Fidelity to Family Group Practices in Pennsylvania, 2008 Final Brief Report

Submitted by the University of Pittsburgh Child Welfare Training and Research Program, School of Social Work, Pittsburgh, Pennsylvania
Project Manager, Mary E. Rauktis, Ph.D.

Background

In less than ten years, Family Group Decision Making (FGDM) in Pennsylvania has multiplied from a 12 county pilot program to an approach that is implemented in most of the 67 counties in the state. Family group decision making is not mandated although it is supported by the judicial system as well as recent increased reimbursement from the Department of Public Welfare. Therefore, as more counties adopt the practice, it becomes imperative to investigate the fidelity of FGDM practices and determine which factors may facilitate or challenge its adoption and implementation (Pennell, Hardison & Yerkes, 1999).

The objective of the FGDM model 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 executive summary:

- What does FGDM look like in Pennsylvania and how is it 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?

Data were collected February 2008 through May 2008 on a non-representative sample of professionals using the non-probability approach of asking the county director to “nominate” individuals who have participated in FGDM in their county. The counties

who responded represented 58% of the 67 counties in Pennsylvania. An email letter was sent to three hundred and fourteen individuals with a link to a website and instructions on how to complete the survey. Two hundred and fifteen completed the survey (68%). Surveys with 75% or more missing answers 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 brief report. However, interested readers are encouraged to review the entire study at http://www.pacwcbt.pitt.edu/FGDM_EvaluationPage.htm and the accompanying powerpoint presentation.

Major Findings

What does FGDM look like in Pennsylvania and how is it being implemented?

- The majority (92%) of the counties use the term "Family Group Decision Making" and over three-fourths of respondents (77%) report that they have written policies and procedures for FGDM; a lesser percentage (68%) report written referral procedures for families.
- The focus of FGDM in PA 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.
- Eighty-two percent indicated that they had a cross-systems implementation team and this appears to be one of the first tasks undertaken. Child welfare, juvenile justice, private providers and mental health are frequently part of the

implementation team. Early intervention, domestic violence, clergy, adult corrections, and housing representatives were also cited, though less frequently, as part of the implementation teams.

- Over one-half (56%) report that a private contactor coordinates the family group decision-making meetings; the average number of CYF staff assigned to FGDM is one.
- 77% of the respondents had not participated in training about FGDM.
- Families are selected for FGDM in two ways: all are included and then ruled out or individual families are asked to participate.
- Family factors that would rule out or exclude a family from participating were primarily domestic violence, sexual abuse and unwillingness to participate.
- Caseworker attitudes and reluctance to "buy in" to the practice were also identified as a factor that limits referrals.
- Families are referred to FGDM at any point in the service pathway.

Practices observed by 80% or more of the respondents and reported to be present "all of the time" were:

- Trained coordinators and facilitators
- The strengths of the child and family are shared
- Information sharing about issues that need to be addressed in the plan is shared
- Children's safety, permanency and well being needs are addressed in the conference
- Families have private time

- Families have time for a meal

Practices that were reported by 20% or more of the respondents to be observed less than half of the time were:

- Post follow up with members of the family
- Families are given the choice to participate

Differences in perception about fidelity practices

While an individual's role did not seem to impact perception of practices, associations were seen between resources and structure and maturity of the practice. For example, the more "mature" (more than 20 conferences) counties were:

- More likely to have written policies
- More likely to have policies on type of family to refer
- More likely to have full time coordinator
- CYF more likely to share the facilitating/coordination role with private provider

Although causality cannot be determined, the association seems to be important and more experienced counties have processes in place that may more fully support the practices of FGDM.

What are the perceived 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, and what factors were challenging to implementation.

Helpers

- No single category accounted for more than 21% of the responses—
    - many and varied responses to what helps to facilitate the practice of FGDM
- Two most common were “training & support” and “leadership attitudes”
- *Take away point: agencies can facilitate implementation in many ways and if one approach is not working, another may help.*

Challenges

- The most common response fell into the category of “barriers created by caseworker attitudes”
- “Structural issues” (problems with time, money, staffing, extra hours of work and caseload size)
- “Family characteristics”
- *Take Away point: Improving structural issues is likely to positively influence caseworker attitudes*

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 approach and that they 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 such as creating a hospitable environment at the agency level for carrying out family group and safe and effective planning during the family group 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 and planned follow up meetings with families concerning, particularly in light of research indicating 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 helping 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 follow up 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 barriers to follow up, 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 issues 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, 2000; Pennell & Buford, 2000). Other identified barriers were system factors involving 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% reported 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 county Children and Youth Services needs based plan. The average number of staff from CYS that is allocated to FGDM is one. Yet, FGDM is an intervention that crosses the adult and juvenile systems; 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 and the 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 (OFYC), the Child Welfare Training Program, and the Administrative Offices 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 working with FGDM was frequently identified as beneficial. Families and former youth are a valuable resource 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 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 if 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 gain insight to 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 challenges to implementing FGDM. 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 FGDM. practice. In addition, there is the selection bias at the two response levels - county and individual. Those that chose not to respond may have a different perception of practice. Another limitation is the amount of missing data, particularly from counties who were new to the practice. Despite these limitations, this study provides a "snapshot" of how the practice has evolved and what is needed to continue 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 FGDM referral policies. Although some counties have policies to determine which families to refer and some have automatic inclusion, there is variation and a great deal of individual judgment being exercised about 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 by implementing 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 provided to the organization at various stages may be needed to augment training, and 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 for children, youth, families and organizations, and to identify with which families it is the most effective.

References

Berzin, S.,C., Thomas, K. L.. & Cohen, E. (2007). Assessing model fidelity in two family group decision making programs: Is this child welfare intervention being implemented as intended? *Journal of Social Service Research, Vol. 34*(2). 55-71.

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

Crampton, D. S. & Williams, A. D. (2000). *Does the type of child maltreatment matter in family group decision making?* Paper presented at the 2000 FGDM roundtable proceedings. Englewood, CO: American Humane Association.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005).Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Pennell, J., & Burford, G. (2000). Family group decision making: Protecting children and women. *Child Welfare, 79,* 131-158.

Pennell, J. (With Hardison, J., & Yerkes, E.). (1999). *North Carolina Family Group Conferencing Project: Building partnerships with and around families: Report to the North Carolina Division of Social Services, Fiscal year 1998-1999*. Raleigh: North Carolina State University, Social Work Program, North Caroline Family Group Conferencing Project.

Weigensberg, E. C., Barth, R. P., & Guo, S. Family group decision making: A propensity score analysis to evaluate child and family services at baseline and after 36 months. *Children and Youth Services Review* (2008).