**Family Group Decision Making:**
**A profile of practices in Pennsylvania 2008**

Final Report
December 1, 2008

Submitted by the Child Welfare Education and Research Program
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# Executive Summary

The evaluation subcommittee of the Family Group Decision Making (FGDM) Leadership team requested that a fidelity study be conducted in order to better understand how FGDM was being implemented. The Pennsylvania Child Welfare Training and Research Program and the Child Welfare Research Program at the University of Pittsburgh conducted the fidelity study. The objective of the study was to determine the consistency of practices with FGDM principles. Between February and May 2008, emails were sent to three hundred and fourteen individuals with a link to a website and instructions on how to complete a survey. Two hundred and fifteen individuals completed the survey (68%). Surveys with 75% or more missing responses were eliminated, resulting in a final sample size of 180. There are a number of key findings and practice implications from the study that will be highlighted in this executive summary. Interested readers are encouraged to review the entire study at http://www.pacwcbt.pitt.edu/FGDM_EvaluationPage.htm with an accompanying powerpoint presentation.

Consistency of Practice to FGDM Principles

The focus of FGDM is primarily for maltreatment although FGDM is used for a variety of reasons and for various populations. It is used at any point in the service pathway. The most frequently identified reasons for not referring a family to FGDM was sexual abuse and family violence. Other reasons included lack of referrals, and caseworker reluctance and lack of clarity about the kind of families to refer. Although many of the respondents reported attending training, approximately 23% had no training in FGDM. Implementation teams were in place and included individuals from many systems, suggesting that cross-systems collaboration was occurring. While the majority of FGDM practices are consistently in place, follow up after FGDM does not occur on a consistent basis. Another area that was inconsistent was voluntary vs. involuntary family participation.

Differences in perception about fidelity practices

Associations were seen between resources and structure and maturity of the practice. “Mature” (greater than 20 conferences) counties were more likely to have: written policies; policies on the type of family to refer; a full time coordinator; and the role of coordination shared between public agency and private provider. Although causality can not be determined, the association seems to be important. More experienced counties have processes in place and resources that may be more supportive of the FGDM.

Challenges and facilitation factors for implementing and sustaining FGDM

The respondents were asked several open-ended questions about what they perceived to be the important factors in helping and sustaining FGDM. Although no single category accounted for more than 21% of the responses, the

two most common were “training & support” and “leadership attitudes”. The “take away point” is that counties and agencies can facilitate implementation in many ways and if one approach is not working, another may help. The most common response to challenges to the practice fell into the category of “barriers created by caseworker attitudes”. Others challenges were “structural issues” (problems with time, money, staffing, extra hours of work & caseloads) and “family characteristics”. It is likely that improving structural issues is likely to influence caseworker attitudes to the practice. Finally, the respondents felt that continued funding, support and leadership were necessary to sustain and expand the practice of FGDM in Pennsylvania.

A limitation to this study is that it provides a point in time view of the state’s practice related to FGDM. In addition, there is the selection bias at two levels - counties that responded, and individual who responded; those that chose not to respond may have a different perception of practice. Other limitations include the amount of missing data, particularly from counties who were new to the practice. However, despite these limitations, this study provides a “snapshot” of how the practice has evolved and what is needed to move forward in the practice.

Recommendations

The responses to the survey clearly indicate that FGDM is becoming an accepted approach and that many of the practices of FGDM are in place. It also seems to have positively impacted relationships with colleagues and families. At the same time, a number of needs and fidelity concerns were identified.

- Identify the barriers preventing follow up meetings, address them and make the meetings part of FGDM best practice standards.
- Throughout the State, standardize and document how and which families are identified for FGDM. Although some counties have policies in place for which families to refer and some have automatic inclusion, there is variation and a great deal of individual judgment being exercised in which families are referred and at what point in the pathway. A process should be in place to better document and describe families—those that participate in FGDM, those that do not and why.
- Leadership is important in supporting and facilitating attitude change and structural change. Leaders who are not directly involved with the direct practice are nonetheless critical in ensuring that the practice is accepted and utilized through making concrete structural changes. Leaders need to consider ways to make FGDM “a way of doing business”. Some structural changes could include flexible hours so that caseworkers attending meetings are not expected to work 15 hour days; offering caseworker incentives to make referrals to FGDM; requiring participation in family group meetings and including it as part of performance evaluations and promotion (Crae, Crampton, Abramson-Madden & Usher, 2008). Expansion and long term sustainability will require leadership to find

alternative and creative solutions such as “braided” funding that utilizes several funding streams.

- The survey highlighted that only a small number of professionals have extensive experience in the practice, and that almost a quarter who responded had no formal training in the practice. Yet training emerged as the most common response regarding perceived factors for facilitating the implementation of FGDM. Training needs to be more broadly defined as “outreach” to other systems and communities and a variety of mediums outside of didactic training need to be employed (written materials, short videos, public service announcements). Technical assistance and Transfer of Learning activities may augment training and help embed the practice into the organization’s culture. While cross-systems implementation teams are in place, the role of former youth and families on the teams is minimal and could be enhanced. In addition, families and youth could play a role in training, mentoring and assisting families who are new to FGDM, and supporting them in following through on their plan.
- An ongoing and state-wide outcome evaluation is needed to determine if FGDM produces positive outcomes for children, youth, families and organizations, and to identify with which families it is the most effective. It will also help to demonstrate the value of the practice to the skeptical and unconvinced.

Reference:

Crae, T.M., Crampton, D.S., Abramson-Madden, A. & Usher, C. L. Variability in the implementation of the Team Decisionmaking (TDM) : Scope and compliance with the Family to Family practice model. Children and Youth Services Review, (2008), doi: 101016/j. childouth.2008.03.007

## Introduction

Since its inception in 1999, Pennsylvania has used Family Group Decision Making (FGDM) as one method for assuring the safety, permanence and well-being of children involved in child protective services. A value supporting the use of family group decision making as an intervention in child welfare is that involvement of the extended family and community, enhances families' capacity to care for their children (Merkel-Holguin, 2001). Although FGDM was initially used when working with families involved in child protection, Pennsylvania is also using it as an intervention with children and families involved with juvenile probation, as well as with adults with substance abuse and mental health issues and those involved with corrections and parole.

The adoption of FGDM has been a grass roots effort, often driven by one or two people in a county who have heard of or observed FGDM and become champions of the practice. These champions might be county administrators, judges, child welfare supervisors or staff of children and youth agencies. The practice is not mandated although it is supported by most county judicial systems and recent increased reimbursement from the Department of Public Welfare has provided some incentives and support for the practice. The advantages to the grass roots adoption approach is that the individuals at the community level have the opportunity to shape the practice based on local resources and partnerships and increasing investment in its success (Waites, Macgowan, Pennell, Carlton-Laney & Weil, 2004). The disadvantage is that local conditions and the desire to contain costs or avoid litigation can also shape the practice in ways that cause it

to lose or drift from the critical elements that make it “family group decision making” (Merkel-Holguin, 1998 & 2000; Schorr, 1997). Therefore, as more counties adopt the practice, it becomes imperative that we investigate how consistently FGDM in Pennsylvania adheres to FGDM principles and practices, and determine which factors may facilitate or challenge its adoption and implementation (Pennell, Hardison & Yerkes, 1999). This is especially timely as Pennsylvania is beginning the process of making FGDM a “standard” practice in all 67 counties. In addition, the outcomes of FGDM will be more closely monitored in order to determine their contribution to Pennsylvania’s performance on the objectives for child welfare practice (Child and Family Service Reviews). Therefore, the objective of the FGDM Fidelity Study was to determine the consistency of practices with FGDM principles. The following questions, which proceed from the study objective, are addressed in this report:

- To what degree is FGDM being implemented?
- Does role or degree of experience associate with differences in perception about fidelity practices?
- What are the perceived challenges and facilitation factors for implementing and sustaining FGDM?

## Methods

In response to this need, a survey was developed by the Child Welfare Training Program Practice Improvement Unit and the University of Pittsburgh School of Social Work, with assistance from the statewide FGDM Training and Evaluation Sub-committees. Limited pre-testing of the survey was done in order

to verify that open and closed items could be answered. A copy of the survey is included in Appendix A. In February of 2008, emails were sent to the Children and Youth Administrators (CYA) of every county in Pennsylvania. They were asked to "nominate" and provide the email addresses of at least ten individuals in their county who are involved in the practice of FGDM in some way**,** e.g. through referral, implementation of the group, providing services, or participating as members of teams. Identifying information such as names and addresses was not collected in order to protect the identities of the potential respondents. The nominees could be anyone involved in the practice, including parents or caregivers, if they had a professional role in FGDM.

Thirty-nine counties (58%) responded with email addresses for respondents, and two counties that implement FGDM did not submit names. Of the remaining 26 counties, eleven notified us that they do not do FGDM and the remaining fifteen counties chose not to respond to the email.

In March 2008, emails were sent to 314 individuals with a link to the website where the survey was located. The respondents were told that this was an anonymous survey about Family Group Decision Making and were asked to follow the link to the survey: reminders were mailed out two weeks after the first email. By the end of April 2008, 215 surveys were submitted for a 68% response rate. Because this was an anonymous survey, reminder emails were sent to all 314 individuals. Therefore, it is possible that someone could mistakenly complete more than one survey. The file was checked and seven duplicated surveys were deleted. In some situations, an individual could legitimately submit

more than one survey. For example, a coordinator may work in two counties and complete two surveys; these surveys remained in the sample. Twenty-eight surveys (13%) with a large number of missing items (more than 75%) were deleted resulting in a final sample size of 180. The number of completed surveys ranged from one to nine per county. The counties that are represented in the sample include: Adams, Allegheny, Armstrong; Beaver; Bedford; Berks; Blair; Bradford; Bucks; Cambria; Centre; Chester; Clearfield; Clinton; Cumberland; Dauphin; Elk; Erie; Forest; Fulton; Indiana; Juniata; Lehigh; Lycoming; Northampton; Northumberland; Perry; Philadelphia; Pike; Snyder; Somerset; Venango; Warren; Washington; Wayne; Westmorland and York. The number of surveys per county can be found in Appendix B.

## Findings

### Description of the respondents

Where are they employed?

- Over one- half worked for a public child welfare agency (61%); 21% worked for a private provider; and 6% worked in juvenile probation

What is their work role?

- 27% were child welfare supervisors; 16% were child welfare caseworkers; 15% were FGDM managers; 10% were county administrators; 7% probation officers; 7% mental health professionals; 6% advocates and 12% other (teachers, judges, foster parents, private provider caseworkers etc).

What is their role in FGDM?

- 29% participated as an implementation team member; 28% were referring workers
- 20% were liaisons to CYF
- 13% were coordinators of FGDM; facilitators (7%) or co-facilitators (4%)

## What does Family Group Decision Making Look like in Pennsylvania?

The following section describes what FGDM looks like in Pennsylvania according to the professionals who responded to this survey.

What is it called?

Although a small percentage use the terms “Family Group Conferencing” and “Family Team”, the majority (92%) of the counties use the term “Family Group Decision Making”.

How long has the county been implementing FGDM? ; How many conferences has the respondent participated in?

Thirty-three percent of the respondents said that their county has been engaged in the practice for more than three years. A smaller percentage (28%) had been doing conferences for a period between 19 to 36 months, and 17% for 7 to 18 months. The smallest group (13%) is the least experienced, implementing FGDM for less than 6 months. However, there is some variation in responses in that participants from the same county provided different answers.

When asked how many FGDM conferences they had participated in over three-fourths (78%) had participated in 20 or fewer conferences, 16% report attending between 21 to 50 conferences and 5% attended 61 to 100

conferences. Only 2 individuals responded that they had participated in more than 200 conferences.

Are there written policies to support the practices?

Policies introduce a practice and support its consistent application. Over three-fourths of respondents (77%) report that they have written policies and procedures for FGDM. Sixty-eight percent of the respondents report that there are written policies to guide which families are referred to FGDM. This may help to further explain some of the comments in the open-ended questions about barriers and need for additional training and technical assistance in identifying which families could benefit from FGDM:

- *"unsure about the nature of cases that should be referred";*
- *"case workers and supervisors waiting for just the right referral";*
- *"How to recognize a possible referral for FGDM".*

How is it financed?

Over one-half (57%) of the respondents said that FGDM in their county was financed through the child welfare needs based budget and plan. Smaller percentages were reported for grant funding (6%), managed care re-investment (3%), system of care initiatives (2%) or human service development funds (1%). 31% did not know how FGDM was financed in their county. Some of the respondents noted that their FGDM was initially funded through system of care and other grants and subsequently sustained through needs based planning or managed care re-investment.

How are people trained and supported in FGDM practice?

There are a variety of ways that individuals are trained and supported in the practice of FGDM: didactic training, technical assistance, statewide and regional meetings, conferences, cross-county sharing and resources from the American Humane Association. The respondents were asked about their experience with training and support. A notable finding was that 23% of the respondents had not participated in any training and 31 % had not attended a statewide meeting. This finding should be investigated further to determine if this refers to individuals in collateral systems (e.g. mental health, education) or to those working in child welfare agencies and why they have not been able to utilize training opportunities. The percentages of "not applicable" and "missing" were higher for national resources, e.g. AHA materials or conference. Those who had received training and resources reported them to be useful, particularly the statewide meetings (54% very helpful) and the training conducted by the Pennsylvania Child Welfare Training Program (57% very helpful).

A review of an open-ended question about additional training provided a variety of ideas without a single unifying theme. Answers to the question "*Suggestions for how training is conducted and who should attend" included* that all caseworkers should attend FGDM training and observe at least one conference or shadow a coordinator, go to other counties to watch groups, use only highly experienced coordinators and facilitators to conduct the training, and include in the training "opportunities to hear from family members who have experienced the process and have feedback to offer". Suggestions for "*more*

*training opportunities"* included a greater number of the FGDM basic training on the training calendar, more overview sessions and a "train the trainer" module so counties can address their ongoing training needs due to turnover. Suggested "*specific topics about families"* included how to engage hard to reach families without pressuring them to participate and how to work with special issues such as sexual abuse. "*Topics related to case workers*" included a presentation or training that persuades caseworkers to recommend FGDM to families. Several respondents said caseworkers may be concerned about the time needed to work with the family developing the plan and that the meetings are long and often in the evening. As a result, they may not discuss FGDM with a family because it seems more time consuming than typical practice. They suggested that the content include acknowledgement and justification as well as statistics and testimony on how time spent in the early stages increases family responsibility and decreases time spent working on the case. In other words, this presentation would "sell" the practice to skeptics.

<u>How is it structured? How is it supported within Children and Youth Services (CYS?)</u>

Over one- half (56%) of the respondents reported that a private contractor coordinates the FGDM conferences. Approximately 19% have CYS coordinating the conferences and 22% report that a hybrid CYS/private contractor is responsible for coordination.

A few of the open-ended comments reflected opinions about the structuring of family group. One of the identified benefits of subcontracting to a

provider and having separate funding is to reassure the family that CYS is not controlling the process. This comment implies that work needs to be done in order to change some families' beliefs that CYS is not helping families.

*"I think that it would be better if we implemented the practice better according to the true structure of family group and not have it paid for and initiated by the CYS agency (even contracted). Families know that the service is paid for by CYS agency and or could probably guess; already sets them up to feel like CYS is in "control and therefore lack of belief in the practice".*

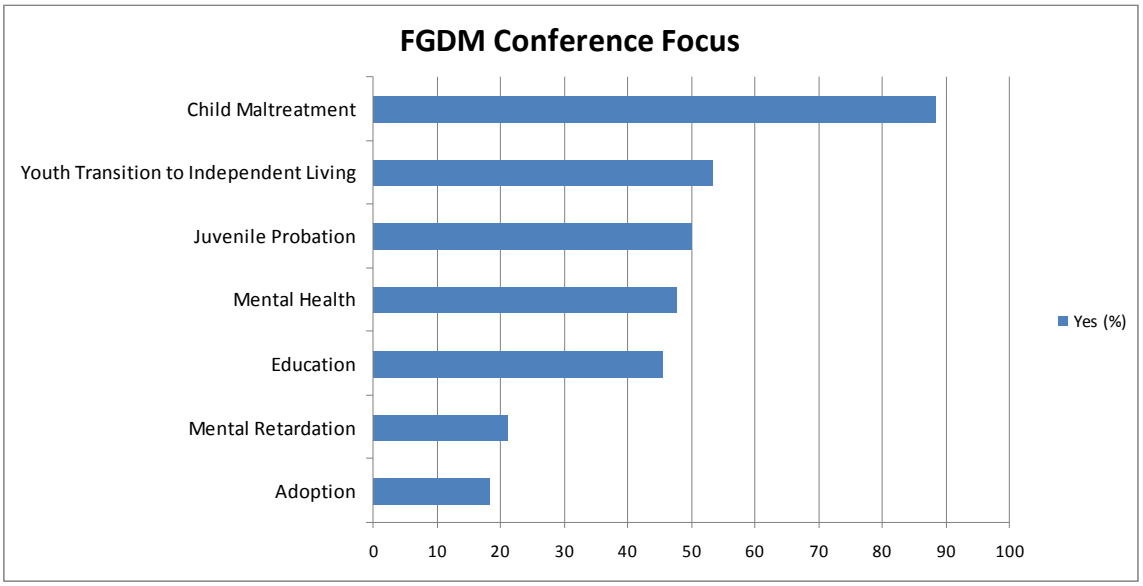
Others commented about the "helping" value of subcontracting: "*having an outside agency handling the planning and organizing"; "having an agency that we contract with to facilitate and implement the conferences".* They did not elaborate on whether the value of subcontracting was due to the expertise of the provider or the outsourcing of the work of planning and organizing conferences.

More than one-half of the coordinators are full time (64%) although 20% of the respondents did not know the status. Related to this question is what level of human resources within CYS is exclusively assigned to the practice of FGDM? Approximately one-half of the respondents (42%) could not answer this question. However, those that did answer report that the average number of CYS staff assigned exclusively to FGDM is approximately one (the modal value—the most frequently occurring answer—was zero). One of the respondents described the difficulty that small counties may initially encounter with resourcing FGDM: they can't hire someone until the practice is more established with referrals, but they can't get referrals without devoting significant resources.

*"Being a small county we tried to do this program in-house. There was not enough to devote one person's time to the task, and when a referral did get made, the worker often had to neglect their regular job responsibilities…"*

What are the foci of FGDM in the county?

Although FGDM was initially implemented with families involved in child welfare, it is an intervention that has been used to address a large range of concerns beyond child protection. The respondents were asked which of the following were a focus of family group conferences: child maltreatment, juvenile probation, education, mental health, mental retardation, youth transition,adoption, other. The respondents could choose all that applied.




The focus of family group is primarily child maltreatment, with 88.3% of the respondents saying that FGDM conferences in their county focus on child abuse and neglect. Another common focus is youth transitioning to independent living (53.3%) or for youth involved in juvenile justice (50%). Mental health (47.8%) and

education (45.6%) were identified as a focus to a lesser degree. Finally, FGDM is used the least for mental retardation (21.1%) and adoption (18.3%).
In the “other” category, family group decision making is also being used in community re-integration of adult offenders, aging, truancy, parental mental health & addiction, and reunification or return from placement

What are the reasons for implementing FGDM practice in your county?

Respondents were asked to rank order from 1 to 8 (with 1 being the most important, to 8 the least), their reasons for implementing family group. The purpose of this question was to determine why counties adopt and implement FGDM. However, because this was a ranking question, many people skipped it, failed to follow the instructions, or had difficulty because they could not pick more than one an item to be “1”. Therefore, only the top three choices are highlighted in this report. For these percentages, only cases where the respondent had ranked a total of eight items (N=110) were used.

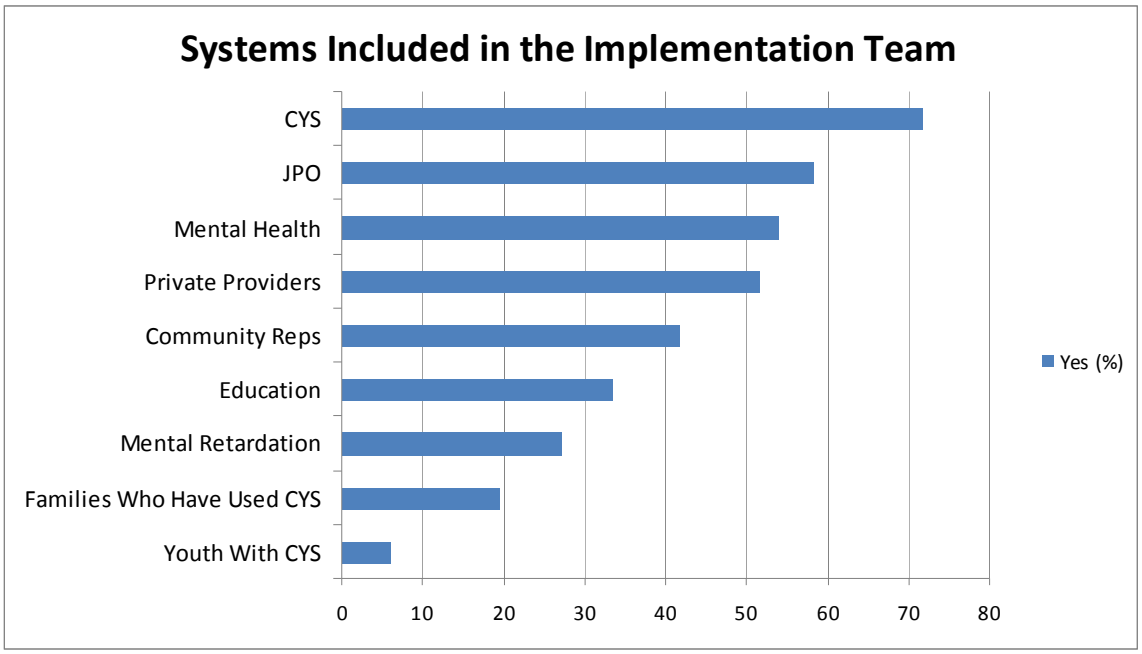
- Improving child safety was ranked “1” by almost one-half (46.9%) of the respondents.
- Improving stability and permanency outcomes was ranked “2” (42.7%).
- Improving the agency’s approach to family engagement ranked third (24.8%).

These reasons are very consistent with the purpose of FGDM as defined by the American Humane Association: “To actively seek the collaboration and leadership of family groups in crafting and implementing plans that support the safety, permanency and well-being of their children” (American Human

Association, 2008). That family engagement is also identified as an important reason for implementing FGDM suggests that it is valued as a way of working with families. Also meaningful is that implementing FGDM as a way of better managing financial resources was not highly ranked as a reason for adopting the practice; only nine percent of the respondents identified this as a primary, secondary or tertiary reason. These findings suggest that in Pennsylvania, the purpose of the adoption and implementation for FGDM is consistent with its philosophy and practice.

Is there an implementation team and who is on it?

The majority (81.6%) report that they have an implementation team. The composition of the teams is displayed in the chart. Individuals could select all that applied, so the percentages do not equal 100%.



CYS, juvenile justice, private providers and mental health are frequently part of the implementation team. Other systems, community members, alumni youth and former families are included to a lesser degree on teams. Respondents were also asked to write in other implementation team members not in the checklist, and this provided an interesting insight into the variety which was not captured in the closed ended items. For example, six respondents said that domestic violence professionals were part of their teams. Other implementation team members identified adult drug and alcohol professionals (8 respondents), Early Intervention and Head Start (2 responses). These are important members to have on the implementation team given the relationship of parental substance abuse and re-entry of children into foster care (MacMahon, 1997). Professionals from aging, adult probation, parole and re-entry, housing authorities and churches were also mentioned as part of implementation teams. The role of former youth and families on implementation teams should be further investigated to see whether or not including them in the group assists the families in creating and following through on a plan.

How are families selected to be approached for the choice of participating in FGDM?

This question was an attempt to determine the process by which families are identified before being approached about FGDM. The themes that emerged from this question were the process (which includes who identifies the family and how they approach them) and then “rule in” and “rule out” factors (system, family and caseworker) that are considered before approaching families.

The most frequesnly mentioned process is that families are selected, usually by caseworkers, supervisors or other system professionals such as probation officers, private providers etc. The other process is that all youth or families who fall into a certain category are automatically considered for FGDM and excluded only if they have certain factors. For example, “all independent living” or “truant “ or “foster care” youth automatically are referred to family group. Other facilitating factors for participation are assessed such as available supports for the family and willingness to participate. Factors that would “rule out” using FGDM out would be domestic violence in the home and or child sexual abuse. So it appears that there are two primary referral processes operating—all are included and then ruled out; or a family is identified by a professional. However, this question had a lot of variation. Interestingly, some of the respondents reported that they would approach a family as a “last resort”. only when other interventions had not been successful Others said that they only approach families when there “is hope”. Eight respondents said that a family can self refer to family group. So while there are primarily two processes in place, a great deal of variation exits within the process.

<u>What would keep your county from having a FGDM conference?</u>

The themes that emerged from the open-ended questions were *system factor*s, *family factors* and *caseworker factors*. *System factors* are related to agency policy and procedures, funding and system resources. An example of a system factor is the lack of written procedures to specify which families are

appropriate for referral. Resource factors would include lack of transportation and lack of community resources to assist the family to participate in the group.

*Family factors* were the most frequently identified factor for not having a family group decision making conference. Sexual abuse, safety concerns and domestic violence in particular, were the most frequently identified factors for not holding a FGDM conference. Another frequently identified family factor fell under "willingness" and this includes family willingness to have FGDM as an intervention as well as the follow through and scheduling that the family needs to do in order for the group to happen. Lack of family support was another frequently identified family factor for not using FGDM. Some other less frequently identified but interesting responses were "active family addictions" and "legal involvement".

Are families with a history of domestic violence or legal problems and addictions being screened out of FGDM and is the practice excluding a group who could benefit from FGDM? It isn't clear from the answers if a *history* of violence would rule a family out, or if exclusion is limited to *active* violence. However, given the significant co-occurrence of domestic violence and child maltreatment (Edleson, 1999; Kohl, Edleson, English & Barth, 2005) and evidence that child welfare can be a gateway to domestic violence services, (Kohl, Barth, Hazen, & Landsverk, 2005) this merits further investigation. Kohl and Macy (2008) identified profiles of victimized women involved with child welfare agencies. They suggested that women with the profile of active substance abuse and legal problems but also moderate social support might be

those who can benefit from FGDM. Other researchers have found that FGDM meetings can be used successfully in child welfare cases that involve domestic violence (Crampton & Williams, 2000; Pennell & Buford, 2000), and when there is active substance abuse (Weigensberg, Barth & Guo, 2008). The identification of these family factors as exclusions is worth further exploration in order to determine if families who could be referred are being eliminated from consideration for family group.

*Caseworker factors* included attitude, behaviors and training. Examples of this would be if the caseworker and the supervisor do not agree about the referral to family group, or negative caseworker attitudes exist about the usefulness of FG for the family. Four respondents said that family group would not be held if there was "no hope" for the family or if they felt that it was not "timely" for the family or if the family would not benefit. Lack of training for caseworkers was identified as a reason as well. Other factors supplied by the respondents included the unwillingness of child welfare professionals to "buy in". This theme was repeated in the open-ended questions about barriers to family group reported in the final section of this report. Finally, 10 respondents said that "nothing" would keep them from having a FGDM conference for a family.

<u>At what point are families referred for FGDM conferences?</u>

Although FGDM has been used in probation and adult corrections, the responses to this question were primarily about the child welfare pathway. Families are referred to FGDM at any decision point in the service pathway: at referral and intake, opening for services, at placement changes or goal changes

or before transitioning to independent living. Some of the respondents said that while it could be used at any decision point, they felt that FGDM was best utilized early in the service pathway.

Early in the pathway, when families are accepted into child protective services, FGDM is used prior to *writing the family service plan*. Another decision point in the pathway is when the child/youth was *at risk of being placed out of the home* and FGDM is used as a method to avoid an out of home placement. Another decision point identified for holding a family group meeting is prior to the child(ren) *being reunified* with the birth family. Finally, at the end of the pathway, FGDM is used prior to the child transitioning *into independent living.*

Some of the respondents said that FGDM was used in *crisis situations or as a last resort,* e.g. “when in crisis, nearing a crisis or when the family situation is so chaotic that a conference serves as a means to provide structure….” or when all other options have been tried and been unsuccessful. In these instances, it is used as a problem solving intervention after traditional methods have failed.

Finally, the respondents also reporting using FGDM for special populations such as truant youth and transitioning age youth irrespective of the pathway decision point.

The responses to the open-ended questions provide some insight into who gets referred to FGDM, what the process is, and when FGDM is likely to be implemented in the pathway. FGDM, as practiced in Pennsylvania, is flexible and used with a number of target groups for the purpose of ensuring child safety.

Although some counties have policies in place for which families to refer and some have automatic inclusion, there is variation and a great deal of individual judgment, “gate keeping”, and possible bias in selecting which families are referred and at what point in the pathway. It is possible that families who could benefit are not being referred due to caseworker or supervisor bias, individual judgment and misunderstanding. It is also possible that families are being referred to family group when other interventions might be more effective. For example, Kohl and Macy’s (2008) research suggests that intensive case management with a mental health focus might be more effective in reducing co-occurring domestic violence and child maltreatment when there are multiple problems (depression, history of victimization and abuse, and low social support). Furthermore, while most of the respondents said that FGDM was used for the purpose of safety, parental substance abuse has been strongly associated with poorer family function and subsequent re-reports to child protective services for maltreatment (Wolock & Magura, 1996) and re-entry into foster care (MacMahon, 1997). Without clear referral criteria and timing guidelines based on evidence, it will be difficult to evaluate the effectiveness of FGDM.

## Are the Principles of FGDM Being Implemented in Practice?

Strengths based, individualized models such as FGDM are best assessed for fidelity by comparing practices to a set of key principles. Joan Pennell developed a series of nine key principles and associated practices for the North Carolina Family Group Conferencing Project (Pennell, 1999).

These are:

1. Build broad based support & cultural competence by:
    - Including a wide range of community & public organizations in planning, guiding, resourcing and evaluating the program and
    - Partners retaining their own distinctive roles & responsibilities

2. Enable the coordinators to work with families in organizing conferences by:
    - Selecting coordinators who respect families & communities
    - Making conference organizing the coordinator's primary role in relationship to the family, and
    - Providing the coordinator with cultural and practice consultation
3. Have the conference belong to family group by:
    - Inviting more family members than service providers
    - Holding conference in a place and in a way that fits the family culture
    - Giving reasons for holding the conference that families & professionals can understand
4. Foster understanding of the family & creativity in planning by:
    - Inviting different sides of the family
    - Broadly defining what is "family"

5. Help the conference participants take part safely & effectively by:
    - Preparing family group & service providers
    - Building in supports & protections

- Arranging transportation, childcare, interpretation etc as needed

6. Tap into the strengths of the family group in making a plan by:
    - Asking information providers to share concerns, knowledge & resources but not to dictate the solutions
    - Ensuring that the family group has private time to come up with its plan
7. Promote carrying out the plan & fulfilling the mission by:
    - Providing timely approval of plans regarding safety & resourcing
    - Integrating supports & resources of the family group, communities, organizations and public agencies
    - Building in monitoring & evaluation of plans and follow up meetings
8. Fulfill the purpose of the plan by:
    - Implementing the plans as agreed or revising them together as needed
    - Supporting efforts of the family group & service providers
9. Change policies, procedures and resources to sustain partnerships among family groups, community organizations and public agencies by:
    - Using program evaluation as a means of changing practice and policy
    - Developing and using integrative & culturally competent approaches

Principles one and two are about creating a hospitable environment at the agency level for carrying out family group. Principles three to seven refer to safe and effective planning at the family group level. Principles eight and nine are about the outcomes at the family level and community level.

Based on these principles, a set of questions was written by CWTP Practice Improvement Specialists and the research staff at the School of Social Work. Although there is not a one to one correspondence with the principles and practices, the questions cover the principles of creating a hospitable environment at the agency and safe and effective planning with the family. There is one item on post conference follow up and plan changes. Questions about changing policies and procedures (Principle 9) were not included in this multi-item scale. This scale is called the “Fidelity to FGDM Practices”.

Table 1 displays the 22 questions and gives the numbers and percentages of respondents who reported that they “never” “occasionally”, “frequently”, “almost all the time” and “all the time” observed these practices in FGDM in their county.

The number of responses varies by item because some of the respondents were unable to answer the question. In calculating percentages, the “not applicable (NA)” and “missing” were excluded in the calculation: however, the number of missing and percentages is noted in the last column. The item with the least amount of missing data was “Coordinator and Facilitators are trained”

(13.9% missing); the item with the most missing data was “post conference follow-up with the members of the family” (31.1%).

When respondents are grouped by the county’s level of experience in FGDM (see Tables 2, 3 & 4 in the next section), the number of “NA/missing” tend to cluster on certain items. In addition, the number of items with 20% or more missing is substantially greater when respondents work in counties that have had 20 or fewer family groups and no groups.

As seen in Table 1, items where the respondents reported high levels of observing the practice (80% or greater “all the time”) include:

- Coordinators and facilitators are trained (84.5%)
- Strengths of the child and family are shared (92.7%)
- Information is provided by the referral source about the issues that need to be addressed in the plan (84.9%)
- Children’s safety, permanency and well being needs are addressed in the conference ((86%)
- Families have private time (92.6%)
- Time for a meal (87%)

These practices are consistent with fidelity to creating a hospitable environment for family group at the agency level, and for safe and effective planning at the family group decision making conference.

The practices that 20% or greater of the respondents report observing less than 50% of the time:

- Post conference follow-up with members of the family (24.2%)

- Families choose to participate (27%)

Although post conferences were not observed to be held consistently, 95% responded affirmatively when asked if the plan could be changed or revised. An open-ended follow up question revealed that any participant in the FG conference can make a request to change the plan or reconvene the group. Therefore, while plans could be changed and follow up conferences could be requested, routine post conference follow up meetings does not seem to be consistently occurring.

The issue of "voluntary participation in FGDM is one that is being currently debated (Personal communication with Mike Doolan, international consultant, PA FGDM Leadership Team, June 17, 2008) and deserves further discussion within Pennsylvania. There is a fine line between encouragement and coercion to participate. The other area that deserves further examination is the proportion of family members attending relative to professionals. There is research that supports that the number of family members attending a FGDM impacts the satisfaction with the meeting, with lower satisfaction associated with fewer family members attending (Williams, Kemling & Weisz, 2004). Many counties participate in an evaluation of FGDM managed by the Child Welfare Training Program. The number of family members and relationship type and professionals is collected at each family group meeting. Although not in this report, the data will be examined to determine the proportion of family members to professionals.

## Does degree of experience associate with differences in perception about fidelity practices?

Lisa Merkel Holguin and others (2003) reiterate that much of the existing FGDM research highlights the time and careful planning necessary for successful practice implementation. To further examine FGDM fidelity in Pennsylvania, survey questions were analyzed by implementation experience. Since FGDM is a voluntary practice, counties are in different stages of adopting it as a standard practice. The counties were grouped into three categories based on the Child Welfare Training Program's FGDM Implementation map: Counties having multiple conferences; Counties having less than 20 conferences; and Counties in the early stages of implementation including expressing an interest but no conferences or not implementing at all. The implementation map is created and maintained by the Child Welfare Training Program for the purpose of tracking the adoption and implementation of FGDM and is updated every quarter. The number of conferences as of 5.28.08 was used to create these categories. The map is included in Appendix C.

**Counties by Category and Number and Percentage of Responses**

| Category | Responses | Counties |
|---|---|---|
| Multiple conferences (more than 20) | 84<br>47% | Erie, Venango, Beaver, Allegheny. Washington, Armstrong, Centre, Lycoming, Snyder, Northumberland Dauphin, Cumberland, Adams, York, Bradford, Bucks |
| Less than 20 | 77<br>43% | Forest, Elk, Clearfield, Indiana, Cambria, Blair, Somerset, Bedford, Fulton, Juniata, Perry, Wayne, Berks, Lehigh, Chester |
| No conferences | 17<br>10% | Warren, Westmoreland, Clinton, Pike, Northampton, Montgomery, Philadelphia |
| Missing | 2 | |

Tables 2, 3 and 4 show the frequencies for each of the 22 items in the Fidelity to FGDM Practices scale for the three groups. As with Table 1, the "Missing" and "Not Applicable" are not included in the denominator when calculating percentages of responses but the number and percentages are included in a separate column. Note the percentage of "not applicable and missing" for respondents who work in counties that have had 20 or fewer conferences. The counties that have had no conferences have a considerable percentage of not applicable responses, ranging from 20% to 58%. The amount of "Not Applicable" and "Missing" are a finding in that they are telling something about what people know or don't know about the practice in the early stages of implementation (See TABLES 2, 3, & 4)

Similar to what was seen in Table 1, "families choose to participate" and "post conference follow-up" is observed less frequently than the other practices. In particular, for counties having 20 or fewer groups, family choice seems to be occurring less frequently than in the counties who have had multiple conferences. This is a finding that deserves further clarification in order to verify and better understand it.

The 22 item Fidelity to FGDM Practices scale has a range of 4 (1= "never" to 5 "all of the time") and higher scores indicate that the practice is more frequently observed. The total possible score for the scale could range from a low of 22 to 110. The internal consistency of the scale was high (alpha coefficient=.93) suggesting a high degree of inter-relatedness among the items. The responses for all respondents on all of the items were combined and

averaged to form one score per respondent. The mean score across all respondents was then averaged. The average score on the Fidelity to PGDM practices scale was 4.51 SD .53 (N=166).

The average scores were then compared and no statistically significant difference was observed among the groups, although the least experienced group had the lowest average score and the largest standard deviation or variety in the responses (Mean= 4.51, SD=.529, N=165). These scores suggest that the respondents observe the practices to be in place almost all of the time.

**Average Scores on the Fidelity to Practice Scale by Experience**

| Category | Mean | N | SD |
|---|---|---|---|
| Multiple conferences | 4.53 | 80 | .369 |
| Less than 20 | 4.53 | 72 | .556 |
| No conferences | 4.30 | 13 | 1.025 |

Other important indicators of fidelity include whether there are written policies for FGDM including which families are appropriate to refer, implementation teams, structure and structuring of FGDM. These indicators were examined while comparing the counties on their experience level.

**Written Policies for FGDM by Experience Level of County**

| Written Policies for FGDM | Multiple conferences Count (Column %) | Less than 20 Count (Column %) | No conferences Count (Column %) |
|---|---|---|---|
| Yes | 70 (86.4%) | 56 (75.7%) | 5 (33.3%) |
| No | 11 (13.6%) | 18 (24.3%) | 10 (66.7% |

Statistically significant (chi-square=.00)

Counties who had not implemented conferences were the least likely to have written policies and procedures. The most experienced counties were the most likely to have written policies for FGDM. Although the data show an association between the number of conferences and the presence of written policies, the question of causality needs further exploration. Exactly when policies are put in place is not clear, and perhaps counties are more likely to wait for some experience before putting policies in place.

**Written Policies for Family Referral to FGDM by Experience Level of County**

| Written Policies for the type of family to refer | Multiple conferences Count (Column %) | Less than 20 Count (Column %) | No conferences Count (Column %) |
|---|---|---|---|
| Yes | 58 (71.6%) | 53 (71.6%) | 4 (25%) |
| No | 23 (28.4%) | 21 (28.4%) | 12 (75%) |

Statistically Significant (p=.001)

Counties that have done conferences are most likely to have policies for which families are appropriate to refer to FGDM. There does seem to be some suggestion of directionality in that the county experience level predicts whether there are written policies for which families to refer to FGDM (Lambda=.143, p=.043).

As reported in a previous section, over one-half of the respondents report that a private contractor facilitates FGDM in their county. Are there differences in how FGDM is coordinated, based on experience level?

**Coordination of FGDM by Experience Level of County**

| Who coordinates FGDM | Multiple conferences Count (Column %) | Less than 20 Count (Column %) | No conferences Count (Column %) |
|---|---|---|---|
| CYS | 17 (22.1%) | 14 (19.2%) | 0 (.0%) |
| Private | 45 (58.4%) | 40 (54.8%) | 9 (56.2%) |
| Combination | 14 (18.2%) | 18 (24.7%) | 4 (25%) |
| DK | 1 (1.3%) | 1 (1.4%) | 3 (18.8%) |

Statistically significant (p=.004)

As counties begin adopting FGDM, the implementation work is either done by a subcontractor or by some combination of CYS and private provider. In addition, approximately 19% of the respondents were not sure who was coordinating. The model may change as the practices are more established; similar percentages are seen in the counties doing conferences with CYS appearing to play a greater role in the facilitation.

**Full Time/Part Time Coordination by Experience Level of County**

| Full or Part time | Multiple conferences Count (Column %) | Less than 20 Count (Column %) | No conferences Count (Column %) |
|---|---|---|---|
| FT | 69 (84.1%) | 37 (49.3%) | 4 (23.5%) |
| PT | 9 (11%) | 14 (18.7%) | 5 (29.4%) |
| DK | 4 (4.9%) | 24 (32%) | 8 (47.1%) |

Statistically significant (p=.000)

This table suggests that respondents from the less experienced counties don't know if the coordination is full or part time.

**Presence of Implementation Team by Experience Level of County**

| Implementation Team | Multiple conferences Count (Column %) | Less than 20 Count (Column %) | No conferences Count (Column %) |
|---|---|---|---|
| Yes | 71 (86.6%) | 59 (79.7%) | 10 (62.5%) |
| No | 11 (13.4%) | 15 (20.3%) | 6 (37.5%) |

Statistically non-significant

More than one-half of the respondents from the counties who have not yet held conferences report that there is an implementation team. Creating an implementation team appears to be one of the first tasks that a county undertakes in adopting FGDM thus demonstrating that the counties are following the guidelines set forth by American Humane Association and the statewide leadership team.

In summary, doing a greater number of FDM groups associates with having policies in place, full time coordination, and involvement of CYF in coordination. In addition, the respondents who work in the counties with a less established practice are not as aware of how family group works as compared to those who work in counties where many FGDM conferences have been held. Causation or "what causes what" cannot be determined from these analyses. For example, it cannot be determined if the more conferences a county has the greater the likelihood of full time coordination, or if the presence of a full time coordinator leads to more conferences. However, the association seems to be important and structural issues are further discussed in the section about facilitation factors. In total, these findings suggest that there is a process to the

county implementation of FGDM and that more established counties have processes that more fully support FGDM practices.

## Does role associate with differences in perception about fidelity practices?

Do the individuals most closely involved with the group, (coordinators and facilitators), have a different perspective on how practices are implemented, compared to those who are only referring, or may be part of a meeting, but are less involved? The average scores on the Fidelity to FGDM Practices Scale were compared for type of role—coordinator, facilitator, co-facilitator, CYS liaison, implementation team member and referring worker.

**Average Scores for the Fidelity to FGDM Practices Scale by FGDM Role**

| Role | Mean | N | SD | Minimum | Maximum | Range |
|---|---|---|---|---|---|---|
| Coordinator | 4.62 | 20 | .147 | 4.29 | 4.86 | .58 |
| Facilitator | 4.60 | 9 | .173 | 4.32 | 4.81 | .49 |
| Co-facilitator | 4.53 | 6 | .456 | 3.91 | 4.95 | 1.05 |
| CYS liaison | 4.58 | 30 | .323 | 3.71 | 5.00 | 1.29 |
| Implementation Team Member | 4.64 | 37 | .513 | 2.00 | 5.00 | 3.00 |
| Referring worker | 4.38 | 41 | .702 | 1.00 | 5.00 | 4.00 |

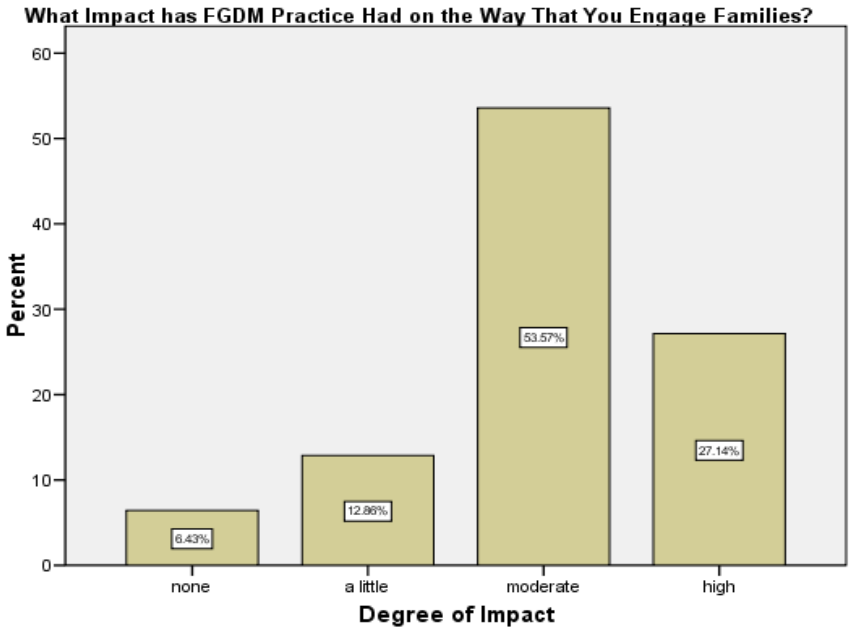
Although the means are all high, suggesting that perceived practices are consistent with family group principles, the scores of the referring workers are slightly lower and have greater variation (SD=4.00 for referring workers compared to the .58 for coordinators). The coordinators and facilitators seem to have very similar perspectives compared to the individuals who are part of the team or who make the referrals. Their inside knowledge may give them a shared

perspective compared to people who are occasionally involved in a group or make a referral. These individuals are likely to be highly experienced and invested in FGDM whereas those making referrals may not be as invested or experienced, and therefore may " not see" the principles in practice to the same degree.

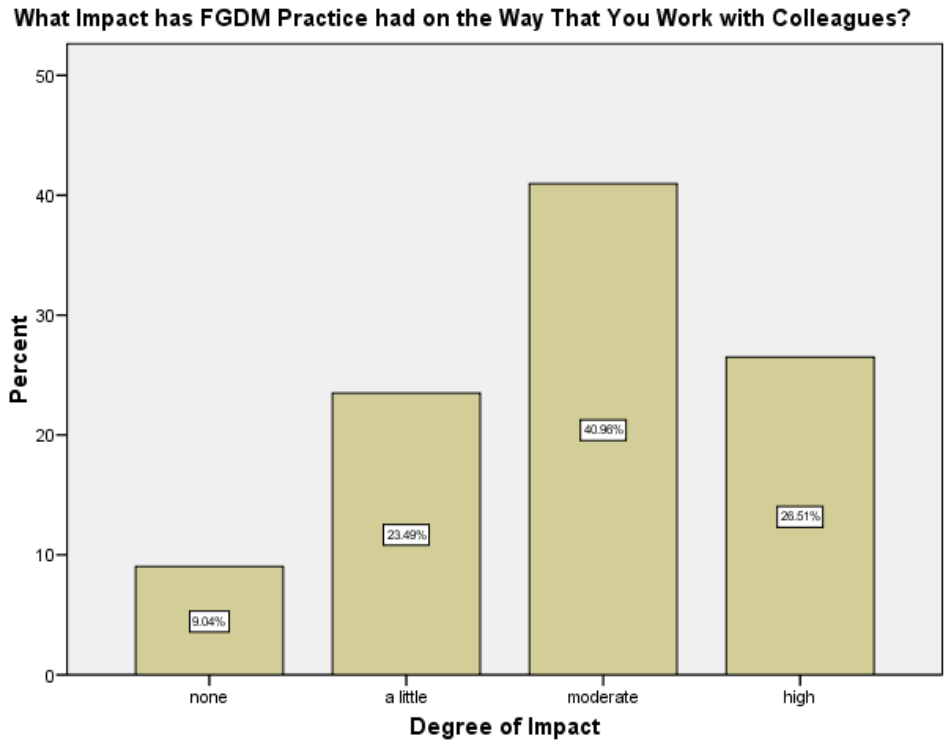
## Perception of the impact of FGDM on work with families and colleagues.

Much of the FGDM literature highlights the transformational power of the practice in making positive changes in relationships. Judge Richard A. Lewis (2005) notes that "Family Group Conferencing changes the relationship between juvenile justice professionals and those we are trying to serve. It joins family, friends and community with our justice system in a supportive rather than adversarial role".

To further explore the transformational power of FGDM in Pennsylvania, respondents were asked: What impact if any, has FGDM practice had on the way that you engage families? What impact if any, has FGDM practice had on the way that you work with your colleagues?




Over one-half of the respondents felt that FGDM has impacted to a moderate degree how they engaged with families. For the 19% that responded “none” and “a little”, it is possible that these individuals have participated in family conferencing and already have good engagement skills. Fifty-four percent felt that it had a moderate impact and 27% felt that their work with engaging families was impacted to a high degree. However, 22% of the respondents were not able to answer this question.




In contrast, only 8% of the respondents did not answer this question on how FGDM practices have impacted the way they work with colleagues. A difference between impact on colleagues and how it has impacted working with families is that the percentage of “a little” impact is larger for work with colleagues compared to families. Again, it may be that the respondents were already engaging in strengths-based interaction with colleagues. However, the next section of this report summarizes the open-ended comments to this question revealing some of the complications that working within an agency implementing FGDM may bring to working relationships.

Because we have seen differences between experienced and non-experienced counties, another question that arises is whether respondents

practicing in counties with the most experience report greater levels of impact than those working in counties with less experience.

The individuals from the most experienced counties reported that it had a high degree of impact on their work with colleagues (Spearman's rho=-.339, P<.00, N=164). It also impacted how they engage with families but the correlation was not significant. Not surprisingly, there was a positive correlation between impact on families and impact on working relationships, suggesting that people who see FGDM having a high degree of impact on how they engage with families also see it highly impacting their working relationships ( r=.396, p=.00, N=164).

The final section of this report is an analysis of responses to several open-ended questions which were included at the end of the survey. The responses were read by the two researchers and themes were identified. After achieving agreement on the themes, the responses were coded independently by each researcher and then consensus was obtained on the coded responses. Finally, the frequency of the themes was calculated.

### What impact, if any, do you think FGDM Practice has had on the way that you work with colleagues?"

Eight independent categories emerged from these data, all of them providing unique information about how FG practice is influencing the interactions between colleagues. The most common category is a group of comments about an increased emphasis on strengths based practice. Of the 105 total responses to this question, 21 remarked on the changes that the

strengths based principles of FG have brought to their practice. For example, one said “we all see the strengths families have more frequently,” another commented, “the strength basis is healthier than the medical/problem focus model,” and another comments “you hear fellow co-workers now talking in the language of strengths…” Some comments reflect the belief that FG has changed workers’ ideas about families: one commented that “staff seem to begin to change their thinking to a more strengths based child welfare.” The numerous responses in this category seem to reflect the reality that workers understand that FG is strengths based, that they are beginning to see how this practice changes their work, and that these changes, while sometimes difficult, are often rewarding as well. “It makes a person look at challenge in a different light, (seeing) positives instead of negatives,” responded one person, clearly demonstrating a strengths based perspective. It is interesting that the most common type of response to this question about colleagues does not relate specifically to worker interactions or relationships. Rather, the comments seem to be an indirect statement about what is changing in the workplace; the increased emphasis on strengths based practice.

Countering this positive set of comments was a large set of comments reflecting doubts and concerns about FG practice, and describing unmet expectations. This category had 17 responses, or 16.1% of the total comments. Examples of these doubts: “My experience with my co-workers is that they are skeptical of the process…” and “It has been difficult to get my colleagues to engage in this process,” and “Many caseworkers do not want to participate in

FGDM no matter how much you preach to them about it because they do not want to ruin their weekends or be in a 5 hour long meeting". Some of these comments reflect a more general attitude about making change happen, for example, "the practice has been slow to catch on with staff," or "because FGDM is a new concept workers are often resistant to the idea." Comments also reflect the difficulty FG workers experience when they experience resistance from others; one said "It is difficult for me to collaborate with agency staff who make statements like 'I will decide what these children/families need to do if they want to keep their children.'"

Unmet expectations about the practice of FG are also voiced, for example, "I expected that the administrative meetings would be run as a family group conference, but find that it is not the case"; "…the agency meetings are not run in the manner of FGDM."

Another 16.1% of the comments reflected an increased cooperation or communication, either within their own agency or between agencies. Examples in this category are "more communication/cooperation," and "We both understand we have a common goal to assist family at this time." In some cases, this cooperation is new to the respondent, especially between agencies. For example, "It helps build a rapport between agencies that I might not have had contact with prior," and "It has strengthened the relationship I have with service providers in our county." Workers see the benefits of FGDM in this cooperative relationship, saying "systems are able to accomplish a lot more in a shorter span of time when the families are engaged." Another person commented "all parties

are speaking the same language and identifying the same goals and values." The value of family group in fostering intra-agency and cross-agency communication was also found to be an important factor in caseworker's decisions to hold a family meeting (Baker, 2006).

Perhaps the most intriguing category of comments came in the 11.4% of remarks (13 comments) that reflect how FG practice has directly changed the interactions between coworkers, or changed practices within the agency. These comments indicate that workers are using the skills from FGDM in dealing with issues between workers or in addressing concerns at the agency level. For example, "The practice calls for more respectful interactions at all levels," or "Our agency has used this model to address concerns within the agency and dealing with office concerns." One person stated "I spend a lot of time focused on my approach to changes within our organization. I always check back and ensure I am modeling family group practice." One respondent even noted that family group practices get used outside of work, saying "We constantly talk about how the core values overflow into our daily lives with friends and family."

Almost two-thirds of the comments regarding the impact of FGDM on work with colleagues fall into the four categories discussed thus far. An additional four categories emerged, each accounting for about 10% of the comments. Only one of these categories actually relates directly to the question, reflecting attitudes about co-workers specifically. This is the category used when respondents described how their role now involves educating others about FGDM. There were eight such comments, accounting for 7.6% of the total. For example, "I

have often shared with colleagues many ideas and techniques we use in conferencing." In some cases these comments seem to reflect a frustration that others are not aware of FGDM; "I must educate them on the practice." In some cases the worker seemed anxious to share FGDM practices; "I try to spread the practice to other caseworkers to gain better working relationships with their families."

The other three categories are more indirect references to the question. One group of comments, reflecting 9.5% of the total comments, discussed changes that result for families that use FGDM. For example, "It has been very helpful in pulling the family together in one direction, and in a direction of case closure," and "It seems that every family could use the family supports and additional resources to maintain their family function." Some of these comments reflect on the question by suggesting that interaction between coworkers has changed to involve more communication about family needs. For example, "There is more discussion around the support of the family and resources accessible to the family," and "I am pointing out family strengths over their deficits and asking workers and colleagues to do the same."

Another nine comments mention FGDM as a "new tool," or "another tool" for dealing with families. These comments sometimes suggest that FGDM is especially helpful in certain cases, for example "It has provided…another tool in working with families, particularly families with recurring dependency issues." Another commented "when a colleague is frustrated with a family they are working with, we have urged consideration of FGDM as a possible solution."

These comments seem to reflect the attitude that FGDM is useful when all else fails, suggesting a tentative acceptance of the practice, but not a whole-hearted embrace of FGDM for all cases.

Finally, the last category of comments reflects individuals who have had very little experience with FGDM, and for whom the practice is new and unexplored. These comments, which accounted for 10.4% of the total, said things like “we are in the beginning steps,” or “we are still very new at this.” Another said “We have not completed our first referral yet.” These comments are a reminder that a significant percentage of the respondents are new to FGDM and have little practical experience with the process.

Overall, these comments provide important insights about how FGDM is changing employee interactions and experiences. The most obvious change for most workers seems to be the shift to a strengths based process. Another significant group of workers see the tools of FGDM becoming a part of their wider work experience, with office experiences and coworker interactions that reflect the more respectful, strengths based approach. Without this diffusion within the agencies, employees may experience considerable cognitive dissonance, as they treat families in one manner, while they themselves are treated in another manner. Although following FG practices and attitudes has not been formally introduced as a management practice, it is clear that in some counties it is making a difference for employees and possibly changing the climate in the agency. It may be worth considering how counties can more formally include or develop practices that resonate successfully with FGDM practices. It will also be

interesting to see whether workers who make more positive comments about FG are more likely to have experienced this diffusion within the agency setting.

### What are the perceived facilitation factors for implementing and sustaining FGDM?

Perhaps the most remarkable thing about the open-ended responses to this question is that no single category accounted for more than 21% of the total responses. In other words, there were many and varied responses, falling into at least 9 distinct categories. Five of these categories account for about 80% of the comments, with the two most common categories being “training” and “leadership attitudes.” These two categories alone accounted for almost 40% of comments; showing two useful clusters for exploration. Before looking more closely at specific qualities of the comments, it is important to reiterate that the data suggests that many different “helpers” seem likely to facilitate FGDM. This lack of a modal response suggests that further analysis may be helpful to determine whether certain categories of respondents were more likely to give certain types of comments.

Comments about training and training support emerged as the single most common response to this question (20.5%), just slightly ahead of leadership attitudes (18.3%). A wide variety of training experiences were commented on, including state-wide implementation meetings, conferences, American Humane Association trainings, specific local training events, regional meetings, site visits, and informal networking between counties. In particular, advice from other counties also working with FGDM was frequently identified as a helper. Typical

was one person who mentioned that assistance from other counties was “a huge help.” Another person mentioned “other counties helping when we struggle” as a facilitating factor.

Some respondents commented on specific individuals who had provided the training, either by name or indirectly. Several individuals were singled out numerous times as excellent trainers or support personnel. Others commented on the type of training they received; for example “the extensive amount of training”, or “a family/community session where judges were available” or “talking to parents who have participated.” The state-wide implementation team trainings were mentioned favorably in several comments; one person noted “the implementation team was a vital part of getting it off the ground.” The comment that “the technical assistance through CWT has been a great help” was typical of several comments about CWTP’s important role as a helper.

The second largest category of comments focused on the role of leadership in facilitating and supporting FGDM’s implementation. This category of comments accounted for 18.3% of the open ended responses and included any comment that specified how leaders, administrators, supervisors, directors, judges, advisory boards or coordinators helped in the implementation of FGDM. These comments were sometimes general; for example “promotion of the practice by administration” or “endorsement by the judges…”

Several comments referred to a specific leader or administrator who was especially helpful. Typical of this kind of comment were: “The support from the

County administrator" and "my direct supervisor has been an amazing advocate for FGDM."

Although a few comments referred to specific ways that leaders helped the process (one mentioned mandating the use of FGDM, for example ) many more comments focused on the importance of support, "buy-in" and belief in FGDM by those in leadership roles. Common words used in these comments were: buy-in, strong support, endorsement, commitment, encouragement, hope, truly believing, and being "on-board". These comments reflect the key role of leaders who may not be directly involved in FGDM, but pave the way for the process to happen. Typical of these comments are the following: "Administrative buy-in to the practice," and "agency support and encouragement" and "support from the state (OFYC) and AOPC". The comment "Implementation team members that truly believe in the FGDM model/philosophy," is reflective of the importance of this intangible quality of "belief in the process." It's important to note that while comments reflect this general "belief in the process" by leadership, these comments are quite likely reflecting actual, tangible experiences with administration or leadership that show support. Some comments reflected this, using words like "working relationship", "cooperation", or "being backed by administration." Thus, while beliefs and attitudes appear as an important facilitator of implementation, the appearance of these comments reflects leaders who have taken many actions that communicate their belief in FGDM. Leadership of the FGDM process may want to reflect on what kinds of actions clearly communicate their support and belief in the process.

Four other categories each account for about 10% of the comments. These categories are: specific agencies (most often a contracted agency that provides FGDM), specific qualities of a coordinator or facilitator, the cross-systems nature of the program, and the process of FGDM itself. Some examples will illustrate the general nature of the comments from each category.

- Specific agencies as a facilitator of implementation (9%): “using a private contractor”, “the agency has been very helpful in walking us through the process,” and “the courts interest in the process has been a help…” Included in this category were any comments that singled out another group that helped with implementation.
- Specific qualities of facilitators or coordinator (12.9%): “our coordinator has been a tremendous help in engaging not only families but casework staff as well”, and “the coordinator’s efforts to unite family members” and “having a facilitator to organize meetings.” Several individual facilitators and coordinators were also mentioned by name.
- The model and process of Family Group itself (10.2%): “Explaining the process and doing the process, so that people in the community can see its effectiveness,” and “This practice creates a spark in those who see the immeasurable value of working with families in this way,” and “Another great helper would be our model.” Many of these comments reinforced the idea that the model sells itself, and

once people get it working, they will experience the power of the model.

- The cross systems nature of the program (8%): “The fact that the community partners, commissioners and judges support the effort countywide…” and “Getting to know staff from other service providers,” and “The comradely of FGDM network, from the state to the counties to the individual people!” In all these comments, the nature of the working relationship between agencies is highlighted as a great support to implementing FGDM.

Two other categories emerged that each had 12 comments, or 6.4% of the responses. The first category included comments that emphasize the important role of families in making FGDM work well. For example, “Families willingness to find solutions to the issues,” and “Families regain hope and feel somewhat empowered.” One person mentioned the role of families in encouraging other families to try FGDM, “Families who tell other families and case manager who have referred families and seen the family change as a result of FGDM.” Involving families in training was mentioned by one person who said that families participated in training sessions, and “the dialogue and examples that families gave were very helpful.”

The second category with 12 comments (6.4%) was a group of comments about the importance of caseworker attitudes in helping with the implementation of FGDM. For example, “Supervisors and caseworkers that believe in the family process” and “caseworkers are instrumental.” One person specified “other

degreed social workers in the agency" as an important support. Overall, several comments emphasized the key role of believing in FGDM, and "buying in" to the process.

Finally, two small groups of comments reflected two final kinds of responses. First, 7 people noted that they were too new to the practice to give meaningful feedback (3.7% of comments). The final category (2.7% or 5 comments) contained comments about the practical nature of the process, and how important these practical aspects could be. For example, "having a full-time coordinator" and "meeting regularly" and "case manager referral" were all mentioned in this category.

As mentioned earlier, a distinctive feature of these comments is that there seem to be so many different aspects of supporting the implementation process. Although the facilitation provided by training and leadership did seem especially important, several other distinct supports emerged. A positive element of this finding may be that agencies can facilitate implementation in many ways, and if one approach is not available, another may help. For example, if leadership is not actively supporting FGDM, then careful attention to training or fostering cross-system ties may work as facilitators of the practice. It may be helpful to try to further refine our understanding of what mix of supports is most helpful for implementing FGDM; but from a practical perspective, if one thing is not working, perhaps emphasizing another support will be successful.

**What are the greatest barriers to implementing FGDM?**

The responses for this question were coded into eight non-unique categories. There were 203 different responses, most responses fit into one category, but many responses had elements from several categories and were coded into all the categories that were appropriate. The most common response fell into the category of barriers created by caseworker attitudes. These comments made up about 29% of all the comments and reflect observations about attitudes and beliefs that caseworkers hold about FGDM. Typical of comments about problematic caseworker attitudes were "those that still think that a punitive plan works better" and "the perspective caseworkers have on FGDM." Some comments were about very specific behaviors; for example "caseworkers who don't return phone calls" and "case managers who do not make the option of FGDM available to their families."

Other comments reflect the broad belief that new practices are naturally resisted, especially by older or more experienced workers. One person remarked that a significant barrier is "some older/mature staff;" another said "change, this is not the way things have been done." One person commented "It is very hard to break 10-20 years of doing child welfare the old school way…"

Comments about the struggle to change to a strengths base perspective are also present, and include comments like "difficulty in changing a mindset from focusing on deficit to focusing on strength" and "those who do not have a grasp on focusing on solutions and not the problems." This attitude problem is also reflected in comments about workers who "question whether families really

know what is best for themselves" or who "exhibit resistance grounded in control and trust issues."

Many comments contain words like "lack of buy-in", resistance, attitudes, and "doubtful workers", getting caseworkers "on board", lack of cooperation, understanding and reluctance. The all-encompassing term "buy-in" is used very frequently, and the lack of "buy-in" is a general theme when looking at how caseworker attitudes create barriers for FGDM. For example "buy-in" may be a stand-in for a feeling that workloads are too high and FGDM represents additional work. On the other hand, "buy-in" may represent doubts about the effectiveness of FGDM. It will be important to explore exactly what "buy-in" means in this context, along with ideas about how it can be achieved.

The second most common category of responses was generally described as "structural issues" with FGDM. In this category we placed all comments that reflected problems with time, money, staffing, logistics, extra hours of work required, and caseloads. 47 people made comments of this type, accounting for 23% of the total comments made. Most common were comments about funding and time. Examples of funding concerns included: "fiscal constraints", "money made available to continue," "getting money for the coordinators position," and "funding issues."

Remarks about time as a barrier to implementation reflected several different concerns. The times that meetings were held was a common concern; for example "Caseworkers do not want to give up their weekends or sit in long meetings" and "evening and weekend conferences." Other time comments

reflected lack of time to prepare for the conferences, lack of time to promote (FGDM) in the community, and lack of time to "coordinate" the FGDM process. Several comments reflected on the difficulty of scheduling conferences due to hectic schedules of families and case workers.

Another type of structural problem reflected the changes necessary in job roles as FGDM is implemented. Comments like "the specifics of job duties," or "double work load for some staff," or "the worker often had to neglect their regular job responsibilities" reflect the changes necessary in worker roles to establish FGDM. A degree of resentment can be felt in comments about the long after-hours meetings, perhaps not typical of a regular caseworker job. For example, one person said "Caseworkers work very long hours and often work overtime with little or no compensation. It is very difficult to be available for FG meetings…until 10 or 11 at night, and then be at work early..." Another similar comment was "professionals do not get paid for their time…"

Another important category of comments suggested that the families involved in FGDM could sometimes create barriers to implementation. This category had 35 comments, totaling 17.2% of all comments made. These comments ranged from families that were "not appropriate for FGDM" to families who absolutely refused to participate in FGDM. Getting families "on board" with the process was a common theme, as well as feeling that families "did not trust the system", or were "fearful or unwilling to change". A general lack of cooperation or difficulty in getting families to participate was seen as a barrier by several respondents, as in these comments: "Getting families to agree to

participate", and "families not wanting to do it," or "families change their minds about participating." Another source of concern was a lack of follow through by families once involved in the FGDM process; one commented "families won't follow through."

Three categories of comments were made by a smaller group of respondents (5%-8% of total comments) but may reflect important feedback on barriers to implementation. First, 7.9% of comments described problems with the FGDM model itself; for example, "having all involved parties agree to follow through", and "staff are unable to allow the neutral facilitator to address issues…" One specific element of the model that was remarked on by several individuals was the difficulty in assuring follow-through after conferences were held. One person noted: "After 30 days, things tend to slow down and return to the way they were before the conference," and another noted "there aren't many follow-ups done with the families…to see if the plan is being followed."

Another issue seen as a barrier to getting FGDM off the ground is the lack of referrals to the program. The low number of referrals relative to the number of families reported for child maltreatment is a recurring issue for the practice of FGDM (Schmid and Goranson, 2003). Problems with referrals were commented on by 11 people, or 5.4% of all comments. "The greatest barrier has been to get the workers to refer families for conferences," was one comment. Other comments simply mentioned system wide "reluctance to make referrals," and "lack of referrals" as significant barriers. Both a lack of referrals and a reluctance to make referrals probably reflect deeper barriers to implementation such as

communication, education and attitudinal issues. Referral problems can be seen as secondary barriers, resulting from underlying, primary barriers.

Attitudes of administrators and leaders were commented on by 14 people, or 6.9% of comments. These comments clearly indicated that a lack of administrative and supervisory support creates a barrier for FGDM implementation. Typical were comments such as “no administrative buy-in to the practice” and “lack of commitment on the part of leadership.” It is interesting, however, that attitudes of supervisors and administrators, so key to the success of FGDM (Question 29), do not seem to have the same significance as barriers. While leaders and supervisors seem to play a critical role in the success of implementing FGDM, their lack of support is perhaps a smaller factor in implementation difficulty. Direct caseworker attitudes seem to play a much more important role in hampering FGDM implementation, as reflected in 29% of comments about caseworker attitudes discussed at the start of this section.

Two final categories account for only a small number of comments, one set concerning the barrier created by a lack of community support (8 comments like “community apathy”) and one set on the lack of outcomes for FGDM (4 comments like “we haven’t seen success locally” and “skepticism about lasting positive outcomes from participation in FGDM”). These two categories combined account for only about 6% of all the comments.

Overall, the most significant feedback seems to concern caseworker attitudes and structural issues. Negative attitudes about the model, change generally, and the shift to a strengths based model are all challenging to FGDM

implementation. In addition, basic aspects of the FGDM model create structural concerns for staff who struggle with long, time consuming meetings held at unusual hours, new job roles for staff, and concerns about funding. Some elements of the model itself create difficulties as it is a model that requires cooperation, planning, and time-intensive preparation. In spite of all these general barriers, some individuals did not see any barriers at their workplace, noting that many problems have been "solved" and that "there aren't many anymore" when reflecting on barriers to implementation.

The two main concerns identified by respondents suggest very different approaches at the caseworker and structural level. Changing caseworker attitudes might require education, training and experience, while structural problems require reflection at the administrative and supervisory level where decisions about hours, staff roles, and time management are made. However, the two concerns are clearly linked, and supportive structural changes will also help to improve caseworker attitudes about FGDM.

## What is Necessary to Sustain FGDM?

One of the last questions on the survey was an open ended question that read: "What do you think is necessary for you to sustain and expand the FGDM process in your county?" There were 155 responses to this question which were read and qualitatively coded into 10 distinct categories. A total of 215 unique comments were coded from the 155 separate responses. Looking at the responses as a whole, it seems possible that this question was interpreted somewhat differently by different respondents. Some people seemed to

resonate with the personal question: what is necessary for you to sustain and expand FGDM? Respondents replied that they needed to seek or provide additional training, or listed other somewhat personal goals. Others interpreted the question as a more basic one about how to expand FG generally and gave thoughtful replies about improving the process of FG, or improving and sustaining the leadership and resources for FGDM.

The most common type of response fell into a category of “improve resources for FGDM.” There were 42 comments of this type, or 19.7% of the total comments. Included in this pragmatic category were both comments about needed financial resources, and suggestions about additional staffing needs. Comments about money were common and included comments calling for “continued state financial support”, “additional funding”, and “stable and consistent funding would help”. Many simply wrote “money” or “funding” although some recognized specific kinds of funding needs; for example “I feel more outside funding will impact sustainability within (our) county,” and one respondent saw a need for “creative, flexible funding.”

Suggestions for increased staff were also common; for example, “more staff”, “additional funding for staff”, and “more coordinators!” These comments reflect the tough job of getting and sustaining funding for FG, and also the delicate balance of having enough staff to do the job without paying for more staff than necessary. This complicated equation is especially hard with a new and growing program like FGDM, the goal is to include more and more cases, and

staff can easily become overloaded. Some comments reflected this challenge, saying “we take 15 referrals per month and currently have one coordinator!”

The second most common category of comments involved suggestions to improve the process of FGDM (33 comments, 15.4% of total comments). In this category were all comments that offered changes to the way FG is currently conducted, either in a specific county, or generally. Many useful ideas were suggested including: “All new hires must support and be willing to encourage families to participate in FGDM”, a need for “workers to be flexible in family needs without compromising the non-negotiables”, and “Recognition of the CYS and private provider staff who are exceptionally committed.” Other comments gave practical changes that could influence family and staff to embrace FDGM; for example, “Perhaps if there were a brochure that the family could read in order to remove their doubts/fears”, and “Caseworkers being more open to giving up a Saturday to participate or observe a conference. Maybe some incentives for caseworkers to do this…” Many of the comments in this category reflect issues already discussed in this paper around difficulties with length and timing of meetings, and coordination between agencies; for example, “Better communication between CYS and the contracted service provider.” Overall, the comments reveal the growing nature of FGDM and the wisdom and experience of those who are currently working with the process. While a process like FGDM can always use adjustment and fine tuning, the comments reflect a view that relatively small changes can improve how FGDM works, not dissatisfaction with the general concepts of FGDM.

The next three categories of comments each had between 25-29 comments, or about 11%-14% of the total comments. The concept of "buy-in" was mentioned in 29 comments, and at least one comment mentioned buy-in for: agencies, schools, families, juvenile justice, JPO, attorneys, judges, courts, caseworkers, staff, supervisors, probation, the community and "new hires" . "Complete buy-in from the courts, agencies, providers and families" is a typical comment. The exact term "buy-in" was most commonly used, but other words or phrases used in this category were "support," "believe in," "better understanding," and "be on board."

The term "buy-in" has several possible connotations, and a careful exploration of the real meanings of this term may be helpful. For example, one aspect of buy-in is belief in, or acceptance of, the principles and philosophy of FGDM. Another aspect is simply the shift from an "unknown" to "known" process, as FGDM moves from something novel to "business as usual." A third element of buy-in has to do with the institutionalization of systems and processes for FG, and the fine-tuning needed to make the process most effective. In general, buy-in seems to be an important factor for the beginnings of FGDM, and can be differentiated from comments about "sustaining" or "continuing" support for FGDM. Unpacking the many meanings in the term "buy-in" would be helpful in any further analysis of how to expand FGDM.

Another category of comments highlighted the importance of education and training for expanding and sustaining FGDM. These 26 comments (12.5% of total) reflected a need to keep staff well trained, as seen in comments such as:

“ensuring that employees are properly trained,” and “more education to staff.” Some suggestions for staff were specific; for example, “For all service providers to have the experience of a FGDM conference”, and “educate the staff on the benefits of FGDM.” This category also contained comments about education needed for other groups; including “the community”, “different agencies”, and “schools”.

Another category was used to capture comments about the effect of more time and exposure to FGDM. These 25 comments (11.7% of total) reflected the understanding that over time, as people use FGDM, it will grow naturally. One respondent says “Just having more conferences,” reflecting this belief. Others said: “the experience from having more conferences”, “more practice”, and “increase awareness and promote the concept to families”. Some of the comments specifically mentioned the need for the passage of time; for example, “Since FGDM is a shift in thinking about how we deal with families, I think it will take time for this philosophy to be accepted by professionals.”

Four additional categories each contained fewer than 10% of the comments. These categories all reflect important thoughts about sustaining and growing FGDM that were mentioned in 9-16 comments. The importance of leadership support was mentioned by 16 respondents (7.5% of total), and included direct leadership of supervisors, and county and state support. One comment was “More of a push from administration for the use of the process”, another said “Agency directors (must) continue to support the program.” A

need for varied kinds of leadership is noted in the comment “continued support from the state and courts”.

Other responses noted the need for highlighting the positive outcomes from FGDM. The 13 comments in this category (6.1% of total) indicated a need to observe success with FGDM. For example, one respondent said “Have more successes and show caseworkers that this does improve the situation,” and another said “success with a meeting, and able to see the results and pass it on to other families.”

Another category of comments reflected the specific role of families in helping FGDM to grow and expand. There were 12 comments in this category (5.6% of total), mentioning several important roles for families. Several comments mentioned the key role families play in communicating the successful outcomes of FGDM; for example, “I would like to see families that have participated in the program recruit and “mentor” other families in the process.” Another comment reflected the value families bring to evaluating FGDM, and noted “We need to bring family members and children who have experienced FGDM to our IT table for how to improve what we do.”

Community outreach was the topic of 9 comments, or 4.2% of the total. These comments stress the need to involve the community in FGDM, and increase community awareness. Example comments include: “More community awareness of the program,” and “Community education and outreach by our contracting agency.” The comments in this category used terms like “outreach,

exposure, awareness, and “getting the word out,” to describe the need to involve the community more in FGDM.

Finally, nine comments (4.21% of the total) were outliers to the other codes, and reflect people who either misread the question (several people wrote “yes”), or wrote other comments that we could not code into any existing category.

The responses to this question provide extensive, thoughtful expertise about sustaining and expanding FGDM in Pennsylvania. These comments speak clearly about the wide variety of actions that will be helpful to keep this practice strong. Pragmatically, funding and staffing need to be adequate, and excellence in training and education needs to continue. Administratively, leaders need to demonstrate “buy-in” to the practice and then “continue to support” FGDM. The critical roles of families, as well as outreach to the community, must be recognized. Finally, as all these elements come together, and time passes, there is a general sense in these responses that FGDM will continue to demonstrate great promise for families.

## Discussion

The responses to the survey clearly indicate that FGDM is becoming an accepted approach and that many of the practices of FGDM are in place. It also seems to have positively impacted relationships with colleagues and families. Many of the open-ended comments spoke to the “transformational” nature of the family group decision making and that caseworkers now talk in the “language of strengths” to co-workers, families and to their own families. The respondents

also talked about how practices are in place: implementation teams have individuals from many systems; FGDM is viewed as an approach that can be used with many target groups; cross system collaboration is occurring. In addition, the practices that link to important FGDM principles, including creating a hospitable environment at the agency level for carrying out family group and safe and effective planning at the family group level, seem to be in place. However, a number of needs and fidelity concerns were identified.

### Lack of follow up post FGDM

The lack of consistent follow up is of concern, particularly in light of research indicating that that FGDM does not connect families to services that will serve them in the long term (Berzin, Thomas & Cohen, 2007; Weigensberg, Barth & Guo, 2008). Follow up meetings can be the start of facilitating these long term connections and help to ensure that families have ongoing relationships in the communities that continue after they have ended their involvement in child welfare services. It is not clear from this survey why such meetings are not occurring. Some anecdotal evidence from the evaluation subcommittee suggests that unless the expectation of follow up is set from the start, follow up meetings are not likely to happen (conversation September 16, 2008). It is important that the barriers, both system and personal, be further explored and addressed.

### FGDM is a Marginalized Practice

While the survey results illustrate that referrals to FGDM are made at many points in the service pathway, the results also suggest that only a small

percentage of the families who are referred to child protection services actually participate in a FGDM conference. Confusion about who to refer and concerns about domestic violence contribute to the marginalization of FGDM from mainstream child welfare practice. The potential exclusion of families with domestic violence is a concern due to the co-occurrence of child safety and domestic violence. FGDM meetings can successfully be used in child welfare cases that involve domestic violence (Crampton & Williams, 200; Pennell & Buford, 2000). Other identified barriers were system factors including agency policy and procedures, funding and system resources. Family Factors included the family willingness to have FGDM as an intervention, as well as the follow through and scheduling that the family needs to do in order for the group to happen. Lack of family support was another frequently identified family factor for not using FGDM.

The survey also highlighted that only a limited number of professionals have extensive experience in the practice. When asked how many FGDM conferences they had participated in, over three-fourths (78%) of the respondents had participated in 20 or fewer conferences, 16% report attending between 21 to 50 conferences and 5% attended 61 to 100 conferences. Only two individuals responded that they had participated in more than 200 conferences. In addition, the number of missing responses suggests that many of the professionals participating in family group have a surface understanding of FGDM. Until professionals have more experience participating in FGDM, it is

likely to remain a “tool” rather than a systematic approach to working with families.

Finally, funding streams and staffing issues suggest that FGDM is still not a standard practice. While staffing and funding considerations were identified as sustaining factors for the practice, 57% of the respondents who could answer the question reported that FGDM is funded through their needs based plan. The average number of staff from CYF that is allocated to FGDM is one. Yet, FGDM is an intervention that crosses the adult and juvenile systems in that when families work together to address issues of child safety, other issues may successfully be addressed e.g. adult drug addition, employment and housing. Finding ways to sustain it outside of the categorical child welfare funding stream will be important in expanding the practice.

## Leadership is Critical

This survey found that leadership attitudes were identified as critical to the implementation of FGDM. Research on other community-based individualized interventions and evidence based practice supports the critical role that leadership plays in ensuring high fidelity (Fixsen, Naoom, Blasé, Friedman & Wallace, 2005). Although a few comments referred to specific ways that leaders helped the process (one mentioned mandating the use of FGDM, for example ) many more comments focused on the importance of support, “buy-in” and belief in FGDM by those in leadership roles. Common words used in these comments were: buy-in, strong support, endorsement, commitment, encouragement, hope, truly believing, and being “on-board”. These comments reflect the key role of

leaders who may not be directly involved in FGDM, but pave the way for the process to happen including support from implementation team members, the state (OCYF), the Pennsylvania Child Welfare Training Program, and the Administrative Office of Pennsylvania Courts (AOPC).

### Training is important

Comments about training and training support emerged as one of the most common responses to the question regarding perceived factors for implementing and sustaining FGDM. A wide variety of training experiences were commented on, including state-wide implementation meetings, conferences, the Child Welfare Training Program, American Humane Association trainings, specific local training events, regional meetings, site visits, and informal networking between counties. In particular, advice from other counties also working with FGDM was frequently identified as beneficial. Families and former youth are valuable resources that could be better utilized in training workers and in introducing the practice to families. This study suggests that they are minimally used in training and in implementation teams.

### Length of Experience with FGDM associates with Fidelity

Doing a greater number of FDM conferences associates with having policies in place, full time coordination, and involvement of child welfare in coordination. In addition, the respondents who work in the counties with a less established practice are not as aware of how family group conferencing works as those who work in counties where many FGDM conferences have been held. While causation can't be determined, these findings suggest that there is a

process to the county implementation of FGDM and that more established counties have processes that more fully support the practices of FGDM. This study did not investigate whether there are ways of speeding up this developmental process, but the open ended comments suggest that the state implementation meetings, help from “mature” counties and cross-county visits to observe groups may help counties along with the experience and maturity that comes from holding many family groups.

### Getting “Buy-In” from caseworkers and supervisors

Some of the most compelling and consistent findings from the open-ended questions seems to concern caseworker attitudes and structural issues. Negative attitudes about the model and the shift to a strengths-based model are challenging to FGDM implementation. In addition, basic aspects of the FGDM model create structural concerns for staff who struggle with long, time consuming meetings held at unusual hours, new job roles for staff, and concerns about funding for FGDM implementation. Some elements of the model itself create difficulties, as it is a model that requires cooperation, planning, and time-intensive preparation

This suggests two very different approaches toward solutions. Changing caseworker attitudes might require education, training and experience, while structural problems require reflection at the administrative and supervisory level, since that is where decisions about hours, staff roles, and time management are made. However, the two concerns are clearly linked, and supportive structural changes will help to improve caseworker attitudes about FGDM.

A limitation to this study is that it only provides a point in time view of the state's practice related to FGDM. In addition, there is the selection bias at two levels - counties that responded, and individuals who responded; those that chose not to respond may have a different perception of practice. Other limitations include the amount of missing data, particularly from counties who were new to the practice. However, despite these limitations, this study provides a "snapshot" of how the practice has evolved and what is needed to continue to provide FGDM in Pennsylvania.

## Recommendations

- Identify the barriers preventing follow up meetings, address them and make the meetings part of FGDM best practice standards.
- Throughout the State, standardize and document how and which families are identified for FGDM. Although some counties have policies in place for which families to refer and some have automatic inclusion, there is variation and a great deal of individual judgment being exercised in which families are referred and at what point in the pathway. A process should be in place to better document and describe families—those that participate in FGDM and those that do not and why.
- Leadership is important in supporting and facilitating attitude change and structural change. Leaders who are not directly involved with the direct practice are nonetheless critical in ensuring that the practice is accepted and utilized through making concrete structural changes. Leaders need to

consider ways to make FGDM “a way of doing business”. Some structural changes could include flexible hours so that caseworkers attending meetings are not expected to work 15 hour days; offering incentives to caseworkers to make referrals to FGDM, requiring participation in family group meetings and including it as part of performance evaluations and promotion (Crae, Crampton, Abramson-Madden & Usher, 2008). Expansion and long term sustainability will require leadership to find alternative and creative solutions such as “braided” funding that utilizes several funding streams.

- The survey highlighted that only a small number of professionals have extensive experience in the practice, and that almost a quarter who responded had no formal training in the practice. Yet training emerged as the most common response regarding perceived factors for facilitating the implementation of FGDM. “Training” needs to be more broadly defined as “outreach” to other systems and communities and a variety of mediums outside of didactic training need to be employed (written materials, short videos, public service announcements). Technical assistance and transfer of learning activities provided to the organization at various stages may be needed to augment training, and transfer of learning may be helpful in embedding the practice into the culture of the organization.
- While cross-systems implementation teams are in place, the role of former youth and families on the teams is minimal and could be enhanced. In addition, families and youth could play a role in training, mentoring and

assisting with families who are new to FGDM, and supporting them in following through on their plan.

- An ongoing and state-wide outcome evaluation is needed in order to determine if FGDM produces positive outcomes, and to identify with which families it is the most effective. It will also help to demonstrate the value of the practice to the skeptical and unconvinced.

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## Table 1

Number and Percentage of FGDM Practices Observed by Professionals (N=180)

| Question | n | Never | Occasionally | Frequently | Almost all the time | All of the time | Missing/ NA* |
|---|---|---|---|---|---|---|---|
| 1. Families choose to participate | 152 | 6 (3.9) | 17 (11.2) | 18 (11.8) | 60 (39.5) | 51 (33.6) | 28 (15.6) |
| 2. Coordinators/ Facilitators are trained | 155 | 2 (1.3) | 2 (1.3) | 3 (1.9) | 17 (11.0) | 131 (84.5) | 25 (13.9) |
| 3. Coordinators/ Facilitators are neutral | 142 | 1 (0.7) | 2 (1.4) | 0 (.0) | 38 (26.8) | 101 (71.1) | 38 (21.1) |
| 4. Meetings held in neutral places in community | 153 | 3 (2.0) | 2 (1.3) | 5 (3.3) | 32 (20.9) | 111 (72.5) | 27 (15.0) |
| 5. Families are prepared prior to the conference | 145 | 3 (2.1) | 0 (.0) | 7 (4.8) | 56 (38.6) | 79 (54.5) | 35 (19.4) |
| 6. Families decide who to invite to the conference | 149 | 1 (0.7) | 2 (1.3) | 1 (0.7) | 38 (25.5) | 107 (71.8) | 31 (17.2) |
| 7. Conferences are at convenient times for families | 151 | 1 (0.7) | 1 (0.7) | 2 (1.3) | 32 (21.2) | 115 (76.2) | 29 (16.1) |
| 8. Youth and children attend the conferences | 143 | 1 (0.7) | 2 (1.4) | 8 (5.6) | 44 (30.8) | 88 (61.5) | 37 (20.6) |
| 9. More family members than professionals attend | 143 | 2 (1.4) | 2 (1.4) | 16 (11.2) | 73 (51.0) | 50 (35.0) | 37 (20.6) |
| 10. Culture of the family is included in planning | 143 | 2 (1.4) | 4 (2.8) | 12 (8.4) | 45 (31.5) | 80 (55.9) | 37 (20.6) |
| 11. Pre conference meetings with professionals are held | 142 | 2 (1.4) | 8 (5.6) | 13 (9.2) | 34 (23.9) | 85 (59.9) | 38 (21.1) |
| 12. Roles of family members are clear | 144 | 2 (1.4) | 2 (1.4) | 12 (8.3) | 45 (31.3) | 83 (57.6) | 36 (20.0) |

* Missing and not applicable are not included in the denominator when calculating percentages of responses

| Question | n | Never | Occasionally | Frequently | Almost all the time | All of the time | Missing/ NA* |
|---|---|---|---|---|---|---|---|
| 13. Strengths of the family and child are shared | 150 | 2 (1.3) | 0 (.0) | 0 (.0) | 9 (6.0) | 139 (92.7) | 30 (16.7) |
| 14. Information is provided by referral source | 152 | 2 (1.3) | 0 (.0) | 1 (0.7) | 20 (13.2) | 129 (84.9) | 28 (15.6) |
| 15. Tangible supports for family and friends are offered and provided | 139 | 3 (2.2) | 6 (4.3) | 9 (6.5) | 37 (26.6) | 84 (60.4) | 41 (22.8) |
| 16. Resource options are available | 140 | 1 (0.7) | 6 (4.3) | 3 (2.1) | 30 (21.4) | 100 (71.4) | 40 (22.2) |
| 17. Children's safety, permanency, and well being needs are addressed | 150 | 1 (0.7) | 0 (.0) | 2 (1.3) | 18 (12.0) | 129 (86.0) | 30 (16.7) |
| 18. Families are offered ideas on how to best use private family time | 138 | 2 (1.4) | 6 (4.3) | 7 (5.1) | 35 (25.4) | 88 (63.8) | 42 (23.3) |
| 19. Participants evaluate the process at the end | 139 | 3 (2.2) | 1 (0.7) | 4 (2.9) | 28 (20.1) | 103 (74.1) | 41 (22.8) |
| 20. Families have private time | 149 | 1 (0.7) | 0 (.0) | 1 (0.7) | 9 (6.0) | 138 (92.6) | 31 (17.2) |
| 21. Time for a meal in conference | 146 | 2 (1.4) | 1 (0.7) | 4 (2.7) | 12 (8.2) | 127 (87.0) | 34 (18.9) |
| 22. Post-conference follow-up with members of the family | 124 | 4 (3.2) | 10 (8.1) | 16 (12.9) | 30 (24.2) | 64 (51.6) | 56 (31.1) |

* Missing and not applicable are not included in the denominator when calculating percentages of responses

## Table 2

Number and Percentage of FGDM Practices Observed by Professionals in Counties with Multiple Conferences (N=84)

| Question | n | Never | Occasionally | Frequently | Almost all the time | All of the time | Missing/ NA* |
|---|---|---|---|---|---|---|---|
| 1. Families choose to participate | 78 | 0 (.0) | 4 (5.1) | 12 (15.4) | 33 (42.3) | 29 (37.2) | 6 (7.1) |
| 2. Coordinators/ Facilitators are trained | 75 | 1 (1.3) | 2 (2.7) | 0 (.0) | 10 (13.3) | 62 (82.7) | 9 (10.7) |
| 3. Coordinators/ Facilitators are neutral | 74 | 0 (.0) | 0 (.0) | 0 (.0) | 25 (33.8) | 49 (66.2) | 10 (11.9) |
| 4. Meetings held in neutral places in community | 78 | 1 (1.3) | 1 (1.3) | 2 (2.6) | 19 (24.4) | 55 (70.5) | 6 (7.1) |
| 5. Families are prepared prior to the conference | 76 | 1 (1.3) | 0 (.0) | 5 (6.6) | 28 (36.8) | 42 (55.3) | 8 (9.5) |
| 6. Families decide who to invite to the conference | 78 | 0 (.0) | 0 (.0) | 1 (1.3) | 23 (29.5) | 54 (69.2) | 6 (7.1) |
| 7. Conferences are at convenient times for families | 78 | 0 (.0) | 0 (.0) | 2 (2.6) | 22 (28.2) | 54 (69.2) | 6 (7.1) |
| 8. Youth and children attend the conferences | 77 | 0 (.0) | 2 (2.6) | 5 (6.5) | 36 (46.8) | 34 (44.2) | 7 (8.3) |
| 9. More family members than professionals attend | 77 | 0 (.0) | 2 (2.6) | 7 (9.1) | 50 (64.9) | 18 (23.4) | 7 (8.3) |
| 10. Culture of the family is included in planning | 76 | 0 (.0) | 3 (3.9) | 8 (10.5) | 28 (36.8) | 37 (48.7) | 8 (9.5) |
| 11. Pre conference meetings with professionals are held | 74 | 0 (.0) | 4 (5.4) | 6 (8.1) | 19 (25.7) | 45 (60.8) | 10 (11.9) |
| 12. Roles of family members are clear | 77 | 0 (.0) | 2 (2.6) | 9 (11.7) | 29 (37.7) | 37 (48.1) | 7 (8.3) |

* Missing and not applicable are not included in the denominator when calculating percentages of responses

| Question | n | Never | Occasionally | Frequently | Almost all the time | All of the time | Missing/ NA* |
|---|---|---|---|---|---|---|---|
| 13. Strengths of the family and child are shared | 78 | 0 (.0) | 0 (.0) | 0 (.0) | 2 (2.6) | 76 (97.4) | 6 (7.1) |
| 14. Information is provided by referral source | 79 | 1 (1.3) | 0 (.0) | 0 (.0) | 12 (15.2) | 66 (83.5) | 5 (6.0) |
| 15. Tangible supports for family and friends are offered and provided | 72 | 0 (.0) | 4 (5.6) | 5 (6.9) | 25 (34.7) | 38 (52.8) | 12 (14.3) |
| 16. Resource options are available | 74 | 0 (.0) | 2 (2.7) | 2 (2.7) | 19 (25.7) | 51 (68.9) | 10 (11.9) |
| 17. Children's safety, permanency, and well being needs are addressed | 76 | 0 (.0) | 0 (.0) | 1 (1.3) | 13 (17.1) | 62 (81.6) | 8 (9.5) |
| 18. Families are offered ideas on how to best use private family time | 74 | 1 (1.4) | 3 (4.1) | 4 (5.4) | 18 (24.3) | 48 (64.9) | 10 (11.9) |
| 19. Participants evaluate the process at the end | 73 | 1 (1.4) | 1 (1.4) | 0 (.0) | 17 (23.3) | 54 (74.0) | 11 (13.1) |
| 20. Families have private time | 78 | 0 (.0) | 0 (.0) | 1 (1.3) | 5 (6.4) | 72 (92.3) | 6 (7.1) |
| 21. Time for a meal in conference | 77 | 0 (.0) | 0 (.0) | 2 (2.6) | 7 (9.1) | 68 (88.3) | 7 (8.3) |
| 22. Post-conference follow-up with members of the family | 68 | 2 (2.9) | 9 (13.2) | 10 (14.7) | 12 (17.6) | 35 (51.5) | 16 (19.0) |

* Missing and not applicable are not included in the denominator when calculating percentages of responses

## Table 3

Number and Percentage of FGDM Practices Observed by Professionals in Counties with Less than 20 Conferences (N=77)

| Question | N | Never | Occasionally | Frequently | Almost all the time | All of the time | Missing/ NA* |
|---|---|---|---|---|---|---|---|
| 1. Families choose to participate | 61 | 4 (6.6) | 10 (16.4) | 5 (8.2) | 25 (41.0) | 17 (27.9) | 16 (20.8) |
| 2. Coordinators/ Facilitators are trained | 68 | 0 (.0) | 0 (.0) | 3 (4.4) | 7 (10.3) | 58 (85.3) | 9 (11.7) |
| 3. Coordinators/ Facilitators are neutral | 57 | 0 (.0) | 1 (1.8) | 0 (.0) | 12 (21.1) | 44 (77.2) | 20 (26.0) |
| 4. Meetings held in neutral places in community | 77 | 1 (1.6) | 1 (1.6) | 3 (4.7) | 13 (20.3) | 46 (71.9) | 13 (16.9) |
| 5. Families are prepared prior to the conference | 58 | 1 (1.7) | 0 (.0) | 2 (3.4) | 21 (36.2) | 34 (58.6) | 19 (24.7) |
| 6. Families decide who to invite to the conference | 60 | 0 (.0) | 2 (3.3) | 0 (.0) | 13 (21.7) | 45 (75.0) | 17 (22.1) |
| 7. Conferences are at convenient times for families | 62 | 0 (.0) | 1 (1.6) | 0 (.0) | 8 (12.9) | 53 (85.5) | 15 (19.5) |
| 8. Youth and children attend the conferences | 55 | 0 (.0) | 0 (.0) | 3 (5.5) | 8 (14.5) | 44 (80.0) | 22 (28.6) |
| 9. More family members than professionals attend | 56 | 1 (1.8) | 0 (.0) | 8 (14.3) | 22 (39.3) | 25 (44.6) | 21 (27.3) |
| 10. Culture of the family is included in planning | 56 | 1 (1.8) | 1 (1.8) | 4 (7.1) | 14 (25.0) | 36 (64.3) | 21 (27.3) |
| 11. Pre conference meetings with professionals are held | 57 | 1 (1.8) | 4 (7.0) | 7 (12.3) | 13 (22.8) | 32 (56.1) | 20 (26.0) |
| 12. Roles of family members are clear | 56 | 1 (1.8) | 0 (.0) | 3 (5.4) | 11 (19.6) | 41 (73.2) | 21 (27.3) |

* Missing and not applicable are not included in the denominator when calculating percentages of responses

| Question | n | Never | Occasionally | Frequently | Almost all the time | All of the time | Missing/ NA* |
|---|---|---|---|---|---|---|---|
| 13. Strengths of the family and child are shared | 60 | 1 (1.7) | 0 (.0) | 0 (.0) | 5 (8.3) | 54 (90.0) | 17 (22.1) |
| 14. Information is provided by referral source | 60 | 0 (.0) | 0 (.0) | 1 (1.7) | 6 (10.0) | 53 (88.3) | 17 (22.1) |
| 15. Tangible supports for family and friends are offered and provided | 54 | 2 (3.7) | 2 (3.7) | 2 (3.7) | 8 (14.8) | 40 (74.1) | 23 (29.9) |
| 16. Resource options are available | 54 | 0 (.0) | 3 (5.6) | 1 (1.9) | 7 (13.0) | 43 (79.6) | 23 (29.9) |
| 17. Children's safety, permanency, and well being needs are addressed | 61 | 0 (.0) | 0 (.0) | 1 (1.6) | 4 (6.6) | 56 (91.8) | 16 (20.8) |
| 18. Families are offered ideas on how to best use private family time | 54 | 0 (.0) | 3 (5.6) | 3 (5.6) | 13 (24.1) | 35 (64.8) | 23 (29.9) |
| 19. Participants evaluate the process at the end | 57 | 1 (1.8) | 0 (.0) | 3 (5.3) | 10 (17.5) | 43 (75.4) | 20 (26.0) |
| 20. Families have private time | 60 | 0 (.0) | 0 (.0) | 0 (.0) | 4 (6.7) | 56 (93.3) | 17 (22.1) |
| 21. Time for a meal in conference | 60 | 1 (1.7) | 1 (1.7) | 2 (3.3) | 4 (6.7) | 52 (86.7) | 17 (22.1) |
| 22. Post-conference follow-up with members of the family | 48 | 1 (2.1) | 1 (2.1) | 5 (10.4) | 15 (31.2) | 26 (54.2) | 29 (37.7) |

* Missing and not applicable are not included in the denominator when calculating percentages of responses

## Table 4

Number and Percentage of FGDM Practices Observed by Professionals in Counties with No Conference (N=17)

| Question | n | Never | Occasionally | Frequently | Almost all the time | All of the time | Missing/ NA* |
|---|---|---|---|---|---|---|---|
| 1. Families choose to participate | 12 | 2 (16.7) | 3 (25.0) | 1 (8.3) | 1 (8.3) | 5 (41.7) | 5 (29.4) |
| 2. Coordinators/ Facilitators are trained | 11 | 1 (9.1) | 0 (.0) | 0 (.0) | 0 (.0) | 10 (90.9) | 6 (35.3) |
| 3. Coordinators/ Facilitators are neutral | 10 | 1 (10.0) | 1 (10.0) | 0 (.0) | 1 (10.0) | 7 (70.0) | 7 (41.2) |
| 4. Meetings held in neutral places in community | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 0 (.0) | 9 (90.0) | 7 (41.2) |
| 5. Families are prepared prior to the conference | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 6 (60.0) | 3 (30.0) | 7 (41.2) |
| 6. Families decide who to invite to the conference | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 2 (20.0) | 7 (70.0) | 7 (41.2) |
| 7. Conferences are at convenient times for families | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 1 (10.0) | 8 (80.0) | 7 (41.2) |
| 8. Youth and children attend the conferences | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 0 (.0) | 9 (90.0) | 7 (41.2) |
| 9. More family members than professionals attend | 9 | 1 (11.1) | 0 (.0) | 1 (11.1) | 1 (11.1) | 6 (66.7) | 8 (47.1) |
| 10. Culture of the family is included in planning | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 3 (30.0) | 6 (60.0) | 7 (41.2) |
| 11. Pre conference meetings with professionals are held | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 2 (20.0) | 7 (70.0) | 7 (41.2) |
| 12. Roles of family members are clear | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 5 (50.0) | 4 (40.0) | 7 (41.2) |

* Missing and not applicable are not included in the denominator when calculating percentages of responses

| Question | n | Never | Occasionally | Frequently | Almost all the time | All of the time | Missing/ NA* |
|---|---|---|---|---|---|---|---|
| 13. Strengths of the family and child are shared | 11 | 1 (9.1) | 0 (.0) | 0 (.0) | 2 (18.2) | 8 (72.7) | 6 (35.3) |
| 14. Information is provided by referral source | 12 | 1 (8.3) | 0 (.0) | 0 (.0) | 2 (16.7) | 9 (75.0) | 5 (29.4) |
| 15. Tangible supports for family and friends are offered and provided | 12 | 1 (8.3) | 0 (.0) | 1 (8.3) | 4 (33.3) | 6 (50.0) | 5 (29.4) |
| 16. Resource options are available | 11 | 1 (9.1) | 1 (9.1) | 0 (.0) | 4 (36.4) | 5 (45.5) | 6 (35.3) |
| 17. Children's safety, permanency, and well being needs are addressed | 12 | 1 (8.3) | 0 (.0) | 0 (.0) | 1 (8.3) | 10 (83.3) | 5 (29.4) |
| 18. Families are offered ideas on how to best use private family time | 9 | 1 (11.1) | 0 (.0) | 0 (.0) | 3 (33.3) | 5 (55.6) | 8 (47.1) |
| 19. Participants evaluate the process at the end | 8 | 1 (12.5) | 0 (.0) | 1 (12.5) | 1 (12.5) | 5 (62.5) | 9 (52.9) |
| 20. Families have private time | 10 | 1 (10.0) | 0 (.0) | 0 (.0) | 0 (.0) | 9 (90.0) | 7 (41.2) |
| 21. Time for a meal in conference | 8 | 1 (12.5) | 0 (.0) | 0 (.0) | 1 (12.5) | 6 (75.0) | 9 (52.9) |
| 22. Post-conference follow-up with members of the family | 7 | 1 (14.3) | 0 (.0) | 1 (14.3) | 2 (28.6) | 3 (42.9) | 10 (58.8) |

* Missing and not applicable are not included in the denominator when calculating percentages of responses

# Appendix A: Survey

Welcome Message

The FGDM (Family Group Decision-making) Leadership Team and the University Of Pittsburgh School Of Social Work are interested in exploring how FGDM looks across Pennsylvania. The purpose of this research study is to identify the core components of FGDM practice in Pennsylvania and to allow for more comprehensive analysis of FGDM outcome data, including the types of practices in place and the degree to which they are being implemented. We hope to recognize and share best practice ideas.

You have been identified by the Children and Youth Services Administrator in your county as someone involved in the practice of FGDM in Pennsylvania. We are inviting you to take part in this research because we would very much like your input on this important family practice. However, your participation in this research is voluntary. You can start the survey and quit it, if you decide that you don't wish to participate.

There are no risks associated with this project, nor are there any direct benefits to you. We hope to share the results of this research with others who are using FGDM in Pennsylvania, leading to better services. You will not be paid for your participation. The survey will take approximately 15 minutes to complete.

All information from this survey will be kept as confidential (private) as possible. The survey data are protected by a password, and only the project leader has access to the data. There is no way to link your email address to your responses on the survey. Finally, you will not be asked for any information that could identify you. This information will be shared in the aggregate form, and no one person will be identified.

A report based on this information will be posted on the Child Welfare Training Program Website (http://www.pacwcbt.pitt.edu/FGDM.htm).

We appreciate your time in completing this survey!

If you have any questions, please contact Mary Beth Rauktis at 412.648.1225 or Wendy Unger 717-795.9048.
To help us to better understand and organize the surveys, please provide the following background information.

**1. Please identify the County that you work in most of the time:**
(drop down check box will all the county names only one option selected)

Adams

Allegheny

Armstrong

Beaver

Bedford

Berks

Blair

Bradford

Bucks

Butler

Cambria

Cameron

Carbon

Centre

Chester

Clarion

Clearfield

Clinton

Columbia

Crawford

Cumberland

Dauphin

Delaware

Elk

Erie

Fayette

Forest

Franklin

Fulton

Greene

Huntingdon

Indiana

Jefferson

Juniata

Lehigh

Luzerne

Lycoming

McKean

Mercer

Mifflin

Monroe

Montgomery

Montour

| | |
|---|---|
| Northampton | Tioga |
| Northumberland | Union |
| Perry | Venango |
| Philadelphia | Warren |
| Pike | Washington |
| Potter | Wayne |
| Schuylkill | Westmoreland |
| Snyder | Wyoming |
| Somerset | York |
| Sullivan | Unknown |
| Susquehanna | |

**2. Which best describes your organization or system?**
(radio button, only one selected)

Public child welfare agency
Private provider
Educational system
Courts
Other Legal system representatives
Medical system
Managed care/insurance Company
County Mental Health
County Developmental Programs (MR)
County Drug and Alcohol
Juvenile probation
Other (**please specify**)_____

**3. What best describes your position?**
(drop down check box only one option selected)

CYS Caseworker
CYS Supervisor
County Administrator
Advocate

Mental Health professional/supervisor
Mental Retardation professional/supervisor
Juvenile probation officer/supervisor
Foster parent
Drug & alcohol professional
Lawyer/GAL
Judge
Psychologist/psychiatrist
School representative/teacher
FGDM management position
Provider caseworker
**Other (please specify) _____**

**4. What is your primary role in family group decision-making?**
(radio button, only one selected)
Conference coordinator
Facilitator
Co-facilitator
CYS liaison
Implementation team member
Referring worker
Other (please specify) )_____

Family Group Decision Making is abbreviated as FGDM in this survey. By FGDM we mean practices that are also referred to in Pennsylvania as "family conferencing", "family group" etc.

These next set of questions are about the practices being used in the FGDM groups with which you are involved.

**5. Please write the complete name that you use for your Family Engagement Model**
(radio button, select one)
family group decision making,
family group conferencing,
family team meetings,
family unity meetings
Other (please specify)_____

**6. How long has your county been implementing FGDM?**
(radio button, select one)
Less than six months
7 to 18 months
19 to 36 months
More than 37 months
Don't know

**7. Approximately how many FGDM conferences have you had (or participated in) since January 1, 2007?**
(Radio button, select one)
Less than 20
21-50
51-100
100-200
More than 200
Don't know

**8. Does your county have written policies and procedures to guide your FGDM practices?**
(radio button, yes/no)

9. **Does your county have written policies and procedures to guide which families are referred to FGDM?**
(radio button, yes/no)

**10. Does your FGDM conferences in your county focus on (check all that apply)**
(multi-select check box)

child abuse and neglect/child welfare
juvenile probation
education
mental health
mental retardation
youth transition/IL planning
adoption
other (please describe_____)

**11. How are families selected to be approached for the choice of participating in FGDM?**
(text box)

**12. What would keep your county from having a FGDM conference**?
(text box)

**13. Generally, at what point are families referred for FGDM conferences?**
(Text box)

**14. How is FGDM financed in your County?**
(radio button check one)
Through the CYS Needs Based Plan and Budget
Through a System of Care grant
Human Service Development Funds
Managed Care Reinvestment Funds

Grant
Foundation
Other (please specify) )_____
Don't know

**15. Generally, who coordinates the conference?**
(radio button, check one)
CYS staff
Private contractor
A combination of private contractor and CYS staff
Human Services Department
Other (please specify)
Don't know

**16. Are coordinators full time or part time?**
(radio button)
Full time Part time Don't know

**17. Approximately how many CYS staff are exclusively assigned to FGDM?**
(write in number, leave it blank if you don't know)

**18. Do you have an implementation team?**
**(radio button yes/no)**

***If yes***
**19. Who is part of the implementation team?**
(multi-select check box) check all that apply
CYS
JPO
Education representatives
Mental health representatives
Mental Retardation representatives
Private providers (therapist, in-home, residential, etc…)
Community representatives (religious groups, boy/girl scouts, YWCA, etc,,,)
Families who have or are using CYS services
Youth with CYS services, past or present
Other (please specify)
Don't know

***If no***
**20. Do you have another structure? Please describe it below**
(text box)

**21. What were your reasons for implementing FGDM? Please rank these items in terms of importance, 1 being the most important reason, 8 being the least important reason.**

(circles with numbers 1 to 8)

Improve child safety
Improve children's' stability and permanency outcomes
Improve agency's or system's approach to family engagement
Enhance families' ability to work with agency or system
Improve the physical, mental health and educational well-being of the child
Balanced and restorative justice
Improve community partnerships
Better use of fiscal resources
Best practice for planning with families
Improve staff morale
Unable to answer

**22. If there is another purpose or reason that isn't listed, please write it here**
(text box)

**23. To what degree have you been able to include or you have observed these practices in place in FGDM practice?**

1=never; 2=occasionally or about 25% of the time ; 3=frequently or about half of the time; 4=almost all of the time or about 75% of the time; 5=100% or all of the time NA is don't know/can't answer.
Check only 1

USE WORD ANCHORS HERE RATHER THAN NUMBERS E.G. "NEVER"; "OCCASIONALLY OR 25%" ETC

| | 1 | 2 | 3 | 4 | 5 | NA |
|---|---|---|---|---|---|---|
| Families choose to participate | | | | | | |
| Coordinators and facilitators are trained | | | | | | |
| Coordinators and facilitators are neutral | | | | | | |
| Meetings are held in neutral places in the community | | | | | | |
| Families are prepared; know the purpose and process of the conference prior to the conference | | | | | | |
| Family members decide who to invite to the conference | | | | | | |
| Conferences are held at times convenient for the families | | | | | | |
| Youth and children attend the conferences | | | | | | |
| More family members than professionals attend | | | | | | |
| The culture of the family is included in conference planning | | | | | | |
| Pre conference meetings with professionals are held | | | | | | |
| The roles of the members are clear | | | | | | |
| Strengths of the family & child are shared | | | | | | |
| Information is provided by referral source about the | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| issues that need to be addressed in the plan | | | | | | |
| Tangible supports for family and friends to attend are offered and provided e.g. child care, transportation costs | | | | | | |
| Resource options are available | | | | | | |
| Children's safety, permanency and well being needs are addressed in the conference | | | | | | |
| Families are offered ideas on how to best use private family time | | | | | | |
| The participants evaluate the process at the end | | | | | | |
| Families have private time | | | | | | |
| Time for a meal | | | | | | |
| Post-conference follow-up with the members of the family | | | | | | |

**24. After the plan's completion, is it changed or revised as needed?**
(Radio button)
Yes/no
***If yes***

**Who can request that the plan be changed? Select all that apply**
(Multi-select check box)
Families,
youth,
caseworkers,
court,
private providers
other (please specify)

**Is another conference held to make the changes?**
Radio button
Yes No Sometimes

**25. If your FGDM conferences have components that are different than the ones listed above, please describe.**
(text box)

**26. Rate the helpfulness of each of these training, education or technical assistance components in assisting your implementation**
1-not helpful 2—somewhat helpful 3—helpful 4---very helpful
NA not applicable/not used

Child welfare training program FGDM training
Child welfare training program Technical assistance
Statewide FGDM Implementation Team meetings
Statewide FGDM outcome reports
American Humane Association (AHA) Resources

Attendance at AHA International FGDM Conference(s)
AHA training

**What additional training or technical assistance would be helpful?**
(text box)

**27. What impact, if any, do you think your FGDM practice has had on the way that you engage families?** (radio button, check one)
1-no impact
2 a little impact
3 a moderate degree of impact
4 high degree of impact

**Could you explain a little more about the impact or lack of impact?**
(text box)

**28. What impact, if any, do you think your FGDM practice has had on the way that you work with your colleagues?**
1-no impact
2 a little impact
3 a moderate degree of impact
4 high degree of impact

**Could you explain a little more about the impact or lack of impact?**
(text box)

We are almost at the end of the survey.
We would like your perspective about FGDM. Please type your opinion into the text boxes. We are very interested in hearing what you have to say.

**29. What have been the greatest helpers/facilitators of implementing FGDM?**
(open ended, text box)

**30. What have been the greatest barriers to successfully implementing FGDM?**
(open ended, text box)

**31. What do you believe is necessary for you to sustain and expand the FGDM process in your county?**
(open ended, text box)

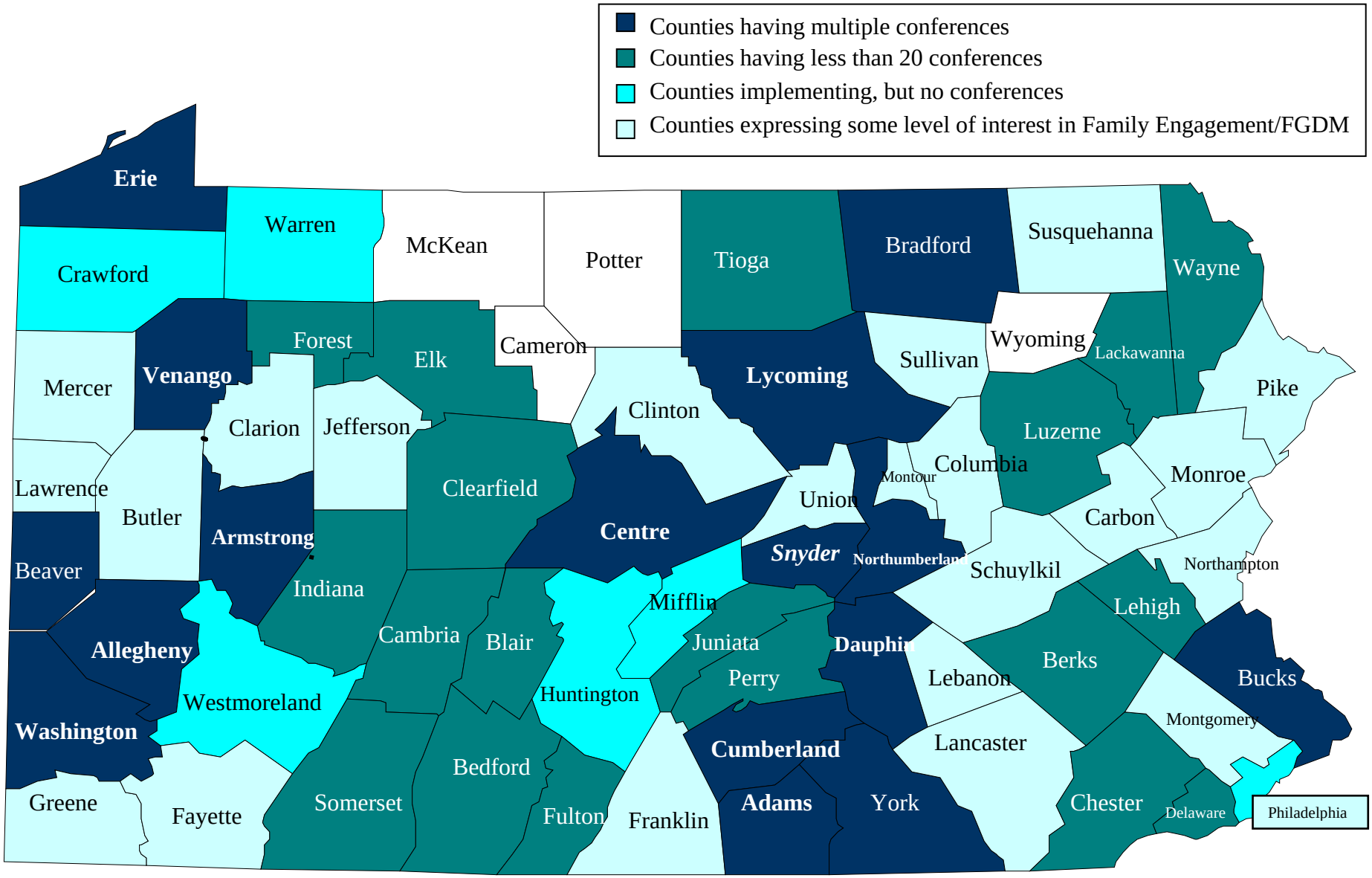
**32. Is there anything else you would like to share about your FGDM practice?**
(open ended, text box)

Thank you for taking the time to fill out this survey. The aggregate report will be posted on the Child Welfare Training Program Website Summer 2008.

# Appendix B

| Responses by County | | | |
|---|---|---|---|
| | Frequency | Percent | Valid Percent |
| Adams | 7 | 3.9 | 3.9 |
| Allegheny | 2 | 1.1 | 1.1 |
| Armstrong | 3 | 1.7 | 1.7 |
| Beaver | 6 | 3.3 | 3.4 |
| Bedford | 4 | 2.2 | 2.2 |
| Berks | 6 | 3.3 | 3.4 |
| Blair | 4 | 2.2 | 2.2 |
| Bradford | 2 | 1.1 | 1.1 |
| Bucks | 5 | 2.8 | 2.8 |
| Cambria | 5 | 2.8 | 2.8 |
| Centre | 8 | 4.4 | 4.5 |
| Chester | 7 | 3.9 | 3.9 |
| Clearfield | 6 | 3.3 | 3.4 |
| Clinton | 2 | 1.1 | 1.1 |
| Cumberland | 8 | 4.4 | 4.5 |
| Dauphin | 5 | 2.8 | 2.8 |
| Elk | 6 | 3.3 | 3.4 |
| Erie | 3 | 1.7 | 1.7 |
| Forest | 2 | 1.1 | 1.1 |
| Fulton | 8 | 4.4 | 4.5 |
| Indiana | 8 | 4.4 | 4.5 |
| Juanita | 4 | 2.2 | 2.2 |
| Lehigh | 5 | 2.8 | 2.8 |
| Lycoming | 9 | 5.0 | 5.1 |
| Northampton | 4 | 2.2 | 2.2 |
| Northumberland | 2 | 1.1 | 1.1 |
| Perry | 1 | .6 | .6 |
| Philadelphia | 2 | 1.1 | 1.1 |
| Pike | 1 | .6 | .6 |

| | | | | |
|---|---|---|---|---|
| Snyder | | 3 | 1.7 | 1.7 |
| Somerset | | 5 | 2.8 | 2.8 |
| Venango | | 9 | 5.0 | 5.1 |
| Warren | | 6 | 3.3 | 3.4 |
| Washington | | 5 | 2.8 | 2.8 |
| Wayne | | 6 | 3.3 | 3.4 |
| Westmorland | | 2 | 1.1 | 1.1 |
| York | | 7 | 3.9 | 3.9 |
| Total | | 178 | 98.9 | 100.0 |
| Missing | System | 2 | 1.1 | |
| Total | | 180 | 100.0 | |




**Appendix C:** Pennsylvania FGDM Implementation (updated 5.28.08)