When do social workers and family members try Family Group Decision Making? A process evaluation

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Abstract

A Family Group Decision Making (FGDM) program attempted to divert children from foster care services and keep them within their extended families. Case characteristics of the referrals were used to explore which families were selected for FGDM, which families decided to try this approach, and which families then developed plans for keeping the children out of foster care. 593 referrals received over a five year period were coded for child, family, parent and maltreatment characteristics. Logistical regression identified case characteristics that were positively or negatively associated with decisions to use FGDM. Both child welfare professionals and family members independently chose to try FGDM more often in cases with identified kinship, parental substance abuse, improper supervision, and/or children with special needs. The findings suggest under which circumstances social workers and family members are willing to try to meet and share their concerns and suggestions in cases of child maltreatment.

Key words: Family Group Decision Making, Family Group Conferences, process evaluation

The focus of Family Group Decision Making (FGDM) is a plan for the care and protection of a child that is developed through a meeting of the child's extended family and community in confirmed cases of child abuse or neglect. FGDM is a rapidly growing practice around the world. For example, a 2004 web-based survey of Family Group Conferencing practice received 225 responses from sixteen countries (Nixon, Burford, Quinn and Edelbaum, 2005). The FGDM research literature is fairly consistent in describing how FGDM works and what the participants think makes it work well (Burford & Hudson, 2000; Pennell & Burford, 2000; Sieppert, Hudson & Unrau, 2000). Burford (2001) summarizes this research as demonstrating that family members will come to meetings when they are given an opportunity; that they participate appropriately and develop plans that are child-centered; that both family members and child welfare professionals believe meetings improve child protection work; and children placed through meetings are more likely to remain with their extended families.

One of the key remaining questions is to determine which families are likely to participate in FGDM. Program evaluation can provide some insight into this issue by comparing families

who were offered FGDM with those who were not, and by comparing families who chose to try FGDM with those who did not. A better understanding of these decisions may reveal how child welfare professionals and families view the potential benefits of FGDM. A Swedish FGDM study is one of the few that examined the referral process (Sundell, 2000). This study found that only thirty-five percent of investigated families were offered an opportunity to try FGDM. In comparing those who were offered a meeting with those who were not, the study found that among the families offered FGDM, the social workers were more positive about FGDM, and the social workers claimed the families they referred to FGDM were less willing to collaborate during the child protection investigation. Of the families offered a FGDM meeting, only about one-quarter accepted. The families who accepted FGDM had more contact with social services, their children had more experience in out-of-home care, and they were viewed by the social workers as having more serious problems than those who declined FGDM.

More recently, the same Swedish research team (Sundell and Vinnerljung, 2004) reported on a comparison of client outcomes between Swedish cases served through FGDM and cases served without FGDM. The results did not show that cases served with FGDM were less likely to experience future maltreatment referrals compared with cases that did not participate in FGDM. The authors noted that if future FGDM studies also show neutral results, then international enthusiasm for FGDM should be questioned. However, the Swedish experience also demonstrates that if we are going to compare cases served by FGDM with those that were not, we need to better understand how social workers and family members decide when to use FGDM. It is possible that cases in which social workers and family members decide to try FGDM are different from cases in which they do not and these differences, rather than just receipt or lack of receipt of FGDM, help explain the findings of this Swedish study and other studies that make these comparisons in case outcomes. This article contributes to this discussion about how decisions are made about when to use Family Group Decision Making. This decision making process must be better understood in order to evaluate the potential benefits of FGDM.

Thus far, there is little theory to guide which cases are appropriate for FGDM (Crampton, 2004). As noted in other research appearing in this journal, child welfare professionals sometimes fail to have explicit criteria for why they opt for intervention A and not for intervention B or C (Knorth, Metselaar, Josias, Konijn, Noom and van Yperen, 2003). Because the social workers from the program in this study also did not have an explicit sense of which cases would be most appropriate for FGDM, this study did not test whether pre-determined referral characteristics were used. Instead, a more exploratory method was used to see if there were hidden criteria that were being used by social workers and family members to decide when to try FGDM.

Due to the exploratory nature of this study, there was no program theory that could be used to develop explicit hypotheses. Instead, the theoretical framework for the study draws from studies of decision making and information processing in organizational theory. These studies make a distinction between *uncertainty* and *ambiguity* (Feldman, 1989). Uncertainty can be resolved by obtaining specific information, while ambiguity cannot. Ambiguity occurs when there are many different ways of thinking about something, and the problem of multiple competing perspectives will not be resolved by collecting more information. Karl Weick suggests that problems of ambiguity require more meetings. He describes these meetings as opportunities where the participants can "argue, using rich data pulled from a variety of media, to construct fresh frameworks of action-outcome linkages that include their multiple interpretations. The variety of data needed to pull of this difficult task are most available in variants of the face to face meeting" (Weick, 1995, p. 186). An FGDM meeting, including parents, family members, social workers and other child welfare professionals in a face-to-face meeting with the purpose of developing a plan for the care and protection of children, is a child welfare application of Weick's suggestion. FGDM may be an effective intervention in child maltreatment cases that are complicated by issues of ambiguity. If this is the case, we would expect

social workers to refer cases and families to agree to try FGDM more often in cases when there are problems of ambiguity and the participants are unsure of any other way to proceed.

Program design

The following analysis is drawn from a study of a program located in Kent County, Michigan, which includes the city of Grand Rapids (Crampton, 2001). Community interest in Family Group Decision Making in Kent County began in 1994 when, as part of the W. K. Kellogg Foundation's Families for Kids Initiative, concerned citizens underwent a year-long community visioning process to develop a comprehensive strategic plan for the local child welfare system. Kent County's 25-year commitment to permanency for children had already significantly reduced the number of children in foster care and the time they spent in foster care; however, the visioning process revealed that people were still not satisfied with the current system. In particular, they were concerned about the over-representation of minority children in foster care and the lack of meaningful inclusion of extended family and community members in the care of maltreated children. With more than half of the foster care placements and adoptions in Kent County involving relatives, it was clear that extended families were taking care of their own children. However, the visioning process revealed an uncoordinated approach to relative caregiver selection, service delivery, and placement. Many relative caregivers believed the system was intrusive and not addressing their needs. Given these concerns, community leaders wanted to develop a process for including extended family and community members in the care and protection of children. Inspired by the use of Family Group Decision Making in New Zealand, Kent County applied for and received funds from the Kellogg Foundation to develop the Family and Community Compact program.

The original design of the Family and Community Compact (FCC) program directly addressed the community's concern about the over-representation of minority children in foster care. Referrals to the FCC were made only in cases of substantiated child maltreatment involving minority children who needed to be removed from their home. In addition, the community representatives decided that the FCC should not accept cases involving child sexual abuse because they believed that programs that already existed in the community were meeting the needs of these children. Since the court cannot require a parent to participate in any program without opening a legal case, and one goal of the FCC is to keep cases out of the court system, it was necessary to make the program voluntary. In 1998, Kent County received a grant from the U.S. Children's Bureau that facilitated the expansion of the program from serving minority children to serving all children regardless of race.

When a case meets the referral criteria (substantiated Children's Protective Services case, out-of-home placement, not sexual abuse), the Children's Protective Services (CPS) worker refers the case to the FCC program. Once the parents agree to participate and the FCC staff determine that it is an appropriate case, the FCC staff begin to organize a compact meeting by contacting family members and other kin identified by the parents and other family members. At the meeting, biological relatives, fictive kin (such as church members), and support people (such as public health nurses, teachers, and ministers) first hear from the protective services worker and other staff about the concerns regarding the welfare of the children. After the case presentation, the professionals leave the meeting and the family and kin attempt to develop a plan for placement of the children with their extended family. If they can agree to a plan, a FCC staff member called the Family Advocate works with the family to link them with community services that will support the placement. If they cannot agree to a plan, the children are placed in foster care. After the children are placed by the FCC, the staff schedule meetings with the family every three months, with a goal of reaching a decision to return the children to their original home or to a permanent placement with a relative within one year.

Method

The following analysis looks at all of the 593 referrals to the FCC program from 1996-2000. The analysis follows a series of three research questions:

1. Of the referrals made to the Family and Community Compact (FCC) program, what were the differences between cases that the referring Children's Protective Services Specialist, the FCC staff, and the Family Court Referee *all agreed* were appropriate for the FCC program and those that were not considered appropriate?
2. Of the referrals that were determined to be appropriate for the FCC program, what were the differences between cases in which families chose to participate in FGDM and those in which the families chose not to participate?
3. Of the families who had a family meeting, what were the differences between those who were able to develop a plan for keeping the children with their extended family and those who were unable to develop a plan?

The referrals are summarized in table 1.

Table 1
Research Questions and Number of Referrals Studied 1996-2000

Research Questions	Yes#	Yes%	No#	No%	Total
Professionals Agreed	322	54%	271	46%	593
Family Agreed	173	54%	149	46%	322
Family Plan	115	66%	58	34%	173

Table 2
Independent Variables

Family Characteristics	Parent Characteristics	Child Characteristics	Type of Maltreatment
Children living with parents	Father Arrested	African American	Abandonment
Children living with relatives	Father Incarcerated	Caucasian	Educational Neglect
Domestic violence	Parent's Mental Health	"Other" race/ethnicity	Emotional Abuse
Homeless	Mother Arrested	Baby born drug positive	Failure to Protect
Kinship concern	Mother Incarcerated	Behavior of Child(ren)	Failure to Provide
Kinship identified	Mother is Pregnant	Includes Infant	Improper Supervision
More than 1 Father	Parent is a Teen	Includes Teen	Medical Neglect
More than 2 children	Previous CPS	Special Needs	Physical Abuse
Paternity Concerns	Previous TPR		Physical Neglect
Single Mother Household	Alcohol		Sexual Abuse
	Cocaine		
	Marijuana		
	"Substance Abuse"		
	Substance Abuse-any		

All of the referral files were reviewed to determine the occurrence of forty case characteristics related to the children, parents, families, and types of child maltreatment. Two researchers independently reviewed the case files to code for the occurrences of these characteristics and then together reviewed the cases they did not code in the same way to reach consensus on how to code all cases and ensure consistent coding of the cases. Case characteristics were coded as mentioned in the case files or not mentioned. It should be stressed that just because a file did not mention a particular case characteristic does not necessarily mean the family did not have that characteristic. It may only mean that the CPS worker making the referral and the FCC staff writing the reports did not think the characteristic needed to be mentioned in the file.

As described above, the independent variables were coded for each case using information gleaned from the case files. Family characteristics included whether the children were living with their parents or relatives at the time of the referral and whether extended family or kinship were already identified as potential support or placement. Parent characteristics included whether there was any mention of the parents using alcohol, cocaine, or marijuana. We also coded cases if they simply said "substance abuse" or if they mentioned any of the above addiction concerns. We coded for whether the parents had previous involvement with Children's Protective Services (CPS) and whether they previously had their parental rights terminated (TPR) as part of a previous CPS referral. Child characteristics included whether the children were African American, Caucasian or something else. Any mention of behavioral problems with the children was noted. A case note that say there are behavioral concerns is clearly not a specific diagnosis, it is merely a case concern noted by staff or other informants. For type of maltreatment, we noted any mention of the specific categories listed in Table 2.
For each research question, the independent variables were tested first in a bivariate analysis to see, for example, if referrals approved by the professionals were more likely to mention substance abuse. Case characteristics that were statistically significant ($p < = .05$) in the chi-square analysis were then entered into a logistical regression. Only variables that were significant in the bivariate analysis were included in the regression analysis in order to minimize multicollinearity, which is potential relationships between variables that may mean some variables are masking the effects of other variables.

Results

Table 3 lists some of the key differences in the study populations.
The table shows the case characteristics that were more frequently mentioned in referrals that proceeded through the program. Perhaps not surprisingly, referrals that identified potential kinship care providers were more likely to be approved for program participation, to have family members who agreed to try FGDM, and to have a plan developed by the family. Case characteristics that frequently confound child welfare decision making, such as parental substance abuse and mental illness, domestic violence, and children with special needs, were more likely to proceed with FGDM.

Table 4 shows the results for the logistic regression for the first research question. Only variables that were significant in the bivariate analysis were included in the regression model and they are all listed in the table. Variables significant in the regression model are in bold type. Many of the variables that were significant in the bivariate analysis were not significant in this model. For example, it appeared initially that African American families were more likely to be accepted into the program, but when other variables were included, race is no longer significant. This analysis suggests that when referrals mentioned potential kinship care providers, concerns about the paternity of the children, an incarcerated mother, parental substance

abuse, special needs of the children, failure to provide, or improper supervision, the referrals were more likely to be approved. When the referrals mentioned that the parents had previously had their parental rights terminated in the case of another child, those referrals were less likely to be approved. The relative risk statistics, along with the sign on the coefficient, makes interpreting the results straightforward. Previous termination of parental rights (TPR) is the only significant variable with a negative coefficient, meaning that having this characteristic makes the referral less likely to be approved. The relative risk shows that previous termination of parental rights reduced the chance of approval by about one-third. All the other variables are positively associated with approval. For example, referrals mentioning special needs of the children were nearly four times as likely to be approved as cases that did not mention special needs. However, the relatively high standard errors for the relative risk ratios suggest some need for caution in interpreting them. Taking this into account, special needs cases are somewhere between two and seven more times to proceed with a meeting. It is the direction, rather than the magnitude of the relative risk that is important. The substantive point is that the analysis suggests that referrals were more likely to be approved when they mentioned potential kinship care providers, concerns about the paternity of the children, an incarcerated mother, parental substance abuse, special needs of the children, failure to provide, or improper supervision.

Table 3
Selected Case Characteristics for the Study Populations

Referral Characteristics	All Referrals N = 593	Professionals Agreed N = 322	Family Agreed N = 173	Family Plan N = 115
Domestic Violence	10.8%	14.0%	20.2%	19.1%
Homelessness	15.3%	19.3%	25.4%	33.0%
Kinship Identified	49.6%	58.7%	79.2%	76.5%
Mother arrested	15.9%	21.4%	28.3%	27.8%
Parental Substance Abuse	38.6%	48.1%	66.5%	70.4%
Parent's mental health	11.1%	12.4%	18.5%	20.0%
Previous CPS	31.0%	35.1%	47.4%	44.3%
Previous TPR	6.4%	4.3%	6.9%	8.7%
Special Needs of children	13.2%	19.6%	25.4%	24.3%
Failure to Provide	11.0%	14.3%	9.8%	12.2%
Improper Supervision	7.8%	10.9%	17.3%	13.0%
Physical Neglect	70.7%	74.5%	75.7%	74.8%

Table 5 lists the results for the second research question. All of the significant variables were positively associated with the families' decisions to try FGDM. Families were more likely to try FGDM in referrals that mentioned that the family was homeless, potential kinship care providers were already identified, there were concerns about the parents' mental health, the family had previous involvement with Children's Protective Services, or that there was parental substance abuse, special needs of the children, improper supervision, or child sexual abuse. Since the Kent County FGDM program officially did not take sexual abuse cases, it is somewhat surprising that some of these cases reach the point at which the family is deciding to try FGDM. Generally, sexual abuse cases make it this far in the process when other issues are

more prominent and/or the sexual abuse is not discovered right away. These cases usually involved concerns about a parent's failure to protect a child from abuse rather than actually perpetrating the abuse; thus these were more ambiguous child sexual abuse cases.

Table 4
Approved/Not Approved for FGDM Binary Logistic Regression All Referrals

Referral Characteristics	Regression Coefficient B	S.E.	Relative Risk Exp(B)
Children with parents	-.449	.242	.638
Children with relatives	.048	.269	1.050
Domestic Violence	.533	.339	1.704
Homelessness	.360	.282	1.433
Kinship Concern	.368	.417	1.444
Kinship Identified*	.461	.223	1.585
More than 1 father	.090	.231	1.095
Paternity concerns*	.509	.252	1.663
Mother arrested	-.137	.483	.872
Mother incarcerated*	1.255	.552	3.507
Mother is pregnant	1.690	1.146	5.419
Previous CPS	.348	.238	1.416
Previous TPR*	-1.069	.448	.343
Substance Abuse-any**	.644	.210	1.904
African American	.002	.259	1.002
"Other" race/ethnicity	-.510	.298	.600
Behavior of Child(ren)	.316	.273	1.372
Special Needs***	1.386	.328	3.997
Failure to Provide*	.843	.328	2.303
Improper Supervision*	.835	.408	2.305
Physical Neglect	.083	.218	1.087
1999-2000	.055	.223	1.056
Constant**	-.943	.363	.390

* $p <= .05$; ** $p <= .01$; *** $p <= .001$

For the final research question, the case characteristics were tested in the bivariate analysis along with some FGDM meeting process measures. The number of family members who attended the meeting was not significant in this analysis. Referrals in which the family developed a back-up plan, made specific requests for clothing, furniture, or legal assistance during the meeting, or specified during the meeting that the parents needed to obtain employment and housing and attend therapy, were more likely to develop a successful relative placement plan. Interestingly, all of these variables highlight the need for frequent exchanges of informa-

tion between the professionals and the family members during the meeting. Only the back-up plan characteristic remained significant in the logistic regression. Additional case review suggested that back-up plans were not necessarily significant because they were implemented but rather that the families' ability to develop back-up plans demonstrated their commitment to the FGDM process. Very few of the case characteristic questions were significant for this research question. Only homelessness and educational neglect were positively associated with the development of a plan in the regression model. Both homelessness and educational neglect are not typically child welfare problems that social workers address by placing the children in foster care. Usually in cases of homelessness referred to CPS, social workers would attempt to

Table 5
Agreed/Did not Agree to try FGDM Binary Logistic Regression

Referral Characteristics	Regression Coefficient B	S.E.	Relative Risk Exp(B)
Children with relatives	-.441	.436	.643
Domestic Violence	.994	.595	2.703
Homeless*	1.004	.471	2.729
Kinship concern	.838	.609	2.311
Kinship identified***	1.823	.422	6.192
More than 1 father	-.027	.392	.973
Father arrested	8.736	15.072	6224.345
Father incarcerated	-7.439	15.087	.001
Mental health**	1.677	.555	5.350
Mother arrested	1.394	.799	4.030
Mother incarcerated	-.584	.850	.558
Mother is pregnant	1.401	.991	4.059
Previous CPS*	.820	.385	2.270
Previous TPR	1.785	1.013	5.961
Substance abuse-any***	1.770	.386	5.869
African American	.861	.479	2.365
Caucasian	.447	.581	1.563
Special Needs***	1.937	.495	6.937
Abandonment	.728	.503	2.072
Emotional Abuse	-1.900	1.271	.150
Failure to provide	-.826	.574	.438
Improper Supervision**	2.278	.706	9.760
Sexual abuse**	3.061	.920	21.351
1999-2000	.095	.415	1.099
Constant	-4.217	.679	.015

* $p <= .05$; ** $p <= .01$; *** $p <= .001$

secure housing for the whole family rather than remove the children. Similarly, they would first enlist the help of a school social worker to try to get a child to attend school, rather than remove the children. When these types of cases to reach the point in which foster care is being considered, we can speculate that the social workers have run out of ideas and need some help in developing some alternative interventions.

Table 6
Developed a Plan/Did not Develop a Plan for FGDM Binary Logistic Regression

Referral Characteristics	Regression Coefficient B	S.E.	Relative Risk Exp(B)
Kinship concern	-1.015	.546	.362
Homeless*	1.481	.663	4.398
Mother is pregnant	6.677	18.574	794.026
Behavior of Child(ren)	-.863	.515	.422
"Other" race/ethnicity	.884	.661	2.421
Educational Neglect*	-2.600	1.287	.074
Improper Supervision	-.778	.568	.459
Back-up Plan*	.946	.430	2.574
Asked questions about CPS	.178	.558	1.194
Clothing requested	.391	.551	1.479
Furniture requested	.309	.611	1.362
Legal assistance requested	.690	.480	1.994
Obtain housing in plan	-.052	.459	.949
Attend therapy in plan	.734	.446	2.084
Obtain employment in plan	.059	.454	1.061
Constant	-.386	.654	.680

* $p <= .05$; ** $p <= .01$; *** $p <= .001$

Discussion

In this study, both child welfare professionals and family members independently chose to try FGDM more often in cases with identified kinship, parental substance abuse, improper supervision, and/or the children had special needs. The finding that identified kinship makes FGDM more likely should not be dismissed as self-evident. Family matters in Family Group Decision Making. When children have extended families who are willing to participate, FGDM is more likely to work. When they do not have any extended family, it will not. However, this study also suggests that measuring willing kinship is not as simple as counting the number of participants in a meeting or even the number of relatives willing to support a placement plan. Even a small number of active and involved kin were able to develop plans for diverting the children from foster care. When family members and social workers are engaged in the process of sharing ideas and resources, they can come up with creative responses to very difficult cases of child maltreatment.

Listed below are a few case examples of kinship already identified:

> The grandmother lived in a senior home and could not take the child. An aunt was willing to take the child with help with childcare, food stamps, etc. At the meeting, the aunt agreed to take the child with support provided by the grandmother and another aunt who also agreed to take in the child if the first placement did not work out.

> At the time of the referral, the relatives made arrangements for the children to live with the grandmother. Through the plan developed at the meeting, the grandmother agreed to continue to care for the children and an aunt agreed to take them if this placement did not work out.

> According to the referral, the mother was addicted to crack cocaine and an aunt and uncle wanted custody of the children. This family later decided they wanted to be licensed for foster care.

As illustrated by these examples, kinship already identified does not necessarily mean the children were placed with the identified relative or even that the children were placed through the FCC program, but having kinship identified made approval for the FCC program more likely. It should be emphasized that having kinship identified is not part of the official referral criteria and should not play a role in the approval process. Nevertheless, the professionals learn in practice that identified kinship makes the process easier. Even in a case, such as in the first example, in which a relative cannot take care of the child, a willingness to help proves to be useful in the plan developed by the family.

This study's finding regarding substance abuse is encouraging. There is tremendous interest in the co-occurrence of substance abuse and child maltreatment. According to a United States government report on substance abuse and child protection, service providers in these two fields do not work well together, and collaborative relationships are rare (U.S. Department of Health and Human Services, 1999). Conflicting perspectives between the two include different definitions of who "the client" is, what outcomes are expected under what time lines, and conflicting responses to relapse. Engagement and retention are extremely difficult in substance abuse treatment, making timely decisions about child welfare cases very complicated (U.S. Department of Health and Human Services, 1999). Family Group Decision Making may be able to address some of these concerns. Brining together substance abuse therapists, child welfare workers and family members in an FGDM meeting may allow them to develop solutions that address common concerns. For example, the children can remain with extended family while the parents pursue treatment, and the children know they will remain with family regardless of the outcome of the treatment. In some cases, the extended family may be able to provide the clout and motivation to keep the parents in substance abuse treatment. When family members feel they have less clout with the parents if the children are kept out of foster care, they can express this concern and develop a plan that will encourage the parents to complete treatment. The foster care cases that can drag on the longest include neglect and substance abuse, as well as improper supervision. Family Group Decision Making may be able to help families push the parents to address their addiction and begin to provide proper care for their children.

The cases that include children with special needs illustrate more of the potential benefits of FGDM. Often the parents in these cases may be well intended, but are struggling with the child's serious medical condition. When the child welfare system intervenes, the parents can become resentful. By bringing their extended family into the process through FGDM, this resentment can be diffused so that the parents focus their attention back where it belongs: on the welfare of their children. Here are some examples of special needs cases:

> The son has juvenile diabetes and the mother missed several of his appointments. The mother was angry that the child was removed from her care because she believed the CPS worker promised her that he would not be removed. In the family meeting it was decided that the grandmother

would take the child and she would monitor all the medical appointments, but the mother would be responsible for getting him to the appointments. Eventually, the child was returned to his mother.

The home is filthy and both children have medical problems that are not being addressed in a timely manner. One child (six months old) has a reflux disorder and was recently discharged from the hospital. The other child (eighteen months old) has an ear infection that is now in both ears. The hospital was also concerned about the children's lack of medical attention. The parents had a previous CPS complaint involving similar issues and Families First (an in-home foster care prevention program) was put in place but the in-home therapist's efforts were unsuccessful.

While the medical issues presented here are serious, the factor that is of most concern to the child welfare professionals is the failure of the parents to attend to their children's medical needs. The professionals may believe that the extended family could convince the parents to follow up on these medical issues more effectively than a social worker could. In some cases, such as in the last example, professionals have already tried to convince the parents to facilitate medical care and have been unsuccessful. Therefore, they may believe FGDM is worth trying.

Given the exploratory nature of this study, the results cannot be used to definitively determine which child maltreatment cases are likely to proceed with FGDM. However, the case characteristics most often associated with decisions to try FGDM provide some clues regarding the potential perceived benefit of FGDM. The research team drew from organizational theory to think about the significance of these results. An FGDM meeting, with family members and child welfare professionals developing a plan for the care and protection of children, is a child welfare application of Weick's suggestion to try face to face meetings in order to resolve problems of ambiguity (Weick, 1995). Overall, the findings from this study suggest that both family members and child welfare professionals may be more willing to try FGDM in cases without a straightforward course of action (such as those with parental substance abuse and mental illness, children with special needs and homelessness). Put simply, when social workers and family members are unsure what to do, they are more willing to try FGDM. This dynamic appears to be consistent with Weick's observations about ambiguity. In order to further explore whether FGDM is more frequently used in ambiguous cases, it will be necessary to survey work referring workers and family members and ask them when they think FGDM may be useful.

Case characteristics that were predictive of cases being approved by child welfare professionals were similar to those that were independently predictive of the cases in which families were wiling to try FGDM. These findings suggest there is some agreement about when to try FGDM between child welfare professionals and family members. Conversely, most of the variables tested in the analysis were not negatively predictive, suggesting that there are few case characteristics that were regarded by professionals or family members as uniformly inappropriate for FGDM. Within the FGDM field, there is some discussion about whether some types of maltreatment should be excluded from the process. In Kent County, child sexual abuse cases are supposed to be excluded. When the Kent County program is discussed at national conferences, conference participants are sometimes critical of this exclusion and the assumption that child sexual abuse cases cannot work with FGDM when other communities have had success with these types of cases. The analysis of the referral files shows that in some cases of child sexual abuse, the referrals in Kent County proceeded despite the intended exclusion of these cases. This finding highlights the ambiguity of child welfare. During the community planning phase, the decision was made to exclude child sexual abuse cases, but in practice these families often wanted to try FGDM because the cases involved the more ambiguous problem of a parent failing to protect a child from an abuser rather than the more concrete concern of a parent committing sexual abuse. The use of FGDM for child sexual abuse cases cannot resolve the ambiguity the people in Kent County share regarding the best way to serve

all sexual abuse cases, but for individual cases it can provide an opportunity for a wide variety of concerned people to come together and develop individual responses.

Conclusion

From 1970 to 1997, the number of children in the United States living in a household maintained by a grandparent increased 76 percent, from 2.2 million, or 3.2 percent of American children, to 3.9 million, or 5.5 percent of American children. Since 1990, the greatest growth by far has occurred in the number of grandchildren residing with their grandparents only, with neither parent present (Casper & Bryson, 1998). In 1997, approximately 200,000 children were living in kinship placements, meaning they were placed with relatives by the child welfare system. While this number is a fraction of the total number of children in the United States living with extended family, it represents 29 percent of all children in foster care (U.S. Department of Health and Human Services, 2000). These figures suggest that millions of families in the United States can facilitate kinship arrangements for children without the involvement of the child welfare system or a Family Group Decision Making service. They also suggest that within the child welfare system, there is a significant reliance on kinship care to care for children removed from their homes. For those families that include children who are at risk from child abuse or neglect, but are unable to facilitate kinship care on their own, FGDM may provide an effective means for helping them care for their children. If FGDM can be effective with these families, it may also prove to be a valuable addition to a child welfare system that is increasingly reliant on kinship care. While there are some families who may not need FGDM, and there are some families who may need more than FGDM can provide, there are many families for whom this intervention may be well suited. It would be very helpful to be able to identify specific characteristics associated with families who could benefit from FGDM and the FGDM processes that encourage good case outcomes. This study begins to address these issues.

This study provides some information about how families are selected for FGDM, how they decide to try FGDM, and how they are able to develop plans for keeping children out of foster care. Results suggest that child welfare professionals and family members are more willing to try FGDM, and that FGDM may work well, when it creates an opportunity for diverse participants to share their concerns and suggestions, in ambiguous cases of child maltreatment. In addition, the study found very few case characteristics that were negatively associated with decisions to try FGDM, suggesting that FGDM may be attempted in a wide variety of cases of child maltreatment.

This study also helps address some concerns raised by early critics of FGDM who argue that FGDM delegates the public child welfare system's authority and responsibility to families (Bartholet, 1999). As stated above, in the FCC program the referring social worker must approve the family's plan based on safety and permanency criteria, so FGDM is not an abdication of decision making to the family, but a sharing of it. This study begins to show why the sharing of responsibility between social workers and family members may improve child welfare decision making, as FGDM advocates believe it will.

Because this study did not link the decision to use FGDM with the outcomes of the cases served, it cannot address the effectiveness of FGDM. However, as noted above, a previous study attempted to make a comparison of client outcomes between Swedish cases served through FGDM and cases served without FGDM (Sundell and Vinnerljung, 2004). This article raises some potential concerns about the Swedish study as it suggests why there may be important differences between cases served with FGDM and those that were not, differences that go beyond the provision of FGDM services. In addition, this study may help communities that are considering trying FGDM to think about which cases may benefit from FGDM (Crampton, 2004).

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