COLLABORATIVE EFFORTS IN CHILD WELFARE PRACTICES: PARENT’S PERSPECTIVE ON TEAM DECISION MAKING (TDM)

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COLLABORATIVE EFFORTS IN CHILD WELFARE PRACTICES: PARENT’S PERSPECTIVE ON TEAM DECISION MAKING (TDM)

A Project

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Division of Social Work
Abstract

of

COLLABORATIVE EFFORTS IN CHILD WELFARE PRACTICES: PARENT’S PERSPECTIVE ON TEAM DECISION MAKING (TDM)

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The child welfare system has struggled to create stable placements for children. In 1992, the Family to Family Initiative created funding to child welfare agencies to address the needs of children in foster care through the use of Team Decision Making (TDM). A total of 18 birth parents were interviewed about their perceptions of the program. Results of this study found that 94.4% of the participants felt they were treated with respect and would attend another TDM in the future if needed. There was a significant association between parents feeling respected and efforts of the facilitator to include their participation in the meeting. Among the female participants, there was a strong correlation between level of involvement in the case plan after the TDM and level of involvement in decisions regarding the care of their children (r = .998, p < .000).

________________________________________, Committee Chair
Serge Lee, Ph.D.

________________________________________
Date

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DEDICATION

I would like to dedicate this project to the two most important people in my life – my children, Alyssa and Kevin. I want to thank the both of you for your patience, love, and understanding. You are both my inspiration in completing this project and I know that all of those hours away from you will prove to be beneficial for the three of us in the future. I love you both.

I would also like to dedicate this to mom. Thank you for all of your help with the kids and for the support you have given me throughout the years. Your encouragement has helped me to accomplish so much. I could never have achieved this without you. I love you.

Last, but definitely not least, I would like to thank my grandma. I know that you are watching me from above, smiling, with your eyes full of pride. You always had faith in me. No matter what I did, you knew that I would be a college graduate. Wow, if you could only be here to see this! I love you and I miss you.
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Chapter 1

THE PROBLEM

Introduction

Within the child welfare system, placement changes for foster care children remain high. According to the Sacramento County Department of Health and Human Services (DHHS) grand jury report, 17.5% of children in foster care have experienced six or more placement changes, 6.1% are in their fifth placement and 8.1% are in their fourth placement (DHHS, 2010). In fact, Sacramento County ranks last for placement stability compared to other large California counties. Several studies have shown that at least half of the children in foster care have been in more than one placement (Connell, Vanderploeg, Flaspohler, Katz, et al., 2006; Staff & Fein, 1995; Webster, Barth, & Needell, 2000 as cited in Crea, Wildfire, & Usher, 2009). While the initial removal of a child from primary caregivers is itself traumatizing, subsequent removals for children can be detrimental. In fact, Crea, Wildfire, and Usher reported that multiple placement changes for foster care children can cause mental and behavioral health issues, a higher likelihood of returning to the child welfare system after reunification, and more at risk for future delinquent behavior.

The states began to develop child welfare programs when the federal government provided funding through Title V of the 1935 Social Security Act (Abramovitz, 2007). Abramovitz reported that child welfare programs were further expanded in the 1960’s. In 1961, a nameless Act established during the Kennedy administration, responded to the
growing poor population in the United States (Sanders, 2003). Sanders discussed that through this law, welfare entitlements were now open to families where the primary wage earner had exhausted unemployment benefits instead of just women and children in homes without male wage earners. According to Sanders, this was when welfare assistance changed from being called Aid to Dependent Children (ADC) to Aid to Families with Dependent Children (AFDC). The 1961 Act also provided federal funding to help support state foster care systems (Davidson, 2008). Most of these families served by the child welfare system were poor and were receiving cash assistance through AFDC; therefore, Congress endorsed the concept of connecting maintenance funds for foster care to the family-of-origin income determination (Davison). The 1961 Act was unintentionally harmful to foster care children because although the families whose homes they were living in were receiving money for their care, it was also sustaining them in foster care rather than moving them out of foster care and back with their families (Sanders).

Following the 1961 Act, more and more children were entering the foster care system due to the failure of the Act to provide a strategy for moving children out of the foster care system (Sanders, 2003). To help improve child welfare practices and to better ensure permanence for children, a new act was passed in 1980 (Sanders). This act discussed by Sanders, which was called the Adoption Assistance and Child Welfare Act, aimed at preventing the removal of children by requiring states to make reasonable efforts prior to placing a child in foster care. In addition, the Act ensured the possibility
of children to return home if they were removed and to provide assistance for adopted
children (Sanders). Sanders reasoned that their efforts made to support the family often
consisted of subsidized services in hopes of creating a more stable environment for the
children, but often failed leaving children to remain in long-term foster care.

In an effort to correct these failures of the 1980 Adoption Assistance and Child
Welfare Act, Congress passed the Adoption and Safe Families Act of 1997 (Sanders,
2003). The Adoption and Safe Families Act was established to ensure that decisions
were made in a timely manner for children’s permanence and to reduce the foster care
drift (Green, Rockhill, & Furrer, 2006). According to Sanders, this new Act was a “shift
[which] may mean giving up on parents” (p. 212). One of the key differences between
the 1980 Act and the 1997 Act was that the latter of the two declared that reasonable
efforts to preserve children in their families would not be required in cases that threatened
the health and safety of a child (Sanders). Other requirements of the Adoption and Safe
Families Act included permanency hearing 12 months after a child’s initial entry into
foster care and that termination proceedings begin when a child has been in
nonpermanent care in the last 15 out of 22 months (Green, Rockhill, & Furrer). Sanders
also reported that the Act established concurrent permanency planning during the
reunification process as a creation of a back-up plan if parents fail to reunify and state
bonuses for each child adopted above a predetermined baseline.

Although the passage of the 1997 Adoption and Safe Families Act has increased
permanency outcomes for children, children in the child welfare system continue to
suffer. The United States family foster care system is not equipped to meet the needs of children, mostly because there has been a decline in foster care families and an incline in children coming into the foster care system (Mattingly, 1998). There have been recent changes to child welfare practices in hopes of better serving children and families through the implementation of the group model, specifically in the form of Family Group Decision Making (FGDM) and Team Decision Making (TDM) meetings. These meetings seek to include families in the decision making process of services related to child welfare.

The FGDM model, which was developed in New Zealand during the late 1980’s (Weigensberg, Barth, & Guo, 2009), is a family-centered practice used in child welfare. The strategy of FGDM was designed to impact the overrepresentation of indigenous Maoris children that were placed in out-of-home care (Weigensberg, Barth, & Guo). FGDM can be described as a gathering of all parties who have an interest in the well-being of a child and his or her family to discuss family resources and strengths, child safety and reports of maltreatment, and any necessary changes needed to support the welfare of the child and family (Berzin, 2006). This practice was introduced to the United States in the 1990’s and emphasizes the rights of children and families with the importance of their inclusion in decision-making (Berzin, Thomas, & Cohen, 2007). Berzin, Thomas, and Cohen report that there are four phases to FGDM which include referral, preparation and planning, FGDM conference, and follow-up planning and events. The FGDM conference, which is the base of the intervention, includes an
introduction, information sharing, family planning, and finalizing the family plan (Berzin and colleagues).

In addition to FGDM, child welfare agencies across the United States have also been utilizing the TDM group model. Mattingly (1998) reported that TDM is a component of the 1992 Family to Family Initiative, established by the Annie E. Casey Foundation. The Annie E. Casey Foundation, founded by Jim Casey in 1948, has demonstrated their commitment to the welfare of disadvantaged children and families (Mattingly). The Family to Family Initiative provides funding to assist communities in improving the foster care system through these goals: (1) to provide neighborhood-based foster care, (2) to ensure foster care resources for children who are removed from the home, (3) to reduce institutionalized placements of children, (4) to increase number and quality of foster families, (5) to reunify children with their families as soon as it is safe to do so, (6) to reduce time in out-of-home care, and (7) to reduce the number of children coming into the system (Mattingly).

In order to fulfill these goals, the Family to Family initiative uses the key strategy of self evaluation. This self evaluation process is done through the use of data, which is intended to help improve child welfare practices (Webster, Needell, and Wildfire, 2002). While many child welfare agencies have viewed data as useless in planning and decision making, data has actually proven to identify neighborhoods in which child removal rates are very high (Webster, Needell, & Wildfire). In other words, neighborhoods where there may be higher needs for community resources can be pinpointed through the use of
data and prevent children from entering the child welfare system. Webster and colleagues identified changing attitudes towards data, applying technology to measuring outcomes, and utilizing self evaluation teams as the three components of the self evaluation process.

Webster, Needell, and Wildfire (2002) reported that applying technology to measuring outcomes was imperative in improving child welfare practices and outcomes. Webster and colleagues utilized the longitudinal studies to examine outcomes such as the rates of placement disruptions and planned reunifications and the length of stay in foster care. In addition to data and the use of technology, the Family to Family initiative recognizes the importance of teams in making child welfare practice decisions, which may include managers, supervisors, information technology staff, line staff, and community partners (Webster, Needell, & Wildfire). The theory behind these meetings is that each individual member brings a special knowledge and expertise to the table in order to create collaborative efforts towards child welfare decision making and planning. According to Webster, et al., Family to Family is based on the principle that child welfare agencies must coordinate with all those individuals concerned with the child such as birth families, foster families, and schools.

Other than self-evaluation, building community partnerships, resource family development and support, and TDM are the additional core strategies of the Family to Family Initiative (Crea, Wildfire, & Usher, 2010). Crea and colleagues described TDM as “a method of child welfare decision making that pursues the input of families,
caregivers, and community members in making placement decisions for children,” (p. 298). According to Crampton, Crea, Abramson-Madden, and Usher (2008) TDM includes six key elements. These elements are (1) a meeting held involving birth parents and youth for all decisions made regarding removals, changes of placement, and reunification or permanency plans, (2) the meeting is held prior to a removal, always before the initial court hearing, or by the next working days in imminent risk cases, (3) community partners are invited to the meetings, (4) skilled facilitators who are not case carrying social workers lead the meetings, (5) information for each meeting is collected for data to ensure TDM effectiveness, and (6) the meeting is used to plan for a first meeting between birth parents and foster families (Crampton, Crea, et al.).

In Sacramento County, TDM meetings consist of a team of people associated with the child or children; usually the facilitator from the department, the county social worker, the social worker’s supervisor, the birth parents and family, community agency representatives, and Parent Leaders. While many models of TDM vary in these specific elements, the main goal of a TDM meeting is to reach a consensus decision regarding the placement of the children (Center for the Study of Social Policy, March 2002). In regards to child placement, Crea, Wildfire, and Usher reported that a large number of children experience at least one placement change and some experience more. The effects of placement changes is significant for both children and agencies; agencies suffer through additional time and money spent for every placement change, while the impact on children is an increased risk of reentering the foster care system and negative impacts
on behavior and mental health (Crea, Wildfire, & Usher). Therefore, TDM is an important practice in relation to positive outcomes for child placement.

**Purpose**

While there have been significant progress in child welfare practices, there are still many challenges to permanency for children. Often children who enter the child welfare system as dependents remain in foster care for extended periods of time; many linger in permanent foster homes until the age of 18 when they’re forced to leave and live independently regardless of their ability to do so. Historically, child welfare decisions have been primarily made within the agency and have placed less priority on collaboration between agency staff, birth families, and community partners. However, the implementation of the Family to Family initiative throughout various child welfare agencies has changed these attitudes and beliefs towards working with families and the community. This Master’s Project focused on TDM specifically within Sacramento County Child Protective Services and its purposes included:

1. Explored the perceptions and views of birth parent TDM team members
2. Described the feelings and impact created on birth parents by the TDM process
3. Explained why birth parents may or may not participate in the TDM meeting

**Theoretical Framework**

When looking at group models, such as TDM, it is important to recognize group theories that are utilized in this approach. The task-centered approach, which is often applied to groups, is a social work practice model that attempts to eliminate or reduce
problems identified by the client through the use of tasks and time limits (Hepworth, Rooney, Rooney, Strom-Gottfried, et al., 2010). Hepworth, Rooney, et al. found that the task-centered model is an eclectic approach, utilizing behavioral and social learning theories in addition to crisis intervention and problem-solving theory and techniques. Major components of the task-centered approach are using tasks to achieve goals and recognizing that clients are capable of solving their own problems (Hepworth, Rooney, et al.).

The task-centered approach can be applied to TDM meetings, as part of the meeting includes an action plan in which individuals are responsible for completing certain tasks to stabilize a child’s placement (Crampton & Natarajan, 2005; Center for the Study of Social Policy, 2002; Crampton, Crea, Abramson-Madden, & Usher, 2008). At the conclusion of the meeting, each participant is given a copy of the decision and the action plan so that those who are assigned tasks know what they are supposed to do and when they are supposed to complete the task (Center for the Study of Social Policy). Crampton and Natarajan reported that the facilitator must keep the discussion on track and contract the work towards group goals in order for successful task completion. Recognizing family expertise, the family is encouraged to share their perspective and to come up with strengths and ideas to create a safer environment for their children (Crampton, Crea, et al.).

Another eclectic approach that can be applied to TDM is the ecological systems perspective, which focuses on the client in his or her environment (Greene, 2008).
of the major concepts included in the ecological systems approach are goodness-of-fit and adaptiveness. Goodness-of-fit, as defined by Greene is the match between one’s environment and one’s needs. Adaptiveness occurs when individuals and their environment respond to one another to create the best goodness-of-fit (Greene). Greene found that when individuals have achieved goodness-of-fit in their environment, their social, cognitive, and emotional development are enhanced; on the other hand, when there is not a goodness-of-fit between individuals and their environment, development is inhibited and individuals experience a lack of ability to cope.

The ecological systems theory uses the tools of ecomaps and genograms to identify resources and barriers in one’s environment through an in-depth look at microsystems, mesosystems, exosystems, and macrosystems. Bronfenbrenner (1979) as cited in Greene (2008) described the microsystem as the client of focus, while the mesosystem are those having face-to-face contact with the client such as the family or peers. The exosystem are those systems not directly in contact with the client, such as the community, the school system, and/or the media (Greene). The macrosystem was noted by Greene as the broader society, including social policies, culture, and/or political systems. The ecological systems approach takes into account all of these levels of systems as they all impact the client in one way or another and need to be recognized by those helping professionals.

Greene (2008) believed that the benefits of the ecological approach are the focus on person-environment fit, the exchange between people and their environments, and
elements that either inhibit or support that exchange. The ecological systems approach emphasizes its connections among individuals at various system levels (Greene). Greene found that “by offering the opportunity to relate to others and to exchange resources and social support, social networks have the potential for contributing to growth and adaptation,” (p. 219). In other words, systems can benefit from one another by the exchange of information and resources. Therefore, individuals and families can benefit from the resources and supports available to them in their own communities.

TDM is based on a collaborative effort between child welfare agency staff, birth families, and community partners. Therefore the ecological systems perspective is a logical approach to utilize in the child welfare system and specifically in TDM. TDM meetings utilize the ecological systems approach in child placement by identifying the best goodness-of-fit between child and environment and also by reducing the child’s stress. “The social worker’s practice role from an ecological perspective is to address situations in which goodness-of-fit has not been achieved sufficiently and a lack of fit is causing a client to experience undue stress,” (Greene, 2008, p. 208). For example, a TDM meeting may be held to remove a child from one foster care family to another. In this case, the child may not have been adapting well to the first foster family and therefore did not experience goodness-of-fit in his or her environment. Once the TDM is held, the team may discover that the new foster family is a better match for this particular child and the child may have better outcomes in adapting to his or her new environment.
The main concern of child welfare practitioners is the safety of the child with the intent to reunify children with their birth families. TDM meetings help to promote child safety and identify the safest and best placement for the child of focus. In order to achieve these results, TDM meetings involve all levels of systems to make the best placement decision for children. The microsystem may be represented by the child if the child is over the age of 10-years-old and family members such as parents, grandparents, aunts, and uncles. Neighbors, teachers, and friends of the family usually make up the mesosystem and may participate in the meeting in support of the family or in hopes of offering kinship care. The exosystem present in the TDM meeting usually consists of community agency representatives, Parent Leaders, and school personnel. The macrosystem is always present in TDM, considering that child welfare policies and practices influence all decisions made regarding placement. For example, there must be an attempt to place Native American children with Native American foster families under the Indian Child Welfare Act.
Chapter 2

LITERATURE REVIEW

Introduction

Former foster youth reported that there are many problems within the Sacramento County foster care system, including the unavailability of their social worker and multiple placement changes (DHHS, 2010). In addition, foster families in Sacramento County also have concerns; many feel that they receive inadequate training and that they are given little information about the children being placed in their homes, such as disabilities, medical history, and behavioral problems (DHHS). The concern for Sacramento County’s foster care system increases, as recent budget cuts have severely impacted Child Protective Services (CPS) (Kalb & Lundstrum, 2010).

Due to these recent budget cuts, Sacramento County CPS has had to lay off a significant amount of staff, including management, social workers, and clerical employees. These layoffs have led to the elimination of Family Maintenance services and have prevented the ability to implement other programs, such as Family Group Decision Making (FGDM). Sacramento County CPS is making a strong effort to sustain other programs that are currently helping families; these programs include Family Treatment Drug Courts (FTDC) and Team Decision Making (TDM). The utilization of these programs demonstrates Sacramento County’s commitment to collaboration with community agencies and birth families by including them in the child welfare process.
The following chapter will briefly discuss the history and the process of FTDC, FGDM, and TDM. It will also discuss the current research and the outcomes of these programs.

**History of Family Treatment Drug Courts**

In the late 1980’s, crack cocaine became a huge problem for the United States criminal justice system (Harrison & Scarpitti, 2002). Harrison and Scarpitti reported that drug-related arrests increased from 519,377 in 1979 to 1,115,200 in 1988; therefore, jails were overcrowded with drug offenders who had much higher rates of recidivism. The city of Miami was especially susceptible, as its distance from drug producing nations such as Latin and South America was close (Harrison & Scarpitti). In Mid-1988, according to Harrison and Scarpitti, Miami became part of a national study that researched the relationships between drugs and crime. This study, known as the Drug Use Forecasting study, found that 65% of arrestees in Miami during a six month period tested positive for cocaine (Harrison & Scarpitti).

As a result of the high recidivism and lack of available treatment for drug offenders, Miami established a drug treatment court in 1989 (Harrison & Scarpitti, 2002). With the goal of preventing recidivism, drug treatment courts were offered to drug offenders instead of jail sentencing (Green, Furrer, Worcel, Burrus, & Finigan, 2007). Harrison and Scarpitti reported that drug treatment courts were based on the rehabilitation model, utilizing treatment teams to administer drug testing, provide drug counseling, and monitor progress. If the city of Miami “really wanted to address the issue of recidivism and keep the same offenders from recycling before the court, they had to respond to the
offender’s drug use and addiction, and not just the criminal charge,” (Harrison & Scarpitti, p. 1444).

While drugs and alcohol have been a contributing factor to the increase in crime rates, they have also been an increasing factor in the removal of children from their families. In fact, it is estimated that 80 to 90% of child welfare cases involve alcohol and substance abuse issues (Feig, 1990). Studies have shown that children whose parents are abusing substances have the longest stays in foster care and the lowest probability of reunifying with their families (Gregoire & Schultz, 2001; Tracy, 1994). In an effort to produce better outcomes for children in the foster care system, child welfare agencies established FTDC programs for their drug and alcohol addicted clients. Modeled after drug courts in the adult criminal system, FTDC interventions intend to combine the goals of recovery for the parent(s) and safety and permanency for the children (Boles, Young, Moore, & DiPirro-Beard, 2007).

The development of FTDC was inspired by the Adoption and Safe Family Act (ASFA) of 1997, which required that child welfare systems focus their attention on permanent placement for children (Boles et al., 2007). Under this legislation, parents who abuse substances must demonstrate recovery from addiction as well as complying with reunification plans; parental rights can be terminated in as little as a one-year period if their efforts towards reunification fail (Rockhill, Green, & Newton-Curtis, 2008; Green et al., 2007). Rockhill et al. reported that drug treatment providers and child welfare workers have expressed concern about this time frame, arguing that 12 to 15 months is
inadequate due to the nature of the disease of addiction and the barriers to treatment entry. In fact, Brook and McDonald (2007) describe the time frames of ASFA and recovery as incompatible.

**The Sacramento FTDC Model**

The Alcohol and Other Drug Initiative, established by Sacramento County in 1995, was enacted in response to the large number of families affected by substance abuse (Boles et al., 2007). Boles et al. reported that the goal of the initiative was to train Department of Health and Human Services staff in assessing and providing intervention services for clients with substance abuse disorders. As a part of this system-wide reform, Sacramento County developed its FTDC program, known as Dependency Drug Court (DDC), to address the needs of substance abusing parents who were involved in the child welfare system (Boles et al.). According to Boles et al., DDC’s are popular among child welfare agencies because they enhance the success of family reunification and comply with the ASFA requirements.

By April 2006, a total of 183 FTDC programs were functioning in the United States in addition to another hundred in development (Bureau of Justice Assistance [BJA] Drug Court Clearinghouse, 2006, as cited in Green et al., 2007). Among these programs, Boles et al. (2007) reported that DDC’s fall under three types – integrated DDC’s, dual track or two-tiered DDC’s, and parallel DDC’s. The parallel model, which is used by Sacramento County, separates the dependency proceedings regarding abuse and/or neglect from the specialized drug court services (Boles et al.). Boles et al. reported that
DDC is offered at the first court hearing and the participation of the client is entirely voluntary. While clients can choose not to participate in the program, there is a threat that the clients may lose custody of their children permanently if they cannot address their drug and alcohol issues (Green et al.). All models of DDC’s utilize a team approach, demonstrating collaboration between treatment providers, child welfare workers, and other social service agencies (Boles et al.).

At the detention hearing in Sacramento County, an Early Intervention Specialist assesses clients for alcohol and other drug (AOD) abuse; if it is determined that the client will benefit from participating in DDC, the Early Intervention Specialist refers clients to the Specialized Treatment and Recovery Services (STARS) program (Boles et al., 2007). According to Boles et al., once an intake is done at the STARS program, the client is assigned a Recovery Specialist who manages the AOD portion of the child welfare case. This includes drug testing, monitoring substance abuse treatment and self-help meeting attendance, in addition to reporting the client’s progress to the court and child welfare social worker (Boles et al.). Boles et al. reported that clients are required to make a certain number of contacts with their STARS Recovery Specialist. If clients do not make these contacts, they may be found noncompliant in DDC and are subject to sanctions (Boles et al.). Other reasons for being found noncompliant in DDC, as described by Boles et al., include missed or positive drug tests, unexcused absences from treatment, failure to show up for a hearing, and neglecting to follow the treatment plan.
In addition to sanctions for noncompliance, FTDC’s offer rewards for clients who are compliant (Worcel, Furrer, Green, Burrus, & Finigan, 2008; Green et al., 2007). Boles et al. (2007) reported that Sacramento County also offers clients rewards for compliance. During the initial hearing in DDC, clients receive a STARS medallion which symbolizes their commitment towards recovery and reunification (Boles et al.). According to Boles et al., subsequent hearings of compliance are rewarded with different stones, including serenity stones, recovery stones, and success stones. Courage stones are given to clients who have made challenging decisions and hope stones are provided to clients who need additional motivation (Boles et al.). Boles et al. reported that at 90 days of compliance and 180 days of compliance, clients are provided with a certificate, take a picture with the DDC judicial officer, and are allowed to give a speech. Clients who have reached 180 days of compliance are considered graduates of the DDC program (Boles et al.).

**FTDC/DDC Outcomes**

In reviewing the literature, three studies evaluated the outcomes of FTDC programs (Boles et al., 2007; Green et al., 2007; Worcel et al., 2008). Common among these studies were measurements related to treatment and child permanency outcomes. Green et al. conducted a study of four different sites, with a total of 451 participants. Participants were divided among a control group that did not participate in FTDC and participants who were enrolled in FTDC; site A also included a group of Tier 1-only participants, which provided drug testing, treatment services, and a specialized case
manager to monitor progress (Green et al.). In regards to reunification and permanency outcomes, Green et al. found that FTDC participants reunified with their children at 43% compared to 32% of those not participating in FTDC. In addition, children of parents who participated in FTDC had quicker permanent placements than children whose parents did not participate in FTDC (Green et al.).

Regarding treatment outcomes, Green et al. (2007) divided participants into four types – rapid success, later success, mixed success, and unsuccessful. Rapid success was defined by Green et al. as parents who entered treatment within 60 days of the petition, had no more than two treatment episodes, and completed treatment. Later success are those that entered treatment later than 60 days, had more than two treatment episodes, and completed treatment (Green et al.). Green et al. described mixed success parents as having two or more treatment episodes, where only some completed, and unsuccessful parents as not having completed any episode of treatment successfully. Those who participated in FTDC were less likely to fall within the unsuccessful group (Green et al.) Green et al. also reported that individuals who were found to be in the mixed success and rapid success groups and who participated in the FTDC had a higher likelihood of reunification than those who did not participate in FTDC and had comparable treatment experiences (Green et al.).

The FTDC study conducted by Worcel et al. (2008) analyzed data from three sites; this study compared mothers who participated in FTDC and mothers who did not participate in FTDC due to capacity constraints, refusing to participate, or their attorneys
and/or social workers not making appropriate referrals to drug court. The total sample consisted of 301 FTDC treatment cases and 919 FTDC eligible and untreated cases (Worcel et al.). Like the results discovered by Green et al. (2007), Worcel et al. also found that treatment outcomes were better for mothers who had participated in FTDC than mothers who had not. In fact, mothers who participated in FTDC entered treatment faster and at larger proportions, spent more time in treatment, and completed at least one treatment episode at larger proportions than those mothers in the comparison group (Worcel et al.). According to Worcel et al., child welfare outcomes were also better for FTDC mothers; FTDC children spent less time in out-of-home placement and were more likely to reunify with their families.

Boles et al. (2007) conducted a study in Sacramento County on the outcomes of FTDC. This study also compared families that participated in FTDC, otherwise known as DDC in Sacramento County, and families that did not participate (Boles et al.). Boles et al. reported that the families who did not participate were those that met the criteria for DDC eligibility, but had entered the system prior to the development of the STARS program. This sample consisted of 111 parents with 173 children; the comparison sample of DDC participants equaled 573 parents with 861 children (Boles et al.). According to Boles et al., DDC participants had more treatment admissions than the comparison group. DDC participants were also more likely to have treatment episodes which included residential treatment (Boles et al.). However, completion rates showed no significant
difference, averaging 63.9% satisfactory treatment completions among DDC parents and
the comparison group (Boles et al.).

While relapse is not unusual for substance abusers, reentry and recidivism among
parents in the child welfare system is not uncommon (Boles et al., 2007). Boles et al.
defined reentry as children who were reunified and then came back into the system before
the case was closed. Recidivism is defined as children who are reunified and return to
the system after the case was terminated (Boles et al.). According to Boles et al., DDC
participants and the comparison groups had similar outcomes in regards to recidivism and
reentry. During the study period, only 1.5% of children experienced recidivism and only
21.7% of children experienced reentry (Boles et al.). Like the studies mentioned above,
Boles et al. also reported that child placement outcomes for DDC parents were better than
the comparison group. In fact, DDC children spent fewer days in out-of-home care and
were almost 1.4 times as likely to reunify (Boles et al.). In addition, more DDC children
had reunified at 24 months than the comparison group (Boles et al.). With outcomes like
these, it is understandable that Sacramento County continues to support this program
despite hard economic times.

**History of Family Group Decision Making**

Restorative justice practices, which emerged in the United States during the
1970’s, have been an increasing alternative to the western model of criminal justice
(Zehr, 2002). Zehr reported that restorative justice practices differ from the western
model of criminal justice because its focus is on the repair of harm caused to the victim
and the community rather than the punishment of the offender. Another important concept of restorative justice practices is engagement (Zehr). Zehr wrote, “The principle of engagement suggests that the primary parties affected by crime – victims, offenders, members of the community – are given significant roles in the justice process,” (p. 24). According to Zehr, restorative justice practices became the core of the New Zealand juvenile justice system in 1989 with the introduction of a program called family group conferencing (FGC).

FGC is a form of restorative justice, which includes families and other significant parties in responding to juvenile justice concerns (Zehr, 2002). Zehr reported that these parties may include justice officials, family members of the victim and offender, victim advocates, and attorneys. According to Zehr, conferences are coordinated and facilitated by social services personnel who design the process to be culturally appropriate and seek family input as to who should be included. Often during FGC, there is a caucus where offenders and their families move to another room to develop a reparations proposal for the victim (Zehr, 2002). The facilitator is required to ensure that a plan is developed which addresses reparation and prevention. In other words, the plan intends to repair the harm, hold the offender accountable, and find ways to help change the offender’s behaviors (Zehr).

In addition to juvenile crime, New Zealand also utilized FGC in response to child abuse and neglect (Roche, 2006). Initially, FCG was used in the child welfare system of New Zealand to respond to the overrepresentation of the indigenous Maoris in out-of-

home care (Weigensberg, Barth, & Guo, 2008). Cases that were once sent to court are now referred to conferences; these conferences involve the family, social workers, and other professional staff (Roche). Van Wormer (2003) described the identified ten principles to the philosophy of FGC; (1) sharing decisions and responsibilities with families, (2) social worker as collaborator, (3) decision making by consensus, (4) decisions reflecting culture, traditions, and participant needs, (5) importance of the quality of relationships, (6) broad definition of family, (7) value of kinship care over foster care, (8) solution-focused, (9) proactive rather than investigative, and (10) recognizing risks and building up social networks. During FGC, problems are identified, families propose plans to reduce and prevent child abuse or neglect, and the plan is discussed by the entire group (Roche).

According to Roche (2006), FGC has become “a popular tool in social-work practice, especially in the United States, where it fits neatly with the major policy shift away from professional-led decision-making processes to ones that seek to draw upon a family’s own strength,” (p. 224). The most common form of FGC utilized in the United States is known as family group decision making, or FGDM. FGDM was first introduced to the United States in the 1990’s in response to the overpopulation of minority children in foster care (Berzin, Thomas, & Cohen, 2007). As of 2003, FGDM is utilized in more than 150 communities within 35 U.S. states (Merkel-Holguín, 2003 as cited in Crampton & Natarajan, 2006). Due to its ability to utilize a strengths-based approach to encourage community support for families and create relationships between the child welfare
agency and the families involved, interest in FGDM continues to grow (Berzin, Thomas, et al.).

**What is FGDM?**

Like FGC, FGDM seeks to empower families and communities by encouraging their shared responsibility in the protection of children through collaborative meetings between child welfare professionals, families, and other community agencies (Weigensberg et al., 2009). Weigensberg et al. reported that FGDM is a key strategy for child welfare agencies to engage the families that they serve in making culturally-appropriate decisions about their children. Plans are developed during an FGDM with the input of service providers, child welfare workers, families, and community members to ensure the safety and well-being of a child; keeping the child in the family or within the community is emphasized (Levine, 2000 as cited in Weigensberg et al.).

The FGDM structure consists of four phases which include (1) referral, (2) preparation and planning, (3) FGDM meeting, and (4) follow-up (Berzin, Thomas, et al., 2007; Berzin, Cohen, Thomas, & Dawson, 2008). According to Berzin, Cohen, et al., the assigned social worker refers the case to the FGDM coordinator. The FGDM coordinator remains impartial and decides if the case is appropriate for FGDM (Berzin, Thomas, et al.). Some meetings may not be referred to FGDM, depending on the nature of the case and whether or not the family is interested in participating (Merkel-Holguin, 2004 as cited in Weigensberg et al., 2009). Preparation and planning are also done by the coordinator and includes working with the family to define its members, inviting
necessary participants, explaining the process of the meeting as well as the roles and responsibilities of each participant, etc. (Berzin, Cohen, et al.).

The foundation of FGDM is the actual meeting conducted between the child welfare agency, community members, and families (Berzin, Thomas, & Cohen, 2007). The four phases within the FGDM meeting include introduction, information-sharing, creating the family plan, and finalizing the family plan (Merkel-Holguin, 2004 as cited in Berzin, Thomas, et al.). According to Berzin, Thomas, et al., the purpose of the meeting is to utilize information from all parties present to agree on a plan that will ensure the safety of the child and support the family. New Zealand legislation, as with other jurisdictions utilizing FGDM, stipulates that the plan is developed during family private time; here the family leaves the room, creates the plan, and returns to the room in order to present the plan to the other parties in attendance (Pennell & Burford, 2000). However, other FGDM models utilize collaborative efforts between all parties in attendance to create a plan that will ensure safety and support the family (Berzin, Thomas, et al.).

The final phase of FGDM, known as follow-up, is usually in the hands of the assigned child welfare caseworker (Berzin, Thomas, et al., 2008). The caseworker monitors the family plan and delivers services (Berzin, Thomas, et al.). However, the family and other service providers are also responsible to carry out the plan as these services may include counseling, childcare, treatment for drugs and/or alcohol, recreation, in-home supports, etc. (Pennell & Burford, 2000). The caseworker may also
refer the family to the coordinator for a follow-up conference if revisions to the family plan were necessary (Pennell & Burford).

**FGDM Research and Outcomes**

Within the literature for FGDM, studies were conducted to measure service impact, child and family outcomes, and model fidelity. Weigensberg et al. (2009) evaluated families that experienced an FGDM conference compared to families that did not in order to determine if there were any differences in the services they received at baseline and by 36-months. Plans produced in FGDM often link families to needed services (Merkel-Holguin, 2003 as cited in Weigensberg et al.). Therefore, it is helpful to understand if families who experience FGDM receive more services than comparison families. This study obtained data using the National Survey of Child and Adolescent Well-being from 3,220 children (Weigensberg et al.). According to Weigensberg et al., the comparison group and the FGDM group were similar in characteristics such as age, race, gender, maltreatment types, and prior reports of abuse and neglect.

The results of the baseline interview found that those families who had participated in an FGDM meeting were more likely to have been linked to parenting services and were more likely to have been referred, arranged, or provided counseling and mental health services (Weigensberg et al., 2009). However, Weigensberg et al. reported that at the 36-month interview, there were no significant differences in services between the FGDM group and the comparison group. “These findings together suggest that although FGDM meetings may facilitate initial connections to counseling, mental
health, and parenting services, over time children and families who do not experience FGDM meetings may be just as likely as those experiencing FGDM meetings to receive these services,” (Weigensberg et al., pg. 389).

One study conducted by Punnell and Burford (2000), analyzed FGDM in relation to family violence, including child abuse and neglect, elder abuse, and mother/wife abuse. Punnell and Burford found positive outcomes for families who participated in FGDM. In particular, of the 115 interviewees in the study, 76 reported that their family was better off after their participation in FGDM (Punnell & Burford). According to Punnell and Burford, the families reporting being better off because FGDM promoted family unity – family members felt that ties were strengthened and there was an enhanced sense of being a family.

In addition, Punnell and Burford (2000) found that safety increased for families who participated in FGDM; maltreatment events for participants went from 233 before the conference to 117 after the conference. The amount of maltreatment events increased for the comparison group from 129 to 165 (Punnell and Burford). Maltreatment episodes specific to children among FGDM participants dropped from 16 substantiations to 8 substantiations, while those who did not participate in FGDM had an increase in substantiations. Mother/Wife abuse also declined after participating in FGDM and rose among the comparison families (Punnell & Burford). According to Punnell and Burford, FGDM had no impact on child-to-adult abuse, which is common among troubled youth within the child welfare system.
In comparison, Berzin, Cohen, et al. (2008) found no significant differences between families who participated in FGDM than families who did not. Berzin, Cohen, et al. studied 110 children within Fresno and Riverside Counties, which were both part of the California Title IV-E Child Welfare Waiver Demonstration Project. This project allowed funding to test FGDM over a period of five years (Berzin, Cohen, et al.). According to Berzin, Cohen, et al., safety-related outcomes, placement stability, and permanency-related outcomes were all measured. Berzin, Cohen, et al. reported that there were no significant differences in substantiated maltreatment episodes between the FGDM group of children and the comparison group. Additionally, there were no significant differences in the number of placement moves or in the number of cases that closed (Berzin, Cohen, et al.).

Berzin, Thomas, et al. (2007) argue that FGDM outcomes cannot be measured without first analyzing implementation and program fidelity issues. Failure of the program could be assumed when studies result in non-significant outcomes, even though implementation of the program may not be based on the original model (Berzin, Thomas, et al.). Therefore prior to the study on outcomes, Berzin, Thomas, et al. conducted a study using direct observations, participant questionnaires, conference characteristic surveys, and follow-up surveys with child welfare workers to measure FGDM implementation. The study sample in Fresno County consisted of 49 children in the treatment group and 27 children in the comparison group while Riverside County sample included 41 children in the treatment group and 22 children in the comparison group (Berzin, Thomas, et al.).
Results of this study showed that both counties included the phases of referral and preparation and 85% of the participants reported that the conference purpose had been properly explained (Berzin, Thomas, et al., 2007). Berzin, Thomas, et al. also found that the delineated steps for an FGDM meeting were consistent with the models in Fresno and Riverside counties. Both county meetings began with an introduction, family planning, and finalization of the family plan (Berzin, Thomas, et al.). According to Berzin, Thomas, et al., family planning took place in two different ways; in Riverside County, family planning happened in collaboration with the facilitator and county workers while in Fresno County, family planning took place in the form of private time. Facilitators and participants in both counties agreed that a clear plan was developed during the conference (Berzin, Thomas, et al.).

While both Fresno and Riverside counties implemented FGDM according to the model, the follow up stage showed some challenging results. According to Berzin, Thomas, et al. (2007), plans were not always followed through with. In fact, by the six month interviews the average completion rate was 2.0 in Riverside County and 2.1 in Fresno County where the rating of 2 was equivalent to mostly completed (Berzin, Thomas, et al.). However, in the 12-month interview in Riverside County, completion rates had dropped and Berzin, Thomas, et al. reported that this drop may be attributed to immediate follow through after the conference and not maintaining with services. In addition, incomplete plans may be due to lack of follow-through by biological parents and relatives and lack of resources in the community (Berzin, Thomas, et al.).
Thomas, et al. found that in both sites, the philosophies of collaboration, family empowerment, and child safety were achieved overall.

**History of Team Decision Making**

Team Decision Making (TDM), which was first developed in Ohio in the late 1980’s by child welfare administrators, is a tool used to protect children from additional harm when they are at risk or have been removed from the home (Crampton, Crea, Abramson-Madden, and Usher, 2008). Since its birth in Ohio, TDM has been adopted by the Annie E. Casey Foundation as one of the core strategies of the 1992 Family to Family Initiative (Crampton, Crea, et al.). Established by Jim Casey in 1948, the Annie E. Casey Foundation’s primary mission is to meet the needs of vulnerable children and families by encouraging human service reforms and community supports (Thielman et al., 2001). Thielman et al. reported that the Annie E. Casey Foundation is based on two principles: “First, there is no substitute for strong families to ensure that children grow up to be capable adults. Second, the ability of families to raise their children is often inextricably linked to conditions in communities where they live,” (p. 5). Therefore, the Annie E. Casey foundation provides funding through grants for distressed neighborhoods with a goal to promote strong, capable families (Thielman et al.).

Crea, Usher, and Wildfire (2009) reported that TDM has been implemented in over 60 sites across 17 states, utilizing a collaborative approach and drawing from the perspectives of birth parents, relatives, and community supports in order to make the best placement decision for a child. Prior to the implementation of TDM, decision making
regarding children in foster care was primarily made by caseworkers and supervisors (Crea, Wildfire, & Usher, 2009), often leaving families out of important decisions.

**TDM Defined**

According to the Center for the Study of Social Policy (March 2002), FGC, FGDM, and TDM fall under the umbrella of family team meetings. Commonalities found in family team meetings include building on family strengths, involving a broad definition of family, using trained staff to coordinate and facilitate, expecting improvements in child welfare practice through their implementation, advanced preparation and planning, and utilizing supportive meeting places for family decision-making (Center for the Study of Social Policy). However, the differences between TDM and other family team meetings is that the purpose is to make an immediate decision regarding a child’s placement (Crampton & Natarajan, 2006). In addition, facilitation skills are more highly emphasized as family plans are made in conjunction with agency staff (Crampton & Natarajan) rather than in family private time that often occurs in FGDM (Pennell & Burford, 2000). “These skills are described as the ability to: focus on family strengths, develop collaborative service interventions, find common ground among diverse participants, help present risks without making the family feel defensive, and keep family meeting participants focused on tasks,” (Crampton & Natarajan, p. 71).

The premise of TDM was the understanding that child welfare agencies should respect a families’ knowledge of their children and approach the issue of child placement utilizing a collaborative effort involving the family, the community, service providers,
and the child welfare agency (Crea, Usher, et al., 2009). DeMuro and Rideout (2002) reported that child welfare decisions around placement are better for families and caregivers when those decisions are made by a team rather than by the bureaucratic decision process. According to DeMuro and Rideout, foster parents can be important team members during a TDM as current foster parents have important information of the child’s needs while potential foster parents have an opportunity to learn more about the child. In addition, when both birth parents and foster parents are a part of the team, foster parents can support reunification efforts and aid in the safe transition home (DeMuro & Rideout).

TDM meetings are held throughout numerous stages of the child welfare process. Crea, Wildfire, et al. (2009) reported that TDM meetings should be held when there is potential to remove a child from the home, when there is a change in placement, or for reasons of reunification and/or permanency. Sacramento County conducts TDM meetings for all of these purposes. However, as with most child welfare agencies utilizing this program, securing time and other resources to ensure that all placement changes are addressed with a TDM meeting is difficult (Crampton, Crea et al., 2008). DeMuro and Rideout (2002) reported that a TDM meeting typically takes one to two hours to conduct. This amount of time may seem minimal, but to child welfare workers who are already overworked with large caseloads, one to two hours spent on one family may be an extreme burden.
Like FGDM, TDM meetings follow common steps. Essential parts of the TDM meeting include introductions, information sharing from the family, an explanation from the caseworker as to why the meeting was called, discussion of safety concerns, feedback from extended family and other team members, the caseworker’s recommended plan of action, additional ideas from other team members to address the situation, a full discussion of risks and strengths, a placement decision followed by action steps to support that decision, and a distribution of the action plan to all team members (DeMuro & Rideout, 2002). Crea, Wildfire, et al. (2009) suggested that by drawing on different perspectives within the group, better decisions regarding placement are made through the use of TDM. In addition, all parties share responsibility in the decision and in ensuring that the plan is supportive to the child (Crampton & Natarajan, 2006).

“The goal is to reach consensus about a decision regarding placement that protects the child(ren) and preserves or reunifies the family,” (Center for the Study of Social Policy, March 2002). However, if consensus cannot be reached, the child welfare agency is responsible for making the decision (DeMuro & Rideout). This may mean the decision falls in the hands of the caseworker, the supervisor of that caseworker, and the facilitator. DeMuro & Rideout reported that if agency staff cannot reach a decision about the placement, then ultimately the decision is made by the caseworker. The final decision, as described by the Center for the Study of Social Policy, is ‘owned’ by the child welfare agency. Even when other professional agencies disagree with the decision, the child
welfare agency must proceed and only child welfare agency staff can appeal decisions through a formal process (Center for the Study of Social Policy).

**Child Placement**

Before the implementation of TDM, child placement decisions were made by child welfare caseworkers who were often overworked and undertrained (DeMuro & Rideout, 2002). According to DeMuro and Rideout, if the caseworker felt that there were safety risks in the child’s current placement, that caseworker would staff his or her concerns with a supervisor; if that supervisor agreed, the caseworker would begin making necessary referrals to look for alternative placements for that child. Prior to a removal, the caseworker would be responsible for preparing lengthy reports to provide to the court in order to get court approval for the removal and placement of the child (DeMuro & Rideout). Once there is a court order to remove a child, that same caseworker is then required to supervise children in their current placement, make referrals for biological family members who are often angry and confused, and implement a concurrent permanency plan for the child (DeMuro & Rideout). DeMuro and Rideout found that this in addition to a whole caseload of children, often leads to caseworker burnout and staff turnover.

Despite the implementation of TDM in many counties and jurisdictions across the United States, child placement for children in the foster care system remains to be a problem. Unfortunately, child placement is one of the many concerns of child welfare practices. Whittaker and Maluccio (2002) identified many other issues, including
overinclusion, underinclusion, capacity, service delivery, and service orientation. Overinclusion refers to families currently served by the child welfare who need not be and which attributes to underinclusion, or those families who are not receiving child welfare services while they are in serious need (Whittaker & Maluccio). According to Whittaker and Maluccio the capacity of the child welfare agencies cannot sufficiently serve the number of families entering the system and the services provided to those families may not be appropriate to their needs. Service orientation, which has a significant impact on child placement, is constantly mediating the tensions between goals of protecting children while also preserving the family (Whittaker & Maluccio).

This tension between child safety and reunification for families derives from the pendulum swing in child welfare practices. For example, the 1980 Adoptions Assistance and Child Welfare Act provided states with additional funding for making efforts towards preventing removals and providing assistance to families in order to reunify children with their birth parents (Sanders, 2003). This change in policy encouraged child welfare agency staff to refocus their attention on the family as a whole more than the safety of the child. On the other hand, Sanders reported that the succeeding 1997 ASFA legislation refocused child welfare practices towards child safety and permanency, offering adoption incentives to states and therefore providing less funding towards stabilizing families in order to promote reunification. These mandates create confusion in practice in regards to child placement whereas the subsequent legislation stresses less importance on parental
rights and the previous legislation emphasizes the importance of family reunification (Whittaker & Maluccio, 2002).

One of the goals of TDM, which is to increase child placement stability and reduce subsequent removals, is an important factor when working with children. “With each change in placement, children may experience an increased sense of rejection and impermanence as well as a decrease in their ability to form emotional ties with their caregivers,” (Webster, Barth, & Needell, 2000, p. 615). Webster et al. conducted a study in California of children who remain in long-term out-of-home care; their findings show a significant difference between placement stability of children in foster care families and children in kinship care settings. For children who were in out-of-home placement for eight years, 71% of children in kinship care were still in their first or second placement compared to 48% of children in non-kinship care (Webster et al.). Factors related to placement changes, according to Webster et al., included gender and age – males were more likely to experience placement instability than females and preschoolers more so than infants. Webster et al. suggest that improved efforts in child welfare practices related to placement stability must include a more thorough assessment and profile of possible placement settings. Even in situations where removal cannot be prevented, TDM is helpful in identifying kinship placements.

**Current Research on TDM**

Due to the fact that TDM is a relatively new practice, there is little research on the effectiveness of TDM. However, studies on TDM have been conducted to assess
collaboration efforts, implementation fidelity, and challenges faced by child welfare agencies in implementing the program. Historically, decisions regarding dependent and at-risk children have primarily been made through the child welfare agencies and the family courts. Prior to the Family to Family initiative, little emphasis had been placed on the importance of involving families and the community in making decisions about child placements, case planning, and preventative measures towards keeping children safe in their own homes. However, the implementation of TDM in many jurisdictions is a significant change to the child welfare process due to the collaborative efforts made by child welfare agency staff, community partners, foster families, birth families, and others closely involved with the family. Respecting families’ knowledge of their children, according to Crea, Wildfire, et al. (2009), is one of the major principles of the TDM process.

Crea, Wildfire, et al. (2009) conducted a TDM study on three different sites: Denver, CO; Anchorage, AK; and Wake County. All three of these sites had been using TDM for quite some time and each collect and enter data into an Access database once the TDM meeting is held (Crea, Wildfire, et al.). Crea, Wildfire, et al. looked at a number of factors related to recommended decisions for placement changes, including the child’s age, race, and gender, the location of the meeting, the number of previous TDM meetings for the family, and the impact of community members, family members, and caregivers present at the meeting. An interesting result of this study was that neither gender nor race significantly predicted recommendations for placement changes;
however the amount of support people in attendance at the meeting and the presence of
caregivers had a strong impact (Crea, Wildfire, et al.). In fact, according to Crea,
Wildfire, et al., the team was 40.6% less likely to recommend a placement change if any
caregiver was present.

With such results, this study has shown the importance of having caregivers
present during a TDM meeting. “By their presence and participation in TDMs,
caregivers may be able to present their perspectives of the presenting problem, and
communicate to other participants what services and supports would be needed to keep
the placement intact,” (Crea, Wildfire, et al., 2009, p. 306). The results showing that
more supportive members in attendance at the TDM meeting may also suggest that
community partners help to make informed decisions about child placement, therefore
concluded their study by noting the importance of communication between child
caregivers and child welfare staff and agencies to promote placement stability.

A similar study focusing on the group dynamic of TDM meetings, specifically
their therapeutic factors and the importance of facilitation skills, also discussed the
relevance of collaborative efforts between child welfare staff and those persons in the
child’s environment (Crampton & Natarajan, 2006). Crampton and Natarajan reported
that TDM facilitators need to work closely with all members of the team in order to
utilize resources specific to each team member. TDM facilitators play an important role
in the team, as their work is to ensure that all experts in the team share their knowledge
(Crampton & Natarajan). For example, child welfare staff has the knowledge of laws pertaining to children, risk assessments, and specific case information. Community agency representatives have the knowledge of services and supports that they can offer the family. Foster parents can provide information on the child’s current behaviors, adjustment to the placement, and services that the child may need. Most importantly, birth “parents are the experts on their own children,” (Crampton & Natarajan, p. 76) and may offer important information as to the child’s temperament, likes, and dislikes.

In addition to the importance of collaborative efforts in TDM, implementation according to the original TDM model is a major factor to the effectiveness of the program. Although there is a specific way to conduct a TDM, there is much variability in the program throughout those agencies that utilize this practice. Therefore, the outcomes of placement decisions and the effectiveness of TDMs vary from site to site. In evaluation research, this concept is otherwise known as implementation fidelity and it “refers to the extent to which practitioners conduct program activities as intended by those who developed the program,” (Crea, Usher, et al., 2009). The most important factor of the TDM process, as stated above, is the representation of all parties who have important information and resources to offer during the meeting. When all necessary members are not present at the TDM, this can have a negative impact on placement outcomes. Another important factor that can also lead to negative placement outcomes is if the meeting is held after the placement, instead of the intended practice of prior to placement and court hearings (Crea, Crampton, et al., 2008).
A study conducted by Crea, Usher, et al. (2009) examined the implementation fidelity of the TDM process, focusing on the area of collaboration between four areas (1) family members, (2) support persons, (3) service providers, and (4) child welfare agency staff. Crea, Usher, et al. studied three TDM anchor sites selected by the Annie E. Casey Foundation – Denver, CO, Cleveland, OH, and Anchorage, AK. Among these sites, birth parent representation during change of placement TDM meetings was high, with 86% attending in Denver, 88% attending in Anchorage, and 71.9% attending in Cleveland (Crea, Usher, et al.). Crea, Usher, et al. also found that agency staff and relatives attended in high numbers throughout all sites, while service providers participated in much lower rates. For removal TDM meetings, simultaneous participation from birth parents and family is 22.3% for Denver, 34.8% for Anchorage, and 22.9% for Cleveland (Crea, Usher, et al.). Crea, Usher, et al. reported that for Cleveland, 14.6% of TDM meetings included no family-related participants which may be due to the fact that Cleveland requires a TDM prior to every placement decision. “Whatever promise TDM offers in seeking input from multiple stakeholders, its ability to produce better placement decisions is also a function of the extent to which the strategy is implemented effectively,” (Crea, Crampton, et al., 2008).

While collaborative efforts are extremely important in successful outcomes for child placement stability and TDM implementation fidelity, there are other factors in the discrepancy between intended implementation and practice. Crea, Crampton, et al. (2008) conducted a study on the implementation of TDM, specifically related to the
commitment of administrators, adequate resources, and the perceived value of TDM by supervisors and frontline workers. The three sites chosen for this study were also three anchor sites selected by the Annie E. Casey foundation (Crea, Crampton, et al.). Crea, Crampton, et al. found that administrators use training and rewards to promote the use of effective TDM implementation. Another finding by Crea, Crampton, et al. was that inadequate resources, such as not enough facilitators and scheduling staff may relate to a discrepancy in implementation fidelity. Frontline staff and supervisors have trouble implementing TDM mostly due to time constraints (Crea, Crampton, et al.). In addition, a common complaint among frontline workers is the fact that TDM meetings are being held after the placement change, which is contrary to the TDM practice (Crea, Crampton, et al.).

While TDM implementation fidelity has a significant impact on placement outcomes, there are many challenges associated with the implementation of TDM. These challenges as described and defined by Crampton, Crea, et al. (2008) include leadership, communication, and resources. Crampton, Crea, et al. conducted 74 focus group interviews involving TDM facilitators, administrators, child welfare agency staff, and community partners in five sites that had made significant progress in TDM implementation. The challenges found among leadership roles was that the strongest support for TDM started with the administrators and then diminished as it moved down to managers, supervisors, and line staff; other leadership challenges were the concern for time and resources (Crampton, Crea, et al.). Crea, Crampton, et al. (2008) also
discovered that initial TDM trainings held by administrators in some sites may have led to some confusion among agency staff. Communication challenges in TDM implementation, according to Crampton, Crea, et al. are related to “a ‘firewall’, which helps ensure that all placement decisions that should be made through the TDM process, in fact, are made through the TDM process,” (p. 518). The difficulty in firewalls is getting them in place and getting agency staff to understand why they are in place (Crampton, Crea, et al.).

The third challenge described by Crampton, Crea, et al. (2008) is the issue of resources. The number of facilitators and schedulers is a common complaint of agency staff and which is most likely due to overall budget constraints (Crampton, Crea, et al.). In Sacramento County, recent budget cuts have reduced the number of facilitators to four and full-time TDM schedulers are facing lay-offs during the next round of cuts. According to Crampton, Crea, et al. when there are a limited number of available facilitators, heavy scheduling demands make it difficult for them to take time off. The most important issue in regards to the challenge of resources is time; child welfare staff members already have time-intensive work (Crampton, Crea, et al.) and large caseloads. This creates challenges when the implementation of TDM requires not only time to schedule the meeting, but typically one to two hours to conduct the meeting. Despite these challenges, research has shown that there are numerous benefits for agencies that utilize this program.
Chapter 3

METHODS

Introduction

This chapter will briefly describe the research methods used to do this study. The first section describes the study design, which is uses both a qualitative and quantitative approach. The second section explains the sampling procedures for collecting human subjects. The third section illustrates the type of instrument used and the way that the data was collected. The fourth section describes the methods used for data analysis. The final section briefly explains how human subjects were protected and how confidentiality was ensured.

Study Design

This research study utilized qualitative and quantitative statistics to conduct a program evaluation on Team Decision Making (TDM), which is relatively new to child welfare practices. Specifically, this study will evaluate TDM based on interviews with biological parents whom have experienced a TDM in Sacramento County. Program evaluations can encompass all three research purposes, including exploration, explanation, and description (Rubin & Babbie, 2007). Using face-to-face interviews, the researcher attempted to explore the perceptions of biological parents regarding the TDM meeting that they participated in. Exploratory studies are typically used when “a researcher is examining a new interest, when the subject of study is relatively new and unstudied, or when a researcher seeks to test the feasibility of undertaking a more careful
The researcher also attempted to describe characteristics of the population being studied using quantitative data. These characteristics include age, ethnicity, gender, number of children, type of Child Protective Services (CPS) intervention, and prior involvement with CPS. In addition, the researcher conducted questions to explain why biological parents either participate or do not participate in the TDM process. Having support persons present, feeling respected by child welfare agency staff, and having a say in the final decision might be reasons for biological parent participation. On the other hand, if parents feel the opposite about TDM, they may be unlikely to participate.

**Sampling Procedures**

The type of sampling procedure used for this study was availability sampling. Availability sampling, as defined by Rubin & Babbie (2007), is a type of sampling that picks human subjects based on their availability and convenience. While this is a risky sampling method due to a risk of bias, it is commonly used in social work research (Rubin & Babbie). Originally, biological parents were approached after the TDM meeting by the facilitators of and asked if they would be interested in being contacted by a researcher. If the parents were interested, they provided their contact information on a consent form and placed the form in a confidential box which was located in the TDM room. The researcher then collected the forms from the boxes and contacted the parents to explain to them the purpose of the study and set up an interview time.
However, the researcher and TDM unit staff quickly became aware that this strategy of availability sampling was not working well. Therefore, in addition to the original method, the researcher began collecting available human subjects by approaching parents prior to their TDM meeting. The researcher explained the purpose of the study, the benefits of their participation, and offered a small gift card incentive after the interview to participate in the study. Furthermore, the researcher created a flyer and posted it in the lobby of the Specialized Treatment and Recovery Services Program, which services CPS clients with drug and alcohol treatment components on their case plans. Subjects collected through this strategy contacted the researcher directly and were explained the purpose of the study over the phone.

**Instruments and Data Collection**

The questionnaire used to document feedback from human subjects consisted of 50 open-ended, closed-ended, and scaling questions. These questions included, and were not limited to, whether or not the parent felt that their input was considered during the placement decision, the parent’s levels of involvement, and whether or not the parent felt respected during the meeting. Questions were organized into five different sections including demographics, parental engagement, parental involvement in decision-making, effects on communication, and final thoughts. Questions regarding parent engagement were structured to capture whether or not the TDM meeting had any impact on parent participation in the case plan and services while questions regarding parent involvement in decisions had more to do with the impact of input provided by parents during the
meeting on the placement decision. Questions regarding communication mostly measured the impact the meeting may or may not have had on communication between the parents and their social worker.

The data was collected through an interview survey. Interview surveys are advantageous in that they decrease the chance of unanswered questions, they have higher response rates, and they allow interviewers to answer questions that respondents may misunderstand (Rubin & Babbie, 2007). Rubin & Babbie reported that interview surveys are often conducted by more than one interviewer. However, this was not the case in this particular study. The researcher was the sole interviewer of all participants. The researcher met the study participants in a private location which was convenient for them, usually at a local coffee shop or in their place of residence. The interviewer came dressed to the interviews similar to the dress of the participants, asked questions exactly as they were written, and wrote down answers exactly as were worded by the participants; these methods were described by Rubin and Babbie as important parts of the interview survey process. The interviews lasted approximately 45 minutes to an hour in length and were collected between February 9, 2011 and April 1, 2011.

**Data Analysis**

The software program used to analyze the data in this research was SPSS. The quantitative data was coded by “assigning separate code numbers to each category of each variable,” (Rubin & Babbie, 2007). Most of the questions on the questionnaire involved simple coding, such as how many children do you have and how many children
are involved with CPS. If the participant answered that they had three children involved with CPS, then the code assigned was “3”. Other questions involved categories, such as age, ethnicity, and whether the participant agreed with the decision that was made during the TDM. These categories were given a number. For example, the question “Were the strengths of your family adequately documented on the board during the meeting?” involved categories “Yes, No, and Unsure”. The categories were coded with a number so that “Yes” was coded as “1”, “No” was coded as “2”, and “Unsure” was coded as “3”. Qualitative data in the form of open-ended questions, such as “What, if anything, would you change about the TDM process?” was not analyzed through SPSS, but was reported in the findings as common themes found among participants.

The type of statistics used to analyze the data included frequency distribution, chi-square, and correlation. Frequency distribution is defined by Rubin and Babbie (2007) as “a description of the number of times the various attributes of a variable are observed in a sample,” (p. 323). For example, frequency distribution was used to report how many people in the total sample were African American, how many were Caucasian, how many were multi-ethnic, and the like. Frequency distribution was also used to determine how many people in the total study were between the ages of 20-35, how many were between the ages of 36-51, and how many were between the ages of 52-67. According to Rubin and Babbie, inferential statistics help to rule out any sampling errors in the findings. Chi-square and correlation are two different types of inferential statistics tests (Rubin & Babbie). These tests were utilized to see if there was a relationship between two
variables. An example of this is to determine whether participants feeling respected had a relationship to their satisfaction with the outcome of the meeting. The results of these tests determine probability level and determine whether a relationship between variables is statistically significant (Rubin & Babbie).

**Protection of Human Subjects**

For this project, the researcher had to submit an application to the Institutional Review Board (IRB) at California State University, Sacramento (CSUS) for the protection of human subjects. The researcher also had to submit an application to the IRB at the child welfare agency. These applications included a detailed description of the study, the data collection methods, and how the researcher was going to ensure protection and confidentiality for the participants. Attached to the application were the consent form and the questionnaire. The original application stated that the study was qualitative however changes were made by the project advisor. These changes included making the study qualitative and quantitative in addition to clarifying where the interviews would be conducted, informing parents that their names will not be identified in the final project, and including examples of the questions from the questionnaire within the application.

Once the researcher made revisions to the application according to the project advisor’s suggestions, the researcher submitted the applications to both IRB’s. The child welfare agency approved the IRB on November 24, 2010. The researcher then submitted the application to the CSUS IRB along with a letter of approval from the child welfare agency on December 8, 2010. However the application was not approved until there was
an additional letter included from the child welfare agency’s TDM program manager. In addition, the CSUS IRB wanted the researcher to make small changes to the consent form regarding confidentiality and where the interviews were conducted. Once these changes were made and the application was resubmitted, the final application was approved on February 1, 2011. The human subject approval number is 10-11-085.

All documentation for this research was kept in a locked cabinet to protect participant confidentiality. Interview documents were assigned an identification number to protect the identity of the participant and all consent forms were kept separate from the interview documents and notes. The participants’ social workers were not informed of their participation so as not to impact their case in a negative way. Human subject participation in this research project was entirely voluntary. Participants had the opportunity to decline to participate before or during the interview process.
Chapter 4

FINDINGS

Introduction

The researcher recruited 18 biological parents involved with child welfare services to explore their feelings and perceptions about their experience with Team Decision Making (TDM), which is a family-centered practice that utilizes a strengths-based team approach towards child placement decisions. The researcher administered a face-to-face interview survey with each participant, which consisted of a quantitative and qualitative, 50-item questionnaire. The first eleven questions included demographic information followed by one likert-scale question and four additional questions about participant engagement. Remaining questions included six questions examining the participants’ feelings about being involved in decisions, fourteen questions about the impact of the program on communication and partnerships with the child welfare agency, and fourteen final questions evaluating the program. The main goal of this research was to evaluate the program based on parents’ perspectives.

Demographics

Demographic information was collected for each participant. This information included gender, age, ethnicity, prior involvement with CPS, type of social worker that attended the TDM, and prior participation in a TDM. Table 1 describes the frequency of this demographic information. Other demographic information was collected including number of children involved in CPS and the ages of those children (See Table 2).
<table>
<thead>
<tr>
<th>Gender</th>
<th>Valid</th>
<th>Male</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
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<td></td>
</tr>
<tr>
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<td>100</td>
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<td></td>
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<td></td>
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<td>44.4</td>
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<td></td>
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<td>50</td>
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<td>100</td>
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<td>100</td>
<td>100</td>
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<td></td>
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<td>55.6</td>
<td>94.4</td>
</tr>
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<td></td>
<td></td>
<td>Dependency SW</td>
<td>1</td>
<td>5.6</td>
<td>5.6</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Total</td>
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<td>100</td>
<td>100</td>
<td></td>
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<tr>
<td>Prior TDM</td>
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<td>33.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>12</td>
<td>66.7</td>
<td>66.7</td>
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</tr>
<tr>
<td></td>
<td>Total</td>
<td>18</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 1 findings show that of the 18 parents that were interviewed, 33.3% (n=6) were male and 66.7% (n=12) were female. Therefore, six biological fathers and twelve biological mothers were included in the study. All participants were between the ages of 20 and 67, with 66.7% (n=12) between the ages of 20-35, 22.2% (n=4) between the ages of 36-51, and 11.1% (n=2) between the ages of 52-61. The majority of the participants were Caucasian (44.4%) and the next highest ethnic group was African American (27.8%). Additional ethnic groups included those that identified themselves as Multi-Ethnic (16.7%), Latino/Mexican American (5.6%), and German (5.6%). Half of the participants (n=9) have prior involvement with CPS, either as adults or youth, and half of the participants do not. Participants were asked which type of social worker attended the meeting to determine the stage of the child welfare process that they were in.

The findings show that most of the participants were in reunification, as 10 of the 18 participants (55.6%) had a Family Reunification Social Worker present during their meeting. Five of the participants (27.8%) reported that there was an Informal Services Social Worker present. This is important to note because in this child welfare agency, Informal Supervision is a program which does not involve the family court and in most of these cases, children either remain in the home or parents voluntarily have the children removed for short periods of time while they work to provide a safe home environment. The rest of the participants (n=3) reported that there was an Emergency Response Social Worker present (5.6%), a Court Services Social Worker present (5.6%), and a Dependency Social Worker present (5.6%). Some of the participants had already
experienced a TDM meeting prior to the meeting in which they were interviewed about.

In fact, 33.3% of the participants had been part of a prior TDM for their family and 66.7% had not.

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Children 0-5 Involved with CPS</th>
<th>Children 6-11 Involved with CPS</th>
<th>Children 12-17 Involved with CPS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>23</td>
<td>14</td>
<td>9</td>
<td>46</td>
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<td>Missing</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>2.293</td>
<td>8.214</td>
<td>14.333</td>
<td>6.451</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>1.592</td>
<td>1.423</td>
<td>1.658</td>
<td>4.954</td>
</tr>
</tbody>
</table>

Table 2 describes information about the participants children involved with the child welfare system, including number of children and their ages. Children were grouped into three age categories, including ages 0-5, 6-11, and 12-17. This group of participants reported a total of 46 children involved with Child Protective Services (CPS). Table 2 shows that of these children, 23 were between the ages of 0-5 with an average of 2.293 years (SD = 1.592 years), 14 children were between the ages of 6-11 (mean = 8.214 years, SD = 1.423 years), and nine children were between the ages of 12-17 (mean = 14.333 years, SD = 1.658 years). Overall, the average age of children involved with CPS was 6.451 years with a standard deviation of 4.954 years.
Collaboration

Collaboration is an important component of TDM. Other studies have shown that children are least likely to move from a placement when there are more people present in the TDM. In addition to biological parents and child welfare staff, TDM meetings usually include extended family members and community members such as service agency representatives.

Table 3

People Attending TDM

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5</td>
<td>83.3</td>
<td>83.3</td>
<td>83.3</td>
</tr>
<tr>
<td>False</td>
<td>3</td>
<td>25.0</td>
<td>25.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 describes the frequency of people that attended the TDM. Categories for these participants included family, community members, agency staff, all of the above, all of the above except family, and all of the above except community members. Family included other parents involved in the case plan and extended family, such as grandparents, aunts, and uncles. Community members usually consisted of other service providers or agencies that were present to provide resources to the family. A total of five
males (83.3%) reported that all of the above were present and one male (16.7%) reported that all of the above, except community members were present. Nine (75%) females reported that all of the above were present and three (25%) females reported that all of the above, except for family was present.

**Engagement**

One of the research purposes was to find out whether TDM helped participants engage in the child welfare process. Levels of engagement focused on whether the parent was participating in services, how involved they were in the child welfare process, and how involved they were in decisions regarding the care of their children. Also, the researcher wanted to know whether or not the TDM facilitator made efforts to encourage participation from the biological parents during the meeting.

**Table 4**  
*Participating in Services Prior to TDM*

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Valid Yes</td>
<td>5</td>
<td>83.3</td>
<td>83.3</td>
<td>83.3</td>
</tr>
<tr>
<td>Male Valid No</td>
<td>1</td>
<td>16.7</td>
<td>16.7</td>
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<tr>
<td>Male Total</td>
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</tr>
<tr>
<td>Female Valid Yes</td>
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</tr>
<tr>
<td>Female Total</td>
<td>12</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 describes the number of participants that were already participating in services towards their case plans. Examples of services include drug and alcohol treatment, domestic violence counseling, and parenting classes. When participants were
asked whether or not they were participating in services towards their case plans, 14 (77.8%) responded that they were already involved in services. Of those 14 participants, five were male and eight were female. Of those parents not participating in services, one was male and three were female.

Table 5
_TDM Helpful in Identifying Needed Services_

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Yes</td>
<td>14</td>
<td>77.8%</td>
<td>77.8%</td>
<td>77.8%</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>22.2%</td>
<td>22.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Table 5 shows that similar results were found when asked whether or not the TDM was helpful in identifying needed services for the child and family. Frequency analysis found that a total of 14 (77.8%) of the participants responded that the TDM was helpful in identifying services and four (22.2%) of the participants responded that the TDM was not helpful in identifying services. An open-ended question was asked during the interview to those participants who responded that the TDM was helpful in identifying services to find out what services were identified. Some of the services identified during the TDM were preschool programs, individual and family counseling, psychiatric services, drug and alcohol treatment, co-parenting classes, anger management, and parent-child interactive therapy. Other services identified included neighborhood resource centers, special education services, and Women, Infants, and Children (WIC).
Table 6
*Crosstabulation Between Participating in Services and Gender*

<table>
<thead>
<tr>
<th>Gender of Participant</th>
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<th>Participating in Services Prior to TDM</th>
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<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Informal Supervision SW</td>
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<td>1</td>
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</tr>
<tr>
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<td>Family Reunification SW</td>
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<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dependency SW</td>
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</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Emergency Response SW</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Informal Supervision SW</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Court Services SW</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Reunification SW</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>9</td>
<td>3</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>
Table 7

Chi-Square Tests

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Pearson Chi-Square</td>
<td>.600&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Likelihood Ratio</td>
<td>.908</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Linear-by-Linear Association</td>
<td>.000</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>N of Valid Cases</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Female</td>
<td>Pearson Chi-Square</td>
<td>7.556&lt;sup&gt;b&lt;/sup&gt;</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Likelihood Ratio</td>
<td>8.089</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Linear-by-Linear Association</td>
<td>.349</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>N of Valid Cases</td>
<td>12</td>
<td>-</td>
</tr>
</tbody>
</table>

Many of the participants were already ordered to do services and working towards reunification. Table 6 is a crosstabulation of type of social worker and whether or not parents were participating in services split between men and women. Three men who were participating in services and one man who was not reported that there was a Family Reunification social worker present during the TDM meeting. One man who was participating in services reported that there was an Informal Services social worker present in the meeting while the other man participating in services reported that there was a Dependency worker present. On the other hand, five women who were participating in services and one woman who was not reported that there was a Family Reunification social worker present during the meeting. Four women participating in services reported having an Informal Services social worker present. In addition, one
woman not participating in services reported that there was an Emergency Response
social worker present and another woman not participating in services reported that there
was a Court Services social worker present.

Table 7 utilizes the chi-square test of independence to determine whether or not
there was an association between type of social worker in attendance at the TDM meeting
and whether or not parents were participating in services prior to the TDM. The
researcher assumed that, for example, parents working with a Family Reunification social
worker might be participating in services prior to the TDM more so than parents working
with an Emergency Response social worker. The results were that there is no significant
association between the type of social worker and parent participation in services prior to
the TDM in either the male or female population (Males chi-square = .600, df = 2, p > .741; Females chi-square = 7.556, df = 3, p > .056). The test of association explains that
parents were participating in services similarly no matter which social worker attended
the TDM.
Table 8
Correlations

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Involvement in the Case Plan</th>
<th>Involvement in Decisions About Care of Children</th>
<th>Age of Participant</th>
<th>Number of CPS Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Pearson Corr. ( \text{a} )</td>
<td>Pearson Corr. ( \text{a} )</td>
<td>Pearson Corr. ( \text{a} )</td>
<td>Pearson Corr. ( \text{a} )</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed) ( . )</td>
<td>Sig. (2-tailed) ( . )</td>
<td>Sig. (2-tailed) ( . )</td>
<td>Sig. (2-tailed) ( . )</td>
</tr>
<tr>
<td></td>
<td>( N = 5 )</td>
<td>( N = 5 )</td>
<td>( N = 5 )</td>
<td>( N = 5 )</td>
</tr>
<tr>
<td>About Care of Children</td>
<td>Sig. (2-tailed) ( . )</td>
<td>Sig. (2-tailed) ( . )</td>
<td>Sig. (2-tailed) ( .353 )</td>
<td>Sig. (2-tailed) ( .685 )</td>
</tr>
<tr>
<td></td>
<td>( N = 5 )</td>
<td>( N = 5 )</td>
<td>( N = 5 )</td>
<td>( N = 5 )</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed) ( . )</td>
<td>Sig. (2-tailed) ( .353 )</td>
<td>Sig. (2-tailed) ( .609 )</td>
<td>Sig. (2-tailed) ( .609 )</td>
</tr>
<tr>
<td></td>
<td>( N = 5 )</td>
<td>( N = 5 )</td>
<td>( N = 6 )</td>
<td>( N = 6 )</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed) ( . )</td>
<td>Sig. (2-tailed) ( .685 )</td>
<td>Sig. (2-tailed) ( .609 )</td>
<td>Sig. (2-tailed) ( .609 )</td>
</tr>
<tr>
<td></td>
<td>( N = 5 )</td>
<td>( N = 5 )</td>
<td>( N = 6 )</td>
<td>( N = 6 )</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed) ( .000 )</td>
<td>Sig. (2-tailed) ( .390 )</td>
<td>Sig. (2-tailed) ( .947 )</td>
<td>Sig. (2-tailed) ( .947 )</td>
</tr>
<tr>
<td></td>
<td>( N = 12 )</td>
<td>( N = 11 )</td>
<td>( N = 12 )</td>
<td>( N = 12 )</td>
</tr>
<tr>
<td>About Care of Children</td>
<td>Sig. (2-tailed) ( .000 )</td>
<td>Sig. (2-tailed) ( .374 )</td>
<td>Sig. (2-tailed) ( .959 )</td>
<td>Sig. (2-tailed) ( .959 )</td>
</tr>
<tr>
<td></td>
<td>( N = 11 )</td>
<td>( N = 11 )</td>
<td>( N = 11 )</td>
<td>( N = 11 )</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed) ( .390)</td>
<td>Sig. (2-tailed) ( .374)</td>
<td>Sig. (2-tailed) ( .292)</td>
<td>Sig. (2-tailed) ( .292)</td>
</tr>
<tr>
<td></td>
<td>( N = 12 )</td>
<td>( N = 11 )</td>
<td>( N = 12 )</td>
<td>( N = 12 )</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed) ( .947)</td>
<td>Sig. (2-tailed) ( .959)</td>
<td>Sig. (2-tailed) ( .292)</td>
<td>Sig. (2-tailed) ( .292)</td>
</tr>
<tr>
<td></td>
<td>( N = 12 )</td>
<td>( N = 11 )</td>
<td>( N = 12 )</td>
<td>( N = 12 )</td>
</tr>
</tbody>
</table>
Table 8 examines the relationship of several key variables using the Pearson correlation. These variables include the age of the participant, the number of children involved with CPS, the participant’s level of involvement in the case plan after the TDM, and the participant’s level of involvement in decisions regarding the care of their children after the TDM. Findings indicate that among the male participants, there was no correlation between the variables used in the correlation matrix especially different levels of involvement and male participants involved in TDM. Among the female participants, there was a strong correlation between level of involvement in the case plan after the TDM and level of involvement in decisions regarding the care of their children (\(r = .998, p < .000\)). All other variables in the correlation matrix show no significant difference.

Table 9

<table>
<thead>
<tr>
<th>Facilitator Made Effort to Include Parent Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Valid</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

It is important to note that out of the 18 participants, 17 (94.4\%) felt that the facilitator made an effort to include the parent’s participation in the meeting. This may be an important factor in parent engagement during the meeting. For example, if the facilitator did not make such an effort, it is likely that parents would not feel like they were a part of the team and a part of the decision-making process.
Decision Involvement

Historically, child welfare agencies have made decisions regarding foster care children and their placements without the input of families. TDM is a family-centered practice that includes parents in the decision-making process. Therefore, measures were taken to see whether the participants in this study felt included in the decisions, what information they shared that was considered in the placement decision, and whether any information was overlooked.

Table 10

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Valid Yes</td>
<td>5</td>
<td>83.3%</td>
<td>83.3%</td>
<td>83.3%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>16.7%</td>
<td>16.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Female Valid Yes</td>
<td>11</td>
<td>91.7%</td>
<td>91.7%</td>
<td>91.7%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>8.3%</td>
<td>8.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Table 10 describes the frequency of men and women who felt that their opinions were either considered or not considered in the placement decision. A total of 83.3% of the men (N=5) felt that their opinions were considered in the decision and only one man (16.7%) felt that his opinions were not considered in the placement decision. A higher frequency of women felt that their opinions were considered in the placement decision (91.7%) and only one woman (8.3%) felt that her opinions were not considered in the placement decision. An open-ended, qualitative question was posed to the participants as...
to what information was shared during the meeting that was considered in the placement
decision. Six of the participants responded to this question that their progress in
treatment and the services that they were doing was considered in the final placement
decision.

Table 11
*Rating of Ability to be Involved in Decisions Now*

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not involved at all</td>
<td>1</td>
<td>16.7</td>
<td>16.7</td>
<td>16.7</td>
</tr>
<tr>
<td>Very Involved</td>
<td>5</td>
<td>83.3</td>
<td>83.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Female Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not involved at all</td>
<td>1</td>
<td>8.3</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Involved</td>
<td>4</td>
<td>33.3</td>
<td>33.3</td>
<td>41.7</td>
</tr>
<tr>
<td>Very Involved</td>
<td>7</td>
<td>58.3</td>
<td>58.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 11 discusses the rating participants gave on their ability to be involved in
the child welfare decisions regarding their children after the meeting. Categories
included not involved at all, somewhat involved, involved, and very involved. One man
(16.7%) reported that he was not involved at all in these decisions, while the remaining
five men (83.3%) reported that they felt very involved. One woman (8.3%) reported that
she was not at all involved, four women (33.3%) reported that they were involved, and
seven women (58.3%) reported that they were very involved in these decisions. There
was no missing data for this question and no participants responded that they were somewhat involved.

Table 12
*Crosstabulation Between Participants’ Satisfaction with TDM Outcome and Gender*

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Participant Satisfaction with TDM Outcome</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Feeling About Decision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agreed</td>
<td>5</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
<td></td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>Feeling About Decision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agreed</td>
<td>11</td>
<td></td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Disagreed</td>
<td>0</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>11</td>
<td>1</td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

Table 13
*Chi-Square Tests*

<table>
<thead>
<tr>
<th>Gender of Participant</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson Chi-Square</td>
<td>(^a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearson Chi-Square</td>
<td>12.000(^b)</td>
<td>1</td>
<td>.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction</td>
<td>2.479</td>
<td>1</td>
<td>.115</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>6.884</td>
<td>1</td>
<td>.009</td>
<td></td>
<td>.083</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear</td>
<td>11.000</td>
<td>1</td>
<td>.001</td>
<td></td>
<td>.083</td>
</tr>
<tr>
<td>Association</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 12 represents a crosstabulation of participants’ feelings about the decision and their satisfaction with the outcome of the meeting. A total of five males agreed with the decision and were satisfied with the outcome. One man was agreed with the decision, but was unsure about his satisfaction with the outcome. A total of 11 women agreed with the decision; all 11 women were satisfied with the outcome. One woman disagreed with the decision and was not satisfied with the outcome. Table 13 reports the findings of the association between the participants’ feelings about the decision and their satisfaction with the outcome of the meeting using the chi-square test of independence. The results found that among the women participants, there was a significant association between their feelings about the decision and the outcome of the meeting (chi-square = 12.000, df = 1, p < .001). On the other hand, there was nothing to report for men because they all agreed to the decision; therefore their feeling about the decision is a constant. This explains that for women, the variables of their feelings about the decision and their satisfaction with the outcome is associated.

An open-ended question was asked of the participants about factors that made them feel satisfied with the outcome of the meeting. Nine participants were satisfied with the outcome of the meeting because the decision was for the child either to return or remain in the home. Three of the participants were satisfied with the outcome because the team had come to an agreement and three of the participants were satisfied because the goal was to eventually place the children back into the home. Other participants were satisfied with the outcome because the decision was the best for the child and because
either overnight visits or more visits with the child was part of the plan developed. One participant was not satisfied with the outcome because she did not agree with the decision for her children to move in with relatives for a few weeks.

**Communication/Establishing a Partnership**

Communication is an important part of the TDM process. Effective communication helps the team feel comfortable and listen to one another. Participants were asked a series of questions regarding communication and how the TDM impacted their relationships, specifically with the social worker.

**Table 14**  
*Parent Treated with Dignity/Respect*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Yes</td>
<td>17</td>
<td>94.4</td>
<td>94.4</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1</td>
<td>5.6</td>
<td>5.6</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Utilizing frequency distribution, Table 14 reports a total of 17 out of 18 participants (94.4%) felt that they were treated with dignity and respect during the meeting. Seven participants responded that they felt respected during the meeting because they were listened to and had the opportunity to be heard. Three of the participants also said that they felt respected because there were no interruptions when they spoke and three of the participants said they felt respected because they were not put down during the meeting. Two of the participants felt respected because they felt as if they were equal to other team members, which is an important aspect of being a team.
The participant who did not feel respected during the meeting stated that they were not listened to and that their opinions were overlooked.

Table 15
*Crosstabulation Between Parents Treated with Dignity/Respect*

<table>
<thead>
<tr>
<th></th>
<th>Parents Treated with Dignity/Respect</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Facilitator Made Effort</td>
<td>No</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>to Include Parent Participation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>17</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 16
*Chi-Square Tests*

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>18.000a</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction</td>
<td>3.986</td>
<td>1</td>
<td>.046</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>7.724</td>
<td>1</td>
<td>.005</td>
<td></td>
<td>.056</td>
</tr>
<tr>
<td>Fisher’s Exact Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.056</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>17.000</td>
<td>1</td>
<td>.000</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 15 is a crosstabulation of the facilitator making an effort to include parent participation and parents’ feelings on whether they were treated with dignity and respect during the meeting. A total of 17 parents felt that the facilitator made an effort to include them in the meeting and felt that they were treated with dignity and respect. Only one
parent reported that they were not treated with respect and they did not feel that the facilitator made an effort to include their participation in the meeting. Table 16, which demonstrates the chi-square test of independence, indicates that there is a significant association between parents feeling respected and the facilitator making an effort to include their participation in the meeting (chi-square = 18.000, df = 1, p < .000). This means that if the facilitator made an effort to include the parent in the meeting, they were more likely to feel a sense of dignity and respect.

Table 17

<table>
<thead>
<tr>
<th>Description of Communication</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Better</td>
<td>7</td>
<td>38.9</td>
<td>38.9</td>
<td>38.9</td>
</tr>
<tr>
<td>The same</td>
<td>11</td>
<td>61.1</td>
<td>61.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 17 provides a frequency distribution of communication between the parent and the social worker after the TDM. Parents were asked as to whether their relationship with the social worker had changed any since they participated in the TDM. No parents stated that their relationship was worse, however 11 (61.1%) responded that the relationship was the same and seven (38.9%) responded that it was better.

Final Evaluation

Since this research study was a program evaluation, participants were asked questions regarding strengths of the program in addition to whether or not they would make changes to the program. Of those who would make changes to the TDM process,
responses included the location of the meeting, that the meeting be more private, that no
team members should participate by phone, that the parent should have more say than the
child, that participants should be notified of the meeting in advance, and that children
should not be in the meeting. One of the participants would have liked the public health
nurse, who was part of the team, to have been able to provide more information to the
family. Another participant felt that the birth mother should have been in the TDM
meeting however she was incarcerated at the time. Seven participants responded that
they would change nothing.

Major qualities of the meeting that the participants liked included being given a
plan/list of services and tasks to complete, that the meeting was organized, that their
opinions were considered and respected, and that the facilitator was skilled. Other
responses included having support present, that everyone in the meeting participated, that
there was an unbiased person included on the team, that the participant’s progress was
recognized, that the team was working to help the family, that the meeting was
informative, that the “good and the bad was addressed”, and that the children were
included. Three people stated that they liked nothing about the meeting.
Table 18
*Crosstabulation Between Participants Who Brought Support*

<table>
<thead>
<tr>
<th></th>
<th>Participants Who Brought Support</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Participant Informed They Could Bring Support</td>
<td>Yes</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>8</td>
<td>10</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 19
*Chi-Square Tests*

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>.012a</td>
<td>1</td>
<td>.914</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correctionb</td>
<td>.000</td>
<td>1</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>.012</td>
<td>1</td>
<td>.914</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td>.011</td>
<td>1</td>
<td>.916</td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>Linear-by-Linear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Association</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 18 describes the crosstabulation between participants being informed that they could bring support to the meeting and participants that actually brought support. Among the 18 participants, only seven participants were informed that they could bring support; the remaining 11 were not informed. Therefore, the chi-square test of independence was used to determine if there was a significant association between participants being informed they could bring support and participants that actually brought support. Table 19 indicates that there is no association between parents that
brought support and parents that were informed they could bring support (chi-square = .012, df = 1, p > .914).

An open-ended question about why participants did or did not bring support showed that five people did not bring support persons to the meeting because they were not informed that they could bring support persons. Other participants that did not bring support people felt that they did not need it and that the meeting was about their child and not them. One participant did not bring support because she did not want anyone to know that her children were removed by CPS. Another participant wanted to bring support, but was told by the social worker that the support person in mind was not needed in the meeting. Of those that did bring support, three of them brought support persons because they were part of the case plan and one brought the support person because the social worker wanted that person in the meeting. Support persons that were part of the case plan were usually the other birth parent of the child.

Table 20

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Yes</td>
<td>17</td>
<td>94.4</td>
<td>94.4</td>
<td>94.4</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>5.6</td>
<td>5.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 20 describes the frequency of parents who would participate in another TDM for their family in the future if needed. All participants responded to this question. A total of 94.4% (n= 17) responded that they would participate in another meeting and
one participant (5.6%) was unsure. Of the participants that would attend another TDM meeting in the future if needed for their family, six responded because it was helpful, four responded because it was for the child, and two responded because the meeting was informative. Other responses included that they had a good experience in the meeting, so that their voice would be heard, and so that they could get organized about what they needed to complete, and one participant stated that the next meeting will be for her child to be returned home. One participant stated that they would attend out of fear of having a new CPS case opened and another participant stated that if they did not attend, then they would be considered an unsupportive parent.
Chapter 5

SUMMARY

The purpose of this study was to evaluate the Team Decision Making (TDM) model within Sacramento County Child Protective Services (CPS) through the experiences and perceptions of birth parents. The researcher wanted to determine whether or not birth parents felt that they were included in the decisions, that their voices were heard, and that they were respected as an equal participant in the meeting. The researcher also wanted to explore whether or not collaborative efforts were made to include not only birth families and child welfare staff, but extended family, support systems, and community partners in the process. Questions were addressed to the parents to also determine whether or not TDM impacted communication with the family social worker, their participation in services, and their ability to be involved in decisions concerning their children.

TDM has been a tool used by child welfare agencies to protect children from additional harm when they are at risk or have been removed by the home. This tool is being utilized in over 60 sites and applies a collaborative approach to the child welfare process by including community partners, agency staff, and family. Prior to the implementation of TDM, child welfare agencies often made foster care decisions without the input of families. In the literature, it has been reported that decisions regarding child placement are better when the decisions are made by a team rather than by the bureaucratic process. Therefore, this research was based on the assumption that families
do better in the child welfare process when they are included in decisions regarding their children. It was also assumed that birth parent participation in TDM meetings would have a positive impact, such as improved communication with the social worker, a higher level of engagement in services and the case plan, and birth parents feeling respected and included.

**Overall Results**

The sample size of this study was 18 biological parents who were being served by the child welfare system and who had recently experienced a TDM. Demographic information was collected, including age, ethnicity, gender, and number of children involved in the child welfare case. Type of social worker was also collected to identify what stage the participant was in the child welfare process. In conclusion, there were a total of six males and 12 females included in this study. The majority of the participants were Caucasian (44.4%), followed by African American (27.8%), Multi-ethnic (16.7%), Latino/Mexican American (5.6%), and German (5.6%). A total of 12 participants were between the ages of 20-35, four between the ages of 36-51, and the remaining two participants were between the ages of 52-67. Between the 18 participants included in this study there was a total of 46 children with an average age of 6.451 years and a standard deviation of 4.954 years. The majority of the participants (55.6%) were being served by a Family Reunification social worker, with the next highest group of participants (27.8%) being served by an Informal Services social worker. Additional participants were either
being served by an Emergency Response social worker, a Court Services social worker, or a Dependency social worker.

TDM utilizes a team approach to making decisions regarding a child placement. As part of a collaborative effort, child welfare agencies invite community members, including service providers and foster parents, extended family, and caregivers are encouraged to participate (Crea, Usher, et al., 2009). Child welfare decisions around placement are better for families and caregivers when those decisions are made by a team rather than by the bureaucratic decision process within the child welfare system (DeMuro & Rideout, 2002). In fact, one of the major principles of the TDM process is respecting the families’ knowledge of their children (Crea, Usher, et al.). This research study found that efforts were made to include a wide variety of individuals in the TDM process. A total of 14 participants reported that community members, family, and child welfare agency staff were included in the TDM meeting.

Because child welfare agencies have historically made decisions without the input of birth parents and families, levels of engagement were of interest to this researcher. This study analyzed whether parents were able to engage more in services and decisions regarding the care of their children after they experienced a TDM. It was found that 77.8% of the participants were already engaged in services. Therefore, it was assumed that there was an association between type of social worker present in the meeting and whether or not the participant was engaged in services prior to the TDM. The chi-square test of independence was used to analyze these variables and results showed that there
was no association in either the male or female population. Even so, this study found that TDM was helpful in identifying needed services for children and their families. The Pearson correlation test examined the relationship between level of involvement in the case plan and level of involvement in decisions regarding the care of children. Results showed that while there was no significant relationship among the male participants, there was a strong significant relationship among the female participants. In addition, this study found that TDM facilitators made an effort to engage parents.

Both women (91.7%) and men (83.3%) felt that their opinions were considered in the TDM placement decision. A total of six of the participants shared their progress in treatment and the case plan and believed this to be a factor in the final decision. This study also found that 83.3% of men and 58.3% of women felt that they were very involved in decisions regarding their children since participation in the TDM. The chi-square test of independence was used to determine if there was an association between satisfaction with the outcome and whether the participant agreed or disagreed with the decision. Five men and 11 women were both satisfied with the outcome and agreed with the decision. The results showed among the women, there was a significant association for these two variables. Therefore, women were more likely to have been satisfied with the outcome of the meeting if they had agreed with the decision. No level of significance was reported among the men, as their responses remained constant. Most of the participants were satisfied with the outcome because the decision was for the children to remain or return home.
Research results also found that 94.4% of the participants felt that they were treated with dignity and respect during the meeting. There was a significant association between parents feeling respected and efforts made by the facilitator to include them in the meeting. For the most part, communication between the social worker and the parent was not impacted by the TDM. Only 38.9% of the participants felt that their communication was better with the social worker after participation in the meeting. The remaining 61.1% of the participants felt that their communication with the social worker was the same after the meeting. Since most of the interviews occurred within a week of the TDM, there had been little contact between the participants and the social worker.

Several participants (n= 11) responded they were not informed that they could bring support with them to the TDM meeting. The results of the chi-square test of independence found that there was no association between parents who brought support and whether they were informed that they could bring support. However, five people reported that they did not bring support because they were not informed they could. Other reasons participants did not bring support were because they did not feel they needed support, they did not want to tell anyone that their children were removed, and that the social worker explained that their suggested support person was not needed in the meeting. Most participants that did bring support did so because the support person was also a part of the case plan.

A large number of participants (94.4%) reported that they would participate in a TDM in the future if needed. Six of the participants felt that they would participate in a
future TDM because the TDM was helpful and four of the participants said they would
attend another TDM in the future because they would do anything to help their child.
Overall, the participants reported many strengths of the program. Participants liked that
they were given a plan/list of services and tasks to complete, that the meeting was
organized, that their opinions were considered and respected, that the facilitator was
skilled, that everyone in the meeting participated, and that the participant’s progress was
recognized. Specific changes that participants would like to see in the program are that
the location be closer to their residence, that the meeting be kept more private, that
people not be allowed to participate over the phone, and that parents should have more of
a say in the meeting than the children.

Implementation

To improve this study, the researcher would have made changes to the
questionnaire as well as to the sampling procedure. Some questions would have been
added to the questionnaire and others would have been changed or deleted. For example,
it would have been helpful to add a question asking participants what happened that
brought them to the attention of CPS. These circumstances may have related to why or
why not participants were engaged in their case plans and may also related to whether or
not they would participate in a TDM meeting. It would also have been helpful to find out
exactly what the placement decision was, as it appears that participants had a better
experience in the TDM when the decision was for the children to return home.
There were questions that I would have deleted from the questionnaire based on the fact that they were confusing to the participants. These questions included question four from section three of the questionnaire asking “What information did you share during that meeting that was considered in the actual placement decision?” and question six from section five of the questionnaire asking “Do you feel that you had adequate representation during the meeting?” Other questions would have been deleted regarding communication with the social worker after the TDM meeting, such as question one from section four of the questionnaire which said “Describe the amount and type of contact you’ve had with your social worker since the TDM.” Often these questions did not apply since participants were interviewed within a week of their TDM meeting. The researcher would have made changes to question eight in section one of the questionnaire which asked “What are the ages of your children?” The researcher should have been more specific to ask the ages of the children that were part of the CPS case, as the literature has shown that younger children in general experiences less placement changes.

The sampling method for this research was availability sampling. While this is a common sampling method used in social work research, it is also risky as it can lead to sampling bias. The main reason that it was problematic for this research was because the population did have a variety of different TDM meetings. For example, many of the meetings were exit of placement meetings which meant that children were reunifying with their parents; therefore participants were more likely to have a positive experience in their meeting. Also when participants were approached to be a part of the study, their
interviews were scheduled usually within the next week. This meant that most of the participants had too recently experienced a TDM to adequately measure whether the TDM had any impact on service participation and/or communication with the social worker.

**Implications for Social Work**

The social work profession is dedicated to enhance the well-being and empowerment of people who are oppressed, vulnerable, and living in poverty. Foster care children are among the diverse populations served by social workers, as they have been abused and neglected by their families. Therefore, the goals of child welfare agencies in serving these children are to provide them with safe and stable environments and protect them from additional harm. Historically, U.S. legislation has failed to address the needs of children in foster care and their families. Funding that has been provided through Aid to Families with Dependent Children, the Adoption Assistance and Child Welfare Act, and the Adoptions and Safe Families Act has been insufficient in addressing the needs of foster care children. In addition, funding for social services are continuing to be cut due to the current economic crisis. Unfortunately, services helping to sustain families are depleted, more and more families become homeless, live in poverty, and there are substantial increases in child abuse and neglect. Therefore, there is a growing need in the field for policy changes for children.

In 1992 with the implementation of the Family to Family Initiative, child welfare agencies began utilizing TDM to reduce the number of foster care children coming into
the system and to provide children who must be removed with more quality, neighborhood-based foster care homes. While it is not always the best to return a child to their families, studies have shown that children do better when they have permanent, stable homes. Children that grow up in the foster care system, moving from home to home, often experience oppression and poverty as adults. Foster care children are more susceptible to mental health disorders and behavior problems, such as substance abuse issues, poor grades in school, and gang activities. It is not unlikely for child welfare agencies to serve foster children and then serve them again as adults with their own children who have experienced abuse and neglect.

As social workers, it is our duty to keep children safe and provide them with opportunities to be successful in life and to accomplish their dreams. Therefore, it is important to embrace family-centered, evidence-based programs such as TDM. Although there is little research of the impacts of TDM on placement stability, TDM is however impacting placement outcomes. Children are more likely to remain in stable placements, get placed with family, and be in least restrictive environments as a result of TDM.

**Recommendations for Future Research**

TDM is a relatively new practice utilized by child welfare agencies to impact the outcomes for children in foster care. Therefore, research regarding TDM is very limited. Studies that have been conducted on TDM focus mostly on implementation fidelity and collaborative efforts. While studies have shown that having community members and family members in addition to child welfare agency staff present during a TDM reduces a
recommended placement change, not much is known about what actually happens to those children and that placement after the meeting. Future research should focus on the stability of placements following a TDM meeting. For example, this researcher recommends a longitudinal study on the stability of a placement that resulted from a TDM over time. Another recommendation for future research is a study that compares placement change data prior to the implementation of TDM to placement change data after the implementation of TDM.

**Conclusion**

In conclusion, it appears as though TDM is a helpful child welfare practice and that overall it benefits the family because it includes birth parents, service providers, and extended family in the decision-making process. Most parents feel that they were respected during the meeting and that they liked the meeting because they had a chance to voice their opinions about their child’s placement. This study was limited because of a small participant sample. However, it was unique in that it focused on birth parents. Birth parents involvement is an important factor in child welfare outcomes and specifically related to TDM, recommended changes are less likely to occur when parents and caregivers are present. After all, parents are the experts regarding their children and can help to identify factors that can lead to a successful placement. Hopefully, more family-centered practices will be utilized within the child welfare system in the future.
APPENDICES
APPENDIX A

Consent Form

Consent to Participate in Research

You are being asked to participate in a research project conducted by Nicole Wentzel, who is a graduate student in social work at California State University, Sacramento, Division of Social Work. The purpose of this study is to determine whether or not parents involved in the child welfare system feel that they have benefited by being involved in a Team Decision-making (TDM) meeting having to do with placement of his or her child; specifically whether or not they felt that their input and suggestions were respected and if they feel satisfied by the outcome.

After setting up an interview time, you will be asked to answer a series of questions regarding your experience with Child Protective Services (CPS), your social worker, and the most recent TDM. The interview is set to last one hour but it could last as long as two hours.

The interview process itself may involve some psychological risks, but the risks are very small. For example, you may feel additional stress, grief, or embarrassment when talking about your experience with CPS, what issues led to the CPS intervention, and issues and concerns regarding your child/children. If you do experience any of these harms, you can access counseling services at no cost to you through your local Family Resource Center (FRC) and other Sacramento agencies. A list of theses services will be provided to you at the end of the interview.

The interview will allow you to express your feelings and concerns about your child welfare case, without impacting the case in a negative way. The information that you provide may help child welfare professionals better understand the views of parents and provide them with a framework for utilizing TDM.

All information that you provide will be kept strictly confidential. Your name will not be disclosed in the final research product; only aggregate results of this interview will be reported. In order to protect your privacy, your name will not be placed on any notes taken during the interview. Instead, the notes taken during your interview will be labeled with an identification number and all consent forms will be kept in a separate, secure location.

You will not receive any form of compensation for participating in this research. Your participation in this research is entirely voluntary. You are free to decide not to participate, or to decide at a later time to stop participating. The researcher may also end
your participation at any time. By signing below, you are saying that you understand the risks involved in this research and agree to participate in it. If you have any questions about this research, you may contact the Research Advisor, Dr. Serge Lee, at (916) 278-5820 or by email at leesc@csus.edu. You may also contact the researcher, Nicole Wentzel at (916) 583-3208 or by email at nicole.wentzel@sbcglobal.net.

_____________________________________  __________________
Signature of Participant     Date

_____________________________________  __________________
Signature of Witness      Date
APPENDIX B

Questionnaire

Interview Questionnaire

Part I. Demographics/General Information

1. What is your age?
   A. 20 – 35
   B. 36 – 51
   C. 52 – 67

2. What is your ethnicity?
   _______ African American
   _______ Latino/Mexican American
   _______ Caucasian
   _______ Asian American/Pacific Islander
   _______ Eastern Indian
   _______ Native American/American Indian
   _______ Multi-ethnic
   _______ Other (Specify)

3. What is your gender?
   _______ Male
   _______ Female
   _______ Transgender
   _______ Transsexual

4. Which social worker was present during the TDM meeting?
   _______ Emergency Response Social Worker
   _______ Informal Supervision Social Worker
   _______ Court Services Social Worker
   _______ Family Reunification Social Worker
   _______ Permanency Services Social Worker
   _______ Dependency Social Worker

5. Do you have any prior involvement with CPS, either as an adult or a youth?
   _______ Yes
   _______ No
   _______ Decline to State
6. How many children do you have? ____ /number of children

7. How many of those children are involved with CPS? ____ /number of children

8. What are the ages of your children?

9. Besides yourself, who else participated in the TDM?

10. Approximately how long ago was the TDM?

   A. Less than 1 week ago
   B. 1-2 weeks ago
   C. 3-4 weeks ago
   D. 4 weeks or more

11. Have you ever participated in a TDM prior to this TDM?

    _____ Yes
    _____ No
    _____ Decline to State

Part II. Helps to Engage Them

1. On a scale of 1 – 10, with 1 being the least 10 being the most, place the number you consider most reflective of the following statements. Skip statement(s) that do not reflect your involvement.

   _____ My level of involvement with the child welfare process prior to the TDM

   _____ My level of self-confidence about the child welfare process before participating in the TDM

   _____ My level of self-confidence about the child welfare process after participating in the TDM

   _____ My level of involvement in the case plan prior to the TDM

   _____ My level of involvement in the case plan after the TDM

   _____ My level of involvement in decisions regarding the care of my child(ren) prior to the TDM

   _____ My level of involvement in decisions regarding the care of my child(ren) after the TDM

   _____ Overall rating of the TDM

2. Were you participating in services towards your case plan prior to the TDM?

3. Was the TDM helpful in identifying needed services for you and your family?

4. What, if any, services were identified?
5. In your opinion, do you feel that the facilitator made an effort to include your participation in the meeting?

Part III. Tool Used to Involve Parents in Decisions
1. Did you feel your input and/or opinions were considered in the placement decision?
   ____ Yes
   ____ No
   ____ Decline to State

2. How do you rate your ability to be involved in these decisions now?
   A. Not involved at all
   B. Somewhat involved
   C. Involved
   D. Very involved

3. How do you feel about the decision made during the TDM?
   ____ Agreed
   ____ Disagreed
   ____ Declined to State

4. What information did you share during that meeting that was considered in the actual placement decision?

5. Was there any information that you shared during the TDM session and it was overlooked or dismissed during the TDM meeting?

6. If so, what information? _____________________________________________

Part IV. Improves communication/Establishes a partnership
1. Describe the amount and type of contact you’ve had with your social worker since the TDM.

2. Do you feel that you and your social worker were working together prior to the TDM meeting?
   ____ Yes
   ____ No
   ____ Decline to State
3. Do you feel that you and your social worker were working together after the TDM meeting?
   ______ Yes
   ______ No
   ______ Decline to State

4. How would you describe your communication with your social worker prior to the TDM meeting?
   A. It was not good.
   B. It was bad.
   C. It was somewhat OK.
   D. It was good.
   E. It was very good.

5. How would you describe the communication between you and your social worker since you participated in the TDM? Would you say it was…
   F. Better
   G. Worse
   H. The same

6. Do you feel that the TDM meeting offered a safe environment for you to be completely honest?
   ______ Yes
   ______ No
   ______ Unsure

7. If Yes, Why ______________________________________________________
   If No, Why ______________________________________________________

8. Did you feel that you were treated with dignity and respect during the meeting?
   ______ Yes
   ______ No
   ______ Unsure

9. If Yes, Why ______________________________________________________
   If No, Why ______________________________________________________

10. During the meeting, did it feel like you the system was working with you?
    ______ Yes
      ______ No
      ______ Unsure
11. If Yes, Why _________________________________________________
   If No, Why _________________________________________________

12. Since the TDM meeting, do you feel that you can address your concerns with the social worker?
   ______ Yes
   ______ No
   ______ Unsure

13. If Yes, Why _________________________________________________
   If No, Why _________________________________________________

Part V. Final Thoughts
1. What, if anything, would you change about the TDM process?

2. What did you like about the TDM meeting?

3. Were you informed that you could bring support persons to the meeting?

4. Did you bring support persons to the meeting?

5. If Yes, Why _________________________________________________
   If No, Why _________________________________________________

6. Do you feel that you had adequate representation during the meeting?

7. Was there a Parent Leader that participated in your meeting?

8. If so, did it help?

9. Were the strengths of your family adequately documented on the board during the meeting?
   ______ Yes
   ______ No
   ______ Unsure

10. Were you satisfied with the outcome of the meeting?
    ______ Yes
    ______ No
    ______ Unsure
11. If Yes, Why ______________________________________________
If No, Why _______________________________________________

12. In case there is an opportunity, would you be interested in participating in another TDM for you and your family in the future if needed?

________ Yes
________ No
________ Unsure

13. If Yes, Why ______________________________________________
If No, Why _______________________________________________

14. Thanks for your time. I appreciate it very much for taking your valuable time to complete this questionnaire. In case you have anything else that you would like to share about your experience with TDM, please write them down on the following lines.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
REFERENCES


