

California Social Work Education Center

C A L S W E C

**FAMILY UNITY MEETINGS:
PRACTICE, RESEARCH, AND
INSTRUCTIONAL CURRICULA**

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CalSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation's largest state coalition of social work educators and practitioners. It is a consortium of the state's 20 accredited graduate schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social Workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is "to facilitate the integration of education and practice." But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become "educated" and then cease to observe and to learn.

To foster continuing learning and evidence-based practice within the child welfare field, CalSWEC funds a series of curriculum modules that employ applied

research methods to advance the knowledge of best practices in child welfare. These modules, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, curriculum modules are made available through the CalSWEC Child Welfare Resource Library to all participating schools and collaborating agencies.

The module that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.

ABOUT THE AUTHORS

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INTRODUCTION

This curriculum has been developed from a literature review, a research project, and focus groups and interviews with practitioners and families who engage in Family Group Conferencing. It includes competencies from the California Social Work Education Center, four modules, and a bibliography.

The following modules have been developed for academics, students, and practitioners who wish to learn about the implementation, process, and outcomes of the Family Unity Meeting (FUM) in San Diego. San Diego provides a case study for studying Family Group Decision Making.

MODULE I. Using the Technical Research Report as a guide, this module includes factors that distinguish between families that accepted or rejected an invitation to a meeting, a description of the meeting process, outcome data on placements and new referrals, the families' perspectives on family change, the use of social support, and family satisfaction with services. Utilizing this module requires some familiarity with the Technical Research Report. Additional discussion of the research is included in other modules contained in this document.

MODULE II. This module provides background information, exercises, and resources on Family Group Conferencing for delivery in a classroom setting in a 2- to 4-hour format by a faculty/instructor/trainer. A PowerPoint presentation is included as a visual aid in the delivery of this module, whose components include:

- A synopsis of Family Group Conferencing
- Legislation supportive of FGC
- History
- Definition

- Philosophy
- Models of FGC
- Process of FGC
- Facilitator's role
- Trends and evaluation of FGC
- Exercises for the classroom
- Suggested videos

Module III. This module is a proposed course syllabus that focuses on Family Group Conferencing and Strength-Based Practice. The primary purpose of the course is to introduce students to the concept of strength-based practice in child welfare and to provide the prerequisite knowledge and skills for Family Group Conferencing (FGC). Potential assignments for course work and a recommended bibliography for each week's topic areas are included. Additional references are added at the conclusion of the syllabus.

Module IV. This module has been developed for field instructors and students who are engaged in Family Group Conferencing as part of the student's field practicum. A table of contents lists the topic areas for field instructors and students, including orientation material; potential policy and procedures; special issues that may arise when doing family group conferencing; and an appendix of forms, handouts, and resources.

Using San Diego County's Family Group Conferencing Program as a guide, this module includes procedures and logistics tailored to their program. When utilizing this module, field instructors and students are encouraged to tailor specific forms, procedures, and logistics to their own program. Additional resources (bibliography and websites) are included to assist in locating other Family Group Conferencing research and programs.

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- All the staff in the Family Group Conferencing Program, San Diego Department of Health and Human Services Agency, San Diego County.

COMPETENCIES

The following competencies are derived from the California Social Work Education Center's list of competencies for students in child welfare settings. The competencies are seen as fundamental to the area of practice of Family Group Conferencing. The competencies are broken into Knowledge and Skill competencies. Values and Ethics are added as part of the overall practice in this area.

KNOWLEDGE OBJECTIVES

- 1.1 Student understands and is sensitive to cultural and ethnic differences of clients.
- 1.2 Student considers the cultural norms, beliefs, values, language, race, ethnicity, customs, family structure, and community dynamics of major ethnic groups in the State of California in assessments and continues training to increase knowledge in this area.
- 1.5 Student considers the influence of culture on behavior and is aware of the importance of utilizing this knowledge in helping families improve parenting and care of their children within their own cultural context.
- 1.9 Student understands and uses knowledge in the provision of child welfare services to cultural and ethnic populations.
- 2.1 Student understands that child abuse and neglect are presenting symptoms of social and family dysfunction.
- 2.8 Student understands the dynamics of family violence, including spouse abuse, and can develop appropriate culturally sensitive case plans for families and family members to address these problems.
- 2.13 Student understands the potentially traumatic effects of the separation and placement experience for the child and the child's family and the negative effects on the child's physical, cognitive, social, and emotional development.
- 2.15 Student understands the principles of permanency planning and the negative effects that inconsistent and impermanent living arrangements have on children.
- 2.16 Student understands the importance of the biological parent maintaining contact with the child in placement, of encouraging parents when appropriate to participate in planning, and of regular parent-child visitations.

- 3.6 Student is aware of his or her own emotional responses to clients in areas where the student's values are challenged, and is able to utilize the awareness to effectively manage the client-worker relationship.
- 3.8 Student understands crisis dynamics, identifies crises, and conducts crisis intervention activities.
- 3.13 Student has knowledge of and understands how to work collaboratively with other disciplines that are routinely involved in child welfare cases.
- 3.15 Student understands group process theory and can develop and implement small groups.
- 3.24 Student understands the strengths and concerns of diverse community groups and is able to work with community members to enhance services for families and children.
- 4.1 Student understands children's developmental needs and how developmental levels affect a child's perception of events, coping strategies, and physical and psychological responses to stress and trauma.
- 4.4 Student understands the potential effects of child abuse and neglect on child/adult development and behavior.
- 4.6 Student understands the stages of the family life cycle as they occur in a variety of familial patterns.
- 4.7 Student understands the interaction between environmental factors especially in terms of racism, poverty, violence, and human development.
- 5.3 Student can understand client and system problems from the perspective of all participants in a multidisciplinary team and can assist the team to maximize the positive contribution of each member.
- 5.10 Student is familiar with a range of collaborative models.
- 6.11 Student understands that decision-making processes in public child welfare practice require ethical reasoning that is informed by professional standards.

SKILL OBJECTIVES

- 1.3 Student is able to develop an ethnically sensitive assessment of a child and the child's family and adapt casework plans to that assessment in the provision of child welfare services, while demonstrating an understanding of the continuum from traditional to acculturated values, norms, beliefs, and behaviors of major ethnic groups.

- 1.4 Students can develop relationships, obtain information, and communicate in a culturally sensitive way.
- 1.7 Student is able to evaluate models of intervention such as family preservation, family-centered services, and family-centered crisis services for their application, possible modification, and relevance to cultural and ethnic populations.
- 2.2 Student is able to assess the interaction of individual, family, and environmental factors, which contribute to abuse, neglect, and sexual abuse, and identifies strengths, which will preserve the family and protect the child.
- 2.9 Student accurately assesses the initial and continuing level of risk for the abused or neglected child within the family while ensuring the safety of the child.
- 2.18 Student works collaboratively with foster families and kin networks, involving them in assessment and planning, and supporting them in coping with special stresses and difficulties.
- 3.1 Student demonstrates social work values and principles; this includes self-determination, respect for human dignity and worth, and respect for individual differences.
- 3.3 Student demonstrates the ability to evaluate and incorporate information from others, including family members and professionals, in assessment, treatment planning, and service delivery.
- 3.7 Student assesses family dynamics, including interaction and relationships, roles, power, communication patterns, functional and dysfunctional behaviors, and other family processes.
- 3.11 Student can engage clients, especially nonvoluntary and angry clients.
- 3.12 Student engages families in problem-solving strategies and assists them with incorporating these strategies.
- 3.14 Student can produce concise, required documentation.
- 3.15 Student understands group process theory and can develop and implement small groups.
- 5.1 Student effectively negotiates with supervisor and professional colleagues, systems, and community resources to further accomplish professional, client, and agency goals.
- 5.2 Student is able to work effectively in a diverse environment.

- 5.8 Student demonstrates a working knowledge of the relationship process of accessing community resources available to families and children, utilizes them appropriately, and updates as necessary.
- 6.2 Student demonstrates knowledge of specific laws, policies, court decisions, and regulations essential to child welfare services.
- 6.5 Student can demonstrate knowledge of how organizational structure and climate impact service delivery, worker productivity and morale, and how students can contribute to improvements.

VALUES AND ETHICS

The following values and ethics are derived from CalSWEC values and standards for child welfare professionals.

- 1. Display knowledge basic to the social work profession and an understanding of the social institutions, organizations, and resources serving children and families.
- 3. Demonstrate skills fundamental to the profession of social work and related disciplines.
- 4. Know, understand, and work competently with the diversity of people within the state and region.
- 6. Assume responsibility for learning in supervision.
- 7. Meet the expectations of conduct established by the NASW Code of Ethics, other professional ethics codes determined by a worker's professional affiliation, and the county's code of ethics.
- 8. Adhere to agency policies, procedures, and evaluations, and use constructive channels to bring about change.
- 9. Apply results of research and evaluation to practice, and collect data in support of the agency's information system.
- 10. Demonstrate, throughout all their child welfare tasks and activities, acceptance of the professional Values for Public Child Welfare Practice.
- 12. Participate in multidisciplinary teams with staff in other programs, with colleagues in other disciplines, and with informal and formal institutions in the community.
- 13. Promote collaborative working relationships among community agencies and the courts toward establishing a comprehensive public child welfare system and family support system.

29. Assess parents' willingness and ability to protect the child.
30. Provide direct and intensive services to parents to strengthen their capacity to care for their children.
31. Through the entire course of the intervention, engage family in using its own strengths and resources.
32. Help create a family plan for legal permanency that includes family preservation and community support in a safe environment for the child.
37. Ensure child's participation in planning and direction for his or her life.
39. In preparing for reunification or out-of-home legal permanency, include foster parents in the planning process.
40. Use social work processes in termination of service.
41. Manage in a professional manner personal feelings associated with providing child welfare services.
42. Work toward enhancing resources available for the child within the agency and in the community, including resources for independent living/emancipation.
43. Strive to prevent child endangerment by engaging resources in the community to support and strengthen families.

MODULE I

RESEARCH

MODULE I RESEARCH

INTRODUCTION

The following module has been developed for academics, students, and practitioners who wish to learn about the implementation, process, and outcomes of Family Unity Meetings (FUMs) in San Diego. San Diego provides a case study for studying Family Group Decision Making.

Using the Technical Research Report as a guide, this module includes factors that distinguish between families that accepted or rejected an invitation to a meeting; a description of the meeting process; outcome data on placements and new referrals; and the families' perspective on family change, the use of social support, and family satisfaction with services. Utilizing this module requires some familiarity with the Technical Research Report. Additional discussion of the research is included in other modules contained in this report.

LITERATURE REVIEW

Public and professional concern has been growing about the number of children in out-of-home placement. Concern has been heightened since these children are disproportionately minority group members. Historically, the most common child protection intervention with multiproblem families was to remove the child from the home. While removal is warranted in situations where the risk is high and the danger is immediate to the child, the removal in more benign circumstances often has proved to be detrimental and disruptive to the family (Fanshel, 1982). Once removed from the home, many of these children spend an unacceptable amount of time in care, and they

experience many placement moves. It is only since the 1980s that efforts have been made to provide more supportive interventions for families at risk of child maltreatment. These approaches have shown mixed results (Davis, English, & Landsverk, 1995; Lahti, 1982). Social work practice in Child Protective Services (CPS) has struggled with finding culturally competent, family-centered, and strength-oriented models that might make more efficient utilization of scarce resources in preventing out-of-home placement.

Family Group Decision Making (FGDM) is a new approach to decision making in child welfare that seeks to have social workers take a collaborative rather than an adversarial stance with families, and shift the balance of power between families and professionals within the child welfare decision-making process. FGDM reflects some of the current trends and value changes in child welfare. These trends and changes include family preservation, family-centered practice, kinship care, strengths perspective, community-based service delivery, and participatory decision making between professionals and users of service (Merkel-Holguín, 2000a). In this solution-focused decision-making model, family members play the central role in decisions about their children (Lupton & Stevens, 1998). The approach attempts to mobilize family resources around a crisis that might otherwise lead to placement or further CPS involvement.

The meeting is managed by a coordinator and/or facilitator from the CPS agency who is responsible for involving extended family members in the conference and approving the family's plan for caring for the child. Extended family members and close family friends are given primary responsibility for making decisions about child safety.

Concerns about the ability of the family to make good decisions are somewhat alleviated by the participation and veto authority of the social worker and the court (Welty, 1997). However, some assert that social workers take a more active role than intended by the model, either by deference from the family, or by guiding the meeting's decisions about services (Lupton, 1998). Some empirical evidence exists to support this claim. Rockhill and Rodgers (1999) report that one half of the parents said social workers had "too much to say" and 48% of parents said they had "too little to say." Acceptance by social workers means they must learn to relinquish control of the problem to the family.

The term FGDM was coined to emphasize that the family (nuclear, extended, and fictive kin) would decide what needs to be done to preserve the family and stop the violence. One of the roots of FGDM can be traced to New Zealand where this approach was legislated into law in 1989 to address child welfare and youth justice (Hassall, 1996). The intervention was developed after Maori groups mobilized against Eurocentric professional-driven treatment models that seemed to emphasize family pathologies and ignore strengths (Walker, 1996). The Eurocentric models assumed that professionals had the solutions to family problems. In the Maori culture, the extended family is involved and takes responsibility for childrearing. The Maoris have a problem-solving process called the Hui. The Hui consists of ceremony, family discussion, and the development of a consensus plan to resolve the problem. It is believed that a form of the Hui can be used to gain family participation in child protection, and thus promote permanence for children in kinship care.

Oregon was the first state to develop a version of FGDM into Child Protective Services (CPS) intervention. In fact, Oregon asserts that the Family Unity Meeting (FUM) version of FGDM was born in Oregon (Nice & Graber, 1999; Note: In this report FGDM will be used to denote the generic form of the family group intervention. FUM will be used to signify a specific application of FGDM that is used in San Diego). This development occurred in the context of family preservation and permanency planning efforts throughout the state and nation. Also, in Oregon as in other states, an increased emphasis was placed on avoiding the courts and seeking more effective community and family-based interventions for child protection (Harper & Coburn, 1998). Connolly and McKenzie (1999) assert developments in Oregon were concurrent rather than an offshoot of what was occurring in New Zealand. They indicate both Oregon and New Zealand developed their models out of similar concerns about child welfare practice. In 1992 Oregon invited New Zealanders to come to the states to share and exchange ideas on best practices. The model in use in Oregon incorporates New Zealand notions of best practices.

FGDM is based on the beliefs that family histories have an impact on decision making, that families are capable of protecting their children, that family relationships can be more influential and effective than professional helping relationships, and that the extended family has primary responsibility for the care and protection of its children over time. This strength-oriented perspective is attractive to historically oppressed groups who distrust professionals as representative of a dominant culture that focused on the weaknesses and deficits of the family and presumed to know best how to correct those problems (Dykstra, 1996; Walker, 1996). Relinquishing the problem to the families

is a way to incorporate the family's cultural methods of caring for children into the CPS system.

FGDM is attractive because the model is voluntary, supports family structure, limits state intervention in private family matters, and meets the requirements of P.L. 96-272. Some support these programs as a cost-saving alternative to out-of-home care.

FAMILY GROUP DECISION MAKING MODELS

FGDM has two basic program models: (a) the Family Group Conference (FGC) developed in New Zealand, and (b) the Family Unity Meeting (FUM) developed in Oregon. The New Zealand model was developed to be consistent with Maori cultural practices. This model begins with information sharing followed by private family deliberation and decision making. The decisions of this deliberation are then presented back to the social worker and other attendees for discussion and approval (Merkel-Holguín, 1996). The professionals involved with the family must agree to the plan unless the plan places the child at risk. It is this time alone that is the differentiating feature of the model. The FUM approach incorporates a family-centered and family treatment perspective. The unique feature of FUM is the structured time for a facilitated discussion of family strengths and concerns. This explicit discussion of strengths highlights a family's attributes, resources, and capacities that proponents of FUM say can positively change the dynamics of the meeting and can help a family craft the plan (Merkel-Holguín). The family unity model follows the structure of goal setting: strengths assessment; identification of concerns, problems, and options; family discussion, and decision making (Hunter College School of Social Work, 1998). CPS workers utilize FUMs to serve a wide variety of functions including assessment, service coordination,

information sharing, strengthening the family support system, and shared decision making (Rockhill & Rodgers, 1999).

A major difference between the models is whether the family is left alone for private deliberation during the meeting. Critics of the FUM approach claim, because the family is not left alone during the meeting, that the power differential between professionals and families will mean decisions are made more on social worker wants than family needs (Rockhill & Rodgers, 1999). FGC proponents say that many families will not divulge family secrets when professionals, whom they may not entirely trust, are present. If information is not shared then the plan is flawed and suspect. They also claim the private time is acknowledgment of family resources and the trust that professionals have in the family to resolve its own problems. Critics of the private time worry about unresolved family issues emerging in an unstructured environment and that further victimization could occur (Merkel-Holguín, 2000a).

Increasingly the trend is to incorporate elements of two models into one another. For example, in San Diego, which uses FUM, private time is often part of the approach. A number of users of FGDM are incorporating a strengths identification stage into their intervention (Merkel-Holguín, 1996).

What the models have in common is the philosophy that:

- The development and safety needs of children are central to the decisions on the placement of children,
- The conference is managed by a facilitator who has responsibility for involving extended family members in the conference and approving the family's plan for caring for the child,
- Families have strengths that can be brought to bear on family problems,

- If families are strengthened and empowered, they can take responsibility for their children's placement outcomes,
- Preservation of the family unit is important,
- The family is preserved by working with families to resolve problems, and
- The development of a viable plan or conflict reduction is the ultimate goal of the meeting (McDonald & Associates, 1998).

INTERVENTION

When should FGDM be considered? The literature suggests that FGDM is appropriate when: (a) out-of-home placement is being considered, and (b) any time it would benefit the family to gather their family and social support (including potential social support) and CPS workers to discuss possible options for the care and protection of children (Fisher, 1998).

The most common candidates for exclusion from FGDM are domestic violence and child sexual abuse victims. Domestic violence service providers have always been concerned about conjoint treatment of the victim and offenders, which they believe will increase risk to the victim. Others argue that the dynamics of child sexual abuse, which sometimes can be unintentionally supported by multigenerational family member denial or can be culturally accepted, severely curtails the efficacy of this approach. Proponents of FGDM maintain that a decade of practice experience suggests that the approach can keep victims safe (Pennell & Burford, 1998; Smith, 1996).

A child's age, emotional development, and mental health status may determine whether he or she is included. Children should not be included in the meeting if a discussion would result in damage to the child. If a facilitator, social worker, or the family

decides it is in the child's best interest, a family member may be excluded from participation.

The intervention involves four phases: (a) referral to an impartial coordinator; (b) preparation and planning for a meeting that entails identifying the concerns of the professionals and family members about the safety of the child, and identifying the strengths of the family for ensuring child safety; (c) the meeting itself; and (d) postmeeting activities. The postmeeting phase entails formulating a service plan from family decisions and carrying out the plan. In this last phase, workers not only provide customary services, but mobilize social support from the informal and formal relationships available to the family.

THE RESEARCH EVIDENCE

The assertions are that FGDM results in fewer children (particularly minority children) living in-out-home-care, reduced family violence, reduced dependency on social services, increased family empowerment, increased social work cooperation and understanding of extended families, increased use of kinship care and resources to ensure family continuity and support for family reunification and permanency, increased empathy, decreased child abuse, cost-related savings in services and placements, and decreased blame toward victims in the extended family network. Social workers also report family participants report a high degree of satisfaction with the process and they assert meetings save money because of a reduced need for placements and services (American Humane Association [AHA], 1998; Burford & Pennell, 1996; Lupton, 1998; Lupton & Stevens, 1998; Merkel-Holguín, Winterfield, Harper, Coburn, & Fluke, 1997). In addition, evaluators report social workers generally indicate a high degree of

satisfaction with the plans developed and feel they keep children safe (Marsh, 1998; Pennell & Burford, 1998). Other gains include a higher agreement with the case plan between social workers and families prior to going into court (Fisher, 1998).

Dissatisfaction with FGDM noted in the literature had to do with inadequate preparation and failure by agencies and family members to carry out the plan (Pennell & Burford, 1998). Pennell and Burford report in their evaluation of 32 Newfoundland families who received FGDM services that the project was least successful in stopping abuse by adolescent children and abuse and neglect in the most chaotic families.

Despite the above claims, even FGDM advocates admit that empirical data is lacking that would allow the examination of whether the claims of FGDM supporters are valid. Most writers say because of the relative “youth” of the intervention, little work has been done on evaluation. The current need is for longitudinal examinations of the model that would focus on both the short- and long-term outcomes in comparison with traditional means of CPS intervention. This research would enable us to determine whether or not FGDM should be more widely utilized and what changes are needed in the current child welfare system to increase its chances for success.

The American Humane Association (1998) provided a review of current initiatives on FGDM in Canada, Sweden, Great Britain, and the United States. A total of eight studies were described, of which four were in progress. Only one study is using randomized clinical trials. Another two are utilizing quasi-experimental designs. Most of the completed evaluations used small samples (40 or fewer treatment cases; Burford & Pennell, 1996; Pennell & Burford, 1998). In one of the published evaluations, it was difficult to determine the effectiveness of the meeting since intensive case management

and wraparound services were provided with no effort to disentangle the separate treatment effects of those interventions. Results from this evaluation were primarily qualitative, and by the authors' description, "anecdotal" (Mills & Usher, 1996). However, results from the evaluations seem to suggest that the approach might be promising. The most substantial evaluation is underway in California (McDonald & Associates, 1998). This evaluation utilizes a larger N (200) than the other evaluations. However, it is using matching rather than random assignment (Bailey, 1997). No results of this evaluation have been published in the literature since it is a work in progress.

The lack of research regarding effectiveness of FGDM concerns many. Richard Gelles (as cited in Shirk, 1999) is quoted as calling the model "...simply one more social work fad. This service is widely touted as effective and has been widely adopted without a shred of scientific evidence that this intervention really works..."

Critics suggest FGDM may create additional safety concerns and emotional trauma for children and adult victims. This vulnerability is particularly evident when preparation is inadequate and when the facilitators do not understand the family's communication patterns or help them put aside family issues that do not directly impact on child safety. This problem could be exacerbated if the worker does not understand or work within the family's culture. Others have criticized the use of the model with the kind of serious cases that have come to dominate CPS caseloads and see the model as an abdication of the professional responsibility to protect the child (Bartholet, as cited in Burford, Pennell, MacLeod, Campbell, & Lyall, 1999). Bartholet also suggests that the child's needs are unrepresented in the process and that FGDM may place children at more risk due to lowered ability by the worker to see that a caretaker utilizes services.

When meetings go wrong there is a greater chance of revictimization. It is the facilitator's responsibility, in collaboration with the family and other community members, to promote safe participation in FGDM. This participation can only happen when the facilitator has adequate time and resources to concentrate on up-front preparation activities.

OVERVIEW OF THE RESEARCH

The research reported on in this paper consists of two studies. The overall purposes of these studies were to: (a) address empirical issues in the literature, (b) describe the meeting process, and (c) identify outcomes of the meetings. Study #1 was a retrospective descriptive case record analysis. Study data were derived from case record review and abstraction of computerized data files at the Health and Human Service Agency (HHSA). The specific aims of the analysis were to: (a) identify factors associated with a family accepting an invitation to a meeting, (b) provide a description of meetings, and (c) identify factors that differentiate between successful and unsuccessful meetings.

Study #2 was a quasi-experimental design utilizing pre- and postintervention measurements. Study data were derived from interviews that occurred in conjunction with the FUM meeting and a follow-up interview that occurred approximately 3 months after the meeting. The interview was conducted with a parent, most likely the biological mother, or a caretaker. The purposes of these interviews were to: (a) gain from the client's perspective what the effect of the Family Unity Meeting was on the family and social network, (b) identify if participants use family resources in problem solving, and (c) determine what their reaction was to services and the meeting.

Study #1 relied on the recording of meeting process and outcome on social workers and other official recorders. Study #2 used the clients to record their perceptions of the meeting.

CONTEXT OF THE RESEARCH

This section describes intervention at the site where data was collected and how the intervention is implemented in San Diego. San Diego County Health and Human Services Agency (formerly Department of Social Services) adopted the Family Unity Meeting concept about 7 years ago. The structure that was implemented is based on the model developed in 1989, in Oregon, by James Nice and Lawrence Graber. The San Diego agency sent two CPS staff up to Oregon to observe meetings. Following their visit, they recommended adoption of the FUM in San Diego. An agency manager quickly became a staunch advocate and lobbied for a specialty unit. In 1995/1996, the Family Unity Meeting Unit was established.

The Principal Investigator, Project Coordinator, and Assistant Project Coordinator observed a total of 10 Family Unity Meetings. The purpose of the observation was to provide a qualitative description of group process, validate model integrity, and give the researchers an understanding of how FUMs were conducted.

Training

HHSA brought James Nice to San Diego to conduct intensive training for select CPS staff. This staff became the pool from which prospective meeting facilitators were drawn. Additionally, HHSA hired a consultant to watch and critique initial meetings. Ongoing training activities consist of a weekly meeting for fulltime facilitators where they discuss and debrief issues such as “what worked well” and “what was a challenge.”

During these meetings, they develop ideas for improving the FUM structure. Additionally, there are monthly forums for unit members, which include speakers and films on facilitation methods. Prospective facilitators are required to watch two or more meetings and then cofacilitate with an experienced facilitator. The meetings are followed by an intensive debriefing session.

Unit Structure

The current unit structure consists of the following:

- 1 fulltime supervisor
- 4 fulltime Protective Services Workers (mix of MSWs and MFTs)
- 1 Social Work Assistant
- 1 Student worker

Phases of the Family Unity Model

This section describes the intervention and is based on observation and literature review.

Preconference Activities

A referral to hold a meeting is received and given to the social worker. The social worker meets with the adult caretakers as well as social workers and other professionals. Activities cover meeting preparation, decisions regarding invitations, safety planning specific to the meeting, and addressing family concerns and expectations about the meeting.

Phase I: Information Gathering

This phase includes the family (nuclear and extended), the social worker, the facilitator, and other professionals. The facilitator begins in ways that are culturally appropriate to the family, reiterates the FUM process and purposes, and reaches

agreement about the meeting's goal and each participant's role. Participants introduce themselves and explain their relationship to the child. During this phase, the worker discusses concerns and court information relevant to the issues specific to the conference with the family. The worker encourages the family to identify strengths that individual members have and that the family possesses as a whole.

The case-carrying social worker presents the facts of the case to all participants. Other professionals share relevant information. The family adds comments and can question the professionals. The professionals do not share opinions or suggest resolutions to difficulties. Sharing of workers' opinions may limit the family in developing their own plan.

Phase II: Private Family Time

San Diego uses the private time approach, which is not usually associated with the FUM. The professionals and other nonfamily members (neighbors, friends, etc.) withdraw, the family discusses the issues presented in Phase I, and then they reach a decision about what is best for the child. Nonfamily members could be invited to remain. A nonparticipant observer can also be present if safety is a concern. To ensure that focus is maintained and that emotionally charged issues do not spiral out of control, the facilitator constantly checks in with the family.

Phase III: Decision Making

The professionals return and the family presents its plan for discussion and final decision making. The facilitator may probe to determine who is doing what and when.

Subsequent Events and Planning After the Meeting

The plan is written, distributed, and implemented. If the family or professionals think it necessary, a follow-up meeting may be called (Fisher, 1998; Merkel-Holguín, 2000a). Most writers suggest that the case-carrying social worker, facilitator, and/or team has a responsibility for monitoring as the family has the responsibility for completing the plan.

PREPARATION AND PLANNING FOR THE MEETING

The literature and available evaluation data suggest adequate preparation and planning are essential to meeting success (Burford & Pennell, 1996; Rockhill & Rodgers, 1999). The facilitator has numerous premeeting activities. The literature gives a range of 21-42 days needed to prepare for a meeting, which could involve anywhere from 5-200 hours of preparation time (Crampton, 1998). Some of the critical activities by Merkel-Holguín (2000a) and Sieppert, Hudson, and Unrau (2000) are:

- Informing parents they have been referred for FUM.
- Ensuring the safety of the child.
- Helping the family decide their own definition of the family.
- Learning about family dynamics and helping families put aside long-standing differences not relevant to the meeting.
- Working with the family to decide who should be invited to the meeting.
- Recruiting family and others in the family's social network to participate.
- Determining whether perpetrators can be safely and constructively involved.
- Clearly defining and communicating participant's role. Preferably, this is done in face-to-face contacts with potential participants.
- Managing unresolved family issues. The facilitator must inform family members before and during the meeting that issues unrelated to child protection will not be discussed.

- Coordinating logistics. Logistics include setting the time, date, and place of the meeting; getting supplies, refreshments, and deciding on seating arrangements; obtaining interpreters if needed; making travel arrangements; and arranging safety plans.

STUDY #1: CASE FILE REVIEW (Slide 1)

Abstract

The sample for Study #1 consisted of all families who were invited to a meeting from March 25, 1999 through January 1, 2002 (N = 747). Data was derived from the review of Family Unity Meeting Health and Human Service Agency (FUM-HHSA) files and the CWS system files. The design was a retrospective case review with an embedded prospective study.

(Slide 2) This study described factors that distinguish between CPS clients who accept an invitation to participate in a Family Unity Meeting (FUM) and those clients who decline to participate. The meeting process was described and an analysis of variables leading to successful outcomes of FUMs is provided.

Logistic regression was used to predict the acceptance of an invitation to participate in a meeting. Families with Reunification as a goal were the most likely to agree to participate followed by Voluntary and Permanency Planning cases. Cases with severe Neglect were the group least likely to participate.

Approximately nine people attended an average meeting. Family member was the largest category in attendance. Maternal relatives were more likely to attend than paternal relatives. The second largest category in attendance was professionals. The average meeting lasted a little more than 3½ hours.

Empirical evidence was found to support the notion that Family Group Decision Making (FGDM) expands the notion of family. Only 38% of children were placed with a parent after a meeting, but 82% of children were placed with a family member. This tendency toward kin placement was most pronounced with Hispanic families. Emotional abuse cases were more likely to be placed with parents than those with other types of abuse. If a maternal grandmother attended the meeting, the child was more likely to be placed with someone other than the biological parent.

Children were not placed with either the parent or family if the social worker had placement as a goal before the meeting. Cases with permanency plans were also less likely to be placed with the family. Social workers were more likely to agree to placement with relatives if they had a concern about parental drug abuse. Families that expressed a concern about physical abuse or had a maternal aunt in attendance at the meeting were more likely to have the child placed with them.

Social workers' and families' concerns diverged. Families were more concerned with economic and financial issues. Social workers were more concerned with child protective service issues (type of abuse, placement issues, etc.) and the behavior of the parent (substance abuse, mental health, etc.). Paying attention to family issues such as finances may be a necessary precursor to allow families to focus on more complex matters such as substance abuse or parenting practices.

Placement outcomes were consistent with workers' goals stated before the meeting. If a social worker said he or she wanted to place a child with the family before the meeting, that placement was the most likely outcome of the meeting. This shows that social workers may be guiding the decisions of the family. If this interpretation is

true, then it raises questions about who makes decisions at the meeting. An alternative conclusion is that the social workers are good diagnosticians who know prior to the meeting what is needed and know what decisions the family will make.

The presence of the child's maternal great-grandmother or grandmother at the meeting predicted placement with someone other than the parent. It is possible that the child was placed with one of these relatives prior to the meeting, and there was no interest in changing placement; or it could mean that if the great-grandmother was at the meeting, the mother was very young. Young maternal age suggested risk to the social worker. The presence of a maternal aunt (the mother's sister) increased the likelihood of family placement. Maternal aunts may be crucial in providing support to children and mothers. Fifty-two percent of families received a new referral for child abuse after the meeting. Twenty-six percent of the families had a substantiated referral. These rates of referrals are consistent with other studies done on San Diego CPS samples, which suggests that FUMs do not elevate risk for children.

Methodology

(Slide 3) The archival data came from official documents prepared for the Dependency Court by HHSA social workers that increased confidence in the accuracy of the data. Furthermore, the quality of the data was augmented by the membership of a former HHSA staff person as part of the research team. The sample for Study #1 consisted of all families who were invited to a meeting from March 25, 1999 through January 1, 2002 (N = 747). Four hundred and thirty-one families who received at least one meeting and 316 families who declined an invitation to participate in a meeting were

included in the sample. Data was derived from the review of Family Unity Meeting-Health and Human Service Agency (FUM-HHSA) files and the CWS system files.

Design, Data Collection, and Sources of Data

(Slide 4) The design was a retrospective case review with an embedded prospective study. This study was descriptive and contained no manipulation of variables. The data were collected during the period of service delivery including the Family Meeting. Data were also collected on prior and postmeeting referral history from the computerized CWS system. Figure 1 provides a list of data collected from the FUM-HHSA files.

Figure 1 Data Collected From FUM-HHSA Files Variable and Measure	
Worker goal for the case Programs (Court Intervention, Family Maintenance, Family Reunification, Intensive Services, Permanency Planning, Voluntary) Referral date Meeting date Accepted (invitation for meeting accepted or rejected) Reason meeting did not occur Family ethnicity Family language Meeting length Number invited to the meeting	Number attended Protective service issues Social worker's recommendation for placement outcomes (child's placement status) Child's age and gender Number and types of people attending meeting Family's psychosocial/behavioral/ problem concerns Social worker psychosocial/behavioral/ problem concerns Family's rating of meetings

(Slide 5) Data in these files described child and caretaker characteristics (parent substance abuse, mental health, physical health, stress, etc.), family dynamics (conflict and communication), type of abuse, and social worker's CPS concerns (physical and

sexual abuse, neglect, inability to protect, noncompliance, abandonment, etc.). Data described the meeting process (number and types of people in attendance, meeting length, etc.). Outcomes (with whom the child is placed after the meeting) were also abstracted from the files. Additional outcome data on whether new referrals occurred was gathered from the CWS system.

The use of archival data always presents validity and reliability concerns. Social work graduate-level research assistants completed the data collection. Abstractors were trained until they had basic knowledge of Child Protective Services, the Dependency Court system, the organization of FUM-HHSA and CWS record files, and skills needed to apply variable definitions for the purpose of data abstraction.

The former HHSA staff person on the research team helped in the clarification of discrepancies in the records, obtaining missing information, and in assisting case abstractors with questions or problems that they had.

Data Analysis

First, a general description of the whole sample was produced with a more detailed description of the study groups. The significance of differences on variables between groups was tested in bivariate analysis of the data. This analysis was carried out in successive cross-tabulations dividing the sample into successive subgroupings as finely as seemed warranted according to differences among study groups.

Analysis then focused on testing explicit relationships. This approach incorporated four types of statistical techniques. Chi-square was used for nominal-level data. Mann-Whitney U was used with ordinal-level variables. T-tests were used with interval-level data. Pearson's r-tests were used to test correlations and the degree of

association among variables. The outcome of this section was to categorize children, caretakers, and families by type of outcome (placed with family members or nonfamily placement). Logistic regression analysis was used to identify study variables that predict accurate classification into outcome type.

Findings

(Slide 6) This section is divided into three parts. The first part (Tables 1-5) includes an identification of factors that distinguish between CPS clients who accept an invitation to participate in a Family Unity Meeting (FUM) and those clients who decline to participate. The second section describes the meeting process, and the final section provides an analysis of variables leading to successful outcomes of FUMs.

**Table 1: Accepting an Invitation to Take Part in a Meeting
Referral Sources for Participants**

Program	Accepted invitation (N = 431)		Declined invitation (N = 316)		Sig.
	Frequency	Percentage	Frequency	Percentage	
Court intervention	116	47.0	131	53.0	NS
Family reunification	163	66.0	84	34.0	.002
IS/IRS	40	50.0	40	50.0	NS
Permanency planning	51	65.4	27	34.6	.109
Family maintenance	33	62.3	20	37.7	NS
Voluntary	38	73.1	14	26.9	.016

(Slide 7) Overall, 58% of clients accepted the invitation and 42% declined. Voluntary cases were the most likely to agree to participate followed by Family Reunification clients. **(Slide 8)** Seventy-three percent of Voluntary clients and 66% of Family Reunification clients who received an invitation agreed to participate.

Permanency Planning cases were also more likely to take part in the meeting (65%) than some of the other programs, but this difference is only approaching significance. Court Intervention and Initial Services/Immediate Response (IS/IRS) cases were the least likely to participate.

Table 2 describes the worker's goal for the family. **(Slide 9)**

Table 2: Worker Goal for Family

Goal	Accepted invitation		Declined invitation		Sig.
	Frequency	Percentage	Frequency	Percentage	
Close case	25	69.4	11	30.6	.157
Family reunification	192	63.4	111	36.6	NS
Visitation	40	62.5	24	37.5	NS
Family maintenance	55	55.0	45	45.0	NS
Relative placement	97	56.4	75	43.6	NS
Other goals	30	53.6	26	46.4	NS

The worker's goal prior to the meeting did not make a significant difference on whether a family accepted or rejected an invitation to participate. Percentage differences would suggest that those families where case closure was a goal were more likely to participate. However, the difference here is not significant. Family Maintenance cases and cases where the worker had "Other Goals" were the least likely to accept an invitation. P-values suggest worker goals are not an important factor in the client's decision to participate in a meeting.

Table 3 shows the ethnicity and language groups of those invited to participate in a meeting. **(Slide 10)**

Table 3: Ethnicity and Language

Ethnicity	Accepted invitation (N = 437)		Declined invitation (N = 94)		Sig.
	Frequency	%	Frequency	%	
White	168	84.0	32	16.0	.624
Asian	23	82.1	5	17.9	.944
African American	74	77.1	22	22.9	.944
Hispanic	128	80.0	32	20.0	.846
Other	43	93.5	3	6.5	.152
Language					
English primary language	363	83.3	73	16.7	.888
Non-English speaking	68	80.0	17	20.0	.813
Spanish primary language	65	82.2	16	17.8	.791

Ethnicity and language spoken in the home did not make a difference on whether a subject agreed to take part in a meeting. However, much data are missing from the “decline to participate” group that limits the ability to speak definitively about the role of ethnicity and language in the decision to take part in a meeting. Ethnic data was missing since FUM workers collected less data on groups who declined to participate than they did with participants.

Table 4 describes the protective service issues that brought potential participants into contact with child protective services. **(Slide 11)**

Table 4: Protective Service Issue

Protective Service Issue	Accepted invitation (N = 384)		Declined invitation (N = 257)		Sig.
	Frequency	%	Frequency	%	
Physical abuse	68	63.6	39	36.4	.224
Sexual abuse	22	55.0	18	45.0	.787
Emotional abuse	13	72.2	5	27.8	.199
General neglect	241	54.9	138	46.6	.017
Severe neglect	34	45.3	41	54.7	.006
No parent or guardian (NPG)	16	50.0	16	50.0	.908
Domestic violence	32	53.3	28	46.7	.883

General neglect cases were more likely than other abuse types to be offered a meeting. Fifty-nine percent of offered meetings went to neglect cases. Sexual abuse cases represented about 7% of cases offered an invitation, which is about 50% of their proportion of child maltreatment cases nationally (United States Department of Health and Human Services, 2001). Neglect cases are proportionally represented according to the national rates of neglect. General and severe neglect cases were the least likely categories to agree to participate. Less than 50% of the severe neglect group accepted an invitation to the meeting.

Table 5 is a logistic regression that predicts among variables previously defined as significant in association with accepting an invitation. **(Slide 12)**

Table 5: Logistic Regression With Accepted/Declined Invitation Dependent

Variable	B	S.E.	Wald	Exp(B)	Sig.
Severe neglect	-.635	.272	5.472	.530	.019
Family reunification	.698	.176	15.768	2.010	.0001
Voluntary	.943	.340	7.694	2.569	.006
General neglect	.135	.165	.671	1.145	.413
Permanency planning	.703	.269	6.837	2.020	.009
Constant	.040	.137	.084	1.041	.771

Significance - $P < .0001$

(Slide 13) The three program variables are still significant in predicting a decision to participate in a meeting. Family Reunification is the strongest predictor followed by Voluntary cases and Permanency Planning. General Neglect as a protective issue is no longer significant when controlled for by other variables. Cases with severe neglect were still the least likely group to participate in a meeting.

(Slide 14) Tables 6-10 are descriptions of the meeting and planning process.

(Slide 15)

Table 6: Meeting Descriptives

Who Attended	Mean	SD	Median	Mode	Range
Number of people invited to attend	8.60	3.13	8.0	7.0	3-20
Professionals at meetings	1.49	.939	1.49	1.0	0-7
Family members	5.63	3.56	5.0	6.0	0-24
Non-family members	1.03	1.57	0.0	0.00	0-11
Children at meeting	.9425	1.23	1.0	0	0-7
Total individuals at the meeting	8.87	3.59	8.0	7	1-24
Meeting length in minutes	214.94	51.15	210.00	240	60-360

Slightly more people attend the meeting than are invited. Possibly family members bring additional people. Almost nine people attended an average meeting. Meetings have between 1 and 24 participants. Family members are the largest category in attendance. A mean of 5.63 family members are reported at a meeting. The second largest category in attendance is professionals (social workers, therapists, probation officers, teachers, clergy, etc.; Mean = 1.49). Nonfamily members include friends and others. The average meeting lasted a little more than 3½ hours. The longest meeting lasted 6 hours and the shortest was 1 hour. Thirty-eight families had two meetings, four families participated in three sessions, and one family had four meetings.

Table 7: Types of Persons in Attendance at Meetings (N = 359) (Slide 16)

Persons attending a FUM	% With the following in attendance
<i>Professionals</i>	
Social workers	96.1
Agency staff	22.5
Clergy	5.7
Probation officer	1.6
<i>Family members in attendance*</i>	
Mother	77.5
Child	52.0
Father	49.4
Maternal grandmother	37.0
Maternal aunt	32.2
Maternal grandfather	19.3
Maternal uncle	18.6
Paternal aunt	17.2
Paternal grandmother	11.5
Paternal great-grandmother	11.5
Paternal uncle	9.0
Paternal grandfather	8.5
Sister	8.3
Brother	8.3
Maternal great-grandmother	6.9

* relationships are to the child or children

The above table reports the individuals who attended a meeting. Not all categories of individuals who attended a meeting are reported. Only categories that attended at least 5% of meetings are reported. The family's social worker was the most likely person to be in attendance at a meeting. The child's mother was in attendance at over three quarters of the meetings and a child and/or father were present at half the meetings. Maternal relatives were more likely to be present than paternal relatives. A maternal grandmother was at 37% of meetings.

Table 8: Reason Meeting Did Not Occur (Slide 17)

Reason	Frequency	Percent
Parent unwilling	127	41.0
Lack of support from other family members	61	19.7
Parent unavailable	42	13.5
Social worker canceled	39	12.6
Lack of resources	29	9.4
Parental substance abuse	7	2.3
Family denial	4	1.3
Domestic violence	1	---

Parent unwillingness is the major reason a meeting does not take place followed by family members' unwillingness.

Table 9 is a recode of family concerns into categories. **(Slide 18)** The table reports the percentage of cases that had at least one concern in a category. For example, CPS concerns were neglect, non-compliance, inability-to-protect, visitation, sexual abuse, physical abuse, placement, etc.

Table 9: Family and Social Worker's Concerns (N = 435)

Concern	% Identified concern by family	% Identified concern by social worker
Parent's substance abuse	38.6	45.7
Family conflict	36.6	34.7
Child behavior	27.5	15.8
Child mental health	22.1	14.0
Financial concerns	21.5	9.2
Poor communication	20.7	19.5
Placement	20.7	19.3
Visitation	15.6	9.7
Domestic violence	14.3	19.6
Parent mental health	12.9	15.6
Neglect	12.6	24.1
Child physical health	11.5	7.4
Child adjusting to reunification	9.4	3.9
Unemployment	8.5	2.1
Stress of children on parents	8.3	7.8
Noncompliance with services	7.8	14.9
Physical abuse	7.4	11.7
Parent's inability to protect	7.1	13.8
Parent's physical health	3.7	2.8
Child's substance abuse	3.7	3.7
Sexual abuse	3.4	6.0
Dirty house	2.5	6.7
Parent's undermining placement	2.3	2.3
Abandonment	1.8	3.4

Social workers identify more concerns than the family. For example, social workers identify domestic violence in 19.6% of cases, but only 14.3% of families have it as a concern. Both social workers and families agree that substance abuses by a parent and family conflict should be the major concerns, but they differ in that social workers saw substance abuse as a concern in more families than the families did. Families are more likely to say child behavior, child mental health, child health, unemployment, and financial concerns were issues to be dealt with. Social workers were more likely to say

neglect, noncompliance, inability to protect, and physical abuse were concerns. Table 10 is a recode of family concerns into categories. **(Slide 19)**

Table 10: Social Worker and Family Concerns Recoded (N = 429)

Concern	% At least one concern identified by family in category (N = 429)	% At least one concern identified by social worker in category (N = 429)
CPS	51.4	63.7
Family dynamics	52.1	46.5
Economics	26.0	10.0
Parent	47.9	65.1
Child	52.6	24.2
	Mean (SD)	Mean (SD)
Total family concerns	2.837 (1.60)	3.07 (1.93)

Social workers had more CPS concerns (physical and sexual abuse, neglect, inability to protect, noncompliance, abandonment, etc.) than the family had, and also more parent concerns (parent substance abuse, mental health, physical health, stress, etc.). Families were more concerned about the child (mental and physical health, adjustment to reunification, etc.), and family dynamics (conflict and communication). Over one quarter of parents were concerned about finances; only 10% of social workers shared that concern. Participants could be described as multiproblem families since they had a mean of about three concerns.

The next series, Tables 11-17, examines outcomes of meetings and seeks to identify factors that lead to successful outcomes. Outcomes are based on public policy notions of success in child welfare as well as the underlying premises of FUM. Both policy and FUM practice support the family as the most appropriate source of caregiving

for children. **(Slide 20)** Cases were defined as successful if the child is with the parents as an outcome of a meeting, and is at least partially successful if at the end of the meeting other relatives take responsibility for the child if the parent cannot. Cases would be regarded as unsuccessful if the child moves to or stays in out-of-home care. **(Slide 21)** Overall, 36.8% of cases were placed with parents.

Table 11: Ethnicity and Placement With Parents or Not (N = 424) (Slide 22)

Ethnic Group	% Placed with parents (N = 157)	% Not placed with parents (N = 267)	Sig.
Hispanic (N = 124)	27.4	72.6	.005
White (N = 163)	44.2	55.8	.011
Asian (N = 22)	22.8	77.2	.113
African American (N = 70)	34.3	65.7	.383
Language			
Spanish speaking	23.4	76.6	.008
Non-Spanish speaking	41.8	58.2	.012

The Hispanic and Asian families are the groups least likely to have the child placed with parents, but the difference with Asians only approaches significance. Spanish-speaking parents were not as likely as speakers of other languages to have their children placed with them after a meeting. Hispanics are the group that is least likely to have a child placed with a parent after a meeting. Missing data on families was not a problem as it was with the group who declined to take part in a meeting (see discussion following Table 3). Workers collected a full set of data on families that had meetings.

Table 12: Program and Placement With Parents or Not (N = 424) (Slide 23)

Program	% Placed with parents (N = 157)		% Not placed with parents (N = 267)		Sig.
	Frequency	Percentage	Frequency	Percentage	
Court intervention	23	21.3	85	78.7	.0001
Family reunification	47	31.1	104	68.9	.0001
IS/IRS	23	59.0	16	41.0	.002
Permanency planning	12	23.5	39	76.5	.001
Family maintenance	21	75.0	7	25.9	.0001
Voluntary	25	36.4	12	63.6	.0001

Court Intervention and Permanency Planning cases were least likely to have a child placed with the parent after a meeting. Family Maintenance and Immediate Services (IS/IRS) cases were most likely to have a child placed with the parents after the meeting. All programs were significant with where the child was placed leading to the conclusion that program type was important in determining child placement.

Table 13: Worker Goal for Family and Placement With Parents or Not (N = 424) (Slide 24)

Goal	% Placed with parents (N = 157)		% Not placed with parents (N = 267)		Sig.
	Frequency	Percentage	Frequency	Percentage	
Close case	17	73.9	6	26.1	.0001
Family reunification	36	69.2	16	30.8	.0001
Visitation	15	39.5	23	60.5	.700
Family maintenance	36	25.2	107	74.8	.001
Relative or parent placement	123	91.1	12	.089	.0001

Workers provided a goal for the meeting. The children most likely to be placed with the parent were those whose social workers had one of the following goals: placement (91.1%), to close the case (73.9%), or family reunification (69.2%). Family maintenance (25.2%) as a worker's goal was the least likely to result in a child's placement with parents.

Table 14 describes attendance patterns at meetings and how they affect the placement decision.

**Table 14: Attendance at a Meeting and Placement With Parents or Not (N = 424)
(Slide 25)**

# in category attending	% Placed with parents (N = 157)		% Not placed with parents (N = 267)		Sig.
	Mean	Standard deviation	Mean	Standard deviation	
Family	5.27	3.57	5.88	3.54	.093
Nonfamily members	.85	1.19	1.10	1.75	.105
Professionals	1.59	.990	1.44	.90	.121
Total	6.92	3.38	7.58	3.60	.071
Specific persons	Frequency	Percentage	Frequency	Percentage	
Mother	132	40.9	191	59.1	.0001
Father	90	43.9	115	56.6	.002
Maternal grandmother	45	29.6	107	70.4	.016
Maternal great-grandmother	2	6.9	27	93.1	.0001

Among specific persons in attendance at a meeting, only those that had significant p-values are reported. None of the categories of types of persons achieves significance but the p-values on all indicate a trend. The trend values indicate that the more people attend a meeting, the more likely a child is going to be placed with the parent. However, placement with parents was more likely to occur if professionals and nonfamily members attended than if a large number of family members attended. If mothers and fathers attend a meeting, it is more likely that they will have the child placed with them. The likelihood of a child's placement with the parent is reduced if either the maternal grandmother or great-grandparent attends. Twenty-nine had a great-grandmother in attendance, only two meetings resulted in the child being placed with the parent.

**Table 15: Protective Service Issue and Placement With Parents or Not (N = 424)
(Slide 26)**

Issue	% Placed with parents (N = 157)		% Not placed with parents (N = 267)		Sig.
	Frequency	Percentage	Frequency	Percentage	
Physical abuse	24	39.3	37	60.7	.757
Sexual abuse	7	35.0	20	65.0	.659
Emotional abuse	8	66.7	4	33.3	.029
General neglect	87	37.2	147	62.8	.346
Severe neglect	9	30.0	21	70.0	.302
No parent/guardian	3	20.0	12	80.0	.141
Domestic violence	9	30.0	21	70.0	.302

The protective service issue does not seem important in determining outcome. Only emotional abuse is significant. In the relatively few cases with emotional abuse (N = 12) over two thirds of the children were placed with a parent.

Table 16 describes social worker and family concerns as they existed prior to the meeting and how they affected placement. **(Slide 27)**

Table 16: Social Worker and Family Concerns and Placement With Parents or Not

Family Concerns	% Placed with parents (N = 153)		% Not placed with parents (N = 265)		Sig.
	Frequency	Percentage	Frequency	Percentage	
Placement	14	16.5	71	83.5	.0001
Child mental health	26	28.0	67	72.0	.030
Non-compliance with services	7	22.6	24	77.4	.065
Dirty house	6	60.0	4	40.0	.112
Parent undermining placement	1	10.0	9	90.0	.069
Family dynamics	87	39.7	132	60.3	.063
Social Workers Concerns					
Noncompliance with services	14	23.0	47	77.0	.065
Unemployment	6	33.7	3	66.3	.064
Placement	14	17.5	66	82.5	.0001
Child protective issues					
0	63	41.4	89	58.6	
1	61	39.9	92	60.1	
2	22	28.9	54	71.1	
3	7	18.9	30	81.1	
Total	153	36.6	265	63.4	.027

Only significant items or those concerns that approached significance are reported. Family concerns about placement and child mental health were more likely to occur in cases where the child was not placed with parents. No other concerns were significant with the placement concerns. Families who had social workers who indicated that they had concerns about placement, noncompliance with services, and more than one child protective service issues were more likely to have their child placed with other than the biological parent.

Table 17: Logisitic Regression With Placement With Parents or Not Dependent (N = 350) (Slide 28)

Variable	B	S.E.	Wald	Exp(B)	Sig.
Hispanic	-.567	.359	2.497	.567	.114
Family maintenance	.445	.816	.298	1.561	.585
Family reunification	-.826	.644	1.645	.438	.200
Permanency planning	.172	.742	.054	1.187	.817
Voluntary	.813	.780	1.087	2.254	.297
Court intervention	-.636	.635	.887	.529	.346
Maintenance as a goal	.252	.563	.201	1.287	.654
Placement as a goal	-1.169	.434	7.239	.311	.007
Closing case as a goal	.291	.675	.378	1.478	.538
Father at meeting	.330	.262	1.586	1.391	.208
Maternal great-grandmother at meeting	-1.628	.805	4.090	.196	.043
# of Nonfamily members at the meeting	-.067	.104	.490	.935	.522
Family concern: Child mental health	.054	.388	.019	1.055	.890
Family concern: Placement	-.767	.437	3.085	.464	.079
Family concern: Undermining placement	-2.016	1.439	1.969	.133	.161
Emotional abuse	1.696	.850	3.983	5.452	.046
Social worker recommendation for placement	-1.424	.233	37.402	.241	.0001
Constant	2.670	.746	12.808	.000	14.411

* All variables except # of Nonfamily Members at the meeting coded 1 = yes, 0 = no. NFM is a continuous variable.

Significance - P<.0001

After a test for multicollinearity, variables that were found to be previously significant or near significant in predicting whether a child was placed with their biological parents and not highly correlated with one another were placed in a logistic regression. Four variables are still significant. **(Slide 29)** The directions of the coefficients indicated that cases where the social worker had placement as a goal before the meeting were cases where children were not placed with parents. **(Slide 30)** Emotional abuse cases were more likely than other types of abuse to be placed with parents. If a maternal grandmother attended the meeting, the child was more likely to be placed with someone other than the biological parent. Two other variables approach

significance in the regression. Hispanics and families with placement as a concern had p-values that indicated trends toward the placement of the child with other than parents.

Tables 18-24 describe factors that predict a child's placement with parents or relatives.

**Table 18: Ethnicity and Placement With Parents or Relatives or Not (N = 428)
(Slide 31)**

Group	% Placed with family (N = 350)	% Not placed with family (N = 78)	Sig.
Hispanic (N = 124)	79.5	20.5	.211
White (N = 163)	84.7	15.3	.123
Asian (N = 22)	57.6	42.4	.005
African American (N = 70)	84.1	15.9	.406

(Slide 32) Overall, 82% of children were placed with their extended family. Hispanic children who had been less likely to be placed with their parents than other children were just as likely as Whites and African Americans to be placed with family. Asian children were placed with their families in fewer instances than were other children. However, the sample of Asian children was quite small (N = 22). The language of the parent did not make a difference where a child was placed.

Table 19: Program Issues and Placement With Parents or Relatives (Slide 33)

Program	% Placed with family (N = 350)		% Not placed with family (N = 78)		Sig.
	Frequency	Percentage	Frequency	Percentage	
Court intervention	86	84.3	16	15.7	.305
Family reunification	126	83.4	25	16.6	.345
IS/IRS	34	89.5	4	10.5	.153
Permanency planning	29	56.9	22	43.1	.0001
Family maintenance	27	93.1	2	6.9	.080
Voluntary	33	89.2	4	10.8	.171

Program, which had been important in predicting the placement with parents, is diminished somewhat. Permanency planning cases were significantly less likely than other programs to have their children placed with family. Family maintenance cases were the most likely cases to have a family placement after the meeting. No other program is significant in predicting family placement.

The next table examines the effect of workers' goals on placement.

**Table 20: Worker Goal for Family and Placement With Parents or Relatives
(N = 424) (Slide 34)**

Goal	% Placed with family (N = 157)		% Not placed with family (N = 267)		Sig.
	Frequency	%	Frequency	%	
Close case	22	88.0	3	12.0	.310
Family reunification	47	94.0	3	6.0	.018
Visitation	31	81.6	7	18.4	.413
Family maintenance	47	50.0	47	50.0	.023
Relative or parent placement	47	94.0	3	6.0	.010
Social worker's recommendation before meeting for placement with family	154	92.2	13	7.8	.000 1

The social worker's recommendations and goals for placement prior to the meeting were the most important factors in predicting family placement. Families where the goal was maintenance were the least likely cases to have the child placed with them. **(Slide 35)**

Table 21: Attendance at Meeting and Placement With Parents or Relatives

# And % in category attending	% Placed with family (N = 350)		% Not placed with family (N = 78)		Sig.
	Mean	Standard Deviation	Mean	Standard Deviation	
Family	5.26	3.56	5.91	3.58	.068
Nonfamily members	.823	1.19	1.10	1.175	.074
Children	1.11	1.31	.870	1.19	.057
Professionals	1.57	1.04	1.04	.896	.133
Total	6.87	3.37	7.60	3.62	.048

Specific Persons	Frequency	Percentage	Frequency	Percentage	Sig.
Mother	180	81.8	78	18.2	.038
Father	180	85.7	30	14.3	.025
Foster parent	5	29.4	12	70.6	.0001
Maternal friend	50	70.4	21	29.6	.0007
Others	58	72.5	22	27.5	.016
Social worker	330	80.9	78	18.2	.016
Maternal aunt	123	88.9	15	10.9	.004
Uncle	39	88.6	5	11.4	.148

Only types and specific persons in attendance at the meeting who are significant are reported. Maternal aunts, mothers, social workers, and maternal friend, if in attendance, predict family placement, in that order. The presence of a foster parent at the meeting drastically reduces the chance of family placement.

The only child protective service issue that predicted placement with family was “No parent or guardian.”

Table 22 examines the effect of family and social worker concerns on placement.

(Slide 36)

Table 22: Social Worker and Family Concerns and Placement With Family

Concern	% Placed with parents or relatives (N = 350)		% Not placed with parents or relatives (N = 78)		Sig.
	Frequency	Percentage	Frequency	Percentage	
Family concerns					
Family conflict	138	86.8.	21	13.2	.042
Neglect	52	92.9	4	7.1	.021
Parent's inability to protect	22	71.0	9	29.0	.038
Placement	61	70.9	25	61.1	.004
Physical abuse	32	97.0	1	3.0	.009
Child's substance abuse	10	62.5	6	37.5	.042
Social worker concerns					
Parent's substance abuse	168	86.2	27	13.8	.029
Placement	57	71.3	23	28.8	.007
Abandonment	10	66.7	5	33.3	.123
# of Social worker's concerns about the child					
0	269	82.8	56	17.2	
1	68	82.9	14	17.1	
2	11	61.1	7	38.9	
3	1	50.0	1	50.0	.079

Family concerns seem to predominate in the decision about where the child will be placed. Families that had concerns about protective service issues (physical abuse, neglect, inability to protect, and placement) were the most likely to have a child placed with them. These concerns more closely mirror the social worker's concerns expressed in Table 9. Children were least likely to be placed with the parent if there were concerns about substance abuse. Social worker concerns about parental substance abuse were associated with placement with relatives. The least likely situation where children were not placed with relatives was if there was a social worker concern about placement.

After a test for multicollinearity variables that were found to be previously significant or near significant in predicting whether a child was placed with family and

were highly correlated with one another were placed in a logistic regression. The results are reported in Table 23. **(Slide 37)**

Table 23: Logisitic Regression With Placement With Parents or Relatives Dependent (N = 350)

Variable	B	S.E.	Wald	Exp(B)	Sig.
# of Family members at meeting	-.115	.206	.311	.892	.577
# of Nonfamily members at meeting	-.126	.105	1.449	.882	.229
# of Professionals at meeting	2.546	36.868	.005	12.756	.945
Maternal aunt at meeting	1.064	.475	5.018	2.897	.025
Social worker at meeting	-7.990	32.558	5.018	.000	.806
Permanency planning	-1.191	.394	9.146	.304	.002
Worker goal of reunification	.417	.673	.384	1.518	.535
SW recommendation for placement ¹	-.694	.124	31.375	.500	.0001
SW concern re: child mental health	-.143	.439	.106	.867	.745
SW concern re: child substance abuse	-.608	.648	.878	.545	.345
SW concern re: parent substance abuse	.929	.336	7.666	2.533	.006
Family concern about family conflict	.365	.338	1.163	1.440	.281
Family concern about neglect	.866	.593	2.133	2.377	.144
Family concern about physical abuse	1.772	1.100	2.596	5.885	.006
NPG	-.019	.767	.001	.981	.980
Constant	8.135	17.300	.221	3413.1	.638

* all variables except: # of family members at meeting, # of nonfamily members at meeting, and # of professionals at meeting are coded 1 = yes, 0 = no. Other variables are continuous

¹ SW = Social Worker

Significance. P<.0001

(Slide 38) Five variables are still significant. The directions of the coefficients indicate if the social worker had placement as a goal before the meeting and recommended placement, then children were not placed with family. Cases from permanency planning were also not placed with family. Social workers were still more likely to agree to a placement with relatives if they had a concern about parental drug abuse. The final area of examination was whether or not there was a new referral after the meeting. Families that expressed a concern about physical abuse or had a maternal

aunt in attendance were more likely than families without those concerns to have the child placed with them.

The cases were selected at random. No data could be found on 30 of those cases. The CWS system was examined to identify if a new referral for child maltreatment was received. Table 24 shows those results. **(Slide 39)**

Table 24: New Referrals After FUM

	Frequency	Percent
No referral	68	48
Referral	74	52
Unsubstantiated	24	17
Inconclusive	13	9
Substantiated	37	26

Slightly more than one half of cases received a new referral for maltreatment, but only 26% of families received a substantiated referral. New referrals were received on average 13.39 (sd = 12.3) months after the meeting. A study of San Diego CPS found that 9 months after reunification with their family, 35.1% had a new referral (Davis et al., 1995). The comparable rate in this sample after 9 months was 36.2%. Another study conducted in San Diego that examined differences in voluntary and court ordered cases found that 42% of children living with their parents received a new referral within 6 months of case closure (Jones, Becker, & Falk, 1999). The comparable rate of referrals in the FUM sample was 27%.

Discussion

(Slide 40) The majority of families that were approached about participating agreed to take part in a FUM. Severely disorganized families, those charged with

severe neglect, were most likely to decline an invitation. These families may feel too overwhelmed to take part in a meeting. Voluntary cases, family reunification (FR) cases, and permanency planning (PP) cases were the most likely families to participate. It is not surprising that voluntary recipients of CPS would be more open to taking part in a meeting than involuntary cases who might regard the invitation to participate as an additional unwanted imposition by the agency. The FR and PP cases would seem to be good candidates for FUM intervention since their program philosophy with its emphasis on the family agrees well with the FUM philosophy. However, PP cases were the least likely cases among program types to have a child placed with the family.

FUM participants came largely from multiproblem families. Sexual abuse cases and domestic violence cases were less likely than other cases to be invited to a meeting. However, the outcome variables used in this study suggests FUM provides as much benefit, at least in terms of placement, for these families as it does for other types of abuse. Greater use of FUM with these cases is warranted.

(Slide 41) Maternal family members were more likely to participate in a meeting than paternal family members. There are a number of possible reasons for differences in participation. First, children are more likely to be placed with the mother or maternal relatives and the social worker has more contact with those relatives. The attendance differential may reflect social workers' bias that fathers are less important to the child than mothers. Social workers may not be making the outreach effort to these paternal family members. The social workers may pay more attention to maternal relatives since the mother is more likely to have the child. More effort might be made to involve

paternal family members since they may be an untapped source of support for the children in CPS.

(Slide 41) Social worker and family concerns diverged. Family concerns in many instances seemed more basic. Families were more concerned with economic and financial issues. Social workers were more concerned with child protective service issues (type of abuse, placement issues, etc.) and the behavior of the parent (substance abuse, mental health, etc.). Perhaps part of this divergence has to do with the roles that families and social workers have. Social workers are charged with protecting the child and behavior of the parent is a risk to the child. Families may have an interest in another set of issues. These family issues may underpin the abusive behavior. Paying attention to family needs, such as finances, may be a necessary precursor to allow families to focus on more complex matters such as substance abuse or parenting practices. Interestingly, 52% of families expressed a concern about the child. Only 24% of social workers indicated a concern about the child. Possibly the difference in concerns was that social workers were more likely focused on the parent because they believe that improving parental behavior will reduce child problems. Therefore, social workers are more interested in parental behavior. The family concern about the child would seem to undercut Bartholet's (Burford et al., 1999) assertion that the model overlooks children in favor of parent needs. Families who expressed concerns about physical abuse were more likely to have children placed with them. Perhaps social workers were reassured about attention paid to CPS issues. Social worker concerns about parental drug abuse also increased the likelihood of placement

with family. This finding may be an indicator of the intractable problem that substance abuse has for child welfare.

(Slide 42) Empirical evidence was found to support the idea that FGDM expands the notion of family. Only 38% of children were placed with a parent after a meeting, but 82% of children were placed with a family member. FGDM facilitates kinship placement, a goal of child welfare for some time. This tendency toward kin placement was most pronounced with Hispanic families. Hispanic children were less likely to be placed with a parent after a meeting than White or African American children; however, differences between those groups in terms of placement disappear when relative placements are considered. The use of relatives as placement resources is consistent with Hispanic notions of family.

Asian children were less likely to be placed with parents or relatives than other children. However, caution should be taken in drawing conclusions from this data since the sample of Asian children was small. It may be that since many of these children were immigrants, relatives were not available. Parents may have immigrated without extended families members. The data suggests Asian families received less benefit from FUMs. More research on the Asian experience with CPS intervention is needed.

Placement outcomes were consistent with worker's goals stated before the meeting. If a social worker said he or she wanted to place a child with the family before the meeting, that placement was the most likely outcome. A number of possibilities might explain this finding. Social workers may be guiding family decisions. If this interpretation is true then it raises questions about who makes decisions at the meeting.

An alternative conclusion is that social workers are good diagnosticians who know prior to the meeting what is needed, and how the family will decide.

(Slide 43) The type of person who attended a meeting also predicted outcome. The presence of the child's maternal great-grandmother or grandmother at the meeting predicted placement with other than the parent. It is possible that the child was placed with one of these relatives prior to the meeting and there was no interest in changing placement or it could mean that if the great-grandmother was at the meeting the mother was very young, which suggested risk to the social worker. The presence of a maternal aunt (the mother's sister) increased the likelihood of family placement. Maternal aunts may be crucial in providing support to children and mothers. Research into the bonds between aunts and children and the mother-sibling bond might help us better understand this relationship.

(Slide 44) If a social worker stated a concern about parental substance abuse prior to the meeting, the child was more likely to be placed with the parent. If the family stated a concern about physical abuse, then the child was more likely to be placed with the family.

(Slide 45) Fifty-two percent of families received a new referral for child abuse after the meeting. Twenty-six percent of the families had a substantiated referral. These rates of referrals are consistent with other studies done on San Diego CPS samples, which suggest that Family Unity Meetings do not elevate risk for children.

(Slides 46, 47, 48, 49, 50, 51, 52)

STUDY #2: PARTICIPANT PERSPECTIVES AND PERCEIVED GAINS (Slide 53)

Abstract

(Slide 54) The sample for Study #2 consisted of 28 families who volunteered to participate in both pre- and posttest interviews. Three different means of data collection were used (interviews, observations, and reviews of telephone interview data conducted by HHSA staff). (Slide 55, Slide 56)

(Slide 57) The following measures were administered by graduate students to parents or caretakers who took part in FUMs: (Slide 58) (a) the *Family Environment Scale* (FES) provides a measure of the family environment; (b) the *Family Support Scale* (FSS) measures how helpful different sources of support are to a family in providing emotional support, help, and advice; (c) the *Parent Outcome Interview (POI)*, a standardized measure designed for use with protective service clients, assesses satisfaction with services and the degree that services helped alleviate the problem that brought the client into contact with CPS; (d) the *Center for Epidemiological Studies—Depression (CESD)* is a short self-report scale that measures depressive symptoms in the general population; and (e) the *Maternal Social Support Index* (MSSI) measures a parent's perceived social support from inside and outside the family. Two measures developed and administered by FUM-HHSA staff or completed by participants were also included in this analysis. These measures assessed parents, caretakers, and social workers' perceptions of the degree of family change and satisfaction with the meeting. The sample was ethnically diverse. Only 25% reported that they were currently married. The modal number of children living with the interviewee was one, but the range of children in the families that had FUMs was 1-10. About three quarters of the sample had

a high school diploma or GED. Approximately one half of the sample was employed. Subjects reported a mean income of about \$17,000 a year with a range of earnings from no income to \$40,000. The average age of the interviewees was 35.4 years, with a range of 18 to 74 years.

One pattern that emerges from the data is that caretakers are more critical of the meeting than either the parent or social worker. More than 60% of the social workers and parents said the placement goal for the meeting was accomplished compared to 50% of the caretakers. Over 80% of all three groups said they would recommend the FUM to others with 93% of social workers supporting the recommendation.

Parents and caretakers were more likely than social workers to say the plan developed at the meeting was carried out. Only 5% of FUM participants thought the effect of the meeting was negative on the family or child. More than 80% of social workers and parents and 60% of caretakers thought the meeting's effect was positive.

The benefits identified by participants were modest. No changes were observed in the family environment or in the amount of depressive symptoms expressed by the parent or caretaker after the intervention. Nevertheless, most respondents said the effect of the FUM on the family and children was positive. Also, some evidence was found to indicate that respondents were more likely to receive help and advice from extended family members. This increase in the use of help and advice seemed to replace advice and help formerly provided by neighbors. Perhaps over the long run the family support provided will be more permanent since neighbors can be transient in a person's life. At postintervention, respondents reported clergy to be a more likely source of advice, help, and emotional support than they had been at the pretest.

Respondents also reported a rise in the number of emotionally supportive persons and an increase in organizational involvement posttest than they had at pretest. This finding is only at a level that indicates a trend ($p < .077$). However, there is no change in either the overall amount or satisfaction with the social support received. It may be too much to ask from what is basically a one-shot intervention that the family environment or the parent/caretaker's mental health would improve.

Seventy-one percent of respondents reported that the family situation improved after the FUM. Only 11% said things were worse. Forty percent of people who said things had improved said the change would not have occurred without the meeting. Eighty-nine percent of respondents said they were at least satisfied with the FUM. This level of satisfaction was higher than the satisfaction reported for the services received from HHSA in general.

Methodology (Slide 59)

The sample for Study #2 consisted of 28 families who volunteered to participate in both a pre- and posttest interview. Because of budgetary considerations, only English-speaking families were recruited for the sample.

Data Collection

Three different means of data collection were used in Study #2 (interviews, observations, and reviews of telephone interview data conducted by HHSA staff). Graduate-level social work students who were trained in the use of study instruments and protocols conducted the interviews. As part of their educational program, the interviewers became skilled in interviewing in high-risk situations. Interviews were

conducted in the respondent's home. If the parent did not wish to be interviewed at home, the interview was completed at a place of the parent's choice.

We also report data analyzed by the research staff that came from two consumer satisfaction surveys developed by HHSA staff. One of these measures was self-administered by a participant after the meeting. The other measure was a phone survey administered by FUM staff to parents, caretakers, and social workers several months after the meeting. This measure gathered data about the respondent's perceptions on outcomes of the meeting.

Measures

Graduate students administered the following measures to parents or caretakers who took part in a FUM. If two caretaking parents attended a meeting, one was chosen at random to complete the instruments. In most cases, the biological mother was the informant. The following instruments were used:

- The *Family Environment Scale* (FES) provided a measure of the family environment for the parent and child (Moos et al., 1974). Four relationship subscales were used to measure environment: cohesion, conflict, expressiveness, and mental health. The cohesion subscale assesses the degree of commitment, help, and support family members give one another and how close members feel to one another. The subscale had excellent reliability with this sample. The expressiveness subscale measures how comfortable members feel about talking about feelings and problems with one another. The scale had poor reliability with this sample. The conflict subscale gathers data about the amount of fighting that goes on in the household. The reliability of this subscale was very good with this sample. The mental health subscale asked respondents to report on various mental health and behavioral traits of members that might stress the family environment. The reliability was excellent with this sample. It is assumed that participation in a FUM will make the family more cohesive, more expressive, less conflict ridden, and have fewer mental health symptoms. This measure was administered at baseline and 3 months postservices to assess the change in the families' supportiveness. The reported reliability is high.

- The *Family Support Scale (FSS)* measures how helpful different sources of support are to a family in providing emotional support, help, and advice on a 5-point scale. Its reliability has been measured at .79 to .91 (Dunst, Trivette, & Deal, 1994). This scale was given at pretest and posttest. The reliability for this subscale was low but useable. It is assumed that the family experience with FUM will lead to an increase in the use of social support, particularly family sources of support.
- The *Parent Outcome Interview (POI)*, developed by the Child Welfare League of America, was given at posttest. This standardized measure is designed for use with protective service clients to assess their satisfaction with services and to assess the degree that services helped alleviate the problem that brought them into contact with CPS. The instrument collects data on the precipitating referral, rating of problem change, living conditions, childcare, child behavioral problems, parental coping, and satisfaction/dissatisfaction with the agency (Magura & Moses, 1986).
- The *Center for Epidemiological Studies—Depression (CESD)* is a short self-report scale designed to measure depressive symptoms in the general population that agrees quite well with other measures of depression. The *CESD* is a highly reliable scale that is widely used in behavioral research. Social support has been shown to moderate depressive systems. This scale enabled us to assess mental health benefits of FUM participation for parents and caretakers (Eaton, 2001).
- The *Maternal Social Support Index (MSSI)* measures a parent's perceived social support from inside and outside the family. The *MSSI* has an alpha coefficient of .72 (Pascoe, Ialongo, Horn, Reinhart, & Berradatto, 1988). These last 2 scales were given as pre- and posttests and assessed the degree of change in the families' use of social support after the Family Conferences.
- Two measures developed and administered by FUM-HHSA staff or completed by participants were also included in this analysis. These measures assessed parents, caretakers, and social workers' perceptions of the degree of family change and satisfaction with the meeting.
- Demographic and informational questions were also included on the research instrument that was administered by the research staff.

Subjects and Procedures

Table 25 describes the process by which someone was enrolled in the research.

Table 25: Case Flow

	Frequency	Percentage
# of Scheduled meetings	240	---
Referrals	115	48
Declined	8	7*
Judged inappropriate for study	13	11*
Unable to locate for first interview	24	21*
Referral arrived too late for pretest	8	7*
No meeting	5	4*
Unknown	5	4*
Completed first Interviews	52	45*
Reason second interview not completed		% of interviews
Unable to locate or incarcerated	10	21
Refused	8	15
Judged inappropriate	4	8
Incarcerated/Institutionalized	2	2
Completed second interviews	52	54**

* Percentage of referrals

** Percentage of interviews. Does not include interviews where no meeting was held or subject was deemed inappropriate for the research.

During the period of data collection (October 25, 2000 to March 25, 2002), a total of 240 meetings were scheduled. An ongoing problem that FUM-HHSA had was getting social workers to refer families to the FUM unit. This referral number excludes Spanish- speaking and North County meetings. North County meetings were excluded because of time and distance factors. We received 115 referrals during the period. Eight families declined to take part in the research after they were contacted and requirements of the research were explained to them. The research team judged 13 referrals to be inappropriate for the research. These subjects reported they intended to leave the county, were impaired at the initial interview, or had an obvious mental health problem that interfered with completing the interview. Three subjects were incarcerated or in drug treatment facilities at the time of the referral and no attempt was made to

interview them. The research team also had difficulty locating potential subjects for both the pre- and postinterview. CPS populations have frequent moves and FUM-HHSA workers were often unable to provide current addresses or phone numbers. Even when we had a valid number, some potential participants would not return calls to schedule interviews. Five subjects who had an initial interview did not have a meeting, and therefore their data was not included in analysis.

The research team was able to enroll a relatively small sample of 52. Twenty-eight subjects were reinterviewed at follow-up. We had problems locating 10 subjects. Eight subjects refused to take part in the posttest. FUM-HHSA staff presented the idea of taking part in the research to FUM participants as part of the intake process. A problem that limited recruitment of the sample was that FUM-HHSA workers would routinely “forget” to raise the issue of the research with potential subjects. Originally, the agency had allowed us to approach the family without the intervention of FUM staff. However, a change occurred in the FUM administrative staff and the new administrator thought that FUM staff had to make the initial contact for confidentiality reasons. FUM workers were provided with an announcement of the study and a signed release to give clients. This release gave the research staff permission to contact the potential research subject. If the client signed the release, a referral was sent to the research staff.

Research staff mailed a cover letter and the announcement when we received the referral. The assistant project coordinator or a research assistant contacted potential study families to assess their interest in participating and to administer the informed consent. If they wished to participate, a baseline interview was scheduled in their home at their convenience. Potential participants were given the opportunity to question the

assistant project coordinator and, if necessary, the principal investigator, about their concerns. Follow-ups were done on respondents until there was a resolution (refusal or agreement to participate). Participation was voluntary; participants received monetary compensation (\$20) for each interview. All project staff signed a confidentiality agreement. Subjects will be identified in the database by a unique identifier. Names of subjects were kept in separate databases. The database and completed interview schedules are kept in a locked office on a nonnetworked computer. This project received approval from the SDSU Internal Review Board Committee on the Protection of Human Subjects.

Methods of Analysis

A number of statistical techniques were used to analyze the data gathered in this study. Simple statistics were used for descriptions. Subjects were used as their own controls. Paired sample T-tests were used to test differences between the FES, FSS, CESD, MSI, POI, and PSI at the baseline and after intervention. Multivariate analysis was considered to identify factors that predict success or failure with the use of FUM.

Findings

Table 26 describes the interview sample.

Table 26: Description of the Sample (N = 28) (Slide 60, Slide 61, Slide 62)

	Frequency	Percentage
Person interviewed relationship to the child		
Mother	23	82
Father	2	7
Grandmother	3	11
Ethnicity		
White	9	32
Hispanic	7	25
African American	10	36
American Indian	2	7
Marital status		
Currently married	7	25
Ever married	17	61
Number of children living with them		
1	12	43
2	7	25
3	4	14
4	3	11
5 >	2	7
Education: Highest degree earned		
High school diploma	15	53
GED	4	14
Associates	2	7
Employment		
Employed fulltime	7	25
Employed parttime	7	25
Unemployed and looking for work	7	25
Keeping house	6	21
Retired	1	4
Spouse or partner employed	13	46
Housing situation		
Rent	17	60
Home owner	7	25
Live in home of someone else	4	15
	Mean	SD
Age	35.4	11.75
Annual income	\$17,091.10	\$12,860.00

The biological mother was the person most likely to be interviewed. The ethnically diverse group was made up of White, Hispanic, and African American families. Only 25% reported that they were currently married. The modal number of children living with the interviewee was 1, but subjects reported a range of children from

1-10. About three quarters of the sample had a high school diploma or GED. No college graduates were in the sample. About one half of the sample was employed. Subjects reported a mean income of about \$17,000 a year with a range of earnings from no income to \$40,000. Most participants were renters. Only 25% of participants owned their own home. The sample, like most research samples involving CPS clients, was low-income.

The average age of the interviewees was 35.4 years with a range of 18-74 years. Table 27 describes reasons the interviewee participated in the meeting. The larger sample was used in this table. Respondents on whom we only have pretest data are included. The responses to this question were open ended and collapsed into categories for analysis.

Table 27: What the Family Wants From the Meeting (N = 44) (Slide 63)

Family Wants	Frequency	Percentage
Child out of placement/Child not going into placement	11	25
Family and agency more supportive of the mother or each other	10	23
More family togetherness	5	11
Better understanding of family dynamics	4	9
Less family conflict	4	9
Improved environment for child	3	7
Visitation	1	2
Better decision making	1	2
Don't know	1	2

The most frequently mentioned family want from the meeting is having a child returned from placement or avoiding placement for the child. **(Slide 64)** Also frequently mentioned were improvements in family functioning such as more support, togetherness, understanding of family dynamics, and reduction in conflict. Table 28 shows the test of two hypotheses: (a) families will report improvement at posttest from

the pretest in family functioning. Specifically the family will report more cohesion, more open communication (expressiveness), less conflict, and fewer mental health symptoms; and (b) respondents will report better social functioning for themselves at posttest than they had shown at pretest. Specifically, respondents will report fewer depressive symptoms at posttest than they had pretest.

Table 28: Family Environment Scale and CESD Scale

Subscale	Pretest		Posttest		Significance
	Mean	SD	Mean	SD	
Cohesion	25.45	4.38	25.05	4.15	.600
Expressiveness	7.91	3.81	7.09	4.61	.563
Conflict	5.91	5.48	4.86	3.73	.294
Mental health	6.31	5.48	5.41	5.12	.351
CESD	15.57	9.65	14.83	10.27	.600

(Slide 65) Small, nonsignificant reductions are noted in family conflict, family mental health symptoms, and the respondent's own reports of their depressive symptoms. These findings are not significant. Therefore, the hypotheses cannot be accepted.

(Slide 66) Tables 29 and 30 are reports of pre- and posttest changes in social support. Two hypotheses are tested: (a) families will report more use of social support at posttest than they had reported at pretest, and (b) families will report more use of family resources at posttest than they had reported at pretest. Social support was broken down into two constructs: help and advice, and emotional support. Help and advice come from those people who help respondents solve problems and reach goals by providing knowledge, skills, or physical help when there is a task to do. Emotional support comes from individuals whom the respondents feel they can count on, who are

nonjudgmental, provide support when they are upset, and who the respondent feels are genuinely concerned about their feelings and welfare.

Respondents were asked to identify a category of people: such as parent, spouse, sibling, cousin, coworker, neighbor, friend, etc. Fifteen categories could be identified. First, respondents were asked if the person was in their network. If the person was not in the network, a score of 0 was assigned. If the person was present in the network they were asked to rate the person on a five-point scale, from 1 = not helpful to 5 = very helpful. Respondents were then asked to rate the overall network from 1 = very unsatisfied to 7 = very satisfied with the support they received.

Organizational network participation was a portion of the MSSSI. Respondents were asked questions about participation in religious, educational, social, political, and other organizations. All other social support data come from the FSS. Only selected items are reported in the table. Overall scale results are reported along with significant items. Nonsignificant items are not reported.

Table 5 reports results from the Advice and Help Social Support Subscale. Among specific types of persons providing support, only significant items are reported.

Table 29: Advice and Help Social Support Subscale (N = 28)

Variable	Pretest		Posttest		Sig.
	Mean	SD	Mean	SD	
Cousins	1.26	1.54	2.04	1.99	.030.
Aunts/Uncles	1.61	1.90	2.48	1.86	.034
Clergy	.913	1.99	2.04	1.75	.014
Neighbors	2.44	1.80	1.65	1.82	.030
# of persons in the advice/help network	9.13	2.42	9.35	2.01	.636
Satisfaction with the amount of help and advice received	5.56	1.24	5.70	1.43	.678
Advice and Help Rating Scale	32.87	10.74	34.52	11.14	.256
Organizational network participation	9.00	2.13	10.26	3.25	.077

(Slide 67) Small nonsignificant increases are seen in the number of persons the respondents can count on for help and advice, respondent's satisfaction with the advice and help they receive, and the overall Advice and Help Rating Scale. The first social support hypothesis is not accepted. **(Slide 68)** However, subjects were more likely at posttest than pretest to indicate that they were receiving advice and help from cousins, aunts, uncles, and clergy. Since the results are significant, the second hypothesis, at least for advice and help, is accepted. FUM participants are making more use of family resources. However, this use is limited since significant changes are not observed in the use of nuclear family support. Also, there is a significant decline from the pretest to posttest in the reported use of neighbors for help and advice.

(Slide 69) Respondents report more use of clergy at posttest for emotional support, help, and advice than at pretest and also report more participation in organizations at posttest than at pretest. However, this finding is only at a level that indicates a trend.

Table 30: Emotional and Caring Support Subscale (N = 28)

Variable	Pretest		Posttest		Sig.
	Mean	SD	Mean	SD	
# of Emotionally supportive persons	9.61	2.69	10.74	2.77	.082
Siblings support scale	3.27	1.76	2.74	1.71	.090
Clergy support scale	.96	1.80	1.96	2.06	.038
Satisfaction with the amount of caring and emotional support received	5.65	1.07	5.65	1.19	1.000
Emotional Support Rating Scale	34.96	10.07	35.70	10.85	.636

Nonsignificant increases are noted in the Emotional Support Subscale, but there is an increase in the number of emotionally supportive persons reported. However, this last finding is at a level that only indicates a trend. Respondents were significantly more likely to say that clergy were helpful sources of emotional support at posttest than they were at pretest. However, respondents were more likely to say siblings were less helpful at posttest than they were at pretest.

Table 31 is a report of results from the *Parent Outcome Interview* given to respondents at posttest.

**Table 31: Participant's Postmeeting Assessment of Participation:
The Parent Outcome Interview (N = 28) (Slide 70)**

	Frequency	Percentage
How is your personal and family situation now, compared to before the FUM?		
A lot better now	13	46
A little better now	7	25
About the same	5	18
A little worse now	1	4
A lot worse now	2	7
Would the improvement have happened without the FUM intervention?		
Yes	12	60
No	8	40
How satisfied are you with FUM?		
Very satisfied	14	50
Satisfied	11	39
Somewhat dissatisfied	1	4
Very dissatisfied	2	7
How satisfied are you with the services you received from Children's Services?		
Very satisfied	13	46
Satisfied	7	25
Somewhat dissatisfied	7	25
Very dissatisfied	1	4

Seventy-one percent of respondents reported that the family situation improved after the FUM. Only 11% said things were worse. Forty percent of people who said things had improved said the change would not have occurred without the meeting. Eighty-nine percent of respondents said they were at least satisfied with FUM. This level of satisfaction was higher than the satisfaction reported for the services received from HHSA in general. Seventy-one percent of respondents said they were at least satisfied with those services.

Table 32 is a report of data drawn from the POI. The data reports what respondents said they liked most about the meeting. Collapsed responses from an

open-ended question are reported. Families liked the opportunity to get together and discuss issues that they had perhaps not been able to fully discuss before.

Table 32: What Respondents Liked About the Meeting (N = 28) (Slide 71)

	Frequency	Percentage
Openness/Communication/Listening	10	35
Bringing the family together	6	21
Planning	4	14
Goal setting	3	11
Social support	2	7
Strengths perspective	1	4
Not like being in court	1	4
Facilitator	1	4

Table 33 is a report of data gathered by the FUM staff and analyzed by the research staff. **(Slide 72)** FUM-HHSA staff did a phone follow-up with parents and social workers several months after the meeting. Follow-ups were done with early recipients of services. Thirty-nine parents, 44 social workers, and 10 nonparent caretakers were included in this review.

**Table 33: Participants' Postmeeting Assessment of Participation:
FUM Data Percentages Reported**

	Parent (N = 39) % saying yes	Social worker (N = 44) % saying yes	Caretaker (N = 10) % saying yes
Placement goal accomplished	64	61	50
Recommend to others	85	93	80
% of follow-through on the plan			
0%	8	23	30
25%	5	11	10
50%	11	14	0
75%	18	25	20
100%	59	27	40
Level of help to the family			
-5 = very negative	5	5	0
-4	0	0	10
1 = no/neutral	13	7	20
2 = positive	3	5	10
3	21	19	10
4	18	41	0
5 = positive	38	24	50
Level of help to the child			
-5 = very negative	3	0	0
-4	3	0	0
-3	3	0	0
-2 = negative	0	0	10
1 = no/neutral	14	3	50
2 = positive	6	13	10
3	14	25	0
4	14	34	10
5 = positive	43	25	20
Parent/Caretaker only (N = 147)			
	Frequency saying yes	% saying yes	
Meeting helpful	140	95	
Would participate in another	141	96	

One pattern that emerges from the data is that foster parents are more critical of the meeting than either the parent or other caretakers. **(Slide 73)** More than 60% of the social workers and parents said the placement goal for the meeting was accomplished

compared to 50% of caretakers. Over 80% of all three groups said that they would recommend FUM to others, with social workers leading at 93%.

Parents and caretakers were more likely than social workers to say the plan developed at the meeting was carried out. Almost one half of the social workers said 50% or less of the plan was carried out after the meeting. Forty percent of the caretakers and 24% of parents agreed with that statement. Seventy-seven percent of families said at least 75% of the plan was carried out.

Respondents were asked to estimate (on a 10-point scale from 5 [very positive] to -5 [very negative]) the level of help the FUM was to the family and child. **(Slide 74)** Only 5% thought the meeting's effect was negative. More than 80% of social workers and parents thought the effect was positive compared to 60% of caretakers.

Similar results were found on the perceived effect on the child. Six percent of parents and 10% percent of caretakers thought the effect of a meeting was negative on a child, while 97% of social workers thought the effect of the meeting was positive for the child. Eighty percent of parents and 50% of caretakers shared the social worker's view of the benefit of the meeting for the child.

Ninety-five percent of 147 participants who completed an assessment after the meeting said the meeting was helpful; 96% said they would complete another meeting. This percentage is higher than the reported levels at the follow-ups, which suggests that some of the perceived benefits may have dissipated after time.

Discussion (Slide 75)

This research has limitations in its methodology that affects the interpretation of data. Since random assignment was not used in this research, cause and effect cannot

be established. Also, no comparison group was used. The sample was also small. Less than one half of the available FUM participants chose to enroll in the research. Since the research team was forced to rely on FUM-HHSA staff to “pitch” the research, we cannot say whether the staff presentation was adequate, or even presented with every client. On the other hand, it is possible that a volunteer subject’s motivation could have caused him or her to provide a more positive view of FUM than subjects who did not volunteer for the research. In addition, the small sample size may have caused us to miss significant differences between pretest and posttest groups on some hypotheses. In addition, “ceiling effects” (high scores on scales and items at the pretest) hindered us from finding effects at pretest.

(Slide 76) The benefits identified by participants were modest. No changes were observed in the family environment or in the amount of depressive symptoms expressed by the parent or caretaker after the intervention. Nevertheless, most respondents said the effect of FUM on the family was positive. Also, some evidence was found to indicate that respondents were more likely to receive help and advice from extended family. This increase in the use of help and advice seemed to replace advice and help formerly provided by neighbors. Clergy were reported by respondents at postintervention to be a more likely source of advice, help, and emotional support than they had been at the pretest.

(Slide 77) Perhaps over the long run the family support provided will be more permanent since neighbors can be transient in a person’s life. This change in support patterns may also be related to the private family phase where nonfamily members leave the meeting and allow the family to work out a plan. Clergy were a source of

support for a considerable number of individuals in the sample. Research is needed on how clergy support and client religiosity affects the delivery of CPS services. The increased religiosity could have been the result of participation in 12-step programs. Participation in 12-step programs might also account for the increased organizational involvement reported by subjects. Substance abuse was a major problem with the sample (see Study #1).

(Slide 78) Respondents also reported a rise in the number of emotionally supportive persons, and they had increased their organizational involvement. The increased organizational involvement probably comes from a greater participation in church activities. Also, some parents may become more involved in educational activities on behalf of students. However, there is no change in either the amount of or satisfaction with the social support received. It may be too much to ask from what is basically a one-shot intervention that the family environment or the parent/caretaker's mental health would improve. Despite the identification of modest gain, Study #1 does provide evidence that families are taking responsibility for the care of their children, which is the intent of Family Group Decision Making. In Study #2 we found the major impetus for taking part in FUM was to have a child returned from placement or avoid a child placement.

(Slide 79) In Study #1, we found participants had far more concerns about finances than the social workers. In Study #2, we found low rates of employment as well as relatively low levels of income, which reinforces the need for CPS to pay attention to these issues.

Caretakers seemed less sure of the benefits of FUM than either social workers or parents. Caretakers may possibly lose the child to a biological parent as a result of a FUM. In two of the meetings observed by the research team, the outcome was placement with the parent, and the caretaker was not happy about that outcome. In other meetings observed by the team, caretaking relatives were losing patience with the biological parent who they saw as having numerous past failures. Biological parents were also mostly positive about participating in the meeting. Perhaps the structure of a meeting reinforces the notion that the family is the key resource, which makes them feel hopeful and satisfied. Social workers were overwhelmingly positive about the meeting despite being more sanguine about whether the plan developed at the meeting was carried out. We learned in Study #1 that the outcome of the meetings were likely to conform to social worker's goals stated before the meeting, which might account for their enthusiasm about the meeting.

On follow-up, families were likely to say things had improved, but only a minority was willing to assign the family improvement to FUM. Social workers seemed to be the most enthusiastic about recommending FUMs to others. Social workers had this view even though they were less likely than parents and caretakers to say the plan developed at the meeting was carried out. They were much more likely to report that they saw a positive benefit to the family and child. Administering the FES to the social workers might have provided some data on what they saw as family change, and provided more empirical support of reported gains from FUM.

MODULE II

**FAMILY GROUP CONFERENCING
CURRICULUM MODULES:
RESEARCH, EDUCATION, AND PRACTICE**

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MODULE II

FAMILY GROUP CONFERENCING CURRICULUM MODULES: RESEARCH, EDUCATION, AND PRACTICE

INTRODUCTION

The following is a proposed course syllabus that focuses on Family Group Conferencing and Strength-Based Practice.

The primary purpose of the course is to prepare social work students in understanding the knowledge and values and developing skills in family strength-based practices in child welfare and specifically in family group conferencing. Students are introduced to the concept of strength-based practice and the prerequisite knowledge and skills for family group conferencing (FGC). The syllabus focuses on the following areas, which are seen as sequential:

- Current Knowledge That Is Needed to Understand Family Group Conferencing and Family Strength-Based Practice (Weeks 1-5)
- Values and Self Assessment Process in Performing Family Group Conferencing (Weeks 1, 4, 10)
- Skills Associated With Family Group Conferencing (Weeks 6-9)
- Family Group Practice Models (Week 11)
- Skill Practice in Family Group Conferencing (Weeks 12-14)
- Evaluation of Family Group Conferencing and Future Trends (Week 15)

Potential assignments for coursework and a recommended bibliography for each week's topical areas are included. Additional references are added at the conclusion of the syllabus.

FAMILY STRENGTH-BASED PRACTICES IN CHILD WELFARE:FAMILY GROUP CONFERENCING EMPHASIS: COURSE SYLLABUS

Course Description Overview

The primary purpose of the course is to prepare social work students in understanding the knowledge and values and developing skills in family strength-based practices in child welfare, and specifically in family group conferencing. Students are introduced to the concept of strength-based practice and the prerequisite knowledge and skills for family group conferencing (FGC), including group theory and process, family systems theory, listening, facilitation and conflict management skills, child welfare, and risk assessment. Additionally there will be attention focused on the family group conferencing models and evaluation of this strength-based practice in child welfare.

Competencies

The following knowledge competencies are derived from the California Social Work Education Center (CalSWEC) list of competencies for students in child welfare settings.

Knowledge Objectives

- 1.1 Student understands and is sensitive to cultural and ethnic differences of clients.
- 1.2 Student considers the cultural norms, beliefs, values, language, race, ethnicity, customs, family structure, and community dynamics of major ethnic groups in the State of California in assessments and continues training to increase knowledge in this area.
- 1.5 Student considers the influence of culture on behavior and is aware of the importance of utilizing this knowledge in helping families improve parenting and care of their children within their own cultural context.
- 1.9 Student understands and uses knowledge in the provision of child welfare services to cultural and ethnic populations.

- 2.1 Student understands that child abuse and neglect are presenting symptoms of social and family dysfunction.
- 2.8 Student understands the dynamics of family violence, including spouse abuse, and can develop appropriate culturally sensitive case plans for families and family members to address these problems.
- 2.13 Student understands the potentially traumatic effects of the separation and placement experience for the child and the child's family and the negative effects on the child's physical, cognitive, social, and emotional development.
- 2.15 Student understands the principles of permanency planning and the negative effects that inconsistent and impermanent living arrangements have on children.
- 2.16 Student understands the importance of the biological parent maintaining contact with the child in placement, of encouraging parents when appropriate to participate in planning, and of regular parent-child visitations.
- 3.6 Student is aware of his or her own emotional responses to clients in areas where the student's values are challenged, and is able to utilize the awareness to effectively manage the client-worker relationship.
- 3.8 Student understands crisis dynamics, identifies crises, and conducts crisis intervention activities.
- 3.13 Student has knowledge of and understands how to work collaboratively with other disciplines that are routinely involved in child welfare cases.
- 3.15 Student understands group process theory and can develop and implement small groups.
- 3.24 Student understands the strengths and concerns of diverse community groups and is able to work with community members to enhance services for families and children.
- 4.1 Student understands children's developmental needs and how developmental levels affect a child's perception of events, coping strategies, and physical and psychological responses to stress and trauma.
- 4.4 Student understands the potential effects of child abuse and neglect on child/adult development and behavior.
- 4.6 Student understands the stages of the family life cycle as they occur in a variety of familial patterns.

- 4.7 Student understands the interaction between environmental factors especially in terms of racism, poverty, violence, and human development.
- 5.3 Student can understand client and system problems from the perspective of all participants in a multidisciplinary team and can assist the team to maximize the positive contribution of each member.
- 5.10 Student is familiar with a range of collaborative models.
- 6.11 Student understands that decision-making processes in public child welfare practice require ethical reasoning that is informed by professional standards.

Skill Objectives

The following skill competencies are derived from the California Social Work Education Center (CalSWEC) list of competencies for students in child welfare settings.

- 1.3 Student is able to develop an ethnically sensitive assessment of a child and the child's family and adapt casework plans to that assessment in the provision of child welfare services, while demonstrating an understanding of the continuum from traditional to acculturated values, norms, beliefs, and behaviors of major ethnic groups.
- 1.4 Students can develop relationships, obtain information, and communicate in a culturally sensitive way.
- 1.7 Student is able to evaluate models of intervention such as family preservation; family-centered services; and family-centered crisis services for their application, possible modification, and relevance to cultural and ethnic populations.
- 2.2 Student is able to assess the interaction of individual, family, and environmental factors, which contribute to abuse, neglect, and sexual abuse, and identifies strengths, which will preserve the family and protect the child.
- 2.9 Student accurately assesses the initial and continuing level of risk for the abused or neglected child within the family while ensuring the safety of the child.
- 2.18 Student works collaboratively with foster families and kin networks, involving them in assessment and planning and supporting them in coping with special stresses and difficulties.

- 3.1 Student demonstrates social work values and principles; this includes self determination, respect for human dignity and worth, and respect for individual differences.
- 3.3 Student demonstrates the ability to evaluate and incorporate information from others, including family members and professionals in assessment, treatment planning, and service delivery.
- 3.7 Student assesses family dynamics, including interaction and relationships, roles, power, communication patterns, functional and dysfunctional behaviors, and other family processes.
- 3.11 Student can engage clients, especially nonvoluntary and angry clients.
- 3.12 Student engages families in problem-solving strategies and assists them with incorporating these strategies.
- 3.14 Student can produce concise, required documentation.
- 3.15 Student understands group process theory and can develop and implement small groups.
- 5.1 Student effectively negotiates with supervisor and professional colleagues, systems, and community resources to further accomplish professional, client, and agency goals.
- 5.2 Student is able to work effectively in a diverse environment.
- 5.8 Student demonstrates a working knowledge of the relationship process of accessing community resources available to families and children; utilizes them appropriately, and updates as necessary.
- 6.2 Student demonstrates knowledge of specific laws, policies, court decisions, and regulations essential to child welfare services.
- 6.5 Student can demonstrate knowledge of how organizational structure and climate impact service delivery, worker productivity and morale, and how students can contribute to improvements.

Values and Ethics

The following values and ethics are derived from CalSWEC values and standards for child welfare professionals.

1. Display knowledge basic to the social work profession and an understanding of the social institutions, organizations, and resources serving children and families.
3. Demonstrate skills fundamental to the profession of social work and related disciplines.
4. Know, understand, and work competently with the diversity of people within the state and region.
6. Assume responsibility for learning in supervision.
7. Meet the expectations of conduct established by the NASW Code of Ethics, other professional ethics codes determined by a worker's professional affiliation, and the county's code of ethics.
8. Adhere to agency policies, procedures, and evaluations, and use constructive channels to bring about change.
9. Apply results of research and evaluation to practice and collect data in support of the agency's information system.
10. Demonstrate, throughout all their child welfare tasks and activities, acceptance of the professional Values for Public Child Welfare Practice.
12. Participate in multidisciplinary teams with staff in other programs, with colleagues in other disciplines, and with informal and formal institutions in the community.
13. Promote collaborative working relationships among community agencies and the courts toward establishing a comprehensive public child welfare system and family support system.
29. Assess parents' willingness and ability to protect the child.
30. Provide direct and intensive services to parents to strengthen their capacity to care for their children.
31. Through the entire course of the intervention, engage family in using its own strengths and resources.
32. Help create a family plan for legal permanency that includes family preservation and community support in a safe environment for the child.
37. Ensure child's participation in planning and direction for his or her life.

39. In preparing for reunification or out-of-home legal permanency, include foster parents in the planning process.
40. Use social work processes in termination of service.
41. Manage in a professional manner personal feelings associated with providing child welfare services.
42. Work toward enhancing resources available for the child within the agency and in the community, including resources for independent living/emancipation.
43. Strive to prevent child endangerment by engaging resources in the community to support and strengthen families.

Outcomes

By the end of this course, the student will be able to:

- Understand and apply family strength-based practices to casework;
- Understand the prerequisite knowledge needed to become a family group conference facilitator;
- Develop and apply listening, facilitation, conflict management, and contracting skills;
- Practice the role of the family group conference facilitator; and
- Understand evaluation and future trends in family group conferencing.

Assignments

Assignment 1: Observation of a Family Conferencing Meeting

Contact the local Family Conferencing Coordinator and request to observe a Family Conferencing Meeting. Write a paper containing the following information and answering the following questions. Please ensure the confidentiality of the family and facilitators in changing personal identifying information.

- Identify members of the family group and how they relate to one another.
- Purpose of the meeting
- Brief process of the meeting
- Issues that surfaced at the meeting

- Safety concerns for any family members
- Identify strengths within the family
- Identify concerns within the family
- Outline of family's plan to address concerns
- Facilitator's role within the meeting

Write a critical analysis of the experience. Please include some or all of the questions as a basis for your critique.

- What was your experience of this meeting?
- What reactions did you have when the family members were identifying strengths? Concerns?
- Did you feel that the family came up with a viable plan based on the strengths and concerns? Why or why not?
- Did the facilitator stay neutral, or did the facilitator intervene in a more authoritarian or therapeutic role? Was the atmosphere safe for the family to deal with conflict?
- How was conflict managed if it emerged?
- What could the facilitator have done differently?

Examples of specific interactions and behaviors in your critique strengthen your analysis.

Assignment 2: Critique a Family Group Conferencing Program

Gather information on a Family Group Conferencing Program in your area. Basic information should include:

- Name of agency
- Private or public status? Church or religious affiliation?
- Length of time in operation
- Organizational chart
- Mission statement
- Funding sources and budget
- Goals and objectives for the program

- Family Conferencing Model that is adhered to
- Training for staff or other agency partners in Family Group Conferencing
- Number of families served in last year and since inception of program
- Strengths of the program
- Problem areas of the program
- Outline of services provided and location of services
- Any outcomes or evaluation done on the effectiveness of the program.

You can consider interviewing a manager, supervisor, or employee as part of the research process. If possible, consider interviewing a family that has been through the process.

Does the program meet its stated objectives and goals? Why or why not? Is the program effective? Why or why not? Please give any recommendations to correct any problems noted.

Assignment 3: Policy Analysis of Family Group Conferencing

Please write a paper on the current policy of family group conferencing as an intervention to strengthen family decision making in child welfare. Highlight major federal and state legislative acts with regard to Family Group Conferencing. Describe the strengths and weaknesses of the laws and subsequent provisions to address the weaknesses. Are there political debates (competing value systems) about Family Group Conferencing? How have the laws affected implementation of Family Group Conferencing? Describe the implementation of policies at the national, state, and/or local level. Did the laws meet their intended purposes? What has been the effect of Family Group Conferencing on children and families (evaluation and results of research)? Does Family Group Conferencing have an impact on families of color in reducing the number of child abuse rereferral rates? What could or can be done to improve family group conferencing as an intervention tool for children and families?

Course Outline and Content Themes

Week 1 Overview of Family Strength-Based Practices in Child Welfare

The trend in Child Welfare in the late 1990s and into the new millennium has been to move from child-focused to family-focused, and from family-focused to family strength-based practice. This class will focus on the definition of strength-based practices for organizations and families.

Readings

Burford, G., & Hudson, J. (Eds.). (2000). *Family Group Conferencing: New directions in community-centered child and family practice*. New York: Aldine de Gruyter (pp. 5-85).

National Child Welfare Resource Center for Family-Centered Practice. (2000a, Summer). Can we put clothes on this Emperor? *Best Practice, Next Practice*, 1, 7-11.

Week 2 Knowledge Needed for Family Conferencing Overview: Part I—Family Theory and Family Dynamics

An overview of selected Schools of Family Therapies is provided (Communications, Structural, Intergenerational, and Strategic) with an emphasis on identifying key concepts necessary for understanding family dynamics.

Readings

Brown, J., & Christiansen, D. (1999). *Family therapy theory and practice* (2nd ed.). Pacific Grove, CA: Brooks/Cole Publishing (pp. 4-46).

Carlson, J., & Kjos, D. (2001). *Theories and strategies of family therapy*. Boston: Allyn & Bacon (pp. 19-40, 190-215).

Week 3 Knowledge Needed for Family Conferencing Overview: Part II—Child Welfare System and Risk Assessment

An overview of the child welfare system and the practice of risk assessment as it relates to the integration of FGC. The limitations of FGC in the wake of risk assessment and safety planning will be discussed.

Readings

Myers, J. E. B., Berliner, L., Briere, J., Hendrix, C. T., Jenny, C., & Reid, T. (2001). *The APSAC handbook on child maltreatment* (2nd ed.). Thousand Oaks, CA: Sage Publications (pp. 305-327).

Dubowitz, H., & DePanfilis, D. (2000). *Handbook for child protection practice*. Thousand Oaks, CA: Sage Publications (pp. 227-267).

Knowledge Needed for Family Conferencing Overview: Part III—Child Development

A review of child abuse and its effect on child development, and a discussion of strengths and resilience of children and appropriateness for being included in FGC is presented.

Readings

Wolfe, D. (1999). *Child abuse: Implications for child development and psychopathology*. Thousand Oaks, CA: Sage Publications (pp. 1-93).

Berk, L. E. (1999). *Infants, children and adolescents*. Needham Heights, MA: Allyn & Bacon (various – instructor may select).

Week 4 Knowledge Needed for Family Conferencing Overview: Part IV—Cultural Diversity and Kinship Care/Caretaker Dynamics

An integrated approach to ethnosensitive child welfare services with African American, Asian-Pacific, and Hispanic families is presented. The place of kinship care in child welfare and its relationship to Family Group Conferencing is discussed.

Readings

Hegar, R. L., & Scannapieco, M. (1999). *Kinship foster care: Policy, practice and research*. New York: Oxford University Press (pp. 1-53, 93-192).

Cohen, N. (2000). *Child welfare: A multicultural focus*. Boston: Allyn & Bacon (pp. 84-155).

Okamura, A., & Quinnett, E. (2000). *Family Group Decision Making models for social workers in the child welfare setting*. Berkeley: University of California at Berkeley, California Social Work Education Center (Module 3; available online).

Week 5 Knowledge Needed for Family Conferencing Overview: Part V—Group Theory and Dynamics

Readings

MacKenzie, R. K. (1997). *Time managed group psychotherapy: Effective clinical applications*. Washington, DC: American Psychiatric Press (pp. 35-62).

Week 6 Skills Needed for Family Conferencing: Part I—Listening Skills

Discussion and practice of the skills needed for the FGC facilitator. This session will focus on listening skills needed for running FGC meetings.

Readings

Stone, D., Patton, B., & Heen, S. (1999). *Difficult conversations*. New York: Penguin Publications (pp. 163-184).

Beer, J., & Stief, E. (1997). *The mediator's handbook*. Gabriola Island, British Columbia, Canada: New Society (pp. 105-114; order through Consortium Book Sales & Distribution, 800-283-3572).

Hill, C. E., & O'Brien, K. M. (1999). *Helping skills: Facilitating exploration, insight and action*. Washington, DC: American Psychological Association (pp. 81-172).

Week 7 Skills Needed for Family Conferencing: Part II—Group Facilitation Skills

Discussion and practice of the skills needed for the FGC facilitator. This session will focus on group facilitation skills needed to run FGC meetings.

Readings

Edelwich, J., & Brodsky, A. (1992). *Group counseling for the resistant client*. New York: Lexington Books (pp. 29-83).

Week 8 Skills Needed for Family Conferencing: Part III—Mediation/Negotiation, Conflict Management, and Resolution Skills

Discussion and practice of the skills needed for the FGC facilitator. This session will focus on mediation/negotiation, conflict management, and resolution skills that are needed for running FGC meetings.

Readings

Beer, J., & Stief, E. (1997) *The mediator's handbook*. Gabriola Island, British Columbia, Canada: New Society Publishers (pp. 1-18, 27-41, 67-102, 133-145).

Bush, R. A. Baruch, & Folger, J. P. (1994). *The promise of mediation*. San Francisco: Jossey-Bass (pp. 191-225).

Keefe, T., & Koch, S. (1999). Teaching conflict management in social work. *Journal of Teaching in Social Work*, 18(2), 33-52.

Week 9 Skills Needed for Family Conferencing: Part IV—Developing Plans and Contracting Skills

Discussion and practice of the skills needed for the FGC facilitator. This session will focus on working with families to develop plans and contracts during the FGC process.

Readings

Beer, J., & Stief, E. (1997) *The mediator's handbook*. Gabriola Island, British Columbia, Canada: New Society Publishers (pp. 50-61).

San Diego Mediation Center. (n.d.). *Introductory mediation skills training curriculum*. San Diego, CA: Author (pp. 51-78; available from San Diego Mediation Center, 625 Broadway, Suite 1221, San Diego, CA).

Week 10 Skills Needed for Family Conferencing: Part V—Self Assessment in the Family Conferencing Facilitator Role

Evaluating one's own practice and using supervision to improve facilitating.

Reading

Okamura, A., & Quinnett, E. (2000). *Family Group Decision Making models for social workers in the child welfare setting*. Berkeley: University of California at Berkeley, California Social Work Education Center (Module 3).

Week 11 History and Models of Family Conferencing

Development of the concept of Family Group Conferencing in New Zealand and Oregon is discussed. Various models of Family Group Conferencing are contrasted.

Readings

Burford, G., & Hudson, J. (2000). *Family group conferencing*. New York: Aldine de Gruyter (pp. 72-283).

Okamura, A., & Quinnett, E. (2000). *Family Group Decision Making models for social workers in the child welfare setting*. Berkeley: University of California at Berkeley, California Social Work Education Center (Module 3).

Week 12 Part I: Mock Family Conferencing Role Play

In the next three classes, we will role play a meeting, including preparing for a meeting and aftermath.

Reading

Okamura, A., & Quinnett, E. (2000). *Family Group Decision Making models for social workers in the child welfare setting*. Berkeley: University of California at Berkeley, California Social Work Education Center (Module 5).

Week 13 Part II: Mock Family Conferencing Role Play

Reading

Okamura, A., & Quinnett, E. (2000). *Family Group Decision Making models for social workers in the child welfare setting*. Berkeley: University of California at Berkeley, California Social Work Education Center (Module 5).

Week 14 Part III: Mock Family Conferencing Role Play

Reading

Okamura, A., & Quinnett, E. (2000). *Family Group Decision Making models for social workers in the child welfare setting*. Berkeley: University of California at Berkeley, California Social Work Education Center (Module 5).

Week 15 Evaluation and Trends in Family Conferencing

Current empirical finding on family conferencing and methods of evaluating family conferencing.

Readings

Burford, G., & Hudson, J. (2000). *Family Group Conferencing*. New York: Aldine de Gruyter (pp 284-333).

Jones, L., & Finnegan, D. (in press). Family Unity Meetings: A description and evaluation, *Journal of Family Social Work*.

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- Beer, J., & Stief, E. (1997). *The mediator's handbook*. Gabriola Island, British Columbia, Canada: New Society Publishers.
- Berk, L. E. (1999). *Infants, children and adolescents*. Needham Heights, MA: Allyn & Bacon.
- Brown, J., & Christiansen, D. (1999). *Family therapy theory and practice* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Burford, G., & Hudson, J. (Eds.). (2000). *Family group conferencing: New directions in community-centered child and family practice*. New York: Aldine de Gruyter.
- Bush, R. A. Baruch, & Folger, J. P. (1994). *The promise of mediation*. San Francisco: Jossey-Bass.
- Carlson, J., & Kjos, D. (2001). *Theories and strategies of family therapy*. Boston: Allyn & Bacon.
- Cohen, N. (2000). *Child welfare: A multicultural focus*. Boston: Allyn & Bacon.
- Dubowitz, J., & DePanfilis, D. (2000). *Handbook for child protection practice*. Thousand Oaks, CA: Sage.
- Edelwich, J., & Brodsky, A. (1992). *Group counseling for the resistant client*. New York: Lexington Books.
- Hegar, R. L., & Scannapieco, M. (1999). *Kinship foster care: Policy, practice and research*. New York: Oxford University Press.
- Hill, C. E., & O'Brien, K. M. (1999). *Helping skills: Facilitating exploration, insight and action*. Washington, DC: American Psychological Association.
- Jones, L., & Finnegan, D. (in press). Family Unity Meetings: A description and evaluation. *Journal of Family Social Work*.
- Keefe, T., & Koch, S. (1999). Teaching conflict management in social work. *Journal of Teaching in Social Work*, 18(2), 33-52.

- MacKenzie, R. K. (1997). *Time managed group psychotherapy: Effective clinical applications*. Washington, DC: American Psychiatric Press.
- Myers, J. E. B., Berliner, L., Briere, J., Hendrix, C. T., Jenny, C., & Reid, T. (2001). *The APSAC handbook on child maltreatment* (2nd ed.). Thousand Oaks, CA: Sage.
- National Child Welfare Resource Center for Family-Centered Practice. (2000a, Summer). Can we put clothes on this Emperor? *Best Practice, Next Practice*, 1(1), 7-11.
- Okamura, A., & Quinnett, E. (2000). *Family Group Decision Making models for social workers in the child welfare setting*. Berkeley: University of California at Berkeley, California Social Work Education Center.
- San Diego Mediation Center. (n.d.). *Introductory mediation skills training curriculum*. San Diego, CA: Author.
- Stone, D., Patton, B., & Heen, S. (1999). *Difficult conversations*. New York: Penguin.
- Wolfe, D. (1999). *Child abuse: Implications for child development and psychopathology*. Thousand Oaks, CA: Sage.

RECOMMENDED READINGS

- Banach, M. (1998). The best interests of the child: Decision making factors. *Families in Society: Journal of Contemporary Services*, 78(2), 331-340.
- Beck, A. P., & Lewis, C. M. (2000). *The process of group psychotherapy*. Washington, DC: American Psychological Association.
- Bolton, R. (1979). *People skills*. New York: Simon and Schuster.
- Cohen, M. B., & Garrett, K. J. (1999). Breaking the rules: A group work perspective on focus group research. *British Journal of Social Work*, 29(3), 359-372.
- Downs, S. W., Moore, E., McFadden, E. J., & Costin, L. (2000). *Child welfare and family services*. Boston: Allyn & Bacon.
- Fisher, R., & Ury, W. (1991). *Getting to yes: Negotiating agreement without giving in*. New York: Penguin Books.
- Friedman, W. H. (1989). *Practical group therapy*. San Francisco: Jossey-Bass.

- Halperin, D. A. (1989). *Group psychodynamics: New paradigms and new perspectives*. Chicago: Year Book Medical Publishers.
- Hansen, J. C., & Falicov, C. J. (1983). *Cultural perspectives in family therapy*. Rockville, MD: Aspen Publications.
- Herring, R. D. (1999). *Counseling with Native American Indians and Alaska Natives*. Thousand Oaks, CA: Sage.
- Horejsi, C. (1996). *Assessment and case planning in child protection and foster care services*. Denver, CO: American Humane Association.
- Levine, S. (1998). *Getting to resolution*. San Francisco: Berrett-Koehler Publishers.
- Negotiating: First books for business*. (1996). Los Angeles: McGraw Hill Publishing.
- Simmons, A. (1999). *A safe place for dangerous truths*. New York: AMACOM, American Management Association.
- Stein, T. (1998). *Child welfare and the law*. Washington, DC: Child Welfare League of America.
- Umbreit, M. S. (1994). Crime victims confront their offenders: The impact of a Minneapolis mediation program. *Research on Social Work Practice*, 4(4), 436-447.
- U. S. Department of Health and Human Services, Children's Bureau. (2000). *Children's Bureau*. Retrieved August 12, 2002, from [http://www.acf.hhs.gov/ programs/cb](http://www.acf.hhs.gov/programs/cb)
- Ury, W. (1993). *Getting past no: Negotiating your way from confrontation to cooperation*. New York: Bantam Books.
- Waldfoegel, J. (1998, Spring). Rethinking the paradigm of child protection. *The Future of Children*, 8(1), 104-119.
- Zimmerman, E. (2000, July). Suffer the children. *San Diego Magazine*, 62-65, 186-187.

RESOURCE SITES

The National Clearinghouse on Child Abuse and Neglect Information, Department of Children and Family Services, United States Government has compiled the following resource sites:

Administration for Children and Families

<http://www.acf.dhhs.gov>

The Administration for Children and Families (ACF) is the agency within the Department of Health and Human Services that brings together the broad range of Federal programs and services that address the needs of children and families.

Children's Bureau

<http://www.acf.dhhs.gov/programs/cb>

The Children's Bureau is the oldest Federal agency specifically charged with the responsibility of looking after the well-being of the nation's children. The Bureau helps the States to deliver child welfare services, such as the protection of children and the strengthening of families (child protective services), family preservation and support, foster care, adoption, and independent living.

Department of Health and Human Services

<http://www.dhhs.gov>

The principal Federal agency for protecting the health of and providing fundamental services for Americans (especially for those least able to help themselves), the Department of Health and Human Services is the largest funder of Federal grants, awarding approximately 60,000 grants per year. The Department is responsible for operating 300 programs, which are administered by 11 divisions. Among these divisions is the Administration for Children and Families.

National Adoption Information Clearinghouse (NAIC)

<http://www.calib.com/naic>

Through the use of adoption literature data, a database of adoption experts, listings of adoption agencies, crisis pregnancy centers, adoptive parents support and search support groups, and excerpts and full texts of State and Federal laws on adoption, the Clearinghouse (NAIC) provides information on all aspects of adoption, including infant and intercountry adoption and adoption of children with special needs. The Clearinghouse is able to respond to questions using its extensive library as well as in-house publications.

National Maternal & Child Health Clearinghouse (NMCHC)

<http://www.nmchc.org>

Funded by the Health Resources and Services Administration and the Maternal and Child Bureau, a branch of the U.S. Department of Health and Human Services, the Clearinghouse (NMCHC) has a wealth of information in its publications catalog available by mail, phone, fax, or online. This catalog is a record of Clearinghouse publications as well as those from outside sources. An integral part of the Clearinghouse is the National Sudden Infant Death Syndrome Resource Center.

Created to improve the accessibility of self-help groups and to stress the value and importance of mutual support, the **National Self-Help Clearinghouse** (same web address as above) aids human service agencies in adding self-help principles to their practices. The Clearinghouse also conducts training activities, provides consultation, facilitates research, provides information and referral services, and is involved with media outreach and several publications.

National Resource Center on Child Maltreatment

<http://www.gocwi.org/nrccm>

Operated by both the Child Welfare Institute and ACTION for Child Protection, this Center aids states, local agencies, and tribes in bettering their services offered to maltreated children and their families. One objective is to promote Child Protective Service models that best fit the various needs of different service providers.

National Resource Center for Family Centered Practice (NRCFCP)

<http://www.uiowa.edu/~nrcfcp/new/index.html>

The National Resource Center for Family Centered Practice (NRCFCP) helps child welfare agency managers and staff translate the tenets of the Adoption and Safe Families Act into family-centered practices that ensure the well-being and permanent placement of children while meeting the needs of families. It also provides other organizations with technical assistance, staff training, research, and information on family-based programs and issues throughout the country. This organization is also involved in outreach projects, such as the Family Resource Center in Cedar Rapids, that was founded on the "patch approach" of service and community.

National Resource Center for Foster Care and Permanency Planning

<http://guthrie.hunter.cuny.edu/socwork/nrcfcpp>

This Center offers information services, training, and technical assistance to other organizations, focusing on issues such as permanency planning, kinship foster care, and family group decision making.

National Resource Center for Information Technology in Child Welfare Services

<http://www.cwla.org>

The National Resource Center for Information Technology in Child Welfare Services, agencies, and family and juvenile courts use automated information systems to improve outcomes in the child welfare system and to improve administration of federally funded programs for children and youth in the system. The Center helps clients collect data (as required by Federal law) for the National Child Abuse and Neglect Data System, the statewide Automated Child Welfare Information Systems, and the Adoption and Foster Care Analysis and Reporting System. Moreover, the center helps its clients understand how to use the data to improve services to children and youth, evaluate results, and make informed decisions about programs and practices.

The ABA Center on Children and the Law

<http://www.abanet.org/child/home.html>

Working to strengthen the laws, policies, and judicial procedures affecting children, the Center, a program of the American Bar Association, also focuses on the training and education of attorneys and social workers, research, and public awareness. Several book and periodical publications, such as the *ABA Child Law Practice*, are available to order.

American Humane Association

<http://www.americanhumane.org>

The mission of the American Humane Association, as a network of individuals and organizations, is to prevent cruelty, abuse, neglect, and exploitation of children and animals and to assure that their interests and well-being are fully, effectively, and humanely guaranteed by an aware and caring society.

American Professional Society on the Abuse of Children (APSAC)

<http://www.apsac.org>

Working to ensure that the best possible professional help is given to everyone affected by child maltreatment, APSAC publishes two periodicals, the *APSAC Advisor* (a news journal) and *Child Maltreatment* (a practice-oriented journal). Other publications include guidelines for practice, books, fact sheets, and letters to editors. Services include professional education, development of a national network of chapters, and a Legislation List Serv.

Child Abuse Prevention Network

<http://child.cornell.edu>

Organizational members of the Child Abuse Prevention Network include The Cornell Family Life Development Center, the International Society for Prevention of Child Abuse and Neglect, the U.S. Army Family Advocacy Programs, the National Center on Child Fatality Review, Prevent Child Abuse New York, SBS Central and the

Shaken Baby Alliance, Survivors and Victims Empowered, and LifeNET, Inc. Web resources include free subscriptions to several E-mail lists for professionals in the field of child abuse, an annotated Prevention Bookmarks index, access to daily press reports on child abuse, and extensive downloadable documents and multimedia resources.

Childhelp USA

<http://childhelpusa.org>

Incorporating research, treatment, and prevention under the umbrella of one organization, Childhelp USA focuses on the many faces of child abuse, from personal suffering to legal battles. Programs include the National Child Abuse Hotline; Residential Treatment Facilities (in California and Virginia); Children's Advocacy Centers; a Children's Center; Foster Care and Group Homes; and increasing education, community outreach, and public awareness.

Children's Defense Fund

<http://www.childrensdefense.org>

Concentrating on the needs of poor and minority children and those with disabilities, the Children's Defense Fund stresses the importance of preventative investment in children. With the mission statement *Leave No Child Behind*, this private, nonprofit organization is dedicated to the Healthy Start, Head Start, Fair Start, Safe Start, and Moral Start of all young children.

Child Welfare League of America (CWLA)

<http://www.cwla.org>

An association of nearly 1,000 public and private nonprofit agencies, the CWLA is the largest publisher of child welfare materials including general trade books, child advocacy books, the *Child Welfare* journal, and the *Children's Voice* magazine. Among its various programs are those advocating kinship care, protecting America's children, and setting standards for child welfare services. A recent advocacy campaign was *Children '98: America's Promise*, focusing on child abuse and neglect, health care, and violence statistics.

HandsNet

<http://www.handsnet.org>

Creating information sharing and online collaboration for use by the human services community, HandsNet services include training, classes, workshops, seminars, and the Webclipper, an online networking system that tracks any given topic daily. The goal of this organization is to create an efficient timesaving tool geared toward keeping professionals informed on what is happening in the world of human services.

National Data Archive on Child Abuse and Neglect

<http://www.ndacan.cornell.edu>

The mission of the National Data Archive on Child Abuse and Neglect is to facilitate the secondary analysis of research data relevant to the study of child abuse and neglect. The Archive's primary activity is the acquisition, preservation, and dissemination of high-quality data sets related to the study of child abuse and neglect. Their website provides a listing and brief description of all the studies in the Archive along with ordering information. Information on Archive publications and upcoming training institutes and workshops is also offered.

National Indian Child Welfare Association (NICWA)

<http://www.nicwa.org>

The NICWA serves American Indian tribes throughout the country by helping to strengthen and enhance their capacity to deliver quality child welfare services. Among the activities in which NICWA engages are community development, public policy development, and information exchange.

PAVNET Online

<http://www.pavnet.org>

Pavnet Online is an interagency, electronic resource on the Internet created to provide information about effective violence prevention initiatives. This "virtual library" on violence and youth at risk is designed to give States and local communities a single searchable resource for relevant data from seven Federal agencies.

Additional Resource Sites

The following information was retrieved on February 8, 2000, from the National Clearinghouse on Child Abuse and Neglect Information (<http://nccanch.acf.hhs.gov>).

The National Child Welfare Resource Center for Family-Centered Practice

<http://www.cwresource.org/aboutus.htm>

This is a service of the Children's Bureau. The Resource Center seeks to enhance the capacity of State and Tribal child welfare agencies to plan, implement, and evaluate family-centered services for children and families. Located in Washington, DC, the Resource Center is a project of Learning Systems Group and the National Indian Child Welfare Association.

Family Network

<http://www.coordinatedyouth.com/FamNet.htm>

This is a process we have designed for bringing families together with each other and with others in their support system. The Family Network team can comprise anyone the family chooses. Typically, it involves key family members, their personal

support people and professional service providers. When a number of professional services are involved, one of the professionals may be designated the "Team Coordinator." Together you embark on a journey of defining a problem to be solved, identifying the resources you all bring to the table, creating steps toward a solution, and evaluating the results of your decisions and actions. CYSC will support the team by training you to work together in a unique way, arranging, coordinating, and facilitating meetings, providing a written record of each meeting for all participants, and offering consultation to any team member who requests help or advice on working more effectively with the team. We will be there and support you every step of the way.

American Counseling Association

<http://www.counseling.org/conference/advocacy6.htm>

This site provides information on working with multiracial families. The multiracial population is one of the fastest growing segments of the U.S. population. In discussing the multiracial population it is first important to identify and define the groups that are encompassed under the heading of multiracial. Literature on the topic of multiracialism has included: interracial couples, multiracial individuals, and families in which a crossracial or transracial adoption or foster care arrangement has occurred. (Kelley Kenney, Chair of the Multi-Racial/Multi-Ethnic Counseling Concerns Interest Network).

MODULE III

**COURSE CONTENT FOR ONE CLASS ON
FAMILY GROUP CONFERENCING**

MODULE III

COURSE CONTENT FOR ONE CLASS ON FAMILY GROUP CONFERENCING

INTRODUCTION (Slide 80)

This module is designed to provide background information, exercises, and resources on Family Group Conferencing for delivery in a classroom setting in a 2- to 4-hour format by a faculty/instructor/trainer. Components of this module include:

- A synopsis of Family Group Conferencing
- Legislation supportive of FGC
- History
- Definition
- Philosophy
- Models of FCG
- Process of Family Group Conferencing
- Facilitator's role
- Trends and evaluation of FCG
- Exercises for the classroom
- Suggested videos
- Bibliography

A PowerPoint presentation (available online) is included as a visual aid in the delivery of this module.

FAMILY GROUP CONFERENCING

When we allow families to accept responsibility for their children, even if we may view the family as dysfunctional, we open up all sorts of positive options that we may not have seen. FGDMs are not magic, nor are they the cure-all tool. However, the model, if used with professional honesty, can have an impact on families we could not achieve otherwise. – An Oregon Facilitator

Family Group Conferencing (FGC) emerged out of both current child welfare legislation and the strengths-based social work practice philosophy. It is within this context that FGC was born. That is, the major paradigm shift from a pathology focus to a strengths-based model provided the fertile ground for FGC to come about as an alternative means of improving outcomes for children in the child welfare system.

CURRENT STATUS OF CHILD WELFARE LEGISLATION

Recent Acts related to child welfare legislation that have enhanced strength-based practices as listed by the Children's Bureau include:

- Promoting Safe & Stable Families Amendments of 2001
- Strengthening Abuse & Neglect Courts Act of 2000
- Intercountry Adoption Act of 2000
- Child Abuse Prevention & Enforcement Act, 2000
- Foster Care Independence Act of 1999
- Adoption and Safe Families Act of 1997
- Child Abuse Prevention & Treatment Act Amendments of 1996
- Child Abuse Prevention & Treatment Act, as Amended, 1996

The Adoption and Safe Families Act (ASFA), signed by President Clinton in November of 1997 (PL 105-89), is regarded as one of the most significant pieces of child welfare legislation over the past 20 years. This law was enacted by Congress in response to the growing problems with the child welfare system. According to the March

1999 State Legislative Report, “ASFA requires numerous changes to state laws and policies to remain eligible for federal funds under Titles IV-B and IV-E of the Social Security Act” (U.S. Department of Health & Human Services, Children’s Bureau, 2000).

The focal point of ASFA is both safety and permanency for children who are in the foster care system due to abuse or neglect. Specifically, the legislation is a reaction to the misinterpretation of the federal mandate for “reasonable effort” to preserve and reunify families. Children were being allowed to remain in or return to unsafe homes. In 1998, 38 states enacted ASFA-related legislation. The primary objectives of ASFA are to:

- Clarify the “reasonable efforts” requirement and identify when efforts to preserve or reunify are not required under federal law,
- Expedite the process of placing children in permanent homes if they are not able to return home (addresses termination of parental rights),
- Emphasize child safety and promote adoption when appropriate,
- Accelerate the time frame for permanency hearings, and
- Provide incentive payments to states that increase the number of adoptions in foster care.

Despite the fact that responding to ASFA was a high priority for state legislatures in 1998, the complexity of this federal legislation continues to pose many challenges. The National Child Welfare Resource Center for Family-Centered Practice newsletter (2000, Summer) addresses some of the anticipated challenges. One of the critical concerns is how this law may create further pressure on frontline staff diminishing the likelihood that effective services will be delivered to families in a timely manner. A second long-term issue relates to both the lack of adoptive homes and difficulty of

crafting permanency options for children where neither reunification nor adoption is a viable plan. As multitudes of children are freed for adoption under ASFA, there is the potential for a new crisis. According to the Adoption and Foster Care Analysis and Reporting System (AFCARS) report from the Children's Bureau, in 1999 there were 117,000 children awaiting adoption and yet the number of children adopted from the foster care system was 36,000 (U.S. Department of Health & Human Services, Children's Bureau, 2000, p. 3).

Currently, the Children's Bureau is involved in various initiatives related to child safety and permanency such as:

- Quality Improvement Centers on Child Protective Services and Adoption Services,
- Child Welfare Waiver Demonstrations, and
- Emerging Practices in Child Abuse and Neglect Prevention.

LEGISLATION REGARDING FAMILY GROUP CONFERENCING

While New Zealand has legislation to guide the implementation of Family Group Conferencing (FGC) under *The Children, Young Person's and Their Families Act* of 1989, the United States has not adopted such legislation at either the federal or state levels. New Zealand's law legally sanctions the procedural use of FGC (Merkel-Holguín et al., 1997). However, in the United States FGC is supported and reinforced through federal and state policy, practice, and law; in particular through ASFA of 1997. FGC may be viewed as a tool to both support families and expedite the process of finding permanent homes for children (Merkel-Holguín, 2000b).

There are both advantages and disadvantages to adopting legislation that would mandate FGC implementation procedures with families. The degree of compatibility between FGC and federal child welfare law brings up issues such as: (a) federal privacy statutes, (b) state child abuse and neglect confidentiality laws, and (c) agency liability for family decisions (Merkel-Holguín et al., 1997, pp. 84-85). For further information on current child welfare laws and policy, see the Children's Bureau website at www.acf.hhs.gov

WHAT IS FAMILY GROUP CONFERENCING? (Slide 81)

Family Group Conferencing (FGC) is a “goal-oriented, strengths-based process that allows families to systematically make decisions about their children’s care and protection” (Wilmot, 2000, p. 3). Through a partnership and collaborative means, the aim is to help strengthen and empower families in order to create safety for children at risk of intrafamilial abuse or neglect. Family participation is a pivotal resource in the child protection decision-making process and is used to expedite permanency for children.

FGC practice is characterized by certain noteworthy traits. It:

- Is family-centered, strengths-based, and culturally competent,
- Mobilizes family resources and community networks,
- Focuses on partnership, balance of power, and collaboration; and
- Uses a solution-focused decision-making model.

In FGC, families, as defined by the family to often include extended family or “fictive kin,” are brought together to discuss family concerns and come up with an agreed upon plan for the child at risk of out-of-home placement or already separated. A

facilitator assists in preparation activities, orchestrating the meeting, and approving the family's plan. The actual conference typically involves an introduction or information sharing, meeting, and a decision or plan.

(Slide 82) Some of the primary objectives of FCG are to (Fisher, 1998; McDonald & Associates, 1998):

- Reduce the use of out-of-home care and number of court proceedings,
- Increase the number of children living with relatives,
- Reduce the number of referrals for child maltreatment investigations,
- Identify and tap resources within family systems in problem solving,
- Decrease parental stress and social isolation while increasing family cohesion, and
- Increase compliance with an agreed-upon and customized service plan.

Universally, the goals of FGC are to improve child safety, increase permanency options for children, and increase family cohesiveness and functioning (Merkel-Holguín, 2003).

FOCUS ON FAMILY PRESERVATION/FAMILY EMPOWERMENT AND STRENGTHS-BASED PRACTICE

Family-Centered Practice

Traditionally, the most common intervention with multiproblem families in child protection was the removal of the child from the home. In contrast to this approach, alternative child welfare practices involve a paradigm shift to more of a family-centered practice. This model of practice is based on preserving and supporting the family while simultaneously protecting the children. FGC relies upon building family capital including providing services to extended family and kinship groups as well as utilizing informal

resources in the community (National Child Welfare Resource Center for Family-Centered Practice, 2000b).

Although the shift from primarily child-focused to family-centered may appear to create a dichotomy between the aims of protecting children and preserving families, the relationship between the goals is critical. *That is, in many cases the best approach to protect children is to strengthen families.*

The family-centered and strengths-based practices embedded in the family group decision making process are consistent with philosophical shifts occurring within child welfare. FGDM is one way to help improve the child welfare service delivery system, and expand their capacity to respond to the needs of children and their families. It redefines family to include extended members and others the family considers important in making decisions about the best interests of their children (Family Independence Agency, 2003).

Essential elements of family-centered practice according to the National Child Welfare Resource Center for Family-Centered Practice (2000a) are as follows:

- The family as a unit is the focus of attention.
- Emphasis is placed on assessing and building on family strengths and on the capacity of families to function effectively.
- Families are engaged in designing all aspects of the policies, treatment, and evaluation.
- Families are linked with a more comprehensive, diverse, and community-based network of supports and services (p. 8).

Ecological and Family Systems Theory

The basic concepts from a family-centered framework are influenced by both family systems and ecological theories. The goal of intervention becomes that of helping families to interact in ways that are more effective and improve the transactions between the family and other environmental systems.

Current Philosophies

FGC is being studied and implemented as it fits with the current philosophies in child welfare. The trends include three central premises including: increasing the use of kinship care, capitalizing on family strengths, and focusing on the participatory decision-making process between the family and the professionals (Merkel-Holguín, 2000b).

Broader Definition of Family

A key FGC principle is the inclusion of a broader definition of family to include extended family, nonbiological family members, and friends; this supports the notion of “fictive kin” as placement possibilities. The underlying belief is in the sanctity of the child’s continued relationship with all family members and his or her culture (Wilmot, 2000).

Strengths-Based and Empowerment Focused

A strengths-based approach identifies the positive capacities within the family and assumes that the family has what it needs to resolve its own problems. This however, does not preclude additional help or resources to develop its own solutions. Through this avenue, the solution is unique to the family and may be owned by them, increasing the likelihood of a successful outcome. The underlying premise is that

families have strengths and ultimately this resolves concerns and promotes change (Okamura & Quinnett, 2000; Pennell & Burford, 1994).

Empowerment, embedded in person-in-environment theory, is about facilitating contexts in which marginalized individuals have a voice and may exert influence over decisions that affect their lives. It gives attention to issues of partnership, participation, and power. Essentially, it recognizes that some people have more power than others and attempts to balance this dynamic resting on the belief that people are capable of change and making their own decisions (Connolly & McKenzie, 1999).

The concept of empowerment is a key FGC. There is the intent to shift the balance of power between families and professionals, creating more of a partnership. The objective is to reduce the role of state in family life and re-emphasize the responsibility of family and community to care for its children (Lupton, 1998). In part, this means involving family members and kin actively in the helping process and providing them with the needed resources and support (Kemp, Whittaker, & Tracy, 2000).

Specifically, empowerment in FGC may take the form of giving the family a solid understanding of family group conferencing prior to the meeting and instilling the belief that they will significantly influence the direction of the family plan or agreement. As families are encouraged to actively participate in the decision-making process they are empowered.

Shared Decision Making.

Shared responsibility infers that the CPS agency is not the sole means for protecting children. Rather, it encompasses governmental agencies at the federal, state,

and local levels, nonprofit agencies, citizen groups, neighbors, and most imperatively, the family. A key assumption is that most often family members have something to contribute to decision making and that they have the most complete source of information (Burford & Hudson, 2000).

Principle Philosophy

FGDM's principle philosophy "is that the safety and well being of children can be enhanced by consensus participation from family members, government workers, and community persons who have direct interest in the case and protection of children" (McDonald & Associates, 1998, p. 2.1).

HISTORY OF FAMILY GROUP CONFERENCING

The Family Group Conference (FGC) model first emerged and was legislatively mandated in New Zealand in 1989; concurrently the Family Unity Model (FUM) was developed in Oregon. Based on these foundations, various models and approaches have taken hold both nationally and internationally, both as pilot projects and within statutory changes (Merkel-Holguín, 2003). According to the National Center on Family Group Decision Making, approximately 25 states are discussing or have implemented some form of family group decision making (Merkel-Holguín).

In child welfare practice, certain conditions have provided fertile ground for FGC to develop. Some of these factors include (Fisher, 1998; Connolly & McKenzie, 1999; Merkel-Holguín, 2000b):

- A significant increase since the 1980s in the size of the foster care population,
- A disproportionate number of minority children living in out-of-home care,
- Many children experiencing multiple out-of-home placements and spending an unacceptable amount of time in these settings,

- Recognition that removing children from their parents can be as harmful as the maltreatment they have experienced,
- Social workers around the country became more dissatisfied with the monocultural approaches to child protection, which neglected to view the child within the context of the family, and
- Institutional racism and prejudices.

(Slide 83) Legislatively, the origins date back to *The Child, Young Persons, and Their Families Act of 1989* in New Zealand which was enacted to establish alternative ways of working with abused and neglected children (Sieppert et al., 2000). The emphasis on FGC also grew out of a certain political context:

- The perceived disintegration of the traditional family,
- Increased emphasis on community participation and accountability,
- A shift toward reducing government intervention, and
- Decentralization of government services to encourage local solutions.

Specifically, the roots are attributed to the indigenous Maori population in New Zealand, as they raised concerns over the standard child welfare practices and their implications on tribal families. They were reacting to the excessive rates at which children were being placed in nonrelative care or governmental institutions. There were significant cultural clashes with the child welfare system through the promotion of Eurocentric models that emphasized family pathologies and ignored strengths (Connolly & McKenzie, 1999).

In response to these injustices, the Maori people lobbied for legislation that would incorporate “tribal values and the use of Whanau Hui (family meetings) into standard practice when looking to resolve issues of care and protection for their children”

(Wilmot, 2000, p. 1). The Maori culture's value of extended family was mobilized in ways that led to alternative child welfare approaches. With a push for a family-centered approach, the family became involved as part of a valid intervention and therein a more effective and culturally competent practice (Okamura & Quinnett, 2000; Wilmot).

Along with the New Zealand model, the child welfare workers in Oregon were recognizing that the "system" was massively failing families and that drawing on family and community resources was needed. Oregon was the first state to incorporate family group decision making into their child welfare practice. Oregon's Family Unity Meeting model was noted for identifying family "strengths" and reframing problems as "concerns". In 1992 Oregon became aware of New Zealand's model, and dialogue about best practice ideas were then exchanged (Okamura & Quinnett, 2000; Burford & Hudson, 2000).

This model is being implemented across the United States in California, Washington, Hawaii, Michigan, and Kansas, and abroad in locations such as Canada, the United Kingdom, Sweden, and Australia. The American Humane Association has played a leading role in bringing the efforts together through yearly roundtables, written materials, and websites. The National Center on Family Group Decision Making is an excellent resource. For further information see their website at www.fgdm.org

FAMILY PRESERVATION: PERMANENCY PLANNING

The permanency planning paradigm encompasses both *family preservation* and *family reunification* approaches.

Permanency planning has been formalized in the United States for many years in response to the foster care explosion and the states' inability to provide continuity of care for children in the child welfare system. It refers to a "systematic process of carrying out, within a brief time-limited period, a set of goal-related activities designed to help children live in families that offer continuity of relationship with nurturing parents" (Connolly & McKenzie, 1999, p. 9).

Family preservation may be viewed as a prevention tool to address the permanency needs of children. It involves providing any necessary support services to the family with the aim of retaining the child in the home. At the heart of family preservation services is permanency for children.

There is much overlap in philosophy and practice between family conferencing and family preservation and permanency planning (Burford & Hudson, 2000). Some of the key characteristics that are consonant among these practices include:

- Viewing the family as the unit for focus of attention; addressing strengths and empowerment;
- Mobilizing the extended family, developing partnerships, and emphasizing community-based services; and
- Focusing on "systematic planning within a specified time for children who are in foster care," stressing the importance for stability and continuity of relationships.

The child welfare system under the Adoption and Safe Families Act (ASFA) delineates the mandates related to improving child welfare outcomes under the permanency planning paradigm. The legislation, in part, requires the following standards (National Child Welfare Resource Center for Family-Centered Practice, 2000b):

- Specification of the duration of reunification efforts,
- Expedition of case reviews and permanency plans, and
- Enforcement of termination of parental rights when children are in placement for 15 of the previous 22 months

MODELS OF FAMILY GROUP CONFERENCING: NEW ZEALAND AND OREGON

(Slide 86) From a historical perspective, two primary models were initially developed and based on these approaches, various models have emerged over the past 10 years (Merkel-Holguín, 2003). The first is the Family Group Conference (FGC) originating in New Zealand and the second is the Family Unity Meeting (FUM) from Oregon. One of the distinguishing components of *FGC is the private family time* while *FUM emphasizes mobilizing family strengths*.

- The FCG model was first developed in New Zealand where it was legislatively mandated through *The Children, Young Persons and Their Families Act of 1989*.
 - “Family Group Conference (FGC) is a legal process based on traditional Maori decision making practices. As a problem-solving forum, it provides an opportunity for the family, including the extended family, to hear the concerns and contribute to the decision making process with respect to the child” (Connolly & McKenzie, 1999, p. 23). The idea is for maximum family attendance and minimal professional attendance.
 - The culture of colonialism and the Western notions of individuo-centrism clashed with New Zealand’s indigenous Maori people creating negative interactions and outcomes with regard to the state welfare system. In the process of attempting to “assimilate” the Maori people into Western culture, large numbers of children were removed from their families or “whanau” and placed under the guardianship of the director-general of Social Welfare. Within this context, family group conferencing emerged as an alternative to the oppressive and often adversarial tactics used in delivering services to children and families (Burford & Hudson, 2000).
 - Under New Zealand’s legislative mandate, FGC is used with all families of children who are abused and neglected. As mentioned, an important feature of FGC is the private family meeting without the presence of professionals (Merkel-Holguín, 2000b).

- The FUM model was concurrently developed in Oregon in 1989.
 - “FUMs were designed to facilitate joint decision making by creating a partnership of family, extended family, community, and child welfare authorities for the safety of children, while promoting family participation and ‘say’ planning for their children” (Burford & Hudson, 2000, p. 276).
 - This version of family meetings is used most frequently by state child welfare workers. As a result of legislation and agency policy adhering to a top-down process, the use of FUMs has increased dramatically in the United States. Although the format varies somewhat, typically a private family deliberation time is not implemented but rather the facilitation of joint-decision making between the family and authorities for the safety of children (Burford & Hudson, 2000).
 - Oregon state law mandates that a FUM should be considered in every case where out-of-home care is being considered (Okamura & Quinnett, 2000).

DIFFERENCES BETWEEN FGC AND FUM MODELS

In a process evaluation report on *The Santa Clara County Family Conference Model*, several models of family group decision making were compared in terms of 19 characteristics (McDonald & Associates, 1998). The models were from programs established in New Zealand, Oregon, Newfoundland, Michigan, Kansas, and California. California included Stanislaus and Santa Clara counties. The characteristics that were compared and contrasted included topics such as: philosophical basis, primary concern, cultural differences, preparation time, length of meeting, participation, private family time, and decision making. For example:

- Comparison regarding when a *conference is used in child welfare cases*:
 - *New Zealand (FGC)*: “after the initial investigation or assessment is completed and there is reasonable cause to believe that the child is in need of care or protection” (McDonald and Associates, 1998, p. 2.10).

- *Oregon (FUM)*: “when out-of-home placement or a return is being considered; used with cases having a high chance of success” (McDonald and Associates, p. 2.10).
- Comparison regarding *participation* and the *issue of power*:
 - *New Zealand (FCG)*: initial phase includes all participants, second phase involves family members deliberating in private time, and third phase is where the coordinator and professionals rejoin the family
 - *Oregon (FUM)*: family and social worker chose who will participate in the conference; veto power over conference is held by families
- Comparison regarding *preparation* for the conference *and length of meeting*:
 - *New Zealand (FGC)*: *preparation is an average of 36 days; meetings generally last from 15 minutes to 5 hours (exceptional cases may take days)*
 - *Oregon (FUM)*: facilitator contacts all participants by phone, letter, or in person to arrange the meeting; a typical meeting lasts from 1½ to 3 hours

Although there are noteworthy differences, all models are based on the extended family and other supportive resources in making collaborative decisions about children who are at risk of maltreatment (McDonald and Associates, 1998).

FAMILY GROUP CONFERENCING PROCESS AND PHASES (Slide 87)

There are four main phases common to the various models, even though the specifics may be implemented differently. The following is based on the New Zealand FGC (Merkel-Holguín, 2003):

- Referral to hold the FGC meeting,
- Preparation and planning for the FGC meeting,
- The conference (FGC and FUM Meetings), and
- Subsequent events and planning following the meeting.

Referral to Hold the FGC Meeting

Referrals of families are obtained from various sources but it is often the social worker on the case who refers to a coordinator; referrals may take place after the initial investigation or assessment is completed, when out-of-home placement or reunification is being considered, or any time it may be beneficial to the family to discuss possible outcomes for the care and protection of the child; there is discrepant information about whether cases involving domestic violence or sexual abuse are appropriate for FGC.

Preparation and Planning for the FGC Meeting

Adequate preparation and planning can be the determining factor between the success or failure of a FGC meeting; it is crucial that all participants understand the purpose of the meeting, clarify their roles, and reduce any anxieties beforehand; time to prepare ranges from 22-35 hours to an average 36 days; the coordinator completes preconference activities such as:

- Ensure safety for the child or adolescent,
- Define or broaden what is meant by family,
- Invite family members and other participants (involve offenders),
- Define and communicate participants' roles—educate family members about the FGC process,
- Manage unresolved family issues, and
- Coordinate logistics.

The Conference

The primary facilitator and cofacilitator are responsible for conducting the family conference; the wider family network participates in this process with an average

number of participants fluctuating between 9 and 14 people; there are common stages involved in the actual conference:

- *Introduction:* meeting starts in ways that are culturally relevant to the family; coordinator welcomes all participants, and reiterates each person's role, the purpose, and goals.
- *Information-sharing stage:* necessary information and facts are provided to the participants in order to ensure the most productive problem-solving process. There are two models in which the information is presented: New Zealand—referring social worker presents facts of the case and the family asks to clarify if needed, and Oregon—participants discuss the strengths and concerns of the family.
- *The family meeting:* depending on the model, this may involve private family time without professionals or nonfamily support persons or a facilitator may lead the discussion; it is a time to problem solve and create a plan; the family has two important questions to answer: “(a) was the child abused or neglected? and if so, (b) what needs to occur to ensure the child is cared for and protected from future harm?” (Merkel-Holguín, 2000b, p. 4).
- *The decision:* a plan is agreed upon by the family in terms of a decision on how to care for the child. It is presented by the family to all the participants and explained in detail; in cases of dissenting views, there may be either veto power or referrals to Family Court for decisions.

In FUM, the stages for the meeting differ and include introductions, defining the purpose of the meeting, a strengths assessment, and concerns.

Subsequent Events and Planning After the FGC Meeting

Documentation involves writing the plan and then distributing it to all participants; the plan includes specific steps for implementing the decision and such items as needed resources, time frames, contingency plans, a monitoring system, and an evaluation plan; both informal and formal resources are relied upon (National Center on Family Group Decision Making, n.d.; McDonald & Associates, 1998; & Merkel-Holguín, 2000b).

THE FACILITATOR'S ROLE IN FAMILY GROUP CONFERENCING

"Conferences are the art of the possible" (Marsh & Crow, 1998, p. 59).

- As written by Okamura and Quinnett (2000), "The family group decision making models of family conferencing or family unity meetings call into play a number of skills at all levels" (p. 4.3).
- Fisher (1998) writes, "Conducting a successful Family Conference requires advanced skills in facilitating group dynamics, and identifying and nurturing family strengths which can be developed to provide for the safety and well-being of the children" (p. 50).

Key point: Family group conference involves group process but it is not a therapy or treatment group.

As the facilitator's role is closely linked to successful outcomes, training is an important component to FGC. The training may include topics such as principles and philosophies of FGC, the court's role and legal aspects, cultural competency, and mediation. Often the trainings include role playing (McDonald & Associates, 1998).

(1) At the micro level: There are core values that relate to the foundational principles of FGC that the facilitator needs to embrace in order to be effective. First, the facilitator needs to have a *belief in the potential of families* to come up with their own solutions. This directly relates to the strengths perspective out of which FGC emerged. It also involves trusting the process.

The second value relates to power issues and the *importance of participatory decision making*. Although there are varying degrees of control given to families depending on the specific model, the input of all individuals in the meeting is important. Facilitators must be aware of *power or control dynamics* and mediate the conference in ways where "equal time" is allowed. The emphasis is on participation, networking, and

collaboration. *A facilitator should “value families and believe in the power of family”* (Okamura & Quinnett, 2000, p. 4.6).

QUALITIES OF A FACILITATOR (Slide 88)

- Neutrality is essential to the outcome of a FGC “The facilitator states their stance as neutral at the beginning of the meeting as well as when they first begin contacting participants” (Okamura & Quinnett, 2000, p. 4.8).
- Acceptance and nonjudgmental about lifestyles, beliefs, and behaviors of others.
- Leadership skills. It is recommended that a beginning facilitator take the Leadership Comfort Scale (Toseland & Rivas, 2009, p. 120).
- Comfort with confrontation and conflict management.
- The ability to focus on behaviors—this is a task oriented group.

DIRECT PRACTICE SKILLS USED BY A FACILITATOR

- Joining with family members when appropriate;
- Listening, observing, clarifying, and defining;
- Paraphrasing and reflecting feelings and content;
- Normalizing and reframing;
- Confronting, mediating, and self-disclosing; and
- Using knowledge about developmental stages to explain behaviors of children.

An important skill for facilitators is that of *reframing* which refers to assisting clients to view situations or problems from another vantage point. This is an invaluable technique and helps to keep the family on target rather than get stuck in blaming others. In addition, the facilitator needs to be self-aware and cognizant of *transference and countertransference*. As the issues that are likely to arise are going to be intense and fraught with established family dynamics, the facilitator must be alert to how he or she impacts the group and vice versa. Last, there must be attention to *cultural factors and*

respect for diversity. One way to do this is start the meeting off with a family custom or tradition, thereby incorporating practices that are comfortable to the family.

At the beginning, it is necessary to establish *ground rules* for the group. Some suggestions include: one voice at a time, no side conversations, respectful language, and no old history (Okamura & Quinnett, 2000).

(2) At the mezzo level: The FGC is a “group” most closely resembling a task group. Thus, group dynamics are going to be present. Just as planning and preparation is an important step in successful group work, it is a vital part of FGC. Engaging the participants prior to the actual meeting is crucial. Participants need a clear understanding of the purpose and their roles. During the conference, there must be attention to the dynamics of the group and interactions of the members. Additionally, community involvement and working with cultural differences is a part of employing skills at the mezzo level (Okamura & Quinnett, 2000; Marsh & Crow, 1998; Shapiro, Peltz, & Bernadette-Shapiro, 1998).

Anger and conflict management is an important skill to develop as a facilitator. As child abuse and neglect issues will most likely evoke strong feelings, there will often be both anger and conflict that surfaces. Being able to effectively manage both in an assertive way is imperative (Okamura & Quinnett, 2000).

(3) At the macro level: FGC must unfold within a certain backdrop of principles and philosophies in order for it to be effectively implemented. For example, an agency not used to involving family members in decision making, will need to make some shifts

in practice philosophy. Implementing change at the macro level involves specific skills (Okamura & Quinnett, 2000).

According to Burford, Pennell, and MacLeod (1995), effective Family Group Conferencing includes these key ingredients:

- Seeing that the integrity and dignity of the family is maintained;
- Insuring that the (child's) safety needs are met;
- Holding the abuser accountable for the abuse; and
- Promoting the sense of togetherness and pride of the community, and showing respect for cultural considerations.

CURRENT TRENDS IN FAMILY GROUP CONFERENCING

The emerging trend within U.S. communities is to incorporate elements of the various family group conferencing models. According to Merkel-Holguín, presently there are “about 40 states and 150 communities implementing FGC” (personal communication, August 6, 2002).

TYPES OF CASES UTILIZING FAMILY GROUP CONFERENCING

As New Zealand has a legislative mandate to use family conferencing with all families of abused or neglected children, FGC has been used with cases of “child sexual abuse, domestic violence, physical abuse, neglect, mental illness, and developmental disabilities” (Merkel-Holguín et al., 1997, p. 4). One of the primary concerns in using FGC in cases of domestic violence or child sexual abuse, however, is the safety of the victims. These two types of cases tend to be the most commonly excluded as there is controversy over the appropriateness of such a case referral to

FGC. Currently in the United States, there are both formal and informal policies used to decide who is selected for case referral to the FGC process.

(Slide 89) At present, FGC is being implemented in settings other than the child welfare system with common values guiding the different approaches. This includes Patch, Wraparound, and Emancipation Conferences.

Patch

Although the Patch approach has roots in Great Britain, it was implemented in Cedar Rapids, Iowa as a federally funded 3-year demonstration project. Similar to both Wraparound and Emancipation Conferences, this approach is aligned with the current movement of the social work field towards strengths-based practice. Patch is an innovative process for agencies to work together with the primary aim of reinforcing natural helping networks within neighborhoods to support family needs (Merkel-Holguín et al., 1997). Patch refers to a “limited geographical area that is served by a locally based team of human service workers” (Adams & Krauth, 1995, p. 87).

The Patch system is a community-centered model of human service delivery. There is a shift from reactive to preventative work. Some of the underlying principles are partnership, community-based workers (Patch team workers are physically housed within the neighborhood), service integration, geographically defined area of service, nontraditional practice, and shared caseloads. According to Merkel-Holguín et al. (1997), “Creating community involvement is the essence of the Patch approach which is localized, integrated, and proactive community oriented” (p. 50). A central tool for intervention involves creating *a partnership between community members and the*

Patch team of workers. The Patch approach has begun to gain ground in the United States and is a promising catalyst for social services reform (Merkel-Holguín et al.).

Wraparound

Whereas FGC was developed within the *child welfare system*, Wraparound grew out of the *mental health system*. The former is an alternative approach to working with families in cases where abuse or neglect has been substantiated, and the latter is an interagency model to help families with children and adolescents experiencing emotional or behavioral problems (Burchard & Burchard, 2000).

Wraparound is best described as a team-based approach to planning and providing services for families and children experiencing significant psychosocial stressors. The basic philosophy is to identify community resources and supports that the family needs where the provision of services is “individualized, strengths-based, flexible, and culturally sensitive” (Burchard & Burchard, 2000, p. 140). The idea is to “wrap” the services around the family. Two of the originators of wraparound, John VanDenBerg and Karl Dennis promote the concept of a “zero reject model” meaning that the family cannot fail; the service plan must change to accommodate the needs of the child.

As an alternative to a more conventional service delivery system, both FGC and Wraparound have common values guiding the approach despite the primary focus being different. For example, both emphasize strengths and empowerment mobilizing family and community resources. Partnerships among family, kin, friends, and communities are pivotal as well as the aim of balancing the power. On the other hand,

there are differences with regard to the intervention itself. In FGC, the family group that formulates the plan is comprised of family and friends, whereas in Wraparound relevant professionals actively participate in this process. In addition, while the family group tends to meet only once, with Wraparound the child and family team meet on an as-needed basis.

Emancipation Conferences

Relying on Family Conferencing principles and guidelines, Emancipation Conferences are conducted for youths age 17 and over in the child welfare system who are anticipating emancipating and entering adulthood. The conference is a voluntary process for the youth. Similar to FGC, the purpose is to gather individuals in the youth's support system who may help prepare the youth for independent living. The focus of the conference is on the youth's strengths and ways to mobilize these for positive outcomes. With the assistance of a facilitator, the participants (often including family, friends, religious leaders, community members, and professionals) discuss options and ideas. The focus of the meeting is to come up with goals and resources for the youth's transition into adulthood.

RESTORATIVE JUSTICE

What Is Restorative Justice?

Family group conferencing not only exists for child protection in cases of abuse and neglect, but it is used also in juvenile offending and family violence. *Restorative justice deals primarily with juvenile offending.* Again, the roots of family conferencing date back to *The Children, Young Persons, and Their Families Act* of 1989 in New

Zealand. This allowed decision-making authority to be given to the family, with the input from the victim and community, in cases of youth offenders (Bright, 1997).

Restorative justice can be defined “as a systematic response to wrongdoing that emphasizes healing the wounds of victims, offenders and communities caused by crime” (Restorative Justice Online, 2002). It is a practical, problem-solving method where the victim, offenders, family, and community decide how to repair the harm. Originating as an alternative response to juvenile crime, it is a victim-sensitive approach to addressing wrongdoing.

Foundational Principles and Key Values for Restorative Justice:

- Justice requires an element of restoration.
- Those directly involved and impacted by the crime should have an opportunity to participate in a response.
- “Government’s role is to preserve a just public order, and the community’s is to build and maintain a just peace” (Restorative Justice Online, 2002).
- *Encounter*: Creates an opportunity for those involved in the crime to talk about what happened and its aftermath.
- *Amends*: There is an expectation that the offender will take steps to repair the harm.
- *Reintegration*: Seeks to restore *both* the victim and offender to wholeness in being a contributing member to society.
- *Inclusion*: Allows those with a stake in the crime to participate in its resolution.

According to Real Justice, a nonprofit provider of restorative justice conferencing, the goals are threefold including *accountability, competency development, and community safety*. Accountability is aimed at assisting offenders to take personal responsibility for their actions. Competency development refers to developing skills necessary for participating as an active member of society such as the capacity for

empathy, conflict resolution, and communication skills. Community safety is about allowing the victims' experiences to be heard and to regain a sense of safety and closure to the incident (Real Justice, 2000).

Programs Associated With Restorative Justice:

- Victim-offender mediation,
- Conferencing,
- Circles,
- Victim assistance,
- Ex-offender assistance,
- Restitution, and
- Community service

There are a *variety of uses* for restorative justice conferencing to include the following: schools (truancy, disciplinary incidents), police (diversion from court, especially for first-time offenders), probation officers, correctional and treatment facilities, colleges and universities (with dormitory and campus incident or disciplinary actions), workplaces (addressing both wrongdoing and conflict).

The Process of Restorative Justice Conferences

Participation in conferences is voluntary and not used to determine guilt of the offender. This type of conferencing may be used in lieu of traditional disciplinary or justice procedures or may be used to supplement the process. Conferencing programs are similar to victim-offender mediation as they both involve the victim and offender in discussion about the crime and the consequences, however, conferencing includes a

wider circle of people like families, community support groups, and social welfare officials (Restorative Justice Online, 2002).

A trained facilitator leads the conference, directing the focus. The conference revolves around distinct phases: *preparation, conference, and the postconference monitoring.*

In the preparation phase the facilitator receives the referral report and reviews the case. During the actual conference, both the victim and offender have an opportunity to “tell their story” and express their feelings about the event. Questions may be posed and then negotiation of a resolution is discussed. A consensus must be reached. In the last phase, monitoring the completion of the agreement takes place and, if needed, resources are located for the parties participating.

SAN DIEGO RESEARCH ON FAMILY GROUP CONFERENCING

The authors conducted research on Family Group Conferencing in San Diego County during 2000-2002. The methodology, data collection, data analysis, and discussion can be found in detail in the research module. Some of the highlights of the research include:

- Voluntary services: families were more likely to participate in FGC than families involved with the court system.
- Maternal members of the families were more likely to participate than paternal members.
- Social workers and families were concerned with different issues. Families focused on basic economic issues and social workers were more focused on child protective issues. Social workers are recommended to put more emphasis on problem solving economic issues.
- FGC expands the notion of “family.”

- Placement of children was consistent with the social worker's goals for the child.
- The presence of the maternal great-grandmother and/or maternal grandmother at a FGC predicted placement of the child other than with the parent.
- Benefits of FGC as perceived by the participants were modest.
- There is some evidence to indicate that FGC participants were more likely to receive help and advice from extended family.
- Clergy were seen as a source of support for a considerable number of individuals in the research sample.
- Social workers are overwhelmingly positive about FGC while respondents of the study were less likely to say a family plan developed at the meeting was carried out.

SUGGESTED EXERCISES

1. Option A: Divide class into groups: Assign each small group one of the following concepts:

- Strengths-Based Practice
- Empowerment-Oriented Focus
- Shared Decision Making

Ask each group to discuss the concept assigned. Ask each member to share an experience in which they have participated in that concept. Have a group member chart these experiences. Have the small groups return to a large group and have the group member who charted experiences share some of the experiences. Were there overlaps in the concepts when sharing?

Option B: Divide class as requested in Option A. In each group, discuss one of the group's family and how they might apply the assigned concept as an intervention. Ask members to be behaviorally specific. Have the groups reconvene the following week and discuss the intervention and its effectiveness.

2. Have the class divide into two groups. Assign the groups one of the following:

- New Zealand and Oregon Models of FGC
- Santa Clara FGC Model

Ask the groups to develop a list of advantages and disadvantages of each model. Compare and contrast. Given the students' experience, what model would they support? Why?

3. Show one of the suggested videos. Have students meet in small groups and discuss. What did they like about the video? What questions did it generate about FGC? Discuss cultural implications in using this model. Would there be some ethnic groups that would embrace this intervention? Would there be some groups that see this as threatening and not fully participate? Why or why not?
4. Have the class discuss the characteristics and role of a facilitator versus a therapist. What are some of the same or similar skills needed? What skills would be different? How does each of the roles handle confidentiality? What steps should a facilitator take in order not to fall into the “role” of therapist during a FGC meeting?
5. Hand out a copy of the research results of the San Diego Study on FGC. Ask students to develop a list of practice implications based on the research. Practice implications can be on the micro or macro levels.
6. For a Macro Emphasis: Discuss any current programs in your area that are doing FGC. What model is being used? What are the client criteria for participating in FGC? Are there any statistics on the program? Is there any evaluation process? What are the outcomes of the program? Additional information such as budgeting, staffing, and public versus private settings can be explored and the implications as an effective resource for families can be discussed.

SUGGESTED VIDEOS

The following information has been obtained from the American Humane Association’s National Center on Family Group Decision Making website. Below is the statement allowing for the reproduction of information from the website.

This material may be reproduced and distributed without permission; however, appropriate citation must be given to the American Humane Association's National Center on Family Group Decision Making (Copyright © 2000, 2001 American Humane Association).

Schools and agencies that are CalSWEC borrowing partners may borrow any of these videotapes from the California Child Welfare Resource Library (562-985-4570 or cfujii@csulb.edu).

Widening the Circle: The Family Group Decision Making Experience

44 minutes VHS

\$20

Originally produced in Canada, *Widening the Circle* describes the intervention by the extended family and various professionals to break the pattern of family abuse. The video follows one family's experience through the process, and shows the interplay between organizations and the family as they partner to stop family abuse. Video includes Facilitator Notes.

To check on availability in the United States, contact the University below.

To order in Canada, contact:

Memorial University of Newfoundland

Distance Education and Learning Technologies, ED1033

School of Continuing Education

St. John's, NL, Canada A1B 3X8

Phone: (709) 737-7575 or 1-866-435-1396 (Outside St. John's)

www.distance.mun.ca

Permanency Toolkit: Family Group Decision Making

25 minutes VHS

\$145

The first in "The Pathways to Permanency" series from Courter Films, this video demonstrates the FGDM process and describes how it works to achieve improved safety and permanency for children and increased family connectedness and functioning. In this video, you will see clips and scenes from various types of Family Group Decision Making meetings. You will hear from professionals working in the area of Family Group Decision Making, as well as from the families who have participated in this process. General principles and components of FGDM are explained.

Order from Courter Films & Associates (www.courterfilms.com).

A Plan for Joseph: An Actual Family Group Conference

75 minutes VHS

\$165

This video is a 75-minute edit from an actual 4-hour Family Group Conference held in Santa Clara County, California including private family time. An extended family returns for a follow-up conference about Joseph, who had been placed with relatives when his mother went to prison for drug abuse. Now released and in recovery, Joseph's mother is frustrated at the resistance of his caregivers to allow her, or even other members of the family, to have regular visitation. Joseph is acting out and is very angry and confused. His relative caregivers believe that it is in his best interest to withhold visits when he misbehaves. Family members have come from hundreds of miles away to try to resolve

these complex issues in a volatile, emotional, and heartfelt session. The conference has been shortened to 75 minutes and a brief narration has been added to clarify the situation. It may be viewed as a whole, or started and stopped to promote discussion among professionals interested in the subject, especially those who are training to run family group decision meetings. Teaching Guide available.

Order from Courter Films & Associates (www.courterfilms.com).

Let Us Put Our Minds Together: The Power of Family Group Conferencing in Washington State

24 minutes VHS Full-length Video (Library has this version)

11 minutes VHS Presentation Video

\$35 either version (currently out of print)

Family members who participated in five different family group conferences in Washington State share moving stories about how their conferences gave them the opportunity to create safe and permanent plans for their children. The video demonstrates the commitment and power that families can bring to the decision-making process as well as their willingness to take responsibility and to create solutions that resolve child abuse and neglect concerns. The video uses clips of simulated conferences as well as interviews with social workers, facilitators, an attorney, and a court commissioner to explain general principles, the FGC process, and benefits of this approach. The Northwest Institute for Children and Families, University of Washington, School of Social Work produced this video.

MODULE IV

FAMILY CONFERENCING MANUAL

(This module is designed for Field Instruction.)

MODULE IV

FAMILY CONFERENCING MANUAL

INTRODUCTION

The following module has been developed for field instructors and students who are engaged in Family Group Conferencing as part of the student's field practicum.

A table of contents lists the topical areas for field instructors and students, including orientation material; potential policy and procedures; special issues that may arise when doing Family Group Conferencing; and an appendix of forms, handouts, and resources.

Using San Diego County's Family Group Conferencing Program as a guide, this module includes procedures and logistics tailored to their program. When utilizing this module, field instructors and students are encouraged to tailor specific forms, procedures, and logistics to their own program. Additional resources (bibliography and websites) are included to assist field instructors and students on other Family Group Conferencing research and programs.

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ORIENTATION

What Is Family Group Conferencing?

Family Group Conferencing (FGC) is a “goal-oriented, strengths-based process that allows families to systematically make decisions about their children’s care and protection” (Wilmot, 2000, p. 3). Through a partnership and collaborative means, the aim is to help strengthen and empower families in order to create safety for children at risk of intrafamilial abuse or neglect. Family participation is a pivotal resource in the child protection decision-making process and used to expedite permanency for children.

FGC practice is characterized by certain noteworthy traits, it:

- Is family-centered, strengths-based, and culturally competent,
- Mobilizes family resources and community networks,
- Focuses on partnership, balance of power, and collaboration; and
- Uses a solution-focused decision-making model.

In FGC, families, as defined by the family often to include extended family or “fictive kin,” are brought together to discuss family concerns and come up with an agreed upon plan for the child at risk of out-of-home placement or already separated. A facilitator assists in preparation activities, orchestrating the meeting, and approving the family’s plan. The actual conference typically involves an introduction or information-sharing, meeting, and a decision or plan.

Some of the primary objectives of FGC are (Fisher, 1998; McDonald & Associates, 1998):

- Reduce the use of out-of-home care and number of court proceedings,
- Increase the number of children living with relatives,
- Reduce the number of referrals for child maltreatment investigations,

- Identify and tap resources within family systems in problem solving,
- Decrease parental stress and social isolation while increasing family cohesion,
- Increase compliance with an agreed-upon and customized service plan.

The universal goals of FCG are to improve child safety, increase permanency options for children, and increase family cohesiveness and functioning (Merkel-Holguín, 2003).

History of Family Group Conferencing

The Family Group Conference (FGC) model first emerged and was legislatively mandated in New Zealand in 1989; concurrently the Family Unity Model (FUM) was developed in Oregon. Based on these foundations, various models and approaches have taken hold both nationally and internationally, as pilot projects and within statutory changes (Merkel-Holguín, 2003). According to the National Center on Family Group Decision Making, approximately 25 states are discussing or have implemented some form of family group decision making (National Center on Family Group Decision Making, n.d.).

In child welfare practice, certain conditions have provided fertile ground for FGC to develop. Some of these factors include the following (Connolly & McKenzie, 1999; Fisher, 1998; Merkel-Holguín, 2000b):

- Significant increase since the 1980s in the size of the foster care population;
- Disproportionate number of minority children living in out-of-home care;
- Many children experiencing multiple out-of-home placements and spending an unacceptable amount of time in these settings;
- Recognition that removing children from their parents can be as harmful as the maltreatment they have experienced;
- Social workers around the country becoming more dissatisfied with the

monocultural approaches to child protection, which neglected to view the child within the context of the family; and

- Institutional racism and prejudices.

Legislatively, the origins date back to *The Child, Young Persons, and Their Families Act of 1989* in New Zealand, which was enacted to establish alternative ways of working with abused and neglected children (Sieppert et al., 2000). The emphasis on FGC also grew out of a certain political context:

- The perceived disintegration of the traditional family,
- Increased emphasis on community participation and accountability,
- A shift toward reducing government intervention, and
- Decentralization of government services to encourage local solutions.

Specifically, the roots are attributed to the indigenous Maori population in New Zealand, as they raised concerns over the standard child welfare practices and their implications on tribal families. They were reacting to the excessive rates at which children were being placed in nonrelative care or governmental institutions. There were significant cultural clashes with the child welfare system through the promotion of Eurocentric models that emphasized family pathologies and ignored strengths (Connolly & McKenzie, 1999).

In response to these injustices, the Maori people lobbied for legislation that would incorporate “tribal values and the use of Whanau Hui (family meetings) into standard practice when looking to resolve issues of care and protection for their children” (Wilmot, 2000, p. 1). Maori culture’s value of extended family was mobilized in ways that led to alternative approaches in child welfare. With a push for a family-centered

approach, the family became involved as part of a valid intervention and therein a more effective and culturally competent practice (Okamura & Quinnett, 2000; Wilmot).

Along with the New Zealand model, child welfare workers in Oregon were recognizing that the “system” was massively failing families and that drawing on family and community resources was needed. Oregon was the first state to incorporate family group decision making into their child welfare practice. Oregon’s Family Unity Meeting model was noted for identifying family “strengths” and reframing problems as “concerns.” In 1992, Oregon became aware of New Zealand’s model and dialogue about best practice ideas were exchanged (Burford & Hudson, 2000; Okamura & Quinnett, 2000).

This model is being implemented across the United States in California, Washington, Hawaii, Michigan, and Kansas, and abroad in locations such as Canada, the United Kingdom, Sweden, and Australia. The American Humane Association has played a leading role in bringing the efforts together through yearly roundtables, written materials, and websites. The National Center on Family Group Decision Making is an excellent resource.

Emancipation Meetings

A variation on the family group conferencing model is held for teens who will be emancipating from group home care or foster/kinship care. The focus of these meetings is to develop a plan for the youth to live on his or her own. The process is similar to a family group conferencing meeting in that the youth invites family, members of the community, or other supports in the youth’s life to focus on a strategy to help the youth

more successfully emancipate. An example of running an emancipation conference is found on Form C.

PROCEDURES

The Role of the Facilitator

“Conferences are the art of the possible” (Marsh & Crow, 1998, p. 59).

- As written by Okamura and Quinnett (2000), “The family group decision making models of family conferencing or family unity meetings call into play a number of skills at all levels” (p. 4.3).
- Fisher (1998) writes, “Conducting a successful Family Conference requires advanced skills in facilitating group dynamics, and identifying and nurturing family strengths which can be developed to provide for the safety and well-being of the children” (p. 50).

Key point: The Family Group Conference involves group process but it is not a therapy or treatment group.

As the facilitator's role is closely linked to successful outcomes, training is an important component to FGC. The training may include topics such as principles and philosophies of FGC, court's role and legal aspects, cultural competency, and mediation. Often the trainings include role playing (McDonald & Associates, 1998).

At the micro level: There are core values that the facilitator needs to embrace in order to be effective, which relate to the foundational principles of FGC. First, the facilitator needs to have a *belief in the potential of families* to come up with their own solutions. This directly relates to the strengths perspective out of which FGC emerged. It also involves trusting the process. The second value relates to power issues and the *importance of participatory decision making*. Although there are varying degrees of control given to families depending on the specific model, the input of all individuals in

the meeting is important. Facilitators must be aware of *power or control dynamics* and mediate the conference in ways where “equal time” is allowed. The emphasis is on participation, networking, and collaboration. *A facilitator should “value families and believe in the power of family”* (Okamura & Quinnett, 2000, p. 4.6).

Qualities of a Facilitator

- “Neutrality is essential to the outcome of a FGC. The facilitator states his or her stance as neutral at the beginning of the meeting as well as when he or she first begins contacting participants” (Okamura & Quinnett, 2000, p. 4.8).
- Accepting and nonjudgmental about lifestyles, beliefs, and behaviors of others.
- Leadership skills. It is recommended that a beginning facilitator take the Leadership Comfort Scale (Toseland & Rivas, 2009, p. 120).
- Comfort with confrontation and conflict management.
- Able to focus on behaviors; this is a task-oriented group.

Direct Practice Skills Used by a Facilitator

- Joining with family members when appropriate;
- Listening, observing, clarifying, and defining;
- Paraphrasing and reflecting feelings and content;
- Normalizing and reframing;
- Confronting, mediating, and self-disclosing; and
- Using knowledge about developmental stages to explain behaviors of children.

An important skill for facilitators is that of *reframing*, which refers to assisting clients to view situations or problems from another vantage point. This is an invaluable technique and helps to keep the family on target rather than get stuck in blaming others. In addition, the facilitator needs to be self-aware and cognizant of *transference and countertransference*. As the issues that are likely to arise are going to be intense and fraught with established family dynamics, the facilitator must be alert to how he or she

impacts the group and vice versa. Last, there must be attention to *cultural factors and respect for diversity*. One way to do this is start the meeting off with a family custom or tradition, thereby incorporating practices that are comfortable to the family.

At the beginning, it is necessary to establish *ground rules* for the group. Some suggestions include: one voice at a time, no side conversations, respectful language, and no old history.

At the mezzo level: The FGC is a “group” most closely resembling a task group. Thus, group dynamics are going to be present. Just as planning and preparation is an important step in successful group work, it is a vital part of FGC. Engaging the participants prior to the actual meeting is crucial. Participants need a clear understanding of the meeting’s purpose and their roles. During the conference, there must be attention to the dynamics of the group and the interactions of the members. Additionally, community involvement and working with cultural differences is a part of employing skills at the mezzo level (Marsh & Crow, 1998; Okamura & Quinnett, 2000; Shapiro et al., 1998).

Anger and conflict management is an important skill to develop as a facilitator. As child abuse and neglect issues will most likely evoke strong feelings, there will often be both anger and conflict that surfaces. Being able to effectively manage both in an assertive way is imperative (Okamura & Quinnett, 2000).

At the macro level: FGC must unfold within a certain backdrop of principles and philosophies. If this is not the case, then change at the macro level is necessary in order for FGC to be effectively implemented. For example, an agency not used to involving family members in decision making, will need to make some shifts in practice

philosophy. Implementing change at the macro level involves specific skills (Okamura & Quinnett, 2000).

According to Burford et al., (1995), effective Family Group Conferencing includes these key ingredients:

- Seeing that the integrity and dignity of the family is maintained;
- Insuring that the (child's) safety needs are met;
- Holding the abuser accountable for the abuse; and
- Promoting the sense of togetherness and pride of the community, and showing respect for cultural considerations.

Facilitator's Road Map

The actual "how to" on the role of the facilitator will vary from program to program. One example of the road map is provided by San Diego County's Family Group Conferencing Program. Form D illustrates a step-by-step process for hosting a family conference meeting.

Materials Needed for a Family Conference Meeting

Family Conference Meetings are held in various sites throughout the county. In order to be prepared, it is recommended that the following materials be obtained. Additionally, a rolling suitcase or cart to transport materials to each site will be needed.

For the Facilitator

- Flip chart stand with flip chart paper (Post-It flip chart paper is preferred) – This is to chart the family strengths and concerns, and can be used for the family plan;
- Markers;
- Pens;
- Blank paper;
- Coffee pot and coffee supplies;

- Drinks (soda/water);
- Bins/tubs to transport materials;
- Food – sandwiches, snacks;
- Plastic silverware, napkins, paper plates;
- Name tags;
- Box of Kleenex; and
- Cell phone (or access to phone).

For the Family

- Handout on Family Conferencing (Emancipation) Meetings – Forms C and F,
- Blank Family Plan – Form G,
- Sample Family Plan – Forms H, and
- Handouts on chemical dependency, domestic violence, and mental health issues (These generally can be obtained from local agencies or from Internet Web Resources in the above areas.)

Meeting Outline

The Social Worker's Role in Preparing the Family

The social worker will contact the family to propose the use of Family Group Conferencing as a tool to empower families in the decision-making process with regard to the children who have been or are at risk of being abused or neglected. The family may be resistant to this idea, not trusting the social worker or “the system” to listen to the family’s input. The social worker may need to “sell” the process when introducing this tool to the family. Form H can be given to social workers as examples on talking with family members about family group conferencing.

The Facilitator's Role in Preparing the Family

The facilitator role is pivotal in the Family Group Conferencing model. Two facilitators are recommended to jointly hold the family conference. The knowledge,

skills, and values are somewhat different from that of a therapist's role and care must be taken to not become a "therapist" while doing Family Group Conferencing.

Given the length of the meeting, it will be important to inform the family that food will be served. The role of food is an important element for needed breaks and "down time" during the meeting process.

The Meeting

Social Worker's Role in the Meeting. The social worker will attend the meeting to share his or her perceptions of the strengths of the family and his or her concerns. The social worker is to provide the history of how the family came to be in the system, information about the family, information on the maintenance and/or reunification plan, and be a resource for the family and facilitator for questions. The social worker shares strengths and concerns, but does not participate in the family conference. A guide for the social worker's role is found in Form B.

Other Professionals' Roles in the Meeting. The professional's role in the Family Group Conference meeting is important. The professional provides support and helps to problem solve and create a plan for the family. The professional, like other participants, supports the process and doesn't interfere with the facilitator's goal of assisting the family to develop a plan. Form G is a sample guide for professionals.

Explaining Confidentiality. In order to enhance the family's willingness to engage in the process, the Family Group Conference process is confidential. This means that social workers, professionals, and family members are not to discuss, nor put in any documents, what occurs in the Conference. Exceptions to this rule include all laws that allow for the breaking of confidentiality due to new child abuse allegations,

threat to self and others, and local policy and procedure that allow for the breaking of confidentiality.

Use of Food. It is important to provide food/meals as part of this process. The meal serves several functions:

- Food can act as a central focus for discussing problematic issues in a more relaxed atmosphere,
- Sessions are long and providing food offers a break to the participants, and
- Food is seen as nurturing and families respond to this nurturing.

Use of Handouts. A copy of the agenda as well as blank paper and pens are given to each participant. Additionally, handouts on resources or on information such as domestic violence, substance abuse, mental health, parenting classes, etc. are made available to the participants. At the appropriate time, a blank copy of the Family Group Conference Agreement and samples of Agreements are given to the family.

Should Children Attend? Each family's case must be assessed for the appropriateness of children attending the family conference. Some factors to consider in allowing children to attend:

- Age of the child – Very young children may be disruptive to the family meeting process. Consideration should be given to having childcare arrangements for very young children.
- Safety issues – Will the children be safe in the meeting? Has a parent threatened them?
- Court orders – A review of court orders around contact with children will need to be done. If it is appropriate for the child to attend to the meeting and a no contact order is in place, the facilitator will request that the social worker obtain an order allowing for the contact.
- Therapists' recommendations – Will this meeting be beneficial to the child/family or harmful?

Developing a Plan. In the San Diego Model, families are left alone to devise a plan to address concerns that have been raised by the participants in the family meeting. The family is given a blank planning sheet as well as a sample planning sheet to develop their plan (Form J). This part of the FGC process may take up to an hour or more. The Facilitator checks on the progress of how the family is developing their plan. The Facilitator also makes him or herself available for questions from the group's participants. If the family appears unable to agree on a plan, the facilitator may re-enter the room to encourage the family to develop their own plan or develop aspects of a plan that they can agree to. The Facilitators will return to the meeting when the family has developed the plan.

The Facilitators will go over all aspects of the plan with the family to ensure that the objectives are achieved, identify who will be involved in achieving those objectives, and determine what steps are needed to complete the objectives. The family and the social worker will receive copies of the family's plan. The social worker will follow up to evaluate if the objectives are being achieved.

Families may be offered or occasionally request a follow-up meeting. This is to continue to assist the family in checking on the progress of the family's plan, make modifications or changes in the plan given new circumstances, and provide support to the family so that they can achieve their goals.

After the Meeting

Debriefing With the Supervisor and/or Cofacilitator

Debriefing the family conferencing meeting is essential. This allows for a number of issues to be followed up on including: the facilitator's ability to follow the conference

model and format, the review of strengths and challenges in the meeting itself, the facilitator's ability to maintain neutrality, and a review of skills or knowledge that might be helpful in future meetings. Form L is one such tool that facilitators and supervisors can use in reviewing a family conference meeting.

Revisiting the Plan

In conjunction with the family, a decision is made as to whether a follow-up family conference meeting is scheduled. The follow-up meeting will address the family's original plan and the progress made on the plan. There are opportunities to refine and modify the plan at this time.

SPECIAL ISSUES

Logistics and Forms

As with any program, logistics and forms are needed to ensure a program's functioning. The Appendix in this manual has several forms that relate to the intake procedures, roles that everyone takes in the family conferencing process, evaluation of FGC, tracking, etc. These forms are examples from the Family Group Conferencing Program in San Diego County. Other counties or programs may want to adapt these forms or substitute other forms in personalizing this manual for their program needs.

About the Cofacilitating Relationship

Just as with any relationship, communication between cofacilitators is essential. The negotiating of the roles before the meeting is important. One facilitator may take the lead on addressing the "content" or tasks to be accomplished in the meeting. The other facilitator might take the lead on monitoring "process," and intervening when needed around feelings that may emerge. A process for working out a facilitator "conflict" (i.e.,

as the meeting progresses the facilitators may disagree as to what direction to take within the meeting) would be important as well. A discussion of facilitating “style” between cofacilitators may help to minimize conflict between them.

List of Do’s and Don’ts

<p>Do watch how the social worker is in the meeting. The social worker is to share information that is needed so the family can make a plan for the children.</p> <p>Do keep the meeting focused – watch for tangents or prolonged arguments.</p> <p>Do watch for the revealing of traumatic material. While the role of the facilitator is to remain neutral, traumatic events may be revealed that may create a crisis for family members. Interventions should be supportive, but not delved into in depth. The issue remains safety for the group and its members.</p>	<p>Don’t give advice – the role of the facilitator is to remain neutral and support safety for all group members to participate in the process.</p> <p>Don’t align yourself with certain members of the family. Align yourself with members that may need support to speak up.</p> <p>Don’t take sides – this will ensure that certain members will not feel safe to speak in the group. The exception would be for the facilitator to align sides with the child, if the child is being scapegoated in the group.</p>
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The Purpose of Facilitator’s Supervision Meeting

In San Diego County, the Supervisor of the Family Conferencing Program gathers all staff and volunteer facilitators together to discuss programmatic as well as case issues. As with any supervision meeting, new staff and volunteers learn from the successes and the “what we could have done differently” debriefs of family conferencing cases. Training in specific issues may occur as the result of knowledge or skill gaps noted by the supervisor. This meeting provides support for facilitators, monitoring of programmatic or case-related issues, and opportunities to highlight successful families who have participated in this process.

SUGGESTED VIDEOS

The following information has been obtained from the American Humane Association's National Center on Family Group Decision Making website. Below is the statement allowing for the reproduction of information from the website.

This material may be reproduced and distributed without permission; however, appropriate citation must be given to the American Humane Association's National Center on Family Group Decision Making (Copyright © 2000, 2001 American Humane Association).

Schools and agencies that are CalSWEC borrowing partners may borrow any of these videotapes from the California Child Welfare Resource Library (562-985-4570 or cfujii@csulb.edu).

Widening the Circle: The Family Group Decision Making Experience

44 minutes VHS

\$20

Originally produced in Canada, *Widening the Circle* describes the intervention by the extended family and various professionals to break the pattern of family abuse. The video follows one family's experience through the process, and shows the interplay between organizations and the family as they partner to stop family abuse. Video includes Facilitator Notes.

To check on availability in the United States, contact the University below.

To order in Canada, contact:

Memorial University of Newfoundland

Distance Education and Learning Technologies, ED1033

School of Continuing Education

St. John's, NL, Canada A1B 3X8

Phone: (709) 737-7575 or 1-866-435-1396 (Outside St. John's)

www.distance.mun.ca

Permanency Toolkit: Family Group Decision Making

25 minutes VHS

\$145

The first in "The Pathways to Permanency" series from Courter Films, this video demonstrates the FGDM process and describes how it works to achieve improved safety and permanency for children and increased family connectedness and functioning. In this video, you will see clips and scenes from various types of Family

Group Decision Making meetings. You will hear from professionals working in the area of Family Group Decision Making, as well as from the families who have participated in this process. General principles and components of FGDM are explained.

Order from Courter Films & Associates (www.courterfilms.com).

A Plan for Joseph: An Actual Family Group Conference

75 minutes VHS

\$165

This video is a 75-minute edit from an actual 4-hour Family Group Conference held in Santa Clara County, California including private family time. An extended family returns for a follow-up conference about Joseph, who had been placed with relatives when his mother went to prison for drug abuse. Now released and in recovery, Joseph's mother is frustrated at the resistance of his caregivers to allow her, or even other members of the family, to have regular visitation. Joseph is acting out and is very angry and confused. His relative caregivers believe that it is in his best interest to withhold visits when he misbehaves. Family members have come from hundreds of miles away to try to resolve these complex issues in a volatile, emotional, and heartfelt session. The conference has been shortened to 75 minutes and a brief narration has been added to clarify the situation. It may be viewed as a whole, or started and stopped to promote discussion among professionals interested in the subject, especially those who are training to run family group decision meetings. Teaching Guide available.

Order from Courter Films & Associates (www.courterfilms.com).

Let Us Put Our Minds Together: The Power of Family Group Conferencing in Washington State

24 minutes VHS Full-length Video (Library has this version)

11 minutes VHS Presentation Video

\$35 either version (currently out of print)

Family members who participated in five different family group conferences in Washington State share moving stories about how their conferences gave them the opportunity to create safe and permanent plans for their children. The video demonstrates the commitment and power that families can bring to the decision-making process as well as their willingness to take responsibility and to create solutions that resolve child abuse and neglect concerns. The video uses clips of simulated conferences as well as interviews with social workers, facilitators, an attorney, and a court commissioner to explain general principles, the FGC process, and benefits of this approach. The Northwest Institute for Children and Families, University of Washington, School of Social Work produced this video.

WEBSITES

National Center on Family Group Decision Making

<http://www.ahafgdm.org/about.htm>

In 1999, American Humane Association (AHA) established the National Center on Family Group Decision Making with a mission to build community capacity to implement high-quality, effective FGDM processes that are philosophically congruent with the central values and beliefs of this approach. The Center's staff work in a number of areas toward this mission, and are dedicated to sharing resources, advancing family-driven practices, creating knowledge, and building links to improve the implementation and evaluation of Family Group Decision Making both in the U.S. and abroad.

The International Institute for Restorative Practices (IIRP)

<http://www.restorativepractices.org>

The nonprofit IIRP provides education and research in support of the development of restorative practices. IIRP is dedicated to: (a) discussing and publicizing definitions, ideas, best practices, theories, and standards for restorative practices; (b) undertaking and publicizing useful research about restorative practices, and (c) encouraging and developing education, training, and educational resources about restorative practices.

Family Group Conferencing Northern Ireland

<http://www.familygroupconferenceforum-ni.org>

The Aim and Objectives of this Organization include: (a) promoting an inclusive understanding of and support for Family Group Conference practice; and (b) involving families, individuals, disciplines, organizations, and communities in order to:

- Facilitate an exchange of information.
- Discuss and share key ideas and issues.
- Help clarify the interface between interested parties in relation to one another.
- Access, share and maximize resources.
- Identify, support and promote the development of good practice.

The National Child Welfare Resource Center for Family-Centered Practice

<http://www.cwresource.org>

This is a service of the Children's Bureau. It seeks to enhance the capacity of State and Tribal child welfare agencies to plan, implement, and evaluate family-centered services for children and families. Located in Washington, DC, it is a project of Learning Systems Group and the National Indian Child Welfare Association.

Casey Family Programs-National Center for Resource Family Support

<http://www.casey.org/cnc>

This site is a one-stop source of information, technical assistance, written materials, and referrals to resource families and child welfare professionals who work with them.

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APPENDIXES

ABOUT FAMILY GROUP CONFERENCING

What Is a Family Group Conference?

The idea of Family Group Conferences began in New Zealand in 1989. It was recognized that family and community play a major role in making and carrying out decisions in cases of child abuse and neglect. Extended family and community friends involved with a particular family are brought into the conference and allowed to come up with solutions to the concerns around the abuse or neglect. The solutions are creative, respectful, and protective to the children of the family. The word has spread about the success of these conferences, which are being held all across the United States. San Diego is now experiencing success using Family Group Conferencing.

In a Family Group Conference, separated families or families at risk of being separated, and people they identify as supportive are brought together to discuss family concerns. Together, with the assistance of a facilitator, the participants discuss the best options and ideas. The resources of everyone in the room are valued and respected.

The main focus is the strengths of the family. The meeting moves with a positive emphasis. For example, the facilitator will NOT ask, "What can we do to fix the problems?" but rather, "How can this family's strengths eliminate these concerns?"

Why Hold a Family Group Conference?

The main goal of the Family Group Conference is to strengthen families. This involves building trust between the participants and finding and adding to previously untapped resources in the family, in the extended family, and in the community.

The "system" does not hold the answers to the issues around the abuse or neglect. The real answers lie within the family and those genuinely concerned with the family for the long term.

What Are the Qualifications to Participate in a Family Group Conference?

The only qualification to participate in a Family Group Conference is the willingness to resolve concerns for the benefit of the children and a readiness on the part of the parents to accept the resources their family and community have to offer.

Who May Participate?

Participants may include close family members, extended family members, friends, or members of the community, such as teachers and religious leaders. Anyone whom the family feels could help add to the productivity of the meeting is invited to participate.

When Are Conferences Held and How Long Do They Last?

Every effort is made to be respectful to the participants in the conference. This means that conferences may be held in the evening or on weekends to accommodate working people. Conferences may last up to 4 hours as the issues are often being discussed for the first time and it takes time to work out agreements. Refreshments are made available.

FAMILY GROUP CONFERENCING HELP SHEET FOR SOCIAL WORKERS

This is a conference where the family and their support group have the opportunity to problem solve and give input on the case plan. Family Group Conferences are not recommended if you do not believe that the family can help with creating safety for the children. **Your role in this conference is very important and yet we encourage family members to do most of the work in the meeting.** These conferences can take between 3-5 hours. This is the outline of a Family Group Conference and what your role is in each phase:

Confidentiality

At the beginning of the conference we explain to the family that what is said in this conference is confidential. No one, including the social worker, can tell others what happened in this conference, unless we discover more unreported child abuse. You *cannot* put in your court reports what is said in a Family Group Conference, without the permission of the family¹. We attempt to create some safety for the family, so family members can openly communicate.

Introductions and Goals

After introductions, we ask family members what they hope to accomplish during the conference. During the Goals part of the conference, we ask the family to state their goals for the conference and then will ask you what you hope to accomplish during the conference. This is how most of the conference will go. The family will speak first and you will add your part after they are done.

Your goals, if not already stated by the family, can be identified as immediate, short-term or long-term, as they relate to the protective issues of the child's situation. (Note: this is not the time to explain or debate your point of view. The facilitators will guide the family away from doing so if they try.)

Some of the common goals for the conferences are:

- Finding a relative placement
- Saving a relative placement by getting other family members to help
- Supporting parental recovery
- Figuring out visitation
- Return children home with support of family members

¹ If the family says something that you think is important for the court to know you can talk to the family after the meeting and include what they say at that point.

History

The social worker is then asked to give the history of how the children became known to the Dependency System. We have asked the parents before the conference if it is okay to break confidentiality. We will ask them again during the conference for permission to break their confidentiality. We ask that you give the history *briefly* in an unbiased and nonaccusatory way. Provide information on where the family is in the children's process (voluntary, 6 months review, etc.) and the parent's progress toward service goals. We find that it is best not to use the word "case," instead use the word "family."

Strengths

The family will then list their strengths. Please be prepared to add some strengths for family members. Frequently we take a break after this. We will bring some food and drinks for this break.

Concerns

After the strengths, the family will list their concerns. Attempt to keep the concerns focused on what must be resolved before the family can reach their goal. Again, the family will list their concerns first. You will be asked if you have anything to add towards the end. Usually the family has listed all of your concerns and you have nothing to add. Sometimes families are in denial and the social worker needs to clearly state concerns. Occasionally a social worker will feel that he or she stands alone in his or her concerns and this can be uncomfortable. This is one of the most crucial aspects of your participation in the conference. If concerns about protective issues are not raised, the family's plan will not be useful to them or to you.

Family Alone Time

We then leave the family alone to discuss and work out solutions without professionals in the room. This time can last from 30 minutes to 2 hours. Some social workers work on paperwork or return phone calls with their cell phones during this time so that they do not feel that this is a waste of time.

Review Family's Plan

The family will call us in when they are done and we review their plan. The social worker's goal is to tell the family honestly if he or she thinks the plan is sufficient and workable. You want to make sure that the plan covers your bottom line concerns about safety. If the family's plan is workable, we tell the family you will attempt to enact the plan. If this is a court case, we ask the family if they agree to have the agreement submitted to the court.

Closing

We close the conference by asking participants to briefly state what they thought of the meeting.

We will type up the family's plan and get them a copy within the next few days. This plan can be attached to the court report *if the parents* approve of it. *We do not follow the family to see if they are following through with their commitments.* That is up to the family and you.

Thank you for referring to Family Group Conferencing!

EMANCIPATION CONFERENCE

A Guide for Youths and Their Support Systems

(Participants Should Plan to Be in Attendance a Minimum of 4 Hours)

Emancipation Conferences are conducted for foster youths age 17 and over who are anticipating entering adulthood. The purpose is to gather individuals in the youth's support system together to help prepare the youth for living on his or her own. The focus of the conference is on the youth's strengths and how these strengths can be utilized as the youth enters adulthood. Together, with the assistance of a facilitator, the participants discuss the best options and ideas. The resources of everyone in the room are valued and respected.

Participants in the conference are those persons who have a willingness to resolve concerns for the benefit of the youth. These persons may include family, friends, religious leaders, community members, and professionals who are working with the youth. Anyone whom the youth feels could help add to the productivity of the conference is invited to participate.

I. Introductions

Participants introduce themselves and give their relationship to the youth.

II. Confidentiality

What is said during the meeting stays in the room. Exceptions will be explained by the facilitators.

III. Purpose of the meeting

The group agrees upon goals for the youth's transition into adulthood.

IV. History

The social worker and the youth will discuss any recent history that is impacting the youth and his/her future.

V. Strengths Assessment

Individuals in the group identify strengths of the youth. What strengths can the youth use in reaching his/her goal(s)?

BREAK/REFRESHMENTS

VI. Concerns

The youth and the group share their concerns for the youth's future. What are we worried about? What must be resolved for the youth to reach his/her goals and independence?

VII. Formulate Solutions to Reach Goals

The group uses this time to resolve concerns, brainstorm solutions, and create an agreement that conveys who will do what to help the youth reach his or her goal(s).

VIII. The Plan

Agreement will be reviewed and finalized with the youth's agreement. Facilitator will type the agreement and mail it to all participants.

IX. Closing Statement and Participant Feedback

WHAT IS DIFFERENT ABOUT EMANCIPATION CONFERENCES?

1. We need to meet with the youth and ask him or her if he or she wants to do the conference. The conference is a voluntary process for the youth.
 - We need to explain how the conference will be conducted and explain the confidentiality issues. We need to get his or her permission to have the social worker discuss his or her most recent history.
 - Share with the youth the emancipation literature and a completed emancipation plan from another conference.
 - Discuss with the youth whom he or she would like to have come to the conference.
2. We do *not* need a parent at the conference. If there is a parent who is coming to the conference, we also need his or her permission to discuss the most recent history.
3. We need the social worker there and the ILS worker. Sylvia Volz, the ILS supervisor, has committed that either one of her workers will be at the conference or she will come.
4. During the conference:
 - We ask the youth for permission to discuss most recent history. Possibly asking the youth if he or she wants to tell the most recent history first.
 - Ask the youth first about his or her goals.
 - Ask the youth to then express his or her concerns about the goals.
5. We need to schedule a follow-up meeting.
6. We could invite the minor's attorney; it may even be best practice to do so.
7. Create a letter for the professionals who will be attending the conference, explaining that it is important for the youth and any family that may be attending to do most of the work. It is also important that the professionals stay for the entire conference.
8. We will decide on a case-by-case basis if we are going to stay in the room for the solution part of the conference. If there is a lot of family, we will ask all professionals to leave the room and give the family time alone. If the conference is predominately professionals, we will stay in the room.

FAMILY GROUP CONFERENCING COORDINATOR/FACILITATOR JOB DESCRIPTION AND ROAD MAP

- I. Primary Responsibility: To organize and facilitate Family Group Conferences.
- II. Steps and Procedures From the Referral to the Conference:
 - A. You receive a referral from a social worker.
 1. Log in the family name and social worker name on a list in the front section of a 3-ring binder.
 2. Record in **FAMILY GROUP CONFERENCING PROGRAM STATISTICS FOR MONTH OF** (current month).
 3. Ask social worker a few prescreening questions:
 - a. "Are you hopeful that an agreement can be reached?"
 - b. "What are the goals/immediate concerns/'bottom line' safety concerns?" Make sure that the goals and concerns match up (e.g., drug abuse: Family Group Relapse Prevention Agreement).
 - c. "Does this family have a support system outside of the protective system that would be willing to participate in a 4-hour conference?"
 4. If the social worker responds positively to these questions, go on to the next step. If not, chances are that this family is not a good bet for a Family Group Conference.
 - B. Mail/fax social worker a **FAMILY GROUP CONFERENCING REFERRAL PACKET**. Phone social worker to schedule a pre-conference. The pre-conference may be done either in-person or by phone.
 - C. Pre-Conference:
 1. Provide a brief orientation to the social worker. Include the **GUIDELINES FOR SOCIAL WORKERS** and **CHEAT SHEET FOR SOCIAL WORKERS**.
 2. Coach the social worker on how to encourage the family to develop a **FAMILY GROUP CONFERENCING PARTICIPATION LIST**.
 3. Offer to do a home visit with the social worker to assist the family in "brainstorming" their participant list, if time allows, and your involvement might be helpful. Arrange for the social worker to contact you when the list is completed, to set up the Family Group Conference.

D. Setting up the Family Group Conference:

1. Contact the family to determine the best day and time for the conference.
2. Match facilitator/cofacilitator with the family in terms of language and ethnicity.
3. Identify and reserve facility.
4. Contact **FAMILY GROUP CONFERENCING STAFF** for availability. Let them know date, time, and location of conference.
5. Submit **SUPPORT FUND CLAIM** for money to buy food for conference.
6. Send out **INVITATION LETTERS** to all participants at least 1 week in advance. Send a copy to the social worker.
 - a. Include directions to the conference.
 - b. Get stamps from the fiscal clerk to make sure the letters arrive in a timely manner.
7. If needed by the parent(s), request support funds for childcare during the conference.
8. Phone everyone on the list the day before the conference to confirm that they will be attending.

E. Pre-Family Group Conferencing Day:

1. Purchase food, drinks, and paper supplies for the conference.
2. Organize packets for each participant. Include:
 - a. **GUIDE FOR FAMILY AND FRIENDS**
 - b. **FEEDBACK** sheets for participants, parents, and social worker(s).
 - c. Blank sheet from **FAMILY GROUP CONFERENCING AGREEMENT**.
 - d. Mailing envelope (optional).
3. Bring sign-up sheet on clipboard.
4. Bring pens for each participant and cofacilitator.
5. Bring flip chart/paper, marking pens in several colors (black, red, green, blue).
6. Bring several copies of blank **FAMILY GROUP CONFERENCING AGREEMENT** for cofacilitator.
7. Bring name tags/tents.
8. Bring food and serving supplies (e.g., bowls, plates, cups, utensils, knife, cutting board) and any food supplies you already have (e.g., coffee, sugar). Bring coffee maker if you plan to serve coffee. Bring ice chest.

III. At the Conference:

A. Setting Up:

1. Arrive 45 minutes early.
2. Arrange tables and chairs, if not already arranged.
 - a. Make sure that there are enough chairs set up around tables to accommodate all participants, including social worker.
 - b. Arrange tables so that all participants can sit around table and have a good view of facilitators and flip chart.
 - c. Make sure that tables are joined (i.e., in a “T” or “V”) so that participants are not sitting at 2 separated tables.
3. Set up the food and drinks on a table away from the participant tables.
4. Put on participant table:
 - a. Sign in sheet
 - b. Participant, parent, and social worker packets
 - c. Pens (enough for each participant).
 - d. Name tents or tags and marking pens.
5. Set up flip chart and lay out marking pens in several colors.
6. Set out packet of several blank **FAMILY GROUP CONFERENCING AGREEMENT** sheets and pen for cofacilitator.
7. Lay out **FACILITATOR FORMAT FOR FAMILY GROUP CONFERENCING** in a place where it can be seen by facilitator and cofacilitator during the meeting.

B. Greeting the Participants:

1. Greet each participant as he or she arrives and instruct him or her to sign in on the sign-in sheet.
2. Ask each participant to make up a name tent or tag with his or her name and relationship to the child(ren) written on it.

IV. The Family Group Conference:

A. Getting Started:

1. Ask participants to sit around the table.
2. Begin the conference using the **FACILITATOR FORMAT FOR FAMILY GROUP CONFERENCING** as a guide.

B. Breaks:

1. The main break generally comes after the **Strengths** section of the conference.
2. Instruct participants to raise their hands if they need an earlier break. You may or may not want to stop the conference during the time a participant is gone from the room on a break.

C. Things to Remember:

1. This is a strength-based process. Use the family's strengths to help resolve concerns.
2. The participants govern the process. Make sure that they come up with their own list of ground rules. Check with them when you have a suggestion, to get group consensus before it is written on the flip chart.
3. After the family has identified their concerns ask the social worker to add any additional safety concerns that have not been addressed (e.g., physical abuse, domestic violence).

D. The **FAMILY GROUP CONFERENCE AGREEMENT**

1. Cofacilitator writes on the agreement form what each participant agrees to do to assist the family.
2. Cofacilitator reads back the completed plan for accuracy and the approval of the group.

E. Closure:

1. Go around the table and ask participants to say what the conference has meant to them and if there is anything else they would like to say.
2. Make sure that the participants fill out the **FEEDBACK** forms and leave them on the table before they leave the conference.

F. Clean Up:

1. Clean up food, pack, pick up, and dispose of all trash.
2. Arrange the tables and chairs the way they were when you arrived.
3. Make sure to lock up, when this is relevant.

G. When the Family Group Conference Coordinator/Facilitator is not attending the conference, ask the facilitators to bring the Family Group Conference supplies and paperwork back to his or her office and arrange to have them returned to the Family Group Conference Coordinator/Facilitator.

V. Completing the Process:

A. The **FAMILY GROUP CONFERENCE AGREEMENT:**

1. As soon as possible after the conference, print out the agreement on your computer.
2. Make copies for each participant listed on the agreement, the social worker, the facilitator, and cofacilitator.
3. Send copies to each person. You can get stamps from the fiscal clerk and mail the copies yourself to get them to the family quickly.

B. Making a Client File:

1. Label a manila folder with the name of the family.
2. Remove all Family Group Conference case information on the family from your binder and place in the folder, including a copy of the agreement.

C. Kudos Letters: Use the Kudos Letter on your computer to help you compose kudos letters to the social worker, facilitator, and cofacilitator. Send these via county mail.

VI. Statistics:

A. After completing a Family Group Conference:

1. Count and enter “yes” and “no” responses on the **FAMILY GROUP CONFERENCE FEEDBACK** statistics form.
2. Enter data from **PRECONFERENCE/CASE INFORMATION** and **FAMILY GROUP CONFERENCE FEEDBACK** into the database.

B. 6 Week Follow Up: Use **6 WEEK FOLLOW UP** form:

1. Call social worker assigned to case when conference took place to obtain follow-up information.
2. Enter information into database.

VII. Updating the Family Group Conference Log:

- A. Update and separate Family Group Conference from uncompleted referrals.
- B. Remove case information from uncompleted referrals and store it in a separate folder.
- C. Store information on completed conferences in individual family folders.

VIII. Other Responsibilities of the Family Group Conference Coordinator/Facilitator

- A. Keep a number of **FAMILY GROUP CONFERENCE PREPARATION PACKETS** for presentations to group conferences, etc.
- B. Make sure there are a number of **FAMILY GROUP CONFERENCE REFERRAL PACKETS** in the forms room of your region.
- C. Keep conference packets for social worker, parents, and participants updated. It may be helpful to have a basket for each category where you store the packets.

- D. Make sure you have a good supply of all forms printed out at all times.
- E. Maintain regular contact with facilitators.
- F. Recruit and inform facilitators of upcoming conference needs.
- G. Attract, recruit, and train new facilitators.
- H. Maintain and continue to develop new conference sites.
- I. Stay in contact with Children's Services staff to generate new referrals for conferences.
- J. Participate in regional Case Consultations whenever possible.
- K. Be available for trainings and community presentations.
- L. Continue to update and refine Family Group Conference materials.
- M. Keep supervisor and manager current regarding statistics.
- N. Keep supervisor informed of program needs.
- O. Maintain Family Group Conference Program integrity through ongoing contact with Coordinators/Facilitators in the other regions.

NOTE: THERE IS NO FORM E.

THE FAMILY GROUP CONFERENCE

A Guide for Family and Friends

(Participants Should Plan to Be in Attendance a Minimum of 4 Hours.)

I. INTRODUCTIONS

Participants introduce themselves and give their relationship to the child(ren).

II. CONFIDENTIALITY

What is said during the meeting stays in the room. Facilitators will explain exceptions.

III. PURPOSE OF THE MEETING

The group agrees upon a common *goal*: Examples: "To find a way to keep the family, summarize the referrals that brought the family together." "To help the mother do all the things she has to do to get kids returned home (e.g., transportation to visits with children, etc.)."

IV. HISTORY

The social worker will give a brief, nonjudgmental summary of the family, summarize the referrals that brought the family to the attention of Children's Services Bureau, provide information regarding where the family is in the Children's process (voluntary, court, 6 month review, etc.), and progress toward service plan goals.

V. STRENGTHS ASSESSMENT

Individuals in the group identify things that are right and good in the family. What do individuals bring to the family that are valued? What strengths can the family use in reaching the agreed upon goal(s)?

BREAK/REFRESHMENTS

VI. CONCERNS

Individuals in the group share their concerns for the child and the family. What are we worried about? What must be resolved if we are to reach our goal?

VII. FAMILY ALONE TIME

The family is left alone to "brainstorm" ideas for resolving concerns and reaching their goal(s). What ideas do the family members have? What has worked in the past? The family creates an Agreement that conveys *who* will do *what* to help the family reach its goal(s)

VIII. REVIEW PLAN

The facilitators and social worker return to review and fine-tune the plan that the family made. Some revisions or further explanations may be made to the plan at this time. The Facilitator will type the plan and mail it to all participants.

IX. CLOSING STATEMENTS & PARTICIPANT FEEDBACK

EMANCIPATION MEETINGS

Help Sheet for Professionals

This is a meeting where the youth and his or her support group have an opportunity to problem solve and create a plan for the youth leaving the foster care system. Your role in this meeting is very important and yet we encourage the youth and family members to do most of the work in the meeting. It is vital that you stay for the whole meeting.

This is the outline of the Emancipation Meeting and what your role is in each phase:

I. Confidentiality

At the beginning of the meeting we explain to the family that what is said in this meeting is confidential. No one, including the professionals, can tell others what happened in this meeting, unless we discover more unreported child abuse. You *cannot* put in your written court reports what is said in an Emancipation Meeting, without the permission of the . We attempt to create some safety for the family, so family members can openly communicate.

II. Introductions and Goals

After introductions, we ask family members what they hope to accomplish during the meeting. When we discuss goals, we ask the youth and family to state their goals for the meeting and then will ask you what you hope to accomplish during the meeting. This is how most of the meeting will go. The family will speak first and you will add your part after they are done.

Your goals, if not already stated by the family, can be identified as immediate, short-term or long-term, as they relate to the emancipation issues of the child's situation. (Note: this is not the time to explain or debate your point of view. The facilitators will guide the family away from doing so if they try.)

Some of the common goals for the meeting are:

- Housing for the youth
- Job for the youth
- Schooling
- Substance abuse treatment

¹ If the family says something that you think is important for the court to know, you can talk to the family after the meeting and include what they say at that point.

III. History

The county social worker is then asked to give the most recent history about the youth. We have asked the youth and the parents, if they are available, before the meeting if it is okay to break confidentiality. We will ask them again during the meeting for permission to break their confidentiality.

IV. Strengths

We will then list the youth's strengths. Please be prepared to add some strengths for the youth. Frequently we take a break after this. We will bring some food and drinks for this break.

V. Concerns

After the strengths, we will list the concerns. We attempt to keep the concerns focused on what must be resolved before the youth can reach his or her goal. Again, the youth and his or her family will list their concerns first. You will be asked if you have anything to add towards the end. Usually the family has listed all of your concerns and you have nothing to add. Sometimes families are in denial and the professionals need to clearly state concerns. Occasionally a professional will feel that he or she stands alone in his or her concerns and this can be uncomfortable. This is one of the most crucial aspects of your participation in the meeting. If concerns about protective issues are not raised, the family's plan will not be useful to them or to you.

VI. Solutions

At this point, we discuss solutions to the goals and concerns. We create a written plan where the youth and all other parties will commit to actions to help the youth be safely independent from the child welfare system.

VII. Closing

We close the meeting by asking participants to briefly state what they thought of the meeting.

We will type up the family's plan and get them a copy within the next few days. This plan can be attached to the court report *if the parents and youth* approve of it. *We do not follow the family to see if they are following through with their commitments.* That is up to the family and you.

Thank you for referring to Family Group Conferencing!

GUIDELINES FOR SOCIAL WORKERS

How do you introduce the Family Group Conference idea to your family?

The following are examples of statements that you can use to “sell” the process.

- This is a strength-based meeting where you get to invite those people who have been loving and supportive of your family.
- How would you like to get the government out of your life and take back your power?
- This meeting is offered only to selected families as a privilege because of your strong, loving, support systems.
- This process is a way to empower your family. Attorneys and court-appointed professionals are not a part of this meeting. You invite who you want to attend.

FAMILY GROUP CONFERENCES

A Cheat Sheet for Social Workers

HISTORY:

- Family has two children: Sherry, age 12; Crystal, age 2
- Children currently live with maternal grandmother
- Mother lives with boyfriend, Larry
- Several referrals made to CPS related to drug use over past 8 years
- Children made dependents 13 months ago because of neglect that is centered around mother and boyfriend's drug use

CURRENT SITUATION/PROGRESS:

- Last three months Vivian, the mother, really began reunification efforts
- She attends NA meetings, has a sponsor, graduated from CRASH, and began to attend a parenting class
- The 12-month hearing just passed and there are 5 months to return the children to their mother or make a different permanent plan

SOCIAL WORKER'S REASON FOR REQUESTING A FAMILY GROUP CONFERENCE:

- Social worker has hope for the family reunifying
- Social worker's perception of family's strengths
- Wants to empower the family, enlist the support of the extended family in order to terminate jurisdiction
- Social worker believes the Family Group Conference would be supporting information for reunification and for the court

You will be a part of the FAMILY GROUP CONFERENCE but your role will be limited (no more than 7 minutes), to presenting the above information.

Your role in this process is de-emphasized, thus empowering the family.

FAMILY GROUP CONFERENCE AGREEMENT

Date of Meeting:_____

Facilitator Name:_____

Cofacilitator:_____

Observer(s):_____

Language:_____

Case Number:_____

Family Name:_____

Social Worker:_____

Phone Number:_____

PARTICIPANT	RELATION	PARTICIPANT	RELATION	PARTICIPANT	RELATION

Name: _____

Case _____

Number: _____

Case _____

PARTICIPANT	AGREES TO:

Family where the children are being kept at home. Mother had a drug addiction and very dirty home.

FAMILY GROUP CONFERENCE AGREEMENT EXAMPLE

Date of Meeting:_____

Case Number:_____

Facilitator Name:_____

Family Name:_____

Cofacilitator:_____

Social Worker:_____

Observer(s):_____

Phone Number:_____

Language:_____

PARTICIPANT	RELATION	PARTICIPANT	RELATION	PARTICIPANT	RELATION
Jesse	Mother	Ethel	Maternal Grandmother	Fred	Maternal Grandfather
Maria	Paternal Grandmother	Raul	Paternal Grandfather	Tyler	Maternal Uncle
Susie	Maternal Aunt	Martha	Mom's Sponsor		

PARTICIPANT	AGREES TO:
1. Jesse	1. Start Parent Care (drug treatment) day treatment program Monday, February 19 th Start individual therapy by March 1 st Allow all family members to call her sponsor, Martha, to see if she is continuing to do her program Talk to her sponsor three times per week
2. Ethel and Fred	2. Take care of the children while mother is in drug treatment Pick up the children in the morning and return them in the afternoon
3. Tyler	3. Drive Jesse to drug treatment Take Chris to Little League on Wednesdays
4. Raul and Maria	4. Take the children and Jesse to church on Sundays
5. Maria	5. Clean house with Jesse on Mondays Help with the laundry on Mondays
6. Martha	6. Talk to Jesse three times per week

Family plan for a family where the children are living with an aunt. The teenager has been acting out and the aunt is unsure if she can continue to keep her. The plan is to keep the teenager with the aunt versus living in a foster home.

FAMILY GROUP CONFERENCE AGREEMENT

Date of Meeting: _____

Case Number: _____

Facilitator Name: _____

Family Name: _____

Cofacilitator: _____

Social Worker: _____

Observer(s): _____

Phone Number: _____

Language: _____

PARTICIPANT	RELATION	PARTICIPANT	RELATION	PARTICIPANT	RELATION
Ellen	Mother	Beth	Aunt	Dave	Uncle
Crystal	Teenager	Ann	Cousin	Joe	Grandfather
Karen	Aunt				

PARTICIPANT	AGREES TO:
1. Crystal	1. Attend school daily Go to Karen's house directly after school Attend drug counseling group on Tuesdays and Thursdays between 7-9 p.m.
2. Ellen and Crystal (Mom and teenager)	2. Go to family therapy starting next week
3. Ellen (Mother)	3. Call family therapist and make appointment for next week Pick up Crystal from her aunt's home and take her to therapy
4. Beth (Aunt)	4. Have Crystal continue to live in her home as long as she attends school and drug treatment regularly Make a chore chart with all the children by Monday Sit and listen to Crystal every night for 15 minutes about her day. She will not offer any advice during these talk times. Attend one Alanon meeting per week
5. Karen (Aunt)	5. Have Crystal at her home after school until Aunt Beth picks her up
6. Joe (Grandfather)	6. Help Ellen to find a job by meeting Sunday at 5 p.m. to review the classified ads Allow Ellen to live with him until she gets a job and saves enough money for an apartment
7. Ann (Cousin)	7. Go to youth group at church with Crystal on Wednesdays at 7 p.m.
8. Ellen, Crystal, Karen, Beth, Ann, Dave, and Joe	8. Will meet the first Sunday of the month to have a picnic and talk about issues

Family plan where the parents have had a drug addiction and there has been ongoing domestic violence. The children are not currently living with the parents. The plan was made to strengthen the family so the children could eventually return home.

FAMILY GROUP CONFERENCE AGREEMENT

Date of Meeting: _____

Case Number: _____

Facilitator Name: _____

Family Name: _____

Cofacilitator: _____

Social Worker: _____

Observer(s): _____

Phone Number: _____

Language: _____

PARTICIPANT	RELATION	PARTICIPANT	RELATION	PARTICIPANT	RELATION
Nancy	Mother	Bill	Father	Rose	Maternal Grandmother
Dale	Maternal Grandfather	Helen	Paternal Grandmother	Betsy	Maternal Aunt
Robert	Friend	Dave	Paternal Uncle		

PARTICIPANT	AGREES TO:
1. Nancy (Mom)	1. Enter into drug treatment on Monday, December 1, before 10 a.m. Visit her children on Monday, Wednesday, and Friday between 3-6 p.m.
2. Bill (Dad)	2. Call the doctor by Wednesday, December 3, to get an appointment to talk about his depression Drug test weekly Start domestic violence counseling by Monday, December 8 Complete domestic violence counseling, going weekly Visit the children Tuesday and Thursday between 3-6 p.m.
3. Helen (Grandmother)	3. Care for the children until they can be returned to their parents Get fingerprinted by December 1 for the children to be placed in her home
4. Rose and Dale	4. Drive Nancy (Mom) daily to drug treatment Take all the children on Sundays from 9 a.m. – 5 p.m.
5. Dave	5. Go with Bill (Dad) to an Alcoholics Anonymous meeting on Wednesday nights at 7 p.m.
6. Robert	6. Call Nancy (Mom) on Mondays and Fridays in the evening and support her. Go out with Bill (Dad) on Saturday night and do something entertaining without alcohol



CRITICAL REFLECTION

FAMILY NAME: _____

FACILITATOR: _____

COFACILITATOR: _____

CONFERENCE DATE: _____

REVIEW DATE: _____

- Was the conference format followed? Did you notice any model drift?
- What went well at the conference? What were the strengths of the Facilitators?
- Were the Facilitators able to keep the meeting focused?
- What were the specific challenges of this meeting? What worked in dealing with these challenges?
- Is there anything that you would have done differently?
- Was neutrality maintained?
- Did the Facilitators refrain from giving advice?
- Was one person the primary Facilitator?
- Did you think the agreement was specific as to who, what, when, and where?

Continue on back if needed.

FAMILY GROUP CONFERENCE LOG

[illegible]

FAMILY GROUP CONFERENCE FAMILY PARTICIPANT LIST

Case No.: _____

Family Name: _____

Day: _____ Date: _____ Time: _____

Primary Facilitator: _____ Secondary: _____

Duration: _____ Expenditures: _____

(Retain receipts for reimbursement)

Location of Interview:

- | | |
|---|---|
| ____ a. Community Library _____
____ b. Church _____
____ c. School _____
____ d. Community Based Agency _____ | ____ e. Indian Reservation _____
____ f. CSB Site _____
____ g. Other _____ |
|---|---|

(A) MEETING PARTICIPANTS

NAME	ADDRESS / PHONE	RELATION
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

EMANCIPATION CONFERENCE

Referring ILS Worker: _____ Date: _____

Phone Number: _____

Social Worker: _____ Phone Number: _____

Family Name: _____ Youth Name: _____

Age of Youth: _____ Family's Primary Language: _____

Has the Youth been contacted about the conference? Please circle: YES NO

Is her or she willing to come to a conference? Please circle: YES NO

Has the Social Worker been contacted about the conference? Please circle: YES NO

Worker's Concerns:

Complete this form and fax with a **face sheet** to Family Unity (fax # 619-694-5240) or mail to W94. **North County** cases send to Family Unity at N168 or fax to 760-480-5412.

If you have any questions please call any of the following Family Unity Facilitators.

Rebecca Slade, Supervisor (858) 694-5275

Katie Aitken (858) 694-5326

Mark Cavanaugh (858) 694-5395

Louisa Roberts (858) 694-5275

Dave Roob (858) 694-5201

Mary Sorgdrager (858) 694-5390

Amy Stephen (858) 694-5373

Perla Wade (858) 694-5313

North County

Brynn Speigel (760) 480-3445

Family Unity Screener _____

Referral Form: 05/02

THE DEPENDENCY COURT RECOVERY PROJECT FAMILY GROUP CONFERENCE REFERRAL

Referring ILS Worker: _____ Date: _____

Phone Number: _____

Social Worker: _____ Phone Number: _____

Family Name: _____ Youth Name: _____

Age of Youth: _____ Family's Primary Language: _____

Has the Youth been contacted about the conference? Please circle: YES NO

Are they willing to come to a conference? Please circle: YES NO

Has the Social Worker been contacted about the conference? Please circle: YES NO

Worker's Concerns:

Complete this form and fax with a **face sheet** to Family Unity (fax # 619-694-5240) or mail to W94. **North County** cases send to Family Unity at N168 or fax to 760-480-5412.

If you have any questions please call any of the following Family Unity Facilitators.

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Perla Wade (858) 694-5313

North County
Brynn Speigel (760) 480-3445

Family Unity Screener _____

FAMILY GROUP CONFERENCE REFERRALS CLOSING INFORMATION

Meeting Held? YES___ NO___

If not, why?_____

Meeting Date:_____

Project Case? YES___ NO___

Spanish Speaking? YES___ NO___

Facilitator:

Cofacilitator: _____

DAVE_____

MARY_____

LOUISA_____

KATIE_____

PERLA_____

AMY_____

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APPENDIXES

THE FAMILY UNITY MEETING EVALUATION (PRETEST)

Name of person(s) interviewed _____

Date of Interview _____

QUALITY OF ENVIRONMENT: FAMILY/HOUSEMATES

Interviewer Direction:

Now I am going to read some statements that describe how well the people you live with get along with each other and how well you get along with them. Please keep in mind that these questions refer to the people you consider family--your spouse, children, and other family members like aunts, uncles, parents, or your roommates. When I read the statement, look at the words on this piece of paper and just give me the number that is next to the word that best describes how often you generally see these kinds of situations. Again, please do not spend a lot of time deciding, just give me your first impression. Ready? (0 to 6 are the range of responses).

6 = Always

5 = Most of the time, but not all of the time.

4 = More than half the time yes, less than half the time no.

3 = About half the time yes, about half the time no

2 = Less than half the time yes, more than half the time no.

1 = Sometimes but most of the time no

0 = Never

How often...

Do members of this household/home really help and support one another? _____

Do members do things on their own in your household/home? _____

Do family/household members keep their feelings to themselves? _____

Do members fight in your family/household? _____

Do members seem to be killing time at home/in your household? _____

Do members of the family/household say anything they want to around home/
in your household? _____

- Do family/household members become openly angry? _____
- Do family/household members allow and support each other in being independent? _____
- Do members put a lot of energy into what they do at home/in your household? _____
- Is it hard to "blow off steam" at home/in your household without upsetting somebody? _____
- Do family/household members get so angry they throw things? _____
- Do members think things out for themselves in your family/household? _____
- Is there a feeling of togetherness in your family/household? _____
- Do members tell others about their personal problems in your household? _____
- Do members come and go as they want to in your family/household? _____
- Are members of this family/household happy and relaxed? _____
- Are some members of this family/household uptight and anxious? _____
- Do some members of this family/household drink to excess (get drunk a lot)? _____
- Are some members of this family/household very sad and depressed? _____
- Are some members of this family/household emotionally unstable? _____
- Do some members of this family/household cause you a lot of emotional problems? _____
- Are members of this family/household concerned about your own emotional health and well-being? _____

CES-D SCALE

Instructions for questions: I am going to read you a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week. Tell me what number on this list most closely describes you:

- 0 = Rarely or None of the Time (Less than 1 day)
- 1 = Some or a Little of the Time (1-2 days)
- 2 = Occasionally or a Moderate Amount of Time (3-4 days)
- 3 = Most or All of the Time (5-7 days)

During the past week:

1. You were bothered by things that usually don't bother you. _____
2. You did not feel like eating; your appetite was poor. _____
3. You felt that you could not shake off the blues even with help from your family or friends. _____
4. You felt that you were just as good as other people. _____
5. You had trouble keeping your mind on what you were doing. _____
6. You felt depressed. _____
7. You felt that everything you did was an effort. _____
8. You felt hopeful about the future. _____
9. You thought your life had been a failure. _____
10. You felt fearful. _____
11. Your sleep was restless. _____
12. You were happy. _____
13. You talked less than usual. _____
14. You felt lonely. _____
15. People were unfriendly. _____
16. You enjoyed life. _____

17. You had crying spells. _____
18. You felt sad. _____
19. You felt that people disliked you. _____
20. You could not get "along". _____

INDEX OF FAMILY RELATIONS (IFR)

The next series of questions are designed to measure the way you feel about your family as a whole. It is not a test, so there are no right or wrong answers. When I read the statement, look at the words on this piece of paper and just give me the number that is next to the word that best describes how often you generally see these kinds of situations. Again, please do not spend a lot of time deciding, just give me your first impression:

- 0 = Rarely or none of the time
- 1 = A little of the time
- 2 = Some of the time
- 3 = A good part of the time
- 4 = Most or all of the time

Please begin.

1. The members of your family really care about each other. _____
2. You think your family is terrific. _____
3. Your family gets on your nerves. _____
4. You really enjoy your family. _____
5. You can really depend on your family. _____
6. You really do not care to be around your family. _____
7. You wish you were not part of this family. _____
8. You get along well with your family. _____
9. Members of my family argue too much. _____

10. There is no sense of closeness in your family. _____
11. You feel like a stranger in your family. _____
12. Your family does not understand you. _____
13. There is too much hatred in your family. _____
14. Members of your family are really good to one another. _____
15. Your family is well respected by those who know you. _____
16. There seems to be a lot of friction in your family. _____
17. There is a lot of love in your family. _____
18. Members of your family get along well together. _____
19. Life in your family is generally unpleasant. _____
20. Your family is a great joy to you. _____
21. You feel proud of your family. _____
22. Other families seem to get along better than yours. _____
23. Your family is a real source of comfort to you. _____
24. You feel left out of your family. _____
25. Your family is an unhappy one. _____

SOCIAL SUPPORT RATING SCALE

Caring and Emotional Support

There may be people in your life who provide you with *caring and emotional support*. These are people who you can count on to care about you, regardless of what is happening to you, and who accept you totally, including your good and bad points. They are ready to help and support you when you are upset, and they are genuinely concerned about your feelings and welfare.

Please rate each of the people below in terms of how helpful they would be in providing

you with *caring and emotional support* if you needed it. Tell me from the list below which one of these numbers best applies to you. CIRCLE "0" to indicate people who are not part of your social network.

- 1 = never helpful
 2 = helpful on rare occasion
 3 = somewhat helpful
 4 = helpful
 5 = very helpful

1.	Father.....	0	1	2	3	4	5
2.	Mother.....	0	1	2	3	4	5
3.	Spouse/Boyfriend/Girlfriend.....	0	1	2	3	4	5
4.	Adult children.....	0	1	2	3	4	5
5.	Brothers/Sisters.....	0	1	2	3	4	5
6.	Cousins.....	0	1	2	3	4	5
7.	Aunts/Uncles	0	1	2	3	4	5
8.	Grandparents.....	0	1	2	3	4	5
9.	Bosses/Supervisors.....	0	1	2	3	4	5
10.	Social workers/Counselors/.etc.....	0	1	2	3	4	5
11.	Best friend.....	0	1	2	3	4	5
12.	Clergy (pastor, rabbi, priest).....	0	1	2	3	4	5
13.	Other friends.....	0	1	2	3	4	5
14.	Coworkers.....	0	1	2	3	4	5
15.	Neighbors	0	1	2	3	4	5

16. Overall, how satisfied are you with the amount of caring and emotional support you receive from the people listed above?

Very Dissatisfied Neutral Very Satisfied

1-----2-----3-----4-----5-----6-----7

17. In general, when the occasion arises, are you the type of person who turns to others for caring and emotional support?

Never Sometimes Always

1-----2-----3-----4-----5-----6-----7

CARING AND ADVICE SUPPORT

Some people can be counted on to give *help and advice*. These people are there when you need advice or instruction to help you achieve your goals or solve problems. They can help you increase skills or knowledge, or they may be able to give you physical help when there is a task that you have to do. Please rate each of the people below in terms of how helpful they would be, if you needed *help and advice*. Use the list below to tell me what number best applies to you.

- 1 = never helpful
 2 = helpful on rare occasion
 3 = somewhat helpful
 4 = helpful
 5 = very helpful

1. Father.....	0	1	2	3	4	5
2. Mother.....	0	1	2	3	4	5
3. Spouse/Boyfriend/Girlfriend.....	0	1	2	3	4	5
4. Adult children.....	0	1	2	3	4	5
5. Brothers/Sisters.....	0	1	2	3	4	5
6. Cousins.....	0	1	2	3	4	5
7. Aunts/Uncles.....	0	1	2	3	4	5
8. Grandparents.....	0	1	2	3	4	5
9. Bosses/Supervisors.....	0	1	2	3	4	5
10. Social workers/Counselors/.etc....	0	1	2	3	4	5
11. Best friend.....	0	1	2	3	4	5
12. Clergy (pastor, rabbi, priest).....	0	1	2	3	4	5
13. Other friends.....	0	1	2	3	4	5
14. Coworkers.....	0	1	2	3	4	5
15. Neighbors.....	0	1	2	3	4	5

- A. Overall, how satisfied are you with the amount of help and advice you receive from the people listed above?

Very Dissatisfied Very Satisfied
 1-----2-----3-----4-----5-----6-----7

- B. In general, when the occasion arises, are you the type of person who turns to others for help and advice?

Never Sometimes Always
 1-----2-----3-----4-----5-----6-----7

MATERNAL SOCIAL SUPPORT INDEX (MSSI)

Interviewer: You are going to read them the remainder of the questionnaire. Ask then to tell you what is most true for them. Circle the best response.

1. How many relatives do you see once a week or more often?
0 1 2 3 4 5 6 7 8 9 10 or more
2. Would you like to see relatives:
More often Less often It's about right
3. How many relatives can you count on in times of need?
0 1 2 3 4 5 6 7 8 9 10 or more
4. How many friends do you see once a week or more often?
0 1 2 3 4 5 6 7 8 9 10 or more
5. Would you like to see friends:
More often Less often It's about right
6. How many friends can you count on in times of need?
0 1 2 3 4 5 6 7 8 9 10 or more
7. How many people would be able to take care of your children for several hours if needed:
0 1 2 3 4 5 6 7 8 9 10 or more
8. How many of these people are from your neighborhood?
None Some Most All
9. Do you have a boyfriend/girlfriend or husband/wife? Yes No

10. If yes, how happy are you in the way your boyfriend/girlfriend or husband/wife lets you know what he/she feels or thinks?

Very happy Happy Unhappy Very unhappy

11. Are there adults, not including your boyfriend/girlfriend or husband/wife, with whom you have regular talks?

Yes No

12. If yes, think about the person you talk with the most. Are you happy with the talks that you have with this person?

Very happy Happy Unhappy Very unhappy

13. How often do you attend meetings of the following groups?

A. Religious (e.g., churches)

Don't belong Less than once a month About once a month More than once a month

B. Educational (e.g., school, parent groups)

Don't belong Less than once a month About once a month More than once a month

C. Social (e.g., bowling groups, scouting groups)

Don't belong Less than once a month About once a month More than once a month

D. Political (e.g., work for local candidate)

Don't belong Less than once a month About once a month More than once a month

E. Other: _____

Don't belong Less than once a month About once a month More than once a month

14. Are you a member of any committee or do you have any other duties in any of your groups?

1 = yes 0 = no

PARENT DEMOGRAPHICS BASELINE INFORMATION

I would like to ask some questions about you; your education and work experience. These questions will help us understand your other responses.

1. What is the highest grade in school or years of school that you have completed? (Circle highest year completed)

None-----0

Elementary & High School---- 1 2 3 4 5 6 7 8 9 10 11 12

College-----13 14 15 16

Graduate or Professional-----17 18 19 20

(If 0-12, go to 2)

(If 13-20, go to 3)

2. Did you get a high school diploma or pass a high school equivalency test? (Circle one answer)

No-----0 (Go to 4)

Diploma-----1

Equivalency test, GED---- 2

3. What is the highest degree that you have completed? (Do Not Read List)

Vocational (adult) school certificate of completion----- 0

None (part college)----- 1

Associate of Arts (AA, Junior college degree)----- 2

Bachelor's (BA, AB, or BS)----- 3

Master's (MA, MS, MSW, etc.) or license----- 4

Professional degree (PhD, MD, JD, etc)----- 5

4. Which of these describes your current work situation? (Read list, check all that apply)

Employed (go to Item 5)

Unemployed, looking for work (If an answer other than Employed, go to Item 7)

Unemployed, not looking for work

Keeping house

Disabled

Retired

Student

Other_____ (Specify)

5. How long have you been at your present job? _____/_____
Months Years
6. Is this full- or part-time? (Circle one)
- Full-time = 1
Part-time = 2
7. Is your spouse/partner employed?
- 1 = Yes (If Yes, go to 7a)
0 = No (If No, go to 8)
- 7a. If yes, is that
- Full-time = 1
Part-time = 2
8. Do you:
- 1 = rent
2 = own your home
3 = live in the home of someone else
4 = other _____
(specify)
- 8a. What is your approximate annual income?_____.
9. What kind of work are you doing/did you do? (Record kind of work, e.g., file clerk, typist, sales, etc.)

10. What kind of work does your spouse/partner do? (Record kind of work, e.g., file clerk, typist, sales, etc.)

11. What is your relationship to (Name of child removed to Polinsky)? _____
12. When (Child's name) was living with you, were there other children living with you at that time?
- 1 = Yes _____
0 = No _____
- If yes how many?_____.

Finally, I have a few questions about your background.

13. Where were you born?

City	State	Country if other than U.S
------	-------	---------------------------

14. What is your date of birth?

Month	Day	Year
-------	-----	------

15. How long have you lived in California?

Years	Months
-------	--------

16. How would you describe your racial or ethnic background?

White	Hispanic	Black	Asian	Other	(Specify)
1	2	3	4	5	

17. Are you currently married?

1 = Yes _____ (If yes, go to 17a)

0 = No _____ (If no, go to 19)

17a. When were you married? _____ / _____
Month Year

18. Is this your first marriage?

1 = Yes _____

0 = No _____ (If no, go to 19b)

19. Have you ever been married?

1 = Yes _____ (If yes, go to 19b)

0 = No _____

19b. How many times have you been married? _____

20. What would you like to happen as a result of the Family Unity Meeting?

Do you have another telephone number I can reach you at in case you are not at this one when I need to do the second interview? _____.

SECTION 1 – REFERRAL SITUATION

1. How did you first happen to talk with a social worker from AGENCY? Or What was the reason you were referred?

Probes: In your opinion, how did PROBLEM MENTIONED come about? What do you think caused this situation? Was it something out of your control?

2. Did you agree with the worker about this problem or about your situation?

Probes: Did the worker tell you that a problem(s) existed that you did not agree with? Did you and the worker disagree about what happened or what caused it?

Ask either questions 3-3c or questions 4-4c. If reason for referral was an INCIDENT, ask question 3. If reason for referral was a SITUATION, ask question 4.

3. Since you first talked to someone from AGENCY, how often has REFERRAL INCIDENT happened again?

Read responses 1-4 only.

1. Not at all *Ask 3a.*
2. Less often than before *Ask 3b.*
3. About the same as before *Ask 3b.*
4. More often than before *Ask 3c.*
8. Other *Have client explain.*
9. Not sure

3a. Why do you feel that INCIDENT MENTIONED hasn't happened again?

3b. What needs to be changed (improved) to prevent REFERRAL INCIDENT from happening again (or, continuing to happen)?

3c. Why do you think REFERRAL INCIDENT happens more often now?

4. Overall, how is (are) the REFERRAL PROBLEM(S) for your family now as compared with when you first talked with someone from AGENCY? Would you say it's

Read responses 1-5 only

1. A lot better now *Ask 4a.*
2. A little better now *Ask 4a.*
3. About the same now *Ask 4b.*
4. A little worse now, or *Ask 4c.*
5. A lot worse now *Ask 4c.*
8. Other *Have client explain.*
9. Not sure

4a. What do you feel is the most important way that REFERRAL PROBLEM is better now?

4b. What do you feel is the most important way that REFERRAL PROBLEM still needs to be improved?

4c. What do you feel is worse now about REFERRAL PROBLEM

5. Did you receive any counseling or other services to help you with REASON FOR REFERRAL?

Have client describe service(s) received.

6. Consider client's responses to questions 3, 4, and 5 (see table below), then ask one question only from 6a-6d.

Services (Q.5)

Rating (Q 3 or 4)	Received	Not Received
<i>Better/Not Happening</i>	Ask 6a	Ask 6c
<i>Same Worse/Still Happening</i>	Ask 6b	Ask 6d

- 6a. *If referral problem(s) better or not happening and service received, ask:*

Do you think IMPROVEMENT MENTIONED would have happened without your caseworker's help?

- 6b. *If referral problem(s) same, or worse, or still happening, and service received, ask:*

Why do you think SERVICE(S) MENTIONED didn't help to improve (or, change) PROBLEM(S) MENTIONED? [Why didn't SERVICE(S) RECEIVED make a difference? What do you think should have been done instead?]

- 6c. *If referral problem(s) better or not happening and no service received, ask:*
Why do you think IMPROVEMENT MENTIONED happened? (What

happened to change things?)

- 6d. *If referral problem(s) same, or worse, or still happening, and no service received, ask:*

What do you think is the reason that PROBLEM(S) MENTIONED has not improved (or, gotten better)? (Why didn't you mention it to your caseworker? Did you ask for any service or for any help from your caseworker? What did your caseworker say?)

7. Overall, how satisfied are you with the services you received or what your caseworker did? Are you

Read responses 1-5 only:

1. Very satisfied Ask 7a.
2. Somewhat satisfied Ask 7a.
3. Somewhat dissatisfied Ask 7b.
4. Very dissatisfied Ask 7b.
5. No particular feeling Ask 7a.
8. Other *Have client explain.*
9. Not sure

- 7a. What did you like most about the agency? (What do you think helped you the most?) Ask 8.

- 7b. What didn't you like about the agency? (What were you unhappy with about the agency?) Ask 8a.

8. Was there anything you didn't like about the agency? (What were you unhappy with?)

- 8a. Was there anything you did like about the agency?

SECTION 2 – OUT-OF-HOME PLACEMENT

1. Since you first talked to someone from AGENCY, have any of your children been placed?

If no child placed, skip to question 6.

- 1a. Are any of your children still in placement or have they been returned home?

2. As you see it, how did it come about that your child(ren) was (were) placed?
3. What do you think might have prevented your child(ren) being placed?

Probes: What could AGENCY have done differently? What could you have done differently? Did your caseworker try to find some other answer to the problem?

4. *If at least one child has returned home, ask:*

In your view, what made it possible for CHILD to return home?

5. *If at least one child has not returned home, ask:*

Do you feel your CHILD(REN) should be returned home to you now? (What do you think will make it possible for CHILD(REN) to return?)

6. Do you feel that any of your children should be placed in foster care for any reason? Do you think things would be better if one of your children was placed in foster care?

If yes, ask:

Have you asked the worker about placement? What did he/she say?

SECTION 5 – DISCIPLINE AND EMOTIONAL CARE OF CHILDREN

Raising children is not always easy, so we are asking about problems that sometimes come up in training children or in relating to them.

1. When you first talked to someone from AGENCY:

Read first question:

If answer is yes, ask: Is this still happening? (or, Has this happened again?) If answer is no, ask: Is this happening now? (or, Has this happened since you first talked to someone from AGENCY?)

Repeat for each question 1b-1l.

	<i>Yes, at referral</i>	<i>Yes, again or now</i>
a. Did your children get on your nerves so much that you sometimes lost your temper with them?	1	1
b. Did you find that hitting your children was the best way to get them to listen?	1	1

	Yes, at referral	Yes, again or now
c. Did you sometimes feel uncomfortable when one of your children wanted to be hugged or held a lot?	1	1
d. Did you sometimes find yourself blaming your children for things that were not really their fault?	1	1
e. Did you sometimes hit your children harder than you should have?	1	1
f. Did you sometimes expect your children to do things that they really couldn't do?	1	1
g. Did things sometimes get out of control when you were punishing your children?	1	1
h. Did you sometimes say things to your children that you regretted later on?	1	1
i. Did people complain about the way you punished your children?	1	1
j. Did you sometimes feel that your children were taking up too much of your time, that they kept you from doing the things you really wanted to do?	1	1
k. Had any of your children been hurt in some way while they they were being punished?	1	1
l. Were there any other problems in relating to your children that I haven't mentioned? <i>Have client explain.</i>	1	1

If no to all questions 1a-1l, skip to section 6.

2. Since you first talked to someone from the AGENCY, do you feel there's been a change in how well you're training your children and relating to them? Do you feel things are:

Read responses 1-5 only:

1. A lot better now *Ask 2a.*
2. A little better now *Ask 2a*
3. About the same now as before *Ask 2b.*
4. A little tense now, *Ask 2c.*
5. A lot worse now *Ask 2c.*
8. Other *Have client explain.*
9. Not sure

- 2a. What is the most important way that the training of your children is better?
- 2b. What still needs to be improved about your children's training?
- 2c. What is worse about your children's training?

3. Did you and your caseworker discuss PROBLEM(S) MENTIONED? Did you receive any counseling or other service to help you with PROBLEM(S) MENTIONED? *Have client describe service(s) received.*
4. *Consider client's responses to questions 2 and 3 (see table below) then ask one question only from 4a-4d.*

Services (Q.3)

Rating (Q.2)	Received	Not Received
<i>Better</i>	Ask 4a	Ask 4c
<i>Same/Worse</i>	Ask 4b	Ask 4d

- 4a. *If problem(s) better and service received, ask:*
Do you think SERVICE(S) MENTIONED was the reason for IMPROVEMENT MENTIONED? (Do you think IMPROVEMENT MENTIONED would have happened without your caseworker's help)?
 - 4b. *If problem(s) same, or worse, and service received, ask:*
Why do you think SERVICE(S) MENTIONED didn't help to improve (or, change) PROBLEM(S) MENTIONED? [Why didn't SERVICES(S) RECEIVED make a difference? What do you think should have been done instead?]
 - 4c. *If problem(s) better and no service received, ask:*
Why do you think IMPROVEMENT MENTIONED happened.? (What happened to change things?)
 - 4d. *If problem(s) same, or worse, and no service received, ask:*
What do you think is the reason that PROBLEM(S) MENTIONED has not improved (or, gotten better)? (Why didn't you mention it to your caseworker? Did you ask for any service or for any help from your caseworker? What did your caseworker say?)
5. *If client has any problem "still or now" (see Q. 1), ask:*
Is there anything *else you* would like your caseworker to do to help you with PROBLEM(S) MENTIONED?

SECTION 7 – CHILDREN'S CONDUCT

Ask section only if family has school-age children. If none, skip to section 8.

Now I'd like to ask some questions about your children's conduct.

1. When you first talked to someone from AGENCY, were any of your children
Read first question:

If answer is yes, ask: Is this still a problem for any of your children?

If answer is no, ask: Is this a problem now for any of your children?

Repeat for each question 1b-1l.

	<i>Yes, at referral</i>	<i>Yes, still or now</i>
a. Breaking and busting things on purpose?	1	1
b. Hitting or fighting with other children?	1	1
c. Lying and not listening to you?	1	1
d. Stealing or copping things?	1	1

Ask families with children ages 10 and up.

f. Hanging around with friends you disapprove of?	1	1
g. Running away from home?	1	1
h. Beating up or assaulting people?	1	1
i. Being picked up or arrested by the police?	1	1
j. Appearing in family or juvenile court?	1	1

Ask only families with teenagers.

k. Getting drunk or using drugs?	1	1
l. Having sex or "sleeping around"?	1	1

If no to all questions 1a-1l, skip to section 8.

2. Since you first talked with someone from AGENCY, have there been any changes in your child(ren)'s behavior? Would you say their behavior is"

Read responses 1-5 only:

1. A lot better now *Ask 2a.*
2. A little better now *Ask 2a.*
3. About the same *Ask 2b.*
4. A little worse now, *Ask 2c.*
5. A lot worse now *Ask 2c.*
8. Other *Have client explain.*
9. Don't know, not sure

2a. What is the most important way your children's behavior is better now?

2b. In what way does your children's behavior still need to be improved?

2c. In what way is your children's behavior worse now?

3. Did you and your caseworker discuss PROBLEM(S) MENTIONED? Did you receive any counseling or any other services to help you with PROBLEM(S) MENTIONED?

4. Consider client's responses to questions 2 and 3 (see table below) then ask one question only from 4a-4d.

Services (Q.3)

Rating (Q.2)	Received	Not Received
<i>Better</i>	Ask 4a	Ask 4c
<i>Same/Worse</i>	Ask 4b	Ask 4d

- 4a. *If problem(s) better and service received, ask:*
Do you think SERVICE(S) MENTIONED was the reason for IMPROVEMENT MENTIONED? (Do you think IMPROVEMENT MENTIONED would have happened without your caseworker's help?)
- 4b. *If problem(s) same, or worse, and service received, ask:*
Why do you think SERVICE(S) MENTIONED didn't help to improve (Or, change) PROBLEM(S) MENTIONED? [Why didn't SERVICE(S) RECEIVED make a difference? What do you think should have been done instead?]
- 4c. *If problem(s) better and no service received, ask:*
Why do you think IMPROVEMENT MENTIONED happened? (What happened to change things?)
- 4d. *If problem(s) same, or worse, and no service received, ask:*
What do you think is the reason that PROBLEM(S) MENTIONED has not improved (or, gotten better)? (Why didn't you mention it to your caseworker? Did you ask for any service or for any help from your caseworker? What did your caseworker say?)
5. *If client has any problem "still or now" (see Q 1), ask:*
Is there anything else you would like your caseworker to do to help you with PROBLEM(S) MENTIONED?

Consider client's responses to questions 3 and 4 (see table below) then ask one question only from 5a-5d.

Services (Q.4)

Rating (Q.3)	Received	Not Received
<i>Better</i>	Ask 5a	Ask 5c
<i>Same/Worse</i>	Ask 5b	Ask 5d

- 5a. *If problem(s) better and service received ask:*
Do you think SERVICE(S) MENTIONED was the reason for IMPROVEMENT MENTIONED? (Do you think IMPROVEMENT MENTIONED would have happened without your caseworker's help?)

- 5b. *If problem(s) same, or worse, and service received, ask:*
Why do you think SERVICE(S) MENTIONED didn't help to improve (or, change) PROBLEM(S) MENTIONED? [Why didn't SERVICE(S) RECEIVED make a difference? What do you think should have been done instead?]
- 5c. *If problem(s) better and no service received, ask:*
Why do you think IMPROVEMENT MENTIONED happened? (What happened to change things?)
- 5d. *If problem(s) same, or worse, and no service received, ask:*
What do you think is the reason that PROBLEM(S) MENTIONED has not improved (or, gotten better)? (Why didn't you mention it to your caseworker? Did you ask for any service or for any help from your caseworker? What did your caseworker say?)
6. *If children have any problem "still or now" (see Q. 1), ask:*
Is there anything *else* you would like your caseworker to do to help with PROBLEM(S) MENTIONED?

SECTION 8 – CHILDREN'S SYMPTOMATIC BEHAVIOR

Ask section only if family has at least one child over the age of 3. If none skip to section 9.

Now I'd like to ask about some nervous difficulties children could have in growing up.

1. When you first talked to someone from AGENCY, were any of your children

Read first question:

If answer is yes, ask: Is this still a problem for any of the children? (Is the child still having this problem?)

If answer is no, ask: Is this still a problem now for any of your children?

Repeat for each question 1b-1j.

	Yes, at referral	Yes, still or now
a. Anxious, afraid, or tense a lot of the time?	1	1
b. Depressed, sad, or withdrawn a lot of the time?	1	1
c. Restless or fidgety a lot of the time?	1	1
d. Being confused or not remembering things a lot of the time?	1	1
e. Sluggish or sleeping a lot of the time?	1	1
f. Getting moody suddenly a lot of the time?	1	1

	Yes, at referral	Yes, still or now
g. Complaining about aches and pains a lot?	1	1
h. Wetting or soiling the bed a lot?	1	1
i. Having nightmares a lot of the time?	1	1
j. Talking about wanting to die, or saying they'd rather be dead?	1	1

If no to all questions 1a-1j, skip to section 9.

2. Does PROBLEM(S) MENTIONED interfere with his/her school work or attendance, or his/her relationship with friends?
3. Since you first talked to someone from AGENCY, have your child(ren)'s nervous difficulties

Read responses 1-5 only:

1. Gotten a lot better *Ask 3a*
2. Gotten a little better *Ask 3a*
3. Stayed about the same *Ask 3b*
4. Gotten a little worse *Ask 3c*
5. Gotten a lot worse *Ask 3c*
8. Other *Have client explain*
9. Don't know, not sure

- 3a. In what ways are your children's nervous problems better now?
- 3b. In what ways do your children's nervous problem(s) still need to be improved?
- 3c. In what ways are your children's nervous problems worse now?

4. Did you and your caseworker discuss PROBLEM(S) MENTIONED? Did you receive any counseling or any other services to help you with PROBLEM(S) MENTIONED? *Have client describe services received.*

SECTION 9 – VICTIMIZATION OF CHILDREN

Now I'd like to ask whether any of your children have had any experience where someone bothered or mistreated them.

1. At the time you first talked to someone from AGENCY, had any of your children

Read first question:

If answer is yes, ask: Has this happened again?

If answer is no, ask: Has this happened recently? (Has this happened since you first talked to someone from AGENCY?)

Repeat for each question 1b-1f.

	<i>Yes, at referral</i>	<i>Yes, happened again/recently</i>
a. Had things taken from them or stolen?	1	1
b. Been attacked or beaten up?	1	1
c. Been threatened by anyone?	1	1
d. Been made to do work for which they were too young, or that was no good for them?	1	1
d. Been forced to do something against the law?	1	1
e. Been molested or taken advantage of sexually by an adult?	1	1

If no to all questions 1a-1f, skip to section 10.

2. *If yes to any questions 1a-1f ask:* Was (were) your children) hurt or injured in some way? What kind of injury was it? How serious was the injury?

2a. Who did this to your child(ren)? (Who was responsible?)

3. Since you first talked with someone from AGENCY, has there been a change in how safe your children are from being hurt or threatened by other people? Do you think that your children are

Read responses 1-5 only:

1. A lot safer now *Ask 3a.*
2. A little safer now *Ask 3a.*
3. About the same *Ask 3b.*
4. A little less safe now *Ask 3c.*
5. A lot less safe now *Ask 3c.*
8. Other *Have client explain.*
9. Not sure

3a. What is the most important way that your children are safer now? (*or, Why do you feel that INCIDENT MENTIONED won't happen again?*)

3b. What is the most important way your children's safety still needs to be improved? (*or, What needs to be done to prevent INCIDENT MENTIONED from happening again?*)

3c. What is worse now about your children's safety? (How are they less safe now? Or, Why do you think that INCIDENT MENTIONED could happen again?)

4. Did you and your caseworker discuss INCIDENT MENTIONED? Did you receive any counseling or any other services to help you with INCIDENT(S) MENTIONED?
5. *Consider client's responses to questions 3 and 4 (see table below) then ask one question only from 5a-5d.*

Services (Q.4)

Rating (Q.3)	Received	Not Received
<i>Safer</i>	Ask 5a	Ask 5c
<i>Same or Less Safe</i>	Ask 5b	Ask 5d

- 5a. *If safer and service received, ask:*
Do you think SERVICE(S) RECEIVED was the reason for IMPROVEMENT MENTIONED? (Do you think IMPROVEMENT MENTIONED would have happened without your caseworker's help?)
- 5b. *If safety same or less, and service received, ask:*
Why do you think SERVICE(S) RECEIVED didn't help to improve (or, change) PROBLEM(S) MENTIONED? [Why didn't SERVICE(S) RECEIVED make a difference? What do you think should have been done instead?]
- 5c. *If safer and no services received, ask:*
Why do you think IMPROVEMENT MENTIONED happened? (What happened to change things?)
- 5d. *If safety same or less, and no service received, ask:*
What do you think is the reason that your children's safety has not improved (or, gotten better)? (Why didn't you mention it to your caseworker? Did you ask for any service or for your caseworker to do something? What did your caseworker say?)
6. *If any incidents happened again or recently (see Q. 1), ask:*
Is there anything else you would like your caseworker to do to help you prevent INCIDENT(S) MENTIONED from happening again?

SECTION 10 -- PARENTAL COPING

All people sometimes have personal difficulties in their lives. I'm going to read a list of common difficulties and I'd like you to tell me whether any describe your situation.

1. When you first talked to someone from AGENCY, were you

Read first question:

If answer is yes, ask: Are you still having this difficulty?

If answer is no, ask: Are you now having this difficulty?

Repeat for each question 1b-1i.

	Yes, at referral	Yes, still or now
a. Having any health problems that limited what you could do?	1	1
b. Having trouble with drinking too much or using drugs?	1	1
c. Feeling depressed or "blue"?	1	1
d. Overwhelmed with work and no one to help you?	1	1
e. Having a lot of fights and arguments with your husband (or the person you're living with)?	1	1
f. Feeling nervous, tense, or worried?	1	1
g. Getting yourself into some trouble with the law?	1	1
h. Hating yourself or wanting to just give up?	1	1
i. Feeling lonely or out of touch with people?	1	1

If no to questions 1a-1i, skip to section 11.

2. You mentioned PROBLEM(S) MENTIONED. Right now, is this at all affecting your ability to run your house or to take care of your children? In what way?
3. Since you first talked to someone from AGENCY, have there been any changes in your personal life or personal difficulties? Are things

Read responses 1-5 only:

1. A lot better now Ask 3a.
2. A little better now Ask 3a.
3. About the same Ask 3b.
4. A little worse now Ask 3c.
5. A lot worse now Ask 3c.
8. Other Have client explain.
9. Not sure

- 3a. What's the most important thing in your personal life that has changed for the better?
- 3b. What's the most important change in your personal life that you would like to see?
- 3c. What's the most important thing that has gotten worse?

4. Did you and your caseworker discuss PROBLEM(S) MENTIONED? Did you receive any counseling or any other services to help you with your PROBLEM(S)

MENTIONED?

5. Consider client's responses to questions 3 and 4 (see table below) then ask one question only from 5a-5d.

Services (Q. 4)

Rating (Q. 3)	Received	Not Received
<i>Better</i>	Ask 5a	Ask 5c
<i>Same/Worse</i>	Ask 5b	Ask 5d

- 5a. *If problem better and service received, ask:*
Do you think SERVICE(S) RECEIVED was the reason for IMPROVEMENT MENTIONED? (Do you think IMPROVEMENT MENTIONED would have happened without your caseworker's help?)
- 5b. *If no improvement or worse and service received, ask:*
Why do you think SERVICE(S) RECEIVED didn't help to improve (or, change) PROBLEM(S) MENTIONED? [Why didn't SERVICE(S) RECEIVED make a difference? What do you think should have been done instead?]
- 5c. *If problem and no services received ask:*
Why do you think the IMPROVEMENT MENTIONED happened? (What happened to change things?)
- 5d. *If no improvement or worse and no services received ask:*
What do you think is the reason that PROBLEM(s) MENTIONED has (have) not improved (or, gotten better)? (Why didn't you mention it to your caseworker? Did you ask for any service or for your caseworker to do something? What did your caseworker say?)
6. *If client has any problem "still or now" (see Q. 1), ask:*
Is there anything else you would like your caseworker to do to help you with PROBLEM(S) MENTIONED?

SECTION 11 – RELATIONSHIP WITH SOCIAL WORKER

Now I'd like to find out some more about how you and your caseworker(s) got along together. I'll read a list of questions and you can answer "always," "usually," "sometimes," or "never."

If more than one worker, ask about current worker or the one assigned longest.

		<i>Always</i>	<i>Usually</i>	<i>Sometimes</i>	<i>Never</i>
1.	Did your caseworker explain to you what she/he was trying to do and why she/he was doing it?	4	3	2	1
2.	Did your caseworker give you confidence that headway or progress could be made on your on your problems?	4	3	2	1
3.	Did (or, does) your caseworker ask for your opinions about your problems, and about the kinds of help you want(ed)?	4	3	2	1
4.	Did (or, does) your caseworker try to help you understand better your own feelings and behavior?	4	3	2	1
5.	Do you feel your caseworker cared (or, cares) about you or was (or, is) concerned about you as a person?	4	3	2	1
6.	Did (or, does) your caseworker fight for you or stick up for you with other agencies or other people? <i>Leave blank if not applicable.</i>	4	3	2	1
7.	Do you feel that your caseworker was (or, is) easy to talk to?	4	3	2	1
8.	Do you feel that your caseworker understood (or understands) your opinions, even if she/he didn't (or, doesn't) always agree with you?	4	3	2	1
9.	Do you have the feeling that you could (or, can) depend on or rely on your case-worker when you ran (or, run) into a problem?	4	3	2	1
10.	Do you feel that your caseworker knew what she/he was doing, that she/he was organized?	4	3	2	1
11.	Did your caseworker help you to talk about subjects that were not easy to talk about?	4	3	2	1
12.	Did (or, does) your caseworker make you feel that everything wrong was your own fault?	4	3	2	1
13.	Did your caseworker let you know when she/he thought you weren't working hard enough on your problems?	4	3	2	1
14.	Did (or, does) your caseworker help you to see your good points as well as your problems?	4	3	2	1

15. Did (<i>or</i> , does) your caseworker visit you regularly and keep in touch with you?	4	3	2	1
16. Was (<i>or</i> , is) your caseworker available when you wanted or needed her/him?	4	3	2	1
17. Do you feel your caseworker was (<i>or</i> , is) Open or "straight" with you?	4	3	2	1

Ask only if case is closed:

You can answer the next two questions "yes," "no," or "not sure."

	Yes	No	Not Sure
18. Before your case closed, did your caseworker talk to you about what you had done together, about what you had accomplished?	1	2	3
19. Did you agree with the decision to close your case?	1	2	3
20. <i>If answered no or not sure to Q. 19, ask:</i> Why didn't you agree?			
21. In general, how satisfied are you with the way you and your caseworker got along together? Are you			

Read responses 1-5 only:

1. Very satisfied *Ask 21a.*
2. Somewhat satisfied *Ask 21a.*
3. Somewhat dissatisfied *Ask 21b.*
4. Very dissatisfied *Ask 21b.*
5. No particular feeling about it *Ask 21a.*
8. Other *Have client explain.*
9. Not sure

21a. What did you like the most about your caseworker? *Ask Q.22.*

21b. What didn't you like about your caseworker? *Ask Q.23.*

22. Was there anything about your caseworker that you didn't like? (What were you unhappy with?)
23. Was there anything about your caseworker that you especially liked? (What was that?)
24. About how often did you see your caseworker? Was it

Read responses 1-5 only:

1. Several times a week
 2. About once a week
 3. About once every two weeks
 4. About once a month, or
 5. Less than once a month
 0. Never
 8. Other
 9. Don't know, not sure
25. Do you feel you talked to your worker about the most important things? (or, the right things?) (What else did you want to talk about with your worker?)
26. Was there anything else you wanted your caseworker to do but, he/she didn't do? (What was that?)
27. Did your caseworker do anything you objected to, were against, or didn't want done? (What was that?)

THE FAMILY UNITY MEETING EVALUATION (POSTTEST)

Name of person(s) interviewed _____

Date of Interview _____

QUALITY OF ENVIRONMENT: FAMILY/HOUSEMATES

Interviewer Direction:

Now I am going to read some statements that describe how well the people you live with get along with each other and how well you get along with them. Please keep in mind that these questions refer to the adult people you live with at the present time, that is your adult family members--your spouse and other adult family members—or your roommates. When I read the statement look at the words on this piece of paper and just give me the number that is next to the word that best describes how often you generally see these kinds of situations. Again, please do not spend a lot of time deciding, just give me your first impression. Ready? (0 to 6 are the range of responses).

6 = Always

5 = Most of the time, but not all of the time.

4 = More than half the time yes, less than half the time no.

3 = About half the time yes, about half the time no

2 = Less than half the time yes, more than half the time no.

1 = Sometimes but most of the time no

0 = Never

How often...

Do members of this household/home really help and support one another? _____

Do members do things on their own in your household/home? _____

Do family/household members keep their feelings to themselves? _____

Do members fight in your family/household? _____

Do members seem to be killing time at home/in your household? _____

Do members of the family/household say anything they want to around home/
in your household? _____

- Do family/household members become openly angry? _____
- Do family/household members allow and support each other in being independent? _____
- Do members put a lot of energy into what they do at home/in your household? _____
- Is it hard to "blow off steam" at home/in your household without upsetting somebody? _____
- Do family/household members get so angry they throw things? _____
- Do members think things out for themselves in your family/household? _____
- Is there a feeling of togetherness in your family/household? _____
- Do members tell others about their personal problems in your household? _____
- Do members come and go as they want to in your family/household? _____
- Are members of this family/household happy and relaxed? _____
- Are some members of this family/household uptight and anxious? _____
- Do some members of this family/household drink to excess (get drunk a lot)? _____
- Are some members of this family/household very sad and depressed? _____
- Are some members of this family/household emotionally unstable? _____
- Do some members of this family/household cause you a lot of emotional problems? _____
- Are members of this family/household concerned about your own emotional health and well-being? _____

CES-D SCALE

Instructions for questions: I am going to read you a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week. Tell me what number on this list most closely describes you:

- 0 = Rarely or None of the Time (Less than 1 day)
- 1 = Some or a Little of the Time (1-2 days)
- 2 = Occasionally or a Moderate Amount of Time (3-4 days)
- 3 = Most or All of the Time (5-7 days)

During the past week:

1. You were bothered by things that usually don't bother you. _____
2. You did not feel like eating; your appetite was poor. _____
3. You felt that you could not shake off the blues even with help from your family or friends. _____
4. You felt that you were just as good as other people. _____
5. You had trouble keeping your mind on what you were doing. _____
6. You felt depressed. _____
7. You felt that everything you did was an effort. _____
8. You felt hopeful about the future. _____
9. You thought your life had been a failure. _____
10. You felt fearful. _____
11. Your sleep was restless. _____
12. You were happy. _____
13. You talked less than usual. _____
14. You felt lonely. _____
15. People were unfriendly. _____

16. You enjoyed life. _____
17. You had crying spells. _____
18. You felt sad. _____
19. You felt that people disliked you. _____
20. You could not get "along". _____

INDEX OF FAMILY RELATIONS (IFR)

The next series of questions are designed to measure the way you feel about your family as a whole. It is not a test, so there are no right or wrong answers. When I read the statement look at the words on this piece of paper and just give me the number that is next to the word that best describes how often you generally see these kinds of situations. Again, please do not spend a lot of time deciding, just give me your first impression:

- 0 = Rarely or none of the time
- 1 = A little of the time
- 2 = Some of the time
- 3 = A good part of the time
- 4 = Most or all of the time

Please begin.

1. The members of your family really care about each other. _____
2. You think your family is terrific. _____
3. Your family gets on your nerves. _____
4. You really enjoy your family. _____
5. You can really depend on your family. _____
6. You really do not care to be around your family. _____
7. You wish you were not part of your family. _____
8. You get along well with your family. _____

9. Members of your family argue too much. _____
10. There is no sense of closeness in your family. _____
11. You feel like a stranger in your family. _____
12. Your family does not understand you. _____
13. There is too much hatred in your family. _____
14. Members of your family are really good to one another. _____
15. Your family is well respected by those who know you. _____
16. There seems to be a lot of friction in your family. _____
17. There is a lot of love in your family. _____
18. Members of your family get along well together. _____
19. Life in your family is generally unpleasant. _____
20. Your family is a great joy to you. _____
21. You feel proud of your family. _____
22. Other families seem to get along better than yours. _____
23. Your family is a real source of comfort to you. _____
24. You feel left out of your family. _____
25. Your family is an unhappy one. _____

SOCIAL SUPPORT RATING SCALE CARING AND EMOTIONAL SUPPORT

There may be people in your life who provide you with *caring and emotional support*. These are people who you can count on to care about you, regardless of what is happening to you, and who accept you totally, including your good and bad points. They are ready to help and support you when you are upset, and they are genuinely concerned about your feelings and welfare.

Please rate each of the people below in terms of how helpful they would be in providing you with *caring and emotional support* if you needed it. Tell me from the list about which one of these numbers best applies to you. CIRCLE "0" to indicate people who are not part of your social network.

- 1 = never helpful
- 2 = helpful on rare occasion
- 3 = somewhat helpful
- 4 = helpful
- 5 = very helpful

1. Father	0	1	2	3	4	5
2. Mother	0	1	2	3	4	5
3. Spouse/Boyfriend/Girlfriend	0	1	2	3	4	5
4. Adult children	0	1	2	3	4	5
5. Brothers/Sisters	0	1	2	3	4	5
6. Cousins	0	1	2	3	4	5
7. Aunts/Uncles	0	1	2	3	4	5
8. Grandparents	0	1	2	3	4	5
9. Bosses/Supervisors	0	1	2	3	4	5
10. Social workers/Counselors/etc.	0	1	2	3	4	5
11. Best friend	0	1	2	3	4	5
12. Clergy (pastor, rabbi, priest)	0	1	2	3	4	5
13. Other friends	0	1	2	3	4	5
14. Coworkers	0	1	2	3	4	5
15. Neighbors	0	1	2	3	4	5

16. Overall, how satisfied are you with the amount of caring and emotional support you receive from the people listed above?

Very Dissatisfied Neutral Very Satisfied
 1-----2-----3-----4-----5-----6-----7

17. In general, when the occasion arises, are you the type of person who turns to others for caring and emotional support?

Never Sometimes Always
 1-----2-----3-----4-----5-----6-----7

CARING AND ADVICE SUPPORT

Some people can be counted on to give *help and advice*. These people are there when you need advice or instruction to help you achieve your goals or solve problems. They can help you increase skills or knowledge, or they may be able to give you physical help when there is a task that you have to do. Please rate each of the people below in terms of how helpful they would be, if you needed *help and advice*. Use this list to tell me what number best applies to you.

- 1 = never helpful
- 2 = helpful on rare occasion
- 3 = somewhat helpful
- 4 = helpful
- 5 = very helpful

1. Father	0	1	2	3	4	5
2. Mother	0	1	2	3	4	5
3. Spouse/Boyfriend/Girlfriend	0	1	2	3	4	5
4. Adult children	0	1	2	3	4	5
5. Brothers/Sisters	0	1	2	3	4	5
6. Cousins	0	1	2	3	4	5
7. Aunts/Uncles	0	1	2	3	4	5
8. Grandparents	0	1	2	3	4	5
9. Bosses/Supervisors	0	1	2	3	4	5
10. Social workers/Counselors/etc.	0	1	2	3	4	5
11. Best friend	0	1	2	3	4	5
12. Clergy (pastor, rabbi, priest)	0	1	2	3	4	5
13. Other friends	0	1	2	3	4	5
14. Coworkers	0	1	2	3	4	5
15. Neighbors	0	1	2	3	4	5

- A. Overall, how satisfied are you with the amount of help and advice you receive from the people listed above?

Very Dissatisfied
1-----2-----3-----4-----5-----6-----7
Very Satisfied

- B. In general, when the occasion arises, are you the type of person who turns to others for help and advice?

Never
1-----2-----3-----4-----5-----6-----7
Sometimes
Always

MATERNAL SOCIAL SUPPORT INDEX (MSSI)

Interviewer: You are going to read them the remainder of the questionnaire. Ask them to tell you what is most true for them. Circle the best response.

1. How many relatives do you see once a week or more often?

0 1 2 3 4 5 6 7 8 9 10 or more

2. Would you like to see relatives:

More often Less often It's about right

3. How many relatives can you count on in times of need?

0 1 2 3 4 5 6 7 8 9 10 or more

4. How many friends do you see once a week or more often?

0 1 2 3 4 5 6 7 8 9 10 or more

5. Would you like to see friends:

More often Less often It's about right

6. How many friends can you count on in times of need?

0 1 2 3 4 5 6 7 8 9 10 or more

7. How many people would be able to take care your children for several hours if needed:

0 1 2 3 4 5 6 7 8 9 10 or more

8. How many of these people are from your neighborhood?

None Some Most All

9. Do you have a boyfriend/girlfriend or husband/wife? Yes No

10. If yes, how happy are you in the way your boyfriend/girlfriend or husband/wife lets you know what he/she feels or thinks?

Very happy Happy Unhappy Very unhappy

11. Are there adults, not including your boyfriend/girlfriend or husband/wife, with whom you have regular talks?

Yes

No

12. If yes, think about the person you talk with the most. Are you happy with the talks that you have with this person?

Very happy

Happy

Unhappy

Very unhappy

13. How often do you attend meetings of the following groups?

A. Religious (e.g., churches)

Don't belong

Less than
once a month

About once
a month

More than
once a month

B. Educational (e.g., school, parent groups)

Don't belong

Less than
once a month

About once
a month

More than
once a month

C. Social (e.g., bowling groups, scouting groups)

Don't belong

Less than
once a month

About once
a month

More than
once a month

D. Political (e. g., work for local candidate)

Don't belong

Less than
once a month

About once
a month

More than
once a month

E. Other:_____

Don't belong

Less than
once a month

About once
a month

More than
once a month

14. Are you a member of any committee or do you have any other duties in any of your groups?

Yes

No

POSTTEST OUTCOMES SECTION

1. Overall, how is your personal and family situation (are) now as compared to when you first talked with someone from Children's Services? Would you say it's

Read responses 1-5 only:

1. A lot better now
2. A little better now.
3. About the same now
4. A little worse now, or
5. A lot worse now
6. Other *Have client explain.*
7. Not sure

2. *If their situation is better, ask 2a, otherwise ask 2b:*

- 2a. Do you think the IMPROVEMENT MENTIONED would have happened without the Family Unity Meeting ?

Yes No (Circle One)

If yes, ask them how they felt the Family Unity Meeting helped?

- 2b. *If the situation is worse or the same, ask:*

Why do you think Family Unity Meeting did not help or improve (or, change) the situation? (Why didn't the Family Unity Meeting make a difference)?

What do you think should have been done instead?

3. Overall, how satisfied are you with the Family Unity Meeting? Are you

Read responses 1-5 only:

1. Very satisfied *Ask 3a.*
2. Somewhat satisfied *Ask 3a.*
3. Somewhat dissatisfied *Ask 3b.*
4. Very dissatisfied *Ask 3b.*
5. No particular feeling *Ask 3a.*

- 8. Other *Have client explain.*
- 9. Not sure

3a. What did you like most about the Meeting ? (What do you think helped you the most?) *Ask 4a.*

3b. What didn't you like about the Meeting? (What were you unhappy with about the Meeting?) *Ask 4b.*

4a. Was there anything you didn't like about the Meeting (What were you unhappy with?)

4b. Was there anything you did like about the Meeting?

5. Overall, how satisfied are you with the services you received from Children's Services? (Overall, not just the Meeting) Are you

Read responses 1-5 only:

- 1. Very satisfied
- 2. Somewhat satisfied
- 3. Somewhat dissatisfied
- 4. Very dissatisfied
- 5. No particular feeling
- 6. Other *Have client explain*
- 7. Not sure

RELATIONSHIP WITH SOCIAL WORKER

Now I'd like to find out some more about how you and your caseworker(s) got along together. I'll read a list of questions and you can answer "always," "usually," "sometimes," or "never."

If more than one worker, ask about current worker or the one assigned longest.

	Always	Usually	Sometimes	Never
1. Did your caseworker give you confidence that headway or progress could be made on your problems?	4	3	2	1
2. Did (or, does) your caseworker ask for your opinions about your problems, and about the kinds of help you want(ed)?	4	3	2	1
3. Do you feel your caseworker cared (or, cares) about you or was (or, is) concerned about you as a person?	4	3	2	1
4. Do you feel that your caseworker was (or, is) easy to talk to?	4	3	2	1
5. Do you feel that your caseworker understood (or, understands) your opinions, even if she/he didn't (or, doesn't) always agree with you?	4	3	2	1
6. Do you have the feeling that you could (or, can) depend on or rely on your case-worker when you ran (or, run) into a problem?	4	3	2	1
7. Did your caseworker help you to talk about subjects that were not easy to talk about?	4	3	2	1
8. Did (or, does) your caseworker make you feel that everything wrong was your own fault?	4	3	2	1
9. Did (or, does) your caseworker help you to see your good points as well as your problems?	4	3	2	1
10. In general, how satisfied are you with the way you and your caseworker got along together? Are you				

Read responses 1-5 only:

1. Very satisfied
2. Somewhat satisfied
3. Somewhat dissatisfied
4. Very dissatisfied, or
5. No particular feeling about it
6. Other *Have client explain.*
7. Not sure