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Decision-making in the Foster Care System

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Abstract

This study documented and analyzed the processes of mental health treatment decision-making, in the context of family support teams, within the foster care system. The research questions explored engagement, perceptions, and self-rated empowerment among family support teams that serve adolescent foster youth with mental health concerns. The sample consisted of 23 participants from core support teams and 36 other adolescent and adult team members who were involved in the study. Data collection methods included observations at family support team meetings and court hearings, 34 semi-structured individual interviews, a self-rated empowerment scale, and informal conversations in the field. Analysis of non-survey data included qualitative content analyses of meetings and grounded theory methods of analysis for the interviews. Three analytic categories were found in the data: *the inter-related processes of decision-making, power, and mesosystem factors that support or hinder decision-making*. *The inter-related processes of decision-making* was chosen as a conceptual label to capture the complexity of arriving at decisions. The second category was named power. *Power* was conceptualized as the ability to influence, or get another person to do something; also the ability to access and use resources. Power was further distinguished by the subcategories: qualities and responses to power. *Mesosystem factors* in this study were the factors within the Children's Division and Court System that encourage or impede the youth and family

support team's deliberations. *Mesosystem factors* as a category was further differentiated into three subcategories: role, transparency, and standardization of practices and procedures. Three family support team exemplars are presented to illustrate these categories. The results of the study pointed to: a) a need to educate stakeholders about how to more fully engage in collaborative decision-making and b) a need to provide more opportunities for problem-solving and open dialogue among the youth and their respective teams.

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CHAPTER ONE: INTRODUCTION

Typically, youth who live in foster care for any length of time will be moved from place to place. Providers, involved adults, and foster youth often fail to communicate necessary information from one placement to the next (Havlicek, 2010, 2011). The lack of continuity of care within Child Welfare is thought to be a driver in the over-medication of foster youth (Alavi & Calleja, 2012; Leslie et al., 2011; Narendorf, Bertram, & McMillen, 2011; Rubin et al., 2012). The mental health issues of these youth are often treated with psychotropic medications. Prescriptions tend to accumulate without any one person able to track or question what is happening (Alavi & Calleja, 2012; Bertram, Narendorf, & McMillen, 2013).

A proposed decision-making model called shared decision-making (SDM) might help with this communication breakdown. This model helps each party, in dialogue with the other, be more actively involved in looking at options and trying out possible courses of action when addressing healthcare situations (Drake & Adams, 2006; Drake & Deegan, 2009; Elwyn et al, 2003; Elwyn et al, 2005; Epstein & Gramling, 2013; Gafni, Charles, & Whelan, 1998; Wensing, Elwyn, Edwards, Vingerhoets, & Grol, 2002). Characteristics of the relationship dynamics of SDM include an empowered, responsible consumer, a respectful, flexible practitioner, and a negotiated distribution of power between the healthcare consumer and the provider or treatment team (Ackerson & Harrison,

2000; Cohen, 1998; Drake, Deegan, & Rapp, 2010). Empowerment to take action, a component of SDM, often counters feelings of helplessness or apathy that can arise from past experiences (Cohen, 1998). SDM is ideal for managing complex and/or chronic health conditions (Epstein & Gramling, 2013; Towle & Godolphin, 1999). SDM even applies to cases wherein communicative capacity of youth and/or individuals with mental health conditions might be called into question (Crickard, O'Brien, Rapp, & Holmes, 2010; Duncan, Best, & Hagen, 2010; Epstein & Gramling, 2013; Fiks & Noonan, 2013; Goscha, 2009; O'Brien, Crickard, Rapp, Holmes, & McDonald, 2011; Wyatt et al., 2013).

The interest in studying and implementing SDM interventions to educate, support, and assist individuals with decision making within the mental health community has grown substantially in the last few years (Center for Mental Health Services, 2010). Between the years 2009 and 2015, 18 empirical intervention studies have been conducted to examine shared decision making outcomes. Most were randomized control trials in which sample sizes ranged from 27-2480 participants (Alegria et al., 2014; Aljuma & Hassal, 2015; Campbell, Holter, , Manthey & Rapp, 2014; Cooper et al., 2013; Dixon et al., 2014; Hamann et al., 2011; Hamann et al., 2014; Hilgeman et al., 2014; Joosten et al., 2009, 2011; LeBlanc et al., 2015; Loh et al., 2007; Mott, Stanley, Street, Grady & Teng, 2014; Simon et al., 2012; Steinwachs et al., 2011; Troquete et al., 2013; Van der Krieke et al., 2013; Westermann, Verheij, Winkens, Verhulst, &

Van Oort, 2013). More details about these studies and their implications are found in Chapters Two and Five.

In the pediatric setting, a systematic review by Lipstein, Brickman and Britto (2012, p. 3) found 52 shared decision-making studies on a wide variety of pediatric conditions. Wyatt et al. (2013) published a systematic review proposal that aimed to identify shared decision-making studies in the pediatric setting. Specifically, their proposal sought to find literature about pediatric SDM intervention research and to outline distinctions that exist between adult and pediatric settings in regards to implementing SDM. In the review of Lipstein et al. (2012) and the proposal of Wyatt et al. (2013), needs for more research about pediatric shared decision-making were identified.

A few studies have documented processes of SDM in youth mental health services (Crickard et al., 2010; Murphy, Gardner, Kutcher, Davidson, & Manion, 2010; O'Brien et al., 2011; Westerman et al., 2013), although little else has been written about SDM for youth (Fiks, Mayne, DeBartolo, Power, & Guevara, 2013; Lipstein et al., 2012; Wyatt et al., 2013). As an example of an SDM study in the youth mental health service sector, Fiks and colleagues (2013) explored ADHD management preferences and goals from the perspectives of parents and found that preferences and goals predicted treatment initiation and future target goals for their children's care. One limitation of this study was its failure to capture the perspectives of youth with regard to their preferences or goals. In other studies,

Crickard et al. (2010), Murphy et al. (2010), and O'Brien et al. (2011) described medication and treatment option management for adolescents with mental health needs. The findings from studies by Crickard et al. (2010) and O'Brien et al. (2011) can be found in Chapter Two.

Purpose

The primary aims of this dissertation research are to document the processes of decision-making, to ascertain the perspectives of stakeholders concerning decision-making within the foster care system, and to evaluate self-reported degrees of empowerment. The intention was to add to the literature regarding mental health treatment decision-making in the context of family support team meetings.

The goal of this research was to understand complex social phenomena using a mixed methods approach. The research objectives were to explore and describe observed stakeholder behaviors, to understand stakeholder perspectives, and to determine to what extent scores on self-rated empowerment scales informed analyses of behaviors and perceptions.

Rationale and Research Questions

Well-being has only recently been the focus of welfare reform efforts, though waves of reform movements in Child Welfare date back to the early 1900's, occurring approximately every 10 years (Murray & Gesiriech, 2004). Typically, an identified problem or issue that has reached a crisis point, according

to society priorities and political agendas (Malm, Bess, Leos-Urbel, Geen, & Markowitz, 2001) spearheads reform efforts. Recent emphasis on social and emotional well-being in Child Welfare is predicated in research documenting sub-optimal functional outcomes for youth who have aged out of foster care (Courtney et al., 2011).

Social and emotional well-being is defined broadly as having the capacities and resources to function, i.e., "those skills, capacities, and characteristics that enable young people to understand and navigate their world in healthy, positive ways" (Administration for Children and Families [ACF], 2012a, p. 1). Addressing the mental health needs of foster youth is a perfect example of a multi-faceted problem for which multiple options for management exist. One option for treatment is psychotropic medication, but the over-medication of foster youth has reached alarming proportions as evidenced by public press reports, a national audit of the foster care system, and changing legislation to tighten oversight (Administration for Children and Families [ACF], 2012b; Lagnado, 2014; U.S. Government Accountability Office, 2012).

Collectively, the young people who enter into foster care have high rates of health problems and mental health concerns, with estimates of chronic health conditions reported at 50% of all youth in care, and up to 80% experiencing severe emotional problems (Mekonnen, Noonan & Rubin, 2009). More than 95% of youth entering the custody of Child Welfare have experienced at least one

traumatic event. For instance, neglect, family violence, traumatic grief or separation, physical, sexual, or emotional abuse; and up to 75% have experienced events that are classified as moderate or severe (Griffin et al., 2011).

The mental well-being of foster youth exists on continuum, whether it is conceived of as adjustment to trauma or diagnosed mental condition. Despite Griffin et al.'s (2011) advice to take trauma into account before making mental health diagnoses, (because symptoms often overlap and cause diagnostic uncertainty), the lifetime prevalence rates of diagnosed mental disorders among the foster care population have been documented at two to four times the rates of mental disorders for youth who have not been in foster care (Havlicek, Garcia & Smith, 2013).

The health problems and mental health concerns typically endure into adulthood and cause ongoing constraints in the quality of life (Burns et al., 2004; Courtney & Dworsky, 2006; Courtney et al., 2005; Courtney, Dworsky, Lee, & Raap, 2009; Courtney et al., 2011; Felitti et al., 1998; Flaherty et al., 2013). Quality of life outcomes of youth who have lived in foster care are bleak, according to a large multi-wave study of foster alumni (Courtney et al., 2011). The foster alumni participants were interviewed at age 17 or 18, and again at ages 19, 21, 23 or 24, and 26 years. Results showed that many of these youth struggled with securing and maintaining housing, obtaining stable employment, and attaining education achievement. They have also suffered disproportionately with

health problems and legal system involvement (Courtney et al., 2011). Pecora and colleagues' *Northwest Study* documented similar findings (Pecora et al., 2010a; Radel, Bramlett, & Waters, 2010). More details about foster youth outcomes can be found in Chapter Two.

Multiple factors influence foster youth mental well-being. One of these factors is the decision-making that happens during the time in care. A decision is an endpoint of a thinking process that involves a series of cognitive steps, (Hansson, 1994; Hastie, 2001). These cognitive steps include the identification of a problem, the identification of factors involved in this problem, an identification of possible outcomes if this problem were solved or changed in some way, and a generation of possible alternatives to take for future action. Once the alternatives have been generated, a value or weighing is attached to each possible alternative. The selection that happens after viewing these alternatives is the decision.

Decision-making about youth mental health in the foster care system occurs within the context of family support team meetings. (It also occurs in other locations and outside the context of family support team meetings, such as at provider appointments. However, these other contexts were not the focus of this study.) Family support team meetings are regularly scheduled meetings that are held to decide foster youth service and treatment planning, permanency options, placement, progress and case review, and treatment plan revision (Missouri Revised Statutes, 2013). Family support teams meet for the first time

no later than 72 hours after a young person is placed in foster care. After the initial meetings, teams meet every month until the young person exits the system to discuss progress, plans, and needs of foster youth. Attending the meetings are the foster youth, caseworker, foster parents, and other adults who have been invited to be a part of the foster youth's team (Missouri Revised Statutes, 2013). Typically, psychiatrists, psychologists, and therapists do not attend family support team meetings.

A central question is: how are mental health treatment decisions made in the context of family support team meetings? And, what are the factors that influence those decisions within these meetings? This study explored the interplay of observed behavioral processes in decision-making, stakeholder perceptions of that process, and self-rated degrees of empowerment within the context of foster care family support team meetings. Establishing baseline information about decision-making processes, perceptions of processes, and self-reports of empowerment among stakeholders was viewed as a foundational step in intervention development (Godfrey, Nelson, Wasson, Mohr, & Batalden, 2003). This study sought to answer the following research questions:

a) How do foster youth with mental health needs and their family support teams engage in mental health treatment decision-making within the context of family support team meetings?

b) How do foster youth with mental health needs and their family support teams perceive the process of mental health treatment decision-making in family support team meetings?
c) What are the stakeholders' perceptions of their own empowerment?

Researcher Perspective

Advanced training in psychiatric and mental health nursing with specialization in the care of children and adolescents (i.e., master's degree in nursing and credentialing as a clinical nurse specialist) prepared me for the duties that I assumed in a National Institute of Mental Health funded study (NIMH R43MH081359-03). I was hired to conduct assessments and provide recommendations to a 'treatment foster care' team. This role was designed to facilitate better continuity of care. In this role, I conducted chart reviews and interviewed multiple individuals for each youth who was involved in the study. These chart reviews and interviews lead to formulation of diagnostic and medication summaries. I presented the summaries to family support teams, participated in weekly team meetings, and conducted psychoeducation with foster parents and foster youth. The lessons learned in this pilot study pointed to a need for better mental health care communication (Havlicek, McMillen, Fedoravicius, McNelly, & Robinson, 2012), and more specifically, brought forth questions about how decisions are made regarding mental health treatment (Bertram et al., 2013; Narendorf et al., 2011).

One particular need that surfaced as the study was conducted was for an improved level of confidence in the ability of foster youth, foster parents, and caseworkers to advocate for the youth's mental health care (Havlicek et al., 2012), especially surrounding psychotropic medication management. In the context of psychotropic medication management, it cannot be assumed, without further evidence, that stakeholders were left out of the decision-making.

My experience was that youth demonstrated varying levels of confidence when it came to self-advocacy. While some were more vocal, most were unable to exert influence in the decisions that were made. Foster parents were articulate, but they expressed a need for more information and support (Havlicek et al., 2012).

My impression of caseworkers was that they were caught in the difficult position of having to make hard decisions, such as consenting to medication changes or consenting to placement changes or hospitalizations, which they often felt ill equipped to make. I observed that caseworkers seemed to be in a position of authority in the family support team meetings, but privately they told me they had difficulty advocating for youth in other healthcare situations.

Furthermore, combing through case files in various agencies, I discovered that the lack of continuity of care was a major problem in the system. It was quite challenging to find various case files and sources of information that were stored in different locations (Bertram et al., 2013). There appeared to be a fragmentation

in record keeping and information sharing. That fragmentation in care caused medications and diagnoses to be added with each subsequent placement and change in provider for foster youth with mental health diagnoses. Over the course of their foster care careers, youth in the study were given an average of eight diagnoses and 13 distinct psychotropic medications (Narendorf et al., 2011). These findings were consistent with other research, which documented disparities in psychiatric care among youth in the foster care system (Rubin et al., 2012). These experiences led to the formulation of a question: would a rich description and analysis of the current dynamics of decision-making, individual perspectives, and a specific investigation looking at empowerment yield meaningful information that could serve as a bridge into quality improvement efforts?

This study is building off this previous research experience in a multidimensional treatment foster care program, *Treatment Foster Care for Older Youth* (TFC-OY). The current research study examined decision-making that occurs within family support team meetings and the focus was on mental health specifically. While the family support team meetings address multiple issues, an important focus in the research setting was addressing the needs of youth with mental health issues. While the foci of meetings are multi-faceted, this study's focus was on the decision-making that addresses mental well-being.

Significance of the Study

Shared decision-making is a type of decision-making that includes the preferences of the identified patient. Shared decision-making is a process of engagement, typically between a healthcare provider and patient, in which each party carries responsibility for choosing among alternatives in order to manage health care problems (Gafni et al., 1998; Drake & Adams, 2006; Elwyn, et al., 2005). This is a topic that has been addressed broadly in the general healthcare literature and more specifically in the mental health population literature (Deegan & Drake, 2006; Deegan, 2007; Goscha, 2009; Wensing et al., 2002). Shared decision-making in a medical encounter has certain characteristics. The provider who uses shared decision-making takes on a democratic leadership style, drawing attention to an identified problem that requires a decision-making process, soliciting conversations about options, discussing preferences for level of involvement, preferences for who participates and how decision-making will happen. Providers who use SDM have conversations with patients about the pros and cons of each option and involve patients in dialogues about how problems are to be managed (Elwyn, et al., 2005). In the case of family support teams, the foster youth is the identified patient; while the remainder of the team is conceptualized as the support team, not the medical provider.

Shared decision-making is supportive of patient autonomy and promotes egalitarian relationships among healthcare consumers and their providers.

Autonomy supportive environments have been linked with positive health outcomes (Ng et al., 2012). Thus, while SDM is recognized as an important component of quality care, the extent to which shared decision-making is occurring in the foster care system is not known. If a picture of shared-decision making were drawn in the context of a family support team meeting, it would appear that everyone had a "seat at the table" (Munson & Freundlich, 2008), that each person's presence was valued for a unique contribution, and people would be talking and listening to one with the implied message that each person's opinions, ideas, and preferences mattered. There might be a chairperson who would ask those in attendance at the family support team meeting what the agenda should be for the day. If a treatment plan had been formed previously, the goals and interventions would be re-visited to make sure they were still appropriate, and each person's expression of ideas would be noted. If problem(s) were identified, each person's perspectives would be solicited to brainstorm possibilities of how to manage or solve them. Members in attendance at the family support team meeting would not be quick to arrive at conclusions or solutions prematurely, but instead, would allow all to take their time in deliberating among options.

Examining the mental health treatment decision-making processes in the foster care system is important for two reasons: (1) seldom does research in Child Welfare take into account the views of foster youth, caseworkers, and foster parents collectively, although Pires (2008) and Shireman (2009) consider this

essential in building effective systems of care; and (2) there is a lack of studies about shared decision-making in younger mental health populations. This research study addresses both gaps in the literature and identified system challenges. More details about the gaps in the literature and the challenges are discussed in Chapter Two. The intention of this research is to add to the body of knowledge about decision-making, which may inform intervention development. The larger goal for system reform is that all stakeholders will view their work as a collaborative, constructive, and supportive endeavor, and that all stakeholders will experience a sense of autonomy and competence in their respective roles. Distally, it is hoped that research and intervention efforts will translate into improved functional outcomes for foster youth.

Methods

This study employed a mixed methods design in which the data are collected in a cross-sectional mode and one data source does not influence the collection of the next one. This type of research approach has been called a 'concurrent, embedded' design by Creswell and Plano Clark (2007). Participants were recruited from five counties in a mid-western state. The sample of 23 participants from core support teams and 36 other adolescent and adult team members were involved in the study.

Data collection methods included observations at family support team meetings and court hearings, 34 semi-structured individual interviews, a self-rated

empowerment scale, and informal conversations in the field. Analysis of non-survey data included qualitative content analyses of meetings and grounded theory methods of analysis for the interviews. More detailed discussion of the research design and methods will be described in Chapter Three.

Sensitizing Concepts and Theoretical Frame

Issues of power and empowerment inform group process theory and decision-making models, especially the shared decision-making model. Within SDM, the sub concepts of patient-

centered care and family-centered care are identified. Being the initiator (autonomy) and advocate of one's own goals (competence) are important components of decision-making. These concepts in turn funnel into self-determination theory.

Deci and Ryan's self-determination theory describes developmental and motivational needs as relatedness, autonomy, and competence (Deci & Ryan, 2000, 2002; Deci, Ryan, & Williams, 1996; Deci & Vansteenkiste, 2004; Ryan & Deci, 2000a, 2000b, 2001; Ryan, Patrick, Deci, & Williams, 2008). Studies conducted by Deci, Ryan, and others suggest optimal functioning, or 'well-being' is achieved when these needs are met (Deci & Ryan, 2002; Ng et al., 2012; Williams, McGregor, Zeldman, Freedman, & Deci, 2004; Williams et al., 2006). Self-determination theory serves as the theoretical frame of this study and will be described more fully in Chapter Two.

Limitations

At least three limitations are identified: (a) This study chose not to study potentially influential factors, such as education, living conditions, socio-economic levels, culture, traditions, social expectations, and material conditions of the participants. These factors were not known in detail, nor controlled for in this study. (b) Certain individuals' perspectives were missing. Individuals, such as court personnel and medical personnel were involved with the foster youth, but not part of the study. (c) This study used a purposeful sample from a closed system and relied on volunteers. Readers will be able to determine for themselves to what extent the findings, analysis, and interpretation of results will be useful for them in their particular contexts. Readers will be able to make this determination based on a detailed documentation of the setting, the participants, and the procedures of data collection and analysis.

Summary

This study sought to understand decision-making in the foster care system. The concerns surrounding mental health care in the child welfare system merit investigation of decision-making processes to assist in improvement of quality of life for foster youth with mental health needs, for caseworkers, and for foster parents (Alavi & Calleja, 2012; Costello, 2002; McMillen, Fedoravicius, Rowe, Zima, & Ware, 2007; Raghavan, Inkelas, Franke, & Halfon, 2007; Shireman, 2009).

This study explored and described current practices because little was known about how decision-making occurs or how stakeholders feel about it. The next chapter reviews contextual factors that frame this research study. Legislation that affects family support team meetings will be discussed. Family group decision-making models and a proposed model of shared decision-making in the foster care system will be reviewed. Chapter Three will detail the methods chosen to answer the research questions.

CHAPTER TWO: REVIEW OF LITERATURE

In order to place the proposed study in context, a literature search was conducted by generating a list of terms with the assistance of an expert in child welfare and a registered nurse with specialized training in library and information science. The list of terms included: Adoption and Safe Families Act of 1997, adult education and foster parents, case managers and social workers, Casey family programs, child welfare, decision making, empowerment, family empowerment scale, foster care/child/parent/mother/father/youth, Fostering Connections to Success and Increasing Adoptions Act of 2008, self-determination theory, and shared decision. Articles were scanned for application to the research questions, summarized by outlining and/or highlighting relevant articles, and broadly arranged for this chapter according to context, well-being, self-determination theory, decision-making, empowerment, adult education, and foster parent training.

The chapter begins by discussing the sociopolitical context of family support team meetings. Two pieces of relevant legislation, Adoption and Safe Families Act of 1997 (ASFA-97) and Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections), are summarized; because they represent policy shifts in Child Welfare. While there are three priority foci in Child Welfare, namely safety, permanency, and well-being, it has

only been in the past two decades that prioritization has shifted toward well-being. The policies contained within ASFA-97 and Fostering Connections are described in this chapter as they relate to well-being.

Next, the chapter transitions to a discussion of sensitizing concepts. The sensitizing concepts that will be discussed in this chapter are well-being, self-determination theory and its sub concepts: motivation and regulation, decision-making, and its sub-concepts: the decision-making ecology and group process theory, power and empowerment, and models of decision-making: the family group decision-making model of decision-making and shared decision-making.

Blumer (1954) defined sensitizing concepts as general points of reference or suggested directions that provide the researcher with ways to view the data. They provide a way of organizing the researcher prior to going into the data collection. The value in having an organizational frame is that it helps manage the information as it is heard, seen, and otherwise experienced in observations and interviews. The organizational frame provides a sort of mental map that allows the researcher to go into the field with some standardization. Instead of going into the data collection without any previous knowledge, the naming of the sensitizing concepts acknowledges that there are a-priori preliminary understandings of concepts like decision-making processes, group dynamics, and empowerment issues. These concepts have direct and indirect relationships to

the research questions, which will be illustrated through discussion in the pages that follow.

Laws and Political Context of Child Welfare and Foster Care

Two recent key pieces of legislation that have affected family support teams are the Adoption and Safe Families Act of 1997 (ASFA-97) and the Fostering Connections to Success and Increasing Adoptions Act of 2008. ASFA-97 mandated that each state document and implement quality improvement efforts. In the state where this study will be conducted, family support team meetings (FSTs) are the mechanism by which families are supposed to be included in service planning and represent Missouri's adaptation of family group decision-making (Munson & Freundlich, 2008).

Munson and Freundlich (2008) audited states' family engagement documentation by reviewing their Child and Family Services Reviews (CFSRs) and Program Improvement Plans (PIPs). Their analysis of 2004 national data on family engagement in CSFRs and PIPs found that most states were not reaching the standard of excellence for including families in case planning and that there were several areas of service delivery in need of reform. Of particular relevance to this dissertation, their data analysis revealed that Missouri had problems in engaging young people and families in family support team meetings, listening and incorporating family input, reaching out to encourage attendance at meetings, developing case plans in collaboration with families, and conducting meetings

according to legislated timeframes; and they reported a noticeable lack of third-party reviewers at FST meetings. The plans to improve the program were documented, however, and training and initiatives to correct poor quality care were built into the goals and suggested action steps (Munson & Freundlich, 2008).

Like ASFA-97, Fostering Connections directly affects family support team meetings. Fostering Connections is an amendment primarily to Parts B and E of Title IV of the Social Security Act. Its main purpose is to improve the provision of foster and adoptive care through several changes in legislation. It affects meetings by widening the family circle of support via kinship care, increasing reimbursement for kinship care, promoting sibling relationships, insisting on youth transition planning toward adulthood, and increasing accountability to provide coordinated healthcare. Since legislation influences how family support team meetings are conducted, relevant details of the Adoption and Safe Families Act and Fostering Connections legislation are provided below.

The Adoption and Safe Families Act of 1997

The Adoption and Safe Families Act of 1997 (ASFA-97) was passed in order to achieve several objectives to promote the adoption of young people in foster care. Trends had indicated that too many young people were the victims of

a phenomenon called ‘foster care drift,’ in which they were basically moved from home to home in the foster care system waiting for permanency that was never realized (Adler, 2001). ASFA-97 promoted quicker adoptions via the hastening of the termination of parents’ rights in certain circumstances (murder, manslaughter, and felonious assault criteria).

A ‘fast track 15-22 months’ to permanency plan was initiated, again pushing states to move foster youth more quickly out of temporary care and into permanent living arrangements. This meant that any child who had been in foster care for 15 out of 22 months was made eligible for adoption through the termination of their biological parents’ rights to maintain guardianship. This essentially terminated the parental rights. Permanency hearings were to be held every 12 months in order to expedite adoptions and such hearings were to be documented.

The law also allocated added health coverage funds for adoptions to states as incentives to move young people out of foster care and into adoptive homes, while also expanding healthcare coverage for adoptive young people. Funding to encourage adoption was added to the budget, and more money was allocated for young people with special needs. The legislation required states to document attempts to move young people toward adoption. One of the barriers to adoption, interstate boundary stipulations, was removed in order to hasten adoption. Additional provisions for safety were built into the legislation. For example,

foster parents were specifically cited in the legislation as key informants who could testify in court cases.

Fostering Connections to Success and Increasing Adoptions Act of 2008

Fostering Connections, as previously mentioned, affects FST meetings through widening the family circle of support, providing kinship care, increasing reimbursement for kinship care, promoting sibling relationships, insisting on youth transition planning toward adulthood, and increasing accountability in the provision of coordinated healthcare. Mandatory oversight mechanisms have been woven into the legislation in response to the over-medication of foster youth (ACF, 2012b; Alavi & Calleja, 2012; Rubin et al., 2012).

Continuity of care and oversight issues. Standards of care in the Child Welfare System vary from state to state, although some federal guidelines apply nationally. Raghavan and colleagues' (2007) descriptive research about states' level of awareness of quality standards documented that the majority of state mental health agencies were not aware of existing standards for young people in Child Welfare. Of almost equal concern, most agencies did not know whether they were providing care according to the quality standards. Ongoing assessments and continuous quality improvement efforts including assessments at times of youth transition between placements and collaboration between the state mental health system and the Child Welfare System were found to be lacking (Raghavan et al., 2007). Raghavan et al. (2007) pointed to the need to track both

process and outcome measures and suggested financial re-allocation of Medicaid spending.

Ensuring accountability regarding the care provided to foster youth is meant to address the needs for appropriate, timely, and effective healthcare for children who are in the custody of the state. Each state is now required to have mechanisms in place for tracking medication use patterns among foster youth because of the apparent overuse of psychotropic medications in particular (ACF, 2012b; Alavi & Calleja, 2012; Rubin et al., 2012). Creating medical homes and auditing psychotropic medication use among foster youth are two ways that the Foster Connection Act has been implemented to improve quality of care. It is up to each state to put these guidelines into practice and keep records of implementation and outcomes.

Planning for the future. As discussed in the next section, **Problems,** foster youth face formidable challenges as they transition from care in the Child Welfare System to life outside of the system. The provisions in Fostering Connections mandate that youth be included in the planning process as they approach emancipation from the system. These provisions attempt to help youth face the challenges using all available resources, as research has shown that youth had mentioned feeling ill equipped to manage life outside of state custody (Office of Children's Administration Research, 2004).

Problems with Child Welfare Quality of Care and Poor Outcomes

As alluded to in the discussion of recent legislation, numerous problems have been identified in the Child Welfare System, including lack of knowledge of standards of care, financial constraints, lack of resources to deliver quality care, credibility concerns about psychiatric diagnoses given, poor continuity of care, and reported poor outcomes of youth served (Courtney et al., 2011; Malm et al., 2001; McMillen et al, 2007; Pecora, Whittaker, Maluccio & Barth, 2010b; Raghavan et al., 2007). Courtney, Piliavin, Grogan-Kaylor and Nesmith (2001), Courtney et al. (2005, 2006, 2009; 2011), and Pecora et al. (2010a) have followed youth in two longitudinal studies, the *Midwest Evaluation of the Adult Functioning of Former Foster Youth Study* and the *Northwest Foster Care Alumni Study*. Outcome data is available from the longitudinal work of Courtney et al. and Pecora et al., who followed youth in the *Midwest Evaluation of the Adult Functioning of Former Foster Youth Study* and the *Northwest Foster Care Alumni Study*, respectively. These studies included several measures of functioning that are compared between young adults who were in foster care and young adults who had never been in care. Details of these functional outcomes follow. Youth who aged out of foster care were struggling at significantly higher rates in multiple areas of functioning (Courtney et al., 2011; Delman & Jones, 2002; Pecora et al., 2010a).

The *Midwest Study* was a multi-state longitudinal foster youth alumni study that recruited participants from Illinois, Iowa, and Wisconsin. Inclusion criteria included entering care before the age of 16, still being in care at age 17, and removal from home for reasons other than crime. The *Northwest Study* compared outcomes of foster youth alumni from Oregon and Washington who were assigned to one of three agencies and included individuals who received either public agency foster care or Casey Family foster care. The Casey Family Foundation-sponsored foster care programs were specifically interested in supporting foster youth toward self-sufficiency. The *Northwest Study* used retrospective chart reviews and interviews with foster youth alumni at one point in time to measure which particular variables were associated with better outcomes, and through this analysis, made several recommendations for future intervention and research. Though the data collected in each study differ in terms of recruitment, inclusion criteria, types of services youth received, and geographic variations, these two studies provide evidence that youth who have lived in foster care have worse outcomes in multiple areas of functioning when assessed during adulthood than do young adults who have not been in foster care. While each study was unique in key ways; the outcome data is presented in table format for consolidation of information. Data are summarized in the Table 2.1 below:

Table 2.1 Functional Outcomes of Foster Youth from the Alumni Studies

Domain of Functioning	***Midwest Evaluation of the Adult Functioning of Former Foster Youth Study**	****Northwest Foster Care Alumni Study**
Academic	83% of women and 77% of men had GED or equivalent by age 26; 11% of women and 5% of men had a 2 or 4-year college degree by age 26* (p. 104)	High school completion 84.8% compared to 87.3 % general population** (p. 122)
Arrests Incarcerations	Criminal justice involvement peaked at age 19 for females at a rate of 20% and for peeked for males at age 23 or 24 with a rate of 44 %; 5% incarcerated at time of interview* (pp. 110-111)	3% in jail at time of the study** (p. 61)
Employment	Employment peaked at age 21 years: males at a rate of 49%; females at 54%* (p. 32)	74% females working and in school; 76.8* males working and in school** (p. 135)
Homelessness	Between 31% and 46% by age 26 years+	22.2% homeless for one or more nights at sometime within a year of leaving Foster care** (p. 135)
Home/Apartment ownership	31% had own dwelling place by age 26 years* (p. 10)	9.3. %** (p. 60)
Substance Use Disorders	16% reported having 12 drinks per year; of those 13% met criteria for alcohol dependence, defined as having more to drink than intended and wanting to stop or cut down on drinking* (p. 57) 23% met criteria for substance abuse and 20% met criteria for substance dependence* (p. 59)	42.8% smoke 46.9% drink alcohol 24.1% drink greater than 150 drinks per year** (p. 115)
Mental Health Disorders	35% reported unusually strong fears of social situations in the last year; 25% reported persistent sad, empty or depressed mood for at least a two-week duration; 60% reported trauma exposure (pp. 51-56)	54.4% experienced symptoms of mental health disorder in past 12 months** (p. 110)
Marriage Cohabitating status	At age 26, 38% of females and 37 % of males were married or cohabitating* (p. 62)	30.4% compared to 43.4% general population** (p. 145)
Parent status	At age 26, 72% of females, and 53% of males had living children. 65% of females and 24 % of males lived with the children	63% at time of interview ** (pp.145, 148)

	they had given birth to or had fathered* (p. 80)	
Physical health disorders	15% self-reported a chronic health condition* (p. 46)	27.5% chronic health disorder** (p. 114)

*Courtney et al., 2011; + Dworsksy et al., 2013; ** Pecora et al., 2010a

Well-Being

Promoting well-being is a priority in Child Welfare (ACF, 2012a). According to Samuels, child well-being may be measured by the various ways in which young people demonstrate functioning, such as with skills, capacities, and characteristics (ACF, 2012a). Lou, Anthony, Stone, Vu, and Austin's (2008) framework of well-being incorporates developmental and age-related domains of health and functioning, while also taking into account contextual factors that can be measured in terms of intermediate and long-term outcomes. The well-being framework produces a positive or strengths-based perspective onto a system that was in the past more concerned with stabilizing crisis (child protection, safety, "best interest of the child"), and not as focused on long-term outcomes of youth who were receiving services (Lou et al., 2008). Domains of well-being include cognitive, physical, behavioral, emotional and social health, and functioning and take into account the chronological age and developmental status of the young person (Lou et al., 2008). Contextual factors that influence well-being, such as supports, finances, community resources, temperament and identity, genetics, and neurobiology, converge to produce functional outcomes (ACF, 2012a; Lou et al.,

2008). Although there are many types of well-being, this study focuses on mental well-being.

Mental well-being. Mental well-being literature over the last 60 years has focused on concepts such as the continuum of wellness and illness, capacity, and more recently, resiliency and recovery (American Psychiatric Association [APA], 2013; Dunn, 1959; Herman, Saxena & Moodie, 2005; Jahoda, 1958; Keyes, 2005; U.S. Department of Health and Human Services, 1999). (The terms mental health and mental well-being are used interchangeably in the sentences that follow.) In the mental health/mental illness continuum, well-being is conceptualized as occurring on an imagined range from health to illness (Dunn, 1959; U.S. Department of Health and Human Services, 1999), and represents a distribution of functioning. Mental health exists on a continuum with illness and suggests being able to recognize one's own potential (i.e., self-awareness), among a host of other factors (Dunn, 1959, p. 790). Components of mental well-being include capacities, such as the capacity to view the self as having strengths and weaknesses with a realistic appraisal, the ability to cope with normal stress, the capacity, and desire to work and/or play productively and the ability and willingness to make some contribution to community (Keyes, 2005). The thinking capacities include the ability to think rationally, logically, and coherently, and are related to having the abilities and skills to communicate appropriately with use of culturally sanctioned language/behaviors and according

to developmental milestones. Mental well-being is realized in the capacity, desire, and motivation to learn, which implies abilities to process, synthesize, remember, and transfer knowledge.

The mental well-being of foster youth is a high priority and will likely be a focal point in family support team meetings. Prevention of, and recovery from, psychological trauma are also priorities in the Child Welfare System because of evidence that ties the relationship of being exposed to a traumatic event to well-being (Ethier, Lemelin & Lacharite, 2004). Young people do suffer lasting effects from untreated responses to trauma in terms of growth and development (Cicchetti & Toth, 2005), ultimately reducing well-being in multiple domains of functioning, not just mental. For example, a sample of 17,337 adults surveyed for the Adverse Childhood Events Study found that child maltreatment significantly predicted future health problems, such as cancer, cardiovascular disease, depression, diabetes, and premature mortality (Anda et al., 2008; Brown et al., 2009; Felitti et al., 1998). The current research study acknowledges the enormous impact of trauma on the well-being of the person. While the focus of this study is on decision-making, deliberation does not occur in a vacuum. Instead, it is conceived of as being influenced by numerous factors, including trauma.

Mental well-being can be broken into social, emotional, and cognitive dimensions. Social and emotional well-being is defined broadly as having the capacities and resources to function, i.e. “those skills, capacities, and

characteristics that enable young people to understand and navigate their world in healthy, positive ways" (ACF, 2012a, p. 1). Cognitive well-being encompasses functional abilities for problem solving and decision-making; these abilities will be explored, as will the concepts of capacity and competence, in the pages that follow.

Social well-being. Wulczyn (2008) compared the concept of well-being to the concept of 'human capital.' Human capital is an economic term that is used to represent the skill set an individual possesses that makes him or her economically valuable. In the Child Welfare context, human capital refers to the specific "skills, capacities and developmental gains" that a child develops in response to environmental conditions (Wulczyn, 2008, pp. 1-3, 6, 8, 9). Wulczyn expanded on the work of Heckman (2000) and Shonkoff and Phillips (2000) to create a developmentally informed model of well-being.

The model explains the social supports, the ability to manage stressors, and the cumulative effects of resources acquired over time that converge to produce human capital (Wulczyn, 2008). The model predicts that positive experiences occurring across time culminate in producing a balance of protective factors, which leads to a continuum of well-being (Wulczyn, 2008). Wulczyn (2008, p. 4) outlined the dimensions of 'human capital' that are seen as synonymous with child well-being: "cognitive ability, literacy and numeracy, language proficiency, visual health, school readiness skills, freedom from abuse

and neglect, freedom from domestic violence, and nutrition." Wulczyn (2008) noted that child characteristics, accordingly, are either strengthened or diminished through relational variables, such as parent involvement, networking opportunities at school, sibling number and spacing, financial assets, availability of intellectual stimuli through relationship and materials, level of parent education, and presence of parent (particularly the father).

Wulczyn (2008) asserted that the goal of the Child Welfare System is to build or strengthen the child's inherent abilities while also maximizing the surrounding environmental supports by way of a responsive, age-sensitive and role-sensitive, expansive, and holistic approach to well-being. Interventions, which target predictable challenges, organizational-structural supports, and evidence-based practices, can strengthen young people's well-being (ACF, 2012a).

Emotional well-being. Mental well-being is said to involve the capacity to grow emotionally, i.e., the ability to recognize emotions, manage, channel, and organize these, and express or suppress feelings using age-appropriate and culturally sanctioned behavior.

A dimension of emotional well-being is resiliency or 'bouncing back' from adversity, or adapting, recognizing feelings, managing them, and learning from experiences especially in the face of loss or stress. Another characteristic of emotional health or well-being is the capacity, desire, motivation, and skills to

form relationships; in other words, the ability to bond and connect with other people. This involves a balance of give and take, and the ability to initiate, maintain, and recover from lost relationships.

Cognitive functioning and well-being. Two cognitive domain outcome measures of well-being are problem-solving skills and decision-making skills (ACF, 2012a; Lou et al., 2008). Problem-solving skills are those skills that enable a person to identify challenges or issues to be solved by noticing and naming the problems, creating short or long term goals or solutions, and generating options to solve these identified problems, testing out possible strategies to solve problems, and then evaluating whether the goals have been met or not. Decision-making skills are those skills needed to deliberate, choose, decide and take action on any of a variety of issues, and incorporate natural intelligence and reasoning skills.

Mental *capacity* is the presence of mental abilities to make decisions or engage in a course of action and is a necessary condition in order to give informed consent, while *competence* is the legal judgment that an individual has mental capacity (Lamont, Jeon & Chiarelli, 2013, p. 685). The individual who has sufficient mental capacity for decision-making should be able to understand choices, consider antecedents and consequences, distinguish similarities and differences among options, know how to distinguish and somehow communicate preferences, i.e., ‘what I like and what I don’t like,’ and be able to assign value and weight to the available options (Buchanan, 2004; Hickey, 2007).

Capacity and competence are necessary conditions for the development of problem-solving and decision-making skills. Both skill sets require the ability to understand information, the ability to recognize issues, problems or challenges to be solved, and the ability to weigh pros and cons. These are skills that can be taught, reinforced, and nurtured with the help of supportive adults as a young person develops. These skills can be nurtured with foster youth during family support team meetings if teams encourage young people to express preferences, weigh options, and contribute to the decision-making process within the meetings (ACF, 2012a;

Matarese, McGinnis & Mora, 2005). By including young people as active participants in these meetings, foster youth are also encouraged to plan for the future. Planning for the future is a goal of the Fostering Connections Act.

One of the questions surrounding the promotion of child well-being within the Child Welfare System is the extent to which the Child Welfare System should be involved to ensure that the needs for well-being are met. According to Samuels, former Commissioner of the Administration on Children, Youth and Families (ACF, 2012a), focusing on social and emotional well-being means translating the knowledge of what well-being is into actions that will affect services. Samuels (ACF, 2012a) and Fraser et al. (2013) note that this concern will shift the focus of Child Welfare toward an understanding of how the maltreatment experience affects individuals and families planning for and

anticipating needs of youth and families who have experienced maltreatment, and most importantly, turning evidence-based interventions into routine practice.

In line with the agenda of the Administration of Children and Families' *Memorandum on Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services* and Section 422 of the Social Security Act, monthly meetings between foster children and caseworkers must focus on case-planning to promote well-being (ACF, 2012a). However, Samuels (ACF, 2012a) has argued that it is not enough to use the word "well-being" in discussions. Outcome measures must be established and tracked. According to Samuels (ACF, 2012a), focusing on social and emotional well-being will also mean understanding service structures and using tools, screenings, and outcome measures of well-being to document the effects of treatments and services.

While the term well-being is used in different ways, self-determination theory fills this concept with substance and helps clarify criteria in dealing with or measuring well-being. Full well-being is defined as ideal functioning in multiple areas of living (ACF, 2012a), or as Ryan and Deci (2001, p. 142) express it, "optimal psychological functioning and experience." Self-determination theory suggests that the meeting of psychological needs for relatedness, autonomy, and competence ensures well-being. The next section of this chapter discusses the assumptions, concepts, and implications of self-determination theory as it relates to this study.

Self-Determination Theory

Self-determination theory (SDT) is a set of assumptions that explain and predict the necessary conditions that motivate human behavior (Deci & Ryan, 2002). SDT addresses both human motivation and developmental processes and explains what conditions are necessary in order for a person of any age to experience optimal functioning or well-being. The basic premise of self-determination theory is that all human beings have three primary psychological needs, for relatedness, autonomy, and competence (Deci & Ryan, 2002). The theory states that when an individual's needs are met, the person experiences a sense of well-being or thriving (Deci & Ryan, 2002).

SDT elaborates certain levels of Maslow's hierarchy of needs. In Maslow's theory of human needs, he described motivation that drives behavior as being prioritized, first survival needs such as food, water, and air, next safety and security needs, followed by love and belonging needs, next self-esteem, and last, the needs for self-actualization (Maslow, 1943). Several growth goals were included in the theory including the desire for discovery of vocation, the knowledge of a set of values, the realization of life as valuable, the attainment of peak experiences, a sense of accomplishment, an amazement for the beauty and wonder of life, the control of impulses, existential issues, and learning to choose based on preferences and specificity (Maslow, 1943). Deci and Ryan's SDT model resembles Maslow's earlier work on

the hierarchy of needs, in presuming that basic needs must be met in order for humans to have well-being. What is missing from SDT is the physiological and safety needs. SDT presumes that Maslow's lower needs are met.

The needs for love and belonging in Maslow's hierarchy correspond with relatedness according to Deci and Ryan's SDT model. Relatedness is viewed as a reciprocal process of caring for and being cared for by others, and has strong theoretical support from the attachment literature (Ainsworth & Bowlby, 1991; Wolff & Ijzendoorn, 1997). The needs for self-actualization in Maslow's hierarchy correspond with Deci and Ryan's needs for autonomy. Autonomy is the condition or state of being the perceived origin or source of one's own behavior. The needs for esteem and confidence in Maslow's hierarchy correspond with Deci and Ryan's needs for competence. Competence is described as a sense of confidence that one is effective within the social environment as well as the perceived sense of mastery in practicing one's capacities (Deci & Ryan, 2002). An understanding of the concepts of autonomy, competence, and autonomy-supportive environments are important for understanding foster youth and foster parents' outward behaviors, internal perceptions of mental health treatment decision-making, and self-perceptions of empowerment. While relatedness is also important, it will not be the focus of this study.

Motivation and regulation of needs are sub-concepts of self-determination theory. Motivation is the willingness or desire to direct one's energy in terms of involvement and persistence and involves activation and intention (Ryan & Deci, 2000b). Deci and Ryan's (2002) conceptualization of motivation introduces the premise that motivation exists along continuum with corresponding degrees of regulation. Self-regulation refers to self-competence in monitoring and adjusting, organizing, controlling one's behavior, or applying and operating under a set of rules (Deci et al., 1996).

SDT explains development and dynamics of extrinsic motivation and the degree to which individuals experience autonomy while engaging in extrinsically motivated behavior (Deci & Ryan, 2002). SDT assumes the conditions of holism, the self-governance of human behavior, and a range and degrees of human development. First, humans are complex systems who can only be understood as wholes. As such, people are assumed to possess an active tendency toward psychological growth and integration (Deci & Ryan, 2002). Second, humans are autonomous. That is, they are responsible and govern their own behavior. Autonomy is demonstrated in an observed exploratory nature and has been described as putting forth energy to practice and expand, learn, grow, and thrive. Inherent among humans is this natural tendency to find interesting or challenging activities. Third, development comes from within. This is supported in the observation that humans put forth effort not just to grow but to make sense of

their own experiences, what Deci & Ryan call, “an ever-more elaborated and unique sense of self.” This effort is also referred to as the tendency toward integration, which actually forms the basis of autonomy. Fourth, development is seen as occurring in degrees and on a continuum, and as occurring in only one direction (Reese & Overton, 1970; Ryan & Deci, 2000b; Woolf, 1998).

Ryan and Deci proposed that there is a continuum of motivation, with corresponding degrees of regulation. As mentioned above, motivation is a willingness or desire to exert effort in terms of engagement and persistence, and involves activation and intention (Ryan & Deci, 2000b), while self-regulation refers to self-competence in monitoring and adjusting, organizing, controlling one’s behavior, or applying and operating under a set of rules (Deci et al., 1996).

Motivation can be seen as occurring along a qualitative continuum with two poles or extremes (Deci & Ryan, 2002, p. 16). On one extreme of the continuum is no motivation, and on the other end of the pole is autonomous motivation (Deci & Ryan, 2002). In between the two extremes are degrees of motivation. In addition, types of motivation occur on continuum along with corresponding type of regulation (Deci & Ryan, 2002). For clarity, motivation is conceptualized along the continuum of a motivation such as an extrinsic motivation to intrinsic motivation provided as a visual created by Deci and Ryan (2002) and illustrated in Table 2.2.

Table 2.2: Motivation and Regulation Continuum

Behavior	Non-self-Determined					Self-Determined
Type of Motivation	Amotivation		Extrinsic Motivation			Intrinsic Motivation
Type of Regulation	Non-Regulation	External Regulation	Introjected Regulation	Identified Regulation	Integrated Regulation	Intrinsic Regulation
Locus of Causality	Impersonal	External Internal	Somewhat External	Somewhat Internal	Internal	Internal

(From Ryan and Deci, 2000b, p. 61; Deci & Ryan, 2002, p. 16)

If the continuum is visualized as occurring left to right, 'amotivation' on the far left, is defined as a lack of motivation or intention to act (Deci & Ryan, 2002, p. 17). It is assumed that amotivation is caused by a feeling of "inability to achieve because of lack of contingency," a lack of "perceived competence," and/or a lack of "valuing either the activity or the outcome" (Deci & Ryan, 2002, p. 17). Amotivation is associated with a lack of regulation, or "non-regulation."

Following the graph, four types of regulation are associated with motivation. The four regulation types are often described as four types of extrinsic motivation. Extrinsic motivation is engaging in a behavior to satisfy

an external source, i.e., to obtain rewards or avoid punishment (Deci & Ryan, 2002, p. 17). The corresponding type of regulation is a range from external to introjected to identified to integrated. Moving a bit to the right along the motivation continuum is "introjected regulation." This type of regulation is thought to be quite controlling in that behaviors are performed to avoid guilt or shame or to attain "ego enhancements" and feelings of worth (Deci & Ryan, 2002. p. 17). Next is regulation through identification, the process of transforming 'external regulation' into 'true self-regulation' (Deci & Ryan, 2002. p. 17). This involves a conscious valuing of a behavioral goal or regulation, an acceptance of certain behavior as personally important (Deci & Ryan, 2002. p. 17). Integrated regulation is seen as the most autonomously formed extrinsically motivated behavior (Deci & Ryan, 2002, p. 17). It shares many qualities with intrinsic motivation. However, behaviors are still considered extrinsically motivated, because they are performed to attain personally important outcomes rather than for their inherent interest and enjoyment. It has been suggested that behaviors are shaped from both internal and external sources. For example, extrinsically motivated behaviors become self-determined through the closely related developmental processes of internalization and integration. *Internalization* involves people's transforming external regulatory processes into internal regulatory processes (Kelman, 1961; Schafer 1968), and *integration* is the process through which these now

> internalized regulations are reciprocally assimilated with one's self (Ryan 1993). As an external regulation becomes internalized and integrated, the person becomes more fully self-regulating of that behavior (Deci et al., 1996, p. 167).

Intrinsic motivation is a sense of motivation for the sake of interest or enjoyment. Positive effects of intrinsic motivation are increased productivity and improved problem-solving capacities (Deci & Ryan, 2002). For example, in one study, students who rated high satisfaction or enjoyment immediately following a reading assignment were able to recall information to complete a test, with a strong correlation noted between enjoyment and subsequent performance (Ryan, Connell & Plant, 1990). Evidence for the claims that intrinsic motivation leads to greater productivity, creativity, and problem solving skills has come from numerous other studies (Deci, Koestner & Ryan, 1999).

Autonomy supportive environments have been found to increase intrinsic motivation (Deci & Ryan, 2002). Examples of autonomy support are providing choices of what to do, showing empathy, and non-controllingness. These supports help maintain intrinsic motivation (Deci & Ryan, 2002, p. 12). In contrast, when subjected to pressuring and coercive environments or ones in which motivation was governed by rewards, intrinsic motivation was noted to be diminished. (See Deci et al., 1999, for a meta-review of 128 studies that document the effects of rewards on intrinsic motivation).

Autonomy supportive health care climates are ones in which patients are urged to take ownership of their own health-related behavioral choices, guided by their own values (Ryan et al., 2008). These climates are characterized by acceptance, respect, and a positive, success-oriented approach to managing obstacles (Ng et al., 2012). In Ng et al.'s (2012) meta-analysis of SDT in healthcare contexts, they found that autonomy supportive health care climates, psychological need satisfaction, and autonomous self-regulation were correlated with disease prevention, management of chronic disease, and improvement in quality of life (Ng et al., 2012).

An understanding of the concepts of autonomy, competence, and autonomy-supportive environments promises to be very useful in understanding foster youth and foster parents' outward behaviors, internal perceptions of mental health treatment decision-making, and self-perceptions of empowerment. The aspects of autonomy and competence are embedded in the current study's research questions. How people engage in decision-making within family support team meetings and how they perceive this process of decision-making can be thought of as a function of both their ability to self-regulate and the extent to which their needs have been satisfied. The focus of this study is not strongly rooted in attachment or relational aspects, although these may be fruitful inquiry for the future. Instead, the focus is on autonomy and competence.

I suggest that the satisfaction of needs for autonomy and competence are necessary conditions for both youth and foster parents to have influence in the context of family support team meetings, that the ability to self-regulate and to exert willful action can be observed through behavioral patterns, and that the extent to which a person feels empowered will inform both a person's inner perceptions and outward behaviors (Grolnick, 2009; Grolnick & Ryan, 1989).

According to SDT, the three important psychological human needs that must be met in order for people to thrive are relatedness, autonomy, and competence. Empirical studies suggest that individuals with greater degrees of autonomous motivation and individuals who interact with such persons will experience greater productivity, greater creativity, and improved problem-solving capacities (Deci et al, 1996; Deci &Vansteenkiste, 2004; Moller, Ryan & Deci, 2006; Ng et al., 2012). Research has been conducted in both classroom and healthcare sectors. Outcomes of these studies suggest that people experience more 'volitional persistence,' better relationships in social groups, more effective performance, and greater health and well-being when these needs are met (Deci et al, 1996; Deci &Vansteenkiste, 2004; Moller et al., 2006; Ng et al., 2012). In short, autonomously motivated individuals who experience autonomy supportive relationships enjoy a greater sense of well-being.

Decision-Making

Decision-making in the Child Welfare system begins with the identification of needs for services. The system uses decision-making strategies in determining the level of risk for families before taking children out of their original homes. By the time children have been placed in foster care, the court has decided that other safe alternatives for placement have been exhausted. At that time, caseworkers, assigned by the court, create case plans and secure placements for children. This section examines the context of decision-making; it includes a discussion of the decision-making ecology, group process theory, empowerment, and two models of decision-making: family group decision-making and shared decision-making.

The Decision-Making Ecology

Baumann et al., (2011; 2014) designed a model of decision-making that explained how decisions are made in Child Welfare. The term used to describe this model is 'decision-making ecology.' This model is built on multiple theories of decision-making and the researchers' professional experiences in conceptualizing decision-making within the Child Welfare System. According to the model, a key to understanding decision-making in Child Welfare is the notion that "errors are inevitable" (Baumann et al., 2011, p. 4), and that decision-making occurs within an agency culture and systemic context. The job of a Child Welfare worker, according to this framework, is as 'decision-making coordinator'

(Baumann et al., 2011, p. 4). Factors that influence decision-making include case factors, such as ethnicity, risk and poverty level of individuals receiving services; organization factors, such as laws and policies; external factors, such as community resources; and decision maker factors, such as individual case worker knowledge, skills, experience, cultural awareness, and ethnicity (Baumann et al., 2011, pp. 5-10). Decision-making is thought to occur on a continuum with three features prominent within the Child Welfare System: the range of decisions to be made, the psychological processes of decision-making, and the consequences of the decision (Baumann et al., 2011, p. 6).

Within the range of decisions to be made, small and large decisions may be considered (Baumann et al., 2011, p. 7). To begin the process, judgments about relative risk, strength of evidence, and weighting or degree of concern are rendered (Baumann et al., 2011, p. 7). At some point, a decision, or determination as to whether or not to take action, is considered. There is a threshold at which a judgment requires one to take action. This can be seen as the difference between noticing, observing, and doing. The point at which the amount and weight of evidence is intense enough to compel one to take action is guided by personal experience of the decision maker. There must be a shift in the threshold in order for action to occur. In other words, the change in the amount of evidence must be deemed sufficient to compel action (Baumann et al., 2011, pp. 7-10).

In the decision-making ecology, outcomes have to do with the effect that the decision has on stakeholders, what Baumann et al. (2011, pp. 8-10) refer to as "consequences." There are three stakeholder groups to be considered: the client and family, the decision maker, and those external to the agency, i.e., the media and the public (Baumann et al. 2011, p. 8). Each stakeholder group has vested interests in the outcomes of decisions. Given that errors occur, and the consequences may be devastating, dilemmas of decision-making occur; caseworkers are in decisional conflict to the extent that they experience discomfort with the uncertainty involved in decision-making (Baumann et al., 2011; 2014). Decisional conflict is thought to be quite difficult to reconcile, because values may be at odds with possible consequences (Baumann et al., 2011, p. 10).

The decision-making ecology framework has been applied to many situations that occur within the Child Welfare System, such as child protection screening, disproportionality, substantiation decisions, placement decisions, burn-out and turn-over, and re-unification (Baumann et al., 2011, p. 5). Interestingly, the decision-making ecology framework puts the caseworker in the center of the model, and not the decision itself, or even the family or child.

Group Process Theory

The proposed research study will collect data on the observable dynamics that occur in family support team meetings (FSTs). The data will be examined with a purpose in mind: a) to

discover 'what' occurs and 'how' individuals behave, and b) to look at contextual information that also informs the decision-making process. It is expected that the characteristics of group dynamics may influence how members of each family support team meeting actually accomplish their work. Group process concepts are discussed briefly as they inform the interactive nature of how decisions are made in family support team meetings.

Since this research study is focused on decision-making processes within family support team meetings, a short detour into issues of power and empowerment follows within this sub-section on group processes. Next, an exemplar model of decision-making, Family Group Decision-making, is summarized and critiqued. Shared decision-making (SDM) follows the literature review of family group decision-making. SDM, a collaborative process, has been suggested as an approach to improve decision-making surrounding mental health treatment.

A group is defined as "two or more individuals who are connected by and within social relationships" (Forsyth, 2010, p. 3). The benefits of forming groups include social support, achievement of and distribution of work, increased

productivity, sharing and pooling of resources, and the dissemination of information in a more efficient manner. Group dynamics are "the social interactions and influences in small groups and the study of these phenomena" (Colman, 2008, no page). Crampton and Natargajan (2006) stated that social workers

should be knowledgeable and skilled in group dynamics especially because of their role in facilitating groups that involve families, noting the concepts of therapeutic factors, facilitation, and the understanding that decision-making applies to family meetings.

Some groups have components of both process and task, but may be focused on one dimension more strongly. Task and process behaviors can readily be observed in any family support team meeting. Tasks are the duties, jobs, or functions that are performed, and may involve arriving at decisions or creating some tangible products. In contrast, process refers to the relationship component, and addresses the how and why of group behavior.

Effective groups are characterized by cohesion, structure, and focus on goal attainment (Beal, Cohen, Burke & McLendon, 2003). Often democratic leadership, in which those with expertise share the leadership responsibilities, works best (Beal et al., 2003). In effective groups, the atmosphere is informal, comfortable, and relaxed (Hirokawa & Pace, 1983). Democratic group processes are those in which power is shared, problem solving ability is high, and in which

members frequently consider how things can be done better, while also supporting creativity among group members. These processes have been supported in the literature as factors that improve group effectiveness (Hanson, 1981; Hirokawa & Keyton, 1995; Hirokawa & Pace, 1983). While the purpose of family support team meetings is to achieve task completion, the ways in which the groups are conducted might have therapeutic value. For example, the sharing of decisions might be an important concept for foster youth to learn and experience. Understanding the benefits of group work allows the researcher to look at the group dynamics from an additional perspective, to see if such factors are present, and to what degree within family support team meetings they are present.

Power. Decision-making and group process intersect at the point of power. Power can be defined as the capacity for influence based on the control of resources (Turner, 2005). This definition is relevant for the interaction processes that occur in the context of family support team meetings. The types of power that were thought to exist in family support team meetings include both legitimate and coercive power. Legitimate power is the kind of power that is experienced appropriately as a matter of acknowledged authority, for example the power exerted by an elected leader of a democratic group (Raven & French, 1958). In family support team meetings, it was thought that the caseworkers held authority, because they are delegates of the state to serve as representative

guardians to foster youth. Coercive power is the kind of power that has the potential of negative consequences or punishments, and has been documented in Child Welfare worker and parent interactions (Bundy-Fazioli, Briar-Lawson & Hardiman, 2009). McLeod (2007) refers to the dynamics between adults and children in care as power imbalances. Even though relational power differentials may exist, it is possible to share power more equitably.

Scholarly findings about power and the foster care system. Table 2.3 shows the key findings of relevant articles that were found when the search terms 'power' and the 'foster care system' were entered into the following databases: CINHAL, Medline, Social Work Abstracts, and Psych-info:

Table 2.3 Literature About Power and Foster Care System

Citation	Purpose/ Scholarly Article Description	Findings
Yang, J. L., & Ortega, D. (2016). Bureaucratic neglect and oppression in child welfare: Historical precedent and implications for current practice. *Child and Adolescent Social Work Journal*, 1-9.	Descriptive article: historical origins of foster care; provides definitions of parent rights, conceptualization of parenting, abuse and neglect. Proposes reasons why neglect and oppression are perpetuated and why children are typically harmed while being in foster care.	Children in foster care and their families are often disadvantaged and of minority status, making continued victimization probable after entering into child welfare system. Specifically, poverty and race are contributing factors of continued oppression. Raising the 'critical consciousness' of individuals during social work education is proposed solution.
Nybell, L. M. (2013). Locating 'youth voice:' considering the contexts of speaking in foster care. *Children And Youth Services Review, 35*(8), 1227-1235. doi:10.1016/j.childyouth.2013.04.009	Narrative study of 5 college students who had lived in foster care. Research question was: "What particular contexts and relationships of power shape the voices of youth in foster care?"	This was a strong article about the ways that Child Welfare does not listen, distorts or uses power in inappropriate ways while children are receiving services. The article is very good at illustrating this with long passages taken from youth perspectives of antecedents to being in care, child removal, and life that is painful and challenging for youth who live by system rules and controlling tactics.
Heineman, T. V., Clausen, J. M., & Ruff, S. C. (2013). Lucy. In T. V. Heineman, J. M. Clausen, S. C. Ruff, T. V. Heineman, J. M. Clausen, S. C. Ruff (Eds.) , *Treating trauma: Relationship-based psychotherapy with children, adolescents, and young*	Case study presentation within a book chapter.	Book chapter about one foster youth's experience of severe neglect, abandonment and severe psychiatric problems; successful placement in foster home and multidisciplinary approach to therapy, ending in a good resolution in what otherwise could have been poor

Citation	Purpose/ Scholarly Article Description	Findings
adults (*pp. 63-76).* Lanham, MD, US: Jason Aronson.		outcome, i.e., a number of placement changes and hospitalizations was averted by a trauma-informed approach.
Magruder, J. J. (2011). A comparison of near-term outcomes of foster children who reunified, were adopted or were in guardianship. *Dissertation Abstracts International Section A, 71*, 3430.	Descriptive study of dispositions of a birth cohort of 5873 foster children from the year 1999 followed to the age of 9 years.	51% were adopted 36% re unified 7% lived with guardians 5% lived in foster care
Powers, J. L. (2011). Understanding the development of self-determination in youth with disabilities in foster care. *Dissertation Abstracts International Section A, 71*, 3794.	Studied variables associated with self-determination of foster youth with disabilities.	No significant relationships were found between type of abuse, family stressors, length of time in foster care, number of placement moves, race or gender and self-determination as outcome. Further analysis revealed relationships between physical abuse and longer length of time in care with autonomy. Greater stress in original families and longer time in foster care predicted higher autonomy.
Schofield, G., & Beek, M. (2009). Growing up in foster care: Providing a secure base through adolescence. *Child & Family Social Work, 14*(3), 255-266. doi:10.1111/j.1365-2206.2008.00592.x	Third phase of a longitudinal study on foster care, examining the effects of "secure base" parenting on foster youth outcomes during adolescence.	Particular parenting practices were associated with better youth outcomes. These practices included: being present and available to increase youth sense of trust; being sensitive to distressing emotional issues and youth's need for help in managing these; acceptance to promote

Citation	Purpose/ Scholarly Article Description	Findings
		self-esteem; promoting sense of competence; and promoting family belongingness.
Macdonald, F. F. (2006). The power of myth: Foster family vs. foster group care. *Annals of The American Psychotherapy Association, 9*(1), 42.	Argument is made for small neighborhood group home model of care for particular subgroup of foster children—those with reactive attachment disorder	Since trust is a core feature that is missing for youth with reactive attachment disorder, these children often resort to defensive tactics in order to maintain a perceived sense of control. Their problematic styles of interaction and behavioral issues may interfere with a successful, typical family foster home placement. The author contends these children may be better served in small congregate care settings with specially trained staff, as models in other parts of the world have shown.
Hopping, D., Power, M. B., & Eheart, B. K. (2001). Hope Meadows: In the service of an ideal. *Children And Youth Services Review, 23*(9-10), 683-690. doi:10.1016/S0190-7409(01)00155-4	Descriptive article about the philosophy guiding a neighborhood/multi-generational model of care for specialized foster care.	Has some philosophical tenets that are worthy of incorporating; views foster children as ordinary and able; reduction of objectification of foster children; instead of commodities in need of management, the model operates out a strengths based perspective; it offers paradigm-shifting alternatives to how foster care is typically delivered within a system of care, i.e. involving multi-generations of support and services within the neighborhood to normalize the experience of being in foster

Citation	Purpose/ Scholarly Article Description	Findings
		care.
Eheart, B. K., & Power, M. B. (2001). From despair to care: A journey of the old and the young at Hope Meadows. *Children And Youth Services Review, 23*(9-10), 691-718. doi:10.1016/S0190-7409(01)00156-6	Description of Hope Meadows, including the inter-generational model of care and mechanisms, stories that illustrate how mutual caring happens for foster youth and older adults.	Specific stories illustrate caring practices of youth and older adults in this non-traditional model of care. Certainly, power is shared equitably among those who live in this setting. Social capital and community support are concepts within the model.
Power, M. B., & Eheart, B. K. (2001). Reflections. *Children And Youth Services Review, 23*(9-10), 805-810. doi:10.1016/S0190-7409(01)00161-X	Description of Hope Meadows, the factors that make it different from normal foster care programs.	Echoes the work of Eheart and Power (2001). Describes the paradigm shift in viewing youth as having ordinary lives as opposed to viewing foster children as youth with problems. The author notes that what makes Hope an interesting model is the interpersonal relationships that are a hallmark of the care.

A more detailed analysis of selected publications on power and the foster care system and its application to the findings in my study are found in the discussion chapter. The benefits to sharing power are discussed under the sub-headings Empowerment, Family Group Decision-making, and shared decision-making below.

Empowerment. Empowerment is a personal experience, a relational concept, and a process in which one person experiences power, control, influence,

and/or decision-making capacity. In some cases, empowerment is self-initiated; and in some cases, another person facilitates or supports these conditions (Tengland, 2008). In the context of a helping relationship, the helper creates a conducive environment for the person being helped to experience empowerment when encouragement is offered to gain better control of a situation and to act in ways that promote problem-solving, decision-making, or taking action (Rogers, 1951). As a consequence, the person who is empowered necessarily chooses and takes some level of responsibility for problem-solving, decision-making, and/or taking action (Ackerson & Harrison, 2000; Tengland, 2008).

In Ackerson and Harrison's (2000) research, social work and mental health clinician-participants defined empowerment as both an end and a means to an end. In other words, it was both an outcome to be strived for and a process of development. It was noted in this particular study that participants had difficulty providing a concrete definition of empowerment that would separate it from other concepts, such as self-determination or enablement. However, they were able to offer characteristics of empowerment and added dilemmas and conflicts that were presented in trying to promote empowerment with particular populations. Characteristics of empowerment included the "ability and willingness to act on the goals and choices that a person determines" (Ackerson & Harrison, 2000, p. 239).

It is relevant to mention the contradictions and dilemmas or conflicts in empowerment, as reported by participants, simply because these contradictions and dilemmas give further clarity to the complexity of bringing about empowerment in practice settings (Ackerson & Harrison, 2000, pp. 240-243). Participants noted that empowerment was a relative state or process, such that the patient or client might have limitations in his or her abilities, competence, and level of judgment (Ackerson & Harrison, 2000, pp. 240-242).

Individuals with serious mental illness were identified as needing protection and clinician control, an apparent contradiction of the idea of encouraging individuals to make their own choices (Ackerson & Harrison, 2000, p. 242). Extending the limitations into locations of service, patients and clients were often held back from fully expressing empowerment due to having to follow the rules within an institutional setting (Ackerson & Harrison, 2000, p. 242). Limited options for expressing empowerment were noticed to exist for patients and for clinicians within these institutional locations.

Foster youth perspectives of empowerment. Human rights advocates and international statutes have called for the representation of young people in the decision-making process in regards to their lives and well-being (Engle et al., 2011; Fass, 2011). A growing body of literature shows that youth are able, interested, and willing to contribute in a meaningful way; and they want to participate in efforts to enhance their well-being through various types of

interventions (Benson et al., 2006; Garcia, 2012). In a review, Benson et al. (2006) detailed several hypotheses and evidence for emphasizing youth strengths and potentials instead of deficiencies and problems as a way to help shape youth development and enhance well-being. For example, Catalano, Berglund, Ryan, Lonczak and Hawkins (2004) found that certain types of programs enhance positive outcomes, like relationship skills, problem-solving skills, and sense of self-efficacy. These programs targeted relational skill development and autonomy and helped build social competencies within a developmentally-rich context (Benson et al., 2006).

The idea of engaging youth to help them develop into productive and healthy citizens has been labeled a 'positive youth development approach' or 'youth movement' (Benson et al., 2006). This youth movement is a strengths-based approach to address a continuum of youth issues ranging from normal development to legal issues, academic, social, and family issues. Matarese et al. (2005) found that several federal organizations, including Federation of Families for Children's Mental Health, the Children's Defense Fund, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS, 2010), support youth involvement and engagement in systems of care issues. Systems of care are extensive organizational social service structures that provide services to youth and families in need (Pires, 2002).

Typically, the issues with which youth and families are confronted in order to receive services from systems of care cross service sectors, such as mental health, legal, academic, and welfare (Matarese et al., 2005). Involving youth in such systems means forming collaborative relationships with youth through actions such as inviting participation in conferences, development of youth groups, often led by peer leaders, outreach via education and support, and policy development (Matarese et al., 2005, p. 20). Benson et al. (2006) reviewed numerous studies about youth development and found that when youth are actively involved agents in regards to bettering their environments, they not only experience ownership in building or developing not just their own identities, but they also have a stake in investing in building a better community and world.

Caseworkers' perspectives of empowerment. Caseworkers have numerous responsibilities in the Child Welfare System. Typical duties include conducting assessments, creating case service plans, communicating with youth, their families and the providers who are involved in the case, coordinating referrals, keeping records, providing direct care activities, conducting meetings, and providing crisis intervention as needed. Despite tremendous responsibility, accountability, and delegated authority, caseworkers are often caught in dilemmas about how best to deliver services, as Baumann and colleagues (2011) described in the decision-making ecology framework. As an example of this service reality, McMillen et al. (2007) investigated a sample of 130 Child Welfare service

professionals about their perceptions regarding quality of care for Child Welfare psychiatric evaluations, medication management, and inpatient treatments and found that professionals were most concerned about short evaluations leading to inappropriate prescriptions of psychotropic medications. They worried that too many medications were being prescribed. They lamented an overreliance on psychotropic medications in order to manage behavioral issues. They complained about inadequate psychiatric care in inpatient environments, as, for example, very short hospital stays and high dosing of medications. They were quite bothered because of a shortage of child-serving psychiatrists who serve the Medicaid population, and especially troubled about poor communication between service providers and service professionals.

The information that was gleaned from McMillen et al.'s (2007) research served as foundation knowledge that barriers exist to the provision of quality services. That understanding was one of the information pieces that supported the multi-disciplinary treatment care approach to foster care. As the *Treatment Foster Care for Older Youth* study came to closure, new possibilities for investigation were identified revolving around shared decision-making and the need for emotion regulation skills training among other implications (Bertram et al., 2013).

Foster parent perspectives of empowerment. The needs, preferences, and concerns of foster parents are of paramount importance in the process of

deliberating among options within the shared decision-making framework. Yet the literature reveals that they have often felt discounted and not included in the system of care (Rhodes, Orme & Buehler, 2001; Rhodes, Orme, Cox & Buehler, 2003; Spielfogel, Leathers, Christian & McMeel, 2011). Foster parents deserve respect and deserve to be included in agency work as mutual collaborators, especially but not only because they are willing to take on this demanding and yet self-directed work of parenting traumatized youth. Furthermore, the learning needs of foster parents have only rarely been examined in the literature.

A small number of studies covered in a systematic review by Shireman (2009) detailed the types of support foster parents needed: respect and recognition (Hudson & Levasseur, 2002), financial and emotional support from the agency and help accessing services (U.S. Department of Health and Human Services, 2002), family and church support (Buehler, Cox & Cuddeback, 2003), and good communication with workers and recognition as part of a team (MacGregor, Rodger, Cummings & Leschied, 2006). In a more recent study, Spielfogel et al. (2011) conducted focus groups with 38 foster parents to find out how they perceived parent management training. Foster parents were doubtful about the parent management training's suggested strategies for helping foster youth with problem behaviors. They, too, expressed a need for more agency training and support. They also doubted service workers' intentions in supporting

them as foster parents; and were skeptical of mental health treatment effects. Finally, they expressed a desire to be trained jointly and collaborate with other Child Welfare professionals to improve quality of care.

The receptivity of foster parents to training is important since contextual factors in the household may make problem behaviors worse for foster children. In a longitudinal study by Vanderfaeillie, Van Holen,, Vanschoonlandt, Robberechts, & Stroobants (2013) for instance, it was suggested that less competent parenting was associated with worse behavioral problems in foster care. The implication was that better trained parents would lead to better outcomes for youth.

Implementation of trauma-informed care principles have recently been emphasized as important in Child Welfare (Henry et al., 2011; Hendricks, Conradi & Wilson, 2011; Lang, Campbell, Shanley, Crusto & Connell, 2016; Hanson & Lang, 2016), and may be seen as a pathway to more effective foster parenting. Public law 112-34, the Child and Family Services Improvement and Innovation Act of 2011, mandated the documentation of trauma informed care practices within state child welfare agencies (Hanson & Lang, 2016). The degree to which these practices impact youth outcomes is an area of new and ongoing research. Dorsey et al. (2012) studied foster parents' self-reported degree of knowledge of youth trauma and determined they need information on types of trauma to which the youth residing in their home have been exposed,

especially if they are expected to provide a therapeutic role. Havlicek et al. (2012) studied the experiences of older youth in transition from residential to treatment foster care and highlighted the needs of foster parents for education, support and validation; concerns about safety, preferences for youth engagement and cooperation; and learning issues about how to manage conflicts and behavior disruptions. Dorsey et al.(2012) studied foster parents' self-reported degree of knowledge of youth trauma and determined they need information on types of trauma to which the youth residing in their home have been exposed, especially if they are expected to provide a therapeutic role.

Besides having knowledge and skills to work with individuals who have experienced trauma, there are particular types of parenting skills that are considered specialty skills that have been discussed in the literature. These include helping youth who have sexualized behaviors, those who have parents that are incarcerated, and children who have lived in extreme poverty or experienced homelessness (Baker et al., 2008; Newby, 2008; Christenson & McMurtry, 2007). Baker et al (2008) recommended that caregivers received specialized training to assist youth with problem sexualized behaviors. Likewise Newby (2008) suggested a special skillset is required for assisting foster youth whose parents are incarcerated. Not only do these foster youth deal with trauma issues, they deal with loss and stigma associated with having a parent who is incarcerated. The parenting needs for this group are specialized; education needs

include knowledge of trauma, loss, adolescent personal stigma, and overcoming personal bias of incarceration. Finally, children who have lived in extreme poverty or experienced homelessness require specialized approaches to care, and parents who have worked with this group need specialized understandings and guidance to provide optimal care (Christenson & McMurtry, 2007).

Havlicek et al. (2012) studied the experiences of older youth in transition from residential to treatment foster care and highlighted the needs of foster parents for education, support and validation; concerns about safety, preferences for youth engagement and cooperation; and learning issues about how to manage conflicts and behavior disruptions. These findings were similar to Baker , Mehta, and Chong's (2013) research that indicated parents wanted to learn how to manage conflicts more successfully and Cuddeback and Orne's (2002) study that assessed whether foster parents received enough information and training prior to and during foster parent training. Findings from Cuddeback and Orne's (2002) were not different between kinship and non-kinship foster families. Both groups reported not having enough training prior to and during foster parenting.

Societal trends have shifted to promote preservation or re-unification of broken families (Kirk & Griffith, 2004; Nesmith, 2013), which means foster parents are now being asked to help bridge relationships between youth and families of origin. Recent studies have documented this trend. For example, Baker et al. (2013) studied 52 foster parents in New York who completed a one-

day, two and one-half hour training on loyalty conflict management with pre-and post-test measures. As mentioned above, the majority of foster parents wanted to learn about managing conflicts in general and felt training was helpful. In a related study, Nesmith (2013) created a small, portable guidebook to teach foster parents how to facilitate family visitation. Nesmith ‘s (2013) qualitative study documented the perspectives of foster parents who felt a new sense of responsibility to help with relationship development between foster youth and their parents, and to role model effective parenting.

Connections between adult education theories and shared decision-making. The concepts of andragogy and self-determination theory each have a moderately strong relationship to shared decision-making. (Shared decision-making will be discussed in more detail later in this chapter.) Andragogy has been variously described and defined. For the purpose of this chapter, it is defined as, “the art and science of facilitating change in adults through self-directed, student-centered approaches to life-long learning” (Caruth, 2013, p. 606). Self-determination theory suggests that human beings experience well-being or thriving when needs for relatedness, autonomy, and competence are met (Deci & Ryan, 2002). These conceptual understandings of andragogy and self-determination theory are connected to shared decision-making because of their sub-concepts: autonomy, intrinsic motivation, and competence. In the classic

view of andragogy proposed by Knowles (Knowles, Holton & Swanson, 2012) there are six assumptions that govern adult learning. These assumptions include:

a) Adults need to know why they are learning something.

b) Adults are more self-directing than not. (This corresponds with autonomy).

c) Adults possess life experience that is a resource for present and future learning.

d) Adults are motivated to learn when it is required for a job or specific responsibility. (This corresponds with the need for competence.)

e) Adults' learning is often centered on solving problems or generating solutions.

f) Adults are more intrinsically than extrinsically motivated. (Knowles et al., 2012)

Knowles and colleagues' (2012) assumptions that adults are motivated by learning needs to fulfill job requirements correspond with self-determination theory's concept of need for competence. Research has been discussed in this chapter about foster parents' needs. Higher degrees of self-reported competence correspond with improved parenting (Chamberlain, Price, Reid & Landsverk, 2008). Better parenting results in improved foster youth behavior (Chamberlain et al., 2008). The reduction in problem behavior has been associated with less

placement disruption (Havlicek, 2011), although various other contextual factors are also relevant to consider in correlating these two issues. For example, in a randomized control trial that explored effectiveness of foster parent training as measured by their own perceptions and from the perspective of improved foster youth behavioral outcomes, Chamberlain et al. (2008) found that implementation of parent management training—a standardized curriculum which incorporated components of behavior modification and foster parent support— resulted in fewer perceived behavior problems as reflected on parent report forms for disruptive behaviors at the end of the intervention as compared to the non-intervention group.

The needs for competence among foster parents were studied in another research setting, in which investigators specifically sought to determine if foster parents felt competent because of training (Cooley & Petren, 2011). In that study, foster parents self-rated themselves as high on competence, but the qualitative data revealed that there were needs for additional education and support that could not be met through pre-service training alone (Cooley & Petren, 2011, p. 1971).

Foster parents' needs for autonomy and motivation have been addressed in the literature. In a study that investigated foster parents' motivation, results showed that foster parents chose to become or maintain status as foster parents for a variety of reasons, such as wanting children in the home, wanting to help as well

as other altruistic motives, with financial incentive in last place (Broady, Stoyles, Caputi & Crittenden, 2010). In another study by Geiger, Hayes and Lietz (2013), foster parents indicated they received intrinsic rewards for their roles as caregivers, which encouraged them to continue fostering (Geiger, et. al., 2013, p. 1361).

Table 2.4 shows five studies that met criteria of being a systematic review and addressing foster parent training. Only four of these reviews documented empirically validated training programs for foster parents (Dorsey et al., 2008; Everson-Hock et al., 2012; Festinger & Baker, 2013; Horwitz, Chamberlain, Landsverk & Mullican, 2010). The training programs often taught positive reinforcement, a behavior modification technique, as a core component, although most programs also included other educational components, such as linking foster parents with community resources and teaching about normative development (Chamberlain et al., 2008). For instance, Chamberlain et al.'s (2008) study employed adult education methods of training by using discussion format, employing use of video, role play, and phone call outreach. For families who could not come to locations of training, home visits were also offered.

Some authors (Dorsey et al., 2008; Everson-Hock et al, 2012; Festinger & Baker, 2013) have noted that there is a lack of studies that document best practices or empirically-validated strategies for training foster parents. However, Horwitz et al. (2010) noted there are at least six evidence-based practice parent

training or intervention programs that are ready to be adopted and implemented. In summary, few studies have been done which document evidence-based practices around foster parent training (Dorsey et al., 2008; Everson-Hock et al., 2012; Festinger & Baker, 2013). Additional elements of training that may potentially be valuable include educating foster parents toward advocacy (Cooley & Petren, 2011). For example, in Cooley and Petren's (2011) mixed methods study, foster parents complained that their needs for understanding of agency politics were unmet. Furthermore, foster parents felt frustrated that despite knowing details about children in their care, they were not empowered to use this knowledge to help in a meaningful way (Cooley & Petren, 2011, p. 1971)

Table 2.4: Selected Studies on Foster Parent Training and Relationship to Adult Learning Principles

Source	**Study purpose/objectives**	**Findings**	**Adult learning addressed? Yes/no/ specify if:**
Chamberlain, Price, Reid & Landsverk, 2008	To test whether parent management training improved foster youth behaviors, reduced placement changes, or increased chances of re-unification or adoption, this randomized control study also examined whether results would be sustained in when train the trainer model of implementing training was substituted for direct interventionist involvement.	Training resulted in decreased problem behaviors in intervention group, which were significantly more pronounced than the control group. Train the trainer method sustained positive results.	Yes; 1, 3, 4, 5.
Cooley and Petren, 2011	Assessment of perceived level of competency in foster parents following pre-service training	Mixed methods study. Findings: while foster parents scored high in quantitative measures of self-perceived competency, qualitative data showed they had additional needs and concerns.	Yes; 1, 3, 4, 4, 5.
Dorsey, Farmer, Barth, Greene, Reid & Landsverk, 2008	Systematic review of foster parent training programs and what they entailed	29 studies were reviewed. Showed mixed results in terms of outcomes of training.	No; this was actually stated in the article.

Source	**Study purpose/objectives**	**Findings**	**Adult learning addressed? Yes/no/ specify if:**
Everson-Hock, Jones, Guillaume, Clapton, Goyder, Chilcott & Swann, 2012	Systematic review of foster parent training programs and how these correlated with physical health, emotional health, problem behaviors and placement Stability	6 studies were reviewed and showing mixed results in terms of outcomes of training.	Not mentioned in this study.
Festinger & Baker, 2013	Systematic review of foster parent training evaluations' effectiveness	7 studies were identified for pre-service training evaluations and 29 were identified for multi-session/ongoing post-foster care placement foster parent training. Results were mixed in terms of evaluation of effectiveness	Not mentioned in this study.

Key:

a) Adults need to know why they are learning something.

b) Adults are more self-directing than not. (This corresponds with autonomy).

c) Adults possess life experience that is a resource for present and future learning.

d) Adults are motivated to learn by role-specific responsibilities. (This corresponds with the need for competence).

e) Adults' learning is often centered on solving problems or generating solutions.

f) Adults are more intrinsically than extrinsically motivated.

Measuring empowerment. In this study, perceived levels of empowerment will be measured through survey, such as the Family Empowerment Scale (FES). The FES was designed to measure the degree to which parents of young people with serious mental illness felt knowledgeable, skilled, and confident to advocate on their young people's behalf (Koren, DeChillo, & Friesen, 1992). The tool is composed of 34 items that measure four domains: systems advocacy, knowledge, competence, and self-efficacy. Adaptations and extensions of the FES are the Youth Self-Efficacy Scale/Mental Health and the Youth Participation in Planning Scale (Walker & Powers, 2007), but these tools are specifically designed for youth. More information about these tools is found in Chapter Three.

Models of Decision-Making

Family Group Decision-Making

Family Group Decision-making (FGDM) is a model of decision making. Though there are many variations, they have in common that they present an organized way of making decisions for families in which a child has

been maltreated. FGDM is traced to Family Group Conferencing, which had its origins in New Zealand (1989) in response to a disproportionate number of Maori youth being placed with non-kin foster parents. The Maori people were concerned that the youth were exposed to norms and cultural values that were different from their own and that youth would lose their sense of identity by being placed in white families.

The legislation created in New Zealand had some unique components. It set aside a special meeting time where youth and their extended family and friends could come together to identify and solve problems related to maltreatment. The law allowed for private meeting time, in which the family could meet without the aid or supervision of the court in order to solve problems using their own strategies. Another aspect of the legislation was the encouragement it gave to families to use their strengths and resources to solve their own problems (Shlonsky et al., 2009).

Shlonsky et al. (2009) created a systematic review intervention protocol in order to determine the evidence base for family group decision-making, particularly around the outcomes of child safety, permanency, well-being, and client satisfaction with the decision-making process. Multiple names were used to describe family group decision-making: family unity meeting model, team decision-making model, family team meetings, family team conferencing, and family group decision-making. Each model shared common characteristics:

family-driven planning, in which immediate family, extended family, friends, and/or community members are brought together in an effort to develop a plan for safety, permanency, and promotion of well-being of an identified maltreated child. The underlying principles of empowerment, culturally-appropriate practice, and competency and strengths of families to solve their own difficulties, which are congruent with self-determination theory (Deci & Ryan, 2002), were cited by Shlonsky et al. (2009) as key characteristics of the model.

The family group decision-making model has been widely adopted worldwide, and over 35 U.S. states use some version of family group decision-making for instances of child maltreatment. There is a wide body of literature about family group decision-making. The model shifts power away from Child Welfare agencies and places it within families. This is thought to increase the likelihood that the child will retain continuity of family ties, even if staying with the birth parents is not possible. It draws on the strengths of the community to solve problems instead of relying on government agencies to do so (Crampton, 2007).

The family group decision-making model is not without its critics. One of the primary tenets of the model is that it allows enough time for private families to work out issues. When professionals do not allow enough time for the private family to work out issues, the fidelity of the model is breached; and thus, the trustworthiness of outcomes cannot be known with certainty. Vesneski

(2009) criticized the family group decision-making model for a lack of uniformity in implementation and the decisional discretion of Child Welfare professionals to funnel either in or out families who might benefit from family group decision-making and funding variations based on outcome measures. Racial disparities, which are known to exist within the system (Knott & Donovan, 2010; Putnam-Hornstein, Needell, King & Johnson-Motoyama, 2013), are also of concern in this model's implementation, such that families of color may or may not have access to its potential benefits (Vesneski, 2009). For example, Vesneski (2009) raised concerns about front-line workers deciding which families could participate in FGDM. It was implied that families of color, in particular locations, were not informed that FGDM was an option for managing problems. In addition, reliance on social worker discretion in FGDM implementation raised important questions about its equitable use in the U.S. Child Welfare System – a system already characterized by few resources and the disproportionate involvement of children of color. The lack of uniform implementation illustrates the ambivalence and uncertainty in the U.S. towards the appropriate balance between child safety and family preservation (Vesneski, 2009, p. 3).

Shared Decision-Making

This section discusses the conceptualization of shared decision-making and how it may be used in the foster care system to improve quality of care.

Shared decision-making is a process of engagement, typically between a healthcare provider and patient, in which each party carries responsibility for choosing among alternatives in order to manage health care problems (Drake & Adams, 2006; Elwyn et al., 2005; Gafni et al.,1998). This is a topic that has been written about broadly in the general healthcare literature, and more specifically in the mental health population literature (Deegan, 2007; Deegan & Drake, 2006; Goscha, 2009; Wensing et al., 2002).

A potential mechanism for improving care within the foster care system is through the development of a normative practice standard to include shared decision-making (SDM) (Crickard et al., 2010; O'Brien et al., 2011). According to Pires (2008), this conceptualization is a shift in thinking from usual practices. In her electronic resource book on building systems of care, Pires noted that family and youth partnership is a "fundamental practice shift, which requires capacity-building to change attitudes (of Child Welfare, other systems partners, and of families themselves), build knowledge about how to partner, and teach and coach partnering skills" (Pires, 2008, p. 39).

Shared decision-making (SDM) has been written about in the medical community since the 1990's. The Institute of Medicine (2001) called for a reformation of healthcare in its landmark article, *Improving the 21st Century Healthcare System. Crossing the Quality Chasm: A New Healthcare System for the 21st Century*, citing many medical errors as the result of a flawed

healthcare system. One of the proposed principles to rectify this situation was patient-centeredness (pp. 48-51), defined as, "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (Institute of Medicine, 2001, p. 6). Thus, SDM is considered a national priority for preventing medical errors and improving patient-centeredness as well as maintaining or improving patient autonomy.

The early literature about SDM was focused on making a single clinical decision for which there was a defined problem and a clear range of solutions at a single encounter. However, SDM has been broadened to include individuals who are managing chronic health conditions, in which there is not a singular right way of managing treatment. In some cases, SDM engages multiple stakeholders in an interactive relationship in order to address the person's care.

Shared decision-making is part of a larger theoretical construct, which is patient-centered care (Balint, 1957; Mead & Bower, 2000; Rogers, 1946; Smith, Dwamena, Grover, Coffey & Frankel, 2011). Patient-centered care is an approach by a healthcare provider toward a patient in which the patient is seen as a person with the capacity to solve his own dilemmas and problems (Rogers, 1946) and has a life situation and psychosocial domains of functioning in addition to the disease process for which he is seeking treatment (Balint, 1957). Mead and Bower (2000) delineated five dimensions of patient-centeredness: a) a

biopsychosocial perspective, b) shared power and responsibility, c) patient as person, d) doctor as person, and e) the therapeutic alliance as the anchor.

Shared decision-making is both a model of treatment and a way of making decisions that includes the perspectives and capacities of more than one person, in which the treatment team, care provider, and identified youth collaborate toward mutually developed treatment goals. Within this model, there is a spirit of cooperation as the treatment team and provider(s) seek to understand what is important to the youth and then work together to arrive at a shared understanding of how to proceed with treatment. It is a relationship-focused communication model (Curtis et al., 2010; Mahone et al., 2011).

Shared decision-making is a verb and a noun (Drake et al., 2010, p. 7). As a verb, it is an action word that involves thinking, communicating, and coming to a decision (Drake et al., 2010). As a noun it is the process of engagement. Shared decision-making is a term that describes a collaborative provider-patient course of action or actions (Drake & Adams, 2006; Goscha, 2009; O'Brien et al., 2011; Towle, Godolphin, Grams & Lamarre, 2006). SDM is differentiated from other forms of decision-making in the healthcare encounter, namely paternalism, the informed decision-making model, and the professional as agent model (Charles, Gafni & Whelan, 1997).

Paternalism. Paternalism is a model of healthcare in which the provider takes on the role of ultimate decision maker due to expertise in disease

management (Stubblefield & Mutha, 2002), while the informed decision-making model is one in which the patient is given all available information and is in charge of choosing a course of action independent of the provider's direction (Gafni et al., 1998). Paternalism has benefits and shortcomings as an approach to decision-making. An assumed benefit would be in a case where a patient and family prefers to give the decision-making responsibility to another person. In fact, some patients and families prefer to relinquish their decision-making rights to an expert disease manager. For example, when a patient has a medical condition that requires detailed and nuanced treatments, the patient and family may prefer that the treatment provider handle the decisions that need to be made. However, when a patient and family forfeit responsibility, they do not take further action to prevent or manage situations affecting their well-being. An unhealthy dependency may ensue. When responsibility is avoided, growth and change are seen as happening to the patient, instead of the patient or family claiming ownership for the growth and change that occurs.

Another instance may involve a patient or family who has difficulty understanding diagnosis and treatments, and again, they may prefer that the provider simply manage the information and direct the care, as opposed to developing a thorough understanding and choosing from among options. Patients and families may prefer to let an expert lead the course of treatment if it is complicated or precarious. An assumption is made that the provider alone carries

all the information necessary to guide the treatment plan. In this case, the expertise of the patient or family in matters affecting his or her own body may be discounted, ignored, or not valued. The patient or family may not ever prepare or understand how to manage their own situation.

A third situation in which paternalism may be the accepted approach to decision-making is within the context of cultural norms, in which it is expected that the provider is the director of the treatment and the patient and/or family is expected to take on the role as passive recipient of care. While this may be congruent with personal or family values or customs, patients or families who are passive may experience a sense of futility or powerlessness, and may fail to recover or thrive during the course of an illness or recovery process as a result.

Certainly, having a provider make decisions for the patient and/or family may be helpful or beneficial if the patient is too overwhelmed to make such a decision independently. However, in this case, the patient or family do not face their burdens or pressures fully. Since ownership for managing the situation is reduced, the degree to which the patient or family feels confident or satisfied that they mastered their own challenges is diminished. At its worst, a paternalistic approach takes power, ownership, and autonomy away from the patient and family to figure out how to manage and navigate their own healthcare.

Informed decision-making model. In the informed decision-making model, the patient is an autonomous agent who makes a decision independently

with full knowledge of the diagnosis and options. In order to arrive at an informed decision, a patient must have knowledge, and capacity, and then must freely choose from among options (Charles et al., 1997). The assumption in this model is that a patient prefers to be completely autonomous with respect to decision-making. This might be used when a patient is well–educated, organized, experiences little or no anxiety and the condition is less serious on a continuum of serious medical conditions. In this situation, the informed decision-making model may work well. However, this type of decision-making process is criticized for relegating the provider role to information-giver, and because the patient's preferred degree of involvement is not taken into account. Furthermore, in complex or complicated situations, in which both the condition and treatments are uncertain, the anxiety associated with decision-making may lead to distress and disorganization as a patient or family faces the challenges of decision-making (Charles et al., 1997).

"Professional as agent" model. The "professional as agent model" (Charles et al., 1997, p. 684) is one in which the professional assumes, or knows because of having communicated directly with the patient, what the patient would want and makes a decision for him or her based on those assumptions. This approach may be used when a patient is not able to give voice to his own preferences, if, for example, s/he is unconscious. In such a case, the assumption is that the provider would make a decision based on what is known about the

patient's wishes, and the provider's own preferences are not a part of the decision-making process. This approach is not consistent with informed consent and would not be accepted medical practice (Charles et al., 1997), unless an advanced directive, a legal document that details the patient's preferences, has already been established.

One issue that foster parents and case managers mentioned in the *Treatment Foster Care for Older Youth* study is that they sometimes didn't know quite how to communicate effectively with providers so that their needs and concerns were taken seriously**.** This difficulty with self-advocacy and advocating for the benefit of foster youth is complicated by a Child Welfare context in which there are directives, court orders, loss of parental rights, and the idea that someone else knows what is in the child's best interest (Bruskas, 2008; Sawyer & Lohrbach, 2005). It seemed there might have been times when a paternalistic approach was taken with foster youth. The intentions and motivations of a paternalistic approach are captured in the phrase, 'the best interest of the child' (Child Welfare Information Gateway, 2013). The paternalistic approach has its benefits and shortcomings as discussed above. The next section discusses how shared decision-making is different from this paternalistic approach.

Overall goals of shared decision-making in foster care. As a young person ages, the ability to reason and make informed choices begins to develop

(Alderson, Sutcliffe & Curtis, 2006; Costello, 2002; Hickey, 2007). By the time of adolescence, the young person should be able to participate in a partnering relationship with his or her treatment team and by the time the youth is old enough to exit the foster care system, he should be an active, full participant in team treatment decision-making. Likewise, foster parents ideally will be involved in decision-making processes. More evidence to support these arguments can be found in the pages that follow. The shared decision-making model is hypothesized to improve confidence and satisfaction of foster youth, caseworkers, foster parents, and psychiatrists. The use of SDM in foster care may: a) improve stakeholder confidence in the ability to handle youth mental health problems, b) improve youth engagement with treatment, c) improve satisfaction in treatment from the point-of-view of foster youth, caseworkers, and foster parents, d) increase psychiatrist satisfaction with the information provided or with treatment approaches, and e) potentially improve psychiatrist confidence in treatment.

Shared decision-making approach: who, what, when and how. A shared decision-making model is recommended for the healthcare relationships in which adolescent individuals in the foster care system participate, starting at or about the age of 12. Ideally, shared decision making is an undercurrent through-out one's time in the foster care system beginning at that point-in-time when the young person is able to understand options and consequences along a

continuum. Within this model, there is a spirit of cooperation as the treatment team and provider(s) seek to understand what is important to the youth. All involved work with the youth to minimize symptoms in order to improve and sustain a youth-described improvement in quality of life (Deegan, 2007; Deegan & Drake, 2006).

A shared decision-making model focuses on a youth's goals, hopes, dreams, and values as the person lives with the effects of a chronic health condition. Aligning with principles of the mental health consumer movement, self-determination, and the recovery model, the essence of the shared decision-making model focuses on the youth's needs, preferences, and personal experience of illness and recovery. The goal of care in shared decision-making is not simply

medication or adherence to treatment, but rather wellness and quality of life. Each person in the treatment relationship is encouraged to participate actively in decisions and work toward solutions to problems.

A shared decision-making model serves as a useful framework for adolescent foster youth, caseworkers, and foster parents as they work together with providers and the treatment team to facilitate recovery for adolescent youth in foster care. In foster care, this model applies to caseworkers, foster parents, and other involved persons who support the youth in getting the care that fits his needs. O'Brien et al. (2011) discussed important issues about shared decision-

making in adolescent mental health treatment, such as preferred level of involvement of youths and families, sociocultural sensitivity in training youth and families, how to encourage youth to speak up regarding preferences, confidentiality and legal concerns, and times when shared decision-making may not be appropriate. For example, in medical emergencies of any sort, they might need some outside agent to make decisions for them. Therefore, there are limits, regarding when and in what circumstances, shared decision-making should be used. Each of these adolescent issues should be addressed within the team.

Shared decision-making for special populations. As mentioned in Chapter One, there has been a growth in research specifically studying outcomes of SDM in the mental health community. In a systematic search of literature for empirical SDM intervention studies that reported outcomes for mental health care recipients, Narendorf and Bertram screened over 500 abstracts to find out the state of the evidence of SDM interventions carried out with the mental health population (Unpublished manuscript, n.d.). None of the studies specifically looked at the Child Welfare population, and only two included children and parents. The types of conditions for which patients were receiving services were mostly Schizophrenia and Major Depressive Disorder (Campbell et al., 2014; Cooper et al., 2013; Hamann et al., 2011) although interventions that were implemented with individuals who had diagnoses of dementia, substance use disorders and PTSD were found (Dixon et al., 2014; Hilgeman et al., 2014; and

Joosten et al., 2009, 2011). The majority of the studies used randomization or controlled designs, and were of sound design and methodology. A few studies included family members as part of the intervention (Dixon et al., 2014; Hilgeman, et al., 2014; Westerman, et al., 2013).

In drawing inferences for how this body of literature could be used for the Child Welfare population, it was discovered that many educational and supportive strategies existed that could be implemented in this population. To date, the research exploring SDM interventions in Child Welfare is lacking, but there is potential for its application.

While the above studies focused on adult patients with typically serious mental disorders, shared decision-making has also been applied to adolescent mental health care. Crickard et al., (2010) and O'Brien et al. (2011), reported on the development of a shared decision-making framework to be applied to youth in community mental health settings, particularly surrounding medication management. Crickard et al. (2010) described how to initiate the mindset and environment to be able to use this framework, in a series of steps, named 'setting the stage' for shared decision-making, facilitating shared decision-making, and supporting shared decision-making.

These steps take into account the fact that it is not customary or usual practice for youth or families who receive mental health services to engage in a shared decision-making process, and emphasizes the needs for preparation

among stakeholders before initiating program changes. Facilitation of the process draws from the wide body of literature available on shared decision-making applied to other healthcare settings. Facilitation occurs through finding out what decisions are of concern, incorporating dialogue, and focusing on health promotion and documentation of progress and outcomes (Crickard et al., 2010). Supporting shared decision-making is comprised of information access and sharing, support surrounding process issues, and organization assessment, trainings, and procedural changes (Crickard et al., 2010).

O'Brien et al. (2011) discussed developmental considerations, preferences for level of involvement of patients and families, a continuum of options for levels of involvement, practical considerations, such as training, role development, consent and confidentiality concerns, and system delivery factors. Similar to other definitions and models of shared decision-making, O'Brien et al.'s (2011) conceptualization of shared decision-making with youth distinguished empowerment as a central component. In this view, empowerment through partnership with youth meant combining advocacy with clinical intervention. Both parties, the client and the practitioner, would ideally be involved in deliberating among options. Agreement could be reached through a relationship-centered approach via communication and trust, where each party was perceived as having special expertise and could share decision-making and collaboration. Empowerment through appropriate involvement meant balancing

the rights of patients and families with their preferences, while recognizing that most people preferred shared decision-making to autonomous decision-making (O'Brien et al., 2011).

Duncan et al. (2010) and Wyatt et al. (2013) have pointed to the growing interest in applying shared decision-making principles to pediatric and/or mental health populations. Shared decision-making holds potential for improving engagement and satisfaction with services. The outcomes of improved engagement and satisfaction may translate into a host of indicators related to an improved quality of life for foster youth that include a reduction in symptoms, medication needs, and hospitalizations, that increases achievements in terms of employment and school completion, improved relationship functioning, and possibly more meaningful contributions to society through work or volunteerism.

Collectively, these functional outcomes would indicate an improvement in well-being (ACF, 2012a). For foster parents, improved engagement and satisfaction may influence their sense of competence and intent to continue fostering. For caseworkers, engagement and satisfaction may lead to worker retention and improved productivity. Even though there is potential benefit in using shared decision-making as a standard of quality care, my email query of regional directors of the Child Welfare System at the national level produced inconclusive results (only two regional directors answered my request for

information), as to whether shared decision-making is a normative practice standard, which points to a need for additional research.

Duncan et al. (2010) conducted a systematic review to investigate effects of consumer or provider directed shared decision-making interventions in the context of mental health treatment on patient satisfaction, clinical outcomes, and health services outcomes. In looking for randomized control trials, quasi-randomized control trials, controlled before and after trials, and interrupted time series studies, only two studies met the inclusion criteria. One study indicated that SDM increased patient satisfaction, and the other study documented increased doctor initiated SDM practices following an intervention. Duncan et al (2010) pointed to the need for more research to discover if there were clinical or service effects that could be achieved through shared decision-making interventions for mental health treatment.

A systematic checklist for reviews by Wyatt et al. (2013) set an agenda to gather relevant literature about shared decision-making in pediatrics because of its unique nature, i.e., the triangulation of minors, their parents or guardians, and healthcare workers in making treatment determinations, the nature of young people's capacity and development; and because no such systematic review had attempted to capture the circumstances that are particular to this population. This article pointed to an interest and potential application of SDM to be generalized to minors.

Fiks and Noonan (2013) endorsed the use of shared decision-making in pediatric settings because of positive outcome research that has been conducted on young people with chronic health conditions. In light of family concerns regarding negative treatment effects, branding and labeling patients without getting to know them as individuals, and worry about the practical concerns of long-term treatments, shared decision-making was considered a win-win opportunity for families and clinicians. While calling for more research, the authors noted that SDM was consistent with the Affordable Care Act's call for family-centered care and more information sharing.

The benchmark. A shared decision-making framework is designed to facilitate effective communication among adolescent foster youth, foster families, and treatment team members within the foster care system. By learning to communicate more efficiently and assertively, caregivers may feel that they are better equipped to advocate on their foster youth’s behalf. Embracing a shared decision-making model empowers youth and families to take a more active role in all phases of the treatment process. It is reasonable to expect that youth and families report a greater sense of empowerment and hope for their lives when these concepts and practices are integrated into routine interactions. It also promotes more effective dialogue among youth, foster parents, caseworkers, and psychiatrists, leading to greater confidence of all parties in the treatment decision-making process.

The shared decision-making literature will serve as a benchmark for how young people, foster parents, and caseworkers participate in decision-making within the context of family support team meetings. In looking at engagement, perceptions, and self-reports of empowerment, new understandings may be discovered that will be a bridge to future intervention development.

Summary

Various contextual factors may influence mental health treatment decision-making in family support team meetings. For example, the passage of the Adoption and Safe Families Act (ASFA) of 1997 and Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections) shifted priorities in Child Welfare. One shift was toward a focus on well-being for youth. The concept of well-being was expanded upon in this chapter. Self-determination theory was conceived of as a useful model for explaining the satisfaction of psychological needs for relatedness, autonomy, and competence that would result in well-being. SDT also explained the necessary conditions that would cultivate well-being.

Other changes that arose from ACSA-97 and Fostering Connections were increased attention toward future planning and a statement of commitment to increase accountability and to more fully include youth and families in decision-making. In summary, ACFA-97 and Fostering Connections-08 were meant to improve the lives of foster youth by increasing their chances of

securing safety, permanency, and well-being. ACFA-97 was seen as a radical departure in the way the Child Welfare System provided services because of its focus on permanency instead of re-unification of families (Adler, 2001; Sempek & Woody, 2010). The reason for this legislation was the growing concern that it was emotionally damaging to young people to have them placed indefinitely in foster care.

Fostering Connections (2008) was important for at least three reasons: a) it mandated increased inclusion of family and youth as more involved participants in Child Welfare case planning, b) it specifically addressed youth needs to plan for their futures, and c) it created mechanisms for continuity of care and oversight of healthcare treatments including psychotropic medication management (Administration for Children and Families [ACF], 2012a; 2012b).

The 'decision-making ecology' was analyzed (Baumann et. al, 2011). The model explained that decision-making is driven by a combination of external influences, psychological variables, and potential consequences of a decision; however, Baumann et al. noted this process is an imperfect science. The decision-making ecology took into account the contextual factors of external influences and psychological variables (Baumann et. al., 2011, pp. 5-6), but did not specifically mention other factors such as group process theory or issues of empowerment that might also be important to consider in any examination of how decisions are made within a system of care. This is a gap in understanding

that my research seeks to fill. By triangulating data collection, i.e. observing, interviewing, and using scaled empowerment instruments, it is hoped that a thorough understanding of decision-making processes can be achieved.

The family support team meetings are opportunities for engagement in dialogues about needs, preferences, concerns, and ideas of youth with mental health needs and their foster families about the decisions that are being deliberated. In reviewing self-determination theory, I suggested that the ways in which each individual engages in decision-making within family support team meetings and how one perceives this process of decision-making might be conceived of as products of self-regulation and motivation. The behavioral patterns, or how an individual talks and acts in those meetings, might be seen through a self-determination theory lens. In that case, the extent to which a person feels empowered (a component of autonomy) will inform both a person's inner perceptions and outward behaviors (Grolnick, 2009; Grolnick & Ryan, 1989).

In applying group concepts related to group dynamics and shared decision-making (Elwyn et al., 2003) to family support team meetings, one can understand how people in the meetings accomplish their work and relate to one another. By analyzing group dynamics, issues of how power is distributed, who has it, how it is managed and negotiated, and what types of information are shared or deliberated upon, patterns or processes may be discovered. In essence,

the nature of family support team meetings is that they involve both tasks and processes (Crampton & Natargajan, 2006), where tasks are the work of a group, and processes refer to the relationship component of group meetings.

Empowering youth and families is important in building competency and strengths of youth and families to solve their own difficulties. This notion of empowering families is consistent with self-determination theory (Deci & Ryan, 2002), and was cited by Shlonsky et al. (2009) as a key characteristic of the family group decision-making model. Empowerment is a personal and social phenomenon that consists of an exchange of power, control, influence, and capacity for making deliberations (Tengland, 2008).

A few studies have documented foster parents' needs and concerns for more information, better communication, support, and involvement (Dorsey et al., 2012; Havlicek et al., 2012; Shireman, 2009). O'Brien et al.'s (2011) conceptualization of shared decision-making with youth identified empowerment as a central component. McMillen et al.'s (2007) qualitative study noted that even caseworkers who possess considerable responsibility, accountability, and delegated authority are often caught in dilemmas about how best to deliver services and may feel powerless to influence mental health service delivery. The literature about educating foster parents using evidence-based strategies was found to be scarce.

A limited number of studies have explored these issues of empowerment in isolation. For example, Ferreira's (2011) secondary data analysis looked at how empowerment was operationalized at the system level and across systems in well-functioning systems of care that specifically targeted youth with serious emotional disorders and did review salient concepts of self-determination and decision-making, but the focus of her study was at the macro level. Garcia (2012) developed a youth-focused curriculum to teach foster youth how to advocate for themselves. Neither of these studies explored the combination of individual and group factors that contribute to mental health treatment decision-making or combined it with an examination of empowerment in a mixed methods design that seeks perspectives of youth, foster parents, and caseworkers.

Just a few studies have begun to explore shared decision-making as a model for youth with mental health needs. Shared decision-making is both a model of treatment and a way of making decisions that honors the perspectives and capacities of more than one person, in which the treatment team, care provider, and identified youth collaborate toward mutually developed treatment goals. Shared decision-making may improve outcomes in several target areas. The outcomes of improved engagement and satisfaction may translate into a host of indicators related to improved quality of life for foster youth including reduction in symptoms, reduction in medication needs and hospitalizations, increases in achievements in terms of employment and school completion,

improved relationship functioning, and possibly more meaningful contributions to society through work or volunteerism. For foster parents it may mean increases in satisfaction and intention to continue fostering and for caseworkers it may result in improved job satisfaction and increased motivation to remain employed as service providers.

The primary aims of this dissertation research are to document the processes of decision-making, to ascertain the perspectives of stakeholders concerning decision-making within the foster care system, and to evaluate self-reported degrees of empowerment. Shared decision-making is an ideal model for communicating in a patient and family-centered approach to Child Welfare. It is not known to what extent shared decision-making components will be observed in family support team meetings or if stakeholders will offer varying perspectives in individual interviews that illuminate unique views about how they perceive the mental health treatment decision-making process. The literature that has been reviewed supports the need to understand more about mental health decision-making in foster care family support team meetings. In addition, the literature reviewed noted that most foster parent training programs have focused on behavior management strategies, assuming that this leads to positive behavior changes for youth. It will be important to explore how self-determination theory might challenge these assumptions.

The self-determination theory and components of shared decision-making served as sensitizing concepts through which to view the data that was collected. As such, they were used to analyze the results of observations, interviews, and survey data to discover what processes surround decision-making within one the foster care system. The research questions were:

a) How do foster youth with mental health needs and their family support teams currently engage in mental health treatment decision-making within the context of family support team meetings?

b) How do foster youth with mental health needs and their family support teams perceive the process of mental health treatment decision-making in family support team meetings?

c) What are the stakeholders' perceptions of their own empowerment?

Through this review, it was found that relatively few studies had researched shared decision-making in pediatrics or youth mental health, nor were there many articles documenting evidence-based strategies to guide foster parent training. Shared decision-making has been widely studied in other healthcare contexts, but as mentioned, is just beginning to be explored in youth mental health care. Mixed methods approach to explore mental health treatment are called for. In summary, the literature review helped clarify areas of overlap among concepts. The next chapter describes the mixed methods approach that will be used to explore issues of engagement, perception, and

empowerment among stakeholders who deliberate about mental health treatment options in the foster care system.

CHAPTER THREE: METHODOLOGY

The process of mental health decision-making in the foster care system merits investigation as detailed in Chapters One and Two. Stakeholder groups involved in this decision-making process include foster youth, foster parents, and caseworkers, as well as various others. These stakeholders come together for monthly family support team meetings in order to discuss case plans, formulate and modify goals, and make decisions about issues related to safety, permanency, and well-being for the benefit of foster youth.

This study aimed to examine the process of decision-making that happens for youth with mental health needs, specifically in the context of family support team meetings, stakeholders' perceptions of the process, and stakeholders' self-ratings of their own empowerment. In this chapter, the research design, including issues of sampling, data collection instruments, procedures, and analysis will be discussed. The chapter will conclude with a discussion of quality standards and the limitations of the study. This methodology has been created to address the research questions elaborated in Chapter 2.

Design

In order to answer the research questions, a mixed methods design was used. Mixed methods research has been defined as, "the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the

integration of the data at one or more stages in the process of research" (Creswell, Plano Clark, Gutmann & Hanson, 2003, p. 212). Another definition comes from Johnson, Onwuegbuzie, and Turner's (2007) description of mixed methods, in which the authors thematically analyzed multiple experts' definitions to formulate this definition:

> Mixed methods research is an approach to knowledge (theory and practice) that attempts to consider multiple viewpoints, perspectives, positions and standpoints (always including the standpoints of qualitative and quantitative research) for the broad purposes of breadth and depth of understanding and corroboration. (Johnson et al., 2007, p. 123)

Timing, Weighting, Mixing and Integration

Mixed methods designs are classified as either concurrent or sequential (Creswell & Plano Clark, 2007). Concurrent designs are ones in which data is collected within the same period, and results of one type of data collection do not influence the tailoring of the other (Creswell et al., 2003). Sequential designs are ones in which the collection of one type of data informs to next type of data collection. This study used a concurrent; 'embedded' or 'nested' design (Creswell et al., 2003). In this design, a quantitative strand is embedded within a predominantly qualitative study (quant + QUAL) to "confirm, cross-validate, or corroborate findings within a single study" (Creswell et al., 2003, p. 229). The

analysis of observed group behaviors, individual interviews, and scaled empowerment scores was studied to determine to what extent the data inform one another. Integration is defined as, "the combination of quantitative and qualitative research within a given stage of inquiry," (Creswell, et al., 2003, p. 220). Integration occurred after the analysis of each data collection point was achieved.

Type of qualitative research. This study employed both qualitative and quantitative methods; however, the qualitative methods were predominant. (The large capital letters, 'QUAL,' signify that qualitative methods are the predominant type of method being used in this study). Qualitative research methods hold particular characteristics, including the search for meaning and understanding, the researcher as the primary instrument of data collection and analysis, an inductive investigative strategy, and a richly descriptive end product. (Merriam, 2002, p. 6)

A basic qualitative approach was employed for the qualitative component of the study. In the case of classification, 'basic' does not mean small or mediocre, but rather is used to describe a type of research that shares some universal attributes of all types of qualitative approaches, as mentioned in the Merriam quote above, but does not hold the specificity of other approaches. For instance, the goal of phenomenology is to arrive at the essence of an experience; the goal of ethnography is to understand the culture of a group of people;

narrative methods attempt to recount life stories of research participants; and case studies investigate bounded systems.

While there are various ways to conduct qualitative inquiry, this study utilized Grounded Theory (GT) strategies of data analysis. Grounded theory research is a type of qualitative research in which the goal is to generate knowledge and build a theory by inductively analyzing social phenomena (Morse, 2001). Historically, this method was developed by Glaser and Strauss (1967). Later, the original authors developed partly different versions of the approach. The GT methodology that is chosen for this study is based on Strauss and Corbin, who developed and refined GT based on their experiences with studying the method, teaching, and conducting GT research studies (1990, 1998).

GT draws from two related philosophies, Pragmatism and Symbolic Interactionism. Both share the same understanding of process and change and of determinism (Corbin & Strauss, 1990, p. 5). In grounded theory, phenomena are seen as dynamic, or changing, in response to evolving conditions. Grounded Theory does not subscribe to a deterministic view of individual and social development; however, the approach recognizes factors that frame conditions of life and, thus, also rejects non-determinism. The approach views persons as having choices in the ways they respond to their experiences (Strauss & Corbin, 1998). In grounded theory, the nature of 'truth' or 'reality' is seen as context-bound and dynamic (Corbin &Strauss, 1990). The goals of Grounded Theory that

are derived from these assumptions are "to uncover relevant conditions, but also to determine how the actors respond to changing conditions and to the consequences of their actions" (Corbin & Strauss, 1990, p. 5).

The purpose of grounded theory is to describe, understand, and interpret social phenomena in a systematic way (Corbin &Strauss, 1990). This is not unique to GT. The ways that description, understanding, and interpretation are achieved that set it apart from other types of qualitative approaches will be discussed under the section on data analysis later in this chapter.

Despite reliance on strategies of GT for data analysis, this study does not possess all of the features of a complete GT study. For example, this study could not use theoretical sampling and data analysis was used strictly to construct well-developed concepts. While there are other qualitative methods of data analysis that may be suitable for analyzing the data in this study, GT methods of analysis were chosen because (1) the research questions asked how people engage in behaviors and how they perceive social processes; these questions lent themselves to the coding and constant comparative approaches to data analysis that are characteristic of GT, (2) the organization of the method from planning to execution to analysis and writing results is systematic and will produce a trustworthy report of findings and (3) the researcher had access to the materials and human resources that were needed to conduct the analysis using this approach.

Rationale for using a mixed methods design. Mixed methods research provides strengths that balance the weaknesses of using either quantitative or qualitative methods alone. As such, there is compensation for the lack of depth in purely quantitative designs and a compensation for the lack of breadth of purely qualitative designs (Creswell et al., 2003; Johnson et al., 2007). Quantitative methods use probabilistic sampling and numerical data analysis to test hypothesis in a deductive way, explain relationships among variables, predict future relationships or processes, and generalize findings to other contexts. Quantitative methods have been criticized for not capturing the voices of participants or their stories; nor do they provide contextual information, such as the circumstances in which a problem takes place, that might be relevant to the research.

Qualitative inquiry methods use data collection strategies to answer questions that expand understanding of how or why processes or patterns occur as they do, and do not necessarily seek to test hypotheses or generalize findings. Qualitative methods have been criticized for lack of generalizability and subjectivity (Marshall, 1996; Sandelowski, 1986). By combining both approaches in one design, weaknesses from either purely quantitative or purely qualitative approaches can be minimized (Creswell & Plano Clark, 2007).

This study used primarily qualitative data (structured observations accompanied by field notes and audio recordings of individual semi-structured interviews) but there was instrumentation that was quantitative in nature

embedded in the design. The Modified Family Empowerment Scale (FES; Koren et al., 1992) was used for the adults in the study and the Youth Efficacy Empowerment Scale/Mental Health and the Youth Participation in Planning Scale (Walkers & Powers, 2007) was used for foster youth. The scales for youth assess similar types of information as the FES, but change the wording to address youth.

These three quantitative research instruments were chosen to strengthen the depth and breadth of understanding of the second and third results of the research questions regarding stakeholders' perceptions about decision-making, i.e. how they perceived the process of decision-making and what their self-perceived levels of empowerment were.

The general value of triangulating methods and/or data sources.

'Triangulation' is a term that comes from navigation literature in which engineers would map locations from multiple reference points to increase the accuracy of prediction when mapping (Schwandt, 2007). In research, the term means to collect data from multiple perspectives; to combine methods in order to gather data using different approaches, for example, using mixed methods in the same study; or to analyze using multiple approaches or theoretical lenses (Schwandt, 2007).

Using observations and interview techniques is based on an assumption or logic that in order to understand or arrive at the most realistic appraisal of human behavior, a researcher might take many measurements or employ various

strategies to study that phenomenon (Holt & Thorpe, 2008). Because people perceive things in different ways based on roles, life experiences, frames of reference, needs, and interests, biases will never be completely eliminated. Of course, it is desirable to diminish the effects of bias on the side of the researcher; and there are many ways to do it, (especially, "the grounded theorist need not to work alone"; Corbin & Strauss, 1990, p. 11,) and all have to do with a reflective stance.

In this study, triangulation occurred during data collection by using a modification of the OPTION Scale questions (Elwyn et al., 2003), and field notes at family support team meetings to look at decision-making processes deductively. Interview data was collected from multiple informants using essentially the same semi-structured interview protocol. The empowerment scale data was triangulated with the observations of meetings and individual interviews to examine stakeholder perceptions about the degree to which they felt knowledgeable, skilled, and competent and empowered to take ownership for navigating the mental health system.

During analysis, the interview data was compared with the family support team meeting and court hearing data and the empowerment scale data in order to understand the processes of decision-making from multiple perspectives. The purpose of triangulation was to increase trustworthiness of the report that was generated after data analysis by exploring a topic from different vantage points

(Miles, Huberman & Saldana, 2014). These various triangulation strategies strengthened the study by increasing the likelihood that a broad understanding of decision-making processes was captured. The sample is considered in the next section, followed by a description of data collection instruments, procedures and analysis techniques.

Sampling and Sample

This section describes the decisions and rationale in creating a strategy for sampling. The section begins with a discussion of the type of sampling chosen and general characteristics of the sample of research participants. Principles of homogeneity in sampling, sampling for saturation, and inclusion criteria are addressed following this discussion.

Type and number of participants. This study used a purposeful sampling strategy. According to Patton (1990), "The logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling" (p.169). Family support teams were found with the assistance of caseworkers who were recruited as voluntary participants. A total of 8 youth and their teams was sought; and originally the plan was that all cases would come from one specialized foster care agency. 21 youth were identified as meeting inclusion criteria, but only four case workers volunteered to be in the

study, and 3 of them were lost to follow-up. The remaining case worker determined that the youth in her caseload would not be good fits for the study. After weekly contact with the agency manager proved unsuccessful in identifying potential participants, recruitment efforts were expanded to partnering agencies and eventually to surrounding counties.

Homogeneity. A homogenous sample is seen as beneficial for examining an issue in depth (Patton, 1990, p. 173). The sampling method employed in this study meets the criteria for a homogenous sample by age of youth participants, but not by personality or intelligence. (Below, inclusion criteria, including the age range of participants, are discussed.) A second, debatable criterion for homogeneity is the likeness or sameness of participants by symptom severity, as all youth in the agency are considered in-need. There are different types of trauma responses, co-morbidity with other conditions and diagnoses, and personality variables that would make these young people unique, and not necessarily similar to one another. These are variables for which homogeneity is not necessarily guaranteed. In summary, homogeneity of the sample is met for age range, but not personality type, intelligence level or symptom variation and presentation.

Sampling for saturation. Ideally, the number of research participants is dependent upon the principle of saturation. In other words, a researcher will sample as many cases as needed until nothing new is showing up in the data

(Patton, 1990). Since it is difficult to predict when saturation will occur, but a number must be chosen for this study, Guest, Bunce and Johnson's (2006) evidence and Patton's (1990) advice is to estimate the minimum number of participants that are likely to be sufficient to satisfy the study's purpose.

Inclusion criteria. A sample of eight youth, along with their family support teams, was thought to be the ideal number for recruitment, but when the numbers of participants proved to be difficult to obtain, with some youth consenting and then changing their minds, any youth who were agreeable along with their teams, were accepted in the final sample. The youth and their teams were observed in meetings and court hearings, interviewed, and asked to fill out empowerment scales. Participants were specifically sought who would be able to understand questions asked and who were willing to provide details about how they perceived family support team decision-making in the context of family support team meetings. Each case was comprised of a foster youth with mental health needs, the assigned caseworker, the foster parent or parents assigned to the youth, and the additional members of the family support team. Ideally, no caseworker would be assigned to more than two foster youth. In other words, at least four caseworkers would provide variation in the sample of caseworkers. In the original plan, the youth would have been participants with mental and behavioral problems, who had received treatments, had failed less intensive service arrangements in traditional foster care agencies, and were classified as

youth with severe need. But this plan was changed to include youth in both this specialized agency and any youth in the general population of Child Welfare who met the age and other inclusion criteria requirements.

The age range of 15 to 18 years for foster youth participants was chosen because at this age it is more likely that youth will be responsible for their own decision-making within the next few years of life. Youth outside these age parameters were excluded for two reasons. (1) Younger participants (less than 15 years) might view decision-making responsibility as something that occurs so far into the future that they have scarcely considered it. (2) Youth over the age of 18 years may be struggling with concerns of emancipation that are not typically seen in the 15-18-year age bracket. All youth were considered highly vulnerable, in terms of their status as wards of the state. Wards of the state require extra protections when involved in research because they do not have traditional parent advocates and could be easily exploited (Varma & Wendler, 2008). Since vulnerability would be present regardless of the age of participants, this was not a factor in selecting age range.

Overview of Membership of Family Support Teams

Family support teams assembled to support the young person in state custody. The membership was comprised of any siblings over the age of 13 years, siblings under 13 years if approved by the supervisor, the Children's Division case manager, and parents if involved in the case; foster parents or other resource

providers, the deputy juvenile officer, the Guardian ad Litem and the Chafee worker or older youth transitions specialist were expected to be present. Supervisors and oversight specialists attended meetings for specific purposes, but were not always at the meetings. Other adults, such as Court Appointed Special Advocates, and others, were invited to the family support team meetings at the request of parents, legal representatives or resource providers. Extensive narrative descriptions of the participants have been intentionally left out of this report to protect the privacy of those involved in the study.

Case A-Alice

Alice's family support team consisted of: her twin sister, the case manager who served as guardian, the case manager's supervisor, the transitional living supervisor at the young person's placement, the Guardian ad Litem, the Court Appointed Special Advocate (CASA), the CASA supervisor, the Children's Division oversight specialist, and the Chafee worker. The parents did not attend the meetings, as the parental rights had been terminated. The deputy juvenile officer, usually present, was absent for the meeting that I attended. Additional details about the participants are found in Table 3.1.

Table 3.1: Alice's Team

Role	**Age**	**Ethnic -ity**	**Gende r**	**Level of Education**	**Length of time in role**	**Court Attend -ance**	**FST**	**Inter- view**	**Empowerment scale score/ FES/YES/ YPP**
Alice (Youth)	17, Turned18 while in study	B/AA	F	Senior in High School	Approx. 5 years	X	X	X	YES=66; YPP=54
Sibling	17, Turned18 while in study	B/AA	F	Senior in High School	Approx. 5 years	No	X	NA	NA

Role	**Age**	**Ethnic -ity**	**Gende r**	**Level of Education**	**Length of time in role**	**Court Attend -ance**	**FST**	**Inter- view**	**Empowerment scale score/ FES/YES/ YPP**
Guardian /CM	27	W/C	F	Master's	3.5	X	X	X	Not completed
Guardian' s Supervis or		B/AA	F			No	X	NA	NA
CM/TLP worker	32	W/C	F	Master's	11 mons	X	X	X	FES =13
Guardian ad litem	55	W/C	F	Doctorate	Approx. 3 years on this case	X	Per phon e	X	FES=11.5
CASA Supervis or		B/AA	F			No	X	NA	NA
CASA	68	W/C	F	Master's	Approx. 5 years	X	Per phon e	X	FES=12.8
CD oversight		B/AA	F	Bachelor's		No	X	X	FES=7

Role	**Age**	**Ethnic -ity**	**Gende r**	**Level of Education**	**Length of time in role**	**Court Attend -ance**	**FST**	**Inter- view**	**Empowerment scale score/ FES/YES/ YPP**
Chafee worker	33	W/C	F	Bachelor's	3.5 years	No	X	X	FES=11.4
Totals	Range 17-68 Years	5 B/AA; 5 W/C	11 Females	Range HS-Doctorate	Range 11 mons-5 years	6 Participants	10 Participants	7 Interviews	6 Empowerment Scales

Legend
FST=Family support team
FES=Family empowerment scale
YES=Youth empowerment scale
YPP=Youth participation in planning scale

Case E-Evelyn

Evelyn's family support team consisted of: the case manager, the case manager's supervisor, who served as guardian, the biological mother, the Court Appointed Special Advocate (CASA), the CASA's supervisor, and the Children's Division oversight specialist. A new employee who was being trained for a caseworker role was attending the meeting by invitation. The biological father did not attend the meetings; the Guardian ad Litem, the deputy juvenile officer, the foster parent, the Chafee worker, and the two minor siblings were absent. All of the individuals involved with Evelyn were White/Caucasian. Additional details about the participants are found in the table below.

Table 3.2: Evelyn's Team

Role	Age	Ethnic-ity	Gender	Level of Education	Length of time in role	Court attend-ance	FST	Inter-view	Empowerment scale
Evelyn (Youth)	17 Years	W/C	F	Going into Senior Year	2 years	X	X	X	YES=74; YPP=55
Guardian /CM	49	W/C	F	Bachelor's	26 years	X	X	X	FES=12.7
Guardian 's Supervis		W/C	F			No	X	X	No

Role	**Age**	**Ethnic -ity**	**Gende r**	**Level of Education**	**Length of time in role**	**Court attend -ance**	**FST**	**Inter- view**	**Empowerment scale**
or									
Mother	34	W/C	Female	Below HS completion	17 years	X	X	X	FES=12.3
CASA sup		W/C	F			No	X	No	No
CASA	42	W/C	F	Master's	1.5 years	No	X	No	FES=11.8
CD oversight		W/C	F			No	X	No	No
Totals	Range 4-49 years	9 W/C	All female except GAL and DJO (who were absent)	Range: Pre-school to Doctorate	Range 2-26 years	4 partici pants	9 Parti-cipan ts	4 partici-pants	4 participants

Case F-Frank

Frank's family support team consisted of: the case manager, who served as guardian, the foster parents, the Guardian ad Litem, the deputy juvenile officer, the Children's Division oversight specialist, the Chafee worker, the Children's Division Adoption Specialist, and the Extreme Recruiter. The parents did not attend the meetings; an aunt-cousin, who had been invited to the meeting, was also absent. Additional details about the participants are found in the table below.

Table 3.3: Frank's Team

Case F	**Age**	**Ethnic-ity**	**Gender**	**Level of Education**	**Length of time in role**	**FST**	**Court attend-ance**	**Inter-view**	**Empower-ment scale**
Frank (Youth)	16	B/AA	M	Going to be Junior in HS	10 years	X	No	No	YES=76; YPP=75
Guardian/CM	50	W/C	F	Bachelor's	6.75years/with this youth- 4 mons	X	X	X	FES=13.1
Foster parent Male	66	B/AA	M	Doctorate	≥20 years; with this youth 7 years	No	No	No	FES=13.5
Foster parent Female	64	B/AA	F	Doctorate	≥20 years; with this youth 7	No	No	No	FES=12.2

Case F	Age	Ethnic-ity	Gender	Level of Education	Length of time in role	FST	Court attend-ance	Inter-view	Empower-ment scale
					years				
Guardian ad Litem*	NA	NA	NA	NA		X	No	No	No
DJO		W/C	F	Master's		X	X	X	FES=10.5
CD oversight			F			X	No	No	No
Chaffee worker		W/C	F			X	X	No	No
CD adoption worker	44	B/AA	F	Bachelor's	4 years	X	X	X	FES=15
FACC Extreme recruiter	27	W/C	F	Master's	10 mons	X	X	X	FES=11.9
Totals	Range 16-66 Years	5 W/C; 4 B/AA;	3 Male and 7 Female	Range High School to Doctorate	Range: 4 months - 10 years	8 present	5 present	4 Inter-views	7 Empower-ment Scales

*Present, but not in the study.

Cases G and H-Gabby and Henry

Gabby and Henry were siblings from the same family. Their family support team consisted of: the case manager, who served as guardian, the mother, the deputy juvenile officer, the Children's Division family reunification specialist, the Chafee worker, the in-home family therapist, the mother's therapist, and the two minor siblings who were not enrolled in the study. A guest at this meeting was the person who was job shadowing with the caseworker. The foster parents and biological father did not attend the meeting; the Guardian ad Litem was absent at this time. Additional details about the participants are found in the table below.

Table 3.4: Gabby and Henry's Team

Role	**Age**	**Ethnic -ity**	**Gend er**	**Level of Education**	**Length of time in role**	**FST**	**Court attendan ce**	**Inter -view**	**Empower -ment scale Score**
Gabby (Female foster youth)	15	B/AA	F	Going to be High School Sophomor e	Children in care X 10 Yrs.	X	X	X	YES=79; YPP=69
Henry (Male foster youth)	17	B/AA	M	Going to be High	Children in care X 10	X	X	X	YES=94; YPP=67

Role	**Age**	**Ethnic -ity**	**Gend er**	**Level of Education**	**Length of time in role**	**FST**	**Court attendan ce**	**Inter -view**	**Empower -ment scale Score**
				School Senior	Yrs.				
Guardian/Case manager	24	W/C	F	Master's	8 mons	X	X	X	FES=14 (rounded up)
Mom	40	B/AA	F	2-4 years of college	Children in care X 10 Yrs.	X	X	X	FES=15.3
DJO		W/C	M	Master's		X	X	X	No
Family reunification specialist		B/AA	M			X		No	No
Epworth (Chafee)worker		B/AA	F			X		No	No
In-home therapist		B/AA	M			X		No	No
Mom's therapist		W/C	F			X		No	No
Shadowing/"FST member in training"		W/C	F			X		No	No

Role	**Age**	**Ethnic -ity**	**Gend er**	**Level of Education**	**Length of time in role**	**FST**	**Court attendan ce**	**Inter -view**	**Empower -ment scale Score**
Minor Siblings		2 B/AA	M and F	Middle School		X		No	No
Totals	Range 15-40	8 B/AA and 4 W/C	4 Male and 7 Femal e	Range Middle School – Doctorate	Range 8 mons-10 years	11 present		5 Com- plete	4 Complete

Case J-James

James's family support team consisted of: the case manager, who served as guardian, the foster parent, the deputy juvenile officer, the Chafee worker, and the permanency specialist. The mother was deceased, father was incarcerated, and not present; the siblings did not attend the meeting; the Guardian ad Litem was absent at this time. All the members of the family support team including the youth were White/Caucasian. Additional details about the participants are found in the table below.

Table 3.5: James's Team

Role	**Age**	**Ethnic-ity**	**Gender**	**Level of Education**	**Length of time in role**	**Court Attend-ance**	**FST**	**Interview**	**Empower-ment scale**
James (Youth)	16	W/C	M	Going into Junior Year	Approx. 5 years	X	X	X	YES=67 YPP=56
Guardian/CM	57	W/C	M	Bachelor's	7 years	X	X	X	FES=13.7
Foster Parent	33	W/C	F	0-1 years of college	4 months	X	X	X	FES=9.8

Role	**Age**	**Ethnic-ity**	**Gender**	**Level of Education**	**Length of time in role**	**Court Attend-ance**	**FST**	**Interview**	**Empower-ment scale**
DJO	37	W/C	M	Master's	15 years	X	X	X	FES=14.5
Guardian ad litem		W/C	M	Doctorate		X	No	No	No
Chafee worker	46	W/C	F	Bachelor's	9 mons	No	X	No	FES=11.2
Permanency specialist		W/C	F	Bachelor's		No	X	X	No
Totals---	Range 16-57	7 W/C	3 Females; 4 males	High School-Doctorate	Range: 4mons-5 years	6 Participants	6 participants	5 Interviews	5 Empowerment scales

Case K-Kaitlyn

Kaitlyn's family support team consisted of: the case manager, who served as guardian, the transitional living supervisor, the Guardian ad Litem, the Children's Division oversight specialist, the Chafee worker, and the 14-year-old minor sibling. Absent from the meeting were the biological mother and father, the five-year-old sibling, the therapist, the house parent at the transitional living placement, and the older youth transitions specialist. Additional details about the participants are found in the table below.

Table 3.6: Kaitlyn's Team

Role	Age	Ethnic-ity	Gender	Level of Education	Length of time in role	FST	Court Attend-ance	Inter-view	Empower-ment scale
Kaitlyn (Youth)	17	B/AA	F	Going into Junior Year	10 years off & on	X	X	X	YES=80; YPP=62
Guardian/CM	50	W/C	F	Bachelor's	6.75years	X	X	X	FES=13.1
CM/TLP worker		B/AA	F			X	X	No	No
Guardian ad litem		W/C	F	Doctorate		X	X	No	No

Role	**Age**	**Ethnic-ity**	**Gender**	**Level of Education**	**Length of time in role**	**FST**	**Court Attend-ance**	**Inter-view**	**Empower-ment scale**
CD oversight		W/C	M			X		No	No
Chaffee worker		W/C	F			X	No	No	No
Sibling	14	B/AA	F	Going to 9th grade		X	X	No	No
DJO		B/AA	F	Master's		X	X	No	No
Totals---	Range 5-50 years	5 W/C; 4 B/AA	7 Females; 1 Male	Range: High School-Doctorate	Range 6-10 years	8 partici-pants	6 partici-pants	2 inter-views	2 Empowerment scales

Cases M and T – Mary and Tom

Mary and Tom were siblings from the same family. Their family support team consisted of: the case manager, who served as guardian, the Guardian ad Litem, the deputy juvenile officer, the male youth's therapist, the female placement provider, the male placement provider, and the grandmother. The parents did not participate in the meeting. Additional details about the participants are found in the table below.

Table 3.7: Mary and Tom's Team

Role	Age	Ethnic-ity	Gender	Level of Education	Length of time in role	Court Attend-ance	FST	Inter-view	Empowerment scale
Tom (Male Foster youth)	17	W/C	M	9 High School credits	Approx. 17 years	X	X	X	YES=100 YPP=75
Mary (Female Foster youth)	15	W/C	F	Going into Sophomore Year HS	Approx. 15 years	X	X	X	YES=73 YPP=54
Guardian/CM	29	W/C	F	Master's	3.3 years	No	X	X	FES=11.6
Guardian Ad Litem		W/C	M	Doctorate		X	X	No	No
DJO		W/C	M			X	X	No	No

Role	**Age**	**Ethnic-ity**	**Gender**	**Level of Education**	**Length of time in role**	**Court Attend-ance**	**FST**	**Inter-view**	**Empowerment scale**
Therapist		B/AA	M			X	X	X	No
Female Placement provider	53	B/AA	F		≥ 9 years	No	By phone	X	FES=12.7
Male Placement Provider	37	B/AA	M	0-1 Year of College	3 years	No	By phone	X	FES=14.7
Grandmother	74	W/C	F	HS diploma	17 years	X	X	X	FES=11.9
Totals---	Range 15-74 Years	6 W/C; 3 B/AA	4 Females; 5 Males	Range High School to Doctorate	Range: 3 years-17 years	6 Partici-pants	9 partici-pants	7 inter-views	6 Empower-ment Scales

Recruitment procedures. The study began through an agency affiliation with which I have done previous research. This private foster care agency serves youth and families. There is a continuum of care available within the organization. Some foster youth have high levels of mental health needs. The meetings that occur for case planning (family support team meetings) occur either at the central agency location or at foster family homes. The location of the study was expanded to neighboring counties in order to obtain the sample. More details about the setting will be described in the discussion of results.

Recruitment for this study began with the affiliation that the researcher had with the organization. The researcher had done work in this particular organization, as a nurse consultant on a previous research grant, and served as a consultant to instruct foster parents on psychotropic medication management. The agency was aware that the researcher has an interest in conducting research in its particular location and the regional director has already provided a verbal endorsement and a letter of support at the time of the study's commencement. In order to proceed with the proposed research study, the researcher obtained permission from Children's Division, University of Missouri-St. Louis, and Saint Louis University Institutional Review Boards. Additional approvals were completed with changes in recruitment strategies, including addition of a gift card incentive. Copies of the updated IRB approvals are on file.

Participation requirements were explained in detail. This included the purpose, aims, research questions, recruitment and sampling procedures and what was being asked of the agency case managers and the participants. Participation in the study involved being observed in family support team meetings, being observed in one court hearing, being interviewed, and filling out empowerment scales. Original plans required that core members of the youth case (caseworker, foster parent, and foster youth) participate in all data collection procedures, collectively. The researcher answered any questions and negotiated any challenges or issues that the administrators or participants had regarding the research. Questions did call for a change in protocol, and these suggested changes were submitted to IRB, and permission secured to implement the changes. IRB and Children's Division administrator's approval was granted for: recruitment to surrounding areas, adding a gift card incentive, attending and observing court hearings, and including other family support team members in the interview and survey process.

The following steps were carried out as part of the recruitment process:

1. Notify the administrator of the agency that the research study had been approved.
2. Arranged for a meeting with the administrator to provide a reminder and overview of the research agenda and to allow for an open discussion of any concerns or questions the administrator may have.

3. Provided the administrator all documents from all IRBs, which detailed permissions that had been secured, and procedures that would be followed in the study.
4. Secured a letter of support, which provides documentation that the administrator understood the proposed research, and is in agreement with all steps of the research process. Provided signed confidentiality note for the administrator.
5. Attended a staff meeting to provide an overview of the research and seek case worker volunteers.
6. Visited several other staff meetings at partnering agencies and executed the same process.
7. Provided written informed consent for all interested research participants.
8. Supervisors and case manager were asked to consider foster youth on his or her case load who are between the ages of 15 and 18, who have mental health needs and who had at least had their first family support team meeting convened at 72 hours.
9. The researcher asked them to consider inviting the guardians and youth to participate in the research study.
10. Steps for recruitment after caseworker or case manager consent obtained.

11. Foster youth consent and assent was sought as specified in *Child Welfare Manual, 3.1.1 Request to Conduct Research Procedures*, and University IRB regulations. Potential youth research participants were given full information about the study, and informed that permission has been obtained already from their guardians, but the choice to participate was voluntary and youth could opt out of the study. Written consent and assent was obtained for each foster youth in the presence of the guardian.
12. Since family support team meetings are considered confidential under state law, all individuals who were in the meeting needed to provide informed consent in order for the observation to be conducted in the meetings.

Data Collection

In order to answer the research questions, three strategies to collect data in the family support team meetings were selected. An interview guide for the individual interviews that followed the meetings was used. There were three empowerment scales to collect information from participants about self-rated perceptions of empowerment. For the discussion of these instruments, this section is organized into qualitative and quantitative collection methods.

Qualitative Data Sources

Four ways of collecting data on group dynamics and the decision-making process in family support team meetings were used. The first was a simple demographic questionnaire, which captured categorical data of the research participants. The second was a modification of the OPTION Scale, used in the observation of family support teams to provide structure to data collection (Elwyn et al., 2003). The third type of data collection within the family support team meetings was field notes, in which reportable details about group behaviors were recognized and recorded in writing. The fourth was the semi-structured interviews that were conducted after the meetings had been observed.

For the foster parents and caseworkers, the demographics that were collected included self-reported gender, age, race, and ethnicity, level of education, particular role in the foster care system, general household membership, and how many family support team meetings were attended per year. Because of the sensitive nature of disclosing income and location of dwelling place, this type of information was not requested, even though the information may have provided relevant context about the participants. The demographic data collected followed the followed the established demographic form attached to the Youth Empowerment Scale (Walker and Powers, 2007) except that zip code was reduced to 3 numbers to protect the participant's privacy,

and the race and ethnicity categories were changed to "select all that apply" instead of the original form, which asked for one category only.

Observations. The OPTION Scale, an empirically tested research instrument to gauge provider level of involvement in shared decision-making (Elwyn et al., 2003; Elwyn et al., 2005), was modified to create a data gathering instrument for observing decision-making in the context of family support teams. In its original form, it was used to observe provider and patient interactions in medical encounters, and scores could be generated to determine to what extent shared decision-making was occurring during these encounters. A core set of shared decision-making competencies was developed through a literature review and qualitative research to establish content validity (Elwyn et al., 2003); it was also psychometrically shown to have good reliability with a Cronbach's alpha of .79 (Elwyn et al., 2003). The modification in the current study was to use the questions on the OPTION Scale, but not the rating system. This turned the tool into an observational instrument without quantification (See Appendix B1.) It was used to analyze how decision-making was occurring in the context of family support team meetings. The SDM competencies in the OPTION Scale are: naming the medical problem and reaching agreement with the patient that this indeed is the problem, explaining options and risks for treatment options that are available to manage the problem, and engaging in dialogue about the decision to be made (Elwyn et al., 2003). The application of shared decision-making to the

foster care system has been discussed in Chapter Two in great detail. The OPTION Scale captures the indicators of a shared or democratic process of making decisions.

Noticeable incidents, such as eruption of emotion, attentive listening, and arguing, ignoring, or noticeable blocks to communication was also be recorded using field notes. The data that was collected in the meetings was triangulated with the data collected in individual interviews and the empowerment scales.

Interviews. An interview protocol was used for individual interviews. Interviews are the best approach to answer research questions when the questions involve issues like how or why, when opinions or values of participants are sought, and when observation alone will not answer the questions (Merriam, 2009). Since discovering and understanding stakeholder perspectives and experiences is one of the research aims, the interview method of data collection is appropriate. A semi-structured interview is one in which open ended-questions and probes are prepared in order to guide the participant and researcher toward a goal-directed interaction that will answer the research questions while allowing for some spontaneity and creativity to occur in the conversation (Merriam, 2009).

The advantages of using a semi-structured guide are the flexibility that is allowed in wording and order of questions. Comparisons among research participants can be made because the same types of information are sought from each participant (Flick, 2014; Merriam, 2009; Seidman, 2013).

An interview guide was prepared to facilitate the conversation between researcher and participants in all individual interviews. Questions were generated from Towle and Godolphin's (1999) research article about shared decision-making competencies. Interviews of participants will occur individually following the family support team meetings. The protocol for the interviews focused on how people experience the process of decision-making in family support teams. The proposed interview questions are found in Appendix A2.

Quantitative Instruments

In addition to qualitative data sources, quantitative instruments were employed in order to find out stakeholders' perceptions concerning the degree to which they felt they had the knowledge, skills, and resources to advocate on the foster youth's behalf. *The Family Empowerment Scale, the Youth Self-Efficacy Scale/Mental Health,* and *the Youth Participation in Planning Scale* were used to measure the feelings of empowerment that youth, foster parents, and caseworkers report. The FES was modified with Friesen in 2015 to allow its use with all family support team members, and was named the Modified Family Empowerment Scale. The scales were the third set of data collected in chronological order, after observations of family support team meetings and individual interviews. After it was found that the scores were missing contextual information, the researched initiated follow-up questions about low-scoring items

for 12 participants who were willing to explain their reasons with one or two words.

9 youth in the study filled out the Youth Efficacy Scale and the Youth Participation in Planning Scale. 25 adults filled out the Modified Family Empowerment Scale: 5 case managers, 5 Foster parents, 1 transitional placement provider, 2 two biological mothers, 1biological grandmother, 1 Guardian Ad Litem, 2 CASA volunteers, 2 Chafee workers, 1 CD oversight worker, 2 DJO's, 1 CD adoption specialist 1 permanency specialist, and 1 extreme recruiter. Total scores were recorded and subscores were analyzed with the interpretation guidelines provided by the authors of the instruments.

General value and rationale for use of empowerment self-rating scales. The empowerment self-rating scales are useful for measuring the intensity or degree to which individuals self-rate an attitude complex (Miller &Salkind, 2002, p. 330). These questionnaires were used to add another dimension to collection of information about stakeholders' perspectives about decision-making processes by examining their own self-ratings of empowerment. The psychology of empowerment is considered as an internal and social experience, as discussed in Chapters One and Two, and is thought to be a necessary ingredient in shared decision-making (O'Brien et al., 2011). The numerical data adds value to the study by approaching the issue of stakeholders' perceptions of empowerment in a

different manner from a semi-structured interview or observation of individual-in-group behaviors. The three empowerment scales are described below.

The Family Empowerment Scale. The Family Empowerment Scale (Koren et al., 1992) assesses caregivers' (of youth with emotional disabilities) self-reports of empowerment. Staples, (1990, p.30; in Koren et al., 1992, p. 308), defined empowerment as "the ongoing capacity of individuals or groups to act on their own behalf to achieve a greater measure of control over their own lives and destinies." Empowerment was summarized as a complex construct, "both a process and a state, as both an individual and collective characteristic, as an attitude, perception, ability, knowledge and action, and as a phenomenon that can be manifested in a range of circumstances and environments" (Koren et al., 1992). Three subscales account for empowerment on different levels: "personal", or the ways in which a person experiences the self on continuum of powerless to having power, "interpersonal", or the degree to which a person believes they have influence in relation to others, and "political" levels of empowerment, which has to do with the degree to which parents would exert influence to affect policies that affect children generally. The three scales in the FES measure the self-rated degrees of empowerment, along the dimensions of attitudes, knowledge, and skills of caregivers.

The 34-item Family Empowerment Scale (FES) has established validity and reliability (Koren et al., 1992; Singh et al., 1995). Validity is defined as the

degree to which a test measures what it is supposed to measure. As part of the research process to develop the FES instrument, Koren et al. (1992, pp. 313-314) established validity through initial item construction, testing the items with 94 parents of youth with emotional disabilities from four geographically diverse settings in the US; conducting focus groups with 29 parents to assess readability, clarity and content of test items; revising items based on analysis and feedback; achieving expert consensus; and conducting factor analysis.

Reliability, defined as the extent to which a measurement gives results that are consistent, was established through measuring for internal consistency and test-retest reliability. Internal consistency and test-retest reliability were above .70 on all subscales, indicating good reliability (Koren et al., 1992). Singh et al. (1995) conducted a factor analysis of the FES and found a four-factor solution, which was compared to the original psychometric analysis by Koren et al. (1992):

> Congruence between the four factors derived in this study and the corresponding factors in the original FES psychometric analysis was high, with congruence coefficients ranging between .88 and .98. Obtained internal consistency estimates of reliability ranged from .78 to .89 for the four subscales, and the split-half estimate of reliability for the FES was .93. (Singh et al., 1995. p.85)

Over the course of 20 years, over 100 articles have been published citing the FES (B. Frieson, personal communication, June 6, 2013). The individual

subscales may be used independently to address family, services, or community, or may be summed together, depending on the choice of interventions, or if it is being used for baseline data (B. Frieson, personal communication, June 6, 2013). This instrument has typically been used in the context of measuring education or intervention. The questionnaire may be used as a pre and post-test to measure self-perceptions of empowerment with parents (for example, see: Brister et al., 2012). In this study, the total scores were used. Gathering the scores on adult participants, and a separate, but equivalent Youth Self-Efficacy Scale/Mental Health for youth, was conceptualized as offering the possibility of using comparison of the scores by case, instead of by subgroup. A case was originally thought to be comprised of each foster youth with his assigned foster parents and case worker, whereas a group would be all foster youth, foster parents, and caseworkers. Later the idea of the case was expanded to include the youth, core adult family support team members, and any other adults who were involved on the team.

The original analysis plan to review total scores was changed after initial empowerment scores seemed to be missing some context as to why individuals chose to rank some items lower. In order to gain understanding about why participants rated certain items with a low value, they were asked to say a word or two about any low-scoring items, defined as choosing a “1” or “2” on any item.

Qualitative comments were written from verbal responses and/or transcribed from audio-recorded responses.

Youth Self-Efficacy Scale/Mental Health. The Youth Self-Efficacy Scale/Mental Health (YES) is a 23-item Likert-type scale questionnaire designed to measure empowerment in a similar way as the Family Empowerment Scale, except that the target group is youth, not caregivers. As part of the research process to develop this instrument, validity and reliability were established through stakeholder feedback sessions and surveys of 188 youth and 60 caregivers (Walker, Thorne, Powers & Gaonkar, 2010). Cronbach's reliability co-efficient for the total empowerment score was .91.

Content validity was established by adapting the FES to youth with mental disorders. First, a sample of youth who had mental disorders was consulted to make wording changes. Next, youth were consulted after item adaptation was completed to obtain feedback. Then, service providers and caregivers were consulted for feedback. Last, a survey was generated. The survey included potential empowerment scale items that solicited information about youth participation in treatment planning, perceptions about goal setting, and demographic data (Walker et al., 2010, p. 53). The scale that was created from this validation process differs from the FES in that it has questions to assess "youth perceptions of…managing their own mental health condition, managing

their own services and supports and using their experience and knowledge to help peers and improve systems of care" (Walker & Powers, 2007, p. 2).

The subscales were shown to be equivalent to the subscales on the FES (caregiver) version. These subscales measured three constructs: empowerment at the self-efficacy level, empowerment at the service level, and empowerment at the community and/or political level (Walker et al., 2010). Youth efficacy was defined as, "a person's perception that he or she is able to take actions that lead to positive mental health care outcomes, either through self-care and coping or through working to optimize the care provided to others" (Walker et al., 2010, p. 52).

In developing this instrument, empowerment was defined as, "a broader, multi-level concept [as compared to self-efficacy] in that it includes not just a person's confidence relative to achieving individual-level outcomes but also his or her confidence relative to having a positive effect on institution, organization and political systems in the wider community" (Walker et al., 2010, p. 54). Service level confidence was defined as, "confidence and capacity to manage services" (p. 53) and systems level confidence was defined as, "confidence and capacity to help improve services and service systems for children with emotional or behavioral challenges" (Walker et al., 2010, p. 53). Confidence closely aligns with the concept of competence in self-determination theory, which is defined as a sense of confidence that one is effective within the social environment as well as

the perceived sense of mastery in practicing one's capacities (Deci & Ryan, 2002, p. 7).

Youth participation in planning scale. The Youth Participation in Planning Scale was developed and tested at the same time as the Youth Empowerment Scale/Mental Health (Walker & Powers, 2007). This instrument measures youth perceptions of inclusion in treatment planning. The results of the instrument development process showed good reliability on three subscales: the extent to which the treatment plan reflected youth perspective (Cronbach's =.90); the degree to which youth felt prepared to participate in treatment (Cronbach's =.75); and the degree to which they felt a sense of accountability in the treatment planning process (Cronbach's =.78) (Walker & Powers, 2007, pp. 6-7).

A sample item that measures autonomy is, "I help decide what is on the agenda for my team meetings" (Walker &Powers, 2007, p. 15). The validity was established through stakeholder feedback and survey analysis, similar to the process of developing the YES. In this case, changes were made after the stakeholders noted the original items "did not set the bar high enough in terms of expectations for participation and did not include other necessary aspects of participation such as the opportunity to be prepared in advance" (Walker & Powers, 2007, p. 4).

The data analysis steps were followed according to the literature.

Data Collection Procedures

Data was collected over a 10-month time period. The first encounter with research participants was typically a brief meeting to collect consent and demographic information. The researcher answered any questions that participants had about the study as part of the consent process. Adolescent and adult participants in family support team meetings provided consent for observations. In order to accomplish this, communication with all participants occurred prior to data collection to explain the study and answer questions. Interviews and empowerment scales were completed with the convenience of the participants in mind, either directly following the meetings or on another occasion. The logistics of the meetings: scheduling, meeting locations, timing of meetings in relation to court hearings, who was invited to meetings, and time allotment, is briefly described below.

Logistics. Case managers scheduled family support team meetings at agency conference rooms, court meeting rooms, or at homes. All meetings were conducted with participants sitting around a table, with the exception of one family support team, in which the members sat in a circle around the living room. The support team meetings took place about one month prior to court hearings for six of the youth. One family support team meeting was scheduled on the same day as the court hearing; and three teams met a few weeks after the respective court hearings. A circuit manager explained that the ordering of meetings prior to court

hearings allowed the team to make recommendations and create reports that would be submitted to the court.

Attendance at meetings. The case managers decided who was invited to the family support team meetings. There were a few meetings in which the foster parents were not present, for various reasons: 3 youth were moving back home, one family had an emergency, and 2 foster parents were tending to other children at home. Youth attended the meetings in all but one case. Biological parents were invited, but absent for three teams. Team members participated by conference call for Alice, Mary and Tom.

Time allotment. The usual length of time for a family support team meeting was one hour, and the range was 20 minutes to one hour and 40 minutes**.** Court hearings were put on a common docket in all but one county. Length of time to wait before a family was allowed to meet with the judge varied from a few minutes to hours.

Observations. One court hearing and one family support team meeting each were observed for all cases except the sibling group Gabby and Henry. Their court hearing was not observed. The OPTIONS structured observation tool and field jottings were used to capture data about group process during FST meetings. Field notes were fleshed out as soon as possible after the meetings.

Surveys. After surveys were completed, the researcher engaged the participants in an interview that was designed to elicit information about how people perceive the process of decision-making in FSTs.

Individual interviews. The procedure for collecting interview data included use of a prepared, semi-structured interview guide, audio-recording of the interview, except in one county when audio-recording was prohibited, and transcription of the audio recordings, using predetermined transcription rules. These interviews followed as soon as possible, after the second family support team meeting or court hearing, and after the surveys are filled out, so that two types of information could be reviewed with the participants. Youth participants were given the choice to nominate an adult support person to sit in the interview if desired. The interview guide asked about the format of the meeting; about thoughts, feelings and perceptions related to the meetings; and asked participants to identify how and when participants feel either encouraged to or discouraged from speaking up in the meetings. The interview guide is found in Appendix A2.

Data Analysis

The data analysis occurred at the same time and immediately following data collection. Specific methods of analyzing the data are grouped according to data collection types below.

Qualitative Data Analysis

The group dynamics information that was recorded and transcribed were analyzed using content analysis. The interview data that had been recorded and transcribed were analyzed with grounded theory data analysis methods. The specific steps that were taken during qualitative data analysis are described below.

Analysis of group dynamics. In order to analyze group dynamics, written data was reviewed from each family support team meeting observation and court hearing. Field notes and analytical memos were written about each family support team meeting based on information recorded on data collection tools and field notes. After the data was analyzed, it was compared with literature on group dynamics and to other data sources (i.e., interview and survey data).

Analysis of interview transcripts and non-survey data. Methods that followed the concepts and principles of grounded theory, as described by Strauss & Corbin (1998), were the primary data analysis strategy for this study, so that well-constructed categories could be developed and reported. Secondarily, content analysis methods, i.e. using the OPTION Scale and a researcher-created Group Analysis analytic tool, were employed in order to understand more about family support team decision-making. The analysis of data began in the field, and was guided by the research questions. Category development began with the transcription of interviews, reading the transcribed text, and assigning preliminary open codes to meaning units.

In the open coding process, ideas, hunches, questions, meanings, and concepts were written in the margins of the interview transcripts. Short narrative summaries were created for interview transcripts, and sometimes included comparisons or additional information about the participant from an additional data source. The process of developing concepts was one of merging open codes and formulating preliminary categories after continuous analysis using the method of constant comparison. A small consultation group of doctoral students, sometimes joined by a senior researcher, met at least 12 times during the analysis process to review how the text was being analyzed, discuss preliminary codes, share ideas about potential concepts, and discuss alternative perspectives about what the data was revealing.

In order to work with concepts, codes were entered into an electronic document and saved in an electronic file, to allow for arrangement and rearrangement of codes on a visual field. Preliminary concepts were merged, arranged and rearranged according to similarities identified in the process of constant comparison. Similar concepts were then merged to form preliminary categories. Concept mapping, writing drafts, arranging data in spreadsheets, asking questions, forming hypotheses, comparing data, using imagination and consultation with the research group and a senior researcher were strategies that were employed to make sure that the categories that were named were accurate and complete representations of what was found in the data.

Constant comparison. The development of categories was an iterative process. Reformulating ideas and revising categories were part of the analytic process. Through the process of comparing bits of data to other bits of data, then codes to codes, then codes to concepts, concepts to concepts, concepts to categories, and categories to categories looking at context, conferring with other research team members, and formulating questions and answers to the data, clarification and reduction of some of the original concepts into categories, subcategories, properties, and dimensions was achieved.

Axial coding. Concepts were organized and arranged into a conceptual ordering. I prioritized certain concepts as having a leading position of value in relation to other concepts. Concepts that served to answer the research questions and had the broadest explanatory value were designated as categories, and other concepts were arranged as sub-concepts to the categories; these sub-concepts that served to further differentiate and clarify the lead concepts were designated as sub-categories. After having developed well-substantiated categories (and related subcategories to the categories by way of axial coding), the categories could be applied in further analyses.

Category refinement. Strauss and Corbin's (1998) suggestions to refine category development by defining its properties and dimensions, making sure that the properties and dimensions are consistent with the conceptual labels, and filling in any poorly developed concepts by reviewing the data and letting go of concepts

that no longer fit, were followed. (A record of open codes, power point slides showing the sorting of open codes, concept mapping, and codebook samples was preserved). Codebooks were developed, tested, and finalized to organize the data with headings that ran across the top: categories, subcategories, properties, dimensions, and line examples. The codebooks in Appendices (--) were used to build a report of findings and to provide an audit trail.

Quantitative Data Analysis

The Modified FES is a 34-item instrument and has been introduced previously in this chapter. Briefly, it was hoped that the Modified FES could provide corroborative or disconfirming evidence about how decision-making happens or is experienced by participants, provide additional perspective about how individuals perceive the process decision-making, and assess self-report of empowerment. Each item can be given a self-rated choice with a five-point range, where 1=never, 2=seldom, 3=sometimes, 4=often and 5= very often.

For the primary analysis plan, the total scores were analyzed first at the individual level. Each score was arranged from low to high scores to examine which participants were scoring in the extremes, and what the number values of each participant were. The total scores of each individual were compared with non-survey data (i.e., content analysis of observations and grounded theory analysis of interviews) to determine what relationships might exist observed group behaviors, and/or the interview data and/or the empowerment scores.

The YES is a 23-item Likert-type scale questionnaire described earlier in this chapter. Each item can be given a self-rated choice with a five-point range, where 1= never or almost never, 2=rarely, 3=sometimes, 4= mostly sometimes, and 5= always or almost always. The total scores for this instrument were triangulated with the other data collection points in a similar way as the FES. The YPP is also a 23-item instrument, and its subscales measure perceptions of involvement in service planning. The total scores for this instrument will be triangulated with the other data collection points in a similar way as the Modified FES and the YES.

Integration

Integration is "the combination of quantitative and qualitative research within a given stage of inquiry" (Creswell et al., 2003, p. 220). Integration can occur in any or multiple phases of a mixed methods study. The elements to consider in choosing when and how to integrate data include the purpose of the research, theoretical perspective, design type, which type of method is the priority, how and when data collection will occur (either concurrently or sequentially), the methods of data analysis that will be used, and the relative ease of integrating the analysis of data (Creswell et al., 221-33). All of these factors inform the stage at which integration should occur. In applying these suggestions to the proposed study, the stage of integration will be at interpretation. Table 3.8

below summarizes application of mixed methods integration as described by Creswell et al. (2003) to this study.

Table 3.8: Integration of Results

Purpose of Research	**Theoretical Perspective Present? Yes/No**	**Design Type**	**Priority**	**Implementation**	**Analysis**	**Ease at which integration can occur**	**Stage of integration**
Exploratory and process based plus confirmatory (Creswell et al., 2003, p. 221). Explore and describe observed stakeholder behaviors, understand stakeholder perspectives, and determine to what extent scores on self-rated empowerment scales	Yes.	Concurrent, embedded design	Qualitative	Concurrent collection of data	Content analysis, grounded theory methods, descriptive and inferential statistics	Not easy because of 3 types of analysis: content, grounded theory and descriptive plus inferential	Interpretation; "examination of the results for convergence of findings" (Creswell et al., 2003, p. 220); compare results of qualitative analysis (categories, subcategories, properties and dimensions) with quantitative analysis (empowerment scores; Creswell et al.,

inform analyses of behaviors and perceptions							2003, p. 223)

Synthesis. After data was analyzed, the data were woven into a preliminary report, which detailed the findings. The analyzed data were compared to the literature on shared decision-making, family group decision-making, and the Child Welfare literature, and a discussion highlighted how the findings were either similar or unlike other research findings from the limited research that has been done on shared decision-making in the seriously mentally ill population. Last, implications were generated from the analysis of the data as compared to the literature.

Quality Standards

Miles et al.'s (2014) quality standards are discussed in Chapter Five.

Protection of Human Subjects

All participants of family support team meetings were informed of the nature of the study and were provided with the informed consent form. IRB approval was obtained from the Children's Division agency and from the University IRB review board prior to any data collection. Research participants were informed of risks: to participate in family support team meetings, in which they were being observed, they faced the risk of discomfort in sharing personal and sensitive information in front of a stranger and the risk of damage to reputation if information from the family support team meetings was not de-identified, and the person's confidential information was breached.

Participants in the individual in-depth interviews faced the risk of discomfort in sharing views about their perceptions of the process of decision-making in family support teams, their needs, concerns, and questions about mental health treatment as well as their perceived level of empowerment. There was also the potential that questions about the process of mental health treatment could cause stress or anxiety or that foster parent and case worker participants might feel that their work is not valued or was being criticized. For youth participants, some youth could have experienced uncomfortable feelings when answering questions on either the interviews or questionnaires that reminded them of painful times in their lives. There was the risk of damage to the individual's reputation if information shared in the interview reflected negatively on the participant and confidentiality was breached.

Youth could have felt pressured to take increased responsibility for their treatment. Foster parents and caseworkers may have also felt pressured to change the way they provided care related to psychiatric treatment for the youth they served and could have felt resentful or angry at having to change the way they provided care. For caseworkers and foster parents there was a risk that other agency employees, such as supervisors, knew about their involvement or lack of involvement in the research.

Protection Against Risks and Informed Consent

Because of the maltreatment experiences of children who are in state custody, and the assumption is sometimes made that parents are unable to contribute to protection of children's interests in research, children in foster care are considered an extremely vulnerable population. Children should not be included in research studies for convenience, when there is not a clear benefit in participation, or when the risks outweigh the benefits in participation.

In this particular study, there are potential benefits to be gained from understanding the unique perspectives of youth in the system of care, and it is specifically their voice that is needed to be heard with respect to shared decision-making. Failing to get youths' perspectives would be antithetical to the purposes of shared decision-making, which are to empower individuals to take an active part in their own treatment, to express preferences and to weigh out options for treatment in a partnership relationship.

All research participants were informed of the voluntary nature of the study, its purpose, risks and benefits, as well as alternatives, timeframe for participation, sampling procedures, procedures for managing and storing data and information about how the data will be used; and an open discussion of any concerns or questions the participants may have had. Written consent for adults and assent forms for youth were signed.

Missouri Statutes specifically address confidentiality of family support team meetings. It is very important to obtain informed consent of all attendees, be they research participants or not. Members may choose to waive their rights to confidentiality but for the purpose of this research, all information that is collected will be considered confidential.

IRB approval was obtained from Children's Division and from the university IRB review board and modifications were approved for sampling and data collection. In order to comply with the spirit of the informed consent process, informed consent was seen as preliminary, and was verified before each observation, interview, or survey. There were two instances in which the consent process proceeded differently, due to scheduling logistics, and who was present in meetings. In these situations, consultation with supervisors, administrators, and the participants themselves guided the action steps of gathering consent and using participant information. For instance, in one family meeting when re-unification was planned to occur within in weeks, and two minor children were already living back home with their mother, the adults determined that they were allowed to attend the family support team meeting. They were not included in the study but both the children and the rest of the team were in agreement with their presence and mine as an observer at the meeting. In the second instance, some guardian ad litem was concerned that his participation in my study would conflict with his

obligation to protect the privacy of the foster youth. An agreement was made to simply not use any of his information except his role as part of the data set.

While it was originally thought that a judge's approval was necessary to proceed with the research, as conveyed through communication and planning with Central Office, each county managed the request to carry out the research in different ways. It was later discovered that attending family support team meetings is not governed by the court, and judge's permission was not necessary. As a matter of respect, judges in all counties were consulted, to inform them of the study. Some judges gave telephone or email approval, while others created court orders for the research to take place.

The planned sequence of gathering permission and consents for participation of family support team members was originally conceived to occur through one agency and case manager contact as the preliminary point of entry to recruit, however, this plan was later adjusted as further understandings about court and Child Welfare personnel preferences became known. Various supervisors and levels of administration were contacted to explain the study and obtain permission to conduct the research.

Protecting the research files and following University and Children's Division guidelines about effective data management procedures helps reduce the likelihood of a breach of confidentiality. Data was securely stored in both electronic and hard copy form. Audio recordings could be particularly revealing

and special precautions were observed to maintain confidentiality when reviewing the recordings and for storage. The hard copy data will be kept for five years in order to provide records in case of publication. Great caution will continue to be taken to protect the hard copy and electronic data files to preserve their integrity. All data saved electronically was stored behind user name and passwords. All data saved in paper form was managed securely. The reports generated from this research were de-identified. All parties were informed of all known risks associated with the project.

Limitations

Design-related limitations will be discussed along with the other limitations in Chapter Five.

Summary

The concerns surrounding mental health care in the child welfare system merit investigation of decision-making processes to assist in improvement of quality of life for foster youth, foster parents, and caseworkers. It was hoped this and subsequent studies will help build the evidence base for shared decision-making in the context of foster care in order to improve mental health treatment for youth in foster care. With improved decision-making processes young people and their caregivers may be empowered to take on more responsibility and control. Treatment decisions may be perceived as more informed and inclusive.

Finally, stakeholders may experience improved relational skills that can improve their quality of life.

This chapter has described the methodology to investigate mental health treatment decision-making in foster care. Family support teams come together to make important decisions related to a young person's well-being. Discovering how the decisions are made, how people perceive these processes, and how this intersects with self-perceptions of empowerment are the foci of this work.

CHAPTER FOUR: RESULTS

In this study, the processes of decision-making in the treatment of mental disorders, in the context of family support teams, within the foster care system were documented and analyzed. The research questions concerned engagement, perceptions, and self-rated empowerment among family support teams that serve older foster youth with mental health concerns.

The research questions were:

1. How do foster youth with mental health needs and their family support teams currently engage in mental health treatment decision-making within the context of family support team meetings?
2. How do foster youth with mental health needs and their family support teams perceive the process of mental health treatment decision-making in family support team meetings?
3. What are the stakeholders' perceptions of their own empowerment?

Data collection methods included observations at regularly scheduled family support team meetings and court hearings, informal conversations, semi-structured individual interviews, and a survey with self-rated empowerment scales within a sample of nine youth and volunteer family support teams across five counties. Data analysis included content analysis of meetings, grounded theory methods of analysis for the interviews, descriptive and inferential statistics for

empowerment scale scores, and analysis of low scoring items on the scales using a qualitative approach.

The chapter begins with the presentation of findings. Analytic categories are described. These are the inter-related processes of decision-making, power, and mesosystem factors that support or hinder decision-making.

Introduction of Categories

Three analytic categories were developed. The categories were labeled: (a) "the inter-related processes of decision-making", (b) "power" and (c) "mesosystem factors" (that support or hinder decision-making).

"The inter-related processes of decision-making" was chosen as a conceptual label to capture the complexity of arriving at decisions. Each component of the inter-related processes informed the other, serving as both antecedents to, and consequences of, the other component. The inter-related processes of decision-making were comprised of four subcategories: agendas, or the plans for meetings; and affective processes, cognitive processes, and relational processes. An outline of the category is found in Table 4.1.

Table 4.1: Category 1 – Interrelated Processes of Decision Making

Sub-categories	Properties	Dimensions
Agenda	Appraising Safety Risks	Low to high degree of risk
	Connectedness	Low to high degree of connectedness
	Placement Stability	Low to high degree of stability
	Well-being	Low to high degree

		Social, emotional, or physical
Affective Processes		Unpleasant to pleasant feelings
		Not expressing to fully expressing feelings
Cognitive Processes	Assessing Needs	Degree of need for services and resources
	Exploring choices and options	Not exploring to fully exploring choices and options
	Drawing Conclusions	incidental to holistic appraisal: looking at one part of meeting or meeting as a whole
		personal to other individuals' attributes: paying attention to either one's own or another team member's characteristics
		commenting on meeting dynamics to commenting on team dynamics
		commenting on internal to commenting on tangential matters
	Planning	not planning to planning
Relational Processes	Engaging	not engaging to engaging
	Deliberation	No deliberation to deliberation
	Agreeing	not agreeing to agreeing
	Collaborating	not collaborating to collaborating

The second category was named "power." Power was further distinguished by the subcategories: qualities of power and responses to power. Qualities are the attributes of power. Four properties of this subcategory were developed: expertise; the ability to establish rapport and connection; oversight mechanisms; and authority. Four properties of this subcategory were named: avoidance and independent action, compromising, empowerment, and cooperation. A selected family support team, who had two foster youth in the study, was chosen as an exemplar to illustrate the category power and its

subcategories, qualities and responses. The outline for the category power is found in Table 4.2.

Table 4.2: Category 2: Power

Sub-categories	Properties	Dimensions
Qualities	Expertise	Low to high degree of expertise
	Ability to establish rapport and connection	Low to high level of ability
	Oversight Mechanisms	Lacking too excessive
	Authority	Low to high degree
Responses	Avoidance / Independent Action	Low to high degree of avoidance and independent action
	Compromising	Not Compromising to compromising
	Cooperation	Low to high degree of cooperation
	Empowerment	Low to high degree of empowerment

The third category was named “mesosystem factors that support or hinder decision-making.” ‘Mesosystem’ is a term originally coined by Bronfenbrenner (1979). Bronfenbrenner's ecological systems theory is a human developmental model that explains how individuals develop through relationships within a continuum of contexts. The first system is the microsystem; it is the process of interaction that an individual experience with caregivers, family members, contemporaries, neighborhoods and typically first encountered organizations such as school and spiritual institutions.

Moving to increasingly complex environmental contexts, the next level is the mesosystem. Mesosystems are interactions between microsystems, for example two institutions’ interaction with one other. The family support team is

situated within the mesosystem. The ecosystem is the next level of context, and is distinguished as the way an indirect relationship with an outside system affects the developing person. Examples of an ecosystem are the parent's experiences at work that affect the parent-child relationship. The relationship between the child and how the parent responds to the work setting influences the dynamics between the parent and child, even though the child may have no contact with the parent's colleagues or environment. The microsystem represents the culture in which a person lives. Various cultural contexts have been identified, such as access to material resources, socioeconomic position, poverty, and ethnicity. These contexts are thought to be the most complex in the model.

Mesosystem factors in this study are the factors within the Children's Division and Court System that encourage or impede the youth and family support team's deliberations. Mesosystem factors as a category was further differentiated into two subcategories: role and standardization of practices and procedures. Properties of role were: differentiation, reasons for involvement, and compliance. Five properties of standardization of practices and procedures were: type, stakeholder perception of predictability, consistency in application, timeliness, and transparency.

One family support team, Case J, was chosen as an exemplar to illustrate the category mesosystem factors. The outline for the category mesosystem factors is found in Table 4.3.

Table 4.3: Mesosystem Factors

Sub-categories	Properties	Dimensions
Role	Differentiation	One role or one of many roles
	Reasons for involvement	Volunteer to career
	Compliance	Non-compliance to compliance
Standardization of practices and procedures	Type	Written, customary, and local/cultural traditions
	Stakeholder perception of predictability	Unpredictable to predictable
	Consistency in application	Inconsistent to Consistent
	Timeliness	Supports solutions to slows down processes
	Transparency	Intransparent to transparent

The next section of this chapter describes the category "inter-related process of decision-making." It is followed by presentations of the categories: power and mesosystem factors.

Category: Inter-related Processes of Decision-making

Family support team meetings and court hearings were orchestrated with pre-formulated agendas, characterized by specific, Child Welfare-oriented topics and action-specific processes. The processes that took place to following through the agendas were affective, cognitive, and relational.

Subcategory: Agenda. The inter-related processes of decision-making started with an agenda and only later actually moved to processes. The agenda provided structure and content to the meetings, while the processes concerned how the meetings were carried out. The agendas that guided family support team

meeting discussions were comprised of the family support team meeting (FST-3) template, and in some meetings, case managers provided the team members with either written agendas or other reports that were separate from the FST-3 papers (FSTM notes, Cases A, E, F, G & H, K, M & T). The print-outs of the templates were distributed in four out of seven teams. A sample of the template is found in the appendices. As mentioned, safety, connectedness, placement stability, and well-being are the properties within the sub-category, agenda. Each of these properties will be discussed in turn.

Property: Appraising safety risks. Because safety is an ongoing priority for youth in Child welfare, it is addressed at every family support team meeting regardless of whether a child is in imminent danger or not. Appraisal of safety risks was an agenda item that is a part of the larger category, the inter-related processes of decision-making. Conditions that affected safety risk appraisals varied across teams. For instance, Alice's parents lost their parental rights due to abuse. However, she had ongoing contact with her mother who had exploited her for money, even while she was in foster care. There was a court order that the mother was forbidden from doing this. Because the mother continued to have communication with her daughter, the team asked her in court and at her team meeting when she had last spoken with her mother and if the mother had asked her for anything.

Like in Alice's case, other parents may have had exploited or neglected their children, so questions were asked in family support team meetings, such as: "Have you had communication with your mother or father?" "How was it?" "Has anyone heard from the parents?" "Are the parents coming to the meeting?" From these questions, teams assessed the likelihood that future interaction or potential harm would occur. In other teams, the parents were being re-unified with their children, so the focus was making sure the parents had the resources that were necessary to provide supervision to their children who were returning home. Supervision was a concern for Evelyn, Mary, and Tom with respect to being able to visit with their respective grandmothers. Likewise, supervision concerns caused a prolonged delay of a return home to Gabby and Henry's biological mother. Finally, Kaitlyn, Mary and Tom's parents maintained parental rights; they were invited to court hearings and family support team meetings, but could not be trusted to supervise their children.

One young person, Tom, was having a number of behavior problems and one team member commented in the follow-up interview that there was a concerted effort to make sure this youth was "safe at all times" (Therapist Interview, Case T, Lines 15-19). Tom's parents were not involved in his care, and were not expected to become involved. The dangers in his situation included a risk for violence or violations of the law, not that there would be maltreatment in the future.

Due to concerns for a path to safe exit, Frank was not permitted to pursue an adoption opportunity with a relative, and Kaitlyn had a placement disruption with an aunt. Crowding was mentioned as a concern in Alice's family support team meeting, and it prevented Frank's relative to be considered a permanent placement for him. Sleeping arrangements were a concern for Frank and Kaitlyn, when their relatives' homes did not have the correct number of bedrooms or beds and for James, who had a temporary, un-walled bedroom set up in the basement of his foster home.

In another family, the young person in the study commented that she understood one of the main reasons the team and workers checked on the family was to make sure that they were safe (Youth Interview, Case G, Lines 29-31).

The conditional matrix in Table 4.4 summarizes the various factors that affected the youth's safety risk appraisal. Across the top of the table are the youth participants' pseudonyms, and the safety risk appraisal factors are listed down the left column.

Table 4.4: Conditions Associated With Safety

	Youth Alice	Youth Evelyn	Youth Frank	Youth Gabby	Youth Henry	Youth James	Youth Kaitlyn	Youth Mary	Youth Tom
Reason in care	Abuse	Abuse	Abuse	Suspected neglect	Suspected neglect	Parent incarcer-ated/ other deceased	Neglect	Neglect	Neglect
Parent involve-ment Participa-tion in services	Parent rights terminated. Non-participatory but does have contact	Re-unification. Participates in services	Parental rights terminated. Non-participatory	Re-unification. Participates in services	Re-unification. Participates in services	Father retains parent rights. Has phone calls from prison.	Parents retain rights. Non-participatory, but does have contact	Parents retain rights. Non-participatory and whereabouts unknown	Parents retain rights. Non-participatory and whereabouts unknown
Issues in care	Exploited while in care	Runaway and drug use while in foster care	Career level of care	No problems	Drug use while in foster care	Runaway and drug use while in foster care	No problems currently, but neglected while in foster care	Runaway, victimized and drug use in past	Runaway, violence, victimized and drug use in past
Place-ment Stability	Multiple placement disruptions	Multiple placement disruptions	No placement instability	No placement instability	No placement instability	Multiple placement disruptions	Multiple placement disruptions in past	Placement instability in past	Placement instability in past
Current living situation	Transitional living program	Foster home. Moving back to mom's	Career level of care	Foster home. Moving back to mom's	Foster home. Moving back to mom's	Foster home	Transitional living program	Therapeutic foster care	Therapeutic foster care

Property: Connectedness. As one of the four properties of the agenda, connectedness was an important factor that impacted the inter-related process of decision-making. Connectedness, as a conceptual label, is not an agenda item, per se, but is meant to summarize the importance of familial or other supportive adult relationships and belonging needs that youth have. (On the actual FST template, topical headers are: permenancy and visitation, child vulnerability, parent or caregiver protective capacity, special needs of the family and resource provider updates.) The degree to which youth experienced belonging, support and taking part in familial or family-like relationships, and professional or of a helping nature, was observed to vary. Some youth appeared to be the recipients of a greater degree of help and investment from supportive others (A, G, H, T) and some youth demonstrated a greater degree of reciprocation of care and affiliation (A, G, H, K, and M). Visitation, communication and relational ties were aspects of connectedness that were discussed as part of the agenda.

Visitation and communication with biological relatives was uniformly discussed in each young person's family support team meetings, even if the parents were no longer involved. For example, Alice and Kaitlyn had regular communication with their parents, although the parents did not attend meetings or court. Alice's mother had a history of manipulating her for money; and the court had issued an order specifically forbidding the mother from taking money from her (CASA Interview, Case A, Audio-Recorded; Lines 844-847). Alice's team

routinely asked her if she'd had communication with the mother, and the answer was yes. Like Alice, Kaitlyn maintained regular contact with her mother. Kaitlyn's mother had not fulfilled the court orders to demonstrate parenting capacity, such as gaining employment and housing, having clean drug screens, having a psychiatric evaluation, completing parenting classes, and attending therapy. Despite her lack of cooperation with court orders, she had ongoing contact with Kaitlyn.

As can be expected, the visitation and communication discussions for Evelyn, Gabby, Henry, Mary and Tom were different than from those of the others because family re-unification was the goal. (Moreover, as mentioned above, by the end of their participation in the study, Evelyn, Gabby, Henry, and Mary had returned to either their parents' or grandparents' home for a permanent placement.) Within the family support team meetings of youth who were planning to return home, team members asked how visits were going generally (Cases E, M and T); and a more focused assessment about managing free time occurred in Gabby and Henry's team meeting.

Relational ties between parents and youth were disrupted for varying reasons, including substantiation of abuse/neglect, death and incarceration of parents. In about 50% of family support teams, the biological parents were invited to attend the family support team meetings and/or court (E, G&H, K, and M&T). In two family support teams, the youth were re-unified with the parents

during the course of the study. These young people returned to the parents' homes to live (E and siblings G&H). Likewise, Mary returned to live with her grandmother.

Having a sense of family belonging was mentioned as an important social need by one family member, who stated,

> He's wanting a family, and now he's so messed up with wanting a family and everything, he can't get his life together…He just, he, that's all he wants. He just wants to belong, feel like he belongs, because he's been throwed around from one house to another and everything. I know how he feels. He just says…all I do is, they've been pushing me from foster home to foster home (GM Interview, Cases M & T, Audio-Recorded; Lines 62-74).

The promotion of sibling bonds was evident in six out of the nine youth in the study. Although none of the youth in the study were maintained in the same placements as their siblings, seven had joint-sibling family support team meetings (Cases A, E, G, H, K, M and T). In some cases, there were other siblings in the family who had graduated out of Child Welfare; their level of involvement with the youth in the study ranged from minimal contact to serving as a foster home placement for one of the youth (Cases A, J, and K).

In five cases, the relational ties between siblings were directly observed in the meetings (Cases A, G, H, K, M and T). For example, in Alice's family, the

siblings maintained a strong relationship with one another, evidenced by the frequent sharing and feedback between them. Gabby and Henry belonged to a larger family unit of four children, who were attentive and interested in one another during their meeting. Kaitlyn took on a role of protector toward her younger siblings, and stated that she wanted to become the guardian for her youngest sibling when she turned 18. Likewise, Mary manifested a high level of attachment and investment in her brother when she said:

> I see my brother in a different way than other people does. I don't know, I just feel that I see him different than other people do. I'm the one that talks to him mostly. He's the one that I really care about. Yeah.
>
> I feel he's gotten better. I see the way he is. I'm the one who's mostly around him. He doesn't act the way he used to be… And he talks to me all the time when he's upset. And he's upset about a lot more things than he used to be.
>
> He just seems like he cares a lot more. He seems like he doesn't care. But when it comes to me, that's when he wants to do things like Chafee...He wouldn't have done Chafee if it wasn't for me. Like I am the one that told him to do Chafee and then he did it. But everyone else has to argue with him about it (Case M Interview, Audio-Recorded; Lines 29-44).

Trust and consistency were elements of connectedness that were coded in interview responses and observed in family support team meetings and court

hearings. Team members filled an important void for youth who did not have parent involvement:

> I think part of it is because they were very, very angry in the beginning, and they didn't know who they could talk to, they didn't know who they could trust, and over time it's been the judge, their guardian ad litem, my supervisor, and myself are the only people who have been with these two girls all the way through (CASA Interview, Case A, Lines 129-132).

This example shows the importance of having reliable, caring adults available for foster youth, and that team members noticed these trustworthy, consistent adults were not necessarily available. As Kaitlyn stated, 'Sometimes you don't have a good foster parent, so you have to take care of yourself. I was taking care of myself…' (Foster Youth Interview, Case K, Lines 11-12).

A helping and invested relationship, which appeared more professional than familial, was an element of connectedness seen in some youth to FST team member relationships. These relationships entailed the young person benefiting from individualized attention shown from particular team members. This was noted in the special relationships that Alice had with the judge and her CASA worker, and the investment that the deputy juvenile officer had with Gabby, Henry and their family.

In summary, connectedness was an important need that was consistently addressed as part of the agenda in family support team meetings. While visitation

and communication with biological relatives was not always possible, having supportive relationships and a sense of belonging was observed as a point of discussion within meetings; furthermore, in follow-up interviews, at participants commented on the importance of family and professional relationships to support youth.

Property: Placement stability. Placement stability was evaluated across family support teams and there was variation in the degree of stablity that was present across families. In two families the placements were stable, but the remainder were either fragile or in a state of transition. The particular nuances in each case had to do with how cooperative the young person was in their current living situation; the motivation of the team members to pursue particular types of living situations; and caregiver resources. Examples of these nuances follow.

First, there were situations of a fragile or tenuous nature. Alice's placement appeared fragile and tenous. She was living at a transitional living placement, but was not following the rules to attend Chafee classes. The Chafee worker said if she was not cooperative with the services, her placement was not secure. Evelyn had just been given a court order to return home to live with her mother. She had a history of runaway and drug use. Her case manager commented that Eveyln's likelihood of staying with the mother depended on her remaining drug-free and following rules.

Mary was being transitioned from treatment foster care to her grandmother's home with the goal of guardianship. Her situation was tenous but seemed relatively secure because she was drug-free and had done the tiings the team wanted her to do while at the therapeutic home. Her brother's placement was fragile because he was not receptive or allowing himself to benefit from services intially, and had a history of violence. However, by the second meeting, he seemed to be participating in more services and at least seemed more accountable. Both Mary and Tom had been placed in therapeutic foster homes, which is a stepdown from residential level of care. While there were plans for Mary to move, there were no plans for Tom to move out of therapeutic foster care, even though he had turned 18.

Gabby and Henry's family was just being re-united. Extensive resources had been used to help the family get to this point. The mother was getting her children back after many years. There was a cautious optimism about the family's ability to enjoy success in living together after having so many challenges and obstacles. Their involvement with the court and chidl welfare had spanned a decade.

James was hoping for a permanent placement with his current foster parent. He also hoped that she would become his guardian. Because James had run away from his last foster home and lied about his situation to the current foster parent, there were concerns that James might have problems again in the

future. The foster parent wanted placement stability for him, and she was considering being his guardian, but she felt uncertain due to past behavior problems she'd found out about. She worried about the repercussions on her if he would have behavior problems in the future. The placement seemed to be conditional and based on whether James would be cooperative and how much the mother was willing to take a chance on James being cooperative. No final decisions had been made.

The last two examples of placement situations are youth who had relatively secure placement established, one in a career foster home, and the other in a transitional living placement. Frank was stable in his current placement, but wished for adoption. The team was not in agreement about the goal of adoption; some members were seeking resources for him and others thought his current foster care situation was stable and were not trying to make adoption happen. Extreme recruitment[1] had been tried and failed, so the current plan was for him to remain with his foster parents. The foster parents were well-educated, and well-

[1] *A specialized 20 week program in which eligible youth were enrolled, Extreme Recruitment was a branded, evidence-based, intensive program of services to help speed up the process of finding relatives and other associated adults who were screened and 'recruited' as potential adoptive placements. The program served youth who typically had long-standing emotional problems and were waiting for some length of time to be adopted. Extreme Recruitment was accomplished through a specialized agency that had access to more resources than an adoption specialist in Children's Division had. The resources included access to more databases to find potential relative placements, and access to media sources to be able to advertise that there were youth who were needing adoptive homes. When an extreme recruiter was involved, the likelihood that an adoptive home would be found was accelerated.

connected in the community; and had made it clear that they would be his foster parents but did not wish to pursue adoption. They had been his foster parents for many years and were prepared to be his placement until he was old enough to age out of foster care.

Kaitlyn seemed to have the most secure placement of any youth in the study because she was following house rules at her transitional living program, getting along with the family support team, seemed to be doing well with her health, and had present and future goals. The supervisor at her home described her as a model resident, and she seemed content with her placement. Minor issues, such as wanting to sleep in later did not seem to be a big concern, and it appeared her placement was secure.

Property: Well-being. Of very high importance for youth in Child Welfare, well-being was another component of the agenda. Well-being, an agenda item that is a part of the larger category, the inter-related processes of decision making, appeared to have at least equal importance as placement stability. Teams addressed four types of well-being in meetings and court hearings. These types were arranged as headers in the top row shown in Table 4.5. Specific examples of each type are grouped below the headers.

Table 4.5: Types of Well-being Addressed Across All Family Support Teams

Physical health	**Emotional/Mental Health**	**Social Well-being**	**Societal expectations for productivity and performance**

Recent wisdom teeth removal.	Mental Disorder	Violence to others in history	Attendance at school
Physical health	Mood shifts	Family conflict	Life skills acquisition
	Communication problems	Wish for adoption	Employment
	Drug problems		School achievement (grades)
	Psychotropic Medication Management		
	Leisure and vacationing		

(Meeting notes; Cases A, F, E, G&H, J, K, M & T)

The type of well-being that was discussed with greatest frequency was emotional and mental health. All of the youth had been assigned psychiatric diagnoses; however, these diagnoses were mentioned by diagnostic label in only one meeting. Mood shifts were seen among three youth, who displayed sadness or tears. Teams brought up communication problems for two of the youth, drug problems for four youth, and questions about psychotropic medication management for one. In a couple teams, youth asked for privileges which might enhance their feelings of emotional well-being.

In one particular team, issues related to well-being seemed to be minimized and not discussed openly. While a paper hand-out was circulated that depicted the type of maltreatment that she suffered, the types of medications she was prescribed, and her diagnoses, these issues were not discussed in the meeting. In another family team, issues of well-being were brought up for discussion,

including the need for dental work, mental health issues, and the use of psychotropic medications. There were questions that could not be answered because of the family's absence at the family support team meeting. In conversations and interviews with various family support team members during the course of the study, there was disagreement about the nature of the youth's mental health issues.

Most teams focused on well-being of the youth and the entire family system. For instance, at Gabby and Henry's family support team meeting, the topics that focused on well-being were: schooling, individual and family therapy, mom and older youth's completion of drug treatment, and scheduling of time over the summer months when all the members would be returning to live with the mother. A family therapist new to the case was introduced and plans were made for him to visit with the two boys in the home. The reunification therapist had a name of therapist for the girls, and stated that individual therapy would be 1x per week. The mother would continue with medication management and her own therapy as well. It was mentioned that mother had a clean drug screen and the older male had completed his drug treatment program. The discussion of the family's schedule and how they would spend their time was also discussed. During that portion of the meeting, the older youth mentioned he was worried about getting along with his sister because they had not lived with one another in a while.

Perspectives about youth well-being varied across team members. For instance, members of James's team offered contrasting perspectives about how James was doing. The DJO stated:

> I actually was very pleased, and just really proud of James, and I'm glad he's doing so well. It's just a really good meeting. James's team, especially works really well together, and they all are just trying to get the best outcome for James Deputy juvenile officer Interview, Case J, Audio-Recorded; Lines 91-93).

In contrast, the foster parent commented:

> He likes to keep things private... You know he's got his own agenda, he's a very smart young person, and he wants to keep some of the things off the table, and out of the minds of the people in charge because he's kind been in charge of himself a lot.
>
> …Because I think he knows divided you fall. So if he can keep certain information from certain individuals, then he can continue to do what he wants to do for himself, which is not always the best thing.
>
> So, I don't know if that makes sense…. He's been in the system for so long that he's adapted survival techniques, because he's always sort of had to look out for himself, because not everyone has been doing that, even if they were his 'quote unquote' care provider. Old habits die hard, but it's not always good to keep those things from other people, because he's not

> getting the help that he might need (Foster Parent Interview, Case J, Audio-Recorded; Lines 53-65).

This example illustrates that it was not necessarily easy to determine if a youth was doing well or if the youth was struggling. The team members may have had different criteria by which they were gauging the young person's wellbeing, such that one member believed the youth was doing well, and the other team member felt he may be having hardships that he was keeping hidden.

In summary, well-being was a focal point of the team meetings. Four types of well-being were addressed, with the most frequently occurring type mental or emotional health. Within that type, teams did not uniformly or thoroughly address mental or emotional health. Teams did focus on both individual and family well-being. Finally, perspectives about how youth were doing varied across participants.

The agenda of family support team meetings laid a foundation or framework for the processes that followed. Agendas were pre-formulated, and provided a consistent structure and content for meetings. Together with the processes, the agendas and the processes comprised the inter-related processes of decision-making. The next section of this chapter describes the processes that occurred within the meetings.

Overview of Processes

The ways that teams experienced or expressed emotions, thought about issues, and interacted with one another were evaluated across teams. There was variation in these processes. Youth and teams displayed and reported a continuum of pleasant to unpleasant emotions, various types of thinking processes, and differing presentations of relational dynamics. Each of these processes will be described in the text that follows.

Subcategory: Affective processes. Among the inter-related processes of decision-making, affective processes was clearly important. The membership's emotional experiences impacted how they interacted with each other and how they channeled energy toward addressing the needs of youth and families. The expressions of emotions that were observed during family support team meetings and court hearings ranged on continuum from unpleasant to pleasant. Expressions included, irritation, frustration, sadness, disappointment, happiness and joy. Examples of behaviors that expressed emotions were: Tom showing almost no observable emotion on his face or in his body language; Alice putting in earphones to block out the conversation in her meeting; the grandmother of Mary and Tom raising her voice; Mary and Kaitlyn crying silently at certain times during their respective meetings; and all members in Cases Alice, Evelyn, Gabby, Henry and Mary smiling and/or laughing at some point during their respective

meetings. Follow-up interviews revealed that team members experienced a range of feelings.

Similar to the outward expression of emotion, the internal feelings varied, as reported in individual interviews. Feelings ranged from undisclosed, anxiety, irritation, frustration, powerlessness, apathy, sadness and disappointment, helplessness, hopelessness, criticized, feeling left out, anger, empathic, empowered, confident, to optimistic and satisfied. A selection of these emotional experiences is provided in the text that follows.

One participant, Tom, was particularly reluctant to reveal any information about himself. When asked his thoughts and feelings about how the meeting went, Tom said, "Don't really have any that I want to talk about" (Case T Interview, Audio-Recorded, Line 30). While he didn't acknowledge any feelings, his case manager speculated: "Tom was upset, because he didn't have extended visitation with grandma" (Case MU and TU, CM Interview, Audio-Recorded, Lines 85-86).

Alice was quite unhappy, as could be observed with her habit of putting in her earphones during the meeting, and her refusal to talk after getting upset. The exact nature of her feelings was provided in her interview:

> I felt irritated because they let my sister talk, but they never really gave me a chance to fully speak about what I wanted to say (Case A, Youth Interview, Case A, Audio-Recorded, Lines 104-105).

She shared in the interview that she was not only “irritated”, but “frustrated,” and described the situation as “unfair.” Her belief was that she could not do anything about the unfairness, and she acknowledged that she was jealous of her sister.

Two participants in Frank’s family support team verbalized frustration during their follow-up interviews, although it was not apparent that either was frustrated in the meeting. The extreme recruiter and DJO (deputy juvenile officer) for Frank were both working toward the young person’s goal of adoption, but they felt they were at odds with other members of the team, who did not seem as motivated to pursue that goal. The extreme recruiter mentioned she was frustrated because a visit was arranged for Frank with a potential kinship provider. However, the case manager did not follow through with phone calls and further arrangements, so the visit fell through. The DJO likewise mentioned she was frustrated that the meeting had been cancelled and there appeared to be a lack of progress toward helping Frank achieve adoption.

The grandmother on Mary and Tom’s family support team also expressed frustration related to how her grandchildren’s case was being handled:

> …they keep telling me they have, you know, we’ve got so much support for them and stuff. Like Tom, they may have a lot of support for him, but they haven’t done anything. All they’ve done is send him to [Drug Treatment Place]. He stayed there until they needed room and they got rid

> of him. He went to, I don't know, that place in H [Named location]. He stayed there until they needed room. He went to [Named County], to a place there and he stayed until they needed room. He went to [Residential Placement]; he stayed until they needed the room. He's just been moved around, shifted around. To me, it's all that's been happening, and one person after another. They keep saying he's got this person and this person to help him. It hasn't seemed to help (Grandmother interview, Case M & T, Audio-recorded, Lines 9-14).

Sadness and disappointment were expressed by Kaitlyn and Mary in meetings, and confirmed in their follow-up interviews. Kaitlyn had wanted to become the guardian for her younger sibling upon turning 18 years, and asked the judge if this could be considered. The judge acknowledged her desire, but told her no, which caused Kaitlyn to cry silently. In the follow-up interview, Kaitlyn stated,

> I didn't like how it went. I got upset because he said I couldn't get my younger sister but afterward I was okay with it (Youth Interview Notes, Case K, Not Audio-Recorded, Lines 54-55).

Mary also experienced sadness and disappointment regarding decisions that were made regarding her relationship with her family members; and tears were observed streaming down her face in her family support team meeting. In the follow-up interview, she said,

> I got upset when my grandma started yelling and my brother can't come home for the week. Because I was really hoping I could see my brother for the whole week (Youth Interview, Case M, Audio-Recorded, Lines 24-26).

An example of an emotion that was not observed or fully expressed in the family support team meeting was James's foster parent's anxiety in taking on her new role. She shared some apprehension, uncertainty, and a strong sense of responsibility as she was discussing her feelings:

> I still have a lot of confusion. A little bit of nervousness, because you know someone's coming into your home, and it's not like we have a perfect home and sometimes I question if this is the best place for him. Because where he had come from was a really good placement for him.… (Foster Parent Interview, Case J, Recorded, Lines 106-109).

She also stated, "I almost feel that like a little bit critical of myself and my ability to be the best placement for him (Foster Parent Interview, Case J, Recorded, Lines 116-117). Finally, she said:

> I also am aware of how serious it is that he needs to have a place where he is not you know hopping around, he needs more permanency in his life, so I don't know, it's not light, it's a young person's life… (Foster Parent Interview, Case J, Recorded, Lines 117-119).

There were two situations in which joy was either observed in the family meetings or discussed during follow-up interviews. The joy expressed in Evelyn's meeting resulted from her high achievement on her ACT test. Members of the team were smiling, giving words of encouragement, and occasionally laughing in response to this news (FST Meeting Notes, Case E, Not Recorded, Lines 41-44). Follow up interviews confirmed this was a happy experience. Another time when joy was observed and confirmed in follow-up interviews was in Gabby and Henry's family situation. The family was being re-united, and both mother and daughter said that the meeting and court hearings were positive. The mother said the family support team meeting was like a family gathering, and Gabby said, "Everyone was happy, and giving hugs. Afterwards, we went to get cupcakes" (Youth Interview, Case G, Not Recorded, Lines 69-70).

Of the two youth who expressed little observable emotion in meetings, both Tom and James interacted minimally with their respective teams and contributed little to problem-solving or decision-making in their meetings. Alice, who was observed to have some distress during her meeting, at first seemed more involved, especially with her twin and her case manager. She attempted to help with decision-making, but later, she withdrew her participation. The youth who were observed crying in their meetings remained involved and actively engaged in problem-solving and decision-making during their meetings. The grandmother who was frustrated had difficulty in relation to the adult team members and

struggled with generating solutions or contributing to decision-making. When youth appeared happy or satisfied, they also appeared more involved with their teams and willing to make contributions toward decision-making. Other adult team members had various expressions of emotion during the meetings. Regardless of the emotional expression, these adult team members remained interested in others, and engaged with decision-making through-out the meetings.

In summary, a lack of emotional expression corresponded with less contributions toward decision-making for two of the youth. Unpleasant emotions, either observed or reported as crying, confusion, or frustration, among both youth and adult team members, corresponded with a higher degree of participation. Pleasant emotions, either observed or reported, also corresponded with a higher degree of participation.

The next section of this chapter describes cognitive processes as a sub-category of the inter-related processes of decision- making.

Subcategory: Cognitive processes. Cognitive processes of the category the inter-related processes of decision-making were grouped into four types: assessing needs, exploring choices, planning and drawing conclusions. Perhaps because youth and families were recovering from separation, loss and traumas, assessing the degree of need for services and resources appeared to be a high priority in the meetings. After this assessment, exploring choices and planning could occur. The last property of the cognitive processes was labeled drawing

conclusions to capture the nuanced mental activities that participants revealed during their semi-structured interviews in response to questions about the purpose of the meetings, individual expectations, perceptions of leadership, influence, communication dynamics, and how the meetings went overall.

Property: Assessing needs. Assessing needs, an appraisal of what may be lacking or deficient, or what may be improved upon, was one of the main purposes of family support team meetings. The dimensions of assessing needs were low to high degree of need for services and resources.

As mentioned previously, there were differing family constellations represented across the youth and their affiliation with respective biological relatives. Parent rights had been terminated in two cases, which meant that the family support teams were no longer focusing on trying to support the family in getting back together. Another youth's father was incarcerated and mother was deceased. In two other families the parents were not participating in services that were required by the court. The remainder of families demonstrated needs for services and resources.

Some families appeared to have needs related to adequate parenting skills. For instance, the grandmother of Mary and Tom struggled to provide adequate supervision and appropriate responses to unlawful behaviors of her grandchildren in the past, and they were placed in foster care. The therapist commented,

> I feel as though as a family there's a lot of areas for improvement, and I feel as though it might be difficult for the grandmother to care for the kids in the aspect, I guess in the way everybody wants her to (Therapist, Case T, Audio- Recorded, Lines 71-74).

Two other families in which parents needed assistance were related to family members' requiring special education and developmental interventions and a mother needing parent skills training. Individual needs for services and resources had to do with needs for services, such as therapy and independent living skills training, and resources, such as transportation and housing. Anticipating the complex needs of youth who had been maltreated was evident in this participant's remark:

> You take that and throw in the fact that they've been removed from their homes and they've been abused, well there you are. Why would you think it's gonna be easy? They need people that understand that and help them know that someone cares, and at the same time provide a dose of reality, not cruelty, but reality (CASA Interview, Case A, Audio-Recorded, Lines 363-367).

In this example, the CASA explained that it should not be assumed that youth would have carefree or easy life experiences going forward. She suggested that certain approaches to these youth, such as being pragmatic, but compassionate, would fill a need for appropriate emotional care and support.

The concern for emotional care and support for youth did not always mean the team assessed a need for psychological therapy. In fact, three youth were not in any kind of counseling. However, in two cases, youth were required to attend therapy despite their resistance. Assessing needs and exploring choices were related but not mutually exclusive processes.

Property: Exploring choices. In all of the family support team meetings, talking about choices occurred. In some cases, the discussion about choices focused on spending, saving or disclosing information about money); while in other cases, the discussion about choices had to do with choosing pro-social behavior or how to manage free time (Adaption of OPTIONS Scale to Applied to Meeting and Court Hearings). The guardian ad litem recognized the importance of examining what the young person's future possibilities were when she said,

> In addition, we would also touch base on the bigger picture for her, and because of her age and maturity we were of course talking about getting the high school diploma, and looking forward to college and what we could all do to make, help her have as many options as she could and to guide her a little bit (Guardian Ad Litem Interview, Case A, Audio-Recorded, Lines 27-31).

In another case, the option of guardianship was being evaluated. The foster mother realized:

> I am coming to understand that maybe you know there are two options which is what the two ladies were there for, which is one is guardianship and the other one is Chafee because as he ages out, Chafee's there to help him, so maybe there's just an African American and Caucasian of these are the two options, and you know here are the benefits you know side by side would be nice to know (Foster parent Interview, Case J, Audio-Recorded, Lines 132-136).

Property: Planning. Another cognitive process was planning. While case managers appeared to assume much responsibility for planning, and their work was documented on case forms, other team members also participated in this process. Case managers' interview responses commented on this aspect of work: how many youths they were required to see; location of visits, the coordination of visits for many family members; other anticipated concerns and issues; and an awareness that respecting other team members' schedules was part of the planning as well. One team member remarked:

> I feel rushed at the end because I know that there's a lot going on in this case, and I know that the DJO [Deputy juvenile officer] and guardian ad litem had other meetings to get to. Sometimes grandma needs to be redirected, she can get off topic sometimes, or stuck on a topic. So just rushed to discuss the visitation before the DJ0 and guardian ad litem left (Case manager interview, Cases M & T, Audio-recorded, Lines 96-99).

Permanency planning, the kind of planning that occurs for foster youth to formalize placement goals, appeared to be a case manager and DJO driven activity, although other members of the team participated in leadership to varying degrees. Especially for youth who were returning to their families, the parents were also observed taking on an increasing degree of ownership in this process. A permanency plan was discussed for each family; this entailed establishing what the goal was for the young person's placement stability, and what the plans were for aging out of Child Welfare in situations in which re-unification with family was not anticipated. Permanency planning was a dynamic process that was based on the fit between the young person and his or her placement provider and the resources put forth to maintain placement or move the person to a more desirable location.

The permanency plans for the youth in the study varied. Two youth lived in transitional living situations and were expected to age out of foster care when they were old enough; both intended to attend college. Three youth had been living in foster care but returned to their biological mothers during the study; of these, one planned to go to college. One youth had been

living with the same foster family for years, but his goal was adoption; he desired to pursue a college education. Another youth was in foster care and the team was exploring guardianship; his future plan was college. Finally, two youth lived in treatment foster care placements, but their goal was to return to live with their

grandmother; one planned to attend college, while the other's plans for the future were uncertain.

The permanency plan table in the appendix illustrates the placement plan, future goals that the youth identified, care plan, including plans for medication and/or therapy, who was most involved in implementing the plan, and what was being done to implement the plan.

Property: Drawing conclusions. The facets of the family support team meetings were addressed in the semi-structured interviews in order to find out individuals' perspectives on: purpose of the meeting, expectations, leadership, influence, communication dynamics, and how the meetings went overall. From participant responses, it was found that most participants understood the purpose of the meetings; had minimal expectations; most identified the case manager as leader in the meetings, but judge was the leader in Court meetings; had varying responses as to who was the person of most influence; and had varying thoughts about how the meetings went overall. Personal thoughts did not always relate directly to team meetings. The dimensions of drawing conclusions about various matters were: incidental to holistic appraisal; personal to other individuals' attributes; commenting on meeting dynamics to commenting on team dynamics; and commenting on internal to commenting on tangential matters.

In response to the interview question about what expectations team members had about the family support team meetings, one participant shared her

views about how there are foster youth factors within each family support team that impact what is discussed. Her belief was that the foster youth's current life circumstances helped the team determine the meeting focus:

I mean it depends on the youth, because each meeting looks very different between the youth. So with the girls we touch on everything that is happening currently, and lately we've been talking a lot more about college, so it's just different between the meetings (Chafee interview, Case A, Audio-recorded, Lines 164-168).

While this team member narrowed in on a specific incident in the foster youth's life, another team member provided a holistic appraisal of the meeting's purpose:

> …to just keep everybody up to speed on where we are, what's going on with the kids, where are they living now, what's happening, what have you seen, have you seen anything we all need to know about kind of thing. The permanency meetings are to talk about, so where are you gonna spend the rest of your life, where are you going to spend the rest of your childhood, what do you want to do after high school, or if you're a younger child, make it more appropriate for them.
>
> These kids that I'm with right now are older, so it's let's talk about what you're going to do after high school. The original idea is to have a permanency plan and follow it. Well we've made several of those, and

> right now the permanency plan for one of them is…living on her own in an apartment (CASA interview, Case A, Audio-recorded, Lines 202-210).

When asked about thoughts and feelings, some team members' responses revealed characteristics of their own personality, while others focused on the other members of the team. The example below provides the grandmother's perspective about her grandson's unlawful behavior. She described how she formulated a judgment about what to do with Tom's entanglement with the authorities, after he was incarcerated for shoplifting:

> Well I was beside myself, I didn't know what in the world, what am I gonna do, I didn't know what to do. So the only thing I can think of is, well get him out of jail and then Monday I'll call K and explain to her what was going on and everything… Well that's the only time that that's happened to me with him, and I was confused. I didn't know what to do.
>
> What would you have done? (Grandmother Interview, Case MU and TU, Audio-Recorded, Lines 156-163).

The grandmother suggested that she was insecure about how to manage her grandson's problems, was in much distress about him being in jail, and was second-guessing how she handled it afterwards.

An example of paying attention to another team member's characteristics is revealed in the example below, from the extreme recruiter. She was comparing

the new case manager to the previous one, and noticed the new case manager was passive:

> The previous case worker was not a barrier, the new case worker was not a barrier, but she's not actively pursuing leads, and doesn't take initiative.
>
> She sits back, takes notes, sends messages (Extreme recruiter, Case F, not recorded, Lines 32-34).

A few participants commented on content issues that occurred within the family support team meetings, while others seemed to focus more on how members were interacting with each other. Among the participants who commented on content issues, the majority commented on the meetings' purpose of focusing on case goals or permanency, and most believed the meetings were structured, achieved the goals that were set, and were productive. A common response was that it went fine or there were no surprises. This comment from a foster youth illustrates this focus on content issues:

> I think it went good. Everything's the same as when we went to court, nothing really changed. I already knew what was going on (Youth Interview, Case E, Audio-recorded. Lines 60-61).

Among those who commented on the interactions in meetings, one participant, noted that having to participate in the meeting by telephone created a problem:

> I really came away from it going this isn't working well, because I have a hard time telling the girls apart on the phone, so a lot of times I didn't know who was talking (CASA Interview, Case A, Audio-recorded, Lines 478-481).

As the participants described their roles, responsibilities, and reactions to the family support team meetings in the semi-structured interviews, some members described personal thoughts or tangential factors that may not have been directly related to the meetings. For instance, one participant described his personal thoughts about how he made decisions in general in his role as a case manager. He suggested that one of the requisites of the job is that you have to be confident in making decisions. However, he asserted that making decisions in Child Welfare is a shared responsibility. There are actually several people to talk to when formulating decisions. He said he believes they make the right decisions (Case Manager Consent Meeting Notes, Case J, Not Audio-Recorded, Lines 121-123).

Another member expressed dissatisfaction about her grandchildren's placement, in response to being asked who leads the family support team meetings. She said:

> I haven't been happy with her. I have not been happy at all, because I can't figure out why she has sent these kids, I drive 100 miles both ways getting them and bringing them back, and they're all the way in north SL,

> they live in an African American family, go to an African American school. M is the only Caucasian girl there in the school (Grandmother interview, Cases M & T, Audio recorded).

In summary, participants executed numerous and varied cognitive processes as part of the comprehensive process of decision-making. Whether it was assessing needs, exploring choices and options, planning, or drawing conclusions, these mental activities were important and necessary mental activities in order for decision-making to occur. Assessing needs occurred at the level of the individual and the family; exploring choices and options occurred in a few ways, across teams (Adaptation of OPTIONS Scale Applied to Meeting and Court Hearings). And, while no single cognitive process appeared more important than another, the one that seemed to be the most nuanced was drawing conclusions. Drawing conclusions was a property that encompassed either narrowing in on specific incidents or making holistic appraisals, noticing internal thought patterns or focusing more on other team members' attributes, being more aware of content discussed in meetings or team dynamics; and was also noted to include a tendency toward goal-attainment or distraction.

Subcategory: Relational processes. Building and/or maintaining human relationships between very different individuals in various roles that are included in decision-making in the foster care system is a layered and dynamic process. The manner in which these relationships were formed or nurtured constituted the

properties of relational processes: engaging; deliberation; agreeing; and collaborating.

Property: Engaging. For the most part, **t**here appeared to be a concerted effort put forth to encourage youth, families, and family support team members to be present, involved, and to participate in decision-making, although there were instances of failure to engage and discouragement as well. Essentially, most participants commented about feeling encouraged to speak up, but there were a few individuals who either felt unsupported or discouraged from full participation. One young person stated, "…they never really gave me a chance to fully speak about what I wanted to say" (Case A, Youth Interview, Audio-Recorded; Lines 104-105). This particular youth had a feeling of being cut off, and this led to disengagement. (More information about this particular youth are found in the exemplar). In another team, the grandmother commented:

> I mean, when I do speak my mind it's about the size of it. That's about how the meeting goes. I mean I'm usually the bad guy, the one that, just like the lawyer, he come to the conclusion, well, the reason why he's in this shape is because [of] you (Grandmother Interview, Case MU and TU, Recorded; Lines 137-139).

This participant expressed a feeling of being rejected when she tried to speak up or express her opinions in the meetings. She interpreted the lawyer's judgment of her parenting style as causative for her grandson's problems.

Two participants commented that they did not have a voice, especially in court:

> I can offer opinions, but I can't speak up. The Case worker and DJO can ask for things, I can only speak when spoken to in court (Extreme Recruiter Interview, Case F, Not Recorded; Lines 151-152).

A sense of injustice was suggested in the Extreme Recruiter's response. Despite having essential information that could be useful or contributive to the case plan, she felt she was discouraged from bringing these up within the court setting. A second team member voiced similar concerns:

> We don't get to talk. We give information in a court report. They received it in a report. It used to be people would talk. Things are changing (Adoption specialist Interview, Case F, Not Recorded; Lines 31-33).

This team member was comparing the current court process to former times when she was apparently allowed to speak openly within the court proceedings. She seemed discouraged that the communication was now only allowed in writing, and that there was not open dialogue.

There were certainly instances of team members who tried to encourage participation. For illustration, two examples are selected. The first is from a case manager and her approach to setting up the conditions for interactions in the family support team meetings. She said:

> I try to set up the meetings where everybody has a say and everybody's opinion is valued and everything. I think I try to do a team approach as to what is, I try to make sure I have opinions from everybody and that everybody has a chance to speak, and that we take everybody's opinions and look at those (CM Interview, Case E, Audio-Recorded; Lines 48-53).

This example shows a case manager who was trying to facilitate family support team members' participation. She explained how she does this: part of this is the way she arranges the meetings. Her way of managing team meetings appeared to be to communicate that individuals' perspectives were appreciated and respected. She mentioned using a team approach, which was a form of sharing power, and finally, she made sure that all members at the table had a chance to talk and be heard.

The second example of engaging is from the perspective of a placement provider, who was describing how foster youth in particular are encouraged to voice their opinions. She stated:

> What we do is sit down and discuss with the child, you know what I'm saying? So that meeting just keep everyone updated on what's going on with their child. If their child gonna be going back into the parent's home or is that child gonna be doing transitional living, which is APPLA, so it just depends. That's mostly what the meeting is for, and also gives the child to voice their opinion with their team, if they feel like they're not

> being treated right in the foster home, or you know, if the case manager is not meeting their needs as the guardian, so it's got a lot of things that work for the kids that have meetings. It gives the kids, like I said, a chance to voice how they feel about where they at (Placement Provider, Case M, Audio-Recorded, Lines 105-114).

This example depicts a foster parent who was open and welcoming of foster youth participation. She explained how the entire team engaged youth. Her understanding was that youth were specifically included in family support team meetings so that they could understand the case plan. She believed youth understood they were allowed to both express their opinions and to complain, and that the team meetings provided a mechanism for youth to express that opinion or complain to more than one person.

From these examples of engaging along a continuum of not engaging to engaging, it is recognized that there were more instances of positive experiences than negative. However, the negative experiences of not engaging team members, as perceived by participants, were unsettling; participants expressed feeling either cut off, rejected, or stifled from fully engaging. On the other hand, engaging team members required awareness of its importance and a deliberate intention to include and invite participation on the part of case managers and foster parents.

Property: Deliberation. The next relational process was deliberation. Deliberation, or the back and forth talking among team members in order to arrive

at decisions, varied on continuum from no deliberation to deliberation. Initiation of topics focused on the priorities of child welfare: safety, permanency and well-being, but also included requests for special privileges. The initiation was generally led by the case manager in family support team meetings and the judge in the courtroom, but youth were observed bringing up requests in some meetings and court hearings as well. Besides safety, permanency and well-being, incidental issues that were brought to the table for discussion included: spending habits; school, therapy or Chafee class attendance; pro-social skills development, i.e., communication skills, boundaries, and following rules. Special privileges were sought to: vacation out of state, participate in a beauty pageant, and attend a youth leadership conference.

A typical interaction style was a question and answer format, in which the adults asked questions, and youth or other team members answered. The asking of questions did not always lead to productive results. For instance, in one meeting, absent members of the team could have supplied answers; thus, problem solving was stalled. Complicating the situation, it was mentioned that the foster parents did not always keep the team informed of what was going on. The discussion was incomplete because of key members' lack of presence to supply needed information.

Generating solutions for problems or issues such as school attendance, placement stability, independent living skills acquisition, and spending free time,

produced similar suggestions. For these issues, creativity in generating solutions was low, and suggestions were few. For special requests, court orders were sought. For dealing with emotional problems, therapy was not uniformly endorsed or suggested (See Codebook, Inter-related process of decision-making – Relational processes – Deliberation p. 19).

Property: Agreeing. The next type of relational process was agreeing**.** Agreeing, or arriving at the same understanding, occurred along a continuum of not agreeing to agreeing. Disagreements had to do with state policies and court rulings. For instance, a case manager described how many Children's Division workers reconciled their disagreement with state policies:

> Sometimes you just have to go with the flow, even though there's lots of things that we would disagree with, a lot of the workers disagree with, sometimes you just have to bite the bullet and deal with it (Case manager interview, Case E, Audio-recorded, Line 147).

An example of a court ruling that a case manager disagreed with had to do with the judge's ruling on needing a psychiatric evaluation for one of the family members. She stated: 'I didn't care much about his ruling regarding the psychiatrist and wanting to review a report' (Case manager interview, Case K, Not Audio-recorded, Lines 104-105)

Agreements often had to do with arriving at a consensus about the overall plan for the youth. Each team meeting ended with members signing paperwork,

noting their agreement with the case plan. If members were in disagreement, it was supposed to be noted on the form. While minor disagreements did occur in the meetings, there were no meetings in which a formal dissent was documented.

Property: Collaborating. Collaborating, a relational process of working together, ranged from not collaborating to collaborating. While there were more positive than negative situations observed, there were certainly a few examples of not collaborating. Instances of a relative lack of collaboration were observed in Alice, Frank, and James's teams. For a less consequential example, a power struggle was observed about school attendance and compliance with Chafee services in Alice's team meeting (FST meeting notes, Case A, Lines 54-74). Of greater importance, Frank's family support team failed to pull together toward the common goal of adoption. One participant on his team said:

> It's unfortunate that there was no progress... It's a travesty that there is a boy who's 17 in care because people aren't doing what they are supposed to do. Setting up visits, follow up with aunt, communicate with aunt, follow up with CD [Children's Division] licensure, communicate with foster parents about meds, appointments. [There has been no movement since one month ago] (Extreme Recruiter Interview Notes, Case F, Not Audio-Recorded; Lines 72-76).

This example suggests that the team did not work with each other to ensure a visit would occur because there was a lack of shared vision toward the youth's dream

of adoption. In this example, the extreme recruiter appeared to be working without team member support or help; the efforts she made in isolation led nowhere.

However, there were a multitude of instances of collaboration. These were observed around the following situations: the discussion of available resources and how to maximize the chance of getting a scholarship in Evelyn's family meeting; the team's sharing ideas about how to get dental services and braces for Frank; the team's contributing jointly in a discussion about how free time would be spent in Gabby and Henry's family; and the team's rallying to generate energy for Tom, who had few ideas for life plans or goals.

Three participants shared their perspectives about working together in a collaborative fashion:

> Everyone has a job to do. Everyone has something to do. [The] Reunification specialist took on jobs. It's not always laid on the case manager; it depends who has the expertise (Deputy juvenile officer Interview, Case G & H, not recorded).

Another participant stated:

> I think he needed to hear that everyone on the team basically has the same concerns, and are expecting the same thing from him, that we're all on the same page… (Treatment Foster Care Placement Provider, Case T, Audio-Recorded; Lines 190-192).

Responsibility appeared to be shared from the point of view of the DJO for James. He stated,

> A lot of times the support team meetings, it's not really a standard meeting for, I don't know how to describe it, I feel like if you're in a good meeting and it's a really good collaboration it's very informal and you're just kind of, I mean you've got to have your goals obviously, but it's just a bunch of people sitting around talking about the family or trying to get them to a positive point in their life (Deputy juvenile officer Interview, Case J, Recorded, lines 109-114).

The collaborative relational dynamic observed in some meetings appeared to impact youth and teams in positive ways. For instance, Evelyn held hope for her academic future beyond high school. Gabby and Henry were able to return home with their mother following a carefully executed reunification process; and Tom made substantial progress in cooperating with his treatment plan, so that by the next family meeting, he was attending classes, doing vocational work, and was generally more goal-directed in his daily life.

In summary, relational processes were certainly an important component of the overall decision-making process. Most teams appeared to be making concerted efforts to engage foster youth and families in the decision-making process. As indicated by interview responses, most team members felt encouraged to speak up in the meetings, although this was not true at court. In looking at the

way discussions unfolded, a typical sequencing occurred in which adult team members asked questions of youth. Various issues were presented, along with the generation of solutions. Teams typically had answers and solutions to questions and challenges by the end of meetings with the exception of one team, when key members were absent. The degree to which teams came to agreements varied across teams. Finally, collaboration was observed to vary, with some teams failing to collaborate and others showing a high degree of collaboration.

The Inter-relatedness of Processes

As mentioned earlier in this chapter, the conceptual label "the inter-related processes of decision-making" was chosen to convey the complexity of arriving at decisions within family support teams. The origin of the prefix, "inter" is derived from Latin, meaning "between," "among," "in the midst of," "mutually," "reciprocally," "together," or "during." The term, "inter-related processes" conveys that each part, the agenda and its properties, and the affective, cognitive and relational processes and their properties, are processes that 'work together,' or cause damage to the decision-making process if they don't. The agendas provided a structure to the meetings, and helped the teams focus efforts toward goal-attainment. Three processes: affective, cognitive and relational, provided substance about how teams worked together to arrive at decisions. The affective processes were ones of expressing emotions and/or experiencing feelings,

cognitive were processes of thinking, and relational were processes of building or maintaining human relationships.

Particular agenda items and processes had a structure to process relationship to one another. For example, appraising safety was not only an agenda item, it was also a cognitive process of assessing needs. A couple of excerpts from interview transcripts illustrate this. The first is from the guardian ad litem of Alice who talked about how the team came together to review several aspects of care for her, one of which was an appraisal of safety:

> A being stable in her placement, I guess we were more for her looking at those college options as well, seeing if that placement remained in her best interest, if she was happy there, if she's safe there... see if there's any danger signs that we need to look at. (Guardian Ad Litem Interview, Case A, Audio-Recorded, Lines 47-55).

This excerpt shows how the evaluation of a young person's safety was part of a larger assessment that also included an examination of well-being, placement, and future planning. The evaluation consisted of looking at safety as one of these various components of Alice's life, potential needs that needed to be addressed.

The second excerpt is taken from Kaitlyn's family support team meeting. The team was discussing visitation with the mother.

> The guardian ad litem asked, "are you are okay visiting with mom on your own?" This question was directed to the two girls at the table. They both

> thought that was fine. The guardian ad litem asked the foster mom, "are you okay with it?" The deputy juvenile officer was asking if the older sibling who is out of state custody can supervise. At times the eldest daughter is in the company of the mother, and at times the eldest has the youngest by herself. The team decided that the eldest sibling should not be in charge of supervising the mom and youngest together. An agreement was reached that only if the two other siblings are involved can the youngest sibling go with oldest sibling (FSTM notes, Case K, Not Recorded, Lines 162-170).

This excerpt shows how the discussion of visitation included an appraisal of safety. Since the mother was not following court recommendations for submitting to drug testing, it was thought that her ability to keep her children safe was unpredictable. The evaluation consisted of examining the ages of the children and determining if they would be able to keep themselves safe even if the mother was impaired.

Connectedness was both an agenda item and a relational process of engaging and collaborating. For illustration purposes, the supportive and professional relationships that the judge and CASA had with Alice showed both the importance of addressing youth's needs for support and were manifestations of engaging and collaborating with team members.

Placement stability was both an agenda item and a cognitive process of assessing needs. This was observed in Alice's team as they spent a portion of time discussing the current placement of the twin, recounting past placement disruptions, determining if the current placement was suitable and evaluating if the current location met the youth's emotional needs.

Well-being, as an agenda item, and the affective process shared an overlapping feature: the recognition, concern for and expression of emotions. As an agenda item, emotional well-being was mentioned, along with what types of treatments, therapies, or medications were used for the youth in the study. As an affective process, emotions were expressed, felt, and reported.

Category Exemplar: Alice's Family Support Team

An exemplar is a representative case or model that is useful for illustrating the associated concepts of a category. Each exemplar is introduced with a description of participants, followed by a story, and finally an application of the category to the case. In this exemplar of the inter-related processes of decision-making, a brief description of the members of Alice's family support team is followed by a story about Alice and her team. Then the inter-related processes of decision-making category is applied to the case.

The team. Alice was an 18-year-old, African American female who had been in state custody since age 13. She was a Senior in High School who planned to attend college, and had a part-time job. In the past, she had been given

diagnoses of ADHD, Depression, Dysthymia, and Anxiety Disorder, and had taken psychotropic medications. Currently, she was on no medications and declined therapy. According to her CASA, she had lived in 11 placements including foster homes, relatives other than parents, and residential care prior to settling in her current placement, which was the transitional living program.

Her twin sister had also been in state custody since age 13. While the sister appeared almost identical in outward body type, physical characteristics, and voice tone/pitch, her demeanor and attitude was more outgoing and energetic than the sister in the study. She attended 12th grade at a local High School, planned to attend college, and had a part-time job. She was recently living in another state with a relative, had a placement disruption, and was moved back to St. Louis with an emergency placement provider. She had been in 12 placements while in foster care. As a recipient of services, she attended family support team meetings and court hearings and received similar services to those of the twin. In her role as a team member during the meeting, she offered advice, opinions and suggestions regarding her sister's placements, plans, and treatment issues.

The case manager was a 27-year-old Caucasian female, who had been in her position for 3.5 years. She was responsible for: notifying the team of the meetings, preparing an agenda and documenting services provided in the meetings, facilitating the discussion of agenda items, documenting status, progress, and recommendations for court reports, attending court hearings, and

providing testimony at court. Beyond these activities associated with family meetings and court, she was accountable for regularly assessing and visiting youth and families, ensuring safety in placement of the young person, and ensuring that needs for health and education were met. All of her job duties were documented and reported to her supervisor and the court.

The case manager's supervisor, an African American female, attended family support team meetings on an as-needed basis. Her job responsibilities included: oversight of multiple case managers' practices, ensuring that Children's Division policies and procedures were followed, creating assignments among the staff, and filling in when needed. For this family's situation, the care coordination was going to be passed from one case manager to another because of the case manager's planned departure; the supervisor anticipated that she would provide direction, supervision, and support to the new worker.

The transitional living supervisor was a 32-year-old Caucasian case manager and resource person who worked at the young person's transitional living placement. She attended the family support team meetings and court hearings, and provided information to the team much as a foster parent would. For the 11 months that she had been in her role, she had had tri-weekly contact with the youth, and all young people with whom she worked in her caseload. She built independent living plans for the young people who live at the placement. She ensured that youth were building skills toward self-sufficiency and provided

informal counseling as youth tried out the tasks associated with independent living.

The Guardian ad Litem was a 55-year-old, Caucasian female who had been working with this case for over 3 years. The guardian ad litem was a representative of the court, who had access to all the records and reports associated with the young person's case. Her job was to complete an investigation, review records, conduct interviews, and learn the young person's wishes. Besides attending family support team meetings, her duty was to communicate the wishes of the young person to the court, make recommendations to the court, and serve as the guardian ad litem advocate in the court system.

The Court Appointed Special Advocate (CASA) was a 68-year-old, Caucasian female who had been in her role for five years. She was a specially trained volunteer of the court who worked closely with the Guardian ad Litem to make sure the youth's interests were sufficiently represented. Coincidentally, the CASA also held an elected government position. In addition to spending time with the youth to understand the person's situation, the CASA attended family support team meetings and court hearings.

The CASA supervisor was an African American female who had been involved with the case for approximately five years. She directed, guided, trained, and supported the work of a team of CASA volunteers, in addition to carrying her own cases. She had become an integral part of this team because she

was one of few team members who had been with the case since the beginning. She attended family support team meetings and court hearings when her schedule permitted, and had periodic communication with the Guardian ad Litem, the court, and the CASA volunteer.

The Children's Division Oversight Specialist was an African American female. As a third party reviewer, she only attended as an outside observer of permanency review meetings. She was responsible for making sure the permanency plan was in place, discussed, reviewed and implemented by the caseworker. Because of her knowledge of policies and procedures, she was both a quality analyst and resource person for the team. She submitted a report of her observations and her case review process to the agency supervisor, the circuit manager and the regional manager.

The Chafee worker was a 33-year-old, Caucasian female. As a case manager for older youth, she attended family support team meetings and court hearings, and also met with youth individually to assist with successfully aging out of foster care. She provided coaching on life skills acquisition, education and career planning, and budgeting, and she made sure that youth would have the resources they needed to move toward self-sufficiency.

Typically, the deputy juvenile officer (DJO), a representative of the court, attended the court hearings and family support team meetings. The DJO was absent in this case. Her duties included: making an investigation before a charge

of child abuse or neglect was substantiated; visiting with youth and families; making sure families have the resources they need when the goal is reunification; writing reports; and then following the family for the duration of the case. Once the child's plan changed in terms of safety and permanency, the role changed to that of a case manager, in which she was tracking service implementation and outcomes, making reports and attending meetings.

There were times when birth parents were part of the family support team meetings, but in this case, the Children's Division had been relieved of reasonable efforts to reunify the family. The parental rights had been terminated, and the parents neither attend court nor the family support team meetings. The team routinely asked the young person if she had contact with her parents, and the answer was yes. There had been times when the mother had manipulated the young person into loaning her money and the court had created orders of protection for the young person. The team continued to ask the young person about the parents and what kinds of interactions had occurred.

The story. Alice and her twin sister came into the foster care system at the age of 13 years because of substantiated abuse by the mother, according to her court appointed special advocate. Initially, Alice and her sister were very angry about their situation, and had much difficulty adjusting to foster care. Both girls were diagnosed with mental disorders. Alice was given diagnostic labels of dysthymia, a low level of depression and anxiety. The CASA said because of the

girl's difficulties with getting along with foster parents, they were moved numerous times since being in foster care.

There were many reasons why the placements failed. In one circumstance, an unrealistic foster parent banished several children to one small bedroom; in another, a foster parent enforced very strict rules about furnishings and arrangement of objects in the home, and was arranging strange eating routines, like cooking all the food for the week on one day and youth could just help themselves to whatever was in the refrigerator when hungry. Another foster parent would not drive to pick up the youth when the youth was out late getting her hair done in a bad part of town. Yet another foster parent refused to pick the youth up from the airport after the youth had been traveling out of state. During the interview the CASA stated:

> …one has been in 11 homes, one has been in 12 in 4 years, and that to me is utterly ridiculous. If the kid doesn't clean up her room, and the foster mother doesn't like it, she tells the kid you must clean up your room, you must clean up your room, and the kid doesn't want to live there anymore, so she doesn't clean up her room. Then she discovers the foster mother is irritated, she quits talking to the foster mother for a month. So with the foster mother getting absolutely no response from the kid she says, 'I don't want you in my house anymore.' The kid goes, 'okay.' They move her…They fuss and fume and carry on and they want to be someplace

> else, so okay, as soon as there's an opening, they move them. If there's not they place them in a respite home for a week or two until they can find another home, and then they move them (CASA Interview, Case A, Audio-recorded, Lines 294-300).

Another challenge for these particular sisters is that they have developed a bad reputation for their behaviors and foster parents often will refuse to take them upon hearing their name:

> So the foster parents and those providing respite in that neck of the woods, they hear the name, and no matter which girl they had, they think that's the one that {did such and such behavior}, and because of their behavior, they have a very difficult time finding anyone who will take them, but you've got to remember, they're seeing two of them, not just one, and sometimes these foster parents don't realize they're talking about the wrong kid. So they go ahead and they move the kids (CASA Interview, Case A, Audio-recorded, Lines 308-310).

This example illustrates that the twins are stigmatized because of their behavior problems and it makes finding placement quite difficult. Furthermore, the CASA expressed frustration that problem-solving and communication does not happen prior to placement changes:

> …But what happens instead of let's see if it will work, or God help us, let's sit down with the foster parents and the child and let's talk. What's

> going on here, what's the problem, why do you think you need to move, why do you think you need to get this kid out of your home? I haven't seen that happen. I think that should be crucial. I think before they move a kid, the foster parent calls up and says I can't handle this kid or the kid calls in and says, I can't stand living here a moment longer, which of course it's always a moment longer, there should be a sit down with whoever is available as soon as possible and say what's the problem here (CASA Interview, Case A, Audio-recorded, Lines 324-330). Another concern that the CASA brought up was the dynamic that had become a pattern in these sisters' family support team meetings. She said that the youth seemed to be "driving the train." She voiced concern that the case manager was not an effective team leader, and was driven by an agenda that entailed checking items off a list, but not necessarily effective problem-solving.

In the family support team meeting that was observed, the team discussed items on the agenda, but as the CASA had stated, when problems came up, there did not seem to be an effort to resolve them. Two specific issues were the twin's new placement and Alice wanting to get her hair done at her placement.

During the discussion of the twin's placement, the CASA brought up some valid points of concern. The meeting notes showed this discussion occurred quickly, but not effectively, in addressing the issue of concern. First, the CASA asked about the placement alternatives for the twin who had just moved back to

St. Louis. The case manager said she thought the current placement was okay. The CASA then said there are eight extra people in that home. The refrigerator is locked and she is concerned about crowding. She suggested a Transitional living program, like her sister lived in, as an option. She brought up the fact that this particular youth had a history of anger and needed space. Again the case manager defended the home and said she does not want the girl to have to move schools again. Then the supervisor said this home was an emergency placement and licensing could check to see if it could become a longer term placement. Alice stated, she thought her sister should be moved before she blew up. An exploration of pros and cons or exploring alternatives, was not conducted. The team seemed to be fairly satisfied to leave the twin where she was currently placed, and made no further plans. Then, the meeting attention shifted to Alice and her case review (My notes, Case A, Jan 13, 2015).

The second issue was a request made by Alice to get her hair done at her home. The case manager asked her what the name and contact information of the hairdresser was. Alice said she didn't know, but wanted this hairdresser to be able to be added to her visitor list. Instead of asking what else could be done, where the youth could go to get her hair done, or who else might be able to provide the hair style services, the youth's request was dismissed.

These instances of life, including her reason for being in care, numerous placement changes, dynamics of the meetings, and characteristics of Alice's

temperament on the days she was observed, give a limited composite of her life story. It is not the whole of what is known about Alice, but it provides a glimpse into certain aspects of her being in foster care and the meetings that she participates in. Alice's story is chosen as an exemplar for the inter-related processes of decision-making for a couple reasons. First, the case manager organizing and executing a family support team meeting with the use of a pre-planned agenda was readily apparent. Of high concern and priority was placement stability. And second, multiple points of view were collected from observations and participant interviews to understand how affective, cognitive and relational processes worked together, and how individuals perceived the efficacy of the meetings.

Application of the Category Inter-related Processes of Decision-making to Alice's Team

The next section of the chapter applies the category, "inter-related processes of decision-making" to Alice's team. The subcategories: agenda and action-related processes are distinguished. Greater emphasis is placed on well-being as a property of the subcategory agenda. This is followed by a description of the subcategories, affective and cognitive processes.

Subcategory: Agenda. An agenda structured the family support team meeting and court hearing. The documentation for the meeting included attendance, the list of items to be discussed and signed agreements of

confidentiality. A template was used to guide the discussion. Paper copies of an agenda were available in the meeting that were individualized to Alice and her sister. As previously discussed, the CASA reported that completing the checklist appeared to have a higher priority than dealing with substantive issues.

Property: Placement stability. Placement stability was discussed as part of permanency planning in the family support team meeting. Specifically, the team focused on assessing the appropriateness of each youth's location of residence, while trying to minimize unnecessary or premature placement changes or disruptions. As the CASA worker noted on pp. 53-54, while Alice's placement was currently stable, she had gone through numerous placement changes up to this point in time.

Property: Well-being. During Alice's family support team meeting, a few issues were opened for discussion: recent wisdom teeth removal, her communication patterns, her spending habits, her diagnosis, preferences for therapy, and school attendance. With the exception of wisdom teeth removal, the team had concerns that Alice was experiencing a lower degree of emotional well-being than what would be considered ideal. Members of the team confronted Alice about her problems, and suggested therapy for her, which she declined. Despite having difficulties, Alice stated that she did not want therapy because therapists change too often and she views her TLP worker as 'sort of like a therapist' (FST Meeting Notes, Alice's Team, Lines 71-72). During the follow-

up interviews, the transitional care program case manager commented that Alice was upset during the meeting:

> My concern was when we were talking about areas of concern for Alice and it went downhill from there and it didn't end on a good note. Alice was very upset during the meeting. And I later processed with her, on the way home after the meeting. And Alice felt like everyone's always on her sister's side. And everyone always says good things about her sister, but then no one says any good things about her. Which I don't feel was necessarily true, but that was her interpretation of it (TLP Worker Interview, Alice's Team, Audio-Recorded; Lines 71-77).

The case manager also noticed that Alice was upset:

> Alice really shut down towards the end, which it's very consistent with how her moods are. She's done that in the past before, so that was the only downside is that she really shut down at the end, instead of continuing the conversation (Case manager Interview, Alice's Team, Audio-Recorded; Lines 55-57).

At the end of the family support team meeting, concerns for Alice's well-being were unresolved. Alice was warned that she needed to improve her spending and start participating more fully in the Chafee program; it was left open for Alice to decline therapy. The CASA supervisor's stern warning about school attendance was met with resistance. Follow-up interviews confirmed that the

concerns for Alice were not resolved, and that she continued to have difficulties of an emotional nature.

Subcategory: Affective processes. Alice in particular demonstrated with her behaviors that she was quite unhappy. This was most evident when she placed her earphones into her ears during the meeting, and refused to talk after getting upset. The exact nature of her feelings was provided in her interview: "I felt irritated because they let my sister talk, but they never really gave me a chance to fully speak about what I wanted to say" (Youth Interview, Alice, Audio-Recorded, Lines 104-105). She shared in the interview that she was not only "irritated", but "frustrated," and described the situation as "unfair." Her belief was that she could not do anything about the unfairness, and she acknowledged that she was jealous of her sister.

While there were a few examples of affective processes that reflected Alice's emotional challenges, other team members demonstrated emotional expressions as well. For instance, the CASA supervisor raised her voice and appeared visibly frustrated as they discussed schooling and Chafee classes; and the case manager appeared irritated at the end of the meeting when Alice asked about her hair maintenance. Positive emotional expressions were observed as well: for instance, members were smiling and/or laughing at certain points during the meeting and court hearing. Follow-up interviews revealed that team members experienced a range of feelings. Similar to the outward expression of emotion,

the internal feelings varied. Feelings ranged from non-disclosed, irritation, frustration, and anxiety to joy.

Subcategory: Cognitive processes. Two cognitive processes, assessing needs and exploring options, are presented with illustrations from Alice's family support team.

Property: Assessing needs. As discussed previously, teams did not uniformly mandate psychological therapy. Alice appeared to have difficulty with emotions and was in need of support. A few conversations about how her needs were identified and subsequently addressed were observed.

The first time Alice's difficulties were mentioned was at court; the case manager from the TLP voiced concern for Alice's emotional health, but she had finished therapy and was not interested in going back (Court Hearing Notes, Alice's Team, Not Recorded).

This same issue was brought up at the FST meeting. When asked what her diagnosis is, the team reported dysthymia and anxiety disorder, but the doctor visit notes documented that she doesn't require therapy or medication management, and the team did not mandate that she attend. The Children's Division worker asked Alice to speak of her view of therapy. As mentioned previously in the section on well-being, Alice stated she didn't want therapy because therapists change too frequently. The team told her that help was available if she changed her mind about this.

Property: Exploring choices and options. Assessing needs and exploring choices and options were related but not mutually exclusive processes. Discussion of options involved talking about future plans in the context of resources. The guardian ad litem recognized the importance of examining what resources were available when she said,

> In addition, we would also touch base on the bigger picture for her, and because of her age and maturity we were of course talking about getting the high school diploma, and looking forward to college and what we could all do to make, help her have as many options as she could and to guide her a little bit (Guardian Ad Litem Interview, Alice's Team, Audio-Recorded, Lines 27-31).

This example illustrates the investment the team member had in exploring choices and options for this youth who would age out of foster care. Other team members appeared similarly invested in helping this youth explore her choices for the future. For instance, the CASA worked mentioned she was interested in helping the youth find the right college that would support her interests.

Subcategory: Relational processes. As described previously, Alice was participating in her family support team meeting until a particular moment in the meeting when she stopped listening and stopped talking. Alice indicated that she felt unsupported or discouraged from full participation in her family support team meeting. She stated "…they never really gave me a chance to fully speak about

what I wanted to say" (Case A, Youth Interview, Audio-Recorded; Lines 104-105). From her point of view, she was cut off. In response, she placed her earphones in her ears, and did not engage with the team, and refused to take an active part in deliberations until the very end of the meeting when she made a final request.

The next section of this chapter introduces the category power. The subcategories, qualities and responses are clarified; and the dimensions of each are described. Next, Gabby and Henry's family support team's story of re-unification is presented. Then, the category of power is applied to this family's team.

Category: Power

Power was recognized as an important relational ability that provided advantages to certain team members. Those who held higher positions of power, or ability to influence, and to access and use resources, possessed particular qualities. These qualities were expertise and ability to establish rapport and connection. These, along with oversight mechanisms and authority, constituted the qualities of power. The ways in which team members reacted to the power differential that existed constituted the responses to power: compromising, avoidance and independent action, empowerment and cooperation.

Subcategory: Qualities. The first subcategory of power was named qualities. Qualities were the attributes of power.

Property: Expertise. Expertise was distinguished as personally accessible wisdom or experience. Expertise ranged on a continuum of low too high. Those with low expertise had less accumulated knowledge and skill, and less experience in their role. Expertise was a type of understanding that particular team members exemplified in their responses about what their role and responsibilities were. A couple of team members who seemed to have more expertise were the CASA for Alice, and the deputy juvenile officer for Gabby and Henry. The CASA was able to draw on experiences of being a mother to respond to foster youth. During her interview, the CASA gave numerous examples of how she was able to assist youth and families during crises. She lamented that case managers seemed limited in their understandings of how to respond adequately to the situations that came up with foster children. She stated:

> This isn't a 9 to 5:00 job, and that's what I see are the biggest issues in dealing with foster children, is that there's no one there that's going to say you are so important and your well-being is so important that I will drop whatever it is I'm doing to come and hold your hand (CASA, Case A, recorded, Lines 606-608).

Because of her experience of being a mother of grown children, the CASA was able to easily identify a challenge in the service system. She noticed that the case managers lacked an attitude of flexibility and child-centeredness. It seemed this was complicated by having a certain number of mandated hours that they

were required to be available to foster children. Her expertise as a mother provided her with a differing perspective of what is required to care for the needs of children. She articulated that case managers may not have that same perspective about what is necessary to provide effective care.

Similar to the CASA, the deputy juvenile officer for Gabby and Henry exemplified a higher level of expertise that was not just from having longevity with the case. He eloquently described the plight of the family, and especially the disadvantage of being in poverty, as being a key reason why the family remained in the Child Welfare system for many years. He said:

> When you're poor it's very difficult… It would have been cheaper for the state to pay her rent than to keep the kids in state custody all those years (Deputy juvenile officer, Case G & H, not recorded, Lines 77-79).

This deputy juvenile officer had been helping the family for about seven years. He singled out the obstacle of poverty. Poverty impeded the family's ability to prove that they could manage without state intervention. It was perhaps because of his years of experience with not just this family, but other families over the course of his career, that he was able to make such an appraisal.

One particular team member who appeared to lack this degree of wisdom was Alice's case manager. She described her role as a list of tasks, and offered no deeper understandings of what the role entailed:

> First, I meet with the child monthly, at least monthly in their placement. I help them find a placement, I meet with the families when the plan is re-unification, and usually otherwise, unless they are relieved of reasonable efforts. I meet with them monthly as well, I schedule and hold the support team meetings to discuss the child and the family's plan for moving forward with whatever their permanency option is. I go to court, I write the court reports, those are the big things, to name a few (CM for Youth A, Lines 14-19).

This particular case manager was efficient and goal-oriented. She was knowledgeable about what was required to take care of an assigned family, and easily recited what was expected in her role. However, she appeared to lack in-depth understandings of youth and families. Her mannerisms at court, in the meetings, and interviews appeared superficial and detached; these mannerisms appeared as a sharp contrast to the CASA, who appeared more engaged, provided rich explanations, and seemed to have much deeper understandings of families.

Another component of expertise was length of time in role, and this varied from a few months to decades. Team members with relatively little experience were the foster parent for James, at just 4 months of experience in her role, the case manager for Gabby and Henry with 8 months in her position, and the extreme recruiter for Frank who had 10 months' experience (Demographic forms, Foster parent, Case J; Case manager, Cases G & H; Extreme Recruiter, Case F).

Team members with much time in respective roles were the foster parents for Frank who had been career level foster parents for over 20 years, the DJO for James, who'd been in his role for 15 years, the grandmother for Tom and Mary who'd been serving in her role for approximately 17 years, and the case manager for Evelyn whose time in role was 26 years.

Property: Ability to establish rapport and connection. A second property of power was the ability to establish rapport and connection, or proclivity, talent and skill in initiating and cultivating human relationships. The dimensions of this ability were low too high. There were some individuals on the family support teams who displayed low level of ability to establish rapport and connection. These individuals were the CD [Children's Division] oversight specialist for Alice, who appeared relatively uninvolved, the mother of Evelyn, who seemed cautious and reserved, the permanency specialist and Chafee worker for James, both of who appeared somewhat removed from the youth and teams, and two of the foster youth: James and Tom. Both James and Tom were emotionally guarded, and did not seem comfortable to reach out to establish connections with others. Certain behaviors of these team members and youth that showed this low level of ability to establish rapport were few words spoken spontaneously to anyone on the team during meetings or court hearings, and not displaying friendliness or openness with body language.

There were a few family support team members who seemed to have greater ability to establish rapport and connection than others; they were the CASA and Transitional Placement Provider for Alice, and the DJO for Gabby and Henry. (Note: these were the same team members who showed high level of expertise). The behaviors these team members showed were warmth and genuineness in verbal interactions, open body language and good eye contact, and statements made during follow-up interviews that conveyed their interest in building relationships with youth and families. For examples of the behaviors that conveyed these attributes, the CASA for Alice is presented. She was very warm and engaging with Alice in the waiting room at Court, asked her about Christmas wishes and plans for Christmas vacation. She appeared genuinely interested in Alice as she sat side by side with her (Court hearing notes, Case A, Lines 52-53). In the family support team meeting, she participated by phone. There was a particular point in the meeting when Alice was becoming defensive regarding her spending habits. The CASA spoke to her in a soothing tone of voice, defused the situation and focused the interaction on Alice's well-being (FST meeting notes, Case A, Lines 64-65). In the follow-up interview the CASA spoke about how the foster youth have come to trust her:

> …we're the only ones who have been there all the way through. People come, people go, and so maybe that's part of why they call me, they know me (CASA interview, Case A, Audio-recorded, Lines 136-139).

This example demonstrates a high degree of investment and gives an indication of not only the CASA's ability to establish a trusting relationship, but also the commitment to stay involved over time. This CASA provided relationship to these twins over many years, and they came to depend on her.

Property: Oversight mechanisms. A third property of qualities of power was oversight mechanisms, or the quality assurance practices that the organization has in place for accountability and responsible delivery of services. Oversight mechanisms varied along a continuum of lacking to excessive. A lack of oversight was noted in Kaitlyn's interview, when she stated matter-of-factly that one's responsibilities as a foster youth are based on the foster parent's actions:

> …depends on who your foster parent is. Sometimes you don't have a good foster parent, so you have to take care of yourself. I was taking care of myself…(Foster youth interview, Case K, not recorded, Lines 10-12).

This statement epitomizes a lack of oversight on the part of the foster care system. Kaitlyn felt she could not rely on her assigned foster parents to provide nurturance to her, nor could she count on the foster care system to catch this problem. Her solution was to parent herself.

As part of a standardized process, Permanency Planning Review Team (PPRT) meetings occur every 6 months. Within the structure of these meetings, an oversight specialist is present. This person is employed to: observe as a third

party, document information about the meeting, analyze whether the team focuses on goals and discusses permanency, and submit a report. Besides this specialist role, which is customary and not considered excessive, there were others on the team who stated their responsibility was to supervise or to ensure that other members of the team were doing their jobs. Table 4.6 provides quotes from the five team members who stated that at least part of their duty was to oversee or supervise another adult.

Table 4.6: Oversight by Role

Role	Quote
CD oversight specialist	“To ensure that case workers are discussing permanency plans and identifying any tasks that are needed, developing some goals to ensure that the team is working towards a permanency plan for each child” (CD oversight specialist interview, Case A, Audio-recorded, Lines 14-16).
Case Manager	"I’m a foster care case manager. I provide services to parents, supervise …make phone calls to make sure appointments are being met" (Case manager Interview, Case M and T, Audio-recorded, Lines 3-6).
Case Manager Supervisor	"Overseeing all the case managers, their case management and their practice, ensuring that all of their policies and procedures are followed" (Case manager supervisor interview, Case E, Audio-recorded, Lines 27-29).
DJO (Deputy Juvenile officer)	‘I ensure that CD [Children’s Division] is following court orders, get reports, ensure the case is smooth and to address any problems if there are any’ (Deputy juvenile officer Interview, Case F, not recorded, Lines 10-11). (Note this example shows that court personnel with case manager responsibilities are monitoring Children’s Division case managers and duplicating efforts).
DJO (Deputy Juvenile officer)	"... I represent the court and ensure that all of the court orders are being followed, and you know attend court hearings as necessary. A big thing is just assessing and continually reassessing the family or the youth needing services and ensuring that they’re getting those services" (Deputy juvenile officer Interview, Case J, Audio-recorded, Lines 14-17).

It appears that there were several checks and balances established within the Child Welfare and court systems to ensure that children, youth and families were well-served. Even though team members stated that part of their role was to check and make sure some other adult was doing their job, this did not mean that

youth were always 100% protected or cared for, as Kaitlyn's statement (page 64) reveals.

Property: Authority. Within the family support team meetings and court hearings, authority was manifested as leadership and law, and was on a continuum of low too high. Those who were in leadership positions, such as the case manager, DJO, and judge manifested the authority to make decisions, carry out actions and direct others. Observations of the meetings showed that the case managers assumed leadership on family support team meetings, while the judge led court hearings. Most interview responses confirmed that case managers led meetings, except for a couple of cases in which participants identified the deputy juvenile officer as leader.

Authority was delegated along a hierarchy. The case manager supervisor for Evelyn's team, for example, discussed oversight mechanisms by which she was responsible for case manager practices, but at the same time, she gave her case managers latitude to make every day decisions in regards to youth activities. Similarly, authority was delegated to James's foster parent for taking James to appointments and signing consents for care.

There were two instances in which individuals used their authority to communicate the importance of youth following rules. In one, the Guardian Ad Litem was praising the young person for her recent progress, but then said, 'I just have to say this. You cannot get a dirty drug screen' (FST Meeting Notes, Cases

M and T, Not Audio-Recorded; Lines 61-62). This authoritative approach seemed to be a sincere effort on the part of the guardian ad litem to instill responsible conduct in Mary who had been in trouble with drugs in the past, and had just completed her treatment program. Her goal was to return to live with her grandmother, but the fear was, Mary would relapse into drug use when she went back with her grandmother.

In another instance, the case manager said:

> Tom was upset, because he didn't have extended visitation with grandma, but that was as a result of his choices, not engaging and not earning those extra visitations, because he was given the responsibility to be able to do that screen and not being able to visit with grandma because of not following rules, or engaging (Case Manager Interview, Cases M and T, Lines 85-87).

By withholding privileges from Tom, the entire team was communicating the importance of youth following rules in order to earn privileges. The authority of the team to follow through with consequences meant that Tom could not go stay with his grandma for a weekend visit that he had requested. The team used its authority as leverage to motivate Tom toward cooperative behavior.

In terms of organizational authority, the court had higher authority than the Children's Division, such that any decisions or recommendations made by the teams in family support team meetings could be changed by judge or court order.

A couple of instances in which this happened were: 1) when James asked to go on a vacation; the team was supportive, but ultimately the agency and the court said no; and 2) when Kaitlyn's team was against unsupervised visits with the mother, but the judge ultimately said the unsupervised visits were approved.

Subcategory: Responses. The ways that team members responded to the noticeable power differential between individuals on the team were by avoidance and independent action, compromising, empowerment and cooperation. Each of these response styles is discussed in the following text.

Property: Avoidance and independent action. Another way that team members responded to the power differential was avoidance and independent action, or a combination of not acting, plus doing other behaviors independent of the team. The dimensions were low to high degree of avoidance and independent action. An example of low degree of avoidance and independent action was the case manager for James picking him up for a meeting at the girlfriend's home and bringing him back to the foster home. The purpose of the meeting at the foster home was to make a home visit, introduce the Chafee worker, determine how the youth was doing in the placement, and assess for any unmet needs. At the foster home, the foster mother was initially not present. The case manager independently conducted an informal assessment of living space and how things were going, and held meeting with the Chafee worker, youth, and researcher.

The foster mother arrived home during the middle of the home visit, but was not included in the meeting at the table when the Chafee worker was discussing what she could do for James, and later, was not apprised of why the Chafee services were offered, nor the choices that were involved with such services. The foster parent was not present when the bedroom was being evaluated, and only joined in a brief interaction after the business of the visit was completed.

The case manager appeared to be avoiding interaction with the foster parent, and doing his work without including her participation. The reason this was considered a low level of avoidance was because the case manager did not seem to be purposely excluding or working at odds against the foster parent. Rather, it appeared that he had an agenda that did not include her participation.

An example of a high degree of avoidance and independent action was when Frank and his foster parents did not attend their family support team meeting, nor call to tell anyone on the team that there were reasons why they couldn't make it. The foster parents and youth had valid reasons for not coming, it was discovered later. But neither they nor the team talked to each other prior to the meeting time to cancel, reschedule, or at least discuss what was going on. Meanwhile, there were 7 people in attendance at the meeting for a youth and foster parents that

were not present (FST meeting notes, Case F, Lines 19-20).

Property: Compromising. One way that team members responded to the power differential was with compromising. Not all team members were willing to compromise, and therefore a continuum existed. The continuum of compromising was not compromising to compromising. Two examples are provided to illustrate instances in which an issue was presented, team members sought a solution, and behaviors of team members were either to not 'give in' to a particular request, or to try to arrange an agreement through winning over one team member and persuasion.

An example of not compromising occurred in the discussion about James's therapy schedule. When the case manager asked about it, James said he has had one visit, and cancelled one visit due to his work schedule. The case manager told him there is a court order to attend therapy, but there is not a court order to work. He explained that in the beginning, you need to attend therapy according to the therapist recommendation. James asserted he'd like to go every two weeks. The deputy juvenile officer chimed in, 'You have to do what the professionals recommend' (FST Meeting notes, not recorded, Lines 77-82). In this particular instance, there would be no negotiation or compromise for James's treatment. Both the case manager and the deputy juvenile officer had a strict response to him and were not willing to be flexible with how the court orders would be carried out.

An example of compromising was the style exhibited by Kaitlyn's case manager. She did not agree with their arguments about the mother supervising her children without a third party present. She felt the mother would not harm the children, even though she was still at risk for substance abuse, and that at least the older girls could easily protect themselves from any potentially unsettling situations. She described how she usually approached points of disagreement with other members of the team by trying to either negotiate, or get one team member to side with her, in order to create momentum for a harmonious outcome:

> [The] DJO [deputy juvenile officer] and guardian ad litem [were] a little over- exaggerating needed supervision. [They] felt it was a huge risk. I always go with if one or the other [is in agreement with me]. If I have one on my side, I'll push. I try to keep the peace. [majority rules] (Case Manager interview, Kaitlyn's Team, not recorded, Lines 71-74).

In this example, it appeared that the case manager was carefully weighing her options about how to proceed. In an earlier part of her interview, she described her role as a negotiator. Perhaps this attitude allowed her to view situations as opportunities for "give and take" as deliberations unfolded.

Property: Empowerment – quantitative results. The third property of responses to power was empowerment. In addition to the qualitative data sources, several quantitative instruments were selected to measure empowerment were the Modified Family Empowerment Scale (FES) (FES), the Youth

Efficacy/Empowerment Scale - Mental Health (YES) and the Youth Participation in Planning Scale (YPP). Minor changes to the original Family Empowerment Scale were created with Friesen, an original author of the instrument, in January, 2015, so that it could be used with all adult research participants, instead of parents only. Friesen helped to review the language of the tool and together, she and I developed a revised instrument that removed the words, "my child" for example, and replaced the language to read, "this foster youth" (Personal Communication, Friesen, January 7, 2015). The instrument has 3 subscales: family, service system, and community/political.

The Youth Efficacy/Empowerment Scale - Mental Health (YES) is an adaptation of the Family Empowerment Scale, developed to assess youths' self-efficacy in three domains: self, system and community advocacy. The Youth Participation in Planning (YPP) Scale also measures youths' ratings of self-efficacy and empowerment. Areas measured with the YPP tool included: self-management of emotional or mental health difficulties, perceived ability to manage their own services, and perceived willingness and interest in advocating for other youth and advocating for service improvement at the system level.

Twenty five adults filled out the Modified Empowerment Scale. The instrument, comprised of 34 items, provided a scale for each item, ranging from 1-5, with each value representing a self-report of how applicable the item is to the person filling it out; 1=not true at all, 2=mostly not true, 3=somewhat true,

4=mostly true, and 5= very true. Scoring procedures are described in Chapter Three. The mean score was 12.3; the median score was 12.3. The lowest score was a 7 and the highest score was a 15.3. The range was 8.3 and the standard deviation was 1.8. The adults with the lowest empowerment scores were the CD oversight specialist on Alice's team, the DJO on Frank's team, the foster parent on James's team, and the permanency specialist on James's team. The adults with the highest empowerment scores were the adoption specialist on Frank's team, mother on Gabby and Henry's team, the DJO on James's team, and the treatment foster parent of Tom.

General assumptions for application of inferential statistics to the empowerment scores were checked as much as possible. First, inferential statistics are meant to be performed for adequate sample sizes. The sample size was small, which is a severe limitation. Second, the empowerment scores were checked for normalcy of data distribution. It was found that the adult scores were normally distributed, but the youth scores were not.

Descriptive information about the sample is provided in Table 4.7. This is followed by histograms of the Modified Family Empowerment Scale (FES) scores for adults and Youth Efficacy/Empowerment Scale - Mental Health (YES) scores, then scatterplots of empowerment to age. Correlation estimates were computed for empowerment scores compared to ethnicity, gender, and adult roles. Since the sample size is so small, it is uncertain if a correlation estimate provides

meaningful information. Interpretation of the results are provided with this in mind.

Table 4.7: Overview of Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age	32	15	74	36.7	17.6
Adult Empowerment (FES) scores	25	7	15	12.4	1.9
Youth Efficacy/Empowerment Scale - Mental Health (YES) scores	9	66	100	78.8	11.5
Youth Participation in Planning Scale (YPP) scores	9	54	75	63.0	8.8
Gender	34 total 21 adult females, 4 adult males. 5 youth females, 4 youth females				
Ethnicity	34 total 8 African American adults 17 Caucasian adults 5 African American 4 Caucasian youth				

Role	34 9 youth 7 caregivers 18 other adult professionals				

Thirty-four participants completed surveys. The mean age of participants was 36.7 years. The range was 15 to 74 years. For the 25 adult participants who filled out Family Empowerment Scales, the mean score was 12.4 (compared to a maximum of 15). Nine youth filled out the Youth Efficacy/Empowerment Scale - Mental Health and Youth Participation in Planning Scale; means were 78.8 and 63.0 respectively (compared to a maximum of 100 and 75, respectively).

Of the adults who filled out surveys, 21 were female and four male. Of the youth, five were female and four were male. Eight African American adults and 17 Caucasian adults filled out Family Empowerment Scales. Five African American and four Caucasian youth filled out the YES and YPP. Three roles were distinguished for analysis: youth, caregiver and other adult professional. Nine youth, seven caregivers and 18 other adult professionals filled out the surveys.

Figure 4.1: Adults Empowerment Scores Histogram

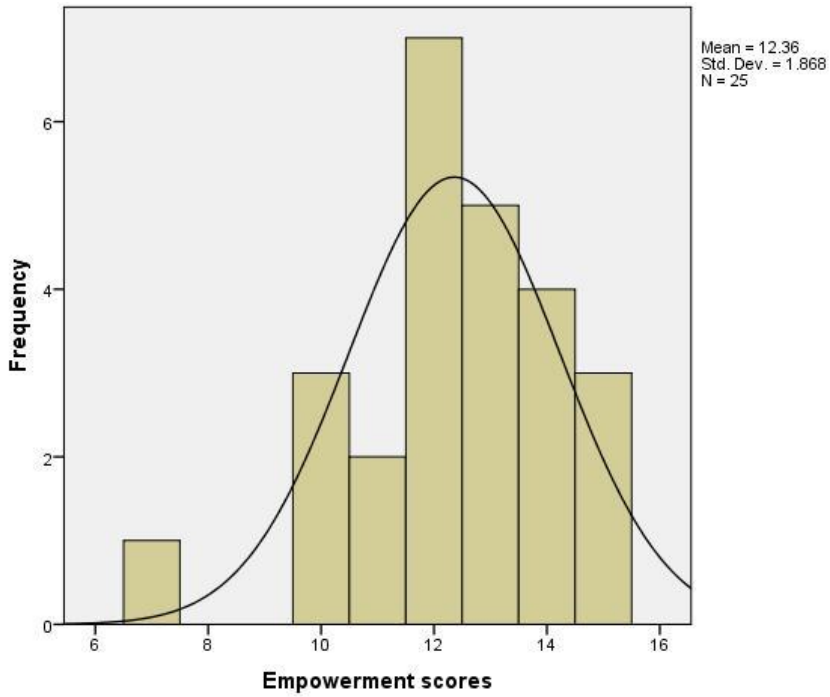
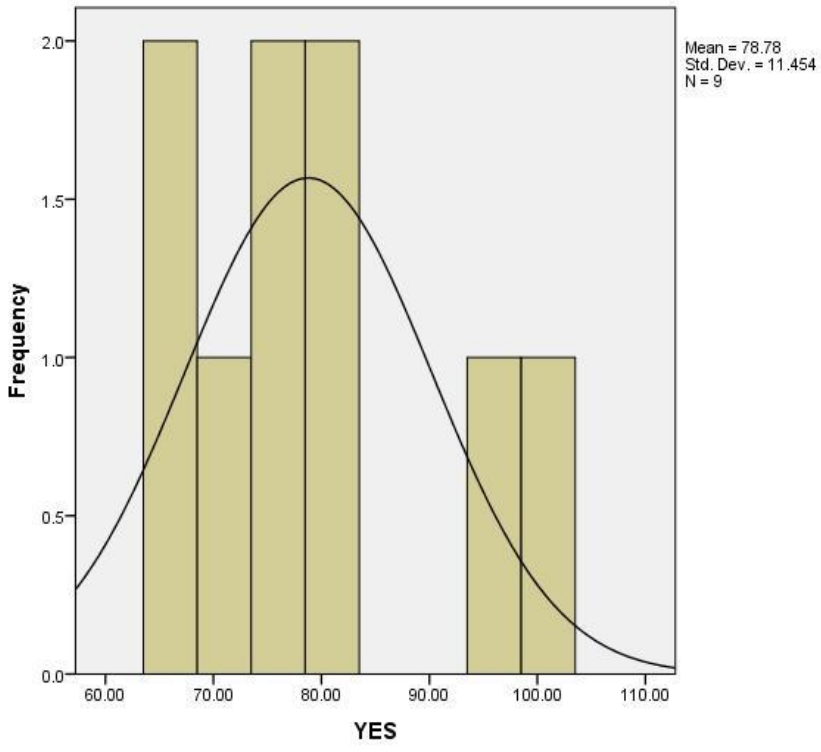


Figure 4.2: Youth Efficacy/Empowerment Scale - Mental Health Scores Histogram



Scatter plots for empowerment to age showed a fairly random distribution of dots, implying that the two variables are not particularly related.:

Figure 4.3: FES (Empowerment) to Age-Adults Scatterplot

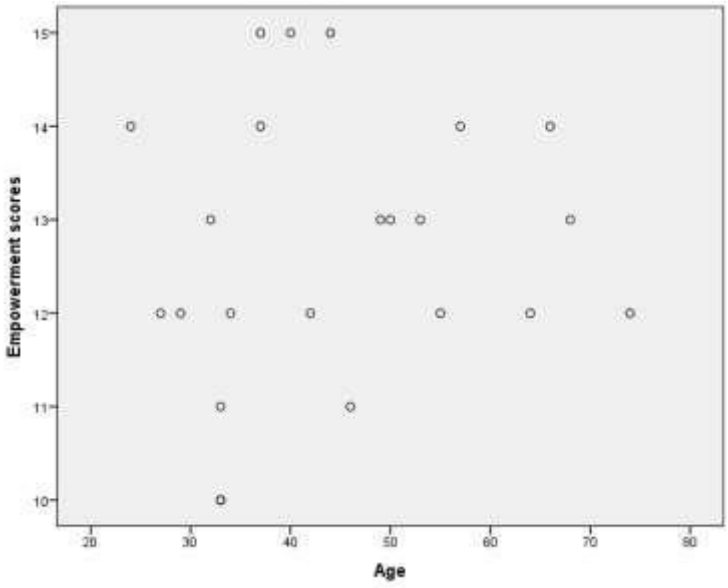
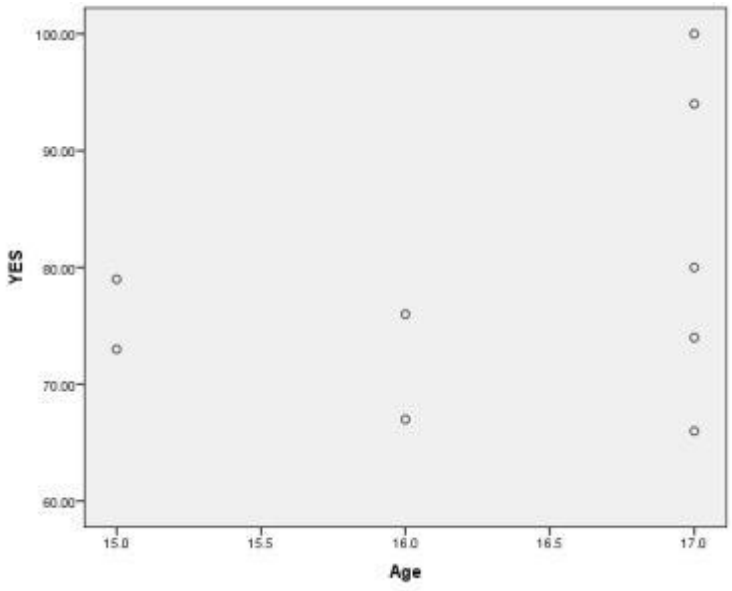


Figure 4.4: YES (Empowerment) to Youth Age – Scatterplot



Note: The scatterplot for youth does not yield meaningful information because it is too small of a sample size.

Correlation estimates allowed the interpretation that there was little evidence of a correlation between age and empowerment (Adults Mean=12.4; SD=1.9). Also, there was little to no correlation among empowerment and ethnicity for the adults as measured by the FES (African American Adults Mean 12.88; SD=2.7; Caucasian Adults Mean= 12.12; SD=1.4), nor for youth as measure with the YES (African American Youth Mean= 79; SD=10.05; Caucasian youth Mean= 78.5; SD=14.7). However, there were some interesting findings in comparing empowerment to other demographic data. Males in the adult age group had higher mean empowerment (FES) scores (M=14.25; SD= .5) than did females

(M= 12.00; SD=1.8). (This was the only correlation coefficient that was found to be statistically significant among the tests that were run). Male youth also scored higher than female youth (Male Youth M=74.4; SD=5.6; Female youth M=84.3; SD 15.4). Adult caregivers had higher mean FES scores (Caregiver Mean=12.7; SD=1.6) than other professionals among 25 adult participants (Other adult professional Mean=12.2; SD=1.99). Additional analysis for empowerment as compared to ethnicity, gender, and adult roles follows.

Table 4.8: Empowerment Compared to Ethnicity

Mean Empowerment Score	Adult Ethnicity	*t*	*r*	*p* value	N
Mean FES=12.3 Mean Score African American Adults (n=8): 12.88 Mean Score for Caucasian Adults (n=17):12.12	8 African American and 17 Caucasian	.943	-.193	.355	25
Mean Empowerment Scores	Youth Ethnicity	*t*	*r*	*p* value	N
Mean YES=72.7 Mean Score African American youth(n=5):79 Mean Score Caucasian youth(n=4):78.5	5 African American and 4 Caucasian	.061	-.023	.953	9

From the analysis of the correlation coefficients measuring empowerment scores and ethnicity, it was found that there was not a correlation for FES empowerment scores and adult ethnicity and there was not a correlation for YES empowerment scores and youth ethnicity.

The mean score for Empowerment for African American adults (n=8) was 12.88. The mean score for Empowerment for Caucasian adults (n= 17) was 12.12. The mean score for Empowerment for African American youth (n=5) was 79. The mean score for YES Empowerment for Caucasian youth (n=4) was 78.5.

Table 4.9: Empowerment Compared to Gender

	Gender	*t*	*r*	*p* value	N
Empowerment Score	21 Female and 4 Male	-2.4	.45*	.024	25
Mean FES=12.3	Mean FES Female=12				
	Mean FES Males=14.25				
Empowerment Score	5 Female and 4 Male	-1.345	.453	.220	9
Mean YES=72.7	Mean Youth Empowerment Female=74.4				
	Mean Youth Empowerment Male=84.3				

*. Correlation is significant at the 0.05 level (2-tailed).

From an analysis of the correlation coefficients of empowerment scores and gender, it was found that there was a correlation for empowerment scores compared to adult gender within this small sample. The mean score for empowerment for female adults (n=21) was 12, while the mean score for empowerment for male adults (n=4) was 14.25. The mean empowerment score for

female youth (n=5) was 74.4, while the mean empowerment score for male youth (n=4) was 84.3. The correlations for youth are suspicious given the sample size of nine.

Table 4.10: Empowerment Compared to Adult Roles

Correlation between Empowerment Scores* (*FES) and Adult Roles						
Empowerment Score	**Roles**	***T***	***r***	***p* value**	**N**	**Missing values**
FES=12.3	Adults: N=25	.583	.121	.565	25	0
Adult Caregiver Mean FES: 12.7 Other adult professional role Mean FES: 12.2	7 Caregivers, 18 Other Adult Professionals					

Modified Family Empowerment Scale (FES) scores were correlated with adult participants' roles. (The roles were coded as 1 for youth, 2 for caregivers and 3 for other adult professionals). There were 7 adult caregivers with a mean empowerment score of 12.7. There were 18 "other adult" or (non-caregiver)

professional with a mean empowerment score of 12.2. The caregivers had a slightly higher mean score for empowerment than the other adult professional roles. While a reverse trend might have been expected, there were some special characteristics of the caregivers. Two of the caregivers held PhD's and were classified as career foster parents. Two of the other caregivers had positions of therapeutic placement providers and had extra level of responsibility and pay for their work. One caregiver had a master's degree and served as a supervisor for a transitional living placement; she had been a case manager in the past. Factors such as their educational level and level of responsibility might explain why the mean scores were higher for the caregiver group.

Comparison of Youth Scores to Referenced Means

Nine youth filled out the YES and YPP. 2 youth fell below the referenced mean for the YES. 2 youth scored above the referenced upper quartile. 7 out of 9 youth fell below the referenced mean (59) for the YPP. 6 youth scores were at or below the lower quartile score (<52). The two youth with the lowest YES scores were Alice and James; they fell below the referenced mean for the YES. The two youth with the highest YES scores were Henry and Tom; they scored above the reference upper quartile mean scores. Mary, Evelyn, and Alice had the lowest YPP scores, and Frank and Tom had the highest YPP scores.

Comparison of Scores to Qualitative Comments

The low scoring responses to empowerment scale items, along with individual interview data, revealed knowledge deficits, lack of self-efficacy, and powerlessness among a few youth and family support team members. The few examples of lack of self-efficacy appeared to be related to perception of self and what could be done within the limits of one's role. Finally, participants revealed a perception of lacking power.

One particular youth had no ideas about how to improve services, or what rights are available to young people with mental disabilities. Further, this youth rated a "never" to a question about taking opportunities to speak out about mental illness because she did not think she had a mental disorder. The low-scoring adults lacked knowledge about how to speak out about poor services, how to organize the system, and how to get a youth released from services that she no longer needed.

Lack of self-efficacy was exemplified by a Chafee worker who thought it was not her role to make decisions about some of the items that were listed on the Empowerment Scale. Another adult participant felt insecure in her role and afraid to speak up about issues of concern.

> Often times I am confused as to the extent of my involvement in the foster youth's care plan and my role as an integral part of his care team. I feel at times hesitant to bring my concerns to the caseworker due to his current

caseload and responsibilities (Foster parent comments on Empowerment Scale, Handwritten, Case J).

Two statements that indicated powerlessness came from the extreme recruiter who revealed a lack of confidence to rely on her team and a very restricted right to make recommendations or speak up in court. A few youth responses suggested powerlessness as well. One youth said he had to have a court order to spend the night at his friend's house, and could not vacation out of state without system approval. Furthermore, he had no choices about the services he received. Two youth stated they were not part of the invitation process for team meetings. The table below provides the Empowerment scale item, the participant rating and qualitative comments related to the low value.

Table 4.11: Powerlessness Examples

Empowerment Scale Item	Participant Rating	Qualifying Comments
When I need help with problems in this particular foster youth's present home life, I am able to ask for help from others.	1=never	'If I see issues there wouldn't be people I'd go to. I wouldn't rely on them. But I don't have decision making power.' (Extreme Recruiter for Frank)
I make efforts to learn new ways to help this particular foster youth grow and develop.	1=never	'I don't have power. The court actually said we're not allowed to make recommendations, only suggestions.' (Extreme Recruiter for Frank)
My opinion is just as important as professionals' opinions in deciding what services this particular foster youth needs.	1=never	'I can offer opinions, but I can't speak up. The Case Worker, and DJO can ask for things, I can only speak when spoken to in court.' (Extreme Recruiter for Frank)

Empowerment Scale Item	**Participant Rating**	**Qualifying Comments**
What kinds of responsibilities do you have?	From interview	"Well, if you want to go to your friend's house they got to get background checked. If you want to go out of town you've got to get that approved…" (Foster youth James)
[The only other one was; I help decide who is invited to my meetings.]	1=never	"I mean I don't really get to decide who comes, they just come." (Foster youth Evelyn)
[Reading from empowerment scale.] I help decide who is invited to my meetings	1=never	"No, because E does that, so I don't have a say on who comes to my meetings."(Foster Youth Alice)
I work with providers to adjust my services or supports so they fit my needs	2=rarely	"I don't have a choice."(Foster Youth James)

Not having power was expressed by these participants as not being able to: rely on team members for help, to speak, or to choose. From these examples, it appeared that individuals were discouraged about, but somewhat resigned, regarding their lack of power. While some members of the team had lower empowerment scores, there were others, as mentioned earlier, who demonstrated empowerment with either interview responses or within their meetings. For example, Mary's foster parent, stated that she readily spoke up in the meetings:

> I felt like, I listened to what they had to say, and of course I just put my input in, you know (Placement Provider Interview, Case M, Recorded; Lines 146-147).

This placement provider appeared to have confidence that her perspective was important and that the team wanted to know what she thought. Similarly, Tom's foster parent believed his voice and input were important:

> During those meetings, like I said, I guess because of the position that I'm in, they're expecting most of the information to come from us...they are really waiting to hear what kind of information we can give, because we have that one on one connection with them and they're living in the household and we're seeing behaviors that no one else on the team has the chance to see (Placement Provider Interview, Case T; Audio-Recorded, Lines 176-182).

In this example, it seemed like the placement provider felt appreciated and included. He was under the impression that the team needed to hear from him, and that his report was going to make an important contribution in the meeting.

In summary, ratings of empowerment and non-survey data about empowerment showed variation among participants from low too high. The Extreme Recruiter and particular foster youth shared their reasons for low scoring items on the empowerment scales by elaborating about ways in which they lacked power. The Extreme Recruiter distrusted the competency of her team; and felt excluded from full participation at court. The youth felt they could not act on their own preferences. The therapeutic foster home placement providers, who had

higher scores and more positive explanations, both felt like they could speak up and that the teams appreciated their input.

Property: Cooperation. The last property of responses is cooperation, or working together. Cooperation ranged on a continuum from low to high. Some team members with a low degree of cooperation were not present for meetings but their behaviors were discussed. For example, Kaitlyn's mother was not present for the family support team meeting or court hearing. There was some discussion about permanency and that the mom was not doing the things she needed to do to be the parent, and her behavior was showing that she did not want to be the mom (Court Meeting Notes, Case K, Not Recorded, Lines 293-295).

Similarly, Mary and Tom's parents were not present at the FST meeting or court hearing. There was some discussion about the parents' involvement. Dad has not been following recommendations from the court, and mom's whereabouts are unknown. (Court hearing notes, Case M and T, Not Recorded, Lines 49-51).

Some participants believed that cooperation was occurring in their teams. For example, the case manager for Frank stated:

> It went well. A lot of people stepped up to try to help. A person [volunteered] to call the dentist], set up visits. Good team support. Positive. There was nothing really negative (Case manager Interview, Case F, not Recorded).

This case manager appeared surprised and pleased with all of the membership's offerings of help. She noticed a collected effort among team members to support the family. Another participant remarked,

> A lot of times the support team meetings, it's not really a standard meeting for, I don't know how to describe it, I feel like if you're in a good meeting and it's a really good collaboration it's very informal and you're just kind of, I mean you've got to have your goals obviously, but it's just a bunch of people sitting around talking about the family or trying to get them to a positive point in their life Deputy juvenile officer Interview, Case J, Recorded; Lines 109-114).

This participant described what he believed were elements of an effective team meeting. When team members approached the meeting with a spirit of informality, openness to being together, and optimism. At another point in his interview, he contrasted these elements with other meetings he'd been involved in, in which the team was not working as smoothly together.

In summary, cooperation was manifested in family support teams along continuum, with certain family members and team members simply not showing up or not following court recommendations to get their children back, and others making careful and intentional efforts to pull resources for the benefit of the entire team.

In family support team meetings, the workings of power were not often visible, but the hierarchical relationships were known. The power differential that existed among the members of the team was felt in the ways members behaved, talked to one another, garnered and used resources and exerted influence. Some team members appeared to use their positions of power to provide assistance to those who didn't have as much (for example the CASA for Alice and the DJO for Gabby and Henry), while others used their authority to try to instill responsibility in youth who were having behavior problems (e.g., the case manager for James and the guardian ad litem for Tom).

Responses to the power differential fell along four types: avoidance and independent action, compromising, empowerment and cooperation. Each of these response types ranged on continuum. Some members were present in meetings but behaved in passive aggressive ways, while others simply didn't show up. The individuals who would not compromise were on one end, and one who tried to negotiate as a matter of principle was on the other. Some members scored low on empowerment, and others scored high. Lastly, some members demonstrated with action an unwillingness to work as part of a united team effort, while others seemed to enjoy cooperation.

In the next section of this chapter, an exemplar about power is presented using one family support team. This team is used to demonstrate how the inner-workings of the category can be observed through this particular team. The

exemplar provides a description of participants of Gabby and Henry's family support team, a story about the family, and an application of the concepts of power that are relevant to this team.

Category Exemplar: Gabby and Henry's Family Support Team

Gabby was a 15-year-old African American female who planned to enter her Sophomore year of High School. She planned to attend summer camp, had obtained a work permit, and anticipated part time-employment at the baseball stadium. She had been in foster care for the last 10 years. She did not take any medications and did not report having any diagnosed emotional or mental health difficulties. In the past she had lived with her parents, with foster parents, and with relatives other than parents, but currently was reunited with her family in her mother's home. She counted 4 different placement changes while she was in foster care.

Henry was a 17-year-old African American male who planned to enter his final year of High School. Like his sister, he anticipated part-time employment at the baseball stadium this summer. He had been in foster care for 10 years. He took psychotropic medications for Bipolar Disorder, received individual therapy, and had completed services for substance misuse. In the past he had lived with his parents, in foster care, and with relatives other than parents. He, too, was currently living with his family in his mother's home.

The case manager was a 24-year-old Caucasian female who worked for a private foster care agency. She had been in her role for 8 months. Similar to other case managers, she was responsible for: notifying the team about the meetings, preparing an agenda and documenting services provided in the meetings, facilitating the discussion of agenda items, documenting status, progress, and recommendations for court reports, attending court hearings, and providing testimony at court. Beyond these activities associated with family meetings and court, she was accountable for regularly assessing and visiting youth and families, ensuring safety in placement of the young person, and ensuring that needs for health and education were met. All of her job duties were documented and reported to her supervisor and the court.

The mother was a 40-year-old African American female. She had involvement with the foster care system for the past 10 years. In order to regain custody of her children, she secured housing, attended parenting and job readiness classes, attended individual and family therapy, drug treatment, family support team meetings, and court hearings.

The deputy juvenile officer's duties were similar to those of other deputy juvenile officers. He assisted the court by gathering and maintaining information, visiting with youth and families, and facilitating the completion of case goals. He had a role that is similar to that of a case manager except that he worked for the court. He was responsible for providing written documentation of his work and

sharing information with the family support team as well as the members of the court.

There were several support people in place for the family: the family reunification specialist, the Chafee worker, the in-home therapist, and the individual therapist. The family reunification specialist's role was to provide intensive services and support to help the family meet needs and goals that were necessary for the children to be returned to the home. The Epworth (Chafee) worker assisted the older youth with acquiring skills and needed resources to achieve self-sufficiency as they age out of foster care. The in-home therapist provided counseling to the boys at their home. This ensured that they got the emotional help they needed in a naturalistic setting. The individual therapist provided individual counseling to address the emotional needs of the mother.

Two younger siblings were also present at the family support team meeting. The children were approximately 11 years and 13 years old and both were middle school students. The 11-year-old boy was friendly and spoke little during the family meeting, but his behavior was attentive and appropriate. The 13-year-old girl was quiet, poised and a bit more reserved than her younger brother. The younger siblings had been returned to the mother's physical custody; at the time of the court hearing, the family was officially reunited, with both guardian ad litem and physical custody of all the children returned to the mother.

The story of Gabby and Henry's family reunification. One oppressively hot summer day 10 years ago, a woman in poverty left her children and grand-baby in the care of a neighbor-friend to fill her gas tank at the local gas station. At some point, the neighbor-friend went home and no one was watching the children. The home was hot, and there was no breeze that day. For unknown reasons, perhaps because of the high index that day, something within the home caught on fire. Soon the entire house was inflamed. Henry, at the time 7 years old, exited safely, then went back in to rescue his younger siblings, but he was unsuccessful. He fled to the neighbors, and subsequently, the fire department saved his brother, sisters and baby nephew. The baby was badly burned.

Upon her return home, the mother discovered her house was destroyed by the fire, the children had been taken to the nearest hospital, and the neighbor-friend was gone. At the hospital, the children were separated from their mother, questioned, each in turn, and subsequently a child abuse and neglect investigation was opened. She recalled being scolded at the hospital: "You are an unfit mother."

The children were placed in protective custody. The mother was now homeless and lacked employment. That led to her children's placement with relatives, while she fulfilled requirements set by the court to demonstrate that she was a "fit" parent. 10 years went by. During all those years, her children adamantly denied that their mother had harmed them in any way. She visited

them, filled their foster home placement refrigerator with food, and always remembered and celebrated their birthdays. However, despite her displays of love and devotion to her children, she felt intimidated by the system:

> You have to do all the things they tell you to do, including getting housing, income, attending parenting classes, getting job skills, meetings, court hearings, visitations, supervision back and forth a lot of times. You have to watch everything you do. They can check on you, go into Facebook, checking and watching you. They are looking for what you do crimes, drugs, alcohol use, what you do to other kids, and even animals (Mother interview, Cases G & H, Not recorded, Lines 76-81).

Eventually, the mother began questioning the practices and procedures of the Children's Division. She found out she had a right to complain. She filed a grievance and got a different case worker assigned to her case.

Meanwhile, from the perspective of Henry, now age 17 years, he was not allowed to talk about his experiences of being in foster care...

> We were not allowed to talk about it. I couldn't talk about it. I couldn't let anyone know. But people know by the way I act' (Foster youth Interview Notes, Case H, Not recorded, Lines 8-10).

Whether it was true or whether he misunderstood what the system was telling him, this presented a conflict for him because he felt he wasn't being true to himself. That he was not able to speak about being in care may have produced

shame. He felt he had to hide who he really was (Foster youth Interview Notes, Case H, Not recorded, Lines 11-14).

He recalled how prior to being in care he loved school, but once he was placed in custody, his sense of confidence diminished. He started to withdraw from the other children at school. He labeled himself as, "lame," and was self-conscious that people were judging him as "not normal." Growing up in a foster home, he did not have the same fashions or materials that the other children at school had. The lack of clothing, shoes, and materials that other kids in his class possessed made him feel like an outsider, and quite self-conscious.

The deputy juvenile officer, who knew the family for six or seven years, said the mother never hurt her children, and there was never any danger. However, the result of re-unification after 10 years was obtained with tremendous investment of human resources. Numerous experts were involved in the family's life in order to assist them in reaching their goals.

Stable housing and consistent income were major obstacles for this impoverished family that lost their home to fire, and who had no savings or back-up resources available. Would this 10 years of separation have been different if this mother had placement stability and consistent income? The condition of poverty formidably challenged the family's ability to solve problems that came up. As the Deputy juvenile officer concluded:

> When you're poor it's very difficult… It would have been cheaper for the state to pay her rent than to keep the kids in state custody all those years Deputy juvenile officer Interview, Cases G & H, Not Recorded, Lines 77-79).

In Gabby and Henry's family support team meeting, the family was delighted to be in each other's presence, and the children showed admiration for the family support team who had gathered in the mother's home to discuss re-unification. An overarching dynamic of love and support was shown as all family members and support team members discussed plans for managing time and using resources. Then, after the court hearing, the report was, "everyone cheered." It seemed like a celebration or victory that was to be savored, as it had been such a long process for the mother to get her children back. When participants reflected on the experience of the meeting, members said it was like a family reunion and like a celebration. Henry remarked, "It was outstanding."

Application of the Category: "Power" to Gabby and Henry's Family Support Team

As previously defined, power is the ability to influence, or get another person to do something, as well as the ability to access and use resources. Two subcategories of power were qualities and responses.

Subcategory: Qualities. Within Gabby and Henry's family support team, the qualities of power could be readily identified. To begin this discussion, two

properties of qualities, expertise and the ability to establish rapport and connection, are selected. First, the property of expertise was noted.

Property: Expertise. Expertise is one's accumulated depth of knowledge, skill and experience, and the dimension is low to high degree of expertise. Within this particular team, the case manager was a person with a low degree of expertise; while she was intelligent, and organized, she did not demonstrate wisdom. At just 24 years, she had accumulated 8 months of experience with this family. By contrast, the Deputy juvenile officer had been involved with this family for at least 6 years. Besides duration of time in his role, he was able to articulate great awareness and understanding of the family's plight.

Property: Ability to establish rapport and connection. The second property labeled "ability to establish rapport and connection" is conceptualized as proclivity, talent and skill in initiating and cultivating human relationships. The dimensions of ability this property ranged from low to high level of ability in other family support teams, but in this family, only the higher end of the range was observed. While several members of the team showed the ability to cultivate relationships, one particular member stood out. The Deputy juvenile officer had an assertive, friendly style in the family support team meeting, and the mother responded well to him. A key to cultivation was longevity, which was distinct from his expertise, and the family appeared to accept and trust him. Furthermore, his style of relating created harmonious dynamics that were observed in the

meeting. He commented, 'I try to give people the opportunity to clarify, to add to…Mom knows I am pretty direct.' Deputy juvenile officer Interview, Cases G & H, not audio-recorded, Line 72).

Properties: Oversight mechanisms and authority. Two properties of power that were not directly observed, but were reported by members of this support team were "oversight mechanisms" and "authority." The mother noted that the oversight mechanisms, or quality assurance practices that the organization has in place for accountability and responsible delivery of services, seemed excessive, as noted in her quotes above about the Children's Division. The use of authority was also apparent in her description of the Children's Division's insistence on her completion of multiple services and programs in order to regain custody of her children.

Subcategory: Responses. Two types of responses were observed as reactions to power within Gabby and Henry's family support team. These were empowerment and cooperation.

Property: Empowerment. Empowerment as a response to the noted power differential, ranged from low to high degree of empowerment. In this particular family there was a shift in empowerment from low too high that was reported by the mother. The mother demonstrated that she experienced a shift in power in a few ways. In the early days of her involvement with the system, the mother was frightened and intimidated. However, gradually, she began to find out as much as

she could about how the system worked and about her own rights. She also demonstrated resourcefulness by staying as actively involved with her children as possible, sharing information and following the recommendations of the court to get her children back.

Finally, she stated that she felt encouraged to speak up in meetings. The sharing of power with others was also apparent, as she prepared for her families return home, accepting advice of the team, and delegating some tasks to her son. From the perspective of the case manager and the children, the mother had high influence; the case manager commented that the mother set an important tone for the family.

The mother demonstrated empowerment by giving power to her children, experiencing it herself, and sharing power with the entire family support team. The mother gave power to her children by providing encouragement concerning their rights. Henry stated, 'Mom told me I have freedom of speech a long time ago, and I remember that' (Foster youth, Case H, Not Recorded, Line 26).

Property: Cooperating. Within this family support team there was a high degree of cooperation. Twelve people assembled in a living room that did not have enough chairs to accommodate them. Anticipating the need, the family reunification specialist brought extra chairs along with him. As the meeting proceeded, the family was respectful and you could see interest and respect shown between members. The younger ones seemed like they really liked the social

worker and were showing affection toward her. The older ones were more watchful, but did speak up at appropriate times. They seemed to have a sense of anticipation about the next week; the hope was for an official court order declaring that the family's case was being closed, expected to be announced by the judge. Gabby seemed content, and a little bit silly; she was definitely interested in the summer camp that the reunification specialist brought up. He said it would be good for people who are creative like her. She was watching everyone and everything. Even though she didn't speak very much, she was certainly engaged.

The mother hinted at the overwhelming nature of managing and coordinating four people's schedules but there appeared to be a sense of support from the team and the children seemed to really want to be back together as a family.

A number of people in this family support team were capable of making a contribution and they willingly shared resources. As the DJO stated,

> Everyone has a job to do. Everyone has something to do. The reunification specialist took on jobs. It's not always laid on the case manager; it depends who has the expertise (Deputy juvenile officer Interview, Cases G & H, Not Recorded, Lines 64-66).

In this example, the DJO shares his perception that the whole team distributes the work. While it may appear that the case manager carries a burden

of responsibility, he argues that the responsibility rests with whoever carries the greatest degree of expertise.

This family story was chosen as an exemplar for power because there was a noticeable power differential among various members of the team. The attributes of power were easily identified and the responses to it were poignant. The mother demonstrated her resourcefulness by staying as actively involved with her children as possible, sharing information and following the recommendations of the court to get her children back. By the time this woman was concluding her work with Child Welfare, she felt encouraged to speak up in meetings, believed the meetings were open, and was knowledgeable about how the system worked. In past times, the mother was frightened and intimidated by the Child Welfare System, but over a 10 year time period, she began finding out as much as she could about how the system worked and about her own rights. It appeared that not just the woman, but also her children, grew in empowerment over time and through experience.

The next section of this chapter introduces the category mesosystem factors. Then, the members of James's family support team and James's story are presented as an illustration. This is followed by the application of the category, mesosystem factors to James's team.

Category: Mesosystem Factors

"Mesosystem factors" was chosen as a conceptual label to depict the factors within two systems, the court and Children's Division that share responsibilities for the families they serve. The system factors either support or hinder decision-making for family support teams. The prefix "meso" means middle. (The term is borrowed from Bronfenbrenner's *Ecological Systems Theory*; Bronfenbrenner 1979). This places the system factors as neither part of a microsystem, such as the core family, nor of a broader scaled scope, as might be observed in the macrosystem, the larger cultural context of a society including political structures and the civil society, socio-economic stratification, ethnic composition and the ideologies and attitudes that accompany socio-cultural positions. As stated in the introduction to this chapter, subcategories of the system are role, or position of each member and standardization of practices and procedures, understood as the definition, clarification, and organization of activities associated with the care of foster youth.

Subcategory: Role. *Role is the position of each team member and that person's competencies and responsibilities. Role differentiation* refers to independent roles with unique (not necessarily better, but specific) characteristics.

Property: Role differentiation. While some family support teams in the study had members who functioned in multiple roles, there were several distinct and unitary roles among the family support team. These roles included typical

ones in adolescent family support teams: adult family members, caregivers, the case manager, the deputy juvenile officer, the guardian ad litem, and the Chafee worker. There were also roles that were unique. These were the CASA, adoption specialist, extreme recruiter, family reunification specialist, and the permanency specialist.

One example of a unique role was that of the Extreme recruiter, who is employed at a special agency that provides adoption and foster care support to youth and families. In her position, she focuses on referred children and youth who are eligible for adoption. The typical profile of a person who enters the program is a late-teenaged youth with emotional or behavioral disturbances who does not have an identified adoption resource. This program is a 12-20 week program, where intense recruitment and facilitated meetings occur every week (Extreme recruiter interview, not recorded. Lines 19-22). The adoption specialist had some similar responsibilities as the extreme recruiter but had access to less resources and her program was not time limited.

There were other team members who had many roles. For instance, the Grandmother of Tom and Mary said she was not a traditional foster parent, but rather, in her perception, she served as the grandmother, mother and father for her grandchildren: “I mean I have been the father, the mother, and the grandma, yeah, I’ve got three roles” (Grandmother interview, Case M and T, Audio-recorded, Lines 106-107). In her role as a grandmother, she tended to spoil her

grandchildren, and was not inclined to discipline them. In her role as mother and father, she provided shelter, food, and for basic needs. In the treatment team meeting and in follow-up interviews it was apparent that the grandmother had challenges in fulfilling roles of grandmother in addition to traditional parent roles. It was difficult for her to provide needed structure and supervision in the way the family support team expected. Since her grandchildren had been having numerous behavior problems, they were placed in treatment foster care, but the goal was for them to return to live with her.

Property: Reasons for involvement. The second property of role reasons for involvement, or the reason one is part of the team. Most members were employees, except for family members. However, the CASA for Alice explained that her role was special because she did not receive payment for her services:

> What makes us different, what makes CASAs different from everybody else on the case, first of all is that were volunteers. That means we don't have any, well I guess you could say almost we don't have any skin in the game, but emotionally, of course we do, of course we do, you can't avoid it... (CASA Interview, Case A, Audio-Recorded, Lines 75-78).

The CASA's explanation of her role suggests that she believed emotional investment varies according to the degree of reward or compensation one receives for work with youth. People who were in roles as paid employees may have had different degrees of emotional investment than those who were volunteers.

Career employees were the foster parents for Frank, the therapeutic foster home placement providers for Mary and Tom, and various other team members who held paid positions (i.e. case manager, DJO, therapist, Chafee worker). Those who were career or therapeutic foster home placement providers had a different pay schedule than traditional foster parents, and had more responsibilities. For instance, Mary's therapeutic foster home placement provider stated she served youth with the highest level of needs:

> I'm really not considered a foster parent, but professionally they want us to say we are therapeutic home, and that can be for a mentally disturbed, it can be for kids that's really have been through a lot of abuse or sexual abuse, or you know, so they have a lot of issues going on with their selves.
>
> That means that you're totally involved. You may have kids, like right now I have two girls that's line of sight, and line of sight is they can't be out of my presence at no time, you know what I'm saying? So it's not like I have a lot of freedom... (Placement provider interview, Case M, Lines 22-27).

Property: Compliance. Another property of role was compliance or the level of cooperation with rules and expectations. The range of compliance varied from non-compliance to compliance. Most foster youth commented on having to follow rules as an expectation of being in foster care. Some mentioned that they had histories of drug use. Others had run away. Eight youth attended their FST

meetings; only two showed lower levels of cooperation in the meetings; they demonstrated resistance to team interaction and reportedly were not attending their Chafee classes.

The mothers also mentioned having to do what was expected; while one mother was compliant, the other mother said she began to question some of the practices of Child Welfare. The other caregivers showed cooperation by attending FST meetings, with the exception of Frank's foster parents, who were not present.

Case managers discussed having to fill out forms and complete paperwork. Some appeared to take this very seriously, and in meetings seemed driven by the completion of forms (Case manager for Alice, Kaitlyn, and Frank), while others seemed more relaxed and informal about using the forms rigidly (Case managers for Evelyn and James).

Subcategory: Standardization of practices and varied across teams in the care of foster youth. The properties of standardization: type, stakeholder perception of predictability, consistency in application, timeliness, and transparency, will be presented in the text that follows.

Property: Type. The types of standardization were written, customary and local/cultural traditions. The written standards were the Child Welfare manual, and the written forms used to document meetings and visits. Two case managers used pre-filled printed copies of paperwork to guide team members in the FST meeting. One case manager had a hand-written agenda on a piece of paper to

remind him what to cover in the meeting. In another team a therapist circulated a summary of a youth's progress for the team. All teams had a confidentiality form that was circulated for all team members to sign.

Customs and local/cultural traditions were evaluated across counties. Different counties had unique mechanisms for scheduling court cases, with one county giving appointment times, and the remainder putting all families on a docket. For teams in which families were given an appointment time, the waiting time was minimal, compared to teams in which families were placed on the docket.

Property: Stakeholder perception of predictability. Stakeholder perception of predictability ranged on continuum from unpredictable to predictable. When participants were asked what they expected would happen in the meetings or court hearings, the participants' responses ranged from having no expectations, to an expectation for "review" of the case progress and case plans, to "the plan would stay the same" (Adoption Specialist and Extreme Recruiter,

Case F), to "hoping to work together toward solutions" (CASA, Case A). Foster youth generally knew what to expect. One youth recited a formulaic agenda,

> We do introductions, say our strengths, say our weaknesses, what could be done to improve the weaknesses, next court date, and what will happen at court (Foster Youth Interview, Case G, Not Recorded, Lines 38-39).

This example shows how routine and predictable the meetings had become to a child who had been in state custody for years. There were no surprises. Another youth said,

> I know what's going to happen. It's been going on for 2 years. It's not that I'm oblivious. Pretty much an FST is what is going to happen. You can't really say, this is what we're going to do. That's kinda what the FST is for (Foster Youth Interview, Case M, Lines 66-69).

Similar to the other example, this youth described a routine process that she had come to expect and understand. Perhaps over a 2-year time period there had been few deviations from a particular format, and she seemed comforted by that routine.

Property: Consistency in application. Another aspect of standardization was consistency in application, or the degree to which practices and procedures happen in the same way with each occurrence. This varied on continuum from inconsistent too consistent. Practices and procedures varied in regards to the ordering of meetings with court hearings. In one county, the schedule was purposely arranged so that the family support team met prior to the court hearing, but in another county, when asked how meetings were arranged in relation to court, the DJO stated:

> I would say it doesn't always work out that way, but it is nice if you have that meeting about or around court, you get the most up to date

> information, because like if you had a meeting a month before court and you write your report and you haven't had much contact, things can change a lot in a month, and certainly it's great when it does happen, but it doesn't always happen that way (Deputy juvenile officer interview, Case J, Audio-recorded, Lines 137-141).

This particular worker provided a flexible understanding of the way court and family support team meetings were to be scheduled. He seemed comfortable with the uncertainty of this schedule.

Another practice that varied was in regards to how youth were placed in foster homes. In one family, a youth was placed in a home after he found his own placement through a friend. He had run away from his other foster home, and the friend's mother agreed that he could stay with her family. (Case manager interview and meeting notes, Case J, Lines 35-37). The foster mother explained how she became a kinship provider:

> I knew him briefly when he lived here years ago, my son and him had been friends, that's why we were able to go through the kinship process instead of just regular foster care...but I didn't really know of him a whole lot (Foster parent interview, Case J, Recorded, Lines 3-13).

This type of placement, in which the youth was choosing where he lived, was unusual. The foster parent was labeled as 'kin', which allowed for a quicker approval and training process in order for her to be approved as a foster parent.

However, on another team, when an aunt was found to be a possible adoptive placement, the decision was made that this kinship arrangement would not be permitted:

> I found the aunt-she is technically a second cousin. She's very committed to being in his life. But there were transportation issues, and she has a 3 bedroom housing. That is a problem. We are waiting for oldest daughter to move out. The 2 older kids share a room, then there's a younger son. CD Licensing wasn't willing to work with them (Extreme recruiter interview, Case F, Lines 27-30).

In this instance, the Extreme Recruiter suggested that it was possible to make exceptions to standard practices. She seemed convinced that the relative could be a suitable kinship placement for Frank, but blamed the Children's Division licensing department for ruining this youth's chances of adoption. Apparently, CD was not inclined to make a deviation in the usual procedures for approving this particular placement.

Property: Timeliness. Timeliness, or how fast or slow practices are carried out, ranged on continuum from supports solutions to slows down processes. There were few instances of court and child welfare processes being carried out swiftly. One exception was James's foster parent getting clearance to become a caregiver for him. While she did have several meetings with the case worker and

a large amount of paperwork to fill out, the actual training to become a foster parent was short.

> But there was only one training that I actually had to go to, about a half-day training. It was really condensed. They provided you with the information to take back home to refer back to if you had further questions (Foster parent, Case J, audio-recorded, Lines 31-33).

This example of timeliness that supports solutions is contrasted with a few examples of court and child welfare practices being carried out slowly, or practices that delay efficient solutions. A few participants lamented the inefficiency of practices. One such inefficiency was the practice of case workers to only work Monday through Friday, and to turn their phones off after 5:00pm.

> If you don't have a CASA and something happens after 5:00 or whatever time it is, I don't even know what time it is, you call your CD worker, the ones that I come across, they don't even look at it, it's after hours, or they might look at it and put their phone down. I see people do that all the time.
>
> Then they go on back to what they're doing, it's after hours. These kids are around longer than 8 hours a day (CASA Interview, Case A, Audio-Recorded).

Another inefficiency was reported by a case manager, who stated that she was required to visit children and youth in whatever county they happened to be

residing in on a monthly basis. This traveling made it difficult to manage the rest of her monthly responsibilities:

> …We were told by our director, department of social service/children's division's director, that we had to begin seeing our children in the county where they're at. Every month we had to drive to wherever our children were placed, that were in the custody of SC county. So at that time, Evelyn was in Joplin that only lasted about a month. Then I had another kid I placed in Springfield, so every month I was driving to Springfield. He said it was very important for these youth to see us every month. So again, I'm hopping in my car driving to Springfield and back one day a month, which that's an entire day trip, so I lose an entire trip, or entire day. Then also, in those counties that we don't work in we don't know the services there, and it's still an ongoing battle with our director now, in getting him to listen to us, to say this is not feasible, it's not good (Case manager interview, Case E, recorded, Lines 151-155).

In summary, there was variation in how efficient and timely practices were carried out. On one hand, participants shared brevity of training and lack of availability of workers "after hours." On the other hand, there were long wait times for court hearings, inordinate amount of time on report writing, and mandatory traveling to remote locations to execute work, which robbed employees of time that might be better spent in other ways.

Property: Transparency. One of the factors within the standardization of practices and procedures that may have either impeded or encouraged the youth and family support teams decision-making was transparency. Transparency or the amount of readiness to share, openness, and honesty one demonstrates in relationship with others, varied along a continuum of intransparent to transparent. Intransparency was observed in two teams. In Evelyn's meeting, there appeared to be a lot of praise and celebration occurring as the team focused its time and energy on discussions of college plans with a young person who had just been re-unified with her family of origin. The team spent considerably less time focusing on the issues that precipitated child welfare involvement. The serious nature of this child's removal from home and subsequent circumstances of earning back trust with her family, were not mentioned. It would be hard to tell with certainty if the team members were denying that problems existed or if they were deliberately failing to report the truth of the issues with which the family continued to struggle. The issues were printed on the FST meeting template, and were of a grave nature (FST printed hand-out, Case E).

Intransparency seemed to be present, too, in James's team. In the family support team meeting, the issues of runaway and past behavioral problems were not addressed. In the individual interviews, it was only the foster mother who believed the team was not completely transparent in sharing information. It was not just that the foster youth had misrepresented his situation in order to move in

with her, but she had the feeling that she was not included as an essential person on the team. In contrast, the DJO and case manager seemed to be quite satisfied with how things were running and felt the team made good decisions. The foster youth was not speaking very much in the meeting, and in the follow up interview reported that, for the most part, he felt he should listen mostly and be respectful.

Transparency was observed in Gabby and Henry's family and team, who appeared ready to be open and honest in relationship with others. The family was delighted to be in each other's presence, and the children showed admiration for the family support team who had gathered in the mother's home to discuss re-unification. The family was respectful and you could see interest, and respect shown between members. The younger ones seemed like they really liked the social worker and were showing affection toward her. The older ones were more watchful, but did put their two cents in at appropriate times (FST Meeting notes, not recorded, Lines 152-156).

A number of practical challenges were openly discussed in the meeting. For example, when Henry needed to get his social security card, there were transportation challenges since the mother didn't drive. Another challenge was managing free time; the team was helping the family plan out how they'd spend the summer months. All family members were in need of therapy; this was going to be accomplished with in-home therapists. The mother hinted at the overwhelming nature of managing and coordinating four people's schedules.

There appeared to be a concerted effort among the team to address the challenges head on. In follow-up interviews, the mother, Henry, and the DJO were forthcoming about the family history and the issues that they continued to face.

The last exemplar is a representative case or model that is useful for illustrating the associated concepts of mesosystem factors. In this exemplar of mesosystem factors, a brief description of the members of James's family support team is followed by a story about James and his team. Then the mesosystem factors are applied to the case.

Category Exemplar: James' Family Support Team

James was a 16-year-old male who planned to enter his Junior year of High School; he played sports, had a girlfriend, and worked a part time job. He had been in foster care since his mother died approximately five years ago. Previously, he had been diagnosed with Attention Deficit Hyperactivity Disorder but was not taking medications. He had completed substance abuse treatment, and beginning a new individual therapy program. In the past he lived in foster care, with relatives other than parents, and with his parents. His most recent placement was with a family in a foster home placement.

The case manager, a 57-year-old Caucasian male, had been in his role for seven years. His job duties were similar to those of other case managers, including the provision of safety, visiting and assessing youth and families, making referrals, linking youth and families with needed resources, conducting

family support team meetings, attending court hearings, and documenting all services provided in the records.

The foster parent, a 33-year-old single mother of three, had been in her role of foster parent for 4 months. Like most foster parents, she provided safety, structure, predictability and emotional security in her home. She also made appointments for the youth, took him to the appointments, attended family meetings and court hearings, and kept communication open to the rest of the family support team.

The deputy juvenile officer, a 37-year-old male, was a representative of the court. His role was similar to that of other deputy juvenile officers. He was a person who conducted investigations, made assessments and referrals, documents services, attended family support team meetings and court hearings, and wrote reports for the court.

The Chafee worker, a 46-year-old female, had been in her role for 9 months, but had only been working with this youth for 2 months. Her job was to ensure that older youth have the skills and resources they need to attain self-sufficiency as they age out of foster care. She provided information about obtaining a college education or vocational training, driver's licensure, employment, budgeting and money management skills, including accessing funding that is available for foster youth, and she attended family support team meetings.

The permanency specialist was a consultant who assisted case managers with permanency planning when the case plan changed to guardianship and/or adoption. She helped finalize case plans and goals; met with children who were placed in adopted homes each month; helped with adoption recruitment; conducted family finding to help engage the biological family into children's lives with the hope of their becoming permanent options; negotiated guardianship and adoption subsidy contracts; participated in select support teams, testified at court hearings, and wrote reports. She was participating in the family support team meeting to provide information to the foster parent about guardianship.

The story. James' mother died when he was around 10 or 11 years old. His father is incarcerated and rarely communicates with him. There are biological grandparents who have never wanted custody of him. The case manager thought the grandparents knew more about his behaviors and risk, and perhaps feared he would bring drug users into the home, or that he would attract other kinds of trouble. The case manager speculated that the grandparents may also remain grief-stricken about the incarceration of James's father, (their son). Meanwhile, since there are no family members who would agree to be kinship providers for him, James had been in foster care for about 5 years.

According to his case manager, James had been a pretty good kid until recently. His situation was unique because he ran away from one placement, and was allowed to stay at the place he found to live. He established his own

placement through a friend, and the mother was okay with James living with the family. The woman who agreed to become his foster parent was not fully aware of everything going on with him when he came to spend the night at her home. James told her that his foster parents had gone out of town and left him to fend for himself. This led her to become very concerned for his well-being, along with the fact that he threatened suicide. She called his case worker and after evaluating him for safety, determined that staying with her was okay.

The case manager shared that James had complained of being lonely and unhappy in the past. The case manager was skeptical that it was really that bad. He speculated that James was just trying to move back to the community to be closer to his girlfriend. According to the case manager, there have been times when James had ideal living conditions that he sabotaged and left.

The case manager stated that James did have friends and a girlfriend of two years. James had a history of be-friending and endearing himself to families. Often at first, the families he endeared himself to wanted guardianship of him, but then he would sabotage this by stealing and they would change their minds. James has been in trouble with the law, has stolen petty items from a store, had some other petty theft offenses, and drug use.

According to his case manager, James showed intelligence with his actions. Even though he had several school changes, he kept up his credits and was on track to be a junior in high school in the next academic year. He

expressed a desire to attend college. The case manager said James wanted to be an agent for a musical group as a career goal.

The foster parent was keenly aware that James was not honest in telling her that his foster parents locked him out of his house, went on vacation, and told him to fend for himself. He had threatened self-harm. She was deeply concerned for his well-being, and stated she was mindful of his needs. In the following excerpt taken from her interview, she spoke about the gravity of his situation, that she felt tremendous responsibility, and that she recognized the vulnerability that James experienced because of his age. She wanted him to feel a part of her family:

> I also am aware of how serious it is that he needs to have a place where he is not you know hopping around, he needs more permanency in his life, so I don't know, it's not light, it's a young person's life and he's getting to the point where he's able to make decisions on his own, and I just pray to God that I can be a positive force throughout whatever's left of his youth...I tell him, you know you are family, you are part of the family, you know this is how family treats one another, sometimes we have to remind him of that or circle of trust, you have to be able to tell me what's going on in your life (Foster parent interview, Case J, Recorded, Lines 117-125). The Deputy juvenile officer (DJO) had a fondness for James and enjoyed

the working relationship he had with the case manager. He was pleased with how

James was doing. During the interview, he had an optimistic perspective about James, whom he believed had realistic goals, and he thought that James was currently doing well. The DJO referred to other youth and support teams, and felt this one was collaborative in comparison with some of the other teams he has been a part of.

While to some, James might appear like a lost child, an alternative perspective is that he is resourceful young person who was able to establish a placement and ties to a family, community and girlfriend. Despite suffering the loss of both parents, he was able to secure his own placement, convince his case manager that this was a suitable arrangement, and win the affection of a new family.

James' story was chosen to illustrate mesosystem factors for two reasons. First, roles could be readily identified and described; and second, stakeholder perception of predictability, consistency in application, and transparency of standardization of practices and procedures were appreciated.

Application of the Category Mesosystem Factors (that support or hinder decision making) to James's Family Support Team

The next section of this chapter applies the category "mesosystem factors" (that support or hinder decision-making) to James's family support team.

Subcategory: Role. While some family support teams in the study had members who functioned in multiple roles, within James' team, there were

several distinct and unitary roles among the family support team. The roles included typical ones in any family support team, and one that was somewhat exceptional: the permanency specialist. A permanency specialist is called upon to serve when a youth is getting ready to be adopted or a family is considering guardianship. Since this specialist was meeting the team for the first time and as a consultant, her level of involvement was somewhat distant, but she did offer information about guardianship and what that responsibility would be if the foster parent chose to pursue it. The following excerpt reveals the permanency specialist's description of her role. She has only one job within her role, and is not involved in all family support teams, but only in circumstances in which guardianship or adoption are being considered:

> So I assist the case managers with permanency planning when the case plan changes to guardianship and or adoption, so I help kind of finalize those case plans and those goals for those kids…I meet with children who are placed in adopted homes each month. I do adoption recruitment for kiddos who are in need of adoptive homes; I do family finding to help engage the biological family into their lives with the hope of them becoming permanent options for the kids. I also negotiate guardianship and adoption subsidy contracts, participate in select support teams, testify at court hearings, and that's it probably in a nutshell (Permanency

planning specialist interview, Case J, Audio-recorded. Lines 10-12 and 16-20).

This consultation role was important because the permanency planning specialist had an in-depth knowledge of adoption, guardianship and contracts. Her contribution in the team meetings was to provide expert knowledge of the business and legal aspects of adoption or guardianship.

Subcategory: The standardization of practices and procedures will be discussed according to the properties of type, stakeholder perception of predictability, consistency in application, timeliness, and transparency. First, type of standardization occurred with written and customary mechanisms. Written guidelines and procedures as well as policy manuals were used to make decision-making a more uniform process. However, there were also customary traditions, such as the sequencing of meetings. This standard was quite flexibly applied in this particular team. For instance, the ordering of when family support team meetings and court hearings were convened was noted to occur with a very strict sequence in another county.

Stakeholder perception of predictability is the team member's sense of certainty about what will happen in the future and ranges on continuum from unpredictable to predictable. Stakeholders reported knowing what to expect in most interviews, with the exception of the foster parent. The foster parent was

somewhat anxious and uncertain and was feeling somewhat overwhelmed by the responsibilities of her new role. She stated,

> I'm still a little bit confused because the subject of guardianship frightens me
>
> > because I know that James wants to be free of the system because that's one less, or several less authoritative figures in his life, and so it just boils down to he has to conquer one, which is me (Foster Parent Interview, Case J, Audio-Recorded, Lines 74-78).

The example shows that the foster parent was not feeling secure about what would happen in James's future life with her, if she assumed guardianship. She had reservations because of his past behavior problems, and worried that he was calculating how to take advantage of the situation without as many adults watching over him.

As far as consistency in application of standards, there was only inconsistency. Not only was the youth allowed to stay in a new placement after he ran away and was caught in deception, the foster parent was trained rapidly to become an accepted kinship provider for him. Regarding timeliness, this particular team worked in a flexible and fluid way to achieve placement stability and permanency for James, which is what he desired. The meeting and court hearing were efficient but problematic for the foster parent who did not feel she was included to the extent that she should be.

Property: Transparency. Transparency is the amount of readiness to share, openness, and honesty one demonstrates in relationship with others. The degree of transparency varies from intransparent to transparent. Within this team, it was observed that information was not shared openly or with complete honesty; this was observed not just in the meeting dynamics, but also in follow up interviews and informal conversation.

In the meeting, the issues of runaway and past behavioral problems were not addressed. She was surprised when a new team member was brought to the family support team meeting at her home. She felt the team did not divulge all of James's options, leaving her to draw her own inferences and try to determine the best course of action with limited information.

> I was kind of taken aback about the lady from Chafee coming because I had never heard of that organization before, and so I don't know that that was explained, quite as well as it could have been in the meeting, to make sense of the services (Foster Parent Interview, Case J, Recorded, Lines 130-132).

The Chaffee worker had been to the home for the consent meeting eight weeks prior to the family support team meeting, but the foster parent was not invited into conversation with her at that time. The foster mother seemingly did not remember that the Chafee worker was previously in her home, and certainly didn't have an understanding of her role on the team.

In the individual interviews, it was only the foster mother who believed the team was not completely transparent in sharing information. This quote taken from her interview shows her concern about not having enough information and feeling left out.

> There's one other thing I wanted to add to it, as far as the transparency of everything, because I've noticed with James's behavior, that some things are being said to some groups of people and some things are being said to others and I think kids of divorced parents will do the same thing. I think that James, it's not his fault, but I think that's kind of how he operates because of the situations that he's been in. (Foster parent Interview, Case J, Lines 195-199)

This example shows that the foster mother noticed a manipulative nature in James. He took advantage of the adults failing to communicate effectively. She was aware that James was perhaps playing some adults off of others to get what he wanted. It was not just that the foster youth had misrepresented his situation in order to move in with her. This foster parent suggested a feeling that she was not included as an essential person on the team.

> Often times I am confused as to the extent of my involvement in James's care plan and my role as an integral part of his care team. I feel at times hesitant to bring my concerns to the caseworker due to his current

caseload and responsibilities (Foster parent Empowerment Scale, Hand-written Comments, Case J)

The foster parent was not certain that her role was valued or appreciated. She may have been reluctant to speak to the case manager about her questions or worries because he suggested through his actions that he was very busy.

In contrast, the Deputy juvenile officer and case manager seemed to be quite satisfied with how things were running and felt the team made good decisions. The foster youth was not speaking very much in the meeting, and in the follow up interview reported that, for the most part, he felt he should mostly listen and be respectful.

This family story was chosen to be an exemplar for mesosystem to provide an example of a particular and unique role that was used in this team and to illustrate components of standardization of practices and procedures because they were sometimes unusual.

Summary

Three analytic categories were presented in this chapter. The category "inter-related process of decision-making" was comprised of an agenda that focused on safety risk appraisal, placement stability, connectedness and well-being, structuring meetings that developed their dynamic through affective, cognitive and relational processes. The second category was power, comprised of qualities and responses. Lastly, the third category, mesosystem factors, was

comprised of role and standardization of practices and procedures that support or hinder decision-making. These categories were distinguished with examples from the data. The next chapter discusses the findings, compares them to the literature, discusses limitations and the application of quality standards, and makes recommendations for future scholarship and practice.

CHAPTER 5: DISCUSSION

Introduction

This chapter reviews the results of this study on decision-making in the foster care system. It briefly summarizes the research questions, methods used to answer the questions, analytical procedures and key findings. This chapter then discusses how the categories of the inter-related processes of decision-making, power, and mesosystem factors informed one another.

The findings are compared to the literature based on the following considerations. First, the findings are compared to the Adoption and Safe Families Act of 1997 (ASFA-97) and Fostering Connections priorities. As a reminder to the reader, the ASFA-97 was a paradigm shift toward permanency efforts for youth in the foster care system in response to 'foster care drift,' a term that captured the situation that many youth found themselves in, staying in foster care for inordinate amounts of time. Fostering Connections' foci were future planning as youth outcomes after having spent time in foster care were quite poor. Fostering Connections increased emphasis on accountability for services that were provided to foster youth. Wellbeing, permanency, increased inclusion of family and youth as more involved participants in Child Welfare case planning, future planning for older youth, and tighter oversight, especially around medication management, became priorities. Second, it was assumed that an examination of group dynamics would shed additional light on how decision-

making happens in family support team meetings. Therefore, this chapter provides an interpretation of findings compared to group process concepts. Third, the sensitizing concept of shared decision-making, viewed as an ideal model for decision-making, was compared to what was found in the study. Interpretations of family support team meetings data suggested that some but not all components of shared decision-making were observed compared to the OPTION Scale. Fourth, Self-determination Theory was reviewed against the findings. Conclusions were made about empowerment scores and behaviors in meetings, linking a possible connection to self-regulation, and individual behaviors. Mesosystem factors are discussed with how role and standardization affected deliberations. A discussion of limitations and the application of quality standards round out this chapter. Finally, recommendations for future scholarship and practice are made from what has been discovered in this work.

Research Questions, Methods and Procedures Summary

The research questions were:

1. How do foster youth with mental health needs and their family support teams currently engage in mental health treatment decision-making within the context of family support team meetings?
2. How do foster youth with mental health needs and their family support teams perceive the process of mental health treatment decision-making in family support team meetings?

3. What are the stakeholders' perceptions of their own empowerment?

Data collection methods included observations at family support team meetings and court hearings, notes on informal conversations, semi-structured individual interviews, and empowerment scales for youth and adults within a sample of nine youth and family support teams across five counties. Data analysis included content analysis of meetings, grounded theory methods of analysis of the interviews, and descriptive, inferential and qualitative approaches to interpret empowerment scale scores.

Discussion of Key Findings

The research questions concerned engagement, perceptions and empowerment. As described in Chapter 4, three major categories were found in the data: the inter-related processes of decision-making, power and mesosystem factors. The findings suggested that decision-making occurred by complex and dynamic processes characterized by pre-formulated agendas and specific, Child Welfare-oriented topics. Key team members, notably the Court Appointed Special Advocate, the transitional placement provider for one youth, and the Deputy juvenile officer in another team, demonstrated two qualities of power: greater degrees of expertise and the ability to establish rapport and connection that allowed them to have certain advantages in ability to influence others.

The social dynamic of power activated various responses. The ways that team members responded to the noticeable power differential between individuals

on the teams were by avoidance and independent action, compromising, empowerment and cooperation. One way that team members responded to the power differential was avoidance and independent action, or a combination of not acting and exhibiting other behaviors independent of the team. Another response, compromising, was a continuum of negotiation, wherein responses of team members were either to not 'give in' to a particular request, or to try to arrange an agreement through winning over one team member and persuasion.

Empowerment, a third response style, was observed in team members' behaviors as either giving, experiencing or sharing power, and was further examined by surveying participants specifically about it, and through interview questions. Family Empowerment Scale scores and Youth Efficacy scores were compared to age, gender, ethnicity, and role. Of these, the only statistically significant correlation was that males in the adult age group had higher mean empowerment scores than did females. Further qualitative analysis of low scoring cases revealed knowledge deficits, lack of self-efficacy and powerlessness among youth and certain adult team members. Cooperation was manifested in family support teams along a continuum, with certain family members and team members not following court recommendations to get their children back, and others making careful and intentional efforts to pull resources for the benefit of the entire team. Finally, mesosystem factors affected deliberations. In essence, most members articulated having distinct purposes that were functions of their role within the

family support teams, knew what responsibilities were assigned to them, and stayed within the boundaries of their defined roles. At least one member (the CASA) noted that this adherence to role was a hindrance when it came to supporting youth case planning or implementation. Standardization of practices varied across teams, and appeared to serve as a factor that either supported or hindered deliberations, depending on the degree of consistency and timeliness of application.

In conclusion, engagement appeared to be a product of affective, cognitive and relational processes; the ability of those in leadership to establish rapport and connection; and a function of responses to power: avoidance and independent action, compromising, empowerment, and cooperation. Perceptions of how team members experienced deliberations in team meetings were elicited from questions about thoughts and feelings in 34 individual interviews. Most participants felt the meetings went well, although some exceptions were described under the property 'cognitive processes' within the category labeled the 'inter-related processes of decision-making.' Besides numerical scores on empowerment scales, non-survey data provided a more thorough understanding of how individuals perceived the giving, experience or sharing of power.

The next section of this chapter reviews the findings on the first category, the inter-related processes of decision-making, compares them to the literature, and discusses in what ways this category is related to the other categories.

Inter-related processes of decision-making. Four agenda topics were identified as structural anchors for family support teams: 1)safety risk appraisals, 2)placement stability, 3)connectedness, and 4)well-being. Safety risk appraisals were conducted at each meeting, due to the nature of children being in Child Welfare. While no youth in the study was in danger of imminent harm, some youth had ongoing communications with exploitive caretakers; some had run away and had used drugs while in care. These factors put youth at risk for being harmed in the future, and were evaluated as part of a comprehensive assessment of how youth were faring in Child welfare. Connectedness was an important need that was consistently addressed as part of the agenda in family support team meetings. Well-being was a focal point of the team meetings. In examining the findings, well-being was indeed a focal point of meetings. Four types of well-being were addressed, with mental or emotional health occurring most frequently. Within that type, teams did not uniformly or thoroughly address mental or emotional health. Teams did focus on both individual and family well-being. Perspectives about how youth were doing varied across participants. However, as discussed in the findings chapter, a greater emphasis seemed to be placed on placement stability.

Affective processes were demonstrated with a continuum of expressions: unpleasant to pleasant, and were compared to how individuals contributed to decision making. Unpleasant emotions, either observed or reported as crying,

confusion, or frustration, among both youth and adult team members, corresponded with a higher degree of participation, which was a surprising finding (Cases A, K, M & T, Family Support Team Meeting Notes). As expected, pleasant emotions, either observed or reported, also corresponded with a higher degree of participation (Cases A, E, G & H, Family Support Team Meeting Notes).

Participants demonstrated numerous and varied cognitive processes as part of the comprehensive process of decision-making. Whether it was assessing needs, exploring choices and options, planning, or drawing conclusions, these mental activities were important and necessary in order to arrive at decisions. Assessing needs occurred at the level of the individual and the family; exploring choices and options occurred in a few ways, across teams (adaptation of OPTIONS scale applied to meeting and court hearings). And, while no single type of cognitive processes appeared more important than another, the one that seemed to be the most nuanced was drawing conclusions. Drawing conclusions was a property that encompassed either narrowing in on specific incidents or making holistic appraisals, noticing internal thought patterns or focusing more on other team members' attributes, being more aware of content discussed in meetings or team dynamics; and was also noted to include a tendency toward goal-attainment or distraction.

Relational processes were certainly an important component of the overall decision-making process. Most teams appeared to be making concerted efforts to engage foster youth and families in the decision-making process. As indicated by interview responses, most team members felt encouraged to speak up in the meetings, although this was not true at court. In looking at the way discussions unfolded, a typical sequencing occurred in which adult team members asked questions of youth. Various issues were presented, along with the generation of solutions. Teams typically had answers and solutions to questions and challenges by the end of meetings with the exception of one team, when key members were absent. The degree to which teams came to agreements varied across teams. Finally, collaboration was observed to vary, too, with some teams failing to collaborate and others showing a high degree of collaboration.

Comparison of findings on the inter-related processes of decision making to the literature. According to Self-determination Theory, the three important psychological human needs that must be met in order for people to thrive are relatedness, autonomy and competence. Relatedness refers to bonding, connecting or belongingness with others. Relatedness is viewed as a reciprocal process of caring for and being cared for by others. Autonomy is defined as being the perceived origin or source of one's own behavior. Competence is described as a sense of confidence that one is effective within the social environment as well as

the perceived sense of mastery in practicing one's capacities (Deci & Ryan, 2002).

Relatedness as conceptualized by Ryan and Deci's Self-determination Theory (2002) is in alignment with two findings from this study: 1)connectedness as an agenda item, and 2) relational processes. Connectedness and relational processes are part of the larger category, the inter-related processes of decision-making. An example that illustrates both connectedness and relational processes is the supportive and professional relationships that the judge and CASA had with Alice; this example showed both the importance of addressing youth's needs for support and the relational processes that were manifestations of engaging and collaborating with team members.

The Self-determination Theory concepts of autonomy and competence were also found to align with findings from this study. Self-ratings of autonomy and competence were measured with an adult empowerment scale, the Modified Family Empowerment Scale (FES), and two youth scales, the Youth Efficacy/Empowerment Scale - Mental Health (YES) and the Youth Participation in Planning Scale (YPP). None of the participants scoring low on the empowerment scales displayed autonomous action per OPTIONS scale analysis. In exploring the reasons why some members rated low on empowerment scale items, it was found that some lacked self-efficacy, as described in Chapter 4. Self-efficacy is similar to the concept of competence as described by Ryan and Deci

(2002), in that both concepts have to do with a person's sense of mastery of the environment or a perception of being capable of acting.

As described above, *ACSA-97* and *Fostering Connections* re-directed the Child Welfare System toward increased attention toward future planning, increased accountability, and more full inclusion of youth and families in decision-making. Another important shift was in prioritizing permanency over re-unification.

Planning for the future. While it was evident in Alice, Evelyn, and James and Kaitlyn' s teams that support teams were looking to the future, for example, by focusing on college plans, in other teams the focus seemed to be more immediate. For instance, in Frank's situation, the focus seemed to be on maintenance of the status quo, while for Gabby and Henry, it was focused on summer plans only. As a young high school student, Mary's concern was focused on being able to return to her grandmother's home, and for Tom, the team tried to help him formulate goals for spending his time appropriately when he aged out of foster care. A component of planning for the future was uniformly addressed in all teams: participation in Chafee services, which help youth prepare for self-sufficiency.

Accountability. Another *Fostering Connections'* priority was the creation of mechanisms for continuity of care and oversight of healthcare treatments including psychotropic medication management. One way in which accountability

was observable in meetings was the presence of third party participants who wrote about the ways the team focused on goal attainment (CD Oversight Specialist Interview, Case A, Lines 14-16).

These third party participants were present in Alice, Evelyn, Kaitlyn, Frank's meetings. The second way in which accountability was noticed was informal, during an interview; the Extreme Recruiter shared her action plan template that she used to monitor youth who were enrolled in her program. On the sheet, it identified target goals, deadlines and who was responsible for each outcome criterion listed. She said these sheets were completed weekly for youth who were in Extreme Recruitment to keep the team on track. These types of forms were not used in regular family support team meetings, but seemed to be a worthwhile tool that could be used within meetings.

Medication management was a problem in one case, because of the teams' failure to share information. The case manager and team did not know the medication that the youth was currently taking or prescribed. Since neither the youth nor foster parents were present for the meeting, this issue was unresolved at the conclusion of the meeting. Medications were not of concern for the remainder of youth in the study, although two others were on prescription psychotropic medications.

Increased inclusion. The priority of increased inclusion of family and youth as more involved participants in Child Welfare case planning was

compared to the findings. Some ways in which families were included in family support team meetings were providing personal invitations, scheduling meetings at times when all could be present, and soliciting input during meetings. In this study, 8 out of 9 youth were present and were involved in their meetings. There was only one meeting in which scheduling was problematic so that the youth did not attend. In the remainder of teams, youth were present and more or less actively involved in the conversation that was taking place on their behalf.

Parents were invited to team meetings for seven youth participants. In some situations their absence was expected, for example if the youth were permanently separated from their parents with no chance for reunification (Cases A and F), or if youth were returning home, and would no longer be in relationship with foster parents (Cases E, G & H). Out of the families in which parental rights had been terminated, parents were not included in the invitation to attend for one of the teams, but were notified of the meeting in the other team; parents did not show up in either case. (While it may seem strange for parents whose rights had been terminated to be invited to family support team meetings, the Child Protective Services Director insisted that they be notified as they were in her words, 'parties to the case.' The parents were informed of the meeting, even though the case manager mentioned that they had not been coming to meetings for the past few years. The mother never responded to the invitation. Incidentally, neither parent attended the meeting, though the father expressed an interest in

coming.) Foster parents failed to attend meetings for four youth in the study (E, F, G and H); however, three out of four of these youth were being re-unified with their biological parents.

Permanency. An additional concern for youth who are served by the Child Welfare System is the amount of time it may take to achieve permanency, and this was specifically addressed in *ACSA-97* and *Fostering Connections*. Interestingly, about half of the youth in the study were re-unified with their families. For Evelyn and Mary, the length of time to re-unification was about 2 years but for Gabby and Henry the length of time to re-unification was approximately 10 years.

Power

Power was a relational dynamic that privileged certain family support team members over others. Particular qualities of power were expertise, ability to establish rapport and connection, oversight mechanisms and authority. It was suggested that some team members appeared to use their positions of power to provide assistance to those who didn't have as much (for example the CASA for Alice and the DJO for Gabby and Henry), while others used their authority to try to instill responsibility in youth who were having behavior problems (e.g., the case manager for James and the guardian ad litem for Tom).

Each of four response types to power ranged along a continuum: avoidance and independent action, compromising, empowerment and cooperation. One response was avoiding communication, perhaps not purposely, while

simultaneously proceeding along a course of action without including team members; others simply did not participate in meetings; both of these styles of response were referred to as avoidance and independent action. Not compromising was on one end of a continuum of response, while an attempt to negotiate as a matter of principle was on the other.

Empowerment scores were studied in comparison to displayed emotions and participation in meetings at the level of the individual. Youth with low scores were Alice and James. Alice showed frustration, irritation, withdrew participation in the meeting, and did seem to have difficulties with handling intense emotions. According to Self-determination Theory, this difficulty is one of self-regulation; she appeared to have this difficulty in the family support team meeting, but not at court. James, in contrast, showed very little emotion and did not speak very much in his family support team meeting, but did ask for what he wanted at court. In conclusion, one youth with low empowerment indicators showed signs of emotional distress while the other youth did not show distress.

The Children's Division oversight specialist for Alice, the permanency specialist and the foster parent for James had the lowest empowerments scores among the adults. In looking at emotions, none showed outward signs of distress, but the foster mother did share her difficult emotions in the interview. None spoke up in meetings. It appeared outward display of emotional difficulty (which Self Determination Theory would characterize as a person who was poorly self-

regulated) only occurred in one of the participants with a low empowerment score. The other participant with a low score, James, had very limited social interaction, but the behavior would not be classified as poorly regulated. A surprising finding was that one of the highest scores for youth empowerment came from Tom, who seemed relatively uninvolved and unengaged.

Comparison of findings on power to the literature. According to Dahl (1957), power is the degree to which one person is able to persuade a second person to do something he or she would not otherwise do. Similar to Dahl, Raven (2008, p. 1) defined social power as a construct of 'social influence' plus the capacity to cause change and use resources.

> In our initial papers (…), we first defined social influence as a change in the belief, attitude, or behavior of a person (the target of influence), which results from the action of another person (an influencing agent). Social power was defined as the *potential* for such influence, the ability of the agent or power figure to bring about such change using resources available to him or her.

In examining the findings of the study, it was found that two of the qualities of power were clearly relational in nature: expertise and ability to establish rapport and connection, while oversight mechanisms and use of authority were mechanisms of controlling resources. It was observed very early on in the data collection that a power differential existed among those involved in

the study. Besides the observed hierarchical relationships among various personnel and team members, the observed communication dynamics in meetings and interview responses suggested, too, that power was a major relational dynamic that provided information about how team members engaged with each other, that it informed how individuals perceived the process of family meetings, as well as how they self-rated their own empowerment. The findings were compared with other scholarly reports that explored power within the foster care system. The analysis of scholarship related to power and the foster care system is rather expansive to allow the reader to thoroughly understand how power has been discussed in the literature and how my study findings fit into this body of knowledge.

Yang and Ortega (2016) stated that children in foster care and their families are often disadvantaged and of minority status, making continued victimization probable after entering into child welfare system. Specifically, poverty and race are contributing factors of continued oppression (Yang & Ortega, 2016). The perspective that the power issues within the foster care system are present, identifiable, and modifiable, frame this review of literature on power and the foster care system as it relates to my study findings.

The literature on power and the foster care system was grouped into three types. The first, was related to approaches to care. The literature described different models of care, such as congregate care for reactive attachment

disorder, security-based parenting, an intergenerational, interpersonal relationship-oriented, non-traditional approach to care found in a location called Hope Meadows, and a multi-disciplinary, trauma-informed approach to foster care. Congregate care with specially trained staff was proposed as a mechanism for helping children with reactive attachment disorder develop alternative response styles to life situations, while taking into account their needs for control (MacDonald, 2006). Security-based parenting practices were associated with better youth outcomes (Schofield & Beek, 2009). Hope Meadows provided some philosophical tenets to foster care that are worth considering. (Eheart & Power, 2001; Hopping, Power, & Eheart, 2001; and Power & Eheart, 2001). In this place, Hope Meadows, foster children were viewed as ordinary, able children and older adults contribute to their development. Developing social capital through interpersonal relationships and engaging youth and older adults in a community of support provided opportunities for youth and older adults to reciprocate care and support with one another (Eheart & Power, 2001; Hopping et al, 2001; and Power & Eheart, 2001). Finally, a descriptive case presentation about one foster youth's experience of severe neglect, abandonment and severe psychiatric problems indicated that successful placement in a caring foster home and multidisciplinary, trauma informed approach to therapy, resulted in a good resolution (Heineman, Clausen, & Ruff, 2013). While none of these approaches to care were found to be principles that guided foster care in my study, at least

one participant observed that an important aspect of care planning and implementation was missing. Specifically, the CASA worker (Case A) identified that particular parenting practices were lacking for Alice, but that if present, her situation might have been different.

The second type of literature related to power was related to perspectives of youth who had lived in foster care. Young people described their experiences prior to entering foster care, time during care, and experiences that affected them afterwards. Nybell's (2013) work depicted stories of youth who expressed feelings of being treated poorly during the process of leaving their families and during foster care itself. One youth recounted being taken away from his alcohol-dependent mother due to neglect; he felt that this was unnecessary, but was also humiliated to be taken out of his school in handcuffs, despite having committed no crime (Nybell, 2013). This use of coercion was similar to the story described by one caseworker in my study, who shared that her previous supervisor dictated that she use threatening tactics to remove Kaitlyn from her mother's home. For instance, when the worker asked for back-up help, the supervisor would not provide it, and instructed her to threaten police involvement if Kaitlyn would not leave her home cooperatively.

Another youth in Nybell's study (2013) was in a punitive foster home, followed by an unloving one, and multiple other placement changes. When he complained, his caseworker did not listen or act on his complaints or requests to

be moved. Eventually he was placed in a loving foster home, but only after the foster home placement provider asked for his removal, following his 16th birthday. This account is similar to a few young people in my study: Alice, who experienced multiple placement disruption; Kaitlyn, who endured multiple failed placements, and Tom who also was moved often during his time in the foster care system. Among the youth in my study, Alice and Kaitlyn attempted to advocate for themselves, while Tom's grandmother attempted to advocate for him, when placements appeared to be inappropriate.

One young person in Nybell's study (2013), severely and repeatedly beaten by her parents, was living in an affluent neighborhood. Though there was evidence of systematic maltreatment, Child Welfare personnel were intimidated by the parents' wealth and community status, and did not intervene to protect the child. Rather than a direct entry into safety, her pathway was made slowly by developing a plan of action with school personnel who took the time to understand what she at first was not saying, but evidencing with bruises. The school personnel worked with her to develop a plan for herself should her situation become desperate. That desperation came one day she was beaten so badly that she thought she would be killed. Upon calling the police, the police officer asked why she was publicly criticizing her mother. The blaming of this child was compared to Gabby and Henry's story. Gabby and Henry's mother was blamed for the fire in her home, and was judged to be an unfit mother, leading to

the placement of her children in out of home care for approximately 10 years. Eventually, it was found that she was able to provide for her children's needs, and Child Welfare was released custody back to her.

These stories shared by Nybell (2013) suggested that youth reconciled their experiences through a process of thinking about, and then taking action, to leverage their own power (voice). Through this reconciliation, youth were able to move past the obstacles that could have been potential barriers to their own well-being (Nybell, 2013). In comparing the ways that team members responded to the noticeable power differential between individuals on the teams in my study: (i.e., compromising, avoidance and independent action, empowerment and cooperation to Nybell's work (2013), responses of compromising and empowerment found were found in both studies. These are discussed elsewhere in this chapter. Likewise, Gabby and Henry's family story, described in Chapter Four, provide indicators of the ways power and empowerment were manifested in my study.

The third type of literature was outcome-based, in which large numbers of youth were studied to identify placement trajectories; outcomes of particular parenting practices on youth outcomes; and relationships between type of abuse, family stressors, length of time in foster care, number of placement moves, race or gender and self-determination. In looking at placement trajectories in a birth cohort of 5,873 foster children from the year 1999 followed to the age of 9 years, 51% were adopted; 36% reunified; 7% lived with guardians; 5% lived in foster

care (Magruder, 2011). In my study, no youth were adopted; three were reunified with biological mothers (33%), one was pursuing guardianship (11%) one was pursuing kinship care (11%), and four (44%) were still in foster care. Of those who remained in care, two were in transitional living programs, one was in a career level foster home placement and one was in a therapeutic foster home placement.

Outcomes of particular parenting practices were compared to my findings. In the third phase of a longitudinal study on foster care, the effects of "secure base" parenting were associated with better foster youth outcomes during adolescence (Schofield, & Beek, 2009). These practices included being present and available to increase youth sense of trust; being sensitive to distressing emotional issues and youth's need for help in managing these; acceptance to promote self-esteem; promoting sense of competence; and promoting family belongingness. While it was not the focus of my study to examine parenting practices, a review of caregiver behaviors and interview responses could be compared to "secure base" parenting practices (2009). From these observations and interview responses, it appeared that the TLP supervisors for Alice and Kaitlyn, and the therapeutic placement providers for Mary and Tom, exemplified all of the secure base parenting practices except providing for a sense of family belongingness. Gabby, Henry and James's caregivers and Mary and Tom's grandmother exemplified all of the secure base parenting practices. However,

there was some concern about the grandmother's judgment and ability to follow through with needed supervision and discipline. Finally, there was not enough information to interpret Evelyn or Frank's caregivers' parenting practices, from what was revealed in meetings or interviews.

Empowerment. While empowerment and self-determination are not equivocal, they share some common features, self-efficacy and autonomy. Powers (2011) studied predictors of self-determination among a sample of 188 foster youth with a mean age of 15.5 years. Powers (2011) found no significant relationships between type of abuse, family stressors, length of time in foster care, number of placement moves, race or gender and self-determination as outcome. But, further analysis revealed relationships between physical abuse and longer length of time in care with autonomy. Greater stress in original families and longer time in foster care predicted higher autonomy (Powers, 2011).

As compared to Powers (2011), facts concerning Child Welfare involvement were not systematically collected in my study. Therefore, it is not possible to compare my study results to type of abuse, family stressors, length of time in foster care, number of placement moves found in Powers' (2011) study results. But, for comparison purposes, Power's attention to gender and race as predictors of self-determination were compared to my study findings on youth gender and race correlations to empowerment. In summary, when examining race and ethnicity to self-determination, Caucasian youth had significantly lower

psychological empowerment (a component of self-determination) compared to minority youth, but there was no relationship between gender and self-determination (Powers, 2011). In my study, the mean empowerment score for female youth (n=5) was 74.4, while the mean empowerment score for male youth (n=4) was 84.3, showing that males scored higher on empowerment. Also, there was little to no correlation among empowerment and ethnicity for youth as measured with the YES (African American youth Mean= 79; SD=10.05; Caucasian youth Mean= 78.5; SD=14.7). In conclusion, in my study and in Powers' (2011) much bigger study, there were dissimilar findings in correlating race to outcome measures, but similar findings showing little to no association between youth gender to outcome measures.

As discussed previously, among the sample of foster youth in this study, empowerment scores varied, and behavioral expressions, which indicated self-advocacy, were also varied. For instance, Alice had low empowerment scores, and a mixture of behaviors that suggested she was trying to advocate for herself but did not have complete mastery of this skill. Evelyn asked for what she wanted in her team meeting, but quickly backed down when she was told no; the remainder of youth did ask for privileges or requests, but did not appear strong in confidence. These findings are consistent with research that has emphasized the need for teaching foster youth how to advocate for themselves (Garcia, 2012).

Among adults who provided additional information about low scoring items on the FES, James's foster parent expressed the desire for more inclusion in the team deliberations. This foster parent not only had one of the lowest adult empowerment scale scores among 25 adults who took the FES, she articulated feeling left out of essential information and that she was unsure of the team's inclusion of her as an essential member. This finding was similar to Buchanan, Chamberlain, Price and Sprengelmeyer (2013); Christenson & McMurtry (2007); Coakley, Cuddeback, Buehler and Cox (2007); Dorsey et al. (2012); Havlicek et al. (2012); Hudson & Levasseur (2002); and Shireman (2009), who documented foster parents' needs for thorough information, effective communication, support and involvement from Child Welfare agencies.

In reviewing literature against my findings, with the question, "What does the literature say, if anything, about foster parent needs for education and teaching adults regarding parenting, decision-making, participation & case planning when they have varying levels of competence?" only a few studies were found that addressed foster parent competence. Only one was found that mentioned using adult education principles in program implementation (Horwitz et al. 2010).

The fact that most foster parents in my study were interested in more information and skills training and motivated to be effective in their respective roles, is consistent with the literature which suggests that foster parents are willing to receive ongoing education and are interested in improving their skills

(Christenson & McMurtry, 2007; Coakley et al., 2007; Cooley & Petren, 2011; King, Kraemer, Bernard, & Vidourek, 2007; Metcalfe & Sanders, 2012). The range of adults' caregiver knowledge and competencies in my study varied from uninformed with little knowledge and skills for assuming parent responsibilities to highly educated and competent in role. This was evidenced by the various levels of education, on a continuum from less than high school completion to PhD level of education, as well as interview responses and empowerment scores that indicated varying levels of empowerment. Adults like James's foster parent and Mary and Tom's grandmother experienced lower levels of knowledge and competency, and voiced concerns about not knowing how to work with agency personnel or to manage problems adequately. This was similar to findings by Cooley & Petren (2011) that documented foster parent needs for understanding agency politics and advocacy training.

Furthermore, four case managers mentioned that they had concerns about service delivery and or how to influence service delivery. These findings were consistent with the results of McMillen's (2007) qualitative study that indicated case managers are often caught in dilemmas about advocacy at the system level. In conclusion, the findings suggested that not just caregivers, but also case managers, ranged in their levels of knowledge and competencies from uninformed with little knowledge and skills for being an educated family support team member to well informed and confident. Implications for team

members' needs for information and training are discussed in the section titled, "Recommendations for Scholarship and Practice."

Mesosystem Factors

Mesosystem factors were factors within the Child Welfare and court systems that support or hinder decision-making. Two subcategories of this category were role and standardization of practices and procedures. Properties of role were: differentiation, reasons for involvement, and compliance. Five properties of standardization of practices and procedures were: type, stakeholder perception of predictability, consistency in application, timeliness, and transparency.

The differentiations of roles within the systems were many; at least 15 roles were represented across the adults who filled out empowerment scales. Roles such as an oversight specialist, re-unification specialist, Extreme Recruiter, and Chafee worker were among those adults on the team with specialized functions. While some specialist roles did not demonstrate apparent productivity or appear to contribute to decision-making (oversight specialist, for example), others appeared to be essential members of the team, for example the Chafee workers.

There were at least three reasons individuals were involved in family support teams: volunteer, family member, or paid employee. Compensation with higher pay was a condition of employment for particular team members, such as

career and therapeutic placement providers. The motivation for being involved or remaining involved as a family support team member was not asked of participants, but it is a consideration when examining the effectiveness of team meetings and what motivates individuals for productive engagement.

In examining compliance, it was found that youth and family members as well as caseworkers complied with requirements as a function of role. Youth and mothers' interview responses often revealed an obligation to follow rules as part of one's responsibilities. It seemed that case managers were compelled to complete forms as a focal point in some team meetings, (case managers for Alice and Frank), although others seemed more relaxed and informal about their use (case managers for Evelyn and James).

Roles appeared well defined and differentiated according to interview transcripts across participants. Some team members stated that their roles prohibited them from being more active participants (for instance the Extreme Recruiter and the adoption specialist), while others noted that the work was accomplished as a team, and individual role differentiation was not as important in achieving outputs. As one participant stated, "Everyone has a job to do. Everyone has something to do. [The]Reunification specialist took on jobs. It's not always laid on the case manager; depends who has the expertise" (DJO Interview Notes, Cases G and H, Not Recorded, Lines 64-66).

The types of standardization were written, customary and local/cultural traditions. The written standards were the Child Welfare manual, and the written forms used to document meetings and visits. These forms were not consistently displayed in meetings, as described in Chapter 4. Customs and local/cultural traditions were evaluated across counties and it was found that some counties used tight scheduling of court hearings, while others put all families on a common docket.

The stakeholder perceptions of predictability ranged on a continuum from unpredictable to predictable; with most participants expressing no expectations of what would happen in meetings. Many stated that they expected for there to be a review of progress. Some said they expected that the plan would stay the same.

Practices and procedures varied in at least two ways: the ordering of meetings with court hearings and how youth were placed in foster homes. There was variation in how efficient and timely practices were carried out. For instance, there were long wait times for court hearings in some but not all counties, inordinate amount of time on report writing mentioned by at least two case workers, and mandatory traveling to remote locations to execute work mentioned by a caseworker, which robbed employees of time that might be better spent in other ways. Various team members (CASA, grandmother, foster parent)shared brevity of training and lack of availability of workers “after hours.” Finally, the

manner in which youth were placed in homes varied from flexible to rigid, as discussed in Chapter Four.

The degree of transparency, or the amount of readiness to share, openness, and honesty one demonstrates in relationship with others, significantly varied. Intransparency was observed in two teams, and appeared to interfere with trust, but not necessarily deliberations, in the teams in which they were observed.

Comparison of findings to the literature. As discussed in the previous chapter, the term 'mesosystem factors' was chosen as the conceptual label to represent the interaction of two systems that support youth and families within Child Welfare. The term was borrowed from Bronfenbrenner's ecological theory. When preparing the initial review of the literature, 'mesosystem factors' (or system factors at the meso level) was not anticipated to become a central finding in the study, although a limited amount of literature was reviewed about bureaucracy. After spending an extensive amount of time analyzing the information from the study, it appeared that 'mesosystem factors' captured the interaction of role and standardization of practices more adequately than bureaucracy. While bureaucracy has a somewhat negative connotation, mesosystem factors speaks more aptly of the interactive dynamic of the Child Welfare and court systems; furthermore the concept label provided an opportunity to put the dimensions of system factors along a continuum, which the study findings suggested.

According to Bronfenbrenner (1979; 1986), the interaction of various systems impact the developing person. These interactions may or may not be characteristics of bureaucracy. A review of recent literature on mesosystem factors and the foster care system shows that the majority of studies focused on role issues and social support as being important factors that impact foster youth and family development and experiences of being in care or being a foster parent (Chamberland, Lacharité, Clément, & Lessard, 2015; Chaney & Spell, 2015; Dyce, 2015; Haidar, 2013; Karimi, Jarratt, & O'Hara, 2014; Hong, Algood, Chiu & Lee, 2015). Table 5.1 gives a brief outline of the focus and purpose of recent studies and key findings.

Table 5.1: Mesosystem Factors Research and Foster Care System

Citation	Focus/Purpose	Findings
Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental psychology*, *22*(6), 723.	Review of literature on ecological systems theory	Levels of ecology delineated as factors that impact the developing family.
Chamberland, C., Lacharité, C., Clément, M. È., & Lessard, D. (2015). Predictors of development of vulnerable children receiving child welfare services. *Journal of Child and Family Studies*, *24*(10), 2975-2988.	What risk and protective factors predict cognitive/language and socio-emotional development among youth in child welfare	Parental stress + child abuse predicts decreased socio-emotional development. Parental stress predicts decreased cognitive/language development. The quality of home environment predicts increased children's

Citation	Focus/Purpose	Findings
		cognitive/language and socio-emotional development. Socio-economic risk and social support no direct association to outcomes. Socio-economic risk decreased quality of home environment. Social support = moderator of child abuse potential and the quality of the home environment.
Chaney, C., & Spell, M. (2015). "In the System: "A Qualitative Study of African American Women's Foster Care Stories. *Western Journal Of Black Studies*, *39*(2), 84-101.	To examine the qualitative experiences of 6 African American women who lived in foster care	Fear and confusion at entry. Mixed findings about living in a loving home while in care Social support important Spirituality and religion important All women doing fairly well afterwards Limitations: sampling methods, location of study
Hong, J. S., Algood, C. L., Chiu, Y. L., & Lee, S. A. P. (2011). An ecological understanding of kinship foster care in the United States. Journal of child and family studies, 20(6), 863-872.	Application of all 5 facets of the ecological systems theory to kinship care research. Policy recommendations provided	Kinship care comprises about 25% of the population of children placed outside the home according to 2007 data. Kinship providers facilitate processing loss, visitation with biological relatives, continuity, sense of stability, less perceived trauma associated with separation; caregivers assume more responsibility and

Citation	Focus/Purpose	Findings
		dedication than non-kin caregivers. Policy implications: there is a need more support and targeted programing for kinship providers, since they are viewed as leading to positive youth outcomes but may have unmet needs for support.
Karimi, H., Jarratt, S. E., & O'Hara, K. (2014). Therapists Working in New and Old Ways: An Integrative Ecological Framework for Non-Familial Intergenerational Relationships. *Australian & New Zealand Journal Of Family Therapy, 35*(3), 207-222. doi:10.1002/anzf.1061	Descriptive article that reviews several care models, including ecological systems model, in order to impact disrupted family processes	From an ecological systems standpoint, all five systems interact with one another; any of the five systems may support or interfere with adaptive family functioning. Networking with multigenerational resources helps families to access emotional support in a non-traditional way. Multiple examples of therapeutic practices were presented.
Haidar, Y.M. (2013). What is the experience of foster care mothers? Doctoral Dissertation. Retrieved from Columbia University Academic Commons, http://dx.doi.org/10.7916/D8X63JT0.	To identify sources of support, family environment, experiences, satisfaction and ecological factors that impact role	**Findings from Non-kinship foster mothers (N=15)** 1. Mesosystem factors: relationships with/communication with biological parents and agency personnel; lack of knowledge and skills for helping with behaviors and emotions of youth; lack of preparation for re-unification.

Citation	Focus/Purpose	Findings
		2. Perceived support from family and agency useful but the agency was not supporting enough. 3. Role stress and role strain; used coping mechanisms to manage stress and strain. 4. Financial constraints and cultural issues also present; Hispanic mothers spoke about culture more than other non-Hispanic foster mothers. **Findings from Kinship foster mothers (N=15)** 1. Mesosystem: lack of time for role. Role negotiations and conflicts, family conflicts 2. Perception of support: comes from family and not as much from agency. 3. Role exhaustion in some women. 4. Finance and cultural issues not as prevalent.

Haidar (2013) and Hong et al. (2015) investigated role factors that impact being foster parents. My findings were similar to Haidar's that role differentiation and role stress are areas of concern for foster parents. Like

Haidar's, my findings revealed a lack of preparation and support from the agency in role implementation. To counter the strain and stress of fostering, Karimi et al (2014) found that networking with multigenerational resources helps families to access emotional support in a non-traditional way. The use of resources from multiple generations was seen in Alice, Frank, Mary and Tom's teams. The older generation roles were CASA, career foster parent and kinship caregiver. Since caregivers, whether kin or non-kin foster parents experience role stress, accessing resources from multiple generations seemed to afford participants with varied perspectives and experience. These findings were consistent with literature that supports gathering this type of support.

In conclusion, caregiver and youth support appears to be a linchpin in situations of adversity (Chamberland et al, 2015; Chaney & Spell, 2015; Hong et al., 2015). For example, social support appears to be an important moderator in the journey of socio-emotional development for children who are abused and neglected (Chamberland et al., 2015). Among children who will return to families in which adversity is present, social support may decrease the likelihood that a parent will harm the child in the future (Chamberland et al, 2015). Furthermore,

Chaney & Spell's (2015) work highlighted the importance of supportive relationships in cultivating resilience for youth who were in foster care. Though my study did not examine social supports with specific interview questions, this would be relevant for future studies

Group Dynamics Findings Compared to the Concepts from the Literature.

In the examination of group dynamics, the elements of structure, formality, focus on goal attainment and leadership style were explored, as concepts derived from the literature (Beal et al., 2003; Hirokawa & Pace, 1983; Hanson, 1981; Hirokawa & Keyton, 1995).

Within the family support team meetings, there was a visible structure but the flow of activities varied. Generally, there was less formality, as compared to court. Within the courtroom, many rules and procedures guided conduct, and the flow of activities. Family support team members did not speak unless called upon. In one particular county, all parties who spoke to the judge, with the exception of the youth, were sworn in to provide testimony under oath. Each meeting and court hearing was planned in advance with the membership. While the family support team meetings typically lasted one hour, the court hearings had no time limit, but were usually 15-30 minutes in duration. In some counties, all cases were put onto a common docket, while in others appointment times were provided. The format and procedures for court and family support team meetings usually followed an agenda, and concluded with written paperwork. There were some teams in which the agenda was not as strictly followed or apparent as a focal point (Cases E and J).

There appeared to be a strong focus on accomplishing tasks and meeting case goals in both court hearings and family support team meetings, with one

exception. As was mentioned in the findings chapter, there was one team in which members did not appear to have a shared vision for the young person's permanency plan, and this prevented the team from working together toward the youth's goal of adoption. While in court the proceedings were led by the judge exclusively, the leadership style varied across family support team meetings, but was typically democratic. For the most part, leadership was observed to be a shared responsibility. However, the case managers appeared to be in a facilitator role in family support team meetings, and the judges were directing the proceedings at court. Interestingly, when participants were asked who led the family meetings, there was a lack of consensus about who was leading at the family meetings; answers included: the youth, it ran itself, the case manager, the DJO, but the most frequent answer was that the case manager led the meeting. All participants articulated that judges led the court hearings. One case manager remarked that she was aware that youth were supposed to be taking on more leadership of the family support team meetings, and another case manager stated he believed the youth on his team did not have the skills to conduct an informational meeting.

In conclusion, the elements of group dynamics that were studied in the court hearings and family support team meetings suggested that a tight structure and formality were evident in court and to a lesser extent in family support team meetings that had a strong focus on goal attainment; the leadership style was

democratic for most FST meetings. Members were not in agreement about who the leader was in family support team meetings, suggesting that leadership was shared and perhaps diffuse; but clearly the judge had leadership behaviors in court that conveyed that he or she was in charge in that venue.

Comparison of findings about shared decision making to the research literature. Shared decision-making was discussed extensively in Chapter Two as a sensitizing concept. In review, shared decision-making is a communication approach between a provider of services and a recipient of services in which the values, preference, needs and concerns are taken into account, and both parties actively consider alternatives to solve an issue (Drake & Adams, 2006; Elwyn, et al., 2005; Gafni et al., 1998). Instead of viewing the provider as expert and ultimate decision-maker, a shared decision-making approach views the recipient of services as an important contributor and expert in his or her own life experience (Deegan & Drake, 2006). The recipient and provider work in a collaborative way to generate solutions (Drake & Adams, 2006; Goscha, 2009; O'Brien et al., 2011; Towle et al., 2006). In this study, the OPTIONS scale was an observation tool that was used to examine various aspects of shared decision making that might have been present or absent in meetings and court hearings (Elwyn et al., 2003).

Initiating and naming problems or issues were embedded into the agenda of the family support team meetings and court hearings. Initiation of topics

focused on the priorities of child welfare: safety, permanency and well-being, but also included requests for special privileges. The initiation was generally led by the case manager in family support team meetings and the judge in the courtroom, but youth were observed bringing up requests in some meetings and court hearings as well. Besides safety, permanency and well-being, incidental issues that were brought to the table for discussion included: spending habits; school, therapy or Chafee class attendance; pro-social and communication skills development, boundaries, and following rules. Special privileges were sought to: vacation out of state, participate in a beauty pageant, and attend a youth leadership conference.

In half of the family support teams, no member specifically stated that there are many ways to deal with a problem. In five youth cases, team members either demonstrated or reported that they thought about or actively solicited youth preferences (E, F, G, J and T). Team members asked things like, “What do you want to do when you get older?” (Family Support Team Notes, Case E, Lines 33-36). “What is your plan?” (Family Support Team Meeting Notes; Cases J, Line 89; FST Meeting Notes, Case T, Line 30). “What college do you want to go to?” (Family Support Team Meeting Notes, Case J, Lines 119-122) “What do you want to do?” (Family Support Team Meeting Notes, Case T, Line 82) “Does the young person still want adoption?” (Family Support Team Meeting Notes, Case F, Line 53). One worker said the youth’s goal and preference were to establish

permanency through adoption (Analytical Memo of Extreme Recruiter Interview, Case F, Lines 155-157). Five youth and three adult team members voiced preferences about how involved they want to be in decision-making.

In all of the family support team meetings, talking about choices occurred. In some cases, the discussion about choices focused on spending, saving or disclosing information about money (A, F, K) while in other cases, the discussion about choices had to do with choosing pro-social behavior or how to manage free time (G, H, M and T). Discussion of options involved talking about future plans in the context of resources. For instance, the future plans for James were conceptualized as involving two options for the youth's disposition.

No team member suggested that a list of pros and cons be generated to evaluate decisions. This particular finding was interesting, given that most other aspects of shared decision-making seemed to be occurring in meetings.

As mentioned previously, most teams appeared to be making concerted efforts to engage foster youth and families in the decision-making process. It was also observed that in five out of six teams when youth appeared to be experiencing more difficulties with emotions, i.e., there was crying or a behavioral problem identified in the meetings, team members responded with more authoritarian approaches (Cases A, J, K, M & T). This resulted in Alice disengaging, James maintaining a distance to the team, Kaitlyn initially being upset, but then accepting the judge and team's recommendations, Mary

cooperating, Tom initially offering a non-cooperative response style but later showing cooperation. Looking again at empowerment scores, Alice and James had lowest scores, while Tom had one of the highest.

A speculative model was generated for these patterns. Observed increased emotional difficulty in youth plus authoritarian approaches from adults leads to decreased engagement and decreased empowerment. This model has its limitations. First, the model did not apply to all teams. Second, the measurement of emotional difficulty was not a focus of this study; therefore a precise measure of it was lacking. Furthermore the number of teams involved was quite small, making this a model that has limited application. To test this out in future studies, more teams would need to be studied, and reliable measurements of emotional difficulty would need to be identified.

In conclusion, shared decision making was thought to be an ideal model of making decisions. At the outset of the study it was unknown to what extent teams would be demonstrating characteristics of it. The analysis of meetings revealed that many components of shared decision-making were present in meetings. However, there could have been opportunities to teach youth and families to be more engaged and to discuss a weighing of values when deliberating among options; and certainly authoritarian styles of approaching youth are contradictory to the spirit of shared decision-making. These areas of concern may be worthy to explore in in future research.

In Which Way Do the Findings Answer the Research Questions?

In review, this study examined the various facets of family support teams who gather to support youth between the ages of 15 and 18 years old who have mental health concerns. Meetings and court hearings were observed to understand how team members engage with one another, how they perceive the process and how they self-rate their own empowerment. Nine family support team meeting observations, one placement review meeting, six court hearing observations observed; 34 individual interviews, empowerment scales, and non-survey data comprised the data set. The answers to the research questions are summarized as follows.

Three core categories were developed by a careful analytic process. The inter-related processes of decision making, power, and mesosystem factors explained how meetings unfolded and how members felt about them. Regarding the first research question, the engagement of family support team members appeared to be a product of affective, cognitive and relational processes; the ability of those in leadership to establish rapport and connection; and at the same time a function of responses to power: compromising, avoidance and independent action, empowerment, and cooperation. With regard to the second research question, most participants felt the meetings went well, although a few participants shared their reasons why they felt differently. Finally, the answer to the third research question: how do stakeholders self-rate their own

empowerment, was addressed in two ways. Besides numerical scores on empowerment scales, non-survey data provided a more thorough understanding of how individuals perceived the giving, experience or sharing of power. From the additional data source, the third research question could be addressed. It was found that those with low scoring items expressed concerns that were grouped as knowledge deficits, self-efficacy challenges that appeared to be role specific, and powerlessness. None of the three categories in isolation would be sufficient to answer the research questions, but when combined, these categories contributed to an overall understanding of how deliberations unfolded and how participants experienced meetings and their own empowerment.

Quality Standards

In order for this research study to be credible, it must adhere to certain quality standards. Miles et al. (2014) categorized quality standards into five domains: objectivity, reliability, internal validity, external validity, and application.

The first criterion, objectivity or confirmability, is described by Miles et al. (2014, p. 311) as "relative neutrality, freedom from unacknowledged researcher bias and explicitness about inevitable bias." In order to enhance objectivity of the report of findings of the current study, recommended practices and procedures were employed. They were: record keeping of meeting notes, process notes and analytical procedures to generate an audit trail, and using the

heavily structured analytic process according to Grounded Theory (Strauss &Corbin, 1998) during the data analysis phase. I retained documents in an electronic and hard copy files that described research methods, processes, and analytic decisions, so that an outsider could review that process and understand what steps were taken during evolving stages of the research process.

The second quality criterion is a related standard: reliability, defined by Miles et al. (2014) as "consistent and reasonably stable data collection methods [are employed] over time and across researchers and methods" (p. 312). There are several ways in which reliability was strengthened in this mixed methods study. By ensuring the research questions were clear and the methods of data collection logically followed from the research questions, the principle of consistency was maintained (Miles et al., 2014).

Reliability was also achieved through reflexivity, or being transparent and self-reflective about my position as a researcher (Merriam, 2002). My position as a researcher was described in Chapter One, but in summary, I have done previous research in the Child Welfare system, and am employed as a nurse consultant in a foster care agency. Prior to this study, I had extensively examined the experiences of eight foster youth as part of a research team. Therefore, I was not entering into the inquiry without previous knowledge of participant characteristics. Furthermore, I had also conducted a literature review prior to entering the field and had formulated sensitizing concepts as part of my

preparation for entering the study. These experiences were disclosed at the proposal stage of the study, and were written about in Chapter Two.

The creation of an audit trail serves to enhance both objectivity and reliability (Merriam, 2002; Miles et. al., 2014). Modifying Merriam's suggested journaling strategy, I had regular face-to-face meetings with a small group of doctoral students and a senior researcher to discuss my research process, including ideas, questions or challenges that come up during data collection, data analysis and drawing conclusions, and meeting notes were generated afterwards.

Considerable attention has been given to internal validity. Internal validity is the degree to which a report is an accurate and representative account of the participants' subjective experience (Merriam, 2002, p. 25; Miles et al., 2014; Schwandt, 2007). While there are at least twelve ways of checking for internal validity according to Miles et al. (2014), not all of these were used in this study. For example, even though member checks are suggested, they were not employed. A second way of establishing validity is to ensure that the particulars of the context of the study are made explicit. I did this in two ways. First, I maintained records of my descriptive notes of the participants, the arrangements of seating and other elements of the physical layout of court hearings and team meeting spaces. Second, I was able to construct a detailed report of the participants, setting, methods and findings in a thorough, specific narrative account.

A related way to ensure internal validity is to produce a trustworthy, thoroughly documented report of findings. This was accomplished by using a detailed and extensive data analysis process, which led to the development of codebooks. The codebooks contain the categories, sub-categories, properties, dimensions and line examples that were generated from the analysis (see Separate Attached PDF files).

As discussed in Chapter Two, a triangulation of research methods and analytic procedures was another mechanism of contributing to internal validity. In this study, triangulation occurred during data collection by using a modification of the OPTION Scale questions (Elwyn et al., 2003), and field notes at family support team meetings to look at decision-making processes deductively. Interview data were collected from multiple informants using essentially the same semi-structured interview protocol. The empowerment scale data was triangulated with the observations of meetings, individual interviews, and non-survey data to gather a more comprehensive understanding of how individuals experienced empowerment. During analysis, the interview data were compared with the family support team meeting and court hearing data and the empowerment scale data in order to understand the processes of decision-making from multiple perspectives. The purpose of triangulation was to increase trustworthiness of the report that was generated. These various triangulation

strategies strengthened the study by increasing the likelihood that a broad understanding of decision-making processes was captured.

The report that has been generated followed principles of content analysis and grounded theory methods, as well as descriptive statistics of empowerment scores. The methods have been described and records of codebooks and SPSS outputs have been retained. The interpretations of data was described as a culmination of close and careful examination, and I attempted to align these interpretations as closely as possible to the observed behaviors and subjective experiences of the research participants. As part of the analytic process, areas of uncertainty were identified, specifically in the naming of concepts and developing categories, and these were refined with deeper analysis.

External validity or transferability is the degree to which the findings can be applied to other contexts or settings (Miles et al., 2014, p. 314). Ways to increase external validity include use of detailed description of sampling, processes, and findings, so that the details of this study can be compared with other settings or theories. Merriam (2009, p. 225) writes the "general lies in the particular," to convey that by studying a situation in depth, lessons can be learned and applied to other situations. It is up to the reader to decide for himself or herself whether or not the findings can be applied or transferred to his or her particular setting or practice.

By considering the utility of the information that was gathered and its possible effects, the quality standard of 'application' was met (Miles et al., 2014). Application is defined as the degree to which the knowledge gained is usable or worthwhile (Miles, et al., 2014, p. 316). There are particular audiences that may use this report or find it worthwhile, including the Children's Division and local Court Systems, and other researchers interested in youth and family empowerment. The lessons generated from the results of this study will lead to recommendations for future practice and/or research.

Limitations

There were some limitations to this study. While I attempted to gather information from multiple vantage points about how decision-making happens and how team members experience that process, certain individuals' perspectives were missing. Individuals, such as court personnel (for example, judges, bailiffs, attorneys), and medical personnel who are involved with the foster youth were not part of the study. An extension of this limitation is that the broader cultural context from which each research participant came was not known or examined. Factors such as the quality or effect of education, living conditions, socio-economic levels, culture, traditions, social expectations, and material conditions of the participants were beyond the scope of this study.

A second limitation was that teams were observed on a limited number of occasions. Therefore, what happened in meetings on any given day could not

necessarily be considered patterns of behaviors or interactions. To balance this limitation, these observations were analyzed along with interview data and survey data about engagement, perceptions and empowerment to extent.

Another limitation of this study was the use of a purposeful sample from a closed system that relied on volunteers. It is hoped that readers will be able to determine for themselves to what extent the findings, analysis, and interpretation of results will be useful for them in their particular contexts. Readers should be able to make this determination based on a detailed documentation of the setting, the participants, and the procedures of data collection and analysis.

Recommendations for Practice and Research

The recommendations that follow stem from the review of findings. It is recommended that adolescent foster youth and invested adult family support team members be provided with skills training for articulating issues, discussing concerns, identifying problems, and collaborating as a team member toward informed decisions about services. These skills can be taught, improved upon, and reinforced with continued practice. Autonomy supportive learning environments have been shown to produce positive outcomes, so orienting teams to principles that support youth and team member autonomy should be part of the training that team members receive.

For members who are new to their respective roles, incorporating learner-centered strategies of teaching about how to advocate personal interests, and how

to advocate for foster youth are available. For instance, some team members may prefer face to face dialogue, role play and interactive work to learn about their roles and responsibilities. Others may prefer videos or computerized online training modules. Some may have transportation barriers that interfere with attending live trainings. In order to accommodate issues of transportation, trainings can be conducted online, over the phone or with videos, but there should be an opportunity to ask questions and get support after normal business hours.

Teaching team members how to actively weigh out the pros and cons of decision making so that members can learn how to assign value to choices, and make careful selections, is a logical target for future training. There are various shared decision making interventions for individuals with mental disorders have provided roadmaps to teach people how to ask effective questions during encounters with professionals, how to speak up about preferences, how to create goals, and how come to appointments prepared (Algeria et al,, 2014; Campbell et al., 2014; Cooper et al., 2013; Dixon et al., 2014; Haman et al., 2011; Hamann et al., 2014; Hilgeman et al., 2014; Joosten et al, 2009, 2011; LeBlanc et al., 2015; Loh et al, 2007; Mott et al, 2014; Simon et al., 2011; Steinwachs et al., 2011; Troquete et al, 2013; Van der Krieke et al., 2013; and Westermann et al., 2012). Decision-making aids have been developed around mental health issues as well. Similar decision-making aids might be created for other typical youth issues such

as communication skills, development of healthy social or familial relationships, college planning, managing finances, healthcare, and transportation issues.

Teen skills training for self-advocacy has been manualized (see for example: Krebs, Pitcoff & Shalof, 2013). Advocacy training can also be implemented for family support team members. Borrowing ideas from motivational interviewing (Miller & Rollnick, 2012; 2013) wellness recovery resources, and using positive peer supports (Jonikas, Grey, Copeland, Razzano, Hamilton, Floyd, & Cook, 2013) are also seen as potentially helpful resources to create training for youth and family teams, especially for youth with substance abuse or mental disorders that may persist into adulthood.

There has been a growth in research specifically studying outcomes of Shared Decision Making in the mental health community over the last few years. In a systematic search of literature for empirical Shared Decision-Making (SDM) intervention studies that reported outcomes for mental health care recipients, none of the studies specifically looked at the Child Welfare population, and only two included children and parents. A few studies included family members as part of the intervention (Dixon et al., 2014; Hilgeman, et al., 2014; Westerman, et al., 2014). In drawing inferences for how this body of literature could be used for the Child Welfare population, it was discovered that many educational and supportive strategies existed that could be implemented in this population. To date the research exploring SDM interventions in Child Welfare is lacking, but there is

potential for its application. Certainly, it is important for family support team members to feel knowledgeable and as if their input matters, as decisions for youth in Child Welfare have important consequences. Youth esteem, well-being, safety and placement stability rest on all team members' conscience. Achieving decisions should be made by a team of informed and motivated members.

Empirical studies could be conducted that measure the outcomes of shared decision-making interventions within the child welfare system. Various dependent variables of interest include: youth and family perceptions of health and quality of life; family support team member satisfaction with role, family support team member rating of empowerment, family support team member perceived autonomy support, decisional conflict, number of placement changes; intent to maintain current job position within one year; educational and employment outcomes. These dependent variables could be tested pre- and post-intervention and could be re-examined after 1-year to test for lasting effects of the intervention.

Future qualitative studies might investigate how shared decision making is being encouraged or hindered by specifically paying attention to, and coding emotional expressions, and the antecedents to these expressions, within family support teams. In order to conduct such a study, it would be important to video-record sessions. Qualitative or mixed methods studies might explore quality of educational experiences or job training, living conditions, socio-economic levels,

culture, traditions, social expectations, and material conditions of family support team members. As one strategy, these factors could be examined in an ethnographic study or might be compared to family support team participation and empowerment. Examining the perspectives of court personnel, educators, and medical personnel would lend additional and quite valuable perspective about decision-making, since these adults are often in positions of authority and make decisions or recommendations for foster youth as well. Lastly, different sampling methods may be employed in the future, rather than asking for volunteers. Creative strategies for including youth with disabilities and who might otherwise be excluded from foster care research might illuminate a wider variation in how decision-making occurs across a more diverse population of participants (Blakeslee et al., (2013).

Looking Back and Looking Ahead

This study endeavored to understand how decisions are made in the context of family support teams because previous research had called into question how mental health treatment decision-making occurs for foster youth. It was thought that exploring family support team meetings, comprised of many vested professionals and volunteers, family members, and foster youth, would be a good starting point to investigate this issue. Missing from these meetings were any medical or educational personnel.

As the research study began, gathering consents from various participants led to informal conversations and suggestions. One participant suggested that gathering perspectives from all stakeholders would be an important change in the study design, as well as attending the court system proceedings, which are open to the public. This participant thought that having these additional view points and location of interest where teams convened would provide useful information. This suggestion was taken seriously, and alterations to the study design were written and approved by two institutional review boards.

Having the viewpoints of various team members as well as the youth and being able to observe how interactions occurred in different settings, allowed me to understand the decision –making dynamics to a fuller extent. For instance, the conduct at court was formal and procedural. While judges are persons in high authority, at no time did there appear to be a singular or arbitrary decision being made. The judges across jurisdictions were kind, patient, and specifically sought input from youth and family members. Judges also sought input from the guardian ad litem and CASA if one was appointed, as well as case managers and deputy juvenile officers.

It appeared that while both case managers for Children's Division and deputy juvenile officers were working for the same outcomes, there existed a sibling rivalry of sorts between these two professional roles. An interesting comment was made in a court waiting room one day as team members waited to

be called for court. The comment was made by a case manager, who stated that she makes regular visits with youth and compiles much data for report writing, but the juvenile officer borrows this to create his or her own report. The implication in her statement was that the deputy juvenile officer was given recognition, but the case manager was the one who did the work.

In examining findings of deputy juvenile officer interviews, two stated that they have oversight responsibilities in relationship to the case workers. This sets up an unusual relationship between these team members, who are part of the mesosystem, in that they are of equal training and ability, and function similarly in role, but one is in the position of overseeing the other. This is but one of the intersections in role that was observed in family support teams. Others who appeared to have similar responsibilities were the Extreme Recruiter, permanency specialist, and adoption specialist. All were focused on similar types of outcomes: creating opportunities for permanency for youth. One of these, the Extreme Recruiter, noted that she felt powerless (i.e., not allowed to speak up at court, while the adoption specialist stated her recommendations had to be given in writing. The permanency specialist had permission to both write reports and testify in court that allowed her more advantage in terms of being able to advocate for youth and families.

Besides these observations about how role delineation and power may interfere with team members making contributions, the remaining remarks are

relatively positive. Family support teams that were observed appeared to be dedicated to helping youth. Most teams had members who were enthusiastic and patient with the processes of conducting meetings and attending court hearings. The exception was one worker who appeared tired and perhaps not as invested in her work, as compared to others, and she left her position before the conclusion of the study. Youth had various levels of engagement, i.e., speaking up with assuredness, being reserved, appearing enthusiastic and appearing capable. Youth also shared various responses to questions about their own empowerment.

It was thought that shared decision-making might not be happening in family support teams. This did not turn out to be true. Teams attempted to discuss choices and options and to seek input from the others at the meetings. Youth generally spoke up in meetings, although at times, communication was stifled. Shared decision-making was happening. However, fine-tuning of professional practices, and educational efforts for all team members might strengthen how well teams engage in decision-making. A review of Gabby and Henry's family support team meeting paints a picture of how collaborative team decision-making can lead to successful resolution. This family had lived under the supervision of the Child Welfare System for 10 years, but reunified. The victory is hard-won for them. They have learned how the system works, have learned skills of advocacy, and they are moving forward to make decisions on their own accord. This is a success due to a family that is engaged, a team that wants very

much for them to enjoy success on their own terms, but a team who is willing to put in needed resources and supports to achieve those ends. This is story of hope, engagement and empowerment that have brought this family out of desolation and into new life.

Acronyms and Definitions

ASFA-97 Adoption and Safe Families Act of 1997

CD- Children's Division

CFSRs-Child and Family Services Reviews

DJO-Deputy Juvenile Officer

FST-Family Support Team

GAL-Guardian ad litem

PIPs Program Improvement Plans SDM-Shared Decision Making

SDT-Self-determination Theory

Child Welfare Agency: An administrative division of the government, providing a range of Child Welfare services, including preservation, protection, out of home care and adoption; respond to reports of abuse and neglect and intervene to protect the needs of the child (Child Welfare Information Gateway, 2012).

Case manager: The Children's Service Worker in the county of juvenile court jurisdiction who has the responsibility for coordinating all services delivered to a child and his/her family. The case manager may or may not provide all of these services directly, but must ensure that the services needed to accomplish the objectives of the case plan are made available through direct provision, referral, or

purchase (includes all types of contracted services) (Missouri Department of Social Services, 2012).

Child: A person within the state who is under the age of eighteen or in the custody of the division of family services who is in need of medical, dental, educational, mental or other related health services and treatment, as defined in this section, or who belongs to a racial or ethnic minority, who is five years of age or older, or who is a member of a sibling group, and for whom an adoptive home is not readily available. If the physical, dental or mental condition of the child requires care after the age of eighteen, payment can be continued with the approval of the division of family services of the department of social services and subject to annual review (Missouri Department of Social Services, 2012).

Family group decision making (FGDM): Refers to practices which support "family centered, strengths-oriented, culturally relevant, community based problem-solving" (Texas DCPS, 2006).

Foster care: A form of substitute care, usually in a home licensed by a public agency, for children whose welfare requires that they be removed from their own homes (Missouri Department of Social Services, 2012).

Foster care/adoptive care families: Families recruited and approved as adoptive families, and licensed to provide foster/adoptive care services. They must be willing to accept licensing if they require financial assistance until custody of the child is transferred for the purpose of adoption, approval of an adoption subsidy

agreement for an eligible child, or the child is removed, whichever occurs first (Missouri Department of Social Services, 2012).

Patient-centered care: Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (Committee on Quality of Health Care in America, Institute of Medicine, 2001, p. 3).

Providers: Medical doctors, nurse practitioners and psychotherapists who diagnose, prescribe, and treat health conditions.

Stakeholder: A person or organization with a legitimate interest in a given situation, action or enterprise

Shared decision making: A model of treatment and a way of making decisions that includes the perspectives and capacities of more than one person, in which the care provider and patient collaborate toward mutually developed treatment goals.

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Appendix A: Interview Protocols and Empowerment Scales

1. Demographic Data Form for Foster Parents and Caseworkers
2. Interview Protocol and Questions
3. Correspondence Regarding Family Empowerment Scale
4. Family Empowerment Scale and Scoring
5. Correspondence regarding Youth Efficacy/Empowerment Scale-Mental Health and the Youth Participation in Planning Scale
6. Complete YES and YPP Packet and Scoring

Appendix A1: Demographic Data Collection Forms

Demographic Data for Family Support Team Members

Identifier: _____

Date_____

PLEASE PROVIDE US WITH A BIT OF INFORMATION ABOUT YOURSELF AND YOUR ROLE:

1. What is your sex? (Check **ONE**): x male ___ female
2. What is your age? ____
3. What is your race/ethnicity? (Check **all that apply to** you):

___ White/Caucasian ___ Black/African-American

___ Hispanic/Latino/a ___ Alaskan/Native American

___ Asian-American ___

other:_____

4. What is the highest grade you completed in formal education? (Check **ONE**):

___ Below High school completion ___ Associate's Degree or equivalent

___ High school diploma ___ Bachelor's Degree or equivalent

___ GED ___ Some Graduate School

___ 0-1 Years of College ___ Master's Degree

___ 1-2 Years of College ___ Some Doctoral Courses

___ 2-4 years of College ___ Doctorate

___ other: _____

What is your role in the foster care system? Check all that apply:

Role	
DJO	
GAL	
CASA	
CASA supervisor	
CM supervisor	
CD oversight specialist	
Case manager	
Foster youth	
Foster parent surrogate	
Chafee Foster Care Independence Program worker	
Foster youth's sister/brother.	
Foster youth's Biological Mother	
Foster youth's Biological Father	
Other Specify: _____	Therapeutic case manager

5. How long have you been in your role? ___ Months ___ years

6. How many adults over the age of 21 live in your home currently? ___

7. How many foster youth under the age of 21 live in your home currently? ___

8. How many youth under the age of 21 who are **not i**n state custody live in your home? ___

9. How many youth under the age of 21 who are not in state custody live in your home? ___

10. How many support team meetings do you attend per year, on average? ___ Months ___ years

SAINT LOUIS UNIVERSITY

Julie Bertram <hummerj@slu.edu>

Re: follow up regarding modified FES for dissertation study

2 messages

Julie Bertram <hummerj@slu.edu> Fri, Jan 23, 2015 at 8:43 PM
To: Barbara Friesen <friesenb@pdx.edu>

Hello Barbara,

A couple weeks ago, we spoke about assessing family support team members using a modified version of the FES. We had talked about the original intention of the tool and other measures for assessing empowerment and decision-making. Since that conversation, I was still interested in using your instrument, but wanted to make sure it was okay with you.

If you can let me know, I would appreciate it.

Thank you,

Julie Bertram

On Sun, Jan 11, 2015 at 5:24 PM, Julie Bertram <hummerj@slu.edu> wrote:

> Barbara,
>
> The University IRB has approved the proposed changes to my study. I would like to be able to submit a note from you so that I could use the modified tool on Tuesday at a family support team meeting. Will you be able to verify that it is okay for me to use the FES in the format that we discussed last Wednesday?
>
> I am attaching it here for your consideration.
>
> Julie
>
> On Fri, Jan 9, 2015 at 4:02 PM, Julie Bertram <hummerj@slu.edu> wrote:
>
> > Dear Barbara,
> >
> > I am following up on a few things related to my study today, and wanted to know if you approve of the modifications I made to the FES after our phone call. I will need to secure this permission before using it with any research participants.
> >
> > Thank you very much for your time and support.
> >
> > Julie Bertram
> >
> > On Wed, Jan 7, 2015 at 3:57 PM, Julie Bertram <hummerj@slu.edu> wrote:
> >
> > > Dear Barbara,
> > >
> > > Thank you for talking with me about the FES today. I am attaching a modification based on our discussion. Thank you for sharing resources.
> > > I am sharing my working matrix that is looking at Shared Decision Making Interventions with mental health care. My colleague Sarah Narendorf are still in process of extracting data and have 15 articles left to review.
> > >
> > > Thanks again for sharing with me. I really appreciate it.
> > >
> > > Julie Bertram
> > > --
> > > Julie Bertram, RN, MSN, Instructor of Nursing

Appendix A2: Interview Protocol & Questions

1. What is your role within foster care?
2. What are the responsibilities of your role?
3. What was the purpose of the most recent meeting?
4. What did you expect would happen in the meeting?
5. Who led the meeting?
6. What role did you play in the meeting?
7. Who do think had the most influence in the meeting?
8. In the meeting when did you feel encouraged to speak your mind?
9. When did you feel shut down?

    a. (If answers to both 8 and 9, ask questions 9 and 10)

10. Could you say what happened when you went from being encouraged to being shut down?
11. Could you say what happened when you went from being shut down to encouraged?
12. What are your thoughts and feelings about how the meeting went?
13. Was anything not finished in the meeting?
14. Probe: Tell me how the meeting ended.

15. Now I want to ask you about what happened one month ago.

16. What was the purpose of the meeting?
17. What did you expect would happen in the meeting?
18. Who led the meeting?
19. What role did you play in the meeting?
20. In the meeting when did you feel encouraged to speak your mind?
21. When did you feel shut down?

    a. (If answers to both 19 and 20, ask questions 21 and 22)

22. Could you say what happened when you went from being encouraged to being shut down?
23. Could you say what happened when you went from being shut down to encouraged?
24. What are your thoughts and feelings about how the meeting went?
25. Was anything not finished in the meeting?
26. Probe: Tell me how the meeting ended.

[Have participant fill out the empowerment scales. Then use the information to ask follow-up questions from the instruments.]

Appendix A3: Correspondence Regarding Family Empowerment Scale

College of Education

One University Blvd.
St. Louis, Missouri 63121-4499
Telephone: 314-803-1912
E-mail: jehf48@umsl.edu

Paul Koren
Research and Training Center
Regional Research Institute
Portland State University
P.O. Box 751
Portland, OR 97207

Dear Dr. Koren:

I am a doctoral student at the University Of Missouri St. Louis College Of Education. I am interested in discovering more about decision making in the foster care system as part of my dissertation work. My research questions are:

(1) How do foster youth, case managers and foster parents currently engage in decision making within the context of family support teams?
(2) How do foster youth, case managers and foster parents perceive the process of decision making in family support teams?
(3) What are the needs, concerns and questions of foster youth, foster parents and case managers as they consider mental health treatment alternatives?
(4)What are the salient issues of foster parents?
(5) How is empowerment distributed among the three groups?

I have created a research protocol which includes observation of family support team meetings, surveys, individual interviews and focus group interviews. I would like permission to use the Family Empowerment Scale to survey participants for my dissertation research. The results will be published in my dissertation, may be presented at conferences, and disseminated in publications. I anticipate a sample size of up to 40 participants. Please let me know at your earliest convenience if I am permitted to use your research instrument.

Sincerely,
Julie Bertram,
Doctoral Candidate,
University of Missouri St. Louis

School of Social Work
Regional Research Institute for Human Services
Research and Training Center for Pathways to Positive Futures

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UNIVERSITY

June 6, 2013

Julie Bertram
Saint Louis University
221 N. Grand Blvd.
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office: (314) 977-8998
fax: (314) 977-8949
email: hummerj@slu.edu

Ms. Bertram,

This letter confirms our permission to use the Family Empowerment Scale for your research. We're delighted that you are interested in using this scale and hope that you find it useful. We would be very interested to hear about your experiences and findings, particularly with respect to aspects of the scale that might be improved. Please also send us a copy of your research once it is complete. Good luck with your study.

For further specific or technical information, please contact Dr. Barbara Friesen at (503) 725-4166 or by e-mail at friesenb@pdx.edu.

Best regards,

Nancy Ferber

Publication Coordinator
Research and Training Center for Pathways to Positive Futures
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Appendix A4: Family Support Team Member Empowerment Scale

Family Support Team Member Empowerment Scale

Modification of Family Empowerment Scale

These questions ask about several areas of life – family, foster youth services, and community. The questions include many different activities that family support team members may or may not do. For questions that do not apply to you, please answer "Never." Also, we know that other people may be involved in caring for and making decisions about this particular foster youth, but please answer the questions by thinking of your own situation. Feel free to write any additional comments at the end.

ABOUT FAMILY…	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
1. When problems arise with this particular foster youth, I handle them pretty well.	1	2	3	4	5
2. I feel confident in my ability to help this particular foster youth grow and develop.	1	2	3	4	5
3. I know what to do when problems arise with this particular foster youth.	1	2	3	4	5
4. I feel this particular foster youths' foster home life is under control	1	2	3	4	5
5. I am able to get information to help me better understand this particular foster	1	2	3	4	5

ABOUT FAMILY…	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
youth.					
6. I believe I can solve problems with this particular foster youth when they happen.	1	2	3	4	5
7. When I need help with problems in this particular foster youth's present home life, I am able to ask for help from others.	1	2	3	4	5
8. I make efforts to learn new ways to help this particular foster youth grow and develop.	1	2	3	4	5
9. When dealing with this particular foster youth, I focus on the good things as well as the problems.	1	2	3	4	5
10. When faced with a problem involving this particular foster youth, I decide what to do and then do it.	1	2	3	4	5
11. I have a good understanding of this particular foster youth's disorder.	1	2	3	4	5
12. I feel I am a good family support team member.	1	2	3	4	5

ABOUT FOSTER YOUTH SERVICES…	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
13. I feel that I have a right to approve all	1	2	3	4	5

ABOUT FOSTER YOUTH SERVICES…	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
services this particular foster youth receives.					
14. I know the steps to take when I am concerned this particular foster youth is receiving poor services	1	2	3	4	5
15. I make sure that professionals understand my opinions about what services this particular foster youth needs.	1	2	3	4	5
16. I am able to make good decisions about what services this particular foster youth needs.	1	2	3	4	5
17. I am able to work with agencies and professionals to decide what services this particular foster youth needs.	1	2	3	4	5
18. I make sure I stay in regular contact with professionals who are providing services to this particular foster youth.	1	2	3	4	5
19. My opinion is just as important as professionals' opinions in deciding what services this particular foster youth	1	2	3	4	5

ABOUT FOSTER YOUTH SERVICES…	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
needs.					
20. I tell professionals what I think about services being provided to this particular foster youth.	1	2	3	4	5
21. I know what services this particular foster youth needs.	1	2	3	4	5
22. When necessary, I take the initiative in looking for services for this particular foster youth and family.	1	2	3	4	5
23. I have a good understanding of the service system that this particular foster youth is involved in.	1	2	3	4	5
24. Professionals should ask me what services I want for this particular foster youth.	1	2	3	4	5

ABOUT YOUR INVOLVEMENT IN THE COMMUNITY…	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
25. I feel I can have a part in improving services for foster youth in my community.	1	2	3	4	5
26. I get in touch with my legislators when important bills or issues concerning	1	2	3	4	5

ABOUT YOUR INVOLVEMENT IN THE COMMUNITY…	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
foster youth are pending.					
27. I understand how the service system for foster youth is organized.	1	2	3	4	5
28. I have ideas about the ideal service system for foster youth.	1	2	3	4	5
29. I help other families get the services they need.	1	2	3	4	5
30. I believe that other family support team members and I can have an influence on services for foster youth.	1	2	3	4	5
31. I tell people in agencies and government how services for foster youth can be improved.	1	2	3	4	5
32. I know how to get agency administrators or legislators to listen to me.	1	2	3	4	5
33. I know what the rights of advocates and foster youth are under the special education laws.	1	2	3	4	5
34. I feel that my knowledge and experience as a family support team member can be used to	1	2	3	4	5

ABOUT YOUR INVOLVEMENT IN THE COMMUNITY…	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
improve services for other foster youth and families.					

COMMENTS_____
_____

Family Empowerment Scale
FES Scoring Directions

Scores for the subscales are simple means. Calculate the mean by adding the scores for the subscale items, and dividing by the number of questions. If there are missing items (up to 3), then add the scores for the subscale items, and divide by the number of answered questions. You can add all subscales for an overall score, but be aware that each of the subscales addresses quite different topics. Many published articles have employed this method (adding for an overall score). Examining each subscale score in relation to other variables of interest is another approach that may give more specific information.

Appendix A5: Correspondence Regarding Youth Efficacy/Empowerment Scale-Mental Health and the Youth Participation in Planning Scale

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Portland State UNIVERSITY

March 18, 2014

Julie Bertram, RN, MSN, Instructor of Nursing
St. Louis University
hummerj@slu.edu

Dear Ms. Bertram,

This letter confirms our permission to use the Youth Efficacy/Empowerment Scale. Please let us know the way in which you plan to use the information; for what purpose, if you plan to reproduce and how many copies will be disseminated. Please cite the article properly, whether the citation is in printed form or on a website.

We are delighted that you are interested in using this information, and hope that you will find it useful. Good luck with your future endeavors.

Best,

Heather Figueroa
Pathways to Positive Futures RTC
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Dear Colleague,

This packet includes the administration and scoring guide for the *Youth Efficacy / Empowerment Scale — Mental Health* (YES-MH) and the *Youth Participation in Planning Scale* (YPP), as well as reproducible versions of each measure.

Background information about the measures is available at http://www.rtc.pdx.edu/PDF/pbCompleteSurveyPacket.pdf.

As part of our ongoing work to improve these measures and to explore youth participation and efficacy/empowerment in the context of mental healthcare, we are asking programs and agencies that use these measures to share de-identified data with the research team at the Research and Training Center on Family Support and Children's Mental Health. If you have not already done so, please contact Janet Walker, Principal Investigator (janetw@pdx.edu; 503.725.8236) to discuss the best way for us to work with you on this. You may also contact me with questions about administration and scoring.

Best Regards,
Janet S. Walker, Ph.D.
Director of Research and Dissemination

Appendix A6: Complete YES and YPP Packet and Scoring

ADMINISTRATION AND SCORING OF THE

YOUTH EFFICACY / EMPOWERMENT SCALE –
MENTAL HEALTH (YES-MH) AND THE
YOUTH PARTICIPATION IN PLANNING SCALE (YPP)

Date, Identification, and Demographic Information

Before you administer the YES and/or the YPP, record the date of administration in the box on the first page of the measure(s). An identification number may be entered in the box labeled *ID #*, found at the top right on the first page of each measure.

Use the *Demographic Information Collection Sheet* to gather background information about each young person to whom you administer the YES and/or the YPP. This information can be gathered via interview, or the youth can fill it out him/herself.

YES

Administration

The *Youth Efficacy / Empowerment Scale — Mental Health* (YES-MH) is designed to assess youths' perceptions of efficacy and empowerment with respect to managing their own mental health conditions, managing their own services and supports, and using their experience and knowledge to help peers and improve service systems. The YES has 20 items on three subscales:

- *Self* (confidence and optimism about coping with / managing one's own condition; 6 items, α = .852),
- *Services* (confidence and capacity to work with service providers to select and optimize services and supports; 7 items, α = .833), and
- *System* (confidence and capacity to help providers improve services and to help other youth understand the service system; 7 items, α = .882).

The subscales can be used separately. The sum of their scores yields a score for overall youth efficacy / empowerment with respect to mental health.

The YES can be administered via face-to-face interview, or it can be self-administered using either a paper or online version. The YES has been used successfully with children as young as 9 years old using an interview, and with children as young as 13 using the paper version.

Scoring

The responses for individual items are summed as follows to obtain the subscale scores:

- *Self*, sum items 1, 2, 3, 5, 6 and 7 (i.e., all items in the first section except item 4).
- *Services*, sum items 8, 9, 10, 12, 13, 14 and 15 (i.e., all items in the second section except item 11).
- *System*, sum items 16, 17, 18, 20, 21, 22 and 23 (i.e., all items in the third section except item 19).

Sum the *Self*, *Services*, and *System* subscale scores to get the total YES score.

The "reversed" items (item 4, 11, and 19) are *not* included in either the subscale or the total scores. These items are used as a means of checking to see whether or not respondents are basing their answers on item content.

Data gathered during the development of the YES showed these characteristics for the subscale and total scale scores:

	Mean	Lower quartile	Upper quartile
Self	22.9	< 19	> 26
Services	26.8	< 23	> 31
System	23.1	< 19	> 28
YES Total	72.7	< 64	> 83

YPP

Administration

The *Youth Participation in Planning* S*cale* (YPP) assesses youth perceptions of whether interdisciplinary teams that create service, care, or treatment plans support meaningful youth participation in planning and decision making. The YPP has been used to assess youth participation on a variety of teams in a variety of contexts, including Individualized Education Planning (IEP) teams, transition planning teams, wraparound teams, youth/family decision teams, and other teams in juvenile justice, mental health, and child welfare contexts.

The YPP has 16 items on three subscales:

- *Plan and planning process reflect youth perspective* (8 items, α = .898),
- *Preparation* (4 items, α = .750), and
- *Accountability* (4 items, α = .784).

The sum of the subscale scores yields a score for overall youth participation in planning.

The YPP can be administered via face-to-face interview, or it can be self-administered using either a paper or online version. The YPP has been used successfully with children as young as 9 years old using an interview, and with children as young as 13 using the paper version.

Scoring

The responses for individual items are summed as follows to obtain the subscale scores:

- *Plan and planning process reflect youth perspective*, sum items 1, 2, 5, 9, 12, 15, 17 and 23.
- *Preparation*, sum items 3, 10, 16 and 21.
- *Accountability*, sum items 4, 7, 14 and 20.

Sum the three subscale scores to get the total YPP score.

The "reversed" items (items 6, 11 and 19) are *not* included in either the subscale or the total scores. These items are used as a means of checking to see whether or not respondents are basing their answers on item content. The current version of the measure also includes four test items (items 8, 13, 18 and 22) that are *not* included in the subscale or total scores. These items will be evaluated in analyses by the Research and Training Center research team for possible inclusion in future

versions of the YPP. The intention is to develop versions of the *Preparation* and *Accountability* subscales with 5 items each.

Data gathered during the development of the YPP showed these characteristics for the subscale and total scale scores:

	Mean	**Lower quartile**	**Upper quartile**
Planning reflects youth perspective	31.7	< 28	> 36
Preparation	11.9	< 9	> 15
Accountability	15.3	< 13	> 17
YPP Total	59.0	< 52	> 67

DEMOGRAPHIC INFORMATION FOR THE

YOUTH EFFICACY / EMPOWERMENT SCALE - MENTAL HEALTH AND THE YOUTH PARTICIPATION IN PLANNING SCALE

PLEASE PROVIDE US WITH A BIT OF INFORMATION ABOUT YOURSELF AND YOUR FAMILY:

1. What is your sex? (Check **ONE**): ___ male ___ female

2. What is the zip code where you currently live? Please use last 3 digits only_____

3. What is your age? _____

4. What is your race/ethnicity? (Check **all that apply to you)**

___ White/Caucasian ___ Black/African-American
___ Hispanic/Latino/a ___ Alaskan/Native American
___ Asian-American ___ other:
_____

5. Have you ever received free or reduced lunch at school? ___ yes ___ no
6. Have you ever taken medication for emotional or mental health difficulties? ___ yes ___ no

7. Have you been given a name or diagnosis for your emotional or mental health difficulties (Examples: ADHD, ODD, Asperger's, etc.)? If so, please write it here:

   _____

   __

8. Check the answer below that best describes where you live ***now*** (Check **ONE**):

___ independent/on my own___ living with parent(s) __living with relatives other than parents

___ foster care ___ group home ___ residential treatment

___ psychiatric hospital ___ homeless/couch surfing ___ correctional facility

___ other (please describe):_____

9. Have you ***ever*** been in any of these living situations? (Check **ALL** that apply):

___ independent/on my own___ living with parent(s) __living with relatives other than parents

___ foster care ___ group home ___ residential treatment

___ psychiatric hospital ___ homeless/couch surfing ___ correctional facility

___ other (please describe):_____

research & training center portland ON FAMILY SUPPORT AND CHILDREN'S MENTAL HEALTH

ID#: YOUTH-_____

This survey asks you about how you manage your emotions and mental health, how you manage services and supports, and how you help change or improve service systems. There are no right or wrong answers.

YOUTH EFFICACY / EMPOWERMENT SCALE – MENTAL HEALTH

Please write the date you are filling this out:

Self	**Always or almost always**	**Mostly**	**Sometimes**	**Rarely**	**Never or almost never**
1. I focus on the good things in life, not just the problems	5	4	3	2	1
2. I make changes in my life so I can live successfully with my emotional or mental health changes.	5	4	3	2	1
3. I feel I can take steps toward the future I want.	5	4	3	2	1
4. I worry that difficulties related to my mental health or emotions will keep me from having a good life.	5	4	3	2	1
5. I know how to take care of my mental or emotional health	5	4	3	2	1
6. When problems arise with my mental health or emotions, I handle them pretty well.	5	4	3	2	1
7. I feel my life is under control.	5	4	3	2	1

Service	**Always or almost always**	**Mostly**	**Sometimes**	**Rarely**	**Never or almost never**
8. When a service or support is not working for me, I take steps to get it changed.	5	4	3	2	1
9. I tell service providers what I think about services I get from them.	5	4	3	2	1
10. I believe that services and supports can help me reach my goals.	5	4	3	2	1
11. I am overwhelmed when I have to make a decision about my services or supports.	5	4	3	2	1
12. My opinion is just as important as service providers' opinions in deciding what services and supports I need.	5	4	3	2	1
13. I know the steps to take when I think that I am receiving poor services or supports.	5	4	3	2	1
14. I understand how my services and supports are supposed to help me.	5	4	3	2	1
15. I work with providers to adjust my services or supports so they fit my needs.					

System	**Always or almost always**	**Mostly**	**Sometimes**	**Rarely**	**Never or almost never**

System	**Always or almost always**	**Mostly**	**Sometimes**	**Rarely**	**Never or almost never**
16. I feel I can help improve services or supports for young people with emotional or mental health difficulties.	5	4	3	2	1
17. I have ideas about how to improve services for young people with emotional or mental health difficulties.	5	4	3	2	1
18. I know about the legal rights that young people with mental health difficulties have.	5	4	3	2	1
19. I feel that trying to change mental health services and supports is a waste of time.	5	4	3	2	1
20. I take opportunities to speak out and educate people about what it's like to experience emotional or mental health difficulties.	5	4	3	2	1
21. I feel that I can use my knowledge and experience to help other young people with emotional or mental health difficulties.	5	4	3	2	1
22. I tell people in agencies and schools how services for young people can be improved.	5	4	3	2	1
23. I help other young people learn about services or supports that might help them.					

Was this survey:

hard to complete ☐ hard to understand ☐ too long ☐ just right ☐

Comments and / or suggestions:

_____

_____

_____

ID#: YOUTH-_____

This survey asks you what happens when you are working with other people on a team to plan for services and supports. There are no right or wrong answers.

YOUTH PARTICIPATION IN PLANNING SCALE

Please write the date you are filling this out:

Please answer these questions based on your experiences WITH YOUR PLANNING TEAM during the PAST 2-3 MONTHS	**Always or almost always**	**Mostly**	**Sometimes**	**Rarely**	**Never or almost never**
1. During planning, I have plenty of opportunities to express my ideas.	5	4	3	2	1
2. I understand what's in my plan.	5	4	3	2	1
3. I help decide what is on the agenda for my team meetings	5	4	3	2	1
4. Team members have specific tasks to do for my plan	5	4	3	2	1
5. During planning, we make changes to my plan based on my ideas.	5	4	3	2	1
6. The goals on my plan are unrealistic.	5	4	3	2	1
7. I get an up to date copy of my plan.	5	4	3	2	1
8. Before a meeting, I am able to get answers to any questions I have about my participation in a meeting.	5	4	3	2	1
9. My plan fits with my background and values.	5	4	3	2	1
10. Before a meeting, someone helps me decide how I want to express my ideas to the team.	5	4	3	2	1

Please answer these questions based on your experiences WITH YOUR PLANNING TEAM during the PAST 2-3 MONTHS	**Always or almost always**	**Mostly**	**Sometimes**	**Rarely**	**Never or almost never**
11. When we are working on my plan, people use professional language that is difficult to understand.	5	4	3	2	1
12. I get to make decisions about the best ways to reach the goals in my plan	5	4	3	2	1
13. Before a team meeting, I am told about all the topics that will be on the agenda.	5	4	3	2	1
14. Team members report to me about what they are doing for my plan	5	4	3	2	1
15. I understand everything that is decided while we are working on my plan	5	4	3	2	1
16. I help decide who is invited to my meetings.	5	4	3	2	1
17. My plan helps me see that I can use my skills and abilities to reach my goals.	5	4	3	2	1
18. During a meeting, the team makes clear decisions about who will do what for my plan	5	4	3	2	1
19. My plan is more about what other people want than about what I want	5	4	3	2	1
20. Team members follow through on what they have agreed to do for my plan.	5	4	3	2	1
21. Someone from the team helps me plan the things I want to say at the meeting.	5	4	3	2	1

Please answer these questions based on your experiences WITH YOUR PLANNING TEAM during the PAST 2-3 MONTHS	**Always or almost always**	**Mostly**	**Sometimes**	**Rarely**	**Never or almost never**
22. During a meeting, people stick to the agenda.	5	4	3	2	1
23. My plan includes the goals that are most important to me.	5	4	3	2	1

Was this survey:

hard to complete ☐ hard to understand ☐ too long ☐ just right ☐

Comments and / or suggestions:

_____
_____

_____
_____

_____

Appendix B: Group Process Analysis

1. Adaptation of OPTIONS Scale
2. Observation Notes of Family Support Teams

Appendix B1: Adaptation of OPTIONS Scale*

Communication act	Foster youth	Foster parent	Caseworker
Who draws attention to an identified problem that requires a decision-making process?			
Does anyone say: "There are many ways to deal with this problem?"			
Who solicits preferences for decision-making?			
Does anyone voice preferences about how involved they want to be in decision-making?			
Does anyone suggest a list of pros and cons be generated regarding decision-making?			
Does anyone explore ideas about how problems are to be managed?			

*No permission is needed to use the OPTIONS Scale.

See http://www.optioninstrument.com/

Appendix B2: Observation Notes of Family Support Teams

Situational variables

1. Date _____
2. Location: _____
3. Time Limit: _____
4. Description of Setting: _____
5. Group size/membership: _____
6. Designated Leader and Role: _____
7. Response to Leadership Style: _____
8. Procedures/Format followed: _____

Communication Acts	Type	Specify	Foster youth	Foster parent	Case worker
	Eruption of Emotion				
	Arguing				
	Blocking				
	Ignoring				
	Active listening by looking/demonstrating attention				

**For each communication act, mark time, use audio recording for verbatim quotes.

Appendix C: Proposed Consent Forms by Type

C1. Assent/Consent to Participate in Research Activities (Minors)

C2. Informed Consent for Child Participation in Research Activities (Parent/Guardian)

C3. Informed Consent for Participation in Research Activities (Adult)

C4. Informed Consent for Participation in Research Activities (Adult support person)

Appendix C1: Assent/Consent to Participate in Research Activities (Minors)

This informed assent/consent form is for young people between the ages of 15 and 18 years who are foster youth in the State of Missouri and who I am inviting to participate in the research study, Decision-Making in the Foster Care System.

Department of Educational Leadership and Policy Studies
College of Education
One University Blvd.
St. Louis, Missouri 63121-4499
Telephone: 314-803-1912
E-mail: jehf@umsl.edu

Assent/Consent to Participate in Research Activities (Minors)

Decision-Making in the Foster Care System

My name is Julie Bertram and my job is to study the foster care system. I am conducting a research study about decision-making in the foster care system. You are being asked to participate in this study because you are a person in foster care between the ages of 15 and 18 years old.

Voluntary participation

I have discussed this research with your legal guardians and they know that I am also asking you for your participation. If you are going to participate in the research, your guardians also have to agree. But if you do not wish to take part in the research, you do not have to, even if your guardians have agreed. It is up to you. Even if your guardian has already said it is okay, it is still your choice if you want to join or not. Even if you say "yes" now, you can change your mind later and it is still okay.

You may discuss anything in this form with your guardians or friends or anyone else you feel comfortable talking to. You can decide whether to participate or not after you have talked it over. You do not have to decide immediately.

There may be some words you do not understand or things that you want me to explain more about because you are interested or concerned. Please ask questions at any time and I will explain these things to you.

Procedures

If you agree to be in this study, I will attend one family support team meeting and one court hearing with you and your family support team. I will take notes of what you and the others say, including incidental conversations, and observations that occur in informal settings. I will ask you to fill out a list of questions about your background, how you feel in the meetings, and how you feel about the planning that takes place in the meetings. You will only need to check boxes and/or use one-word answers that will be supplied to you when you fill out the list of questions. If you need help, it will be read and explained to you. Last, I will ask you to talk with me about your ideas and feelings about decision-making in FST meetings. I will talk with you about your experiences and record your talk on an audio-recorder. The amount of time that you will be in the study is detailed below:

Participation in What	**Duration (Start to finish of the study--estimated 3 months)**	**Frequency**	**Length of time for each part of study**
Consent and assent process	X	Once and ongoing	1 hour initially
Regularly scheduled meetings	X	Once per month	1-2 hours
List of questions	X	Once	30 minutes
Individual Interview	X	Once	1 hour

PHI

Some of the information that is discussed in family support team meetings is called Protected Health Information. Protected Health Information (PHI) is any health information through which you can be identified. PHI is protected by federal law. A decision to participate in this research means that you agree to let me use and share your PHI for the study explained above.

The only people who will know that you are a research participant are your guardian, others who are with you in the family support team meetings, and I. I will not share your personal ideas with anyone else in any ways that would identify you or be traced back to you. Please ask me to clarify this if you do not understand. The two exceptions in which I would have to let others know what you tell me are:

- if necessary to protect your rights or welfare (for example, if you are injured and need emergency care or when the Institutional Review Board monitors the research or consent process); or
- If required by law.

Risks and Benefits

I do not expect that you will be hurt or feel bad in any way because of my study The possible risks associated with this study are: a) uncomfortable feelings when being observed or interviewed and b) other people not involved in the study

finding out about your personal information. It is really important that you tell right away if you feel hurt in any way while in this study. Please tell me, your guardian, or another trusted adult if you feel hurt. That person will ask you how they can help and/or make sure that you will get the help that you need.

Your benefit for participation in this study may include: a) an opportunity to be listened to and heard and b) you may help me learn how to improve services for youth like you in the future.

A $10 dollar Target Gift Card will be provided upon completion of the study activities as an incentive for your participation.

If you wish, you may ask for your guardian or other trusted adult support person to be present or nearby for the interview process in order for you to feel more comfortable for the interview. Please initial your preference below.

_____ No. I do **not** wish to have adult present during interview.
_____ Yes. I do think I will want to have adult present/nearby during interview.
_____ _____ _____ (Name of Adult Support Person) is the named adult person selected to be present/nearby during interview

Confidentiality

Information about you that will be collected from the research will be put away and no one but me will be able to see it. Any information about you will have a pseudonym on it instead of your name. Only I will know what your real name is and I will lock that information up with a lock and key. It will not be shared with or given to anyone except as stated above.

I will do everything I can to protect your privacy. By agreeing to participate, you understand and agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, your personal identity will not be revealed.

The research design itself does not require the release of your protected health information. However, I have to follow the rules of my profession, which is nursing.

- That means I must report to authorities any suspected, reported or observed non-accidental physical injury or neglect of any person under the age of 21 or who is in state custody. I must report information that leads me to believe you are in immediate danger of physical harm.
- I am also ethically obligated to inform guardians and/or caseworkers if, in my professional judgment, you are in immediate danger of attempting suicide or have expressed intention of harming another person.
- Your safety is my first concern even above the concern of collecting information.
- The plan for reporting issues related to safety as specified above, is to tell your guardian and caseworker, and/or emergency personnel and will include a written report so that you can get the help you need. If such a reporting occurs, this information will also be reported to the University and Children's Division Institutional Review Board.

Right to Refuse or Withdraw

You do not have to be in this research. No one will be mad or disappointed with you if you say no. It is your choice.

You can think about it and tell me later if you want. You can say, "yes" now and change your mind later and it will still be okay.

Who to Contact

If you have any questions or concerns regarding this study, or if any problems arise, you may call Julie Bertram, 314-803-1912, or faculty advisor, Dr. Wolfgang Althof, 314-516-6818. You may also ask questions or state concerns regarding participants' rights to the Office of Research Administration, at 314-516-5897.

Remember: Your participation in this research is voluntary. If you decide to participate, you are free to withdraw at any time and no one will be upset with you.

Signing this form means you have read the above statements and have been able to express your concerns, to which the investigator has responded satisfactorily. You believe you understand the purpose of the study, as well as the potential benefits and risks that are involved. You authorize the use of your PHI and give permission to participate in the research described above.

Signing your name at the bottom means that you agree to be in this study. You and your guardian will be given a copy of this form after you have signed it.

Legal Guardian's Signature	Date	Parent's/Guardian's Printed Name
Child's Signature	Date	Child's Printed Name

Grade in School___

Signature of Investigator or Designee	Date	Investigator/Designee Printed Name

Appendix C2. Informed Consent for Child Participation in Research Activities (Legal Guardian)

This informed consent form is for legal guardians of young people between the ages of 15 and 18 years who are foster youth in the State of Missouri and who I am inviting to participate in the research study, Decision-Making in the Foster Care System.

Department of Educational Leadership and Policy Studies College of Education

One University Blvd. St. Louis,
Missouri 63121-4499
Telephone: 314-803-1912 E-mail: jehf@umsl.edu

Legal Guardian Informed Consent for Child Participation in Research Activities

Decision-Making in the Foster Care System

My name is Julie Bertram and my job is to study the foster care system.

The foster youth that is in your guardianship is being asked to be a part of a research study because he/she is a person in foster care between the ages of 15 and 18 years old.

You can choose whether or not you want the foster youth in your guardianship to join. If you agree, I will discuss this research invitation with the foster youth and let them know that you are in agreement with their hearing about the study. If the foster youth chooses to be a participant, the guardians also have to agree. But if the foster youth does not wish to take part in the research, he or she does not have to, even if the guardians have agreed.

You can decide whether or not to give consent for the foster youth in your guardianship- to participate or not - after you have thought it over. You do not have to decide immediately.

There may be some words you do not understand or things that you want me to explain more about because you are interested or concerned. Please ask me questions at any time and I will explain these things to you.

Participation is voluntary

You do not have to grant permission for the foster youth to be in this research if you do not want to. It is up to you. Even if you say it is okay, it is ultimately the young person's final choice if he/she wants to join or not. If you decide not to give permission for the youth to be in the research, it is okay. Even if you say "yes" now, you can change your mind later and it is still okay.

Procedures

If you agree that it is okay for the foster youth to be in this study, I will attend one family support team meeting and one court hearing with him/her and the family support team. I will take notes of what the foster youth and the others say during the meetings. I will take notes of what you and the others say, including incidental conversations, and observations that occur in informal settings. I will ask the foster youth to fill out a list of questions about his/her background, how he/she feels in the meetings, and how he/she feels about the planning that takes place in the meetings . For the list, the foster youth will only need to check boxes and/or use one-word answers that will be supplied. If the foster youth needs assistance, it will be read and explained. Last, I will ask the foster youth to talk with me about ideas and feelings about decision-making in FST meetings. I will talk with them about their experiences and record this talk on an audio- recorder. The amount of time that the foster youth will be in the study is detailed below:

Participation in What	**Duration (Start to finish of the study-- estimated 3 months)**	**Frequency**	**Length of time for each part of study**
Consent and assent process	X	Once and ongoing	1 hour initially
Regularly scheduled meetings	X	2 X	1-2 hours
List of questions	X	Once	30 minutes
Individual Interview	X	Once	1 hour

PHI

Some of the information that is discussed in family support team meetings is called Protected Health Information. Protected Health Information (PHI) is any health information through which a person can be identified. PHI is protected by federal law. A decision to participate in this research means that you agree to let me use the foster youth's PHI and share this PHI for the study explained above.

The only people who will know that the foster youth is a research participant are the guardians, others who are with the youth in the family support team meetings, and I. No information about the foster youth, or provided by him/her during the research will be disclosed to others without your written permission, except:

- if necessary to protect the person's rights or welfare (for example, if injured and need emergency care or when the Institutional Review Board monitors the research or consent process); or
- If required by law.

Risks and Benefits

I do not expect that the foster youth will be hurt or feel bad in any way because of my study. But the possible risks associated with this study are: a) uncomfortable feelings when being observed or interviewed and b) other people not involved in the study finding out about the youth's personal information. It is really important that the foster youth tell right away if he or she feels hurt in any way while in this study. The foster youth will be instructed to please tell me, you, or another trusted adult if he/she feels hurt. That person will ask the foster youth how they can help and/or make sure that the foster youth will get the help that is needed.

Youth benefits for participation in this study may include: a) an opportunity to be listened to and heard and b) he/she may help me learn how to improve services for youth in the future.

A $10 dollar Target Gift Card will be provided upon completion of the study activities as an incentive for your participation as a guardian.

If the foster youth wishes, he or she may ask for you or other trusted adult support person to be present or nearby for the interview process in order to feel more comfortable for the interview. You will need to agree with the foster youth's choice prior to this person being invited to provide support. This choice will be documented on the youth assent/consent form that you sign.

Confidentiality

Information about the foster youth that will be collected from the research will be put away and no-one but me will be able to see it. Any information about the foster youth will have a pseudonym on it instead of the real name. Only I will know what the youth's real name is and I will lock that information up with a lock and key. It will not be shared with or given to anyone except as stated above.

I will do everything I can to protect the foster youth's privacy. By agreeing to allow the foster youth to participate, you understand and agree that the data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, the foster youth's personal identity will not be revealed.

The research design itself does not require the release of your protected health information. However, I have to follow the rules of my profession, which is nursing.

- That means I must report to authorities any suspected, reported or observed non-accidental physical injury or neglect of foster youth. I must report information that leads me to believe that a foster youth is in immediate danger of physical harm.

- I am also ethically obligated to inform guardians and/or caseworkers if, in my professional judgment, the foster youth is in immediate danger of attempting suicide or have expressed intention of harming another person.

- Youth safety is my first concern even above the concern of collecting information.

- The plan for reporting issues related to safety as specified above, is to tell you and/or the caseworker, and/or emergency personnel and will include a written report so that the youth can get the help that is needed. If such a reporting occurs, this information will also be reported to the University and Children's Division IRB.

Right to Refuse or Withdraw

You do not have to give permission for the foster youth to be in this research. No one will be mad or disappointed with you if you say no. It is your choice. You can think about it and tell me later if you want. You can say, "yes" now and change your mind later and it will still be okay. Likewise, the foster youth has the right to opt in or opt out of the research, and is allowed to change his/her mind about participation at any time.

According to federal guidelines,

> "The IRB shall require **appointment of an advocate for each child who is a ward**, in addition to any other individual acting on behalf of the child as guardian or in loco parentis.
>
> "One individual may serve as advocate for more than one child. The advocate shall be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any

way (except in the role as advocate or member of the IRB) with the research, the investigator(s), or the guardian organization."

Who to Contact

If you have any questions or concerns regarding this study, or if any problems arise, you may call Julie Bertram, 314-803-1912, or faculty advisor, Dr. Wolfgang Althof, 314-516-6818. You may also ask questions or state concerns regarding participants' rights to the Office of Research Administration, at 314-516-5897.

Remember: Youth participation in this research is voluntary. If you decide to allow the foster youth to participate, you are free to withdraw him or her at any time.

Signing this form means you have read the above statements and have been able to express your concerns, to which the investigator has responded satisfactorily. You believe you understand the purpose of the study, as well as the potential benefits and risks that are involved. You authorize the use of your foster youth's PHI and give permission to participate in the research described above.

Signing your name at the bottom means that you agree that it is okay for the foster youth in your guardianship to be in this study. You will be given a copy of this form after you have signed it.

Legal Guardian's Signature	Date	Parent's/Guardian's Printed Name
Date		Child's Printed Name Grade in School___
Signature of Investigator or Designee	Date	Investigator/Designee Printed Name

Appendix C3. Informed Consent for Participation in Research Activities (Adult)

This consent form is for the family support team members who are being invited to participate in the research study, Decision-Making in the Foster Care System.

Department of Educational Leadership and Policy Studies College of Education

One
University Blvd.
St. Louis, Missouri 63121-4499 Telephone: 314-803-1912
E-mail: jehf@umsl.edu

Informed Consent for Participation in Research Activities
Decision Making in the Foster Care System

Participant _____ HSC
Approval Number 466206-4

Principal Investigator Julie Bertram PI's Phone
Number 314-803-1912

My name is Julie Bertram and my job is to study the foster care system.

You are invited to participate in the research because you are involved in the care of foster youth as a ***stakeholder***.

What procedures are involved?

If you agree to participate in this research, you can expect:

- To fill out a short demographic sheet
- To be observed in a family support team meeting on one occasion
- To be observed in one court hearing related to this foster youth
- To fill out a questionnaire
- I will take notes of what you and the others say, including incidental conversations, and observations that occur in informal settings.
- To participate in an individual interview (May be very short depending on role)
- To have the individual interview audio-recorded

The expected duration of time for your role in the study is as follows:

Role	**Participation in What**	**Duration**
Case Worker	Recruitment communication	1.5 hours
Case Worker, Foster Parents, Members of FST, Foster Youth	Regularly scheduled meetings	2-4 hours
Case Worker, Foster Parents, Members of FST, Foster Youth	Individual Interview	10 minutes to 1 hour
Case Worker, Foster Parents, Members of FST, Foster Youth	Demographic data form and Empowerment Scale	Up to 20 minutes for surveys

What are the potential risks and discomforts?

There is *minimal risk* associated with this research. The degree of discomfort is subjective and is likely to be low. There may be subjective discomfort in sharing personal and sensitive information and the potential for a breach of confidentiality. For family support team members there is a risk that other agency

employees, such as supervisors, know about your involvement or lack of involvement in the research.

If you become significantly uncomfortable with being observed or interviewed, you may elect to stop participation in the study at any time.

Are there benefits to taking part in the research?

There are no direct benefits for you participating in this study. However, your participation will contribute to the knowledge about decision-making in the foster care system.

A $10 dollar Target Gift Card will be provided upon completion of the study activities as an incentive for your participation.

Confidentiality

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity. Any information that is obtained in connection with this study, and that can be identified with you, will remain private and will be disclosed only with your permission or as required by law.

Great caution will be taken to protect the hard copy, audio- recorded data, and electronic data. All research data will be stored in secure storage, locked cabinets or password protected computer files. These efforts should help reduce the likelihood of a breach of confidential information.

Questions

If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Julie Bertram, 314-803-1912 or the Faculty Advisor, Wolfgang Althof, 314- 516-6818. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research Administration, at 516-5897.

Remember: Your participation in this research is voluntary. If you decide to participate, you are free to withdraw at any time.

You will be given a copy of this form for your information and to keep for your records.

I have read the above statement and have been able to express my concerns, to which the investigator has responded satisfactorily.

All signature dates must match.

_____ _____

Participant's Signature Date Participant's Printed Name

_____ _____

Investigator's Signature Date Investigator's Printed Name

Appendix C4. Informed Consent for Participation in Research Activities (Adult Support person)

This consent form is for the adult support person who is being invited to participate in the research study, Decision-Making in the Foster Care System.

Department of Educational Leadership and Policy Studies

College of Education

One University Blvd. St. Louis,
Missouri 63121-4499
Telephone: 314-803-1912 E-
mail: jehf@umsl.edu

Informed Consent for Participation in Research Activities
Decision Making in the Foster Care System

Participant _____
HSC Approval Number 466206-4

Principal Investigator Julie Bertram PI's Phone Number 314-803-1912

Why am I being asked to participate?

You are invited to participate in a research study about **decision-making in the foster care system** conducted by Julie Bertram under the supervision of faculty advisor, Dr. Wolfgang Althof, at the College of Education at the University of Missouri-St. Louis. Decision-making means thinking and talking about how to solve a problem.

You have been asked to participate in the research because you have been identified as a ***trusted adult support person***. A trusted adult support person is a person who the foster youth has identified as a person who is safe and worthy of trust.

I ask that you read this form and ask any questions you may have before agreeing to be in the research. Your participation in this research is voluntary. If you decide to participate, you are free to withdraw at any time.

Role

This study includes an interview with individual foster youth to find out their feelings about family support team meetings. The interview should take about an

hour and will be audio-recorded. The individual foster youth has a choice of having a support person present during the interview or nearby. The purpose of having a support person available is to increase feelings of comfort and security. If you choose to accept the invitation to be the support person, you will simply be in the room or in a nearby room in case the foster youth needs you. You do not need to answer any questions or participate in any way during the interview.

Risks and benefits

It is not expected that you will be harmed in any way as a result of your participation in this study. Furthermore, I do not expect the foster youth to be harmed in any way. However the possible risks for your association in the study are: a) stress or worries about the interview that the foster youth participates in, b) hearing private information that causes uncomfortable feelings or dilemmas for you, c) the possibility that your feelings toward the child hear might change as a result of witnessing the interview, and d) the possibility that other people not involved in the research study may find out about the your participation as a support person.

It is also possible that the young person will disclose information having to do with his/her safety or well-being. If this happens, your role is to support the person until a plan for safety is secured. The possible benefits for you as a research participant are: a) the opportunity to learn more about how foster youth experience family support team meetings and b) the satisfaction that you are able to assist a person who is in need of support.

Voluntary Participation

Your participation in this research is voluntary. If you decide to participate, you are free to withdraw at any time.

What about privacy and confidentiality?

Protected Health Information (PHI) is any health information through which a person can be identified. PHI is protected by federal law under HIPAA (the Health Insurance Portability and Accountability Act).

A decision to participate in this research means that you agree to keep the foster youth's PHI private.

The only exception to this rule is that you may disclose the foster youth's PHI in the following circumstances:

- if necessary to protect the foster youth's rights or welfare (for example, if he/she is injured and needs emergency care or when the University of Missouri-St Louis Institutional Review Board monitors the research or consent process); or
- If required by law.

Can I withdraw or be removed from the study?

You can choose whether to be in this study. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. The investigator may withdraw you from this research if circumstances arise which warrant doing so. If you decide to end your participation in the study, please complete the withdrawal letter found at http://www.umsl.edu/services/ora/assets/WithdrawalLetter.doc, or you may request that the Investigator send you a copy of the letter.

Who should I contact if I have questions?

The researcher(s) conducting this study is Julie Bertram and the faculty advisor is Dr. Wolfgang Althof. You may ask any questions you have now. If you have questions later, you may contact the researcher(s) at 314-803-1912 or the Faculty Advisor, Dr. Wolfgang Althof, 314-516-6818. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research Administration, at 516-5897.

You will be given a copy of this form for your information and to keep for your records.

I have read the above statement and have been able to express my concerns, to which the investigator has responded satisfactorily.

All signature dates must match.

_____

_____

Participant's Signature Date Participant's Printed Name

_____

_____

Investigator's Signature Date Investigator's Printed Name