Northern California Training Academy

Participatory Planning in Child Welfare Services Literature Review

Selected Models, Components and Research Findings

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Participatory Planning in Child Welfare Services Literature Review: Selected Models, Components and Research Findings

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Funded by the California Department of Social Services

October 2008

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INTRODUCTION

Purpose of the review

The questions that this report addresses are *how participatory planning is being implemented in models and programs working with children and families within the child welfare system* and what has been learned, from empirical studies, about *how these participatory planning practices benefit children and families.*

Participatory planning is a strength-based approach to working with families and individuals who may have multiple needs that are complex. Specifically, the National Center on Family Group Decision Making at the American Human Association describes participatory planning as a practice that is family centered, family strength based, culturally sensitive and involves the community. Agencies and programs that include participatory planning in the provision of their services use an approach that brings teams of people together and works to build a plan that is strength-based, and individualized. The theory behind implementing participatory planning in child welfare services is that through supporting and collaborating with families, true positive change will occur.

This review provides a summary of the available and most promising participatory planning models and the available research evidence and proposes future directions for both practice and research. The purpose of this review is to high light some of the most promising aspects of using participatory planning activities in child welfare services and to discuss some of the positive outcomes of using such an approach. The review concludes with specific suggestions for enhancing existing participatory planning models that may improve practices within Child Welfare Services.

Why use participatory planning?

Historically, it has been a common practice in the United States for child welfare services to focus greater time on finding alternate placements for children removed from their birth parents due to abuse and neglect rather than focusing on preventative efforts to keep children with their birth families (CWLA, 2003). However, involving families in a collaborative process in the decisions made for children has led to some positive outcomes for children and youth in the child protective system (Shemmings & Shemmings, 1996). In a review carried out by the Children's Bureau in 2001 and 2002 (US DHHS, 2003) it was found that states that included parents in case planning had a significantly higher percentage of cases rated as "substantially achieved" (at least 90%) for stabilizing children's living arrangements and meeting positive child outcomes, such as children and youth returning home from residential care (Tam & Ho, 1996).

Participatory planning is expected to be an effective way to bring about positive family changes because it is a process that works to match services and supports with the needs of the family. Involving families in both the planning and implementation process is believed to bring about greater commitment and the belief that true positive changes can occur. Research finds that people who are included and asked to participate in making decisions that affect them are more likely to follow through with the plans and decisions that are made (Maddux, 2002). Additionally, when individuals feel valued and respected in contributing to decisions made about themselves, they are more likely to have increased self-esteem, self-efficacy, and a greater sense of empowerment (Thomspon, 2002; Maddux, 2002). These are all important attributes that are expected to contribute to a greater commitment and drive to make positive family changes that are long lasting.

Importance of involving families

There are numerous studies attesting to the importance of forming partnerships with families, especially parents, in child protection work (Thoburn et al., 1995). In part this is attributed to the fact that family involvement is related to positive child and family outcomes (Tam & Ho, 1996), such as better outcomes for children's mental health (Tolan, McKay, Hanish & Dickey, 2002) and decreased family conflict. Mental health outcomes are improved when treatment is modified to best meet the needs of the family, (i.e., are individualized) (Morrissey-Kane & Prinz, 1999), which improves retention and a desire to follow through with the plan. Thus, finding effective and meaningful ways to involve families in important decisions, such as participatory planning, is believed to be an important endeavor for bringing about positive long term outcomes for children and their families.

LITERATURE SEARCH

Literature searches using the terms "Family Group Conferencing", "Family Group Decision Making" "Family Making Meetings," "Family Unity Meetings," "Wraparound Services," "Child Welfare Services," "Individualized Services", and "Participatory Planning" were conducted using the Academic Search Premier, Current Contents/Social and Behavioral Sciences, PsychInfo, Social Sciences Citation Index, and Social Work Abstracts. These databases were selected to locate peer-reviewed literature. Additional information and studies were also located using other searches on the National Center on Family Group Decision Making, Child Welfare League of America, Office of Juvenile Justice and Delinquency Prevention, and the American Humane Association.

EVIDENCE-BASED FOCUS

The literature review also focused on the importance of program evaluation because such a focus provides a clearer understanding of the utility for using

participatory planning methods in child welfare services. Particular attention was given to how particular families are affected by the participatory planning method, what populations are served the best using a particular model and how the effect and outcomes are measured and reported. Sound evaluations of the effectiveness of using participatory planning practices is important because this will better inform specific ways to improve program practices within child welfare services.

VARIOUS PARTICIPATORY PLANNING PROGRAMS

The following paragraphs relate examples of the various types of models that incorporate participatory planning practices. Within the Child Welfare System participatory planning can be used for such circumstances as family reunification, permanence planning, strengthening family supports, increasing positive family communication, transition planning, and working with youth involved in the juvenile delinquency system. Though this is not an exhaustive list, it provides some ideas for where participatory planning may be effective.

FAMILY GROUP CONFERENCING (FGC)

One of the most widely implemented models of participatory planning in child welfare is a form of Family Group Conferencing or Family Group-Decision Making. FGC is a process for involving families, immediate and extended, in the planning and decisions that are needed to meet the needs of children involved with the Child Welfare System and focuses on family strengths (Morris & Tunnard, 1996).

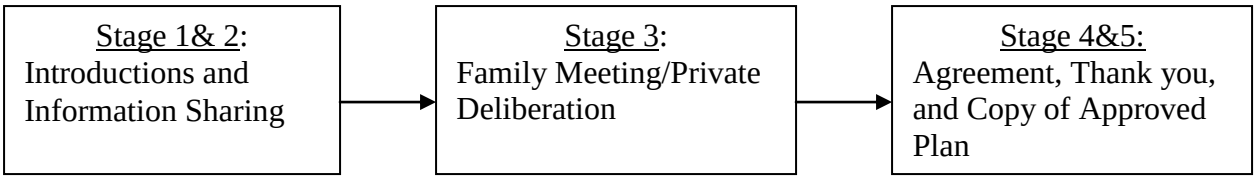
What is Family Group Conferencing?

There are many different approaches to having families brought together to make decisions about their children and having families involved in the process of problem solving and planning. These various approaches have been termed family unity meetings, family team decision-making, and family group conferencing. While there are many different names used to describe various models, all of them share the underlying principle that *families must be involved* in the decision making process in order to attain the most promising positive outcomes for children and their families. The main difference among these models is the amount of control families have in making decisions at the meeting and in the development of the individualized plan. Children may also participate, which has commonly been absent from child protective services when case plans are constructed (Morris & Tunnard, 1996). For detailed information concerning the specific differences among these approaches, see a document produced by The Center for the Study of Social Policy entitled, "*Bringing Families to the Table: A Comparative Guide to Family Meetings in Child Welfare*, which outlines the differences and commonalities of the newer FGC approaches.

Research has found that the important components and steps for implementing successful Family Group Conferences (adapted from Merkel-Holguin, American Humane and Pennell & Anderson, 2005) include:

- *STAGE 1*: The first step involves the introduction of the key members attending the team meeting which is facilitated by a coordinator. The coordinator welcomes all participants, reiterates the purpose of the FGC meeting and facilitates the group in coming to an agreed upon meeting goal and what each participants role is in the meeting.
- *STAGE 2*: This second stage is termed the information-sharing stage. This is when the referring social worker discusses the specifics of the case and family members are given permission to ask questions concerning the presentation of the case. During this stage professionals are asked not to give their recommendations and opinions.
- *STAGE 3*: This is when the family meeting takes place. This means that non-family members and professionals are not to participate in the meeting so that families can make their own plans. Families are asked to address the following questions 1) was the child abused and/or neglected? 2) what needs to happen to ensure that the child is not abused or neglected again (ensuring safety and protection)? During this stage of the FGC, family group members are afforded the opportunity to confront problems, draw on their own cultural beliefs and practices to formulate solutions, and develop a plan that makes sense to them. (*NOTE: this is not a required stage in the FGC process for Family Unity Meetings)
- *STAGE 4*: This is when the family's plan is discussed with all meeting participants. The plan may be refined, a system of monitoring and evaluating the plan is decided upon and the child welfare workers approve the plan.
- *STAGE 5*: All participants are thanked for attending the meeting and evaluation forms may be handed out to the FGC coordinator and other participants to provide feedback about the meeting process. After the FGC meeting all participants should receive a copy of the approved plan.

Family Group Conference Process*



*Adapted from Connelly's (2006).

There are also important *processes* that are important to implementing effective FGC's, which include:

- Validating and using the strengths of the families (Vesneski & Kemp, 2000).

- ❖ Enhancing family involvement by ensuring adequate preparation time and increased attendance by family members (Rockhill & Rodgers, 1999; who examined the effectiveness of 26 FGC meetings, 163 participants))
- ❖ At least 20 hours of preparation time. Mrisky (2003) suggests that at least 20-25 hours should be spent per case, which typically leads to family members feeling more positive about the meetings and wanting to contribute to developing the family plan (Cashmore & Kiely, 2000).

EMPIRICAL EVIDENCE: FGC MODEL

There are few peer-reviewed empirical studies looking at the effectiveness of using Family Group Conferencing in the child welfare system and how and why FGC promotes positive child and family outcomes over the long term (Robertson, 1996). However, the existing articles and empirical research offer some promising results.

***Process-Oriented Outcomes*:**

A) Satisfaction

- **Families**
  A consistent finding across reports and studies are that families are generally satisfied with the FGC process and experience it as a friendly, comfortable, and useful meeting (Holland et al., 2005; Velen & Devine, 2005). Typically families report that their feelings are respected, feel that they can express their opinions freely, and they feel empowered in contributing to the family plan (Cashmore & Kiely, 2000; Pennell, 2002; Sandau-Beckler et al., 2005; Schmid, 2005). To date there are no studies that have examined how family satisfaction is linked to long term child and family outcomes. However, generating greater acceptance and approval for the Child Welfare System is a promising outcome in and of itself.

- **Children and Youth**
  Currently there are mixed results when looking at children and youth's satisfaction with participating in the FGC process. In one study it was generally found that children were satisfied with the process, with 82.9% reporting that they felt that they contributed to the plan in a meaningful way and 91.5% reporting that they felt safe (Velem and Devine, 2005). However, in another study (Clarkson & Frank, 2000) it was found that children typically did not feel heard during the FGC process and that children perceive their participation as difficult (Rasmussen, 2003). Some of the contributing reasons for why children do not feel that they can easily participate and contribute to the FGC process are because children do not understand the process, they do not feel included in the process, or they lack the confidence to speak in front of the group. However if adequate preparation time is given to address these concerns prior to the FGC

meeting then children's satisfaction with the process is expected to increase

- **Professionals (e.g., Social Workers)**
  While some workers report skepticism with the FGC process and appropriateness of involving families in the decision making process (Velen & Devine, 2005); typically social workers are satisfied with the process and with the final approved plans, believing that it provides safety and permanence for children (Merkel-Holgiun, 2003; Velen & Devine, 2005). One of the most positive findings reported by social workers is that there is reduced conflict with families and as a result they feel they have a better relationship with their clients (Velen & Devine, 2005).

B) Important Contributors to Successful Family Participation and Family Plans

The available literature finds that important factors contributing to successful family participation during the family meetings are adequate pre-conference preparation (at least 20 hours) (Pennell, 2002; Velen and Devine, 2005), involving extended family members (Marsh & Crow, 1998), having the FGC take place in a comfortable location (Merkel-Holguin, 1998), allowing families to ask questions during the information sharing stages (Nixon, 1998), and involving children in the process (American Humane Association, 2003). Children can be involved by: 1) contributing their artwork to explain their thoughts, 2) have a letter prepared ahead of time that lists the main points that the child wants to discuss, 3) ask the child if they want to have a friend present, 4) allow the child permission to leave the meeting as wanted, 5) and allow the child to provide feedback after the meeting is finished. In a study conducted by Marsh & Crow (1998), looking at family group conferencing in the UK within various pilot sites, they found that all of the children and youth who were over the age 10 attended the FGC and that very few young children declined to participate. Though the research is limited, it appears that children want to attend these meetings and when adequately prepared feel satisfied with the process.

In one study conducted by Pennell (2002) evaluating the effectiveness of using FGC in child welfare services planning in North Carolina, it was found that on average FGC coordinators spent 35 hours and child welfare workers spent 7 hours preparing for the initial conference. The conferences typically lasted 4 hours with the family group time (without professionals) lasting approximately 1 hour and 20 minutes and on average 8 family group members and 4 service providers were in attendance. This evaluation looked at the effectiveness of FGC among 27 families (67 children, average family had 2 children).

Results also were consistent with prior studies finding that holding the conference in a neutral location, not at a social service office, such as a church or community center increased participant's satisfaction with the FGC process

(Pennell, 2006). On average participants were satisfied with each of the 16 FGC evaluation items, with all items ranging in score from “agree” to “strongly agree”. Participants felt the FGC was well organized, liked the conference process, felt they were able to participate, and were satisfied with the final approved case plan. Families were dissatisfied and felt betrayed when Child Welfare Services closed cases once a family crisis was over but before the FGC plan was successfully completed, followed through, and all family member concerns in the plan had been adequately addressed (Pennell & Burford, 1998). This study did not look at the long term implications for child and family well being in implementing the FGC, but it appears that families feel respected and satisfied when the FGC process is carried out as designed.

One of the most promising findings of the FGC *process* is that both families and referring social workers accept and agree upon a plan 95-97% of the time (Walker, 2005; Merkel-Holguin, Nixon, & Buford, 2003). Typically these plans are comprehensive, strength-based, and individualized, and families show greater commitment to follow through and implement the plan (Crow & Marsh, 1997; Schmid & Goranson, 2003).

Child and Family Outcomes: Long Term Effectiveness:

Currently there are few rigorous peer-reviewed studies examining the long term effectiveness of using FGC for child and family well-being. Most studies report on the “process” of using family group processing and do not use control or comparison groups (Lupton & Stevens, 1997; Marsh and Crow, 1998). More systematic and controlled comparisons are needed to adequately determine if FGC’s ensure family safety and protect children in the long term.

A) Placement Stability

Across studies, it is found that FGC leads to stabilizing placements without endangering children’s safety and has kept children with their siblings and family members (Anderson, 2003; Crampton, 2001; Gunderson, 2004; Merkel-Holguin, 2003; Walter R. McDonald, & Associates, 2000).

B) Family Well-Being

Research has found that FGC’s reduces domestic violence (Pennell & Burford, 1997; Pennell & Burford, 2000b; SSRIU, 2003). In particular, after one to two years following a FGC, families reported reduced substance use problems, increased family cohesion, and decreased family violence (Pennell & Burford, 1997). However, these positive results are attained when the social worker or FGC coordinator receive specific training in how to deal with such high risk and complex factors as substance abuse. It is recommended that someone on the FGC team is well equipped to speak about and locate community resources to sufficiently deal with multiple and complex family risks.

C) Child Positive Outcomes

One area that has received more focused attention is how FGC's impact child well-being. One study, The Newfoundland and Labrador Family Group Decision Making Project, which included 32 families, examined the effectiveness of using FGC's for child outcomes (Pennell & Burford, 2000). A total of 472 people participated in the conferences and 115 of them were interviewed as part of the evaluation. This study employed a comparison group and found that the families who had participated in a FGC meeting had fewer CPS events compared to the matched comparison group. In follow-up interviews it was found that the children who received FGC's had parents who reported providing better care to the children and children suffered less abuse and neglect. In another study looking at the effectiveness of FGC's in Michigan, similar results were found (Crampton, 2003). Specifically children who received placements by using the FGC process were less likely to have additional contact with CPS, experiences less frequent moves, and were more likely to remain with extended families. Though not peer-reviewed, in an evaluation conducted by the Texas Department of Family and Protective Services (2006), it was found that implementing a Family Group Decision Making Process resulted in foster care placements dropping from 54% to 38% and relative placements increasing from 29% to 45%. Additionally, children were reportedly being less anxious than families who received traditional services (assessed by caregiver's perception over the telephone).

However, contradictory results were found in another study wherein 97 children who received FGC meetings were compared to 142 children that received traditional CPS planning methods (Sundell & Vinnerljung, 2004). This study controlled for child's age, gender, type and severity of problems, and family background. Taking these control factors into account the study found that children whose plans received the FGC process experienced HIGHER rates of re-referrals to CPS (for abuse) and were in out-of-home placement for longer periods of time. In a matched comparison group study (Center for Social Services Research, 2004) looking at the effectiveness of FGC in two California communities, it was also found that children who received the FGC process in case planning did not result in significant differences in the number of placement moves or differences in the number of substantiated cases of child maltreatment.

These inconsistent findings may be attributed to the way in which the FGC process was implemented, different populations of children and youth being served, and/or due to a monitoring bias. Those families who participated in a FGC may have received greater contact with CPS and other community supports.

PROGRAMS AND MODELS USING THE FAMILY GROUP CONFERENCING APPROACH

Family Unity Meetings: A Variation of FGC

The Family Unity Model originated in Oregon in 1990 and is part of the state's child welfare system. The Family Unity Meeting is mandated to take place within 30 days of a child being taken into the care of the state. The most significant differences between a Family Group Decision Making meeting and the Family Unity Meeting is that during the Family Unity Meeting there is not specific time set aside for family members to meet alone (professionals are always present) and parents have the right to exclude the participation of any family member. This gives parents more control over who can attend the family meeting and with whom information is shared. Additionally, there is not explicit focus on family strengths during the Family Unity Meetings (Adams & Chandler, 2004). Typically, these differences result in less preparation time needed for the Family Unity Meetings. Currently, research is needed that compares and examines the differences between these models. One noted benefit of the FGC meeting is that families appreciate and are satisfied with the private family meeting time that is specifically set aside for them.

Family Team Decision Making

Decisions, Decisions, Always More Decisions

Source: Campbell, M. (1982). Decision-making in child welfare: A self instructional manual.

The Family Team Decision Making model is *specifically focused* on bringing important adults in the child's life together to make a decision around *issues of placement*, such as reunification, removal, or change in placement. Typically, birth parents, the children, extended family, non-relatives, current caregivers, case worker, community partners (such as a CASA worker), service providers, and a facilitator participate in the family team meeting. If a decision cannot be reached than the public child welfare worker has the final decision making authority. It is important that the Team Decision Making meeting occur prior to the child being moved and always before the initial court date.

Team Decision Making or Individualized Course of Action is a process of involving families in placement decisions and was originally supported by the *Family to Family* Initiative launched by the Annie E. Casey Foundation in 1992 and is currently in place in many states, including California. The purpose of this initiative is to decrease the number of children in out-of-home care, number of placements, the number of days spent in out-of-home care and have agencies use data to support their practices (Annie E. Casey Foundation, 1992). An important component of the *Family to Family Initiative* is that there must be self-evaluation wherein data is used to facilitate the planning, implementation, and evaluation of specific programs, interventions, and models.

Currently there are few empirical peer-reviewed journals attesting to the effectiveness of using Team Decision Making for child and family outcomes. Some evidence suggests that TDM results in children experiencing fewer moves, decreased time being placed away from homes, fewer children being removed from their homes, and children being placed within their own neighborhoods (Mattingly, 1998). However, while there may be within-group positive changes in using FTDM, it appears that there are few differences in the aforementioned outcomes when compared to families receiving traditional services. In a recent randomized-controlled comparison study (Berzin, 2006) within two California counties (Fresno and Riverside), there were no differences between the two groups with regards to child maltreatment rates, placement stability, or permanence. Therefore, while there are beneficial effects in using FTDM, these effects may not be more beneficial than using traditional services. More rigorously controlled studies are needed to determine the consistency of these findings.

Family to Family offers useful tools for programs to use in order to efffectively measure both process oriented outcomes (i.e., family satisfaction) as well as child and family outcomes when using the FTDM approach.

MEASURES TO EVALUATE EFFECTIVENESS OF FGC

In order to better understand how effective and in what ways Family Group Conferencing (or versions of this model) works, programs and agencies are encouraged to participate in evaluative efforts. Here are some current measures being used:

- *Family Group Conference Evaluation* form (Pennell, 2001). This measure assesses participants satisfaction with 16 different aspects of the conference (i.e., satisfaction with the conference process, the final plan, individual's satisfaction with their participation) on a 4-point Likert scale of "strongly agree" (4) to "strongly disagree" (1) and to open-ended questions.
- *Decision Process Measure* (Pennell, 1990). This measure asks respondents to rank decision-making processes from most to least

important in making and finally deciding upon the family group's plan based on the private time at the conference.

- *Satisfaction Questionnaire* (provided in a 2006 evaluation report produced by the Texas Department of Family and Protective Services) developed by a Parent Collaborative Group and implemented in a Texas evaluation. This questionnaire asks family members to rate their level of satisfaction with the FGC process and meeting (see Appendix A).

RESOURCES FOR FAMILY GROUP CONFERENCING

- Team Decision-Making Protocol/Policy Outline
  Annie E. Casey Foundation (2003): This protocol provides information for holding FGC meetings involving birth parents and youth prior to a child being removed, experiencing a change in placement and reunification.
- Family Team Decision Making: A Focus on Decision Making and Next Step Actions Iowa Department of Human Services (2004)
  Provides information pertaining to how facilitate family team meetings
- Family group conference / New Zealand Youth Court: http://www.justice.govt.nz/youth/fgc.htmlFamil
- Family group conferencing: principles and practice guidance / developed and written by Patrice Lawrence and Jane Wiffin. -- London : Family Rights Group ; Barnardo's Childcare Publications, 2004.
- Family Group Conference home page / Winchester Local Education Office, UK: http://www.hants.gov.uk/TC/edews/fgchome.html
- Family group conference: information for parents, extended families and friends / British Columbia Ministry of Children & Family Development: http://www.mcf.gov.bc.ca/child_protection/pdf/brochure_parents_2
- National Center on Family Group Decision Making (American Humane Association): http://www.americanhumane.org/site/PageServer?pagename=pc_fgdm
- RealJustice: http://www.realjustice.org/
- The North Carolina Family-Centered Meetings Project provides training resources and annual reports from North Carolina FGC project. Available on-line at: http://www.ncsu.edu/chass/SocialWork/fcmp/index.html

WRAPAROUND APPROACH

Another commonly used and cited form of participatory planning is the Wraparound approach to working with families. One of the deciphering differences between the Wraparound approach and FGC's is that Wraparound services have an explicit intent to revisit the individualized plan on at least a monthly basis. Thus, a big component of the Wraparound approach is that the services are on-going and modifications to the individualized family plan can be made as familial risks and supports change.

What is the wraparound approach to working with families?

Wraparound services have been described as an approach that "implements individualized, comprehensive services within a system of care for youth with complicated multidimensional problems" (Burns & Goldman, 1999). It is family focused and strength-based, emphasizing individualized services and provides these services in the least restrictive setting that is appropriate in meeting the child's needs (Burchard & Clarke, 1990). An important component of the wraparound process is using the family as the decision making participants or active participants *and* to enhance family strengths and modify the plan as needed. Another important aspect of the wraparound process is to view the approach as process oriented intervention rather than a service (Buchard, Bruns, & Buchard, 2002). In fact families are to be involved at all levels of the decision-making process, assisting with formulating of the child's' treatment plan, designing the child's treatment plan, and with implementing the child's treatment plan (Grundle, 2002).

The wraparound approach began to be used in the 1990's as a process model to help youth who were identified as being at risk for institutionalization (Burchard & Clarke, 1990). The wraparound process has been implemented within various fields, such as mental health, developmental disabilities, youth, seniors, child welfare, and justice departments. It is most commonly used with families who have children who have severe behavioral and emotional problems and with families who have family members with chronic or severe physical illnesses and disabilities.

How does the wraparound model work?

The wraparound approach is a strength-based approach that works with at risk families, brings professionals together and identifies natural supports. The main premise of using a wraparound approach is the idea to "wrap" supports and services around at-risk individuals and families, rather than expecting them to conform to the existing services. Specifically the important components of the wraparound approach are:

- It is an individualized support: those who need the support are best in identifying what supports they need and will accept.
- Is culturally competent: need to respect the timing, values, and culture of the family
- It is strength-based: every family has strengths, no matter how at risk they are. Have to identify these resources and strengths of the family, best way to support them.
- Focuses on safety: all family members need to have their basic needs met and family members are safe, so crisis plans are made to prevent the potential for future risks.
- Plan needs to be comprehensive: need to address more than one or two issues for which they may seeking individual support

EMPIRICAL EVIDENCE: WRAPAROUND SERVICES

***Process-Oriented Outcomes*:**

A) Satisfaction

- **Families**
  Previous research finds that families are more satisfied with wraparound services when they are encouraged to participate in the case planning process, they feel supported by the wraparound staff, and there is explicit focus on family strengths (Breaut et al, 2005). When parents and caregivers feel valued and supported they generally report higher satisfaction with wraparound services. In one evaluation study, (Malysiak, et al., 1996) among 48 parents receiving Wraparound services, parents reported high satisfaction (71% and higher) with various aspects of the participatory panning process, such as having adequate information to make decisions with the family support team, believing their strengths were considered in the planning process, and feeling that their own opinions and ideas were valued and respected. Thus, it appears that involving families by using the wraparound approach to make important decisions concerning their children is beneficial to parents/caregivers.

- **Children and Youth**
  There are few studies identified which assessed if children and youth were satisfied with receiving wraparound services. In one study (Rosen, Heckman, Carro, & Burchard, 1994) examining satisfaction among 20 children and adolescents, they found an overall high satisfaction rating with services and that higher satisfaction was significantly related to a greater sense of involvement with the treatment plan. However, this is a small sample size and did not use a comparison group to identify if youth were generally more satisfied with receiving wraparound services as compared to receiving conventional or traditional services. The important highlight of this study is that children/youth were more committed to the plan when they felt more satisfied and involved with the process.

B) Cost-Effectiveness

In the Untied State**s,** studies examining the cost-effectiveness in using the Wraparound approach for providing services typically find that wraparound services costs are no different or a less than providing traditional services to children/youth (Buchard and Clark, 1990). While this has been a general finding, Bickman et al. (2003) in a quasi-experimental group comparison study found that costs were significantly higher (42%) for a group of severely emotionally and behaviorally disturbed youth (SEBD) (N=72) receiving wraparound services as compared to SEBD youth receiving treatment as usual. The finding of the previous study is in

contrast to a study conducted in Ontario which found that the cost for families receiving wraparound services cost significantly less than families who received traditional services (Brown, 2003). Further research is needed to tease out possible reasons for these discrepant findings.

Child and Family Outcomes: Long Term Effectiveness:

Child & Family Positive Outcomes

Most of the identified data examining the influence of using the wraparound approach for providing services to children and families has focused on child/youth related outcomes such as child mental health.

In a study (Copp, Bordnick, Taylor, & Thyer, 2007) examining the effectiveness of using wraparound services with 15 children and families with a computer-based field assessment system, it was found that clinical functioning as assessed using the Child Behavior Checklist (CBCL; Achenbach, 1991) and the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1994) did not significantly change from baseline to 6 months later after receiving the wraparound services. However, this study had high attrition (only 15 families examined out of the total 45 children), small sample size, and did not include a measure of fidelity to the wraparound model. Therefore is not known how consistently and comprehensively the wraparound services were administered.

In another study (Stambaugh, Mustillo, Burns, Baxter, Edwards, & Dekraii, 2007) it was also found using the CBCL and the CAFAS and comparing three different treatment modalities/interventions over 18 months (wraparound only group, a MST-only group, and a group who received both wraparound and MST) that youth who received MST services showed more improvements in clinical symptoms than those who received only wraparound services. Similar results were found in a randomized study looking at the effectiveness of using wraparound versus a treatment as usual group whereby there were no significant differences in children's clinical outcomes (Bickman, Smith, Lambert, & Andrade, 2003).

In research looking at the effectiveness of using wraparound services versus conventional treatment for *offending youth*, the results are more positive. One randomized study using a pretest/posttest design (Carney & Frederick, 2003), found that for 73 youth who received wraparound services versus 68 youth receiving treatment as usual, the youth receiving wraparound services missed school less often, did not run away from home as frequently, were reportedly less assaultive, and less likely to be picked up by the police. There were no significant differences between the two groups, however, in subsequent offenses.

More recent studies and presentations are also finding that youth receiving services using the Wraparound approach evidence greater improvement in mental health functioning (Bruns et al., 2006; Pullman et al., 2006; Rast et al.,

2008); improved school achievement (Bruns et al., 2006), lower recidivism rates (Pullman et al, 2006); and fewer residential placements (Rast et al., 2008) when compared to youth receiving treatment as usual or traditional services.

There are some studies that find contrasting results to the ones above when comparing wraparound services in child welfare to families who receive treatment as usual. Specifically, some studies find that that children/youth's clinical symptoms and functioning increases for individuals receiving the wraparound services as compared to those who receive treatment as usual (Evans, Armstrong, Kuppinger, Huz, Johnson, 1998; Clark et al., 1998). However, when there is fidelity to wraparound services, results show that children's clinical symptoms decrease and there are positive outcomes for children's mental health (Bruns, Suter, Force, & Burchard, 2005).

What can be concluded from these inconsistent findings? It appears that when there is adherence to the wraparound process, than there are positive results for child and family well-being. However, it is less clear as what components of the wraparound process lead to these positive outcomes. Further, in evaluating the effectiveness of wraparound services there will be different results depending upon the outcomes being studied and the individuals being served. In examining the literature it appears that the Wraparound approach is especially promising for children and youth who have Severe Emotional and Behavioral problems and who have been identified as juvenile delinquents. It also appears, though there is not a wealth of conclusive evidence, that the Wraparound approach may be more cost effective when providing services to this particular population of youth. Programs and agencies adopting wraparound services need to identify the intent and goals for using wraparound services, for whom these services are being used, and then effectively evaluate if these outcomes and goals are met.

SELECTED PROGRAMS AND MODELS USING THE WRAPAROUND SERVICES APPROACH

Circle Around Families

Circle Around Families: The *Circle Around Families* (CAF) is a family focused development initiative working with 147,000 people in Lake County Indiana and works with seriously emotionally disabled children and their families. It is a system of care for children and their families and involves family participatory planning by utilizing the wraparound process and includes an emphasis on using existing family and child strengths. In using the wraparound process, a Service Coordinator works with the family and their child and other people that are important to the family and child, creating a team to develop a "service map" that is based on existing family strengths and available resources.

The goals of CAF are to 1) enhance mental health services for children and adolescents with serious emotional disturbance by providing both traditional and

non-traditional services, 2) implementing interagency collaboration and blending funding streams by using the wraparound process, and 3) empowering parents through their involvement and participation. Currently there are no published child and family outcome data examining how participation in the CAF services affects the functional life of the family and children's clinical status. However, there is a study currently being conducted. More information can be accessed at: http://www.circlearoundfamilies.org/index.html

Circle of Care

Funded by the Center for Mental Health Services (CMHS), *Circle of Care* is designed to support Federally recognized tribal governments and urban Indian programs in efforts to appropriately implement and evaluate culturally appropriate mental health service models for American Indian/Alaska Native children who have serious emotional problems and their families (Freeman, Iron Cloud-Two Dogs, Novins, & LeMaster, 2004; Thurman, Allen, & Deters, 2004).

The guiding principles for the *Circle of Care* model are (taken from Novins, Freeman, Thurman, Iron Cloud-Two Dogs, Allen, LeMaster, & Deters, 2006):

- Programs are community-based, build upon the strengths of research partners and the need to recognize the various and different traditions and viewpoints within a family and community
- All programs should be collaborative, learning from each other and appreciating the contributions all of all team members
- That change for families and communities is possible and implementing the evidence-based process can contribute to positive changes.
- Programs need to disseminate results to key stakeholders
- All programs need to identify and achieve specific outcomes for families and communities.

Reclaiming Futures

Reclaiming Futures is a specific treatment model that incorporates the wraparound approach (a "systems of care" model) for working with teens who have substance abuse problems and who are in the juvenile justice system (Yahner & Butts, 2007). *Reclaiming Futures* is designed to bring together multiple agencies, is multidisciplinary, and uses *family-driven service teams* that all work together to plan interventions for many drug-involved juvenile offenders by creating a personal care plan.

The theory behind *Reclaiming Futures* is that youth with substance abuse problems will experience more positive outcomes when the service of delivery systems are coordinated and managed appropriately and when youth receive evidence-based substance abuse treatment. *Reclaiming Futures* is a model that also works to bring about organizational change and this in part involves

including families in the operations of juvenile courts, adolescent mental health, operations of the juvenile probation agencies, and the substance abuse treatment system (Butts & John, 2007).

Currently an independent pilot evaluation has been conducted among 10 communities (Anchorage, Alaska; Santa Cruz, California; Chicago, Illinois; southeastern Kentucky; Marquette, Michigan; the State of New Hampshire; Dayton, Ohio; Portland, Oregon; the Sovereign Tribal Nation of Sicangu Lakota in Rosebud; South Dakota; and Seattle, Washington) using the *Reclaiming Futures* model. The results form this pilot evaluation found that local agencies succeeded in involving families in the *Reclaiming Futures* programs and that from 2003 to 2007 there was significant improvement in mean family involvement scores (from 2.1 to 3.9) (Butts & John, 2007) showing that overtime the process of involving families improved. There was also significant improvement in interagency collaboration and involving many community supports. While evidence suggests promising process results there are no published empirical studies examining how and if the *Reclaiming Futures* model leads to individual improvements and positive outcomes.

More information concerning the *Reclaiming Futures* model is found at: http://www.reclaimingfutures.org/

Fostering Individualized Assistance Program (FIAP)

The Fostering Individualized Assistance Program was developed by Hewitt Clark and others in 1995 and 1996 at the University of South Florida to improve permanency outcomes for foster children. The purpose of FIAP is to provide individualized wraparound services to foster children who have emotional and behavioral problems and their families and caregivers. In 1996, Clark, Lee, Prange, and McDonald conducted a random assignment study comparing children who received traditional services (78 children/youth) with those who received the FIAP (54 children/youth). The evaluation revealed that children who participated in the FIAP model (i.e., received wraparound services) were significantly less likely to change placements, FIAP boys had significantly lower rates of delinquency and fewer externalizing problems, and older FIAP youth were significantly more likely to be in permanency settings with relatives or parents. While this is one study, the program appears to attain successful results in using wraparound services to serve children and youth who have emotional and behavioral problems.

A detailed description for the FIAP model can be found in McDonald, Boyd, Clark, and Stewart, 1995.

MEASURES TO EVALUATE THE EFFECTIVENESS OF WRAPAROUND SERVICES

In order to better understand how effective and in what ways Wraparound Services (or versions of this process) works, programs and agencies are encouraged to participate in evaluative efforts. Here are some current measures being used:

- *Wraparound Fidelity Index* (WFI; Bruns, Suter, Force, and Burchard, 2002). This measure assesses participants satisfaction with 16 aspects of the conference (i.e., satisfaction with conference process, the final plan, individual's satisfaction with their participation) on a 4-point Likert scale of "strongly agree" (4) to "strongly disagree" (1) and to open-ended questions. In a study in 2006 the WFI was implemented to examine empirically the relationship between organization and system level supports for bringing about positive changes for children and families (Bruns, Suter, & Leverenz-Brady, 2006). For caregivers and youth, sites where there were greater levels of organization and system supports demonstrated higher fidelity to the wraparound model (higher WFI scores) and higher participant satisfaction.
- *Partnership Assessment Tool* (Integrated Care Network, Nuffield Institute for Health). This measure assesses the effectiveness of partnerships based on six principles: recognize and accept the need for partnership, develop clarity, ensure commitment, develop and maintain trust, create clear partnership arrangements, and monitoring and learning from these partnerships.
- *Wraparound Observation Form* (WOF; Epsein et al., 1998; see attached questions in Appendix B). This process-oriented measure assesses the fidelity of wraparound services adhering to wraparound principles, such as parents being included at every step of the process, services have to be based in the community, services have to be given in an inter-agency format, outcomes of every service must be measured, etc). The WOF contains 34 items that are closed-ended wherein respondents are asked to select either "Yes", "No", or "Not Applicable". The measure demonstrates good reliability.

RESOURCES FOR WRAPAROUND PROGRAMS

- A detailed report that discusses the wraparound framework and the necessary conditions needed to adequately administer the model is entitled, "Implementing High-Quality Collaborative Individualized Service/Support Planning: Necessary Conditions", which can be retrieved from the Research and Training Center on Family Support and Children's Mental Health at Portland State University in Portland, Oregon, from www.rtc.pdx.edu.
- Various resources can also be retrieved from the National Wraparound initiatives website: www.rtc.pdx.edu/nwi. There is extensive information concerning the theory, evidence, and best practices for effectively implementing the Wraparound approach.
- Manuals for Implementing wraparound interventions:

- Eber, L. (2003). *The art and science of wraparound.* Bloomington: Forum on Education at Indiana University.
- Grealish,M. (2000). *The wraparound process curriculum.* McMurray, PA: Community Partners.
- VanDenBerg, J., & Rast, J. (2003). *Wraparound coaching and supervision toolkit.* Englewood, CO: Vroon VanDenBerg.

❖ San Diego Children's System of Care Wraparound Training Academy provides certification training for becoming a Wraparound Facilitator. More information can be attained from: Liz Marucheau can be reached at 619-563-2769 or liz.marucheau@sdcounty.ca.gov

BEST PRACTICES: WHAT WORKED?

In examining the available literature and research on participatory planning there are some key factors that have been identified which contribute to successful models implementing participatory planning practices. These model components that were effective from the models and participatory planning practices reviewed include:

WHAT WORKS?

ESSENTIAL COMPONENTS FOR FAMILY GROUP CONFERENCING:

Preparation

- Adequate preparation (at least 20 hours) is needed for a successful family group meeting

Family Participation

- The program needs to focus on "empowering parents" by supporting them to develop solutions and assist in developing the family plan
- Schedule the FGC meeting in a neutral and comfortable place
- Schedule the FGC meeting early enough in the day so that the meeting is not cut short
- Recognize traditions and culture and incorporate the family's culture into the opening, closing, and process of conducting the FGC
- Include children in the process and spend time preparing them prior to the meeting to ensure that their "voices are heard"

Stabilize Crises

- Address parent/caregivers pressing needs so that the team can develop proactive crisis/safety planning

Follow Through

- Even after a family "crisis" ends workers should ensure that the agreed upon plan is followed through and that families continue to receive support

Evaluate the Program

- An outcome evaluation needs to be conducted which can assess if the program objectives and goals were met
- Conduct an implementation evaluation to understand what processes are being carried out and how they relate to outcomes

ESSENTIAL COMPONENTS FOR USING THE WRAPAROUND MODEL:

Wraparound Model Itself

- The wraparound model is a *process* of providing services to children and families, it is not a program or type of service
- Identify community supports and involve the community in constructing the individualized family plan

Individualized

- The intention of the wraparound model is to create services one child at a time, meeting the unique needs of the family and the child
- To create a family plan that is family centered and specific to the family

Strength-based

- Focuses on the family's existing assets and skills and how these positive qualities of the family can contribute to the family plan
- It takes the focus away from pathology

Comprehensive

- The needs of families are typically addressed in three or more life domains: safety/crisis, medical, legal, educational/vocational, living situation, psychological/emotional, and social.

Flexibility

- It is important that the family plan is followed as agreed upon, but there also needs to be flexibility as the child and family's needs change and strengths develop
- The team members need to meet regularly (some advocate once a month) to monitor progress and make changes and modifications to the plan as needed

Evaluation

- The family plan needs to include outcome measures such as child well-being

- Conduct an implementation evaluation to understand what processes are being carried out **and** how they relate to outcomes

CONCLUSIONS

There is growing interest and popularity to implement participatory planning in the family social services arena. However, despite this growing interest, currently there are some inconclusive findings and lack of empirically tested effectiveness for improving positive outcomes for children and families in the long term. These inconclusive findings are common when contending with such complexity. As stated by some researchers, "Theoretically, involving parents, changing parenting attitudes and behaviors, and improving parent-child interactions should have both short- and long-term positive effects on child development . . . However, there is little research evidence to support the assumption that parent services affect child outcomes." (Wagner & Clayton, 1999).

While there is not sufficient evidence in peer-reviewed journals to conclude that Wraparound services or Family Group Conferencing consistently results in better outcomes than alternative treatments for particular groups of children and families, there is some encouraging and positive evidence. The research generated thus far illustrates the effectiveness of the participatory planning model, mainly involving families in the decision making process for contributing to some positive outcomes for families and children. Some of the most noted process oriented findings are that families are generally satisfied with the participatory planning process (FGC's and Wraparound), exhibit greater commitment to receiving services and feel more empowered when they are involved in contributing to decisions that affect them and their families. Participatory planning, specifically the Wraparound approach, appears to lead to decreased clinical symptoms, decreased recidivism rates, and increased school achievement for Severely Emotionally Disturbed children and youth.

While there are some promising consequences of using participatory planning methods in child welfare services, most of these models are not supported by rigorous and/or comprehensive longitudinal data. Further research is needed that addresses both the short and long term outcomes of incorporating participatory planning for children and their families. Although there are some positive results in using FGC and Wraparound Services, currently it is difficult to draw conclusions from the small number of experimental (Evans, Armstrong, Kupperinger, 1996) and quasi-experimental studies (Bickman, Smith, Lambert, et al., 2003; Hyde, Buchard, Woodwarth, 1996). This is in part attributed to the lack of fidelity in control and measurement (Bruns, Suter, & Leverentz-Brady, 2006).

Specifically, Farmer, Dorsey, & Mustillo, 2004, concluded that, "currently the evidence base for wraparound seems to fall short on the weak side of 'promising.' …Although various researchers and authors have been involved, the publication outlets for this work have been narrow (and frequently not peer

reviewed)" (p. 869). Due to the paucity of existent rigorous evaluative research, agencies should be cautious and effectively evaluate the consequences of incorporating participatory planning services for children and families (for suggested ways to use evidence-based practices see Appendix C).

To better inform the use of participatory planning in child welfare services it is recommended that evaluations use experimental designs and random assignment. The goal of such evaluations are to determine what services lead to better child and family outcomes than traditional child welfare services. Furthermore, evaluations should continue to understand the process by examining the degree to which program implementation remains consistent with the theories, goals, and implementation objectives of each model and intervention.

Further research and development in the area of participatory planning in child welfare services can help to inform social policy by providing a more thorough look at model fidelity and how specific participatory planning processes relate to child and family outcomes. At this time the most promising finding is that families and children are more satisfied with being active participants and decision makers and feel empowered doing so. Also social workers feel that they have better working relationships with families when families are given the opportunity to actively contribute to their plans. Thus, improving relationships and generating greater trust are positive outcomes in using participatory planning in Child Welfare Services. As succinctly stated by Walker (2008), wraparound services (or similar participatory planning models) is, "…a single, coherent posture or mode of helping that is fundamentally respectful, optimistic, and empowering" (pg. 8).

Any agency that wants to adopt a participatory plan is advised to address the following questions in order to choose the appropriate program:

- What are the expected outcomes of using a specific participatory planning model/or process? (e.g., reduction in the re-occurrence of substantiated child maltreatment cases)
- For whom are these models appropriate? (which families will benefit)
- What changes are required of workers?
- What changes are required to implement the intervention or program?
- In what context are these interventions and programs going to operate?
- Is the program and/or intervention cost effective?

Addressing these questions prior to adopting a participatory planning model and/or approach should lead to better implementation and to more positive results for children and families in need of supportive services.

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APPENDIX A: Satisfaction Questions

(Note: These questions do not come from a standardized measure, but may assist in evaluating part of the process in using Family Group Conferences and if and what modifications are needed)

Empowerment

1. I felt comfortable about sharing important information with those involved in this family plan.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

2. I was comfortable asking the professionals/service providers questions.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

3. My opinions and decisions about how to ensure the children's safety and wellbeing were respected.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

4. I feel I will be able to help ensure the child(ren)'s safety.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

Clarity of Expectation

1. The purpose of the agency and the agency's intervention was explained to me.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

2. The steps involved in the development of a plan to keep the child(ren) safe were explained to me.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

3. The sources of available help were explained to us.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

4. I understand what will happen if the plan is not followed.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

Identification of Issues in Family Plan

1. The family plan identified the needs of this family.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

2. The family plan ensures the child(ren)'s safety.

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

APPENDIX B:
WRAPAROUND OBSERVATION FORM
(Author: Epstein et al., 1996).

Directions: Please circle the appropriate response below each question.

1) Information about support services in the area is offered to the parent/team.

YES NO NOT APPLICABLE

2) Plans include at least one public and/or private community service.

YES NO NOT APPLICABLE

3) Team choose community placements for child(ren) rather than out-of-community placements whenever possible.

YES NO NOT APPLICABLE

4) Individuals (non-professionals) important to the family are present at the meeting.

YES NO NOT APPLICABLE

5) The parent is asked what treatments or interventions he/she felt worked/didn't work prior to Satellite.

YES NO NOT APPLICABLE

6) Satellite staff advocates for services and resources for the family (e.g., identifies and argues for necessary services).

YES NO NOT APPLICABLE

7) All services needed by family are included in plan (i.e., no services were rejected.

YES NO NOT APPLICABLE

8) The steps needed to implement the service plan are clearly specified by the team.

YES NO NOT APPLICABLE

9) Strengths of family members are identified and discussed at the meeting.

YES NO NOT APPLICABLE

10) Convenient arrangements for family's presence at meeting are made (e.g., time, transportation).

YES NO NOT APPLICABLE

11) The parent/child is seated or invited to sit where he/she can be included in the discussion.

YES NO NOT APPLICABLE

12) Family members are attended to in a courteous fashion at all times.

YES NO NOT APPLICABLE

13) The family's perspective is presented to professionals from other agencies.

YES NO NOT APPLICABLE

14) The family is asked what problems he/she would like to work on.

YES NO NOT APPLICABLE

15) The parent is asked about the types of services he/she would prefer for his/her family.

YES NO NOT APPLICABLE

16) Family members are involved in designing the service plan.

YES NO NOT APPLICABLE

17) In the plan, the family is assigned tasks and responsibilities that facilitate their independence (e.g., accessing resources on own, budgeting, maintaining housing).

YES NO NOT APPLICABLE

18) The team plans to keep the family intact or to reunite the family.

YES NO NOT APPLICABLE

19) Professionals from other agencies who care about or provide services to the family are at the meeting.

YES NO NOT APPLICABLE

20) Professionals from other facilities or agencies (if present) have an opportunity to provide input.

YES NO NOT APPLICABLE

21) Problems that can develop in an interagency team (e.g., turf problems, challenges to authority) are not evident or are resolved.

YES NO NOT APPLICABLE

22) Services are not terminated because of the multiplicity or severity of the child's/family's behaviors/problems.

YES NO NOT APPLICABLE

23) For severe behavior challenges (e.g., gangs, drugs) discussion focuses on solutions (e.g., services and stuff to be provided) rather than discharge.

YES NO NOT APPLICABLE

24) The service plan goals are discussed in objective, measurable terms.

YES NO NOT APPLICABLE

25) The criteria for discharge of services is discussed.

YES NO NOT APPLICABLE

26) Objective information on child and parent functioning is used as outcome data.

YES NO NOT APPLICABLE

27) Key participants are invited to the meeting (i.e., family members, DCFS worker, teacher, therapist, other significant to the family).

YES NO NOT APPLICABLE

28) Basic information about the family is gathered prior to the meeting.

YES NO NOT APPLICABLE

29) All meeting participants introduce themselves.

YES NO NOT APPLICABLE

30) The family is informed that they may be observed during the meeting.

YES NO NOT APPLICABLE

31) A service plan is completed at the meeting.

YES NO NOT APPLICABLE

32) A service plan is agreed on by all present at the meeting.

YES NO NOT APPLICABLE

33) Team members are supportive of other Satellite staff (e.g., share information, respond to each other's ideas, offer to follow through on specific tasks).

YES NO NOT APPLICABLE

34) Team members develop goals/outcomes and solve problems together.

YES NO NOT APPLICABLE

APPENDIX C: THINKING ABOUT EVIDENCE-BASED PRACTICES

As stated throughout this review, any participatory program, model, and/or intervention that is adopted should identify measures for success and the expected outcomes of using a particular approach. Below is a diagram which provides one way in thinking of how to plan and implement an evidence-based approach: