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**Family Group Decision Making  
Annual Evaluation Report**

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# I. Executive Summary

Family Group Decision Making (FGDM) is a model and strategy which focuses on family strengths and capacity for change rather than on problems and deficits. FGDM was first used in New Zealand in 1989 as part of child welfare reform. The basic structure of the model involves bringing together extended family members to decide on a plan of safety and placement for children in families referred to Child Protective Services (CPS). The model is used in other venues (e.g., juvenile justice) but has been adopted in Arizona mainly for child welfare purposes.

The Family Group Decision Making Program is a relatively new effort by the Arizona Department of Economic Security (DES). The Department recognized the need for such a program based on the high numbers of children placed in foster care, the recognition that children remain in foster care too long, the interest in improving the permanency of placements for children, and the intent to have safety and placement plans better adapted to families' needs. The aim of the program is to encourage and prepare families to develop and implement their own placement plans to ensure child safety. The focus of the program is on finding a safe place outside the home for children by encouraging decision making with extended family (kin and other people who care about the children), and providing support to the family in the form of services (through family, community, or DES resources). The program goals include decreased dependency filings, expedited permanency for children, decreased subsequent CPS referrals, increased family involvement and increased satisfaction with CPS.

The program was pilot tested in Districts I (Maricopa County) and IV (Yuma County) beginning in 1999 and was expanded to other sites in October of 2001. It has expanded statewide to include ten Family Group Decision Making Program Specialists. The program is currently supported by both federal and state funds.

The first phase of the evaluation effort focuses on the implementation of the Family Group Decision Making Program. The evaluation began in February 2001 and evaluation activities have included providing a training to program staff in logic model design; development of an evaluation plan for year 1; development of data collection forms, participant surveys and 6-month follow-up interview questionnaire; and completion of site visits and phone calls to conduct key informant interviews with 39 staff members including specialists, supervisors, and case managers in Districts I and IV that have been involved in FGDM meetings between February 1, 2001, and August 31, 2001. This report also includes reviews of the enabling legislation, relevant literature, policy and procedures documents. Preliminary descriptive data are also included for forty-seven cases referred to the program since February 2001. Due to the limited time frame and small numbers of cases, detailed outcome data are not included in this year's report.

Results from the implementation evaluation reveal strong positive attitudes and convictions about the value of the program from many of the staff involved. Key issues identified include needs for a streamlined referral process, clearer expectations and procedures for follow-up, and expanded opportunities for training and team building. The recommendations offered include team construction of a project logic model, statewide communication materials, and simplifying potential barriers to referral such as placement in foster care and the complexity of the referral form.

## II. In This Report

This report includes descriptions of the legislative requirements, a brief review of relevant literature, results from the first part of the evaluation plan (implementation information based on site visits and key informant interviews) and preliminary descriptive data about families who have been served thus far by the Family Group Decision Making Program implemented by Arizona Department of Economic Security.

The evaluation of the Family Group Decision Making program utilizes the developmental stages of the “Five-Tiered Model of Evaluation” (Weiss and Jacobs, 1988) as the guiding principles for the evaluation plan. (See Appendix A for an example of the approach). In the early development of a program’s history, it is most appropriate to focus on process and implementation issues. As the program matures, and additional data on clients become available, the focus shifts from implementation to outcomes or results of the program. The emphasis of this approach acknowledges the evolution of programs and allows evaluators and program personnel to focus on data collection that best mirrors the available and pertinent information that can help improve the program. The first year of the evaluation plan for Family Group Decision Making, therefore, highlights the implementation phase of program development. Subsequent evaluation information, to be reported in the second year, will emphasize outcomes and other longer term influences of the program.

## III. Program Background

**Family Group Decision Making (FGDM) is rooted in the belief that families have a shared history, wisdom, untapped resources, and an unrivaled commitment to their children. It is about empowering families and their friends to think and plan creatively for their children, to create community partnerships, and to utilize family strengths to resolve child welfare concerns. It is also an invitation to families to be responsible for the outcomes of a plan of their own creation. (American Humane Association/ National Center for Family Group Decision Making website)**

### Philosophy

The Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) prompted many states to implement reforms in order to qualify for supplemental federal appropriations. A number of prevention services have been developed as part of a strategy to promote “reasonable efforts” to preserve the family before a child is placed in substitute care (Pecora, Reed-Ashcroft, & Kirk, 2001). The Omnibus Budget Reconciliation Act (1993) influenced most spending to be targeted toward family support services. One of the programs supported by these funds is Family Group Decision Making.

The Family Group Decision Making (FGDM) model focuses on family strengths and capacity for change rather than a view limited to problems and deficits. Merkel-Holguin (1998) ascribes an increasing national trend to adopt FGDM strategies as consistent with several philosophical shifts within the profession of child welfare. Specifically, the FGDM model includes the following emphases:

- Family-centered, strengths-based, and solution-focused interventions;
- Shared responsibility for child protection among agencies, community and family;
- Kinship care as a preference for out-of-home placement.

A central characteristic of the FGDM model is the family meeting, the primary purpose of which is to draw together extended family and other people who know and care about the child to work together to develop a plan for the protection and care of a specific child or children. According to a brochure developed by the Arizona Department of Economic Security (DES), "The Family Group Decision Making meeting is a tool for families to solve their problems based on a simple, traditional belief: the family has the strengths and resources to keep children safe and well cared for." The objectives of the program include child safety, accountability for plan follow through, shared decision-making, reduced conflicts between the family and CPS, and an increased sense of self-determination on the part of the family. The program is designed to eliminate court involvement whenever possible, minimize assistance from DES and allow families to develop their own plans for long-term protection and care for their children. The program philosophy is based on the belief that there is a better chance that a family will follow through with recommendations contained in this plan when the family itself develops the plan.

## **Legislative Requirements**

In accordance with A.R.S. § 8-901, the Family Group Decision Making Program has been established in the Arizona Department of Economic Security for the purpose of providing an opportunity to help families find solutions to problems that threaten their family's stability. The legislation indicates that the Family Group Decision Making Program will be implemented statewide by October 1, 2001, and that the program will address the following goals:

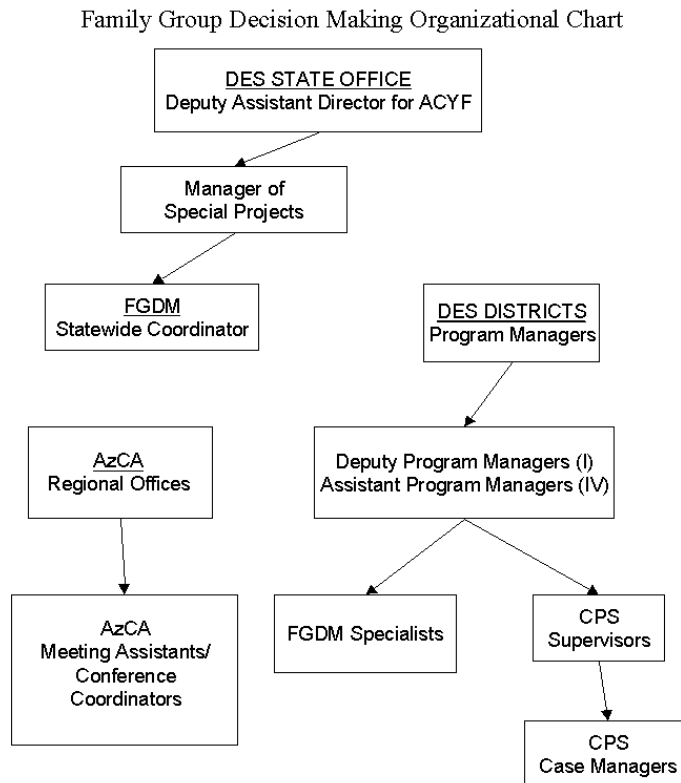
- *Provide for care and protection of children*
- *Provide a process to assist families to develop family action plans to protect children*
- *Give participants information about the departmental and court processes*
- *Assist and facilitate in preparing families to meet to develop a plan adapted to the needs of their family*
- *Respect and value the culture of families*
- *Support family in choosing a monitor or monitors from the family who will hold participants accountable for plan follow-through*
- *Increase plan compliance by encouraging the family to develop their own individual plan*
- *Allow shared decision making and shared responsibilities between the family and case manager*
- *Reduce conflict between the family and case manager*
- *Reduce conflicts between the family and CPS*
- *Increase the family's ability to become self-determined*

These legislative goals served as the framework for the evaluation plan that was developed and submitted to the Department of Economic Security in July of 2001. The basic evaluation design includes the examination of process and outcome data across the sites and the achievement of legislative program goals and objectives. Details on which evaluation methods will address each legislative goal can be found in Appendix B. More details on the design of the evaluation are reported below in section IV and VI.

## Implementation in Arizona

The Arizona Family Group Decision Making program was originally funded by federal money beginning in 1999. A pilot program was instituted at that time in two DES districts: District I (Maricopa County) and District IV (Yuma County). In District I, the program began with two specialists, and has now expanded to four. These specialists are located in DES offices in Mesa, Tempe, Glendale, and Thunderbird. District IV was divided into two sites. One specialist, based in Bullhead City, handles cases in Bullhead City, Lake Havasu City, and Kingman. A second specialist deals with cases in the Yuma area. The program has had several interim statewide coordinators. The current, permanent, statewide coordinator began work with the program in June of 2001. The organizational chart below broadly maps out the main DES departments and staff positions that are involved with the Family Group Decision Making Program.

### Exhibit 1. Organizational Chart



Arizona's Children Association (AzCA) was awarded a contract in 1999 to assist the Department of Economic Security (DES) in the project. During the pilot program mentioned above, AzCA staff in District IV served both as conference coordinators and conference facilitators. As of February, 2001, AzCA staff in Districts I and IV function mainly as conference coordinators or meeting assistants. They arrange for the logistics of the meetings including meeting location, travel, food, note-taking and other arrangements necessary to make the meeting run smoothly (e.g., child care). They are also contracted to arrange for services for the families during and after the meeting, and to make calls six months after the meeting date to assess long-term follow-up on the developed plans and satisfaction with the Family Group Decision Making program and satisfaction with services provided.

With the passing of the above-mentioned legislation, the program was expanded statewide in October of 2001. As of August/September 2001, Family Group Decision Making specialists have been hired in all six districts, bringing the total number of specialists to ten: Four in District I, two in District IV, and one each in the remaining districts. The newest specialists (in Districts II, III, V and VI) were just starting work as this report was being written, and were therefore not included in the initial data collection process. However, all districts will be included in future reports.

## IV. Evaluation Purpose and Design

In February of 2001, LeCroy & Milligan Associates, Inc., was awarded a contract from the Department of Economic Security to conduct an evaluation of Arizona's Family Group Decision Making Program. The overall purpose of the evaluation is to provide information regarding the implementation and impact of the Family Group Decision Making Program. In designing the evaluation, LeCroy & Milligan Associates incorporated both process and outcome features in the design. As is the case in any new program, it is important that outcome evaluation not be entered into prematurely. This is especially true in a program such as Family Group Decision Making where the process of implementation is critically important to achieving desired outcomes. Pennell and Weil (2000) point out that Family Group Decision Making "...is about building partnerships within and around families to protect child and adult family members and advance their well being" (p. 254).

The evaluation is designed to describe the following aspects of the Family Group Decision Making program in Arizona:

- Overall program structure
- Program Implementation
- Demographic data on numbers and characteristics of participating families
- Participant and staff satisfaction with the program
- Effectiveness of the FGDM model in terms of achieving legislated outcomes
- Acceptance of the program by caseworkers
- Effectiveness of training and policies related to FGDM

In order to gather this information, LeCroy & Milligan Associates is combining qualitative and quantitative methodologies. This combination of methods will allow a multi-faceted description of the program. These methods include:

- Review of current literature regarding model history and best practices in other communities;
- Review of program materials;
- Site visits to all sites implementing the program;
- Key informant interviews with program staff, including Family Group Decision Making specialists, referring case managers, unit supervisors, and program supervisors;
- Post-meeting data collection, including demographic information on the family, CPS history, and plan developed;
- Satisfaction surveys to be completed by all meeting participants;
- 6-month follow-up conversation with all families;
- Case studies of several participating families.

## V. Review of the Literature

The nature of the literature available on Family Group Decision Making and similar models makes it difficult to unambiguously recommend well-documented and effective strategies. There are not many reports that have incorporated vigorous designs that could indicate what specific characteristics lead to the most effective types of programs. For example, Merkel-Holguin (2001, p. 215) notes that while some of the results of evaluations are “very promising, additional research that further explores issues of child permanency; child and family safety, functioning and well-being; and family stability...” needs to be accomplished.

Many of the reports cited occur either in the “gray literature” (e.g., unpublished theses, presentations at international special topic conferences, unpublished evaluation reports outside the United States) or in two other main sources: 1) *Protecting Children*, an advocacy journal of the American Humane Association (AHA) whose mission is to “prevent cruelty, abuse, neglect, and exploitation of children and animals and to assure that their interest and well-being are fully, effectively, and humanely guaranteed by an aware and caring society”; and 2) *Family Group Conferencing* (Burford and Hudson, 2000). The former journal has included acknowledgment from the Director of AHA that “much remains to be done in FGDM including more opportunities for comprehensive evaluations of the process” (*Protecting Children*, v. 16 n. 3, 2000). The latter edited volume is one of the best sources for descriptive information from world-wide application of the Family Group Conferencing/Decision Making. However, it must be kept in mind that the following evidence in this literature review can be characterized as *practice-based* and represents the best thinking and perspectives of practitioners of the model, but does not always include the more objective perspective of outside/academic evaluators and researchers. This type of practice-based literature relies on “knowledge derived from reflection on cumulative experience and validated through...subsequent experience” (Center for Substance Abuse Prevention, 1999). Thus, the context for this new program in Arizona is one of a relatively new field that acknowledges gaps in its own knowledge about what works. Other family group decision making programs in the U.S. are currently being evaluated, and some results have been reported, but it will take time for more rigorous studies to be shared in the literature.

## History

The Family Group Decision Making (FGDM) model developed in New Zealand in the late 1980's. In response to allegations of institutional racism and discriminatory practices against the indigenous Maori, a government committee recommended major changes in New Zealand's child welfare services. The Children, Young Persons and Their Families Act (1989) built on traditional Maori approaches to conflict resolution and formalized "Family Group Conferencing" as a new method of decision-making in cases of child abuse (Love, 2000). The family conference idea is modeled after the "whanau hui", a Maori gathering in which the extended family group makes decisions about issues affecting its members. In Maori society, the community as a whole is responsible for taking care of and nurturing the children. When conflicts or problems of any kind arise, "whanau hui" are held, and "all family and community members take responsibility to restore the balance and harmony that has been disrupted" (Ribich, 1998, p. 21). These meetings reflect the Maori world-view, which is built on "the indivisibility of whanau [family] well-being from individual well-being" (Love, 2000, p. 19). The Children, Young Persons and Their Families Act (1989) mandated these conferences, established a new organizational structure for responding to allegations of child abuse, and legally mandated attendance of the child, parent or guardian, other family members, the referring worker, and a legal representative (Connolly with McKenzie, 1999). The family was also entitled to invite other participants if it wished.

The model soon gained popularity in other countries, where social work professionals were seeking methods for improving family involvement in child welfare, and other indigenous peoples were voicing similar experiences to the Maori (Burford & Hudson, 2000; Vance & Eloffson, 1998). There was a growing recognition that "state interventions into matters having to do with children and young people need to be understood and developed within a context of family, community and culture." (Burford & Hudson, 2000, p. xxiii). In Sweden, the UK and other countries, Family Group Conferences were introduced as part of a movement "to promote recognition of the rights of children, while balancing the responsibilities of parents and the role of the state in their upbringing" (Nixon, 1998, p. 13).

In the United States, Oregon's Family Unity Model developed concurrently with New Zealand's program. In this version of the program, there is no private family time and the focus is on family strengths (Connolly with McKenzie, 1999). In the last 10 years Family Group Decision Making has spread across the United States. Family Group Conferences are being used in child welfare, juvenile justice (e.g., *Protecting the Children*, 2000), family reunification (Wilmot, 2001), and other settings. In child welfare, the growing interest in FGDM processes can be attributed to several factors (Merkel-Holguin, 1998):

- A shift in child welfare philosophy, towards family-centered and strengths-based practice.
- Reform of the child welfare system to generate shared responsibility between social service agencies, communities and families.
- Increasing emphasis on kinship placement for children being placed out of their homes.

## Theoretical Context

The Family Group Conference model reflects a larger paradigm shift occurring in the helping professions: traditional CPS practice was based on professionals making decisions for families, on the assumption that dysfunctional families are not capable of doing so on their own; newer models are based on partnership and shared power between the family and the professionals. As described by Waldfogel (1998),

in the family group conferences, families play the lead role, and it is the CPS workers and other professionals who are asked to leave the room for part of the meeting...proponents of this model argue that it represents an important change in the way that CPS workers and parents approach one another, and one that will help build partnerships between them. Family group conferences may also help strengthen and empower families, increasing their capacity to protect their children in the long run. (p. 180)

This new model is based not on identifying the problems of the family, but rather on looking for positive strengths and experiences (Nice, 2001). Attention is placed “on the crucial role of the family in the healthy development of children” (Allen & Petr, 1998, p. 4). A strengths-based perspective (Walton, 2001, p. 84) includes such assumptions as the following:

- Clients have many strengths
- Clients are respected as the experts on their own situations
- Client motivation is based on fostering client strengths
- The worker’s role is one of collaboration with the client
- Any environment is full of resources
- Awareness of strengths helps in avoiding the “victim mindset”

Turnell and Edwards (1999, p. 61) emphasize that “this should not be seen as an attempt to minimize the abuse. Rather, it can reinforce the idea that the family’s life and experience can form a foundation on which change can be built.” In this context, “professionals’ awareness of and respect for the family’s positive attributes, abilities, talents, resources, and aspirations guide the entire helping process.” (Allen & Petr, 1998, p. 11) Furthermore, Family Group Decision Making seeks to increase the family’s sense of empowerment and self-determination, while ensuring that all family members are safe and respected (Maluccio & Daly, 2000).

In addition, Family Group Decision Making recognizes that families, and their problems, exist within a broader social and environmental context. This approach recognizes that

...the relationships between client families, their extended family and cultural contexts, key aspects of neighborhood and community environments, and the many formal and informal systems...may be involved in the effort to maintain family stability and keep children safe. (Kemp, Whittaker & Tracy, 2000, p. 73)

According to Nice (2001), Family Group Decision Making also represents an attempt to solve conflicts through collaboration, negotiation and mediation, rather than litigation. These approaches build on connections between people and informal techniques, and are more likely to lead to win-win outcomes with which all involved can feel comfortable.

As with any new paradigm or process, there are concerns that have been raised about the use of Family Group Decision Making in child welfare. At the 2000 National Roundtable on Family Group Decision Making, participants identified four broad areas of concerns: *resources* – including both the resources needed to run the programs, and the ability of families to access needed resources; *child safety*; *challenges* for family and staff; and *long-term outcomes* and *follow-up* (Crampton, 2001).

Some child-centered professionals have expressed concern that family decisions may not focus on the best interests of child. They worry that the child's safety may be compromised if the emphasis is on family unity (Allen & Petr, 1998). Others have resisted the loss of power, continuing to believe that they "know what's best" for families facing charges of abuse and neglect (Nixon, 1998). Lupton (1998) summarizes this tension well, as she questions whether "the empowerment of some must necessarily imply the loss of power on the part of other key groups" (p. 109). Kemp, Whittaker & Tracy (2000) recognize this same concern. They note that, while these practice models necessitate a change in the hierarchy of relationships, the knowledge and experience that professionals bring are still essential to the process.

Other concerns relate to tensions underlying shifting resources in child welfare. Describing the use of Family Group Conferences in Britain, Wilmot (1998) notes that:

it is clear that interest in the FGC model may be driven by a number of, possibly conflicting, political and ideological objectives, including both a recognition of the rights of families to have a greater say in decisions about their children and a concern to reduce the extent of these families' reliance on state support (p. 110).

According to Pecora, Reed-Ashcroft, and Kirk (2001), family-centered practices are by nature resource-intensive. Yet, many advocate FGDM because the process frequently results in children moving out of the child welfare system.

## The Family Group Decision Making Model as Described in the Literature

**The goal of this approach is to allow families greater control over the decisions and plans to ensure the safety and well-being of their children and to foster greater cooperation, collaboration and communication between child welfare professionals and the families they work with. (Merkel-Holguin, 2001, p. 197).**

The structure of the Family Group Conferences developed as a result of experiences in New Zealand; thus the model is practice-based, rather than research-based. The guiding principles of all Family Group Decision Making programs are similar:

- Everyone involved or affected by the issue should be encouraged to attend;
- Every participant is given an opportunity to speak and express his/her opinions on the issue;
- Every contribution will be listened to and considered;
- No participant is allowed to prevent another from attending, speaking, or being listened to. (Moore & McDonald, 2000)

While the model has been adapted to fit the specific needs of different locations and populations (see below), most programs have a similar structure. The process usually includes four stages (Merkel-Holguin, 1998):

- Stage I: Referral and selection processes
- Stage II: Preparation
- Stage III: The Family Group Meeting
  - Introductions/Information Sharing
  - Private family time
  - Presentation of family plan
- Stage IV: Follow-up

The process typically begins when a case manager refers the case to FGDM. Families are then contacted by FGDM coordinators to discuss needs before the meeting takes place. Some coordinators also serve as facilitators during the meeting. Meetings can last 3-6 hours or longer. The actual meeting time is scheduled into three parts: Information gathering (where details about the situation, the process, resources, strengths and concerns are discussed); family time (where the participants meet privately to decide on the best course of action); and decision making (where the family presents its plan to the professionals). A written report outlining the family's plan is prepared and distributed to all participants. All of these components are described in more detail below.

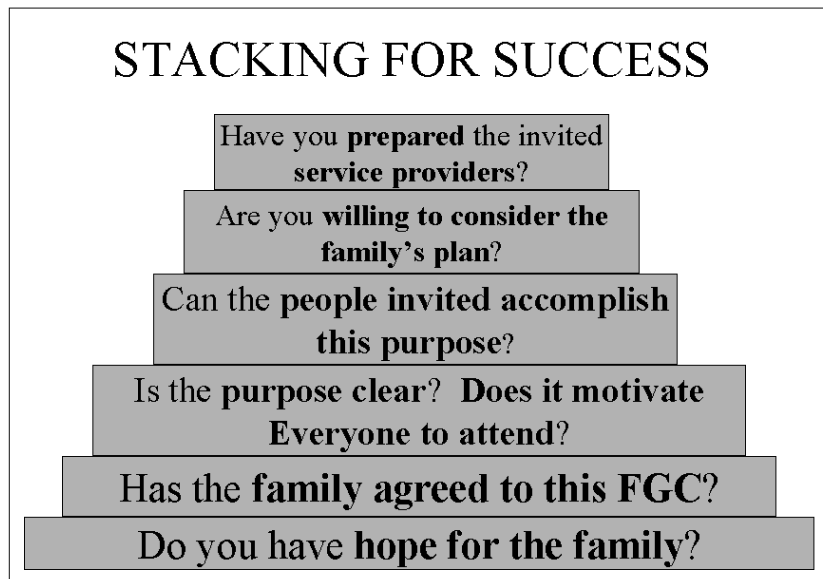
### **Stage I: Referral and selection**

There continues to be much discussion about which families should be referred to Family Group Conferences. As mentioned above, New Zealand mandates Family Group Conferences for all families in which a child protection concern exists (Connolly with McKenzie, 1999). In other countries, mandatory referral continues to be a subject of debate. Marsh and Crow (2000), reporting on experiences in England and Wales, note that when referral is voluntary, about one-third of social workers do not refer cases, although they do support the program. At the same time, they add that mandatory referral can result in inappropriate families undertaking the process. In the United States, most Family Group Decision Making programs are voluntary (Merkel-Holguin, 2001).

There is also a difference of opinion as to what makes a family 'appropriate' for the program. Some communities have excluded sexual abuse or domestic violence cases, fearing that Family Conferences in such cases will allow the abuser to further harm or manipulate the victims and/or the extended family, will shame the survivor, or will result in coerced forgiveness of the abuser (Pennell & Burford, 2000). Others feel that if the key principles of respect, equal participation and group decision-making are followed, then FGDM can be used with even the most complex cases (Nixon, 1998). In these cases, FGDM can play an important role in breaking the silence around abuse, and in broadening family responsibility for its prevention. To date, there is no research to suggest what types of families with which FGDM may work best.

According to Nice (2001), FGDM can be used with any family, and any problems, as long as the professionals have hope for the family, can identify family strengths, the family is willing to participate and the purpose of the meeting is clear. Exhibit 2 is called a "Stacking for Success Chart" which illustrates Nice's key questions when considering a family for referral to FGDM.

## Exhibit 2. Stacking for Success



Jim Nice and Patricia Evans cited in Nice (2001).

This approach is supported by research from England and Wales which showed that successful conferences were held with a wide variety of cases, and at all stages of case management (Marsh & Crow, 2000).

### **Stage II: Preparation**

According to some sources, the preparation phase can be the most important piece of ensuring the conference's success (Gunderson, 1998; Merkel-Holguin, 2001). During the preparations, the conference coordinator (FGDM Specialist in Arizona) compiles a list of all those whom the family wishes to invite, locates these people, and contacts each individually. These contacts ensure that

...all participants must be well informed about how the conference is going to go, what information is going to be shared and how it will be handled. Facilitators must know as much as possible about family members and issues of power, safety and alliances and decision making. (Gunderson, 1998, p. 11)

The number of participants at family conferences varies greatly with some meetings having as few as a half dozen participants and some gatherings including over 50 participants. Studies suggest that these preparations can take between 20-35 hours per family conference (Merkel-Holguin, 2001). During this phase, logistical preparations are also made; this may include finding a neutral location and time, arranging travel for out-of-town family members, and other arrangements necessary to ensure family participation (e.g. child care, work releases).

### **Stage III: The Meeting**

As developed in New Zealand, Family Group Conferences follow a pre-determined structure (Connolly with McKenzie, 1999). The meeting has at minimum three phases:

- Introductions/Information Sharing
- Private deliberation
- Agreement

Meetings may begin with some sort of opening, be it a prayer, poem, or other family tradition. All those present introduce themselves and their relationship to the child(ren). The professionals then typically explain the reason for calling the conference, the history of CPS involvement with the family, and the issues to be resolved at the meeting. Next, the professionals leave the room and the family discusses the situation in private. This private family time should last as long as needed, and can last several hours. The agreement stage represents the true partnership aspects of the model (Connolly with McKenzie, 1999); it is during this portion of the meeting that the family presents their plan and the professionals and the family negotiate any remaining concerns. The meeting ends with some sort of closing, in parallel to the family tradition that opened the meeting. Reports on total meeting time vary from three hours to whole days.

As the model was adapted to other countries and communities, some changes were made. For example, the Family Unity Model developed in Oregon has more structured facilitation, and does not include private family time. This model also includes a structured discussion of family strengths and concerns (Merkel-Holguin, 1998). Many communities in the United States have adapted and combined elements of these different models in order to meet their unique needs (see for example, Vance & Eloffson, 1998).

Several evaluation reports indicate that the majority of families are able to come up with a plan for the safety of the children. It is not uncommon to find that greater than 90% of the cases completing plans during the family meeting time (e.g., Rodgers, 2000; McDonald & Associates, 2000). Furthermore, Merkel-Holguin (2001, p. 213) points out that “family plans are rarely vetoed.” Since most of the safety plans are accepted by the case managers it is difficult to judge the program’s success by this indicator.

### **Stage IV: Follow-up**

After the meeting is completed, follow-up and monitoring are essential to ensure that the family’s plan is implemented and the children remain safe and well cared for. Follow-up may include, for example, provision of resources called for in the plan and/or ongoing communication among those responsible for implementation (Vance and Eloffson, 1998). In some cases, a family member is responsible for monitoring the plan; in others, the social service agencies ensure implementation. Merkel-Holguin (2001) notes that follow-up is the weakest link in the Family Group Decision Making process, as few formal structures have been developed for monitoring the family plans. An evaluation of an Oregon Family Decision Meeting program (Rodgers, 2000) indicated that plans developed include child protection concerns but lacked specifics regarding timelines and outcomes for compliance/noncompliance. Clearly specified expectations are key to any follow-up on the part of the family or other designated monitors.

Many evaluations of family group conferences indicate a need for more thorough follow-up and monitoring. "The quality of monitoring or review procedures... is continually being called into question" (Merkel-Holguin, 2001, p. 214, citing Lupton & Stevens, 1997, and Renouf, Robb, & Wells, 1990). They note that evaluations completed in New Zealand in the early 1990s indicated that many of the family plans are not in fact implemented. Worrall (1996, cited in Downs et. al., 2000) reported that 5 of 6 kin placements from family group meetings broke down after a six-month period. The families "cited a lack of supportive services and believed that with better services they could have maintained placement" (p. 298). This is particularly true for special needs children. Other studies "also found that key components of the plan were not implemented" (p. 215). However, the relationship between plan implementation and subsequent child abuse and neglect referrals has not been established.

## **Previous Evaluations**

As noted at the beginning of the literature review section, there are few examples in the academic research literature of evaluations of Family Group Decision Making. Therefore, in addition to describing the available studies, we include a few reviews of related types of programs.

Pecora et al. (2001) reviewed a number of evaluations and studies of family-centered services in general. They noted that the most common result has been no dramatic differences between control and treatment groups, but consider the findings far from conclusive because many of the studies had been confounded in several ways. For example, the administration of the family programs was not always consistent across groups in terms of referral, staff training and community resources. The evaluations themselves were often non-experimental in design or prematurely used an experimental design during program implementation (i.e., when the treatment model was evolving). The randomization schemes sometimes had problems and small samples were common. Poor case targeting, differences in treatment across sites, inappropriate assessment measures and poorly administered assessment measures could all have contributed to the lack of significant findings. Furthermore, Pecora and colleagues noted an under-use of qualitative study designs. There is also the issue of the "dosage" or intensity of the program, i.e., "...we cannot expect single services to produce dramatic changes in complex social problems" (Pecora et al., 2001, p. 20). They concluded that the field in general lacks conclusive evidence that family-based service programs prevent child placement and information about which types of family-based service programs are most effective with different client subpopulations.

With regard to Family Group Decision Making, Garcia, Molt and Kook (2001) note that good preliminary outcome research does exist. Outcomes typically addressed by the evaluations include placement (number, type, length), contact with child welfare agencies (usually referrals, reports to CPS) and satisfaction with the program (e.g., Crampton, 2001).

For example, McDonald and Associates (November, 2000) conducted an outcome evaluation of the Santa Clara Family Conference Model. They found that the program was successful in terms of preventing child maltreatment, keeping children within the family system, and reducing court involvement. They noted no significant differences in placement or court costs between the family conference group and a comparison group of cases with children entering substitute care for the first time. The family conference model cases were slightly less likely to have recurrent substantiated incidents of child

maltreatment. They also reported elements associated with these positive outcomes that included having large numbers of resource persons available, cultural competency on the part of the facilitators, and a need for post conference follow-up.

Pennell and Burford (2000) conducted interviews with family members and comparison group family members, from one Canadian site, on average twelve to thirteen months post conference. They concluded, based on satisfaction reports, self report, and qualitative analyses of progress reports, that the families who participated in FGDM had enhanced family unity despite incomplete plans. In addition, Pennell and Burford noted increased safety and a reduction in maltreatment when compared to similar families who had not participated in conferences. Although quite limited, this is the outcome study most often cited in other Family Group Decision Making articles and presentations.

Shore, Cahn, Yancy & Gunderson (2001) followed 70 cases of children who were in foster care and in the system for more than 90 days. They noted that this is the largest long-term follow-up study on family conferencing to date. They completed a content analysis of the family plans for immediate outcomes and sifted through a set of pre-collected data on the families to look at long-term outcomes. They reported that 97% of the children involved had a family plan developed. A low re-referral rate (6.8%) suggested that the program may be effective. They cautioned, however, that additional work should be done to hear from all those involved with the process, including the case workers, to explore why and under what conditions these results are more likely to occur.

## **Recommendations for Practice from the Literature**

These evaluations included several recommendations for program improvement. Garcia, Molt and Kook (2001) suggest that programs make the referral process as easy as possible. Pecora and colleagues (2001) have noted several fundamentals of program implementation that are relevant for consideration with FGDM:

- Be careful and rigorous about how to specify the treatment model. Clearly describe the theory base, intervention methods, caseload size, intensity and approach to concrete services. Dosage does matter. Program designers need to consider what it will take to make a difference.
- Adequately staff the service. Carefully consider selection criteria, training, performance standards and use of paraprofessional staff.
- Provide supervision and clinical consultation to staff in order to minimize treatment model drift.
- Establish an organizational and community climate supportive of continuing program innovation and ongoing quality assurance.
- Collect cost-benefit data. Be able to tie key outcomes to service costs.
- Identify “realizable” proximal and distal outcomes.

Pennell and Burford (1997) conducted a two-year outcome study of 32 families and based on their experience recommend the following:

- Provide written copies of the plan to participants
- Ensure a clear mechanism for monitoring and evaluating plans
- Include a system for monitoring the monitors
- Orient new workers to model and family plan
- Reconvene/Review meetings as needed
- Provide necessary resources and supports to families to carry out the plan

## **VI. Program Implementation**

### **Evaluation Methodology**

For this report, data used to assess program implementation was gathered through four methods:

1. Review of documents and materials
2. Key informant interviews
3. Site visits
4. Participant data collection forms

First, a brief description of each of the methods used is presented below. The results of the different methods are described following these introductory paragraphs. Embedded in each of the results sections are suggestions for program improvement provided by the staff during the key informant interviews.

#### ***Review of documents and materials***

The Policy and Procedures Manual for the Family Group Decision Making program was initially developed in December of 2000 and is still evolving. The information included below is based on the versions dated 6/05/01 for District I and 7/05/01 for District IV. Revisions are being made with the goal to craft a single Family Group Decision Making policy and procedures document for all the Districts. A variety of program documents were also gathered from all of the FGDM specialists. These included training materials distributed to Case Managers and Supervisors (program descriptions, articles on family-centered work, etc), program brochures, and materials distributed at family meetings.

#### ***Key informant interviews***

Family Group Decision Making specialists, case managers, unit supervisors, district deputy program managers and the statewide FGDM coordinator were interviewed between July and September 2001. A total of 40 staff people were interviewed in Districts I and IV including:

- 6 FGDM specialists
- 20 case managers:
  - 8 Intake/Investigation
  - 9 Ongoing
  - 3 Other type (e.g., combined intake/ongoing)
- 8 unit supervisors
- 2 district-level staff members
- 1 state-level staff member
- 2 contracted conference coordinator staff members (Arizona's Children Association staff from Districts I and IV).

Those interviewed represented a broad range of perspectives and experience and reflected all levels of the organization chart. Most had several years of experience in CPS and social services. A few of the case managers were new to the job (just a few months) while several others had worked more than 20 years in the field. Of the 20 case managers interviewed, eleven had referred cases to FGDM and nine had not.

A structured interview guide was used for all interviews. The guide was adapted to address the different experiences of the different staff positions. Interview questions included the following topics:

- Familiarity/experience with the program and materials about the program
- Training about the program
- The FGDM process (e.g., referral, the meeting, follow-up)
- Perceived goals, objectives, strengths and concerns;
- Suggestions for new specialists;
- Suggestions for program improvement;
- Other questions specific to the interviewee's position

### ***Site visits***

LeCroy & Milligan Associates staff visited five (5) sites where the Family Group Decision Making program is being implemented:

- District I:
  - Mesa
  - Tempe
  - Glendale
  - Thunderbird
- District IV:
  - Bullhead City

Because no meetings had been held in Yuma (the second site in District IV) at the time of data collection for this report, personnel from that site were interviewed by telephone only. Each site visit included interviews with the FGDM specialist assigned to that site, review of case files and completion of post-meeting data collection forms, and interviews with case managers and unit supervisors.

### ***Participant data collection forms***

During each site visit, some participant data was collected on cases referred to FGDM from February - August, 2001. Participant data collection forms were developed and include demographics on the families referred, details about placements, acceptance of plans by staff and courts, and other process and outcome variables. Much of the data on these early participants were not available or complete because it was collected well after the meetings occurred. Results of the preliminary descriptive analysis are included in the next section. These forms are currently in use in all of the districts; beginning in August, 2001, all FGDM specialists will complete forms for all cases referred to Family Group Decision Making. Future reports will thus be able to provide more complete information about the families and the meetings.

## Results

### *Families served*

Below are results of the preliminary descriptive analyses for available information:

#### Exhibit 3. Characteristics of FGDM Referrals

<b>CHARACTERISTICS OF FGDM REFERRALS            FEBRUARY- AUGUST 2001            N= 47</b>		
	<b>Families who completed meetings</b>	<b>Families who cancelled meetings</b>
• <b>Number of Families</b>	31	16
• <b>Type of Referral</b>	16 INTAKE 14 ONGOING	4 INTAKE 11 ONGOING
• <b>Prior Dependency Records</b>	2	4
• <b>Prior CPS Referrals</b>	30	13
• <b>Median number of prior CPS referrals</b>	3 (Range 1-16)	4 (Range 1-7)
• <b>Primary Language</b>	27 English 2 Spanish 2 Mixed Spanish/English	13 English
• <b>Number completing plans</b>	30 (97%)	NA
• <b>Number of plans accepted by CPS</b>	28 (93%)	NA

- Half of the children in referred families were male, half were female. The ethnicity of the children in the referred cases included 43% white/Caucasian, 23% African American, 25% mixed heritage and 14% Hispanic.
- Fifteen (52%) of the FGDM cases that held meetings also involved the courts. Of the court-involved cases that had developed plans, and also had a subsequent hearing after the FGDM meeting, 69% (9 of 13) of the plans were approved by the court.
- For the cases which held a meeting:
  - 43% of the children involved in the case were in some kind of relative placement at the time of referral to FGDM; 53% were placed elsewhere (e.g., shelter, foster care, group home, emergency receiving home) at time of referral.
  - 87% of children were in relative placement after the family plan was developed (e.g., relative licensed, relative unlicensed, guardianship with kin, in home with original primary care giver). 13% of the children were placed elsewhere after the family plan was developed.

### ***Program Goals – Staff Perceptions***

Program staff generally agreed on the goals of the program, although some focused on different elements than others. The goals described included:

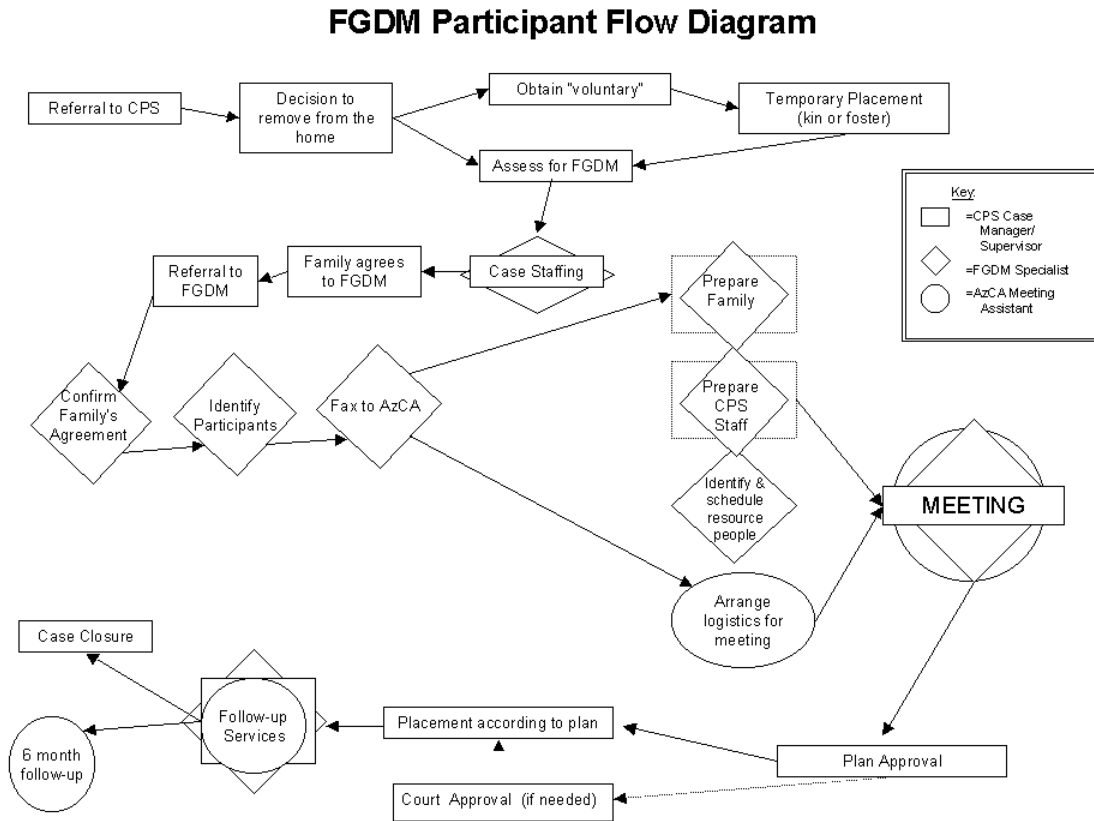
- To strengthen families and recognize existing strengths in families
- To ensure the safety of children
- To keep children with family, so they can grow up in a safe, stable, nurturing environment
- To keep children out of the CPS/foster care/court system and assure that they achieve permanency as soon as possible
- To collaborate and share decision-making with families
- To equalize power between CPS and families
- To enable families to use their expertise to solve their own problems
- To create family plans that will work

Specialists appeared to focus more on the collaborative, power-sharing aspects of the program, while case managers focused more on permanency and safety planning. Most staff felt that with proper administrative support, and with time for the program to develop, the program could meet these goals. In general, staff perceptions of program goals are consistent with the goals of the program as seen in the literature and the legislative goals.

### ***Family Group Decision Making Model***

Based on the information gleaned from the interviews and materials review, a draft participant flow diagram has been created. Following the model, specific issues about the steps and suggestions from staff for program improvement are described. The participant flow chart below is a general representation of the critical parts of the Family Group Decision Making Program. It does not represent the policy issues, rather it shows both the activities and the main staff responsible for each phase/step. Detailed sections on each stage of the model, as implemented in Arizona, are included below. These sections are based primarily on interviews with specialists and case managers.

**Exhibit 4. Participant Flow Diagram**



In general, most of those interviewed were supportive of the idea of FGDM. They welcomed the opportunity to share their experiences and provide input for program improvement. General suggestions are included in the box below; suggestions relating to specific phases of the program are described in the sections that follow.

***DES Staff Suggestions for the Overall Program:***

- Allow time for the program to develop, for staff to get used to it, before making any decisions about its future.
- Ensure trust between case managers and facilitators – power struggles serve no purpose.
- Need to generate more positive attitudes towards the program – concern for the families should outweigh concerns over workloads.
- Learn from the successes and mistakes of other FGDM programs – make sure these things are in place from the start.
- Be involved in the national movement – learn from ongoing research and new developments.

## Referrals

Several barriers to referrals were identified in the interviews. The most frequently mentioned barrier to referral was the policy requirement that the children be placed in foster care before being referred to Family Group Decision Making. It was ironic to many of those interviewed that a program that seeks to decrease ultimate placements in foster care would actually have that sort of placement as a requirement for service. This was mentioned by case managers, supervisors and specialists alike.

Several perceive the referral process itself to be a barrier to referral. Taking the time to confer with a specialist is seen by some as a waste of time. Some also expressed frustration with previous attempts to refer to FGDM because the case did not meet the strict eligibility criteria. The case managers also did not have a clear understanding of these criteria. For example, initially, only intake cases were referred to FGDM. Not all of the case managers were aware that ongoing cases are now eligible for referral. Others realized ongoing cases could be referred, but believed the "15 month" time limit to be too restrictive. Thus, unclear expectations are also considered to be a barrier to referral.

Another barrier related to general attitudes toward the program is seen in some of the responses that indicated the roles of the case manager and the roles of the specialist were not always clearly delineated. A few of the case managers mentioned that it seemed as though the specialists were doing the same type of things that would normally be a part of the case manager role. Others were more positive and felt that the specialists' efforts in trying to reach extended family members helped the case managers in their jobs.

Several of those interviewed indicated that the families may be difficult to successfully refer because family members may be suspicious of CPS and unwilling to participate. Some of the case managers and supervisors also believed that not all families are appropriate for referral. Highly transient families might not have extensive or adequate connections to provide the support necessary to have a Family Group meeting. Furthermore, some felt that not all families have hope or motivation for addressing their long-standing familial problems.

### ***DES Staff Suggestions for Referrals:***

- Continually evaluate what is working and what isn't. Have honest conversations with case managers about families whose meetings/placements were not successful in order to learn from the experience.
- Make the referral process as easy and expedient as possible. Much of the information on the referral form is available on CHILDS and facilitators could just get it from there.
- Clarify which families are most appropriate; help case managers determine which families to refer.
- Greater management support, more encouragement of referrals.

## Preparation phase

All specialists agreed that the preparation phase was essential to the meeting's success. Tasks during this phase include:

- compiling a list of family members
- meeting individually – in the home – with potential participants
- meeting with the case manager and supervisor
- identifying and contacting relevant resource professionals, both those involved with the family and those who can provide additional relevant information
- arranging meeting logistics, including time, place, food, transportation, lodging and any other special needs (i.e., work releases).

Specialists differed in how they interpreted some aspects of the preparation phase. Some preferred to be very familiar with the family's CPS history, while others found that when families discovered they were not familiar with this information, the family members were more likely to trust the specialist. There was also difference of opinion regarding the role of the case manager in preparing the meeting. Some felt that all preparation discussions for the meeting should go through the specialists. Others found it helpful for case managers to prepare the family for the meeting because they already know the family and might be meeting with family members about other issues. These small differences appear to reflect adaptations for different personality styles and different dynamics of families.

The AzCA meeting assistants begin the logistics portion of the preparation phase as soon as they receive a fax from the specialists with the names of extended family members to be invited. The meeting assistants make all the arrangements for the location, travel, food and other details necessary for the conference to occur. Some of the interviewees expressed frustration with this part of the process while others did not.

### ***DES Staff Suggestions for Meeting Preparation:***

- Specialists need to be more available to case managers involved in FGDM cases, and make sure that contact is ongoing and consistent.
- Prepare a simple, easy-to-understand information packet that case managers can share with families to help them decide about participating.
- Put effort into providing better food, fresh coffee, etc. This sends a message to the family that "we care".
- Provide as much money as is needed to make the conference happen – this will save money in the long run.

## Meeting phase

From the interviews, it became clear that the Arizona model of Family Group Decision Making is evolving. The program in Arizona combines elements of several different Family Conferencing/Family Group Decision Making models. Like the original New Zealand program, conferences in Arizona include private family time. Like Oregon's Family Unity model, Arizona includes a structured discussion of family strengths and

concerns. All family meetings held in Districts I and IV follow a set outline and include the same components (see Meeting Outline in Appendix C). These include:

- Introductions
- Presentation of meeting guidelines and meeting purpose
- CPS information update
- Family strengths
- Family concerns
- Presentations by resource professionals
- Case planning guidelines
- Private family time
- Presentation of the plan; agreement by the case manager
- Signing of plan by all present

Some specialists have experimented with changes in the organization of the meetings, in order to meet the unique needs of different families. For example, the family's CPS history and the reasons for calling the meeting are usually discussed before the family's strengths and concerns. However, in some meetings, this information is not shared until after the family's strengths, to allow a more positive tone to emerge.

All specialists appear to be distributing the same handouts to families during meetings. This material includes:

- Outline of the meeting
- Role of the monitor
- Information about available resources
- Information on custody options

***DES Staff Suggestions for Meeting Facilitation:***

- Stopping the conference so that the facilitator and case manager can discuss concerns seems to contradict the message of openness and honesty.
- The best facilitators are those who have CPS case management experience. Ideally, they should have experience in both Intake and Ongoing cases, so that they can understand the full dynamics of these families.

**Follow-up Phase**

When asked about roles in follow-up and monitoring of the plans developed by the families, different staff provided different answers. Some case managers and supervisors believed the specialists should have full responsibility for monitoring the family after the meeting, while others believed the case manager should handle this. Most of the specialists noted that the plan monitor(s) selected by the families had the main responsibility. A number of the specialists also indicated that the contracted provider for conference coordination, Arizona Children's Association, was a main source for monitoring and follow-up, especially with regard to services requested by the families. Follow-up to the meetings is clearly a weak area, and much clarification needs to occur regarding roles and responsibilities of the different staff after the meeting. One of the frequently stated concerns by some of those interviewed during the site visits is that families are "cut loose" and left to their own devices without appropriate supportive services in place to ensure their successful completion of the developed plans.

The staff that do have continued contact with the families include the case managers, who typically need to complete paperwork and processing tasks related to case closure, placement procedures, and other activities under the auspices of their role as case manager. The monitor selected by the family is supposed to contact the case manager if any problems arise in the completion of the family's plan (see Appendix D for an example of the monitor role expectations shared with all the referred families). The FGDM specialists are also somewhat available to the families should they wish to have a follow-up meeting (e.g., if placement of the child(ren) is "disrupted" or other major difficulties occur). However, follow-up meetings have been rare and, in fact, did not occur for any of the families included in this report as of August 31, 2001.

The most frequently requested follow-up services are incorporated as part of the participant data collection process and include the following:

- Guardianship Assistance
- Mental Health Counseling
- Substance Abuse Counseling
- Parenting Classes
- Parent Aide
- Domestic Violence Counseling
- Other (e.g., Utility Subsidy, Anger Management, Marital Therapy, Medical Training, Transportation, Family Counseling and other types of counseling)

Although AzCA is contracted to arrange for follow-up services, nearly all of the families have used other community-based resources to meet their needs (e.g., Alcoholics Anonymous, church-based services). In fact, there have only been two occasions in District I that required the AzCA meeting assistants to arrange direct service for the families.

#### ***DES Staff Suggestions for Placements and Follow-up:***

- Ask relatives from out-of-state to prepare some kind of portfolio showing their home and demonstrating that they would be an appropriate placement, so that case managers can feel comfortable with these placements.
- Have follow-up meetings if anything changes.
- Ensure monitoring of cases for 6 months to one year.
- Specialists should be responsible for follow-up with family.
- Case managers should be responsible for following the family.

### ***Policies and Procedures***

The general stages described in the policies and procedures documents both echo the phases of Family Group Decision Making in the literature and represent the process as used by specialists currently engaged in the program. The specialists sometimes describe details of the stages that are not addressed in the policies (e.g., how much detail about the case to share with the extended family, exactly how long to spend on the information sharing portion of the meeting, whether it is better to discuss strengths first or just before the family begins its private family time).

Initially, in the earliest version of the pilot program, referrals could be made to Family Group Decision Making Program only from intake/investigation cases. Subsequently,

dependent children who have been in foster care for less than 15 months can also be referred. The policy documents indicate that children in referred cases must be placed in foster care to receive the program. This initial placement outside the home is preferably accomplished through the signing of a voluntary dependency document by the parent. The rationale behind this requirement is based on an interpretation of the guidelines for the federal funding which currently supports the bulk of the program efforts. Additional elements for referral, as described in the policy manual, include that there be no great risk from domestic violence issues, that the parent be willing to participate, and that the safety of the child be of utmost concern. Although not yet included in the written policy, there was discussion of mandatory staffing meetings among case managers, supervisors and specialists in order to decide if a family is appropriate for referral to Family Group Decision Making.

In the early stages of the program, District IV used contractors to provide all aspects of the program. Now, District IV is similar to the other districts in that DES specialists complete the main preparation and facilitation tasks and contracted "meeting assistants" from Arizona's Children Association complete the logistics of meeting planning. Originally, only Districts I and IV offered the Family Group Decision Making Program. The program is now offered in all six DES Districts. Other staff responsibilities include that the existing case manager completes all documentation regarding placements and referrals and forms related to court requirements, etc. The case managers initially were the ones to inform the families about the program and let them know that the specialist would contact them. More recent versions of the policy indicate that the specialists are the main informants and sources of meeting preparation discussions.

Based on discussions with the key informants (more details below), it is clear that most of them have tried to follow these policies but are concerned in particular about the requirement for foster care placement as a prerequisite to referral. Some of those interviewed also expressed frustration over the rapidly changing elements of the policy. Both of these concerns indicate a need for clarification and consistent communication throughout the levels of DES administration.

***DES Staff Suggestions for Policies and Procedures:***

- Reconsider the contracting out of certain services, as different agencies may have different philosophies of how things should be done.
- Change or eliminate the contract with AzCA – the process would be smoother and easier if the specialist/coordinator and the support person were in the same office.
- Make the program a given, not an option. Workers need to understand that it is agency policy to support FGDM, even if they personally do not like or believe in the program.
- Recognize and make staff aware that it will take some time to pull together the meetings.
- Continue to push for more family decisions and less CPS directives as there appears to still be quite a bit of agency guidance in the plans.
- Change the policy so that foster care is not mandated in order to be referred to the program – allow children to stay with relatives until the meeting.
- Allow FGDM with cases that are over two years old.
- Consider criminal cases – even if one parent is in jail, the family may still be appropriate.

## ***Program materials***

For the most part, materials are consistent across sites and Districts. Some specialists provide more materials (e.g., academic articles) at their trainings than do others. These additional materials do not appear to affect the workers' knowledge and understanding of the program, as most reported that they were more likely to understand the program through conversation than through written materials. Specialists also have an internal one-page document describing division of roles between the two facilitators.

## ***Staff Training in FGDM***

Staff training since the program's inception has been widely varied and has included:

- Textbooks
- In-house presentations by a FGDM specialist
- Informal conversation among case managers, specialists and other staff
- Full day FGDM training
- Workshops at conferences (e.g., Child Abuse Prevention conference)
- Observing meetings conducted by experienced facilitators
- National Roundtable Conference in North Carolina
- Jim Nice training in August of 2001 (all FGDM staff hired at the time attended)

Most felt that the information was useful and they also provided suggestions for improving staff training. These are described below.

### **Suggestions for FGDM Trainings from Case Managers and Supervisors**

- Make the presentations as concrete as possible.
- Provide case studies, or scenarios, describing the experiences of a specific family.
- Have a case manager or supervisor who has been through the process describe their experiences.
- Focus on the roles and responsibilities of case managers in the FGDM process (including how long the process takes and what they will need to do after meeting).
- Highlight changes in policy and procedures, so that those who have seen the presentation previously do not need to attend the entire presentation.
- Present the information in an informal, "family-like" setting.
- Relate examples to the work of case managers.
- Distinguish between intake and ongoing cases.

The amount of training the specialists had received mirrored the length of time they had been working with Family Group Decision Making. The more recently hired specialists did not have as much training. All were positive regarding the trainings provided in August 2001 and expressed interest in more frequent interactions/team training so they can share experiences they've had with the families referred to the program. Not every specialist went through the same training prior to the Jim Nice trainings beginning in August 2001. Some observed other conferences with experienced facilitators. Some attended the national roundtable conference on family group decision making in North Carolina in June.

**DES Staff Suggestions for Training:**

- Make workers aware that, even if placements are not successful, FGDM can have a positive impact on the family.
- Disseminate information about success rates, so that case managers will know the program is working.
- Educate the Guardians Ad Litem about FGDM and include them in the process, to reduce resistance.
- Create greater awareness of what foster care really does to kids, and that children do much better when placed with family.
- Give every case manager an opportunity to observe a conference at least once. If this is not possible, videotape a conference for them to see.
- Create a short document to describe the role of the case manager in Family Group Decision Making.

**Insights and Recommendations from Staff: Suggestions for New FGDM Specialists**

All of the interviewees were asked to share one thing that they would like the newly hired FGDM specialists to know. This information provides important information for potential training areas. Responses were varied, and included a full range of technical and philosophical suggestions. These suggestions are described in the box below.

**General:**

- Don't be afraid to try something different.
- Think outside the box.
- Be empathetic.
- Recognize your own humanity, and that this project will bring up your own issues.

**Suggestions from Specialists:**

- Don't underestimate families – they will amaze you.
- Ask a lot of questions – learn from those who have been doing this for a while.
- Use others as a resource – plagiarize freely, but always give credit.
- Don't be afraid to not know what you're doing.
- Don't be discouraged if the meeting seems to have failed – you don't know what seeds you've planted.
- Get as much training as you can.
- This is a very satisfying job.

**Meeting Facilitation:**

- Be assertive; don't let family members manipulate the situation.
- Always keep the child as the focus of attention.
- Be comfortable defusing conflicts that may arise during the meeting.

**Communication with other CPS staff:**

- Keep communication with the case manager open with throughout the process, as the case manager continues to visit the children and be in contact with the parents.
- Trust the case manager's insights regarding family strengths and concerns.
- Make sure you debrief afterwards, with the case manager and supervisor.
- Use every opportunity to increase interest and commitment to the program, and to share actual experiences with other CPS staff.
- Be in ongoing contact with supervisors, remind them about the program, consult about possible referrals.
- Respect the workload of case managers; don't give them extra work.
- Share information with case managers about cases that have worked, and those that have not.
- Be prepared for different personalities and potential resistance.
- Recognize that old habits die hard – there are many new programs in CPS, staff can't always keep track of all of them.

***Staff Views on Program Strengths and Concerns***

In response to questions regarding the perceived strengths and concerns of the program, interviewees provided a range of ideas (See Appendix E for a complete list of the responses.). In general, they believed that the program benefits the families served by empowering their decision making, improving their ownership of issues and the placement plans, and providing an opportunity for self improvement and strengthening relationships, both within the family and between the family and CPS. Concerns revolved mostly around the referral process, the amount of work and time involved in the preparation and meeting stage, limited and unclear follow-up, role clarity, inconsistencies in the provision of services by the contracted meeting coordinators, the complexity of the process and attitudes of staff.

***Costs of Program***

According to program documentation, the Decision Package for budget years 2002 and 2003 submitted by the Department requests \$846,600 to implement the comprehensive program statewide by October 1, 2001. The dollars were intended to fund 13 FTE's (10 have been actually hired). The federal dollars currently committed to the program were intended to be combined with the state appropriation to finance the statewide implementation. The second year is expected to be funded at \$714,000. Refer to the Cost Addendum Report for specific details.

## VII. Future Outcome Evaluation Plans

This evaluation report covers the period of time from February to August 2001. There have therefore only been a few cases approaching the 6-month time period for follow-up interviews and outcomes documentation. Any reporting on data for such a small number of cases would be limited and misleading, and is not included in this report. The 2<sup>nd</sup> year Annual Evaluation Report will include a detailed analysis of outcomes including the following: placement, client satisfaction, family plan monitoring and completion, request and provision of services, subsequent reports to CPS, results of court-involved cases, and number of dependency petitions.

## VIII. Conclusions and Recommendations

The following section presents a summary of the “lessons learned” from the first efforts of the implementation stages of this program. As the program evolves, a deeper understanding of the program processes will occur. The preliminary conclusions and initial recommendations are presented in the final part of this section. In general, there are several main points or “themes” to keep in mind:

- This is a new program in early stages of implementation. Many of the issues discussed here represent fairly typical “growing pains” for developing programs. For example, several of the key informants indicated a need for continued team building and the need to clarify the roles of staff involved with the process.
- The issues presented here are similar to those encountered by other Family Group Decision Making programs in the United States. The experiences of Arizona’s Family Group Decision Making appear to be consistent with the circumstances of other programs. For example, the difficulty in overcoming initial resistance to change (e.g., as evidenced by the lower than expected referral rate) and the need for clearer expectations regarding follow-up procedures and monitoring are commonly described in the literature.
- The relative newness of the program and the time involved with development of procedures mean that there is a limited amount of data on the cases available at this stage. However, forms and processes have been developed such that full data will be available for the evaluation report in Year 2.

The main conclusions and recommendations based on all the information presented in this report revolve around the following issues:

- Referral Process
- Follow-up procedures
- Clear communication of structure and clarification of roles
- Staff training and team building
- Record keeping

### ***Recommendations Regarding the Referral Process***

- The referral requirement of placement in foster care should be reassessed.
- The referral form needs to be shortened and the same form needs to be used across all districts and sites.
- The steps required of case managers to make referrals could be simplified.

The referral process has been under continued revision. Currently, there are differences in the process between the two districts considered in this report. Requirements for referral (i.e., placement in foster care) are a source of frustration for many of the staff involved with the program. Any efforts to streamline the referral process would encourage more case managers to make referrals to the program. A similar controversy about referral processes is evident in the literature from other FGDM programs.

### ***Recommendations About Follow-up Procedures***

- Clarify/define the roles and expectations of the family monitors and clearly communicate about other follow-up responsibilities of family members, FGDM specialists, CPS case managers, and AzCA meeting assistants.
- Clearly differentiate the differences between monitoring and follow-up.
- Make time for additional team meetings that include all the involved staff from DES and AzCA to clarify the exact nature of the follow-up activities expected for families who have completed meetings.
- Collect data regularly regarding the progress the families make on their plans.
- Devote resources to these follow-up tasks to ensure that the families have the best possible chance to be successful.

Follow-through is assumed to be a task of several people involved in the process. The source of responsibility seems to depend on who is asked the question. Case managers believe specialists should be the main ones responsible for ensuring that tasks associated with the plan are completed. Specialists note that the family bears the main burden as one to two family monitors are always chosen by the family as part of the plan formation. The specialists believe it is the responsibility of the monitor to contact the case manager or specialist if any problems arise. They also note that it is in the contract of the Arizona's Children Association that they do follow-up. According to results of the interviews, there have only been two occasions thus far when the AzCA meeting assistants needed to arrange direct service care since most of the families utilize community resources (e.g., Alcoholics Anonymous) for their service needs. The follow-up calls made by the Arizona's Children Association staff are intended to gather data as opposed to monitoring progress along the way. There appears to be a serious need for more structure in this area. Clarification of all staff roles related to follow-up on the plans and support for the families is critical for the successful completion of the plans. As noted in the literature review, the need for resources in the follow-up phase is critical to the success of the program.

### ***Recommendations for Clear Communication of Structure and Clarification of Roles***

- The FGDM team, consisting of the statewide coordinator, specialists, meetings assistants and other staff critical to the process, should take time to construct a program logic model.
- Clarify role expectations for all staff involved in the program and communicate clearly and regularly with all persons involved in the process of FGDM.
- Develop statewide, consistent presentations, hand-outs and other materials on FGDM to be shared with CPS case managers, families and other targeted audiences.

One of the situations where confusion occurs regarding the structure of the program and the roles of different staff is the preparation phase of the process. Clear expectations need to be presented both to the CPS case managers and supervisors associated with the cases and the families who are considering FGDM as an option. Under most circumstances, the specialists prepare the participants for their roles in the meeting. However, some of the case managers interviewed were uncertain regarding the separation of their role as case manager and what they are “allowed” to say to the families before the meeting is held. Some of the case managers feel that the specialists are “doing my job” yet some of them value the extra effort to find extended family members to help in the decision making. Again, these are not uncommon difficulties for FGDM programs in the initial stages of implementation. The specific recommendations listed at the end of the literature review section include several that address the issue of role clarification.

The process of creating a program logic model, as recommended above, can provide an opportunity both for clarity of purpose and team building. The graphical representation of the program can also be used to share with others the structure of the program and expectations. This is echoed in the recommendations from the literature regarding the need to clearly describe the “theory base, intervention methods, caseload size, intensity and approach to concrete services” (Pecora et al., 2001, p. 22).

### ***Recommendations for Staff Training and Team Building***

- Schedule regular, perhaps quarterly, team building opportunities for staff to share experiences they have had with the families and for new specialists to receive mentoring and training.
- The statewide coordinator can develop a consistent, ongoing strategy for communicating across all districts and sites with all FGDM staff (DES and AzCA) about program developments, changes and needs.
- The statewide coordinator can assist implementation in new sites by ensuring that district boundaries are transcended particularly in provision of training opportunities for new specialists.
- Ensure that new specialists receive consistent training opportunities and that all specialists can continue to gain exposure to national trends in FGDM programs.

Many of the staff interviewed suggested changes for improvement that indicate a need for continued/expanded staff training and team building. They used words such as “ensuring trust” and made explicit requests for additional management support. Specialists in particular indicated an interest in being involved in the bigger picture of

FGDM as it is evolving in the United States. They stated a specific interest in learning from ongoing research and new developments.

***Recommendations for Record Keeping***

- DES should continue to refine and streamline all forms to provide consistent data collection across districts and sites.
- LeCroy & Milligan Associates will schedule site visits to include staff training in data collection forms.

Initial efforts have been made by the program to create consistency across sites in the use of common data collection forms, roll-up reports and procedures and policies. These activities need to continue. Particular emphasis should be placed on data collection on families that are considered for referral to FGDM and families who have completed meetings and are in the follow-up phase of the program.

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## Appendix A. 5-Tier Approach to Evaluation

Level	Purpose	Tasks	Data
<b>Tier 1:</b> <i>Needs Assessment</i>	<ol style="list-style-type: none"> <li>1. Document size and nature of problem.</li> <li>2. Determine unmet need for services.</li> <li>3. Propose options to meet need.</li> <li>4. Establish data baseline.</li> </ol>	<ol style="list-style-type: none"> <li>1. Review existing community data.</li> <li>2. Conduct review of existing resources.</li> <li>3. Identify resource gaps and unmet needs.</li> <li>4. Set goals and objectives.</li> <li>5. Recommend program.</li> </ol>	<ol style="list-style-type: none"> <li>1. Extant data.</li> <li>2. Interviews--community leaders, participants.</li> <li>3. Existing resources.</li> </ol>
<b>Tier 2:</b> <i>Monitoring &amp; Accountability</i>	<ol style="list-style-type: none"> <li>1. Monitor program performance.</li> <li>2. Meet demands for accountability.</li> <li>3. Aid in program planning and decision making.</li> <li>4. Provide groundwork for evaluation.</li> </ol>	<ol style="list-style-type: none"> <li>1. Determine need and capacity for data collection/management.</li> <li>2. Develop procedures for data collection.</li> <li>3. Gather/analyze data to describe program along <i>clients, services, staff, costs</i> lines.</li> </ol>	<ol style="list-style-type: none"> <li>1. Management information system (MIS) data at program level.</li> <li>2. Case records.</li> </ol>
<b>Tier 3:</b> <i>Quality Review &amp; Program Clarification</i>	<ol style="list-style-type: none"> <li>1. Develop detailed picture of program as implemented.</li> <li>2. Assess quality and consistency of program.</li> <li>3. Provide information to staff for program improvement.</li> </ol>	<ol style="list-style-type: none"> <li>1. Review monitoring data.</li> <li>2. Expand program description using info about participant's views.</li> <li>3. Compare program with standards and expectations.</li> <li>4. Examine client views about effects of program.</li> <li>5. Clarify program goals and design.</li> </ol>	<ol style="list-style-type: none"> <li>1. MIS monitoring data.</li> <li>2. Case material.</li> <li>3. Other qualitative and quantitative data (customer satisfaction questionnaires, interviews, focus groups).</li> </ol>
<b>Tier 4:</b> <i>Achieving Outcomes</i>	<ol style="list-style-type: none"> <li>1. Determine what changes have occurred among clients.</li> <li>2. Attribute changes to program.</li> <li>3. Provide information for program improvement.</li> </ol>	<ol style="list-style-type: none"> <li>1. Choose short-term objectives to be examined.</li> <li>2. Choose research design appropriate to program.</li> <li>3. Determine measurable indicators of success for outcome objectives.</li> <li>4. Collect and analyze data about effects on clients.</li> </ol>	<ol style="list-style-type: none"> <li>1. Client specific data (interviews, questionnaires, goal attainment measures, functional indicators).</li> <li>2. Client and community social indicators.</li> <li>3. MIS data.</li> </ol>
<b>Tier 5:</b> <i>Establishing Impact</i>	<ol style="list-style-type: none"> <li>1. Contribute knowledge development in the field.</li> <li>2. Produce evidence of differential effectiveness of treatments.</li> <li>3. Identify models worthy of replication.</li> </ol>	<ol style="list-style-type: none"> <li>1. Decide on impact objectives.</li> <li>2. Choose appropriate, rigorous research design.</li> <li>3. Identify techniques to measure effects.</li> <li>4. Analyze information to identify program impacts.</li> </ol>	<ol style="list-style-type: none"> <li>1. Client specific data.</li> <li>2. Client and community social indicators.</li> <li>3. MIS data.</li> <li>4. Comparable data for control groups.</li> <li>5. Longitudinal data.</li> </ol>

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## Appendix B. Legislative Goals and Evaluation Methods

Legislative Goal	Evaluation Method
<i>Provide for care and protection of children</i>	Review of subsequent CPS reports; post-meeting data collection
<i>Provide a process to assist families to develop family action plans to protect children</i>	Key informant interviews; post-meeting data collection
<i>Give participants information about the departmental and court processes</i>	Key informant interviews; satisfaction surveys
<i>Assist and facilitate in preparing families to meet to develop a plan adapted to the needs of their family</i>	Key informant interviews; post-meeting data collection
<i>Respect and value the culture of families</i>	Satisfaction surveys; case studies
<i>Support family in choosing a monitor or monitors from the family who will hold participants accountable for plan follow-through</i>	Key informant interviews; post-meeting data collection; 6-month follow-up surveys
<i>Increase plan compliance by encouraging the family to develop their own individual plan</i>	Key informant interviews; post-meeting data collection; 6-month follow-up surveys, case studies
<i>Allow shared decision making and shared responsibilities between the family and case manager</i>	Satisfaction surveys; key informant interviews; case studies
<i>Reduce conflict between the family and case manager</i>	Satisfaction surveys; key informant interviews; case studies
<i>Reduce conflicts between the family and CPS</i>	Satisfaction surveys; key informant interviews; case studies
<i>Increase the family's ability to become self-determined</i>	Satisfaction surveys; case studies

## **Appendix C. The Family Group Decision Making Meeting Outline** (recreated from FGDM handout)

- Introduction of facilitators, meeting logistics and description of facilitators' roles;
  - Foundation for success
  - Review and agreement as to the purpose of the meeting;
  - Definition of safety;
  - Overview of the Family Group Decision Making process;
  - Introduction of participants and their relationship to the children, and identify the roles of non-family participants;
  - Obtain family's permission for any observers to remain;
  - Meeting opening (some family ritual such as prayer, poem, song, etc.);
  - CPS information update
  - Strengths (case manager, providers, community members, friends, extended family, grandparents, parents, children);
  - Concerns (children, parents, grandparents, extended family, friends, community members, providers, case manager – (Bottom Line);
  - Resource professionals provide information about what they have learned from listening to family about their needs. Answer questions;
  - Case planning guide, elements of a case plan. (who does what, when and for how long);
  - Private Family Time. The family creates the plan, makes a back-up plan, and identifies monitors. (The facilitators remain available to answer any questions, and when the family is finished, the facilitators and the case manager rejoin the family).
  - Discussion of the plan and agreement from the case manager. The plan is reviewed for completeness, making sure that issues of responsibility (who does what, when, and for how long) are clear.
  - Sign the plan.
  - Offer follow-up meeting.
- Meeting closing.

## **Appendix D: The Role of the Monitor in Family Plans**

(recreated from a FGDM handout)

**DEFINITION:** The Monitor is a person(s) chosen by the family during family private time who will monitor the progress of the plan towards completion.

**OBJECTIVE:** To ensure the safety and well being of the child.

### **Tasks**

The monitor could be assigned to do any of the following:

- Ensure that the children are safe and well cared for in the home in which they are placed through regular contact with some or all of the participants;
- Monitor the progress of those participants who are responsible for completing tasks in the family plan. The monitor reports progress to the CPS case manager;
- If there is a concern for the safety of the children the monitor should do one or more of the following:
  - a. Make sure the back-up plan is implemented, including calling another family meeting if necessary;
  - b. Make a Child Protective Services report;
  - c. Report concerns to the CPS Case Manager;
  - d. Request the CPS Case Manager arrange for a follow-up meeting.

Obtain releases of information so the Monitor can have contact with the service provider for any of the participants who have agreed to services (i.e. if substance abuse treatment and urine analysis is being completed, the Monitor can receive information about results).

- **SUCCESSFUL MONITORS POSSESS THE FOLLOWING QUALITIES:**
  - a. Ability to keep the safety of the children a priority at all times
  - b. Ability to put aside their own personal feelings to assure the case plan is successfully followed.

## Appendix E: Staff Views on Strengths and Concerns about Family Group Decision Making

Strengths	Concerns
<ul style="list-style-type: none"> <li>• Beneficial to children and families</li> <li>• Empowering families and enabling them to make their own decisions</li> <li>• Family can improve itself (cost-effective for the state)</li> <li>• Family comes up with its own plan</li> <li>• Brings families closer together, builds family ties and support</li> <li>• Shows parents that people are willing to “go the extra mile” to come to the meeting, really do care about them</li> <li>• Family can come up with a better plan than case managers</li> <li>• Neutral outsiders facilitating – allows case managers to stay out of family dynamics</li> <li>• Facilitators meet, talk and build relationships with families – can reach some difficult families</li> <li>• Time to get to know family members/possible placements – alleviate fears, concerns</li> <li>• Families don’t need CPS to tell them what to do (“the state is not a parent”) – places the responsibility on the family</li> <li>• Involve extended family</li> <li>• Generate an honest confrontation with difficult issues</li> <li>• Allows family to stay involved</li> <li>• Helps move people out of the system faster – faster way to get to permanency</li> <li>• Keep kids out of foster care</li> <li>• Solve problems without the courts</li> <li>• (Some) parents are more comfortable releasing kids to family</li> <li>• Family, not agency, based</li> <li>• Family buy-in</li> <li>• Facilitator contacts family members, reduces work of the case manager</li> <li>• Some judges have bought into the program</li> <li>• Collaboration with the community</li> <li>• More options for families</li> <li>• Children do better with more family support</li> </ul>	<ul style="list-style-type: none"> <li>• Change scares people, will be slow to implement</li> <li>• Need for clarity regarding roles and responsibilities</li> <li>• Duplication of services – family placements are already being done by intake workers</li> <li>• Length of meeting</li> <li>• More effort needs to be put into the food – show the family that CPS cares for them</li> <li>• Children have to be in foster care to refer to FGDM - children already placed with relatives can’t be referred</li> <li>• Foster care requirement traumatizes children, defeats the purpose of keeping them out of care</li> <li>• Voluntaries are frowned upon, EXCEPT for this process</li> <li>• Difficult to get support and cooperation from some workers and supervisors</li> <li>• Presentation to family is key – starting with negative comments can set the wrong tone</li> <li>• Strengths and concerns section of meeting can last too long</li> <li>• Provision of services is weak (“contractor is slacking”)</li> <li>• FGDM coordinators should monitor case for 6 months to ensure follow-up</li> <li>• Cases should be monitored for as long as other CPS cases</li> <li>• Too many people involved in the process</li> <li>• Need to be follow-up meetings to revisit the plans</li> <li>• Some cases are too complicated</li> <li>• Some families have multi-generational dysfunction – can they make these decisions? Care for the kids?</li> <li>• Difficult to find families that are appropriate</li> <li>• Parents might feel that everyone is ganging up on them</li> <li>• Having a plan does not mean the family will improve</li> <li>• More work if things fall apart</li> </ul>

<ul style="list-style-type: none"> <li>• Families more willing to cooperate if they have more power</li> <li>• Time efficient for intake cases</li> <li>• Coordinators are able to find many more family members</li> <li>• Older children can be part of the meeting – express their opinions, know that they are cared about</li> <li>• Some ethnic groups – more open and appropriate for whole family to be involved</li> <li>• More people investing more time in a family leads to more positive effects</li> <li>• Opens communication between people who don't normally communicate well – family members with each other; and family members with CPS</li> <li>• Force people to focus on the kids, put aside other differences</li> <li>• "I don't see any"</li> </ul>	<ul style="list-style-type: none"> <li>• Potential for violence during meetings with families with DV history</li> <li>• Weekend meetings are hard for case managers – need to take into account people's other responsibilities</li> <li>• Forces CPS staff to get emotionally involved – some don't want to do this</li> <li>• Extends the length of intake cases</li> <li>• Extra work – cases still need to be worked on during preparation phase</li> <li>• Ensuring that family members are committed to participation and kin placement</li> </ul>
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