SUPREME COURT OF PENNSYLVANIA

Family Group Decision Making

From Research to Application

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I. Introduction

Historically, the foster care system as it evolved in the United States was initially focused on rescuing children from poverty.[1] In the 1930s, however, the concept of foster care began to focus on preventing child abuse and neglect.[2] This emerging focus on child safety combined with a growing psychoanalytic movement that was premised on the belief that parents could be rehabilitated and that child-rearing by a substitute family should be temporary.[3] At around the same time, social workers began to professionalize their approach to helping people and to define themselves as an organized, disciplined science. This led to the adoption of the scientific model, which relied heavily on the diagnosis of problems and the administration of treatment. The concept of "traditional social work practice," as utilized herein, is based upon this professionalized concept of social work, in which the professional social worker, who is the family's case worker, identifies the problem and specifies the treatment plan.[4]

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1 Roger J. R. Levesque, *The Failures of Foster Care Reform: Revolutionalizing the Most Radical Blueprint*, 6 MD.J.CONTEMP.LEGAL ISSUES 1 (1994-95) (hereafter, *The Failures of Foster Care Reform*).

2 *Id*. *See also* Stacy Robinson, *Remedying Our Foster Care System: Recognizing Children's Voices*, 27 FAM. L.Q. 395 (1993) ("The role of protecting a minor falls upon the parents as natural guardians first. In cases of abuse and neglect, however, where a parent has failed to protect the child, the state steps in as *parens patriae*. This often means moving the child from the home and placing the child in foster care." (footnote omitted)).

3 *The Failures of Foster Care Reform, supra,* n.1.

4 Ann Weick, *et al.*, A *Strengths Perspective for social work practice*. SOCIAL WORK, 1989. 34(4): p. 350-354.

Despite the conception of foster care as providing temporary, safe, and stable havens for children while helping parents to better care for them, and the notion that children benefit from permanent relationships and should therefore either be returned home quickly or placed in another permanent arrangement, the foster care system became a bureaucracy that outgrew its original purpose.[5] The result was foster care drift, where many children spent a majority of their childhood in foster care, often in multiple placements.[6]

Although the traditional child welfare intervention for families with serious child safety concerns has historically been to remove the child from the home into foster care, removal in more benign situations has often proven to be problematic and disruptive to the family and the child involved, and has led to children spending unacceptable lengths of time in care and experiencing excessive placements.[7] Recognizing that this was unsatisfactory social work, since the 1980s, public child welfare agencies have focused on providing more supportive, non-adversarial interventions for families of children at risk for maltreatment and removal, including utilizing different models of family-based decision making.[8]

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5 *The Failures of Foster Care Reform, supra,* n.1.

6 *Id*.

7 Loring Jones, Donna Daly, *Family Unity Meetings: Practice, Research, and Instructional Curricula,* CALIFORNIA SOCIAL WORK EDUCATION CENTER, UNIVERSITY OF CALIFORNIA AT BERKELEY (2004), http://www.csulb.edu/projects/ccwrl/FUM.pdf (last visited November 19, 2013) (hereafter, *FUM: Practice, Research, and Instructional Curricula*).

8 *Id*.

There are many different approaches to bringing families together with their support network, community members, and service providers to make decisions about the safety and care of children, and to involve the family in problem-solving and planning. Collectively referred to as "participatory planning," the various models are based on the same philosophy, share terminology, and have overlapping components.[9] They have many labels and names, including family group decision making, family group conferencing, family unity meetings, family team decision making, and family team conferences, to name but a few. Different designations are used to describe different models, although similar models that share key features may not share a name, and models with the same name may differ significantly in practice.

While there are many terms and appellations invoked, all of these models are premised on the underlying idea that involving families, broadly defined, in child protection work and the decision-making processes related thereto will achieve the most positive outcomes for children. Moreover, broadly speaking, all of these participatory planning models share the objectives of child safety, child and family well-being, and permanency. They each include facilitation by trained individuals, and varying levels of advance preparation.[10]

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[9] A 2005 survey identified over 50 different names for family-based participatory planning. *Four Approaches to Family Team Meetings*, THE ANNIE E. CASEY FOUNDATION (2013), http://www.aecf.org/~/media/Pubs/Topics/Child%20Welfare%20Permanence/Other/FourApproachestoFamilyTeamMeetings/FourApproachestoFamilyTeamMeetings.pdf (last visited November 19, 2013) (hereafter, *Four Approaches*).

[10] *Bringing Families to the Table: A Comparative Guide to Family Meetings in Child Welfare*, CENTER FOR THE STUDY OF SOCIAL POLICY (March 2002), http://www.cssp.org/publications/child-welfare/child-welfare-misc/bringing-families-to-
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The main differences among the competing models are (1) the timing of the meeting, (2) the purpose and goals of the meeting, (3) responsibility for facilitation, (4) the level of advance preparation, (5) the amount of control the family has in making decisions at the meeting and in developing the plan for the child's best interest,[11] and (6) the frequency of subsequent meetings.[12] Although participatory planning is generally related to positive child and family outcomes, there is a great deal of uncertainty about which model or components to employ to achieve optimum results.

This uncertainty is not resolved by examining the available research and evaluations, including social evaluations. Although family group engagement is conceptually compelling, there is sparse evidence-based research into which models work or which elements or components are necessary to achieve child safety, well-being, and permanence.[13] Moreover, the difficulty of determining which models are

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the-table-a-comparative-guide-to-family-meetings-in-child-welfare.pdf (last visited November 19, 2013) (hereafter, *Bringing Families to the Table*).

[11] *Participatory Planning in Child Welfare Services Literature Review: Selected Models, Components and Research Findings*, NORTHERN CALIFORNIA TRAINING ACADEMY, THE UNIVERSITY OF CALIFORNIA, DAVIS, EXTENSION, THE CENTER FOR HUMAN SERVICES (July 2008), http://humanservices.ucdavis.edu/academy/pdf/FINAL2Lit%20Review%20Participatory%20Planning.pdf (last visited November 19, 2013) (hereafter, *Participatory Planning*); *Family Group Decision-Making October 2006 Final Evaluation*, TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (October 2006), http://www.dfps.state.tx.us/Documents/about/pdf/2006-10-09_FGDM_Evaluation.pdf (last visited November 19, 2013) (hereafter, *Texas Evaluation*).

[12] *Bringing Families to the Table*, *supra*, n.10.

[13] Mary Elizabeth Rauktis, Lauren Bishop-Fitzpatrick, Nahri Jung, Joan Pennell, *Family Group Decision Making: Measuring Fidelity to Practice Principles in Public Child Welfare*, CHILDREN AND YOUTH SERVICES REVIEW, Vol. 35, Issue 2 (February 2013), http://repository.lib.ncsu.edu/publications/bitstream/1840.2/2497/1/CYSR2052.pdf
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effective is exacerbated by the overlapping terminology applied to the range of models, and the unquantifiable variable that an agency's implementation of a particular model may be subject to unintended drift resulting from a lack of fidelity to the model's core principles.[14]

With these observations in mind, I will begin by addressing the Family Group Conferencing Model in Section II. After first describing the model in Section II.A, as it has been implemented in New Zealand, Pennsylvania, Washington, and Oregon, and identifying its crucial components, I will review the available research in Section II.B, focusing on evaluations from Washington; Texas; Hawai'i; Allegheny County, Pennsylvania; The Netherlands; and San Diego, California; and subsequently discussing other relevant research. I will end my discussion of Family Group Conferencing with a brief summary in Section II.C.

In Section III, I will discuss the Family Team Conferencing model, describing the practice paradigm in Section III.A, reviewing the available research in Section III.B from Indiana, and summarizing the discussion in Section III.C. In Section IV, I will review the Team Decision Making practice model. I will first outline this practice model in Section IV.A. In Section IV.B I will discuss the relevant research from several evaluations, and in Section IV.C I will conclude with a brief summary of what the research reveals.

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(Author's personal copy) (last viewed November 19, 2013) (hereafter, *Measuring Fidelity*).

[14] *Id*. Indeed, *Measuring Fidelity* discusses an analyst who predicted that one of the biggest challenges in the efficacy of a peculiar model of evidence-based practice would be measuring an entity's fidelity to its proposed paradigm.

Next, in Section V, I will discuss blended approaches from North Dakota, North Carolina, and Hawai'i that utilize more than one model for different purposes. In Section VI, I will discuss the limited research that has compared one model to another, assessing constructs employed in California, Florida, and Texas. Finally, in Section VII, I will set forth my conclusions, after careful deliberation, of this review of the emerging but almost infinitely varied modalities of family engagement.

II. Family Group Conferencing

A. FGC Practice Model

1. New Zealand

The model known as Family Group Conferencing is sometimes referred to in the research as Family Group Decision Making. However, the term "family group decision making" is also often used as an umbrella term encompassing every model of family-based participatory planning. Accordingly, when used herein, "Family Group Conferencing," or FGC, refers exclusively to the New Zealand model discussed below, and "family group decision making" refers more generally to all types of family-based participatory planning.

In direct response to the public outcry in New Zealand about the disproportionate number of indigenous Maori children taken from their families and placed into the foster care system, often within Caucasian homes far from their families and communities, and precipitating multiple placements and exorbitant lengths of time in out-of-home care, the New Zealand legislature codified Family Group Conferencing (FGC) as the mandatory participatory planning model in all cases of child abuse and neglect with the 1989

passage of the Children, Young Persons, and Their Families Act.[15] The model was designed to accommodate the historical decision-making process of the Maori people, and to provide family members with the opportunity to make decisions for the safety of their children.[16]

Pursuant to the New Zealand model of FGC, once a claim is made about a child's welfare, the family's case worker will investigate the allegations.[17] Where the investigation causes the family's case worker to believe that the child is in need of care or protection, the family's case worker will notify a family group coordinator to begin to prepare for a FGC, and will present the agency's concerns about the child to the family court.[18] The family court judge will make a decision about what is best for the child in the short term: if the situation is urgent, the child will come into the care of the agency to ensure his or her safety; if the situation is not urgent, there may be no change.[19] If the

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15 Melissa Hanson, *Family Group Conference Facilitator's Manual*, NATIONAL RESOURCE CENTER FOR PERMANENCY AND FAMILY CONNECTIONS, SILBERMAN SCHOOL OF SOCIAL WORK AT HUNTER COLLEGE (2004), http://www.nrcpfc.org/webcasts/archives/05/trainingmanualnov04.pdf (last viewed November 19, 2013) (hereafter, *FGC Facilitator's Manual*); Children, Young Persons, and Their Families Act, 1989 (NZ).

16 *FGC Facilitator's Manual, supra*, n.15.

17 *See* Children, Young Persons, and Their Families Act, 1989 (NZ), § 15 ("Any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally, or sexually), ill-treated, abused, neglected, or deprived may report the matter to a social worker or a constable.").

18 *The Family Court,* CHILD, YOUTH, AND FAMILY, NEW ZEALAND MINISTRY OF SOCIAL DEVELOPMENT, http://www.cyf.govt.nz/keeping-kids-safe/ways-we-work-with-families/family-court.html (last visited March 31, 2014).

19 *Id*.

child comes into the care of the agency, he or she may be placed into short-term foster care with extended family members or nonrelatives.[20]

After the family's case worker has referred the family to FGC, a trained coordinator is responsible for organizing the FGC with the goal of creating a plan to keep or return the child to the care of a family member as soon as possible. Participation in the New Zealand model of FGC is voluntary; although families are free to decline, they are encouraged to participate.

Once a family agrees to participate in FGC, the coordinator engages in extensive preparation for the meeting by attempting to contact as many members of the extended family as possible, the family's natural support network (which may include clergy, friends, neighbors, and teachers), and support professionals such as domestic abuse counselors, mental health professionals, and drug or alcohol counselors. In this respect, the coordinator may determine that an individual who would otherwise be entitled to attend should not do so because "that person's attendance would not be in the interests of the child or young person, or would be undesirable for any other

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[20] The child's temporary placement following the investigation, but prior to the FGC, is a vitally important decision. When a family comes to the attention of the child welfare agency, and the agency, after an investigation, determines that the child is in need of care or protection, the child may be placed, temporarily, while the FGC is arranged, or in less urgent circumstances, may stay in the parental home pending the FGC. Where the child is not removed, FGC may be utilized to prevent removal. That is, FGC may be employed to provide the birth family with the social services and community and family support needed to maintain their child in the home. In such circumstances, the FGC may also result in a secondary plan for the family group to employ if the parents are not successful in their efforts. If the child has to be removed from the family home pending the FGC, the removal may be to a relative, friend, or to stranger placement. It is not clear if New Zealand responds uniformly in any peculiar way in such circumstances. It is noteworthy that in Pennsylvania, a policy of concerted response to avoid stranger care has been adopted.

reason."[21] Every participating individual is prepared in advance of the meeting and understands its goals.[22] The family's case worker also attends the meeting.

The meeting opens with a discussion of the events that led to the meeting, why the family's case worker believes the child to be at risk or in need of care and protection, what has already been done to help the child and family, what has worked so far and what has not, and anything else the family wants to discuss that is relevant to the safety and well-being of the child and the child's placement.[23] After a full airing of these family dynamics, the professionals leave the room, empowering the family to devise a plan for the child's placement that addresses the relevant safety concerns. Once the family has created a plan during this "private family time," they present it to the professionals and the family's case worker. As long as the family's plan adequately addresses the safety issues identified by the family's case worker and specifies who will complete the tasks necessary to keep the child safe, the family's case worker will accept the family's plan.[24] The plan may then be submitted to the family court, which will examine the plan and decide whether it is in the child's best interest, and may issue

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21 *See* Children, Young Persons, and Their Families Act, 1989 (NZ), § 22(1)(b). In addition, at some point in the process, caregivers and their family situation will be subject to an assessment by the social worker, which may include a criminal history check to ensure that they have no criminal record for violent offenses.

22 *FGC Facilitator's Manual*, *supra* n.15.

23 *The Family Court,* CHILD, YOUTH, AND FAMILY, NEW ZEALAND MINISTRY OF SOCIAL DEVELOPMENT, http://www.cyf.govt.nz/keeping-kids-safe/ways-we-work-with-families/family-court.html (last visited March 31, 2014).

24 *Id*.

court orders to assist the family and the agency in carrying out the plan.[25] If the family was unable to agree on a plan at the FGC, the family court judge will decide on a plan for the child's care and protection.[26] The family's case worker will assist the family in carrying out the plan, and the family court will ensure that the plan continues to meet the child's needs for care and safety.[27]

Within the FGC model, there are several defining elements. First, preparation is strongly emphasized. Preparation includes recruiting family members and support persons to participate in the meeting, and time to prepare them so they are ready to engage appropriately.[28] This involves identifying and inviting all extended family members (subject to the coordinator's decision that a person's attendance would not be in the interests of the child or would be otherwise undesirable), explaining to all participants their respective roles, and resolving any family issues that could derail the meeting. Consequently, in New Zealand it takes an average of 35 hours per case over an average of 36 days to prepare a case sufficiently for FGC.[29]

Second, there must be a consummate professional to prepare the family for the conference. This individual is a trained and independent coordinator or facilitator responsible for convening the family group, the family's support network, and relevant

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25 *The Family Court,* CHILD, YOUTH, AND FAMILY, NEW ZEALAND MINISTRY OF SOCIAL DEVELOPMENT, http://www.cyf.govt.nz/keeping-kids-safe/ways-we-work-with-families/family-court.html (last visited March 31, 2014). The family court may issue court orders to help with the care and safety of the child, including, for example, orders for services, custody, support, or restraining orders.

26 *Id*.

27 *Id*.

28 *Bringing Families to the Table*, *supra*, n.9.

29 *Id*.

agency personnel, in order to facilitate a successful meeting. Because of the potential for complex and difficult family dynamics, the skill of the facilitator is at times identified as the most critical component of a FGC's success. The coordinator is never the family's case worker, and is extensively trained and prepared to ensure neutrality while preparing the family to create a plan for the child's safety and well-being.[30]

Third, family members should always outnumber service providers and resource personnel, as the model strongly encourages participation by as many family members as possible (subject, again, to the coordinator's discretion regarding whether the presence of an individual would not be in the interests of the child or would be otherwise undesirable).[31] Fourth, after the initial phase of the meeting, the service providers, family's case worker, and facilitator leave the family alone to have private family time, when the family itself develops the plan that protects and cares for the child involved.[32] Fifth, following private family time, the family members present their plan to the service providers, family's case worker, and other conference attendees for discussion and approval. The family's case worker approves the plan if it adequately addresses the agency's safety concerns for the child, and the family court will ensure that the plan is in accord with the child's best interests. Sixth, all information shared at the meeting is confidential and cannot be used outside of the meeting.[33] Seventh, while the family is

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30 *Id*.; Kelly Browe Olson, *Family Group Conferencing and Child Protection Mediation: Essential Tools for Prioritizing Family Engagement in Child Welfare Cases*, 47 FAM.CT.REV. 53 (2009) (hereafter, *Essential Tools*).

31 *Bringing Families to the Table*, *supra*, n.10.

32 *Id*.

33 *Four Approaches*, *supra* n.9.

responsible for implementing the plan, the family's case worker is responsible for post-meeting tracking and follow-up.[34] These elements define the New Zealand model of FGC.[35]

2. Pennsylvania

In Pennsylvania, nearly all of the child welfare agencies participating in the state's unified roundtable initiative have adopted a practice model based on New Zealand's FGC.[36] As with the New Zealand model, the process in Pennsylvania begins when a family's case worker refers a family to FGC.[37] The FGC coordinator prepares

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34 *Id*.

35 *Essential Tools*, *supra* n.30.

36 *Measuring Fidelity* , *supra* n.13.

Pennsylvania historically has had a county-based judiciary. This system has perpetuated in child welfare, and, until seven years ago, each of Pennsylvania's 67 counties approached child welfare with individualized practices. At that juncture, the state began to unify practice by bringing counties together through a tripartite system consisting of permanent County Roundtables, Leadership Roundtables, and, in turn, the State Roundtable, to formulate statewide policy. Although the process has been voluntary, more than 85% of the state participates enthusiastically. The Roundtable Initiative is administered by a central Office of Children and Families in the Courts, which is part of the Administrative Office of the Pennsylvania Courts, and is funded by federal Court Improvement Project and state Department of Public Welfare monies. Over the last seven years, through initiatives begun at the State Roundtable and implemented through the Leadership and County Roundtables, Pennsylvania has dramatically reduced its number of children in care. The downward trend continues. *See State of Child Welfare 2014,* PENNSYLVANIA PARTNERSHIP FOR CHILDREN, THE PORCH LIGHT PROJECT (2014) http://www.porchlightproject.org/reports/socw14/SOCW_2014_report_final.pdf (last visited April 4, 2014) (reporting that while 29,024 children were served in foster care in 2009, the number fell to 21,416 in 2013 -- a 26% decline).

37 This paper was inspired by Pennsylvania's effort to adopt, and to the extent necessary to develop, the best model for its children, beginning prior to removal from the parental home and concluding only when the child is stable and safe. Notably, in (…continued)

for the conference by meeting with the parents/caregivers, describing the purpose and process of FGC, explaining the participants' respective roles, clarifying expectations,

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Pennsylvania, a child would not be removed to stranger care absent any alternative. If there was fair warning that a child was at risk, there would be an expectation that the agency would have planned for the moment of removal by identifying emergency caretakers from within the child's family or extended network. If such caretakers were not available, Pennsylvania would expect the case worker to engage in family finding to identify an emergency caretaker to prepare for the possibility of the child's removal. Pennsylvania would also engage in proactive preventative social work in an effort to avoid removal if the child had come to the agency's attention before this juncture. Even assuming that the child had never come to the agency's attention before the moment of removal, Pennsylvania would expect the intervening case worker to explore family, friends, clergy, and the like within the child's neighborhood to keep the child in the same school and community, and to keep a sibling group together. A case worker failing these efforts would expect difficult questions and scrutiny from the judiciary and an attempt to return the child to the child's neighborhood at the emergency shelter hearing which, by law, must occur within 72 hours of a child being taken into protective custody. 42 Pa.C.S. § 6332.

Similar to other states, Pennsylvania statutory law further requires judicial findings that the agency made reasonable efforts to prevent the child's placement, that the placement is the least restrictive to meet the child's needs, and that no less restrictive alternatives were available. *See* 42 Pa.C.S. § 6351(b). *See also* Pa.R.J.C.P. 1512 (if the child is placed, requiring the court to state on the record its findings that remaining in the home would be contrary to the welfare, safety, or health of the child, reasonable efforts were made by the county agency to prevent the child's placement, the child's placement is the least restrictive placement that meets the needs of the child, supported by reasons why there are no less restrictive alternatives available, and if preventive services were not offered, that such lack of services was reasonable under the circumstances); Pa.R.J.C.P. 1514 (requiring these findings to be made prior to removing a child from the home).

To assist the courts in making these determinations, the General Assembly recently codified family finding in Pennsylvania, defined as "[o]ngoing diligent efforts between a county agency, or its contracted providers, and relatives and kin to: (1) Search for and identify adult relatives and kin and engage them in children and youth social service planning and delivery [and] (2) Gain commitment from relatives and kin to support a child or parent receiving children and youth social services." 62 P.S. § 1302. These efforts will begin when a child is accepted for services and periodically thereafter. 62 P.S. § 1302.1.

and obtaining an agreement to participate from the parents. During this preparation phase, the coordinator also works with the parents to select who else should be invited to the conference, identifies the objectives of the conference, and determines when and where the conference will take place. When a sufficient number of quality family members and friends are not readily available, this phase includes a search to increase the number of available participants by contacting kin and other informal support persons and by reviewing available files in order to obtain information about people who once played an important role in the family members' lives, but with whom they have lost contact. Pennsylvania employs a family finding model established by Keven Campbell to achieve this goal.[38] The FGC coordinator may also be the facilitator at the meeting, or a different professional may serve as the conference facilitator, who is responsible for convening and organizing the deliberations.

In Pennsylvania, the meeting follows a specific structure that includes an introduction, a review of the guidelines for the meeting, an overview of family tradition, a brief history of the family's involvement with the agency, the sharing of strengths and concerns, a review of the family case worker's safety concerns and available resources, the sharing of a meal, private family time, and presentation of the plan.[39] After the

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[38] The Kevin Campbell Family Finding Model in particular "offers methods and strategies to locate and engage relatives of children currently living in out-of-home care. The goal of Family Finding is to connect each child with a family, so that every child may benefit from the lifelong connections that only a family provides." *See What is Family Finding and Permanency*, National Institute for Permanent Family Connectedness, http://www.familyfinding.org/ (last visited March 18, 2014).

[39] *Pennsylvania Family Group Decision Making Toolkit: A Resource to Guide and Support Best Practice Implementation*, PENNSYLVANIA FAMILY GROUP DECISION MAKING LEADERSHIP TEAM (2008),
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family members present their plan for the care and protection of the child, the professional participants of the group review it and, if possible, accept it, finalize it, discuss with the family how to implement and monitor it, and decide which individuals will assist the family to secure needed services and resources.

Pursuant to statutory authority provided in the Pennsylvania Juvenile Act, 42 Pa.C.S. § 6351, a court must enter an order for the "disposition best suited to the protection and physical, mental, and moral welfare of [a dependent] child. . . ." Accordingly, once the family has created a plan, and the family's case worker has accepted it, the court will review it to ensure that it meets this statutory requirement and, if so, incorporate it into a court order. The court will continue to monitor the plan to ensure the child's best interests are being met. The use of follow-up meetings, while possible and encouraged, varies among the counties.

3. Washington

In Washington, the success of a year-long pilot project implementing New Zealand's modl of FGC in Kent County led to state-wide implementation in 1996. The Northwest Institute at the University of Washington supervised this project, which

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http://www.pacwcbt.pitt.edu/Organizational%20Effectiveness/FGDM%20Evaluation%20PDFs/FGDM%20Toolkit.pdf (last visited April 11, 2014). The Pennsylvania Family Group Decision Making Leadership Team is comprised of child welfare professionals, juvenile justice professionals, court officials, state officials, and private providers, and it provides resources for implementation, shared learning opportunities, training, data collection, and tools to enhance FGC.

continued for ten months and involved the hiring of six FGC coordinators.[40] At the conclusion of the ten month implementation period, a number of administrative regions in the state collaborated to ensure continuation of the practice model, to extend its availability to a greater extent across the state, and to develop a network of state and private agency coordinators in order to allow the model to continue with a blend of agency and contracted coordinators.[41]

FGC in Washington is premised on the New Zealand model. Conferences are voluntary, and, once the family consents,[42] the family's case worker refers the case to a FGC facilitator, who, in consultation with the parents, brings together extended family members, close family friends, the family's case workers, service providers, attorneys, and any other significant person the family wishes to include, as long as they are able to contribute to the welfare of the child.[43] It typically takes two to three weeks to plan an

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40 *FGC Facilitator's Manual* , *supra*, n.14.

41 *Id*.

42 *Id*. It has been Washington's experience that almost all families involved in child welfare will consent to and benefit from FGC, and almost all conferences result in plans to which the social worker will agree and that keep children safe.

43 *Id*. If the location of the parents is unknown, or if the parents do not respond to attempts to contact them, then the social worker may presume consent and proceed with the meeting. The facilitator typically has a partial list of family members and social workers gleaned from the file. This is supplemented with names provided by the parents. If the parents are not able to name family members, the facilitator can focus on "fictive kin," who are "like" family to the parents. For each family member contacted, the facilitator can attempt to obtain another name to contact, and to obtain appropriate consent from the parents. The facilitator can then collaborate with the parents as to which individuals on this list should be invited. The facilitator also is responsible for determining which service providers to include. This usually includes guardian *ad litem* and attorneys (usually for the parents).

effective Washington State FGC.[44] Washington requires that sex abuse and domestic violence cases include consultation with appropriate social workers and service providers, and the facilitator is responsible for ensuring the safety of any victims at the conference.[45]

The Washington FGC is divided into three stages:[46] First, in the information sharing phase, which typically takes one to two hours, the family's case worker and any service providers share information about the case with the group, in order to discuss strengths and concerns about the family as they relate to the safety of the child involved and to answer any questions the group may have. The family is not asked to provide information during this part; rather, this is the time for the family's case worker to inform the family of the safety goals the final plan must incorporate. The family's case worker and service providers should share information, but refrain from giving advice, to allow the family to come to their own conclusions.[47]

Next, in the private family time phase, which Washington has found takes about two to three hours, the family's case worker and service providers leave the room and the family meets alone to discuss the child's needs, to create a plan that will ensure the child's safety and well-being, and to discuss the needs of parents or caregivers. In the third and final phase, the family presents the plan they have created to the family's case

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44 *Id*.

45 *Id*. Domestic abuse cases may be held without the perpetrator present; that person may send a letter or participate by phone if their presence would intimidate family members.

46 *Id*.

47 *Id*.

worker, who reviews the plan with the family to determine if it meets the child's safety needs. If it does, then the family's case worker approves the plan; if it does not, the family's case worker will ask the family to consider changes to meet the safety goals. Following the conference, both the family and the agency monitor the family for fidelity to the plan. If the family requests a follow-up meeting, the same facilitator coordinates the subsequent meeting.[48]

4. Oregon

Oregon implemented its own version of FGC in 1990, which it called the Family Unity Meeting model (FUM).[49] This model is premised on the best-practices of New Zealand's FGC, and provides the parents with veto power, which enables the birth family to limit the attendance of extended family members and other potential participants.[50]

This model focuses on engaging the family in service planning by providing a facilitated conversation of the family's strengths and concerns. The meeting takes place within 30 days of the child being taken into care by the state. Because of their veto power, parents have the ability to keep information about the allegations of abuse or neglect secret from other family members. The social worker who is not the family's

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48 *Id*.

49 *Bringing Families to the Table*, *supra*, n.9.

50 Although Oregon's FUM model traditionally excluded private family time, *see id*., the model may now include it. *See Flexible Practice Within FGDM Conferencing Models: Finding the Fit and Flow,* MINNESOTA DEPARTMENT OF HUMAN SERVICES (2008), http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_141322.pdf (last visited April 2, 2014) (providing that Oregon recently added private family time to its practice model).

case worker and includes as many family members as possible, subject to the potential veto. Follow up meetings are common.

5. Core Components of the New Zealand Model of FGC

In the Family Group Conference Facilitator's Manual,[51] the authors outlined nine core components of the New Zealand model of FGC: (1) the conferences must be voluntary on the part of the family's case worker and the family; (2) the parents' agreement to the conference must be based on informed consent, and children twelve years and older must also consent;[52] (3) the family's role as the primary decision maker should be reinforced at every step; (4) the impartiality and neutrality, real and perceived, of the facilitator must be ensured to promote the family's feeling of autonomy and empowerment; (5) child safety and the safety of all participants should be of primary importance and concern; (6) preparation is a vital component of successful outcomes; (7) the family should have all the information they need to make decisions for the child; (8) the family must have as much time as they need to meet in private to make decisions; (9) and the family's case worker must understand that if the plan created by the family meets the safety and protection needs of the child, he or she is obliged to agree to and implement the plan.[53]

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[51] Melissa Hanson, *FAMILY GROUP CONFERENCE FACILITATOR'S MANUAL*, NATIONAL RESOURCE CENTER FOR PERMANENCY AND FAMILY CONNECTIONS, SILBERMAN SCHOOL OF SOCIAL WORK AT HUNTER COLLEGE (2004), http://www.nrcpfc.org/webcasts/archives/05/trainingmanualnov04.pdf (last viewed November 19, 2013).

[52] *Id*. The inclusion of a child younger than twelve should be made in collaboration with the child's therapist, the parents, the social worker, and the coordinator.

[53] *Id*.

Preparation, which the authors of the Family Group Conference Facilitator's Manual consider to be the most critical element, should address the family's fear or lack of confidence in resolving the child's safety issues, any other concerns the group members may have, the meeting format, the philosophy on which FGC is based, the family's role in the meeting, and the goal of the meeting.[54] In one study conducted in 2002 in North Carolina, it was found that, on average, family group conference coordinators spent 35 hours, and child welfare workers spent 7 hours, preparing for an initial conference.[55] The conference typically lasted 4 hours, with private family time lasting approximately 1 hour, 20 minutes, and included an average family group of 8 individuals and 4 service providers.

Various research studies have similarly identified components that are important to implementing effective FGCs. Such components include fidelity to the model;[56] an independent coordinator responsible for convening the family and agency personnel;[57] adequate preparation time; having the FGC take place in a comfortable location;[58] family participation and inclusion, which includes having more family than professionals; having "both sides" of the family represented, and ensuring a broad definition of

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54 *Id*.

55 *Participatory Planning*, *supra*, n.11.

56 *Measuring Fidelity*, *supra* n.12. Fidelity to the model is defined as whether an intervention is carried out in a manner that is true to its key principles and practices. This may play a large role in the achievement of successful positive treatment outcomes.

57 *Guidelines for Family Group Decision Making in Child Welfare*, AMERICAN HUMANE ASSOCIATION AND THE FGDM GUIDELINES COMMITTEE (April 2010), http://www.americanhumane.org/assets/pdfs/children/fgdm/guidelines.pdf (last visited November 19, 2013) (hereafter, *FGDM Guidelines*).

58 *Id*.

family;[59] involving children in the process, especially when they are over the age of 12;[60] validating and using the strengths of the family;[61] allowing the family to ask questions during the information sharing stage;[62] allowing for private family time; and family autonomy, meaning that the family develops the plan and presents it to the family's case worker, who approves it as long as it meets the defined safety concerns.

It cannot be overemphasized that adequate preparation time is crucial to enhancing family involvement and increasing attendance by family members.[63] Indeed, a consistent theme in the research is that extensive preparation is essential.[64] In this respect, a 2003 Michigan study found that expanding the population served by FGC without a corresponding increase in program funding prevented the staff from fully preparing to the extent required by the model, and, therefore limited the overall effectiveness of the program.[65]

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59 *Participatory Planning*, *supra*, n.10; *Measuring Fidelity*, *supra* n.13.

60 *Id*.

61 *Participatory Planning*, *supra*, n.11.

62 *Id*.

63 *Id*.; David Crampton, *Research Review: Family Group Decision-Making: A Promising Practice in Need of More Programme Theory and Research*, CHILD AND FAMILY SOCIAL WORK 2007, Vol. 12, 202-209, http://www.researchgate.net/publication/227657576_Research_Review_Family_group_decisionmaking_a_promising_practice_in_need_of_more_programme_theory_and_research (last visited November 19, 2013) (hereafter, *A Promising Practice*); Laura Mirsky, *Family Group Conferencing Worldwide: Part One in a Series*, INTERNATIONAL INSTITUTE FOR RESTORATIVE PRACTICES EFORUM (February 20, 2003), http://www.iirp.edu/iirpWebsites/web/uploads/article_pdfs/fgcseries01.pdf (last visited November 19, 2013).

64 *A Promising Practice*, *supra*, n.63.

65 *Id*.

In its Guidelines for FGC, the American Humane Association listed the best practices as including the following: FGC should be organized for all families and become the mainstream, standard way of working with family groups when children come to the attention of the welfare agency and whenever there is a significant planning issue to resolve; the same person should prepare and facilitate the meeting, although it does not matter whether that person is from the welfare agency or a private entity, as long as the facilitator is neutral and has no prior relationship with the family; the family should decide who to include, and the coordinator should help the family widen its circle as much as possible; the facilitator should extensively prepare (identifying family group members; finding family; engaging the family group in face-to-face visits to educate them about the goals and the process; preparing children; and preparing other group members); balancing the presence of the family group with service providers so there are more family members present; the facilitator should ensure that all participants agree that the information shared at a family meeting is privileged and cannot be used for any reason outside of the meeting; provide for ample private family time; and ensure acceptance of the plan by the agency if child safety concerns are adequately addressed.[66]

In another review of FGC literature, the author of the review identified four key elements that contribute to success, which are notable for their similarity to those listed above: extensive pre-conference preparation, a skilled and neutral (independent)

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66 *FGDM Guidelines*, *supra* n.57.

facilitator, extended family participation, and private family time.[67] The author of this literature review further identified three barriers to process effectiveness: referral bias (by the family case worker), ideological drift,[68] and implementation misperceptions (where FGC is viewed as too time and resource intensive).

In a 2003 review of available national and international research on FGC, the authors of the review made the following observations about how FGC works in practice which, again, in relevant part echoes the seemingly universal themes: preparation of participants is crucial to a successful conference; family members usually agree to participate even though it can be stressful to do so; family members generally should outnumber professionals; families usually develop plans that are seen to be safe and are accepted by the agency; FGC plans typically blend requests for formal services with family-delivered supports; private family time is an essential element of the process; family members report being satisfied with FGC; family members perceive that they have considerable voice and decision-making authority; FGC increases the involvement of fathers and paternal relatives; family case workers and service providers are also

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[67] Jocelyn Helland, *Family Group Conferencing Literature Review*, INTERNATIONAL INSTITUTE FOR CHILD RIGHTS DEVELOPMENT (October 2005), http://www.rcybc.ca/groups/Project%20Reports/fgc_lit_review.pdf (last visited November 21, 2013).

[68] *Id*. (citing research that ideological drift was a major concern in New Zealand, and which identified concerns that FGC could be used to squeeze resources out of families, as an assessment tool for professionals, as a 'rubber stamp' for professional plans, or as a way to pressure people into admitting offenses or behaviors without due process rights).

satisfied with the process; family case worker rates of referral fluctuate; and FGC provides cost neutrality or savings.[69]

B. Research Regarding FGC

1. Washington

In 2001, Washington evaluated all of the family group conferences conducted by two facilitators north of Seattle, encompassing 70 families with 138 children, to assess the success of FGC by examining long term outcomes of cases that were at least six months post-FGC.[70] The evaluation concluded that the Washington model of FGC resulted in permanent placement for 84.5% of the children.[71] For the remaining 15.5% of the children, either the plan was not achieved or it resulted in nonpermanent placement.[72] Following placements, the re-referral rate (premised on subsequent founded allegations of abuse and neglect) was 6.8%. Examining whether placements were stable over time, the study concluded that the majority of children were in the

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69 Lisa Merkel-Holguin, Paul Nixon, Gale Burford, *Learning with Families: A Synopsis of FGDM Research and Evaluation in Child Welfare,* AMERICAN HUMANE ASSOCIATION, PROTECTING CHILDREN JOURNAL Vol. 18, No. 1&2, (2003), http://www.americanhumane.org/assets/pdfs/children/fgdm/pc-pc-article-fgdm-research.pdf (last visited November 19, 2013).

70 Nancy Shore, Judith Wirth, Katharine Cahn, Briana Yancy, Karin Gunderson, *Long Term and Immediate Outcomes of Family Group Conferencing in Washington State*, INTERNATIONAL INSTITUTE FOR RESTORATIVE PRACTICES (June 2001), http://www.iirp.edu/iirpWebsites/web/uploads/article_pdfs/fgcwash.pdf (last visited November 19, 2013).

71 *Id*. Permanence was defined in accord with the Adoption Assistance and Child Welfare Act of 1980 as "the least restrictive (most family-like) setting available and in close proximity to the parents' home, consistent with the best interests and special needs of the child." This definition encompasses the views of the modern permanency movement.

72 *Id*.

placement identified in the family plan: only ten percent (14 out of 138) experienced difficulties in their intended placement and were instead removed to out-of-home care.[73]

Information about the placement location prior to FGC was available for 114 children. The evaluation examined the placement locations for these children prior to the FGC and explored how it changed after the conference. The following table shows where children were placed before and after FGC:[74]

	Pre-FGC placement	**Post-FGC placment**
Living with parent(s)	20%	43%
Living with relatives	55%	31%
Living with non-relatives	25%	9%
Tribal jurisdiction	0%	4%
Plan not achieved	N/A	13%

The authors observed a surge in the percentage of children living with their parents and a decrease in the number living with other relatives. Additionally, the percentage of children living with a non-relative also decreased after FGC. The authors concluded that FGC appeared to be an effective way to achieve permanent child and family continuity, but acknowledged that additional studies are needed to assess long term impact.[75]

2. Texas

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73 *Id*.

74 *Id*.

75 *Id*.

Texas implemented the New Zealand model of FGC, which it referred to as Family Group Decision Making,[76] in 2000, and evaluated the model early in the implementation process.[77] The Texas model was developed with help from the Casey Family Program's State Strategy, and the conference was offered 30-45 days following a child's removal.

The evaluation compared the living arrangements of children before and after their family's participation in the program, and found that, following participation, foster care placements fell from 54% to 38%, and relative placements increased concomitantly from 29% to 45%.[78] The evaluation further found that following implementation of the program, more children whose families had participated in FGC exited care (48%) compared to those in families which did not participate (33%).[79] Of those children who exited care, 31% of those participating in FGC returned home, relative to 14% of those who were served through traditional case services; slightly fewer children whose families participated in FGC were living permanently with a relative (14% compared to 16%); and children who exited care and whose families participated in FGC experienced shorter lengths of stay in care by just over a month.[80] Notably, these findings were especially pronounced for African-American and Hispanic children.[81]

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76 *Texas Evaluation*, *supra*, n.11.

77 *Id*. The evaluation included 3,625 conferences.

78 *Id*.

79 *Id*.

80 *Id*.

81 *Id*. Specifically, 32% of African-American children whose families attended a FGC returned home, relative to 14% whose families received traditional services; 39% of Hispanic children from families participating in the program returned home compared

(…continued)

3. Hawai'i

In 1996, Hawai'i codified New Zealand's model of FGC, referred to as "'Ohana conferencing." As of 2004, there had been 3,016 conferences, 97% of which produced acceptable agreements.[82] In a study comparing foster care placements where the family's case worker and the parents consented to 'Ohana conferencing following removal, to placements that resulted without a conference, the authors of the study made several observations. First, they observed a selection bias where family case workers referred cases to 'Ohana conferencing that had fewer reports of abuse or neglect.[83] Second, the average time 'Ohana conferenced cases remained open was 11.9 months, while the average time non-'Ohana cases remained open was 20.2 months.[84] Third, children of families who had an 'Ohana conference were placed in a licensed foster home an average of one time fewer than children whose families did not have a conference.[85]

(continued…)
to 13% receiving traditional services. The increase in rates for Caucasion children who returned home was noted as well: 22% compared to 11% for the FGC and traditional services respectively. The rates of placement with relatives between the groups did not differ.

82 Lorenn Walker, *A Cohort Study of 'Ohana Conferencing in Child Abuse and Neglect Cases*, PROTECTING CHILDREN, Vol. 19, No. 4, 32; http://lorennwalker.com/articles/Protecting_Children_Article.pdf (last visited November 21, 2013).

83 *Id*. ("Because conferencing is a voluntary process in the United States and other countries, except New Zealand where it is mandated, and professionals use their judgment on which cases to refer, there is an element of selection bias in almost all the studies of the process outcomes").

84 *Id*.

85 *Id*.

Fourth, children whose cases were subject to ‘Ohana conferences were placed in emergency shelters significantly fewer times than children in non-conferenced cases (with an average of one time for non-conferenced cases and an average of .24 times for conferenced cases).[86] Fifth, there was no statistical difference in the average number of times children were placed with relatives for each group of children.[87] Sixth, significantly fewer children were subjected to court-ordered permanent custody by the state when an ‘Ohana conference was used (1.8% of conferenced children versus 30% for non-conferenced children). The study also indicated non-quantifiable results of participant satisfaction resulting from the use of conferences.

4. Allegheny County, Pennsylvania

Allegheny County was the first Pennsylvania County to implement family group decision making in the late 1990’s, modeled after New Zealand’s FGC, and had its program evaluated by Dr. Fred Wulczyn of Chapin Hall, University of Chicago, in a ten year study of 2,908 children who received the FGC approach. The Allegheny County study examined the impact of FGC[88] by comparing the results of children who did and did not receive the intervention.[89]

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86 *Id*.

87 *Id*.

88 Although Allegheny County refers to its model as family group decision making, for consistency, and because it is premised on the New Zealand model of FGC, I have referred to Allegheny County’s model as FGC.

89 Fred Wulczyn, Bridgette Lery, Chapin Hall at the University of Chicago, *Family Group Decision Making in Allegheny County: Impact on Out-of-Home Placement,* ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES (January 2013), http://www.alleghenycounty.us/dhs/outcomes.aspx (last visited November 19, 2013).

It is noteworthy that the model of FGC employed in Allegheny County was utilized not only as a post-removal meeting to achieve permanency and safety, but also as a way of preventing removal in the first place. In this regard, of the children receiving FGC during the time of the study, they did so at one of three points: (1) when a child was reported for maltreatment and was at risk of a first out-of-home placement, and the goal of FGC was to prevent removal; (2) when the child was already residing in an out-of-home placement, and the goal of FGC was to find stable placement in the least restrictive setting and achieve timely permanency; and (3) when the child had returned home after placement but was at risk of returning to placement, and the goal of FGC was to prevent a subsequent removal.[90]

The timing of FGC and the expected outcomes are summarized as follows:[91]

Intervention Group	**Expected Effects**	**Number**	**Percent**
Total Referred		2908	100%
Group 1: Referred before first placement	Placement prevention	2216	76%
Group 2: Referred during placement	Least restrictive placement, stability, timeliness to permanency	330	11%
Group 3: Referred between placements	Re-entry/subsequent placement prevention	362	12%

The results showed that for children in the first group, who were at risk of a first out-of-home placement, those who received FGC were slightly more likely to be placed in out-of-home care (12%) than children in the comparison group (10%). Among those

90 *Id*.

91 *Id*.

who were placed in out-of-home care, children who received FGC early in their service history, following a substantiated report of maltreatment, were more likely to be placed with kin (43%) than children in the comparison group (24%). Children who received FGC after several "service events"[92] were more likely to be placed, and tended to be placed faster, than children in the comparison group who did not receive FGC.[93]

For the second group of children, who were already residing in out-of-home placement when FGC was offered, and where FGC was expected to speed movement to permanency for these children, FGC had no measurable impact on the time it took to achieve permanency (defined as reunification and permanent legal custody). Although there was no significant relationship between FGC participation and faster permanency generally, the study suggested such a relationship for the subset of children in kinship care specifically: children who were in out-of-home placement in kinship care when FGC was provided exited to permanency twice as fast as the comparison children who did not receive FGC, on average.[94]

For the third group of children, who had returned home after placement, but were at risk of returning to placement, 24% of the children who received FGC, and 44% of children who did not receive FGC, re-entered out-of-home placement within one year of exiting their first out-of-home placement.[95]

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92 *Id*. "Service events" include a maltreatment report, case acceptance, referral to FGC, and placement.

93 *Id*.

94 *Id*.

95 *Id*.

Importantly, the author of the Allegheny County study noted that although 20,798 children were reported for maltreatment during the study, only 14% received the FGC intervention, and suggested that wider application across the eligible population would be required to see system-wide improvements.[96] Additionally, the author noted the importance of timing, explaining that the eligible children who received FGC in the study did so at one of three points along their service trajectories, and that while a majority (76%) received it before they were ever placed, a notable portion received it after placement had started (11%) or concluded (12%).[97] In this regard, the author suggested that the timing of the intervention should be aligned with the targeted outcome.[98]

5. Netherlands

The Netherlands has been utilizing the New Zealand model of FGC since 2001, and has examined its outcomes as compared to what preceded it. Following the New Zealand model, the Netherlands' "Eigen Kracht-conference" (EKC) brings together families and their support network to decide how to solve problems related to the care of children. A meta-analysis of conferences that occurred between 2003-2010 showed that they were attended by 10-15 people, that almost all conferences (95%) resulted in a written plan that met the family case worker's safety concerns, that the families involved consistently indicated that they were satisfied with the process and the results,

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96 *Id*. (". . . it is thought that implementation at scale will lead to broad improvements in outcomes for children.").

97 *Id*.

98 *Id*.

and that about two-thirds of participants viewed the situation as improved following the conference.[99]

When FGC resulted in a plan that changed a child's placement, the resulting placement was usually less restrictive than placement changes that occurred without the benefit of FGC.[100] For example, FGC decreased the duration of an out-of-home placement and often led to the child being placed with someone who attended the FGC.[101] Although the number of out-of-home placements was the same for families who did or did not participate in FGC, for those who participated in FGC, the resulting out-of-home placements were, on average, three months shorter.[102] Additionally, research from Amsterdam found that the agreements reached during FGC for 57% of children resulted in their placement with an individual participating in the FGC.[103] Moreover, the number of subsequent reports of maltreatment for families who had participated in the conference was less than half of the number for families who had no conference.

Interestingly, the research from the Netherlands indicated that FGC is considered effective even in complex situations, including cases of domestic violence. On the basis of its success, it was implemented nationwide by legislation, and is today considered a legal right.

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99 *Eigen Kracht-conferences: Results and Cost Benefits*, AMERICAN HUMANE ASSOCIATION, http://www.americanhumane.org/assets/pdfs/children/pc-ekc-results-profitspdf.pdf (last visited November 19, 2013).

100 *Id*.

101 *Id*.

102 *Id*.

103 *Id*.

6. San Diego

San Diego has implemented its own version of FGC, which it calls the Family Unity Meeting (FUM). Notwithstanding the name of San Diego's model, the description of it demonstrates that it shares the crucial components of FGC.[104] An evaluation of San Diego's FGC indicated that participants reported a high degree of satisfaction with the plans and felt the plans kept children safe.[105] The authors of this evaluation concluded that dissatisfaction with FGC generally was tied to inadequate preparation time and the failure by agencies and family members to carry out the plan.[106] The authors of the San Diego evaluation argued that preparation and experienced, trained facilitators can ameliorate such dissatisfaction and, additionally, can make FGC effective even in situations involving child and adult abuse victims. In this respect, the authors concluded that adequate preparation and planning are essential to meeting success, which they found generally took between 21-42 days.[107]

Of families who were invited to participate in San Diego's model of FGC from March 1999 through December 2001, those families that had reunification as the goal were most likely to accept the invitation, while families whose cases involved severe neglect were least likely to accept. Overall, 58% of families accepted the invitation to participate, and 42% declined it.[108] Although sexual abuse cases represented about half of child maltreatment cases, the study found that only 7% of families in cases

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104 *FUM: Practice, Research, and Instructional Curricula, supra*, n. 6.

105 *Id*.

106 *Id*.

107 *Id*.

108 *Id*.

involving sexual abuse were invited to participate.[109] Additionally, the study indicated that the average meeting included nine people, with the largest participant group being family members and the second largest being professionals; with maternal family members most likely to attend. The average meeting lasted 3½ hours. Following the meetings, 38% of children were placed with a parent, but 82% were placed with a family member (including a parent).[110] The tendency towards kinship care was most pronounced with Hispanic families.

Emotional abuse cases were most likely to result in parental placement, and if the maternal grandmother attended the meeting, the child was more likely to be placed with someone other than the biological parent. Following the meeting, 52% of families received a new referral for child abuse, of which 26% were substantiated; these results were consistent with other samples of families that did not participate in FGC in San Diego. While the study authors observed that FGC did not elevate risk, they also concluded that it did not reduce risk either, although this could have been because of increased vigilance by family members.[111]

7. Other Observations about FGC

In addition to the state evaluations discussed above, various other studies have scrutinized FGC elements and outcomes to examine referral bias, family acceptance of a referral, long term outcomes for children, family well-being, and, finally, the impact of inadequate preparation time, as briefly reviewed below.

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109 *Id*.

110 *Id*.

111 *Id*.

Several studies have examined the referral process built into various models of FGC to determine which families are offered, and which accept, invitations to participate in FGC. In this regard, a Swedish study from 2000 examining the referral process found that only 35% of investigated families were offered an opportunity to participate in FGC.[112] Examining why this was, the researchers conducted interviews with family case workers, who suggested that their reluctance to refer families to FGC stemmed from their distrust of the extended family or their fear of losing control over the process. The researchers noted that selection bias in the referral process may limit the overall effectiveness of FGC. A 2003 study in London also examined referral bias, and found that when FGC is voluntary, a substantial number of family case workers did not refer families, and when referrals are compulsory, the number of families who consent to FGC increases.[113]

A survey from Miami in 2000 by the National Council of Juvenile and Family Court Judges found that 62% of family case workers responsible for making referrals excluded cases of sexual abuse, 46% excluded cases of spousal violence, 15% excluded cases where there was a pending criminal case, and 15% excluded cases involving severe physical abuse.[114] One child welfare expert opined that the exclusion of certain types of cases may be explained by a lack of familiarity with the practice

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112 *A Promising Practice*, *supra*, n.63.

113 *Id*.

114 Susan M. Chandler & Marilou Giovannucci, *Family Group Conferences, Transforming Traditional Child Welfare Policy and Practice*, 42 FAM.CT.REV. 216 (2004) (hereafter, *FGC, Transforming Policy and Practice*).

model or the low comfort level of participants in the process.[115] As experience and acceptance of the model by family case workers increased, the scope of cases referred to FGC was also broadened.[116]

Although there may be wide acceptance of FGC in cases of child neglect, there are more concerns and doubts in cases of child abuse. While some advocates believe child abuse cases are not appropriate for FGC, others believe all cases are well-suited to resolution through FGC.[117] There is little research to support either position.[118]

Once referred, it is up to the family whether to accept FGC. In the Swedish study from 2000, which examined referral bias and family acceptance, the authors found that of the families offered FGC, only about a quarter accepted.[119] The families who accepted had more prior contact with social services, their children had more experience residing in out-of-home care, and they were viewed by the family case workers as having more serious problems than those families who declined. Interviews with the families who opted not to utilize FGC indicated that they declined the invitation because they were aware of no extended family members who could be expected to participate, the parents did not have faith in the extended family, the parents did not want the extended family to be aware of their problems, or the parents knew what they wanted and were not interested in alternative services.[120]

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115 *Id*.

116 *Id*.

117 *Id*.

118 *Id*.

119 *A Promising Practice*, *supra*, n.63.

120 *Id*.

A 2003 study in Michigan also found that of 593 referrals to FGC from 1996-2000, only 173 (29%) accepted.[121] Families were most likely to agree to try FGC in cases involving the special needs of the child, improper supervision, parental substance abuse problems, parents' mental health concerns, homelessness, and prior involvement with the child welfare system.

In terms of long term outcomes for children, in a 2008 literature review of models of participatory planning, the authors of the review concluded that across all available studies, FGC led to stabilizing placements without endangering child safety, and has kept children with their siblings and family members.[122] A 1995 study entitled "The Newfoundland and Labrador Family Group Decision Making Project" evaluated 32 families who participated in FGC over a one year period, and compared those families to families who received traditional child welfare social services.[123] This study found that those who participated in FGC had more child welfare events (*i.e.*, child maltreatment referrals, police reports of domestic violence, and emergency responses) before the conferences, and had fewer events after the conference, when compared to the control group.[124] The authors of this particular study concluded from follow-up interviews that children in the FGC model experienced less abuse, and their parents

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121 *Id*.

122 *Id*.

123 *Id*.

124 *Id*.

were generally providing better care, compared with children from the matched comparison who received traditional child welfare services.[125]

A 2003 study from Michigan similarly found that children who experienced FGC were less likely to have subsequent contact with the child welfare agency, experienced less frequent moves, and were more likely to stay with family members.[126] Specifically, of those children whose families received FGC, one-third of them were eventually returned to their parents, and the other two-thirds maintained in legal guardianship with relative caregivers. After three years of implementation, the county child welfare agency involved in this study experienced a 23% reduction in the number of children of color entering the child welfare system, apparently because of the effectiveness of FGC.

A Michigan study from 1996-98 examined 257 families who were referred to FGC, and compared the outcomes of the 96 families who accepted and participated to those of the families who decided not to participate.[127] Overall, the families served by FGC compared favorably with those served through traditional foster care: children in FGC were less likely to have additional contact with family case workers; they moved less often between temporary homes; they were less likely to be placed in an institutional setting; and were more likely to remain with their extended family members in legal guardianship.[128]

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125 *Id*.

126 *Id*.

127 *Id*.

128 *Id*.

In terms of family well-being, FGC has been shown to reduce domestic violence.[129] Specifically, one study reported that one to two years following the conference, families reported reduced substance abuse problems, increased family cohesion, and decreased family violence when the family's case worker or FGC facilitator received special training in how to deal with such high risk and complex factors.[130]

There are, however, contradictory results. In a 2004 study in Sweden where 97 children who received FGC were compared to 142 children who received traditional child welfare services,[131] the children whose families participated in FGC experienced higher rates of re-referral to the child welfare agencies for reports of abuse, and were in out-of-home placement for longer periods of time. Over time, however, the children whose families participated in FGC experienced less intrusive involvement with the child welfare agency.[132]

Finally, with respect to the impact of inadequate preparation, the 2001 Miami survey conducted by the National Council of Juvenile and Family Court Judges reported that 38% of family members who participated in FGC indicated that they did not find private family time useful.[133] One expert has suggested that this was a consequence of inadequate preparation time, which may have prevented the family members from understanding the process, or from too much control by the agency prior to private

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129 *Participatory Planning*, *supra*, n.11.

130 *Id*.

131 *A Promising Practice*, *supra*, n.63.

132 *Id*.

133 *FGC*, *Transforming Policy and Practice*, *supra*, n. 114.

family time, which may have left the family members feeling that the plan had already been decided by the agency.[134]

Generally, families are consistently satisfied with the process of FGC and experience it positively.[135] Whether family satisfaction is linked to long term child and family outcomes, however, has not been examined. Moreover, there are mixed results in terms of child and youth satisfaction, with one study finding that children were generally satisfied with the process (with 82.9% reporting that they felt they contributed to the plan in a meaningful way and 91.5% reporting that they felt safe),[136] and another study finding that children typically did not feel heard during the process.[137] It is generally believed, however, that adequate preparation can ameliorate the misgivings of children.[138]

C. FGC: A Summary

An interesting aspect of these studies is which families are offered, and which accept, the invitation to participate in FGC, and which families are either not offered FGC or decline the invitation to participate. Research regarding the referral process indicates that FGC works better when there is an automatic trigger, rather than the discretion of the family's case worker.[139]

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134 *Id*.

135 *Participatory Planning*, *supra*, n.11.

136 *Id*.

137 *Id*.

138 *Id*.

139 *Id*.

With this observation aside, here is what we know about FGC generally: First, once family case workers become comfortable with the model, they generally like it, and report positive results, reduced conflict with families, better collaboration after meetings, and better plans for children (compared to traditional practices).[140] Second, meetings are successful in producing acceptable, workable plans that are supported by family, family case workers, and professionals. Family case workers accept most of the plans produced by the families in FGC, and very few conferences produce no plan.[141] Third, evidence on outcomes is not conclusive.[142] While most evidence suggests better outcomes for children and families, there is also evidence of increased rates of re-referrals.[143] Fourth, while also not conclusive, evidence suggests that FGC outcomes are promising. Reported results, as discussed herein, include reductions in re-abuse rates; increases in kinship placements that are as stable or more stable than traditional services; success in maintaining a child's connections with siblings, parents, and relatives; child safety; cost neutrality; increased participation from fathers and paternal relatives; and a reduction of children in foster care.[144]

When implemented with fidelity the research suggests long term positive results through the use of the New Zealand-based model of FGC in terms of placement

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140 *North Carolina's CFTs: What the Research Says*, Children's Services Practice Notes for North Carolina's Child Welfare Social Workers, Vol. 13, No. 1 (December 2007), http://www.practicenotes.org/v13n1/research.htm (last visited November 19, 2013) (hereafter, *North Carolina's CFTs*).

141 *Id*.

142 *Id*.

143 *Id*.

144 *See* also *North Carolina's CFTs, supra,* n.140.

stability, family well-being, and child well-being. The research generally indicates that of the children who require out-of-home placement, most children who receive FGC remain with extended family; FGC plans create stability for children; and FGC increases family supports and helps family functioning.[145]

In terms of such positive research, the Washington State study indicated that the implementation of FGC allowed more children to remain with their parents. Similarly, the Texas study of FGC found relative placements increased, the chances of children exiting care increased, more children exited care to return home, and children experienced shorter lengths of stay in care. The Hawai'i evaluation supported these conclusions as well, indicating that FGC significantly decreased the length of time cases remained open, significantly reduced the number of children placed in emergency shelters, and decreased court orders for permanent custody to the state. In the Netherlands, FGC has resulted in less restrictive placements, more frequent placement of the child with someone who participated in the FGC, reduced the time spent in out-of-home placements, and a reduction by half of the number of subsequent maltreatment reports.

There is, however, some indication of higher rates of re-referral following FGC, and an increase in the amount of time spent in out-of-home care. The Allegheny County study in particular indicated that when FGC is utilized for children at risk of a first out-of-home placement, it increased the likelihood that they would be subject to an out-of-home placement. Moreover, when children were already residing in out-of-home care, FGC did not measurably impact the time to permanency. For children who were

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145 *Participatory Planning*, *supra*, n.11.

at risk of returning to another placement after having returning home, FGC actually increased their chances of re-entering out-of-home-care.

It is difficult to know whether certain results are a consequence of the model, or of the implementation of the model. Indeed, there has been some concern in the field that attempts to implement FGC with insufficient resources to accommodate extensive preparation will lead to programs that do not produce the benefits inherent to the model, and that the reputation of FGC will suffer as a result, with the lack of positive results being used as a reason to retreat from the model. To be effective, the research suggests adhering to program integrity and insisting that FGC include adequate preparation time, which is a key distinction between FGC and other models.[146] Without this thorough, time-intensive preparation, the FGC approach reflects more traditional case-planning methods.[147]

III. Family Team Conference

A. FTC Practice Model

Family Team Conferencing evolved during the implementation of a class action child welfare settlement in Alabama in the early 1990s from a variety of approaches of family based decision making. The class action settlement agreement was based on a set of best practices from the field of child welfare, education, developmental

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146 *A Promising Practice*, *supra*, n.63.

147 *Id*.

disabilities, and mental health.[148] Under the settlement agreement, the state of Alabama agreed that each child is entitled to an individualized service plan developed with the participation of parents and other family members, the family's informal support system, and professional service providers, who come together to make all placement decisions for the child. After FTCs were implemented in Alabama, the principal architects of the system's reform efforts left the Alabama system and formed the Child Welfare Policy and Practice Group, a private, nonprofit technical assistance organization to advance the lessons learned in Alabama.[149] The Child Welfare Policy and Practice Group was invited by the Edna McConnell Clark Foundation's "Community Partnerships for the Protection of Children" initiative to implement a new practice approach.[150] The FTC was the core of this initiative. This model of participatory planning involves family members participating in facilitated meetings that include a discussion of their strengths, needs, and goals; parents bringing together other relatives or other people from their support network; and older youth attending and speaking for themselves. The product is a safety plan for the child that addresses services needed for family stabilization.

FTC brings together this team of individuals (family, friends, neighbors, community members, child welfare professionals, and any other professional support) to set goals for the family, assess the family's needs, and design individualized support

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148 *Family Team Conferencing*, CHILD WELFARE POLICY AND PRACTICE GROUP, http://www.childwelfaregroup.org/documents/FTC_History.pdf (last visited November 19, 2013).

149 *Bringing Families to the Table*, *supra*, n.10.

150 *Id*.

systems and services, with a focus on family and child safety.[151] The first FTC is held with the family's initial interaction with the child welfare agency, and continuously as needed until the family is no longer involved with the agency.[152] The focus of FTC is always primarily on child safety. Consequently, the family's case worker may remove a child from the parental home prior to or during the preparation phase of FTC if the child is in imminent risk. The meeting is usually initiated when a child is at risk of removal from the home or the first emergency removal has already occurred.[153] Meetings are voluntary and occur routinely and frequently at all key decision making points, such as dealing with escalating risks of harm, reunification planning, concurrent permanency planning, addressing child behavior problems, planning for the termination of parental rights, or dealing with a crisis.[154] Subsequent meetings may occur whenever a

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151 *Id*.

152 *Bringing Families to the Table*, *supra*, n.10; *Handbook for Family Team Conferencing, Promoting Safe and Stable Families In Community Partnerships for Child Protection*, THE CHILD WELFARE POLICY AND PRACTICE GROUP (2001), http://www.cssp.org/publications/child-welfare/community-partnerships-for-the-protection-of-children/family_team_conferencing_handbook-promoting-safe-and-stable-families.pdf (last visited November 19, 2013) (hereafter, *Handbook for FTC*) (suggesting that FTCs should be held if there are uncontrolled risks of harm, if the family is stuck and progress is not being made, if the family wants to care for the child, if the birth parents or primary caregivers are concerned about the child's behavior, if a relative expresses interest or concern for children, or if agencies or professionals believe they can help the family through whatever crises brought the family into the child welfare system).

153 *Family Team Decision Making,* Advocates for Children and Youth Issue Brief, Vol. 5, No. 8 (January 2008), http://www.acy.org/upimages/FTDM_Issue_Brief.pdf (last viewed April 8, 2014).

154 *The Handbook for FTC, supra,* n. 152. The Handbook suggests, however, that FTC may not be appropriate in certain circumstances, such as certain types of sexual abuse (*i.e.,* sibling incest), domestic violence cases, where there is a restraining order or warrant for one of the parents, when the termination of parental rights has already been determined and the child is stabilized in a permanent or adoptive home.

placement decision must be made, services and goals need to be adjusted, when there seems to be insufficient progress, or at any other time requested by the family. The model envisions periodic meetings, such as at monthly intervals, to ensure that strategies are working.[155]

The goals of FTC include planning how to keep children safe in their own homes and preparing the children and their family for all permanency decisions.[156] The family decides who should be included in the team; a trained facilitator should conduct the meeting and may be from within or outside the child welfare agency, but is usually the family's case worker.[157]

The family's case worker prepares for the FTC by exploring the family's strengths and needs, establishing non-negotiable issues, usually related to child safety, identifying team members, enumerating family goals and outcomes, establishing confidentiality rules, organizing and reviewing the case file, making a list of critical questions that need to be addressed at the meeting, and obtaining additional assessments as needed.[158] Preparation involves face-to-face meetings with family members in order to prepare them, and typically takes a couple of hours.[159]

The family determines the outcomes for the meeting, except as to the issues identified by the family's case worker as non-negotiable, and the team makes decisions

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155 *Handbook for FTC, supra,* n. 152.

156 *Bringing Families to the Table*, *supra*, n.10.

157 *Id*.

158 *Family Team Conferencing*, CHILD WELFARE POLICY AND PRACTICE GROUP, http://www.childwelfaregroup.org/documents/FTC_History.pdf (last visited November 19, 2013).

159 *Four Approaches*, *supra* n.9.

within these established parameters.[160] Notably, there is no private family time.[161] Meetings are typically 1-2 hours; follow-up meetings are ongoing as needed and may be briefer.[162] The meeting begins with an introduction of the purpose for the meeting, a summary of the case history, an explanation of the participants' respective roles, and a discussion of the family's needs. The team will create a plan that includes short and long term goals to address the family's needs, the steps they will take to achieve these goals, and what services will help them accomplish these goals. After the plan is created, the meeting closes, and each participant receives a copy of the plan.[163] The family's case worker tracks progress with input from the team and makes adjustments as necessary.[164]

B. Research Regarding FTC

1. Indiana

Indiana began reforming its child services agency in 2005 with the help of the Annie E. Casey Foundation and the Child Welfare Policy and Practice Group, and introduced a practice model that appears to be premised on FTC,[165] but which is called

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160 *Id*.

161 *Handbook for FTC*, *supra* n.152.

162 *Four Approaches*, *supra* n.9.

163 *Handbook for FTC, supra,* n. 152.

164 *Id*.

165 *Case Practice Reform Overview*, INDIANA DEPARTMENT OF CHILD SERVICES (2009), http://www.in.gov/dcs/files/8DCSPracticeModelOverviewUpdate.pdf (last visited November 19, 2013). Indiana's reform is premised on five practice skills: Engagement (the skill of effectively establishing a relationship with children, parents, and essential individuals for the purpose of sustaining the work that is to be accomplished together); Teaming (the skill of assembling a group to work with children and families, becoming a (…continued)

"Child and Family Teaming."[166] Meetings are coordinated and facilitated by the family's case worker and are held at all key decision points in assessment and ongoing case management (including safety planning, preventing removal, placement, visitation, care/service planning, and reunification).[167]

According to the Indiana Department of Child Services, by December 2008, Indiana achieved the following as a result of less than three years of FTC: median length of stay in care decreased by 19%; the number of children in care longer than one year decreased by 8%; and the percentage of children placed in their own home or with relative caregivers increased 6%.[168] Among the states, Indiana now ranks 10th in reunification, 2nd in timeliness of adoption, 3rd in permanency, and 11th in placement stability.[169] According to the AECF, between 2005 when it launched its reform effort and 2012, Indiana saw a 40% reduction in residential placements, a 15% reduction in

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(continued…)
member of an established group, or leading a group); Assessment (the skill of obtaining information about the salient events that brought the children and families into the services and the underlying causes bringing about their situations); Planning (the skill necessary to tailor the planning process uniquely to each child and family, including designing incremental steps that move children and families from where they are to a better level of functioning, assessing circumstances and resources, making decisions on directions to take, evaluating the effectiveness of the plan, reworking the plan as needed, celebrating successes, and facing consequences in response to lack of improvement); and Intervening (the skill to intercede with actions that will decrease risk, provide for safety, promote permanence, and establish well-being).

166 *Id*.

167 *Id*.

168 *Id*.

169 *Case Study, Indiana Child Welfare Improving Practice to Improve Outcomes*, THE ANNIE E. CASEY FOUNDATION (2012), http://www.aecf.org/~/media/Pubs/Topics/Child%20Welfare%20Permanence/Other/IndianaChildWelfare/IndianaChildWelfareImprovingPractice.pdf (last visited November 19, 2013).

the use of foster care, a 30% increase in the use of in-home placements,[170] a 90% increase in placements with relatives, and a 70% increase in adoptions.[171]

C. FTC: A Summary

When Indiana implemented its model of FTC, it saw a reduction in the median length of stay in care and in the number of children who were in care for over a year, and an increase in the number of children who either remained in their own home or were placed with a relative, all of which suggests promising results. Further independent research into the practice model and its effects would be a valuable addition to the child welfare field.

IV. Team Decision Making

A. TDM Practice Model

Family to Family is an initiative launched by the Annie E. Casey Foundation and offered to states and communities beginning in 1992 as a team approach to child welfare premised on four strategies:[172] (1) building community partnerships with organizations and leaders in neighborhoods with high child protection referral rates; (2) team decision making, which brings together a team to make all of a child's placement decisions; (3) resource family recruitment, development, and support, which involves

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170 *Id*. (Indiana considers any child under its care as a placement, even if the child remains in the parental home).

171 *Id*.

172 *Core Strategies*, ANNIE E. CASEY FOUNDATION, http://www.aecf.org/Home/MajorInitiatives/Family%20to%20Family/CoreStrategies.aspx (last visited November 19, 2013).

finding and maintaining foster and kinship homes that support children and families in their own neighborhoods; and (4) self-evaluation, where analysts interpret outcomes to assess how to change policy and practice. The objectives of the Family to Family initiative include helping families to safely care for their children in their own homes through appropriate support, guidance, and help and, in emergency situations that require the separation of a child from his or her family, to have the child live with caring and capable relatives or with another family in the child's own community. To achieve these objectives, the goals of the Family to Family initiative are: decreasing the number of children in out-of-home care; developing a network of family foster care that is more neighborhood based, culturally sensitive, and located primarily where the child lives; reducing reliance on institutional placements (called "congregate care") by meeting the needs of children through relative or family foster care; and reunifying children with their families as soon and safely as possible.[173]

Family to Family employs Team Decision Making (TDM) meetings every time a placement decision has to be made for a child, including decisions to remove a child from his or her home, change placement, or reunify a family.[174] The team includes birth families, community members, resource families (individuals or families from the community who can care for the child), service providers, and child welfare agency staff to ensure a network of support for the child and the adults who care for them.[175] The

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173 *Id*.

174 *Bringing Families to the Table*, *supra*, n.10.

175 *Family to Family Key Elements, Team Decision Making*, ANNIE E. CASEY FOUNDATION (September 28, 2006), (…continued)

team makes the placement decisions together and all involved are jointly accountable for them.[176] The philosophy of TDM is that, by including family and community members, it is more likely that they will "buy-in" to the agency's decisions.[177] It is the family's case worker, however, who has the ultimate decision-making responsibility.

The goal of the meeting is to prevent removal, to arrange kinship placement, or to otherwise provide foster homes in the child's home neighborhood.[178] The meeting is held before the child's move occurs, or, in cases of imminent risk, by the next working day, and always before the initial court hearing in cases of removal.[179] In the event of an out-of-home placement, TDM is used to ensure that the birth parents, foster parents, and the entire team work together toward reunification.[180] Meetings are mandatory,[181] and typically take 1-2 hours, with no built-in follow up, as the family's case worker is responsible for ongoing monitoring and planning.[182]

The family's case worker invites participants and plans the meeting, and an internal social worker, who is not the family's case worker, acts as facilitator and leads

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http://www.aecf.org/upload/pdffiles/familytofamily/keyelements.pdf (last visited November 19, 2013).

176 *Family to Family, Tools for Rebuilding Foster Care, Implementing the Values and Strategies of Family to Family*, THE ANNIE E. CASEY FOUNDATION (2001), http://www.aecf.org/upload/pdffiles/familytofamily/implementing.pdf (last visited November 20, 2013) (hereafter *Tools for Rebuilding Foster Care)*.

177 *Id*.

178 *Bringing Families to the Table*, *supra*, n.10.

179 *Id*.

180 *Id*.

181 *Four Approaches*, *supra* n.9.

182 *Id*.

the meeting.[183] Preparation is the responsibility of the family's case worker or someone from the community functioning as an advocate for the family,[184] and is limited to making sure that all available participants can get to the table quickly, especially for pre-removal decisions. This is achieved by arranging beforehand with community partners that they be available on short notice.[185] The family's case worker also arranges transportation and childcare for participants when necessary, choses the location, and plans the time.[186] When inviting participants, the family's case worker provides each with a brief overview of the presenting issues and risks to the child, emphasizes that they will make significant decisions for the child's care and welfare, and reviews available services.[187] If there is a threat of domestic violence, it may be necessary to meet separately, or to exclude the abusive party from the meeting.[188] The family's case worker is clear that the ultimate decision-making authority is with the agency if the group cannot reach consensus and discusses rules of confidentiality regarding the proceeding.[189]

At the meeting, the family is encouraged to share information about itself, and the family's case worker confirms the reason for the meeting and presents the family history, including prior referrals, child protection investigation information, and existing

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183 *Tools for Rebuilding Foster Care*, *supra* n.176.

184 *Bringing Families to the Table*, *supra*, n.10.

185 *Id*.

186 *Id*.

187 *Id*.

188 *Id*.

189 *Id*.

case plans.[190] The family and other team members are encouraged to provide their perspective, and the family's case worker may recommend a plan of action. The team is invited to react to the plan or suggest their own, revising it as necessary. The facilitator leads the discussion, identifying and clarifying potential outcomes, and suggesting specific roles for each team member. The facilitator also helps the team to identify every member's responsibility in implementing the plan. If the team cannot agree upon a plan, the agency staff will meet separately to create a plan.

Because the TDM model is used immediately after a child's removal, there is little time to gather the team together or to prepare them, a key distinction from the practice of FGC. Further differences are the inclusion of the family's case worker as a team member, the creation of the plan by the entire team, the absence of private family time, and the retention of ultimate decision-making authority in the family's case worker.

B. Research Regarding TDM

1. Anchor Site Evaluation of TDM and Family to Family

After Family to Family was launched in 1992, the AECF supported an effort to expand its implementation.[191] In 2005, however, the AECF resources were stretched too thin, prompting a self-assessment that led to the identification of anchor sites on which to focus resources beginning in 2007.[192] The self-assessment prompted another

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190 *Id*.

191 Lynn Usher, Judith Wildfire, Daniel Webster, David Crampton, *Evaluation of the Anchor-Site Phase of Family to Family*, THE ANNIE E. CASEY FOUNDATION (2010), http://www.aecf.org/~/media/Pubs/Initiatives/Family%20to%20Family/EvaluationoftheAnchorSitePhaseofFamilytoFamil/anchoreval.pdf (last visited November 19, 2013).

192 *Id*.

evaluation that was completed in 2010, which identified several “key elements” that defined the TDM model, including holding the meeting for all placement decisions; holding the meeting before the child’s move occurs or shortly thereafter; inviting neighborhood based community representatives to the meeting; a skilled, neutral facilitator; and collecting information about each meeting to track child and family outcomes.[193]

The 2010 evaluation compared TDM and the broader Family to Family initiative to whatever existed in that area before. According to the Annie E. Casey Foundation, the outcomes of their Family to Family model included a reduction in the number and proportion of children in congregate care; a shift of resources from congregate care to family foster care and family services; a decrease in the lengths of stays in out-of-home placement; an increase in the number/proportion of planned reunifications; a decrease in the number of re-entries into care; a reduction in the number of placement moves experienced by children in care; an increase in the number of siblings placed together; and a reduction in the number of children served away from their own families.[194]

The evaluation found that a timely TDM is crucial to the success of the model, and identified a strong relationship between holding a meeting within one day of the triggering event, and the likelihood of a recurring event.[195] Meetings held more than one day after the triggering event were less successful at reducing the likelihood of a

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193 *Id*.

194 *Id*.

195 *Id*.

recurrence than meetings held sooner.[196] Additionally, the presence of relatives at the meeting (not surprisingly) increased the likelihood of relative placement.[197] Children of all races whose parents attended the initial removal meeting were from 67% more likely to twice as likely to experience reunification or exit from care to a relative within one year than children whose parents do not attend. The evaluation, however, found no significant effect for the following elements: an experienced facilitator, the presence of community partners, or the location of the meeting.[198]

2. Alameda County, CA

Following the implementation of TDM in Alameda County, California, in 2002, an evaluation examined its impact from 2005 through 2008. The evaluation indicated a decrease in initial entries into out-of-home care (from 698 in 2005 to 535 in 2008), an increase in initial placements with relatives (from 8.3% in 2005 to 24.9% in 2008), and a

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196 *Id*.

197 *Id*.; *Measuring Fidelity* , *supra* n.13. A 2011 research project into TDM found that relative attendance at the meetings correlated with increased relative placement, and the presence of birth parents correlated to increased reunification.

198 *Id*.; *Executive Summary, Evaluation of the Anchor-Site Phase of Family to Family*, THE ANNIE E. CASEY FOUNDATION (2010), http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid=%7B0B379E86-3BD9-4FAF-A3B2-96845501B2B7%7D (last visited November 19, 2013). The evaluation further found that children entering care with no siblings were 39% more likely in Denver and Cleveland and 44% more likely in California sites to maintain a family connection through neighborhood placement or relative placement when TDM was employed in their cases. Children entering care with siblings in Denver and Cleveland were 91% more likely to maintain a family connection through placement with a sibling, neighborhood placement, or relative placement, and children in sites outside California were 17% more likely to be placed with a relative than children with no exposure to TDM. When a relative was present at the TDM intervention, there was a 23% increased likelihood of placement with the relative. With the use of TDM, children in sites outside California were 18% more likely to be initially placed in a family setting.

decline in initial placements in "Foster Family Agency"[199] homes (from 60.6% of initial entries in 2005 to 43.4% in 2008).[200] Although the evaluation conceded that initial placements in Foster Family Agency homes, combined with regular foster homes, accounted for two-thirds of initial placements, it noted that this was down from more than 80% in 2005.[201] Initial placements in shelters or other congregate care settings also decreased.[202] The evaluation viewed these collective changes in the pattern of initial placements as consistent with increased reliance on family based care. The characteristics of placement are identified in the following chart:

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199 This term is defined as a residential option for children with developmental disabilities, and which are privately operated organizations licensed to care for children in certified foster family homes. *See, generally, Foster Family Agency*, STATE OF CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES, http://www.dds.ca.gov/LivingArrang/FFA.cfm (last viewed April 7, 2014).

200 Lynn Usher, David Crampton, Daniel Webster, Judith Wildfire, *Site Profile, Alameda County, California,* THE ANNIE E. CASEY FOUNDATION (2009), http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={8AE175B6-01B8-4190-9D7D-FC641353D890} (last visited November 19, 2013).

201 *Id*.

202 *Id*.

Characteristics of Placement—Alameda County, CA				
Characteristic of Initial Placement	**2005**	**2006**	**2007**	**2008**
Initial Placement				
Relative Home	58 (8.3%)	50 (8.7%)	95 (15.2%)	133 (24.9%)
Foster Home	142 (20.3%)	111 (19.2%)	170 (27.3%)	129 (24.1%)
Foster Family Agency Home	423 (60.6%)	356 (61.7%)	300 (48.2%)	232 (43.4%)
Group/Shelter	60 (8.6%)	49 (8.5%)	44 (7.1%)	31 (5.8%)
Guardian	15 (2.1%)	10 (1.7%)	13 (2.1%)	10 (1.9%)
Other*	0 (0%)	1 (0.2%)	1 (0.2%)	0 (0%)
Sibling Placement Status				
No Siblings Entered Placement	426	367	368	356
Placed with All Siblings	148 (54.4%)	106 (50.5%)	141 (55.3%)	112 (62.6%)
Placed with Some Siblings	47 (17.3%)	42 (20.0%)	61 (23.9%)	37 (20.7%)
Placed with no Siblings	77 (28.3%)	62 (29.5%)	53 (20.8%)	30 (16.8%)
Recurrence of Maltreatment within 6 months.^				
No	1725 (89.8%)	1811 (90.6%)	1607 (91.8)	857 (91.9%)
Yes	196 (10.2%)	187 (9.4%)	144 (8.2%)	76 (8.1%)
Percent Placed initially < 1 mile from home **				
Relative Home	50.8	38.6	52.4	33.7
Non Relative Home	4.5	5.4	6.0	5.5
Total	9.4	9.3	15.1	13.6
Family Connection?***				
No	438 (62.8%)	373 (64.6%)	343 (55.1%)	282 (52.7%)
Yes	260 (37.2%)	204 (35.4%)	280 (44.9%)	253 (47.3%)
*Includes pre-adopt, and court-specified home				
**Calculation of percent of entries placed initially within 1 mile was based only on instances which had removal and placement addresses.				
***Family connection refers to initial placement with a relative or guardian, or at least one sibling, or within one mile of removal address.				
^Base period for 2008 is Jan. 1 to Jun. 30 due to data cut-off of 12/31/08				

The evaluation demonstrated an increase in the number of children placed with all their siblings (from 54.4% in 2005 to 62.6% in 2008), and observed that a consequence of increased reliance on kinship care was to help children remain close to their home neighborhoods; compared to non-relative foster home placements, a much higher proportion of children in placement with relatives were within a mile of the child's

original home, although this measure declined notably for 2008.[203] A positive trend examined by the evaluation was the rate of recurrence of maltreatment within six months, which declined from 10.2% in 2005 to 8.1% in 2008.[204]

In addition, the implementation of TDM reduced the number of placement moves for children who entered care each year and were still in care a year later. Specifically, for children who remained in care for at least twelve months, the number of children subject to only 1 or 2 placements increased from 59.6% in 2005 to 73.5% in 2007, while the number of children subject to 3 or more placements during that same time decreased from 40.4% to 26.5%.[205]

Among children with very short first stays in care, of seven days or less, the rates of reentry into care following reunification declined, from 20% in 2005 to 14% in 2007.[206] Among children with longer first stays in care (exceeding seven days), the percent reentering care following reunification was consistently just below one in four.[207] The number of children exiting care to reunification and adoption did not change with the implementation of TDM.[208] Nor was there any change in the number of children who had been in care for two years or more achieving permanency.[209]

3. Cuyahoga County, OH

203 *Id*.

204 *Id*.

205 *Id*.

206 *Id*.

207 *Id*.

208 *Id*.

209 *Id*.

The results from Cuyahoga County, Ohio, which was one of the first counties to implement Family to Family and TDM beginning in 1992, were less positive.[210] A 2009 evaluation of the model, which examined the trending impact of the model from 2005-2008, found that the rate of children initially entering out-of-home care in Cuyahoga County from 2001 through 2005 who were placed into congregate-care settings rose in 2007 and then declined slightly in 2008. The authors of the evaluation observed that this occurred in the context of a 32.2% reduction in the number of children entering care from 2005-2008 (from 947 to 642).

Interestingly, the decline in the number of children entering care for the first time was accompanied by an increased reliance on foster homes and a decrease in the use of unlicensed relatives. Specifically, while the percentage of children initially placed in a foster home rose from 41.8% in 2005 to 56.5% in 2008, the rate of initial placements with a family connection (defined to include when the child was placed with a relative, placed with at least one sibling, and/or placed in the child's home neighborhood) decreased from 65.2% in 2005 to 53.1% in 2008. These figures are shown in the following chart:[211]

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210 Lynn Usher, David Crampton, Daniel Webster, Judith Wildfire, *Site Profile, Cuyahoga County (Cleveland), Ohio*, THE ANNIE E. CASEY FOUNDATION (2009), http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={490FD652-E8F0-46C5-ABFB-C7EFF31D1597} (last visited November 19, 2013).

211 *Id*.

Characteristics of Initial Placements: Cuyahoga County				
Characteristics of Initial Placement	**2005**	**2006**	**2007**	**2008**
Initial Placement				
Foster Home	396 (41.8%)	382 (43.4%)	362 (49.9%)	363 (56.5%)
Relative Home - Licensed	10 (1.1%)	12 (1.4%)	4 (0.6%)	4 (0.6%)
Relative Home - Unlicensed	388 (41%)	330 (37.5%)	211 (29.1%)	157 (24.5%)
Group Home	0 (0%)	1 (0.1%)	1 (0.1%)	0 (0%)
Residential Treatment	37 (3.9%)	55 (6.2%)	60 (8.3%)	45 (7%)
Emergency Shelter	36 (3.8%)	15 (1.7%)	24 (3.3%)	25 (3.9%)
Other Institutional	61 (6.4%)	58 (6.6%)	46 (6.3%)	37 (5.8%)
Own Home	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Adoptive Home	14 (1.5%)	22 (2.5%)	14 (1.9%)	11 (1.7%)
Other	5 (0.5%)	6 (0.7%)	3 (0.4%)	0 (0%)
Sibling Placement Status for Children Initially Placed in FosterHomes				
No Siblings Entered Placement	215	232	218	199
Placed with All Siblings	56 (30.9%)	53 (35.6%)	54 (37.8%)	40 (24.4%)
Placed with Some Siblings	53 (29.3%)	32 (21.5%)	33 (23.1%)	40 (24.4%)
Placed with no Siblings	72 (39.8%)	64 (43.0%)	56 (39.2%)	66 (40.2%)
Children initially placed in home neighborhood	**334 (39.6%)**	**315 (41.1%)**	**221 (36.1%)**	**157 (28.7%)**
Family Connection at Initial Placement[1]				
No	330 (34.8%)	331 (37.6%)	321 (44.3%)	301 (46.9%)
Yes	617 (65.2%)	550 (62.4%)	404 (55.7%)	341 (53.1%)

1 Family connection components include: placed with relative, placed with sibling and placed in neighborhood

Additionally, approximately 90% of children whose initial stays in care ended within one year (but longer than one week) had only one or two placements while in care, and this number remained constant from 2005-07. Among children remaining in care longer than one year, but less than two years, placement stability improved, with

the number of children experiencing only 1 or 2 placements increasing from 75% to over 80%, and those experiencing three or more placements decreasing commensurately.[212]

The rates of predicted exit from care to reunification, adoption, or exit to a relative within six months, one year, and two years did not change to any significant degree.[213] The evaluation explained this by noting that in the face of declining numbers of children entering custody, as seen during these years in Cuyahoga, it is not unexpected to see reunification rates that, at best, remain stable, as it is possible that children who can be reunified quickly do not enter care at all, "leaving instead a caseload of children and families with more significant challenges to reunification."[214]

Finally, the percentage of children and youth achieving permanency after remaining in care for two years or more in Cuyahoga County declined from 24.9% in 2005 to 21.1.% in 2007.[215]

4. Maine

The Annie E. Casey Foundation partnered with Maine to improve its child welfare agency in 2001 premised on the Family to Family/TDM model, and obtained technical support for this endeavor from the local Casey Family Services Division.[216] With the

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212 *Id*.

213 *Id*.

214 *Id*.

215 *Id*.

216 *Fixing a Broken System: Transforming Maine's Child Welfare System*, THE ANNIE E. CASEY FOUNDATION (2009), http://www.aecf.org/~/media/Pubs/Topics/Child%20Welfare%20Permanence/Other/FixingaBrokenSystemTransformingMainesChildWel/AECF_FixingABrokenSystemFinal_Final.pdf (last visited November 19, 2013).

help of the AECF, officials in Maine sought to reduce the number of children in congregate care and increase permanent placements, and called this project the "congregate care rightsizing initiative."[217]

As reported in literature produced by the AECF about Maine's model, after its reform efforts began in 2001, by 2008 Maine experienced the following results: a decrease of children in foster care from 3200 (in 2001) to 2000; a 77% decrease in the number of children in residential care; a 28% increase in the number of children placed with relatives; and a 60% increase in children reunified with their families within 12 months of the state taking custody of them.[218]

C. TDM: A Summary

The AECF research from Alameda County, California, shows that TDM can be effective at reducing the number of children in congregate care, increasing the number of children who are placed with relatives or reunified with their parents, decreasing the likelihood of reentry into care, increasing the number of siblings who are placed together, and reducing the frequency of placement moves for children in care.[219] Maine also experienced a decrease in children in foster and residential care, and an increase in children placed with relatives or reunified with their families.

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217 *Id*.

218 *Id*.

219 *Family to Family, Tools for Rebuilding Foster Care, Reconstructing Foster Care*, THE ANNIE E. CASEY FOUNDATION (2001), http://www.aecf.org/upload/publicationfiles/family%20to%20family%20reconstructing.pdf (last visited November 20, 2013).

The Cuyahoga County, Ohio, evaluation was less positive. It showed that following implementation of TDM, although there was a decrease in children entering care and an increase in stability, there was also an increase in the number of children entering congregate-care settings and a decrease in the percentage of children placed with a relative. The authors of the evaluation suggested that those children who could safely remain with their parents likely did so without first entering care at all, and were therefore not accounted for in the evaluation. In addition, the evaluation suggested that to be effective, the TDM should be held within one day of the triggering event and should include relatives and parents at the meeting.

V. Blended Approaches

A. North Dakota

One interesting combination of two different practice models has been implemented by the Village Family Service Center, which offers family engagement programs in North Dakota.[220] This organization utilizes what appears to be TDM or FTC early in the family's involvement with social services. This meeting includes the following elements: it is held when there is an imminent risk of removal or no later than 72 hours after an emergency removal to make immediate decisions regarding a child's placement; the family's social worker makes the referral; preparation time is limited due to the crisis nature of the placement decision; the trained facilitator, who has no case

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220 *Comparison of Family Team Decision Making and Family Group Decision Making*, THE VILLAGE FAMILY SERVICE CENTER, https://www.thevillagefamily.org/files/public/Family%20Engagement%20Programs/FTDM%20vs%20%20FGDM.pdf (last visited November 19, 2013).

specific responsibilities, makes contact with those on the invite list (which is compiled by the family's case worker); the meeting usually takes 1-2 hours; it involves family members and service providers working as a team; and the family's case worker maintains ultimate responsibility if the team does not reach consensus.

In addition, the Village Family Service Center utilizes what it calls family group decision making, and which appears similar to the New Zealand Model of FGC, to make a decision that creates safety, permanency and well-being for the child in due course.[221] This meeting involves a referral by the family's case worker to a trained facilitator with no case specific responsibilities; comprehensive preparation (requiring 3-4 weeks); broad family participation, with family members outnumbering service providers; private family time; usually takes between three to five hours; the creation of a plan for the child's safety which, if possible, is accepted by the facilitator, and subsequently monitored by the meeting participants in conjunction with the referring family case worker. The following chart explains the difference between the "emergency" FTC and the "long-range planning" FGC, as used in tandem by the Village Family Service Center.[222]

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221 *Id*.

222 *Comparison of Family Team Decision Making and Family Group Decision Making*, THE VILLAGE FAMILY SERVICE CENTER, https://www.thevillagefamily.org/files/public/Family%20Engagement%20Programs/FTDM%20vs%20%20FGDM.pdf (last visited November 19, 2013).

Comparison of FTC (which the Village Family Service Center refers to "Family Team Decision Making") and FGC (which the Village Family Service Center calls "Family Group Decision Making")

	FTC	FGC
Purpose	To make immediate decisions regarding the child's placement.	To make a decision that creates safety, permanency, and well-being for the child.
Distinctive Elements	Held when there is an immediate risk of removal or after an emergency removal has taken place.	Comprehensive preparation and private family time. Both elements position the extended family network as primary decision makers.
Decision Responsibility	The family's case worker maintains responsibility if consensus regarding the placement issue is not achieved.	The family makes and then presents their initial plan. At this time, the plan is reviewed to strengthen and clarify it.
Preparation	Often limited due to the crisis nature of a pending or previously made placement decision. The family's case worker completes referral paperwork. The facilitator makes contact with those on the invitation list.	A critically important part of the process in order to engage family in participating and leading the process. The facilitator typically spends 3-4 weeks preparing for the conference.
Participants	All who attend must have the family's permission to participate. The team includes family members and service providers.	The family decides on participants with the facilitator during preparation. Typically, more family members are present than service providers.
Length of meeting	Usually one to two hours.	Usually three to five hours.
Implementation	The family's case worker is primarily responsible to implement the decision from meeting; other participants play supporting roles.	Participants may carry out and monitor their plan, in partnership with the family's case worker. Follow-up conferences can be scheduled to adjust or change the original plan. The family's case worker maintains all county case responsibilities.

B. North Carolina

North Carolina also utilizes such a blended approach, considering FGDM in that state to be a versatile and flexible model, where different meetings are used for different purposes.[223] For example, the first time the agency becomes involved with a family may include a FTC to make an immediate placement decision, where a subsequent

[223] *Child and Family Team Meetings in North Carolina*, Children's Services Practice Notes for North Carolina's Child Welfare Social Workers, Vol. 8, No. 2 (March 2003), http://www.practicenotes.org/vol8_no2/CFT_NC.htm (last visited March 26, 2014).

meeting may be required for permanency planning and be more closely patterned on the FGC model, including extensive preparation time.[224] If problems arise with implementation of the plan, another meeting can be held that, like TDM, involves a more central role for the family's case worker.[225]

C. Hawai'i

Although Hawai'i implemented FGC in 1996, it subsequently refined its model in Honolulu and later examined the impact of this refinement. In a final report from December 2012, the Hawai'i Department of Human Services described evaluations conducted in Honolulu following the experimental implementation of a two-tiered service delivery model. Specifically, this model built upon the successful 'Ohana Conference discussed above, and added to that the "Early 'Ohana Intervention."[226]

The Early 'Ohana Intervention appears to be similar to the general concepts of the TDM and FTC models described above, in that it is a quickly convened meeting involving the family and the family's case worker at the beginning of a case, within 24 hours of the family case worker's decision to consider removing the child, in order to prevent the child from entering foster care and, if removed, to find an immediate relative placement. There are a couple of important hallmarks of the Early O'Hana Intervention model, one of which is that referral is automatic, and it requires the facilitator to meet

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224 *Id*.

225 *Id*.

226 *Family Connections Hawai'i, Final Report,* DEPARTMENT OF HUMAN SERVICES, STATE OF HAWAI'I (December 31, 2012), http://familyfinding.org/uploaded_files/fck/files/Family%20Connections%20Hawai'i%20Final%20Report%2012-31-2012.pdf (last visited March 18, 2014).

with the family when the child is about to be taken into care, regardless of where or when this occurs. Accordingly, facilitators meet with the family, including extended family members when they are interested and available, in hospitals, police stations, or elsewhere, over weekends, in the middle of the night, or on holidays.[227]

The Early ‘Ohana Intervention is followed, within a month, by an ‘Ohana Conference, which, as discussed above, is premised on the New Zealand model of FGC. Rather than choosing between existing practice models, Hawai’i has decided to add to its matrix by keeping FGC while supplementing it with the Early ‘Ohana Intervention to allow it to achieve the separate goals of preventing removal or locating a relative for immediate placement, and, several weeks thereafter, to engage in thoughtful permanency planning through family engagement.[228]

After studying results in Honolulu, the Hawai’i Department of Human Services reported that when an Early ‘Ohana Intervention took place, children were less likely to be removed; those children who were removed stayed in care for a shorter period of time; and, within a year, were more likely to be reunified with their family.[229] It further reported that the earlier the subsequent ‘Ohana Conference took place, the sooner the child was reunified.[230] The results of this combined approach are promising, although more long term research into outcomes would certainly be helpful.

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227 *Id*.

228 *Id*.

229 *Id*.

230 *Id*.

VI. Comparative Research

A. California

Few studies have been conducted to compare different approaches of participatory planning to one another. There is one study in particular that is frequently cited by critics of FGC. This study, published in 2008, evaluated two family group decision making models employed in California using a random assignment to examine outcomes.[231] The study involved two counties, over five years, with 70 children assigned to one of the two FGC models, compared to 40 children assigned to the comparison group, who received traditional child welfare services.

It appears that the treatment group in one county, Fresno, received services generally in accord with the New Zealand model of FGC, but the study also mentions that the specific design of this model was intended to last only six months and to include just one conference.[232] This is contrary to the ongoing nature of New Zealand's model, which may include multiple conferences over the life of the case.[233]

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231 Stephanie Cosner Berzin, Ed Cohen, Karen Thomas, and William C. Dawson, *Does Family Group Decision Making Affect Child Welfare Outcomes? Findings from a Randomized Control Study*, Child Welfare, Vol. 87, No. 4, 35 (2008), http://www.scribd.com/doc/27096420/Family-Group-Decision-Making-Child-Welfare-2009-Berzin (last visited November 19, 2013) (hereafter, *Findings from a Randomized Control Study*).

232 Id. ("Their approach [in Fresno] incorporated a formal strengths assessment phase and private family meeting time during the conference. Fresno County's intervention was designed to last 6 months with only one conference.").

233 *Four Approaches to Family Team Meetings*, THE ANNIE E. CASEY FOUNDATION (2013), http://www.aecf.org/~/media/Pubs/Topics/Child%20Welfare%20Permanence/Other/FourApproachestoFamilyTeamMeetings/FourApproachestoFamilyTeamMeetings.pdf (last visited November 19, 2013).

The model in the other county, Riverside County, was similar, but did not include private family time, meaning that the plan was decided upon by all attendees, including the family's case worker as well as other professionals. Additionally, the county provided families with multiple conferences after their initial conference.[234] The evaluation compared the results of both models to the third group, who received traditional child welfare services.

The authors concluded that, overall, results did not indicate more positive outcomes for children receiving the two interventions, "but did indicate that children were not worse off than those receiving traditional services."[235] In particular, the study found that following the conferences, substantiated maltreatment reports were rare, with only six cases in Fresno County and seven cases in Riverside County. However, there was no difference between the two treatment groups and the comparison group in terms of substantiated cases of maltreatment during the five-year study period.[236]

The study additionally concluded there was no significant difference in placement stability in terms of the frequency of moves among the three groups (the two intervention groups and the comparison group); no statistical difference in permanency in the three groups; and no significant difference in the number of closed cases in the three groups. Of the cases that closed, the majority did so due to family stabilization or because the family refused further services.[237] The authors, therefore, concluded that

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234 *Findings from a Randomized Control Study, supra,* n.231.

235 *Id*.

236 *Id*.

237 *Id*.

although prior studies had suggested there may be benefits to FGDM, this study did not support that suggestion. They tempered this conclusion, however, by noting that the sample sizes may have been too small to detect statistical significance.[238]

While this paper is intended to be a survey of family engagement models, rather than a critical inquiry into those models, brief comment on this study is warranted. As noted at the outset of this paper, one of the variables of family engagement is a lack of fidelity to a given model. It appears that neither Fresno nor Riverside designed nor employed a model of family engagement that adhered with fidelity to the characteristics that are generally considered necessary for successful FGC, as demonstrated by the provision of only one conference in Fresno and the absence of private family time in Riverside. Thus, one may question whether the results of this evaluation can fairly be attributed to FGC in general. Indeed, what may be most notable is that, notwithstanding the individual characteristics of the models employed, the results were no worse than the "traditional services" provided to the comparison group.

B. Florida

Partnership for Strong Families (PSF) is the lead community-based care agency in two judicial districts in Florida, delivering comprehensive child welfare services.[239] Upon receipt of a grant from the Children's Bureau in 2008, part of the United States Department of Health and Human Services, PSF was able to test two models of FGDM.

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238 *Id*.

239 *Family Connections Grant: Family Empowerment through Family Team Conferencing: Final Report*, PARTNERSHIP FOR STRONG FAMILIES, http://www.pfsf.org/public/images/forms/Final_Report.pdf (last visited November 19, 2013).

PSF and two Florida counties partnered with Casey Family Programs to implement and evaluate the different models, and called the initiative Foster Care Redesign.

Going into the evaluation, the authors of the final report hypothesized that, based on best practices around the country, several key components were required for a successful model: a facilitator who is not the family's case worker; adequate preparation; the involvement of extended family and support; the involvement of key service providers who can meet the family's needs; in cases that involve domestic violence, the inclusion of a support person to prepare abuse victims and attend the FTC; private family time to permit the family to develop their own case plan; and a follow up meeting at all critical junctures throughout the life of the case.[240]

The evaluation compared three groups: Group 1 involved a FTC led by a social worker with no outside facilitator and no service providers invited to participate. The conference occurred within 14 days of the triggering event which necessitated the family's case worker to assign the case. There was a minimal preparation for the meeting, and no private family time. Group 2 included mandatory FTC meetings for every new case, involved a social worker working with a facilitator to run the meeting, and allowed service providers to participate. There was four to nine days of preparation time, during which the family was prepared for the meeting. Conferences lasted approximately two hours. Group 3 involved all the components of Group 2 but added private family time. Consequently, these conferences lasted 4-6 hours.[241] The

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240 *Id*.

241 *Id*.

evaluation examined 623 families and concluded that the cost was the same for each group.[242]

The outcomes of the evaluation were mixed. Specifically, the evaluation found that the rate of re-entry into foster care within twelve months following the intervention was 14.9% for Group 1, 10.2% for Group 2, and 30.4% for Group 3.[243] Additionally, reunification within 12 months of entry into care for Group 1 was 58.8%, for Group 2 it was 50.3%, and for Group 3 was 36.6%.[244] There was no significant difference in the average number of placements children experienced within the three groups.[245]

The authors of the final report concluded that the evaluation called attention to the importance and value of skilled and highly trained professionals, who are not the family's case worker, to plan and facilitate the FGDM. Examining the negative results of Group 3 (which included private family time) on reunification and stability, the authors noted that they could only speculate as to why this factor appeared to have negative consequences, because no social workers participate with the family during private family time. They concluded that more time is needed to ascertain whether the differences they observed are sustained and meaningful.[246]

C. Texas

242 *Id*.

243 *Id*.

244 *Id*.

245 *Id*.

246 *Id*.

In Texas, following the initial implementation and evaluation of FGC discussed above, the legislature passed a bill in 2009 requiring an evaluation to determine the effectiveness of two models of FGDM discussed below.[247] The evaluation examined the impact of these two models on preventing removal, and separately examined their impact on accelerating a child's exit from the foster care system.

The first model appears to have aligned with TDM or FTC, and was defined as a "quick response to child safety concerns" which was used as an early intervention to prevent removal where possible.[248] It was offered at one of two points along the family's service trajectory: (1) either at the investigation stage when allegations of abuse or neglect first arose, or (2) during "Family-based Safety Services," which are "protective services provided to a family whose children are not [yet] in the managing conservatorship of [the child welfare agency] . . . . The level of service is determined by the degree of risk to the child."[249] It appears that when the family is receiving Family-based Safety Services, the child welfare agency is working with the parents to keep the child in the home but also considering the possibility of removal.

The second model was FGC, defined consistently with the New Zealand model described above except for one significant difference: it was focused on either preventing removal when the family was receiving Family-based Safety Services, or on

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247 Eugene Wang, *Family Group Decision Making, Impact on Removals and Permanency in Texas*, TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (August 2010), http://www.dfps.state.tx.us/Child_Protection/Family_Based_Support/fgdm.asp (last visited November 19, 2013).

248 *Id*.

249 *Id*.

exploring placement options if it became apparent that removal would be necessary.[250] In either case, the goal of FGC was to develop a permanency plan to protect the child from future harm.[251]

The evaluation examined the impact of three alternatives on the likelihood of removal: first, the use of FTC during the initial investigation (prior to the provision of Family-based Safety Services); second, the use of FTC following the investigation during the provision of Family-based Safety Services; and third, the use of FGC during the provision of Family-based Safety Services.[252] The evaluation concluded that the use of FTC during the investigation stage of service reduced the odds of removal by 8%; FTC during the Family-based Safety Services stage of service reduced the odds of removal by 15%; and, finally, FGC during the Family-based Safety Services stage of service reduced the odds of removal by 8%.[253]

The Texas evaluation also separately examined the impact of FTC and FGC on accelerating a child's exit from the foster care system through family reunification, permanent placement with relatives, or adoption. This aspect of the evaluation

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250 *Id*.

251 *Id*. FGC as used in the evaluation was defined as follows:

> Family Group Conferences are a subcomponent of Family Group Decision-Making. These are meetings where families join with relatives, friends, the community, and [a social worker from the child welfare agency] to develop a plan to ensure children are cared for and protected from future harm. . . . Through the use of family time, the "family group" is vested with a high degree of decision-making authority and responsibility. During family time, the "family group" joins together to discuss and develop a plan for the child's safety and well being.

252 *Id*.

253 *Id*.

examined 80,693 children who had either the FTC or FGC intervention as described below, but were nonetheless removed from their home. These children were subject to either (1) FTC during the initial investigation, prior to removal; (2) FTC following the investigation and removal; or (3) FGC following the investigation and removal.[254] The results indicated that of these three alternatives, the use of FTC during the investigation stage, prior to removal, was the most effective at helping children ultimately attain permanent placement. Specifically, twelve months following the intervention, 62.2% of children who had FTC during the investigation stage of service were in permanent placement; 43.5% of children who had FTC following removal were in permanent placement; and, lastly, 39.2% of children who had FGC following removal were in permanent placement:[255]

254 *Id*.

255 *Id*.

Time to placement

	3 months	6 months	9 months	12 months	15 months	18 months
Overall (everyone)	6.4%	11.8%	20.6%	39.4%	50.6%	63.1%
Family Team Conference (FTC) – Investigation	12.7%	22.6%	37.4%	62.2%	74.5%	85.1%
Family Team Conference (FTC) – after Removal	7.4%	13.4%	23.2%	43.5%	55.2%	67.8%
Family Group Conferences (FGC) – after Removal	6.4%	11.7%	20.5%	39.2%	50.4%	62.9%

VII. Conclusions

To keep in mind the distinctions between TDM, FTC, and FGC, the following chart identifies their differences, in relevant part:[256]

[256] *See, generally*, *Family Teaming: Comparing Approaches*, THE ANNIE E. CASEY FOUNDATION, http://www.ncjfcj.org/sites/default/files/teaming-comparing-approaches-2009.pdf (last visited March 18, 2014). As used in the chart, the family's case worker refers to the case worker who is working with the family, and the facilitator is the individual who runs the meeting.

	Team Decision Making (TDM)	Family Team Conferencing (FTC)	Family Group Conferencing (FGC)
Origins	Developed in 1992 by the Annie E. Casey Foundation as a team strategy.	Developed in 1994 in Alabama with assistance from the Annie E. Casey Foundation in response to a class action settlement agreement.	Developed in New Zealand as a response to concerns about the number of indigenous children taken from their homes and placed into the foster care system.
Research	Annie E. Casey Foundation.	Indiana and the Annie E. Casey Foundation.	Multiple sources.
General Objectives of the Model	To reduce reliance on congregate care by meeting the needs of children through relative or family foster care; to reunify children with their families as soon as it is safe to do so; to better screen children being considered for removal to determine what services might be provided to the family to keep children at home safely; when removal is necessary, to place children in their own neighborhoods.	To develop an individualized service plan created with input from family members and their support network and professional service providers to resolve all placement related decisions, with the primary goal of keeping children safe in their own homes or their own communities.	To gather together as many members of a child's immediate and extended family, their support network, interested members of the community, and professional service providers, to develop and implement a plan to keep children safe. To allow for maximum family input and family decision making. To reduce dependency upon the child welfare system.
Goals of the Meeting	To make immediate placement-related decisions, including removal, placement moves, safety planning, permanency, and reunification.	To create an individualized service plan focused on safety, placement, and permanency; to prevent removal; to prevent placement disruptions; and to identify kinship placement options.	To make critical decisions as needed or to achieve permanency and family independence; to create a plan to prevent removal; if removal is necessary, to provide placement with a family member; to plan for reunification.
Timing	Occurs before the child is removed or placed, or, in emergency situations, by the next working day after removal; when there is a placement change, reunification, or any other permanent move.	Occurs upon the family's first interaction with the child welfare agency and continues as needed until the family is no longer involved with the agency; the first meeting may occur before a child is	Occurs about a month after the investigation, or, in cases of imminent risk where the child was removed, about a month after the removal.

		removed or, in cases of imminent risk, within 2 weeks after removal.	
Referral	The family's case worker arranges for TDM whenever placement is contemplated, a change in placement may occur, or reunification is imminent.	The family's case worker obtains agreement from the family for FTC.	Referral is usually by the family's case worker, after the investigation, and is voluntary.
Structure	Meetings are mandatory, and must be held prior to any placement or change in placement or before any court hearing in cases of imminent risk.	Meetings are voluntary and occur only with the family's approval at the first system interaction and anytime thereafter when a plan requires modification.	Meetings are voluntary and can occur at any point within the case or as a means to avoid ongoing involvement with the child welfare system.
Preparation	The family's case worker organizes each participant and provides them with a brief overview of the presenting issue and the purpose of the meeting, gathers the team together quickly, arranges the location of the meeting (generally in a community setting); and arranges child care as needed. Preparation time is limited because of the emergency nature of the meeting.	The family's case worker prepares the family; arranges for the meeting to be held at a convenient, neutral location; invites participants; addresses any barriers to participation such as transportation or day care concerns; identifies issues to address; reviews all assessments; makes a list of critical questions to answer at the meeting; makes a list of family strengths and needs; and establishes non-negotiable safety parameters.	The facilitator invites the family, the family's case worker, community representatives, and all other members of the group; organizes the FGC; and engages in extensive preparation by attempting to enlarge the participating group and to prepare them to engage appropriately. Preparation typically takes about 35 hours per case over about 36 days in New Zealand, and about 30 hours and 21 days in the United States.
Facilitator	An internal, trained social worker, but not the family's case worker.	The family's case worker.	The facilitator is usually the individual who coordinated the meeting; is extensively trained and neutral; and is never the family's case worker.
Role of the family's case worker	To convene the team and prepare for the meeting.	Prepares the family and facilitates the meeting.	Makes the referral; participates during the conference (except during private family time); presents possible community/agency

			resources for the family's consideration during private time; and identifies critical issues to be addressed in the plan.
Team membership (all approaches include parents, extended family, nonrelative supports, community resources, service providers, and the family's case worker)	Individuals who have the family's permission or a right to participate and who can be gathered together quickly; the family's case worker.	Individuals who the family decides may participate, with input from the family's case worker, who also participates as a team member.	As many appropriate members of a child's extended family network as possible. The family's case worker is part of the group but does not create the plan with the family during private family time.
Decision Making Responsibility	The team makes the plan, and is jointly accountable for the outcome. It is the family's case worker, however, who retains ultimate decision making authority if the team cannot reach a consensus.	The team, including the family's case worker, who is also the facilitator, makes the decision within the established safety parameters.	The family creates the plan during private family time and presents it to the family's case worker, who accepts it as long as the child's safety needs are met.
Length of Meeting	1-2 hours.	1-2 hours.	3-5 hours. Follow up meetings are generally 1-2 hours.
Private family time	No	No	Yes
Implementation of the plan	The family's case worker implements the plan with support from the team; the team can arrange for a follow up meeting if they chose.	The family's case worker (who also facilitates) assumes responsibility for monitoring the plan, following up with team members to ensure that assignments have been completed, and assessing progress within two weeks of the FTC; subsequent meetings occur whenever a plan requires modification or another placement decision has to be made.	The family is responsible for implementing the plan with the family's case worker's assistance. The family's case worker is responsible for tracking progress and following up with the family; subsequent meetings occur upon the family's request or as otherwise needed.

A. Features of FGC, FTC, and TDM

Each of the models discussed herein are premised on the philosophy that engaging families, broadly defined, in child protection and the decision-making process related to questions of, *inter alia*, safety, removal, placement, reunification, and permanency, will achieve the most positive outcomes for children and their families. Although the concepts of family based decision making are conceptually compelling, there is insufficient research into which models work best in which circumstances, and which elements or components are necessary to achieve the objectives of child safety, well-being, and permanence. As the chart above exemplifies, the models each depend to varying degrees on advance preparation and a skilled, trained facilitator. FGC also includes private family time, while this feature is omitted in the TDM and FTC models.

1. Adequate Preparation

Although adequate preparation, and the time necessary to engage in such preparation, is required under each model, each requires different degrees of preparation. Advance preparation for TDM is the most limited because of the often emergent nature of the meeting. It is conducted by the family's case worker, and is limited to quickly gathering together a team of individuals, providing a brief overview of the presenting issue, and arranging the logistics of the meeting. Preparation for FTC is also completed by the family's case worker, but is more expansive than the level of preparation necessary for TDM. In particular, preparation for FTC requires the family's case worker to invite participants, to foresee and address any barriers to participation, to identify the family's strengths and needs, and to specify which questions should be

resolved at the meeting within the safety parameters. FGC requires the most extensive preparation and is conducted by the facilitator rather than the family's case worker. FGC is more focused on gathering together as many appropriate extended family members as possible, and takes about 30 hours. This level of preparation takes place over about three to four weeks (in the United States). While the facilitator does much of the preparation, it is the family who makes the ultimate decisions for the care, safety, and permanency of the child.

2. An Experienced Facilitator

An experienced, trained facilitator is also necessary under all models. Depending on the model, the facilitator may be from within or outside the child welfare agency, and, in the case of FTC, is often the family's case worker. Adequate training is essential to enable the facilitator to prepare and guide the family towards the goals of the meeting.

3. Private Family Time

Private family time distinguishes FGC from TDM or FTC (which do not include it). In this respect, if the professionals do not leave the room and allow the family private time to deliberate the details of the plan, it is questionable whether the family will feel empowered to speak honestly about their concerns or take responsibility and ownership of the plan. The lack of private family time is generally contrary to the underlying principles of conferencing theory, which provides that the family alone should take responsibility and demonstrate its capacity to design a plan for the child's safety, care, and well-being. Many FGC proponents feel "there should always be family alone time

in order to provide the family with autonomy and primary responsibility for the decisions that come from the meeting,"[257] and understandably feel that denying the family private time to create a plan will leave the impression, if not the reality, that the agency has already created the plan, and the purpose of the meeting is simply to present the plan to the family.

B. Best Practices of FGC

Research into the best practices of the FGC model has reinforced repeatedly that there are several core components and principals that are required for success. Specifically, to be effective, FGC should be carried out with fidelity and should include an automatic referral process. The FGC approach depends on, and to a large extent is defined by, extensive preparation (35-45 days in New Zealand, 2-3 weeks in Washington, 30-45 days in Texas). Preparation should including finding and inviting family members, addressing their fears or concerns about the process and their ability to resolve the child safety issues, anticipating and resolving any family disagreements that could otherwise derail the conference, educating the family about the model and their role in the process and objectives, ensuring that everyone knows and agrees that information shared is privileged or confidential and cannot be used outside of the meeting, and situating the meeting in a comfortable, neutral location. Inadequate preparation could doom the chances of success. Because of the primacy of the task of preparation, FGC requires a trained, impartial, independent facilitator, who is not the family's case worker, to prepare for the meeting and facilitate it.

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257 *Essential Tools, supra* n.30.

FGC also depends on family empowerment, and the family's primary role should be reinforced every step of the way by having family members determine who to include in the meeting, with help from the coordinator to widen the family circle. The family should also be vested with final decision making authority, subject to the parameters established by the family's case worker for child safety, which is exercised by developing the plan during private family time. There should always be more family members than service providers at the meeting (at least a two-to-one ratio), the meeting should include as many appropriate members of the extended family as possible, and should include representation from both sides of the family. When necessary to find appropriate family members or significant participants to ensure success of FGC, the coordinator should employ a mechanism of family finding. Fictive kin, who are "like family," should be included, as should children 12 years old or older. Within the FGC model, confidentiality is important to enable the free exchange of ideas. The family implements the plan and the family's case worker tracks their progress to ensure success. Follow up conferences can occur as needed, and take less time to prepare and to complete. Barriers to process effectiveness include referral bias by the family's case worker, and ideological drift or a lack of fidelity to the model.

C. Research of FGC

Most of the available research into the models of family-based decision making has addressed FGC in particular. The lack of long term studies comparing competing approaches to one another highlights that there is currently a need for additional research and analysis into which models are successful and why.

Although the research on FGC is not conclusive, it is positive. Generally speaking, families are successful in developing plans for the safety of the child which are accepted by the family's case worker and the courts. Families generally report being satisfied with the process of FGC and appreciate their enhanced role in it. FGC has been noted to increase the involvement of paternal relatives. When implemented with fidelity, children who receive the FGC intervention are more likely to stay in their homes and, if they require out-of-home placement, are more likely to stay with a relative. In this respect, the Washington model of FGC resulted in permanent placement for 85% of children, and doubled the number of children living with their parents, suggesting that it was an effective way of achieving permanent child and family continuity.

The Texas model of FGC found that it increased relative placements, that more children whose families participated in FGC exited care compared with those whose families did not, and that twice as many children returned home as compared to children who did not receive the FGC intervention. The use of FGC in Hawai'i resulted in more cases closing after less than a year, compared to over 20 months for non-conferenced cases, resulted in children being much less likely to be placed into foster homes or emergency shelters, and caused significantly fewer children to be subject to court-ordered permanent custody to the state. The Allegheny County study showed that children who received the FGC intervention were more likely to be placed with relatives than children who did not receive the intervention. Some of the studies have suggested that FGC results in more favorable outcomes for African American and Hispanic families.

Some evaluations of FGC, however, have suggested that it has led to higher rates of re-referral for abuse, and higher rates of re-entry into foster care, following the intervention. While this data may be viewed as negative, it may also demonstrate a strength of the FGC process. Given that FGC brings together a large family group to share responsibility for ensuring a child's safety, it may be that the mode inherently causes increased vigilance on the part of these involved family members. Further research into the causes of increased rates of re-referral following FGC would be very helpful in understanding this dynamic.

The study from Fresno and Riverside counties in California involved two models of family group decision making, both of which were patterned on FGC but with significant departures. Specifically, the model in Fresno was limited to one conference, and the Riverside model, although offering multiple conferences as needed, excluded private family time. The results from the use of these two models were not positive, but the study indicated that children who received the interventions were not worse off than children receiving traditional child welfare services. This research suggests that even where a flawed, imperfect model of FGDM is employed, the results are comparable with results obtained through traditional child welfare.

D. Research of FTC

When Indiana implemented its model of FTC, with the assistance of the Annie E. Casey Foundation, it reported that it saw a reduction in the median length of stay in care and in the number of children who were in care for over a year, and an increase in the number of children who either remained in their own home or were placed with a relative, all of which suggests promising results. In addition, a study from Texas

indicated that the use of a model similar to FTC during the initial investigation into concerns of child abuse or neglect, but prior to the removal of the child from the family home, was effective at helping children attain permanent placement. Ultimately, however, more independent research is needed to appropriately evaluate the effectiveness of this model.

E. Research of TDM

The TDM model appears to be the most agency-driven representation of family group decision making. The family's case worker prepares the family for the meeting, participates in all phases of the meeting, identifies the presenting issue, and presents the family history, including prior referrals, child protection investigations, and existing case plans. The family's case worker recommends a plan of action, and the team collectively makes the placement decision. If the family fails to agree upon the plan, however, the family's case worker, who retains the ultimate decision-making authority, will create and implement the plan.

The AECF research from Alameda County, California, shows that TDM can be effective at reducing the number of children in congregate care, increasing the number of children who are placed with relatives or reunified with their parents, decreasing the likelihood of reentry into care, increasing the number of siblings who are placed together, and reducing the frequency of placement moves for children in care. Maine also experienced a decrease in the number of children in foster and residential care, and an increase in the number of children placed with relatives or reunified with their families.

The Cuyahoga County, Ohio, evaluation was less promising. It showed that following implementation of TDM, although there was a decrease in the number of children entering care and an increase in stability, there was also an increase in the number of children entering congregate-care settings and a decrease in the percentage of children placed with a relative. The authors of the evaluation offered an explanation for these results, suggesting that those children who could safely remain with their parents likely did so without first entering care at all, and were therefore not accounted for in the evaluation. In addition, the evaluation suggested that to be effective, the TDM should be held within one day of the triggering event and should include relatives and parents at the meeting. The presence of relatives at the meeting increased the likelihood of relative placement, and the presence of parents at the meeting increased the likelihood of reunification.

F. Referral Bias

The research detailed above highlights an interesting aspect of the various models: there is a lack of consistency in the range of families to whom the child welfare agency offers the particular model of intervention. With TDM, referral to a conference is mandatory, and generally requires meetings to be held prior to any placement or change in placement. In contrast, with FTC and FGC, the family's case worker has discretion about whether to invite families to participate, and the intervention will occur only with the family's agreement. Some advocates believe that almost all families will benefit from family group decision making, while others believe that certain cases are inappropriate for conferencing. Although there is no empirical data to support either position, family case worker discretion about which families receive an invitation could

potentially reduce the efficacy of the model, as families to whom the meeting is not offered obviously will not receive the benefits. The variable of family case worker selection can be limited with well-defined referral criteria, or, as with TDM, making the process mandatory.

In this respect, the research examining to whom FGC is offered, and which families accept the invitation to participate, indicates that FGC works better when there is an automatic trigger to referral, or if referral is mandatory, rather than when it is left to the discretion of the family's case worker. Specifically, family case workers have shown reluctance to invite families to participate in FGC when the allegations involved sexual abuse or when the family's case worker distrusts the family or more generally fears losing control over the process. A Miami study similarly found that family case workers generally did not make referrals in cases involving sexual abuse, spousal violence, where there were pending criminal charges, or severe physical abuse. This research supports the position that, in some circumstances, families who could benefit from the model are not receiving the opportunity to do so because of family case worker reluctance or cultural bias. This bias may reflect upon the more positive research results, with family case workers only referring those families who are already poised to take full advantage of the process.

With regard to which families accept the family case worker's invitation, Washington found that almost all families who are invited will agree to have an FGC, while the Swedish and Michigan studies found a much lower acceptance rate. The Swedish families indicated that they declined the invitation because they had no extended family, did not want their family to be aware of their problems, or the parents

already knew what they wanted and were not interested in exploring options. A study from San Diego found that families whose goal was reunification were most likely to accept an invitation to participate in FGC, while families whose cases involved severe neglect were the least likely to accept.

Family case worker referral bias and a family's reluctance to accept the invitation can both be addressed by making the process of referral mandatory. In addition, these factors can be ameliorated by training family case workers to familiarize them with the practice, to increase their acceptance of it, to enable them to help families understand the benefits of conferencing, and to provide them with tools to address the family's concerns. Adequate preparation could likewise increase the likelihood of family acceptance by overcoming perceived barriers to participation.

G. Recommendation

Because the models vary in their objectives and timing, it may be that they are suited for different purposes rather than interchangeable. A combination of elements from the several models discussed herein, which by design address different issues in distinct circumstances, is warranted. Thus, rather than comparing alternatives to each other, it is suggested that these models may function quite well together as an integrated family engagement child welfare strategy.

In particular, current research and evaluations of the three models discussed herein and general practices of the child welfare system suggest the need for a two-tiered approach to family group decision making. First, research suggests the need for a first-tier meeting that includes family members who can be gathered together rapidly

(within hours or a day), and is designed to make an immediate decision about child safety or removal at a point of crisis with as much family participation as practical under the presenting reality. In such circumstances, the family's case worker may need to assume a more prominent role in decision making if the family itself is unable to construct a plan for the child's care and safety.

Second, once the child's immediate safety and care is addressed through the initial, quickly convened first-tier of family group engagement, a second-tier meeting may be necessary for longer term permanency planning which cannot be addressed in an emergency situation. This second tier meeting would be a more extensively planned, traditionally prepared FGC, including a wide array of extended family to make longer term decisions and vesting the family with greater control over such decisions. Such a two tiered approach has been employed in North Dakota, North Carolina, and Hawai'i.

Within such a two-tiered model, as discussed above, there should be very clear referral guidelines or a mandatory referral process to limit family case worker selection bias; a skilled, neutral facilitator should prepare by utilizing a process such as family finding to widen the family circle as much as possible during the second-tier permanency planning meeting; within both tiers, the skilled, neutral coordinator should engage in sufficient preparation to achieve the relevant goals; and, finally, the family should be empowered every step of the way to make the necessary decisions.

Finally, it is apparent that more independent research into the various models of FGDM is needed. Although FTC and TDM in particular have been utilized to varying degrees since the early 1990s, there is insufficient long term empirical research into

their success. However, it is notable that the available research into all models of FGDM generally indicates that any form of family engagement is likely to produce results that are, at worst, comparable to traditional child welfare decision making processes, wherein family case workers, attorneys, and judges make critical placement decisions with little or no family input, and, at best, are significantly superior.

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