time spent with the families. It is also recognized that some practices might not be emphasized as much as others in the circuit protocols developed to serve families using FCP. Response differences between these four positions, particularly those between case managers and CPIs, are still noteworthy and merit highlighting. As one example, a higher percentage of case managers (50.5%) than CPIs (39.4%) strongly agreed that "Cases are more successful if I sufficiently engage the family." Responses to a statement about cultural sensitivity indicated that a high percentage of case managers, 72.6 percent, and a much lower percentage of CPIs, 53.5 percent, strongly agreed that it was important to be "aware of and sensitive to cultural differences between me and the family."

Responses to some statements indicated substantial differences between the combination of case managers and their supervisors and the CPIs and their supervisors. Strong agreement with "looking for strengths in each individual and family" was evident among the case managers and case manager supervisors (around 70%) compared to responses among the CPIs and CPI supervisors (between 48%

and 52%). The case manager supervisors had a high percentage (70%) strongly agreeing that "the relationship between a family and their extended family and/or support system members can be an important factor in their success," while the other positions had between 52 percent and 57 percent strongly agreeing with this statement. As a final statement highlighted here, three of the four positions had over 73 percent of their respondents strongly agreeing that "it is important for all parties serving and involved with the family to work together." The lowest percentage strongly agreeing with this statement was for CPIs at 62 percent.

The level of support for the statements referring to FCP practices also varied across the innovation sites. Three statements with the highest level of support measured as the highest average percentage of "strongly agree" responses across positions in each innovation site are displayed in Table 5.

**Table 5: "Top Three" FCP Practices that have the Highest Level of Staff Support
in each Innovation Site
(FCP Online Survey, Phase 2, 2011)**

FCP Practices	Circuits		
	1	3/8	11
1. It is important for family members to be involved in making decisions about their family and their case.	✓	✓	
2. Helping families become more self-sufficient is part of my role in a case.	✓		
3. I look for strengths in each individual and family I work with.	✓		
4. It is important for all parties serving and involved with the family to work together.		✓	✓
5. In out of home cases, it is preferable for children to be placed with a relative or non-relative caregiver the children know, preferably one who lives in the same area as the parent(s).		✓	
6. The services provided to the family should address the specific needs of that particular family.			✓
7. It is important to be aware of and sensitive to cultural differences between the family and me.			✓

Perceptions of Family Team Conferences

An activity that is included in the FCP protocols in each innovation site is a family team conference (FTC). There were several questions included in the second FCP online survey that addressed different approaches in the timing of family team conferences and/or locations. Preferred frequencies for different family team conference conditions and requirements were compiled by staff position and innovation site. Additional probing on family team conferences in the second FCP online survey asked respondents to indicate if and why they were a good demonstration of FCP. This set of questions also asked the respondents if they had participated in a family team conference. Among the case managers, 10 (or 10%) of the respondents had not participated in a family team conference. The number of CPI respondents that had not participated in a family team conference was 25 (or 35%).

Comparing the case manager percentages calculated for the first FCP online survey with the second FCP online survey, the percentage that had not participated in a family team conference was higher in the first survey, approximately 25 percent. Reasons that family team conferences are a good demonstration of FCP that were identified by at least 70 percent or more by at least two of the four staff positions are displayed in Table 6 below. For most of the items listed in Table 6, the percentages displayed for the CPIs and CPI supervisors are lower than those for the case managers and case manager supervisors.

Table 6: Percentage of Respondents Identifying Reasons Family Team Conferences are a Good Demonstration of FCP by Staff Position at All Innovation Sites Combined (FCP Online Survey, Phase 2, 2011)

Reasons FTCs are a Good Demonstration of Family Centered Practice	Case Managers	CPIs	Case Manager Supervisors	CPI Supervisors
Promote active participation by family members	83.2%	54.9%	81.5%	73.9%
Promote trust-based relationships	70.5%	50.7%	70.4%	65.2%
Promote respect of the family	71.6%	53.5%	74.1%	73.9%
Promote honesty	72.6%	53.5%	70.4%	60.9%
Promote openness	80%	56.3%	77.8%	60.9%
Recognize individual and family needs and services	81.1%	59.2%	81.5%	78.3%
Focus on family and individual strengths and needs	82.1%	54.9%	74.1%	69.6%
Encourage other relatives or family friends to have a role in caring for the child(ren)	70.5%	47.9%	77.8%	65.2%
Encourage decision making by the family members	81.1%	50.7%	74.1%	73.9%

Additional Findings in Evaluation Brief for Year 1 (Phase 1)

There were additional findings compiled and presented in the *Family Centered Practice in Three Florida Innovation Sites: Evaluation Brief-Year 1 (Phase 1)* that are not included in this *Brief. (*Go to http://www.ounce.org/pdfs/FL_FCP_Brief.pdf). They include: (a) a set of FCP "essentials" that were identified during the focus groups with child welfare staff and service providers; (b) a comprehensive display of qualitative evidence of FCP by staff position collected through semi-structured interviews and focus groups; and (c) case file review data about use of FCP constructs.

Family Centered Practice Outcome Indicators

A component of the evaluation addressed more extensively during Phase 2 was the identification of indicators for FCP outcomes. In the original evaluation design and logic model, there were short-term and long-term outcomes identified. The short-term outcomes were a reduction in the out-of-home placements and an increase in job satisfaction. Reduction in out-of-home placements is consistent with the foster care redesign that has been a central focus for several circuits in Florida over the past few years. Percentages representing the level of agreement that FCP improved their job satisfaction were presented in an earlier section of this *Brief*. Referring to this measure of job satisfaction, the percentages among case managers indicated an increase in the level of agreement with this statement across the two phases, but the percentages for all survey respondents combined remained consistent across the two phases. The long-term outcomes identified in the original design and logic model were an increase in reunification of children with families and a decrease in the reoccurrence of child maltreatment.

In consultation with members of the evaluation Leadership Team representing the Department of Children and Families, it was recommended that this evaluation consider reliance on child welfare measures that were available through an existing website hosted by the Center for the Advancement of Child Welfare Practice at the University of South Florida. There were several measures on this website reviewed for this purpose, with the selection of measures that had attributes considered most consistent with FCP and appropriate for this evaluation narrowed to the following:

- Rate of Children Active in Out-of-Home Care (per 1,000 children)
- Rate of Children Active in In-Home Care (per 1,000 children)
- Percent of Children in Out-of-Home Care in Relative Placements
- Percent of Children Entering in Out-of-Home Care Reunified within 12 months (C 1.3)
- Percent of Children Discharged due to Reunification with Parents/Caretakers
- No Reoccurrence of Maltreatment at 6 or 12 months

When reviewing the measures listed above with members of the Leadership Team, several limitations associated with each measure and their use for measuring progress with FCP were identified. The variations in the time periods for full implementation of FCP practice in each site were noted often during the evaluation. Circuit 1 considered their experience with and more focused implementation of FCP to be earlier than the other innovation sites, going back to 2007. In the other two innovation sites, development of protocols, policy and form changes as well as essential foundational training and coaching occurred at varying paces. The summer of 2011 was considered a more accurate time point for full FCP implementation in Circuits 3/8 and a similar assessment was believed to be the case for Circuit 11.

Other reasons caution is advised when referring to the outcome indicators are related to data entry and the extent to which a measure reflects the performance of one or more child welfare units and service providers. The prevalence of reporting incidences to the hotline and conducting investigations in each community varies across sites. The handling of cases that are investigated and in need of services but diverted from the child protection system varies across the sites. Diversion cases are not always entered in the statewide data system, Florida Safe Families Network (FSFN), or included in the numbers that are compiled for the calculation of the available measures. It was also noted that some of the measures represent the performance of all child welfare staff and service providers in a community and others reflect performance in one agency. As an example of this last qualification, the

rates per 1,000 children in a county or circuit reflect action taken by all providers in a community, while the placement and reunification percentages are more closely connected to the performance of case management services offered through the local community-based care agencies and contracted local providers.

Finally, in comparing child and family outcomes across different time periods, it must be recognized that Florida and the other states began to experience an economic downturn in December 2007 that turned into the deepest and longest recessions ever experienced by the United States in the postwar period (Federal Reserve Bank of Minneapolis, n.d.; National Bureau of Economic Research, 2008). That recession in the form of high unemployment rates, underemployment and home foreclosures has placed many families in Florida and elsewhere under extreme economic stress. There is growing evidence of an association between widespread economic hardship and increases in the rate of severe child abuse injuries (Personal Communication, David Rubin, January 6, 2012; Berger 2010 presentation at http://www.chp.edu/CHP/050110). Thus, it is reasonable to expect increases in child maltreatment referrals, placements and re-referrals during the time of the recession and continuing into 2012 because of the delayed recovery. With these limitations acknowledged, a comparison of the measures across the innovation sites was conducted for a time period extending from January 2008 through June or October 2011.

When comparing the average monthly **rates of children active in out-of-home care per 1,000 children** for over a year and a half before the innovation sites (January 2008 to August 2009) were selected (September 2009) to about the same length of time after the sites were selected (October 2009 to June or October 2011), there were reductions across all innovation sites. The rate reductions were evident despite increases in these rates during a more recent four month time period, July 2011 through October 2011. Depending on the number of months included for the time period after the innovation sites were selected, the reduction in the average active out-of-home rates was between 8.8 percent and 9.15 percent in Circuit 1, 7.63 percent and 7.77 percent in Circuits 3/8, and 7.6 percent and 7.7 percent in Circuit 11. A rate reduction was also observed for the same time periods statewide, around 8.7 percent. The reductions at this rate over the specified time periods were consistent with a statewide priority and initiative to reduce out of home care.

The monthly rates of **children active in in-home care per 1,000 children** over the same time periods before and after the month of the selection of innovation sites (September 2009) had similar patterns across two of the innovation sites. In Circuit 1, the average rate was relatively high (7.39) before September 2009 but dropped to 6.87 in September 2009. After September 2009, the average rate in Circuit 1 was on the rise with the monthly rates for December 2010 through October 2011 exceeding the average for the before innovation site selection time period. In Circuits 3/8, the average rate before the selection of the innovation sites was 5.33 with a drop to 4.02 in September 2009. Since that time, the monthly rates for active in-home care have been higher each month through October 2011. In Circuit 11, the average rate active in-home care per 1,000 children was higher (1.65) for the time period after the selection of the innovation sites (September 2009) compared to the time period before (1.39). For the state as a whole, the pattern is more consistent with what was observed for Circuits 1 and 3/8. Across all innovation sites, the monthly rates of in-home care per 1,000 children have been on an upward trend since September 2009.

The child placement outcome indicator selected is the monthly **percent of children in out of home care in relative placements**. This measure is believed to be very closely linked to FCP. It is also believed to be a FCP performance indicator that is primarily linked to the community-based care agencies. Across all three innovation sites, this percentage has been on the rise since the innovation

sites were selected with a favorable impression of FCP when comparing the monthly averages before September 2009 (January 2008 to August 2009) and after (October 2009 to June 2011). Refer to Figure 9 below.

Figure 9: Percentages of Children in Out-of-Home Care in Relative Placements by Innovation Site during Time Periods Extending Before and After Selection of the Sites
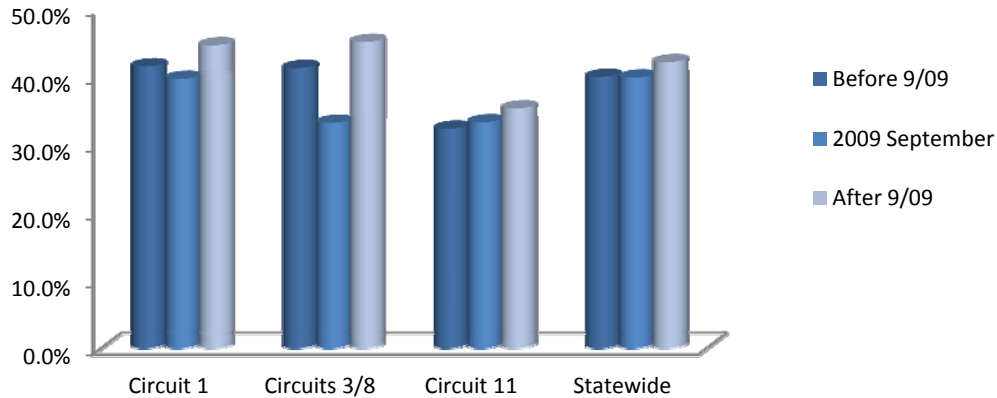
At this point, the measures addressing reunification with the families and subsequent child maltreatment do not show the steady patterns of change over time that might be expected when implementing FCP. As pointed out earlier, there could be a variety of reasons measures do not demonstrate the desired changes. These measures are considered "long-term" outcome indicators. The measures depend on the status of cases at discharge and the possibility of long periods of time serving the families. Trends that present a favorable outcome for FCP since September 2009 might not be realistic based on the time and effort required to integrate FCP into protocols and training across the community agencies serving families. A similar view of the subsequent re-occurrence of child maltreatment indicators is appropriate here. Time periods needed to observe the expected changes for these long-term outcomes should be extended beyond the time full implementation of FCP is ensured.

Family Centered Practice in the Judiciary

A major project completed during Phase 2 of this evaluation was a set of interviews with individuals in key positions affiliated with the family and dependency courts in each innovation site. During the months of April and May in 2011, nine judges and one magistrate, 21 Children's Legal Services (CLS) attorneys and 19 Guardian ad Litem (GAL) volunteers participated in semi-structured interviews. The questions asked during the interviews addressed their familiarity and experience with:

- Family Centered Practice (Awareness and Meaning)
- Interaction with Families
- Services (What is important to consider?)
- Participation in the Courtroom (i.e., extended family, children)
- Goals of Dependency Court
- Successful Endings in Dependency Cases
- Recommended Changes (Dependency Court/Child Welfare System)

The qualitative data collected in this set of interviews garnered a wealth of information about FCP knowledge and implementation in each innovation site. Evidence of progress in both was present in each innovation site. However, there were variations in the strength of FCP across the roles interviewed. Overall, the CLS attorneys were the most knowledgeable about FCP, and their responses indicated their application of FCP might be further along. Several judges also shared an impressive familiarity with and implementation of a family centered approach in the courtroom. The role that demonstrated a lower level of knowledge of FCP was the Guardian ad Litem volunteers. However, there were some exceptions to these general observations. It should also be noted that even without specific awareness of the term FCP, interaction with and treatment of families in the cases served could have reflected a "family centered" approach through respect for the family and encouraging their participation in the courtroom. A summary of several key findings related to each role in this set of interviews are listed below:

Guardian ad Litem Volunteers

- Familiarity with FCP was limited (only 6 of 19 or 31% of those interviewed had heard of FCP). Despite the lack of familiarity with the term, most GALs expressed family-centered views.

- Major concerns expressed by the GAL volunteers included families being overloaded with services and not being able to get the intended benefit, lack of communication between involved parties in the case, heavy caseloads for case workers and lack of focus on the child's best interest.

- When asked the goal of the dependency court, GAL volunteers focused primarily on the rehabilitation of the parents, providing oversight, intervening in dysfunctional families and protecting children. Some also mentioned reunification with the parents and keeping families together.

Children's Legal Services Attorneys

- Among the CLS attorneys interviewed, recognition of FCP was evident across the vast majority (19 of 21 or 90%).

- While most CLS attorneys agreed that families were allowed to participate in the courtroom, less than half of the attorneys indicated that families were encouraged to be active participants.

- CLS attorneys recognized child safety as important but emphasized preserving, strengthening and reunifying families.

Judges

- FCP was a concept that judges were aware of but their descriptions of FCP were not comprehensive, with two judges referring to the unified court model.

- Views regarding the participation of children in the courtroom were mixed with six of 10 welcoming children without conditions and the other four preferring limited participation of children with reasons noted.

- Regarding the goals of dependency court, all mentioned child safety but four of 10 mentioned acting in the best interest of the child, and that was thought to be keeping the families together or to reunify.

Family Centered Practice Implementation Achievements and Challenges

Without exception or qualification, the implementation of FCP across all three innovation sites has had multiple achievements and challenges. Lists of both were developed and shared with the innovation sites during Phases 1 and 2. Referring to chronicles prepared during Phase 1 for each

innovation site to document their path and series of strategies for moving toward FCP, there were several accomplishments relevant to FCP highlighted. Planning by teams and work groups representing multiple agencies and venues, the development of protocols that encompassed FCP, and training/coaching of innovation site staff consumed early phases of the movement to FCP. Brief descriptions of achievements in each innovation site that were documented in chronicles or presentations delivered at summits and conferences during the evaluation time frame are provided below.

Innovation Site Family Centered Practice Achievements

Circuit 1 (Escambia, Okaloosa, Santa Rosa and Walton)

In 2002, some of the basic principles of FCP were included in the case management system of care. By 2007, Circuit 1 began a foster home development initiative that included a FCP pilot. A Family Engagement Task Force was created and was comprised of supervisors and program managers to assess the skill level of staff, gaps and strategies for understanding, teaching and supporting family engagement techniques in the values, practices and routines of the partner agencies. A circuit steering committee included leadership from the Department of Children and Families, Families First Network, Guardian ad Litem program, Medicaid, Access Behavioral Health and Children Legal Services. This steering committee was tasked with developing the plan that included activities necessary for the entire community to move forward in changing practice with benchmarks tracked each month. Circuit 1 leadership recognized early on that this is cultural change in practice and that it would take time to improve our current practices. Some re-design of the system of care has been necessary. Several activities involved consulting with experts, such as the National Resource Center NRC for Permanency and Fostering Connections, to help improve the skills of staff and change the culture. The FCP principles have been integrated into the workforce, community integration meetings, judicial meetings, annual conferences, training and at other forums. As the overall system of care continues to evolve, it remains centered around the core principles of FCP.

The integration of some activities consistent with FCP was relatively smooth due to their presence for several years. One example was family team conferencing. More engagement from community partners in family team conferences continued to support that effort. All cases in the system are eligible for at least one or as many as needed family team conferences. In addition to comprehensive training, coaching for all staff was implemented. The supervisors were a key component in this overall effort. Three consulting groups were part of the coaching for a year. After that time, a sustainability model was developed to continue to support the supervisors in the circuit. The circuit also developed a unified required training calendar for all staff with the training open to all community providers. Circuit 1 has been actively monitoring progress in Quality Assurance FCP standard performance and the CFSR. Performance monitoring using the CFSR standards and Quality Assurance FCP standards has helped them identify strengths and weaknesses.

In another set of achievements shared here that promoted FCP, Circuit 1 has a Clinical Response Team in each county, which is a multi-disciplinary team that focuses on high risk cases to prevent removals and engage services quickly. The circuit has increased supports to relative/non-relative caregivers in order to form a support system similar to foster parents to help families stay together whenever possible. They have also conducted more training with foster parents to assist with co-parenting.

Circuits 3/8 (Alachua, Baker, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Madison, Suwannee, Taylor and Union)

A major redesign of the foster care system was the primary impetus that laid the groundwork for the implementation of FCP in Circuits 3 and 8. The redesign initiative began in 2007-2008. The redesign broadened the focus from primarily out-of-home placements to include diversion and in-home services. Ensuring the safety of the children, the preservation of the family and the timely reunification of the family when out-of-home placements were necessary became paramount. The redesign effort included participants in 25 workgroups or committees. As described in relevant documentation for this redesign, several outcomes were developed to measure success "through collaborative, strength-based, and culturally appropriate family-centered practice."

To reach the desired outcomes for child victims of maltreatment and their families, senior leaders at the Department of Children and Families and the community-based care agency, Partnership for Strong Families (PSF), set broad goals to describe the redesign work to staff, community partners and local policy makers:

- Remove children only when their immediate safety cannot be assured and shift our practices to leave children safely in their homes by assisting their parents;
- Introduce preventative services to prevent removals, supporting families to find solutions;
- Develop community support for prevention services;
- Retool and redesign existing services and protocols;
- Analyze results and identify "Best Practices"

With these goals as a basis, many process and procedural changes were implemented over several years. An opportunity to pilot and evaluate a new family team conferencing process and model through a federal grant also contributed to the FCP implementation.

More recently in Circuits 3/8, Solution Based Casework (SBC) was adopted as a key component of the practice model in 2010 for guiding child welfare staff in their casework. Senior leaders for the Department and Partnership for Strong Families describe the decision to incorporate SBC into the system of care as the next step in foster care redesign. They indicate that the family-centered practices in the model support changes in processes that were made as part of the redesign. The investment to implement SBC was viewed as the way to weave all the various FCP initiatives in Circuits 3/8 together under one cohesive model to maintain a focus on positive outcomes for children at risk of maltreatment and their families.

In late 2011, Circuits 3/8 reached their full implementation of SBC with the overlay of FCP and integration of already existing strategies such as decision team consultations, early engagements with families, family team conferencing and an individualized service array as part of their utilization management. SBC training has been conducted and continued monitoring is occurring. Success identified included improved communication and collaborating across the entire system and family networks, the use of a "shared conceptual map" brought about with SBC that shifts the casework focus from measuring compliance to measuring skill acquisition and demonstration for the creation of child safety. Additionally, some service providers have reported that the parents feel more empowered as the model encourages them to organize and prioritize the steps they will take to create safety, permanency and improved well-being for their family.

Circuit 11 (Miami-Dade County)

In Miami-Dade County, there has been over a decade of initiatives in the child welfare system to serve families using a more family-centered approach. In 1999, the Dependency Drug Court program developed as a pilot in Miami-Dade County. This program has continued to expand in different phases and to increase funding streams to continue its success. The strong influence of the community-based care (CBC) alliance and the emergence of Our Kids as the lead agency in 2005 could be considered a new chapter in developing more FCP in the child welfare system. Since that time, there have been efforts to improve several aspects of the child welfare system that address timely permanency and family preservation. In 2006, a "third party monitoring project" with Chapin Hall highlighted that infants were remaining in foster care longer than in other regions of the state. In response, Our Kids initiated a pilot to directly improve timeliness and likeliness of permanency for infants and toddlers. This initiative helped our community discover that earlier engagement with families helped tremendously. There was a subsequent expansion in the focus of the workgroup to include children 3-5 and youth 15-17 years of age. Our Kids assigns agencies prior to the official transfer staffing with Department investigators and requires a representative (usually the case manager) who will work with the family and be present at shelter.

Interest in infant mental health topics fueled interest in FCP early in Miami-Dade County. In October 2005, a Memorandum of Understanding with numerous community stakeholders, including the dependency courts led by Judge Cindy Lederman, Our Kids and the University of Miami began offering and tracking services to families to receive dyadic therapy (now called Child Parent Psychotherapy). Full case management agencies have trained therapists to help these families develop safe bonds and promote healing and attachment. Beginning in fiscal year 2008-09, more concerted attention to reducing the number of child removals in Circuit 11 led to efforts to engage and provide services for families earlier or immediately after making contact. New programs were created to provide services in the home that improved parenting skills and helped stabilize the family. The introduction of Structured Decision Making (SDM) was also implemented starting in November 2009. This decision-making framework was considered more objective with tools that would lower the subjectivity in the decisions that were made regarding children and placements out of the home.

As a final achievement noted, foster parent and biological parent co-parenting have also become a focus of the FCP efforts in Circuit 11. In April 2010, the Annual Foster Parent Conference sponsored by Our Kids featured co-parenting in a plenary session. Our Kids and the community are following the Quality Parenting Initiative (Q.P.I.) and have had additional training, brainstorming sessions and a type of town hall meeting with foster parents, judges and the other community members. Co-parenting was a topic and additional explanation and training were offered.

Phase 2 Family Centered Practice Challenges based on Focus Groups with Child Welfare Staff

Despite the progress, challenges implementing FCP remain across all innovation sites. Challenges implementing FCP was the central theme for the focus groups in Phase 2. Based on the set of focus groups conducted with CPI and case manager supervisors during Phase 2, there were several challenges identified that were common or similar across the three sites. Some of these were reiterations of what was shared in Phase 1, and others were brought to the group for the first time in Phase 2. The challenges presented here cover coordination and communication issues among those stakeholders and partners serving families, family team conferences, joint visits between child welfare staff (CPIs and case managers) and the families, and a final set that includes additional challenges that surfaced and/or more specificity related to challenges mentioned earlier. A summary list of the key challenges is presented below.

1. **Communication, coordination, and sharing a commitment** to serve families using a FCP approach among child welfare professionals and community partners were impeded by the following challenges:

   o Separate office locations for child protective investigators, case managers, and service providers

   o Extensive amounts of travel time to attend meetings

   o High caseloads

   o Absence of or very limited opportunities for child welfare staff and service providers to interact and share their expertise

   o Child Protection Teams control decisions regarding the children and do not practice FCP

2. **Lack of coordination and/or inconsistencies between child welfare staff and the judiciary** were evident when:

   o Case plans prepared during family team conferences were revised by judicial staff or client attorneys

   o Understanding and application of FCP varied across judges and attorneys within a circuit.

   o CPIs and case managers are not respected in meetings with judicial staff and in courtrooms

   o Perspective held by CPIs that CLS attorneys extend their authority beyond the responsibilities of their position

3. **Family team conference challenges included the following:**

   o Unclear goals and variation in topics/concerns covered

   o Challenges identifying and recruiting participants (family members, service providers, child welfare staff, others)

   o Scheduling family team conferences with sufficient notice at appropriate intervals, convenient times and locations for participants

   o Inadequate preparation of families for the family team conferences

   o Inappropriate and inadequate facilitation of the family team conferences

4. **Joint or early engagement home visits presented the following challenges:**

   o Participation of CPIs and case managers was praised by child welfare staff but there was still some confusion over:

     ▪ Staff roles and responsibilities

     ▪ Timing for case transfers

     ▪ Making sure the child welfare staff assigned to the case could participate in the early or joint visit with the family

5. **Other challenges included:**

   o Scheduling Multidisciplinary Staffings or Decision Team Conferences (DTCs) to maximize attendance and productivity

   o Service providers not providing sufficient feedback about the progress of families being served

- Electronic Information Systems for Entering and Storing Case Information (broad access helpful, need clear understanding of locations for information that is uploaded to other systems, cut backs on staff available to enter data on cases)
- Training (need more "in the field" and on-the-job training/feedback, supervisors need more advanced trainings, staff required to be off-line without sufficient number of staff remaining to respond)
- Assessment responsibility and duplication (if professionals other than child welfare staff conduct assessments, they do not always have sufficient information about the family)

Next Steps for Family Centered Practice

Referring to the list of challenges in the previous section, there were multiple lessons learned. There are also steps that are needed within each innovation site that could provide valuable direction for other circuits throughout the state. Training content and format are on the list of challenges but these are also ways to address some of the needed fixes. Skill development among staff for improving their engagement with families and their attention to the criteria in all six FCP constructs in this evaluation is an excellent place to start. Coordination and communication among the child welfare partners in the system of care, including the courts, has been and will continue to be an ongoing challenge. Protocol and other procedural adjustments might augment some of the remaining issues, but staff turnover and changes in policy at the state level might also lead to possible disruptions in future paths to progress in this endeavor. As noted by the innovation sites, the paradigm shift to FCP takes time. It takes commitment and a team approach that can be hard to achieve. The central themes or tasks identified by each innovation site in their future efforts to further FCP are listed below:

Circuit 1

- Participate in the child protection transformation pilot project with an emphasis on better safety assessment through family engagement
- Supporting the supervisors' initiative and their role in training/coaching
- Schedule an event to revisit FCP concepts and plan next steps to sustain the practice
- Develop protocols to support concurrent placement and planning
- Continue to strengthen up-front service engagement
- Promote the infant mental health training initiative
- Promote the "Safe and Together" initiative
- Provide more relative/non-relative out of home care support
- Expand the certified pet therapy team initiative in courtrooms (Escambia County).

Circuits 3/8

- Continue working towards full integration of the Solution-Based Casework model into our system of care through continued attention to model fidelity and skill development of front line workers and supervisors
- Continue to utilize, monitor and refine our already existing family centered practice initiatives (e.g., decision team staffings, diligent search processes, early engagement and family team conference)

- Currently working to establish an "audacious goal" to improve legal permanency for youth in our system of care
- Utilize the cold case and permanency roundtable processes developed by the Casey Family Programs to impact permanency for all children in care
- Focus attention on children ages 0-3 in out-of-home care by:
    - Partnering with Casey Family Programs and Florida State University to provide in depth training on "Applying the Science of Early Child Development in Child Welfare"
    - A parent/ child visitation pilot in partnership with the University of Florida, the Judiciary and the Early Learning Coalition
- Continue to partner with our community around the development of a second Neighborhood Resource Center in Alachua County

Circuit 11

- Continue to provide prevention/diversion
- Continue to make learning a priority in supervision
- Continue to address skill and talent development in case managers
- Continue to replicate the family centered highlights in the drug court model (i.e., especially the case ownership)
- Build capacity in family finding, family team conferencing and youth life conferencing in the full case management agencies.

Summary

FCP is taking hold in Florida based on the evidence compiled for this evaluation in three innovation sites. Data collected using multiple methods and six measurement constructs identified the presence of family centered practices from the beginning to the end of cases that served families with a wide range of complexity in life circumstances and resources. Applying FCP during initial contact as well as during all interactions in all settings with families was considered key. Family centered practices were documented in the in-home as well as the out-of home cases. Within this positive portrait, the evaluation identified where progress implementing FCP was the most advanced and where it was slower to develop. Variations in the evidence for each FCP measurement construct were presented in frameworks that provided valuable feedback for each innovation site for their use internally as well as for site and staff position comparisons. Both quantitative and qualitative evaluation methods generated a more complete and relevant understanding of the current status of FCP.

Achieving more progress on the implementation of FCP is an ongoing process. Additional training that includes on the job or at the site feedback and guidance was considered paramount among the needs. Better and wider access to updated information on cases in electronic information systems across a broad spectrum of staff and agency partners was also considered a helpful step. Honing techniques to engage families successfully from first contact through subsequent interactions in a family and individual's system of care was also essential. Adoption of a team approach across staff positions, agencies and providers was another imperative that is not only difficult to achieve but requires continuous attention and support. Learning from the innovation sites in this evaluation will be a valuable checkpoint in any movement toward FCP in Florida.

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