



**IDAHO DEPARTMENT OF HEALTH AND WELFARE
CHILD PROTECTION AND WELFARE STAFF
PERCEPTIONS AND EXPERIENCES OF
FAMILY GROUP DECISION MAKING**

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Executive Summary

Evaluation Questions

This report addresses on the evaluation objective of identifying factors relating to FGDM utilization. This report focuses on the evaluation question; What conditions facilitate and impede utilizing FGDM services by IDHW personnel?

Method

Throughout IDHW regions 1 and 2, 28 potential participants were recruited through email correspondence from the evaluator and 23 agreed to participate, for an 82% response rate and an 8.8% margin of error. Following an informed consent procedure participants were asked questions about (a) their understanding of FGDM, (b) factors that influence their decisions to make referrals for FGDM, (c) their perceptions of how FGDM fits with IDHW agency and their personal practice (d) conditions that make FGDM easier and challenging to use as a practice tool, and (e) additional information that they wanted to include about FGDM.

Content analysis was applied to the data that included; (a) reading through the entire set of interview transcripts to identify initial codes to apply to the data, which resulted in 57 unique codes; (b) applying these codes to the data for initial analysis; (c) identifying codes that were common within logical subsets of questions; (d) identifying codes that were present across these logical subsets of questions; and (e) using the information from steps two, three, and four to identify themes in the content. The logical subsets of questions were (a) understanding of FGDM; (b) referral making factors; (c) FGDM fit with practice; (d) FGDM risks and benefits; and (e) facilitating conditions and barriers. The evaluator also applied quantitative frequency analyses throughout his work where it would inform the results.

Results

Highlights of the results include;

1. Most participants who were interviewed understood FGDM as being a case planning tool focused on safely maintaining natural families through engaging their existing support systems;
2. The level of engagement between the client family and their extended family, including fictive kin, is the first consideration participants apply when deciding about making an FGDM referral.
3. The data also indicate that participants are thoughtfully comprehensive when they evaluate the appropriateness of an FGDM referral with a specific case.
4. Participants perceive FGDM as fitting well with both the departments' family centered practice model and their own personal approach to practice.
5. The primary sources of this goodness of fit focus on family centered practice that empowers families through trusting their expertise about their situations.
6. The two most frequently stated risks associated with FGDM were (a) the presence of conflict in the extended family, and (b) exacerbating conflicts within families.
7. Some participants reported that although FGDM can be a powerful case planning tool that most workers would use earlier rather than later in a case, the time allowed between adjudication and case plan hearings precludes making a FGDM referral and incorporating the resulting family plan into what is presented in court. *This issue emerged as an overarching theme in the data.*
8. The two most frequently stated benefits of FGDM were (a) engaging family support systems, and (b) identifying family and child resources.
9. Participants reported that locations of FGDM services and meetings and transportation for families were barriers to family participation and for them making referrals for FGDM.

10. Facilitating conditions that were stated included; the neutrality of an outside facilitator; the engagement of the extended family and fictive kin, including the presence of kinship involvement or placement; the support of the IDHW and of individual colleagues, supervisors, and chiefs; the local availability of extended family members and other family support system members; and the opportunity to engage in a strengths based and family centered practice.

Two overarching themes that emerged from the data included; (a) IDHW staff members in regions 1 and 2 believe in empowering families through identifying their strengths and trusting family members' expertise; and (b) IDHW staff members consistently reported that they would make more FGDM referrals if they were able to have the process completed, resulting in a family plan, in a manner that coincided better with mandated case planning time frames, specifically case plan hearings.

Policy and Procedure Implications

The primary implication of these findings for policy and procedure is reconciling the tension between the current procedures for implementing FGDM and mandated time frames for case plan hearings in the courts. It is apparent that barriers to FGDM implementation are rooted in this practical consideration so thoughtful action is necessary to increase the diffusion of FGDM as a practice tool in IDHW regions 1 and 2.

Practice Implications

The primary practice implication of these findings is a positive one: Continue activities that diffuse the principles of the family centered practice model. The initial and ongoing training activities that support the family centered practice model diffusion should be continued. Since some IDHW staff members are independently applying methods akin to FGDM meetings with families they are

serving the department may want to consider methods of supporting them that will strengthen their ability to do this effectively.

In complex systems policy and practice are intricately interwoven. Fortunately this component of the FGDM evaluation has identified a specific policy and procedure implication that, if acted on, will enhance implementation of FGDM.

Acknowledgments

Program evaluation efforts include the efforts of many individuals and the individuals who have facilitated the activities resulting in this report should be acknowledged.

The Idaho Department of Health and Welfare (IDHW) child protection and child welfare staff members from IDHW regions one and two who so generously shared their thoughts and experiences, and took time away from managing very full work loads to participate in interviews, are owed a debt of gratitude. I am very grateful to the supervisors of the Coeur d'Alene, Kellogg, St. Maries, Sandpoint, Lewiston, Moscow, Orofino, and Grangeville IDHW field offices for their supporting staff participation and facilitating my communication with their workers to arrange for interviews. Completing this phase of the evaluation required extensive travel and Arlene Mortensen of the Idaho Child Welfare Research and Training Center (ICWRTC), through coordinating this travel, was instrumental in bringing this effort to fruition.

Patty Gregory and Rick Phillips of the ICWRTC, and Mardell Nelson, Roxanne Printz, and Brian Pope of the IDHW have my deepest thanks for their ongoing work with me on clarifying numerous issues throughout this evaluation. The ideas that they have so generously shared are interwoven throughout my work on FGDM in Northern Idaho. Michael Frumkin, the Dean of the Eastern Washington University School of Social Work has consistently supported my personal efforts and those of the ICWRTC, and for this I am certain we are all grateful.

No program could ever be implemented without the clients who participate. I am grateful to the clients who have engaged in FGDM meetings. Their efforts provided the substance of all that was discussed with the participants in these interviews.

Introduction and Overview

This report is part of a comprehensive evaluation of the Family Group Decision Making (FGDM) pilot program in Idaho Department of Health and Welfare (IDHW) regions one and two, conducted by Eastern Washington University (EWU) and the Idaho Child Welfare Research and Training Center (ICWRTC) for the IDHW. This report focuses on one part of the larger evaluation, specifically IDHW child protection and child welfare staff members' perceptions of, and experiences with FGDM.

This report addresses on the evaluation objective of identifying factors relating to FGDM utilization. To this end this report focuses on the evaluation question; What conditions facilitate and impede utilizing FGDM services by IDHW personnel? This question was answered through engaging in key informant interviews with IDHW child protection and child welfare staff members in the Coeur d'Alene, Kellogg, St. Maries, Sandpoint, Lewiston, Moscow, Orofino, and Grangeville IDHW field offices.

Method

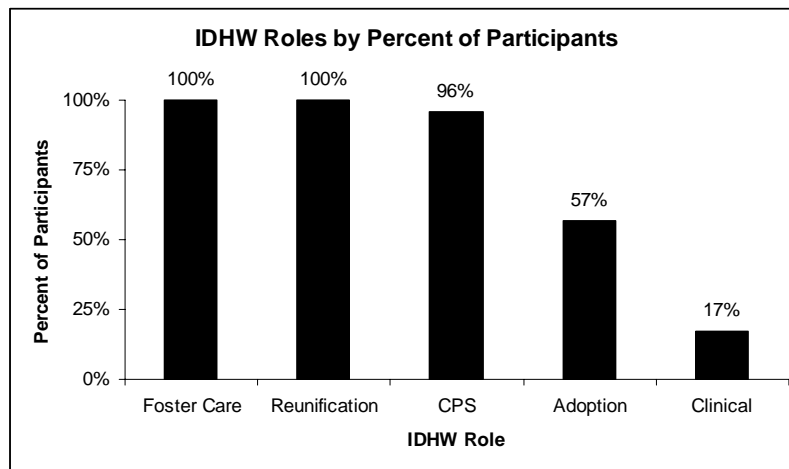
Participants

The evaluator contacted supervisors in the Coeur d'Alene, Kellogg, St. Maries, Sandpoint, Lewiston, Moscow, Orofino, and Grangeville IDHW field offices through an email message that described the purpose of the interviews and requesting contact information for field office staff members. All of the supervisors responded with the necessary contact information and the evaluator directly contacted each staff member using a standard email message (Appendix A). In some instances IDHW staff members initiated telephone calls with the evaluator to arrange meeting times.

There were 28 IDHW staff members who were recruited as potential interview participants. Of these 28 there were 23 who agreed to participate and were available for interviews, resulting in an 82% response rate. Every participant had primary responsibilities as a child protection investigator, child

welfare case manager, or a child welfare clinician. In some field offices the child protection and child welfare duties were combined for staff members. Participants had worked with IDHW for a median of four years, within a range between six months and 22 years. Twenty-five percent of the participants had worked with IDHW for two years or less and 75% had worked with IDHW for 9.5 years or less. Figure 1 displays the IDHW roles participants had engaged in by the percent of participants. As one can see all of the participants had engaged in foster care and reunification roles, and 96% had engaged in child protective services (CPS) roles. One remarkable finding is that workers who had engaged in CPS and foster care roles also identified themselves as being involved in reunification, which reflects a family centered practice orientation.

Figure 1. IDHW roles participants had engaged in by the percent of participants.



Interview Procedures

When the evaluator met each participant he initiated the informed consent through a conversation with them that included;

1. Beginning with a direct assurance that their participation in this conversation was voluntary and asking if they wanted to proceed;
2. Describing the overarching FGDM evaluation effort and where the interview fit into the evaluation;
3. A statement that they would be asked about;

- a. Their understanding of FGDM,
 - b. Factors that influence their decision to make referrals for FDGM or not,
 - c. Their perceptions of how FGDM fits with their agency and personal practice,
 - d. Conditions that make FGDM easier and challenging to use as a practice tool, and
 - e. Any additional information that you want to include about FGDM.
4. A description of the procedures being used to ensure their privacy and the confidentiality of their responses;
 5. A statement that their decision to proceed with an interview is completely voluntary;
 6. A statement that the interview questions, informed consent process and document, and the procedures for ensuring confidentiality were approved by the EWU Institutional Review Board for Human Subjects Research.

Once this conversation was completed the evaluator gave each participant a copy of the informed consent document (Appendix B) and asked them to read it. After each participant read the written informed consent document they were invited to ask any and all questions that they may have about participating. After any questions asked by potential participants were answered the evaluator asked them if they wanted to proceed with an interview. Once they verbally agreed to participate the evaluator asked them to sign the informed consent document. The evaluator retained the copy of the informed consent document signed by the participants and gave them an additional copy to retain for themselves. Every potential participant who was recruited agreed to participate in an interview.

The evaluator asked participants scripted questions and typed their responses into a Microsoft Access™ database that he had constructed to collect interview data. The database was on the evaluator's laptop computer that was password protected, and the database had an additional password protection. Data were transferred to a CD-ROM by the evaluator on return to Cheney, Washington and this disk was secured in his EWU office.

- The specific questions that the evaluator asked participants included;
1. Please tell me your name, how long you have worked for DHW, and in what roles.
 2. Please describe Family Group Decision Making to me in your own words.
 3. What characteristics of the alleged or substantiated child maltreatment in a case influence your decisions about making Family Group Decision Making referrals?
 4. What characteristics of the client family in a case influence your decisions about making Family Group Decision Making referrals?
 5. What characteristics of the child in a case influence your decisions about making Family Group Decision Making referrals?
 6. What other things that I have not asked about influence your decisions about making Family Group Decision Making referrals?
 7. How does Family Group Decision Making fit with the IDHW Family Centered Practice Model as you understand it?
 8. How does Family Group Decision Making fit with your own preferred approach to practice?
 9. What are some of the risks that you perceive from using Family Group Decision Making?
 10. What are some of the benefits that you perceive from using Family Group Decision Making?
 11. What conditions make it easier to use Family Group Decision Making as a practice tool for you?
 12. What conditions make it challenging to use Family Group Decision Making as a practice tool for you?
 13. What conditions make it easier to use Family Group Decision Making as a tool for the families you work with?
 14. What conditions make it challenging to use Family Group Decision Making as a tool for the families you work with?
 15. No evaluator can anticipate all of the conditions and circumstances surrounding any practice; What things have I not asked about that you

want me to know about Family Group Decision Making and your practice with families?

The evaluator asked follow up questions of participants to probe for meaning and clarity. Data were subsequently extracted from the database into a Microsoft Word™ document¹ for content analysis and SPSS™ for quantitative analysis.

Results

Data Analysis

The data analysis procedures followed the principles of Content Analysis². The steps that evaluator followed in this content analysis included;

1. Reading through the entire set of interview transcripts to identify initial codes to apply to the data;
2. Applying these codes to the data for initial analysis;
3. Identifying codes that were common within logical subsets of questions, including;
 - i. Understanding of FGDM,
 - ii. Referral making factors,
 - iii. FGDM fit with practice,
 - iv. FGDM risks and benefits,
 - v. Facilitating conditions and barriers,
4. Identifying codes that were present across these logical subsets of questions;
5. Using the information from steps two, three, and four to identify themes in the content.

The evaluator also applied quantitative frequency analyses throughout his work where it would inform the results. The initial coding procedures³ were described in the text above, and this results section will proceed to the codes that were

¹ This document contained 38 pages of text and 321 individual responses from participants.

² Berg, B.L. (2007). *Qualitative research methods for the social sciences – sixth edition*. Boston: Pearson Allyn & Bacon.

³ The initial coding procedures resulted in 57 distinct codes to apply with these data.

common to each logical subset of questions. When interpreting these frequencies one should apply an 8.8% margin of error to the data⁴.

Understanding of FGDM

Table 1 displays the percent of responses that corresponded with initial codes present in the understanding of FGDM subset of questions. There were 23 responses in this subset and the subset included the request “Please describe Family Group Decision Making to me in your own words.” As one can see in Table 1 the most frequent responses corresponded with the initial codes that included;

1. Child focused for safety, permanency, reunification,
2. Case planning,
3. Families support systems,
4. Focus on safety, and
5. Fictive kin.

These data indicate that most IDHW staff who were interviewed understood FGDM as being a case planning tool focused on safely maintaining natural families through engaging their existing support systems. This focus on safety reflects the primary responsibilities of child protection and child welfare systems as does the focus on permanency and reunification. It is encouraging that fictive kin were included in many staff members’ description of FGDM. The staff who were interviewed tended to view FGDM as a case planning rather than assessment tool, which is congruous with how FGDM is incorporated into the family centered practice model.

Referral Making Factors

Table 2 displays the percent of responses that corresponded with initial codes present in the referral making subset of questions. There were 91 responses in this subset and the subset included the questions;

⁴ This margin of error is based on Bernoulli’s binomial distribution with a response probability of .50, a 95% confidence level, and a sample size of 23 from a population of 28 IDHW staff who were identified by their supervisors as being in a position to make an FGDM referral.

1. What characteristics of the alleged or substantiated child maltreatment in a case influence your decisions about making Family Group Decision Making referrals?
2. What characteristics of the client family in a case influence your decisions about making Family Group Decision Making referrals?
3. What characteristics of the child in a case influence your decisions about making Family Group Decision Making referrals?
4. What other things that I have not asked about influence your decisions about making Family Group Decision Making referrals?

Table 1. Percent of responses present in understanding of FGDM question.

<i>Code Name</i>	<i>Percent of Responses</i>
Child focused for safety, permanency, reunification	43%
Case planning	35%
Families support systems	26%
Focus on safety	26%
Fictive kin	22%
Family centered	17%
Task oriented	17%
Empowering families	13%
Trusting family members as experts	13%
Use of an outside facilitator & neutrality	13%
Holding perpetrators accountable	9%
Identify family & child resources	9%
Prevent foster care placement	9%
Identify family strengths	4%
Overcoming impasses or roadblocks	4%
Preserving families	4%

As one can see in Table 2 the most frequent responses corresponded with the initial codes that reflected statements about the level of engagement between the client family and their extended family, including fictive kin. Although there are numerous other considerations that go into making an FGDM referral none of these were remarkable, especially when one applies the margin of error to the data. Nonetheless these data indicate that IDHW staff members are thoughtfully comprehensive when they evaluate the appropriateness of an FGDM referral with a specific case. These data also reflect a realistic perspective on the part of

IDHW staff members through the prominence of engagement between client and extended families and the possibility of engaging in FGDM.

Table 2. Percent of responses present in referral making factors questions.

<i>Code Name</i>	<i>Percent of Responses</i>
Family engagement - extended	26%
Family engagement - client	16%
Children's needs	13%
Using personal judgement	12%
Extended family conflict	11%
Families support systems	11%
Timing of referral in case activities	10%
Child focused for safety, permanency, reunification	9%
Focus on safety	9%
Kinship involvement exists	9%
Children's family bonding	8%
DHW staff using their own FGDM	7%
Identify family & child resources	7%
Sexual abuse or DV as limitations	7%
Children's involvement in meeting	5%
Extended family appropriateness	5%
Intergenerational abuse	5%
Use of an outside facilitator & neutrality	5%
Case planning	4%
Empowering families	4%
Family availability	4%
Parents functioning levels	4%
DHW colleagues & staffings encouraging FGDM	3%
Family centered	3%
Identify family strengths	3%
Overcoming impasses or roadblocks	3%
Trusting family members as experts	3%
Culture of family	2%
Family financial issues	2%
Family substance abuse	2%
Legal concerns, restraining orders, custody disputes	2%
Location of FGDM services & meeting	2%
Privacy and confidentiality of family	2%
Transportation for families	2%
DHW disagrees with family plan	1%
Fictive kin	1%
Prevent foster care placement	1%

FGDM Fit with Practice

Table 3 displays the percent of responses that corresponded with initial codes present in the FGDM fit with practice subset of questions. There were 46 responses in this subset and the subset included the questions;

1. How does Family Group Decision Making fit with the IDHW Family Centered Practice Model as you understand it?
2. How does Family Group Decision Making fit with your own preferred approach to practice?

As one can see in Table 3 the most frequent responses corresponded with the initial codes that included;

1. Goodness of fit with DHW practice,
2. Goodness of fit with personal practice preferences,
3. Family centered,
4. Empowering families, and
5. Trusting family members as experts.

These data indicate that IDHW staff perceive FGDM as fitting well with both the departments' family centered practice model and their own personal approach to practice⁵. It is encouraging that primary sources of this goodness of fit, in the minds of IDHW staff members, focus on family centered practice that empowers families through trusting their expertise about their situations.

FGDM Risks and Benefits

Table 4 displays the percent of responses that corresponded with initial codes present in the FGDM risks and benefits subset of questions. There were 46 responses in this subset and the subset included the questions;

1. What are some of the risks that you perceive from using Family Group Decision Making?

⁵ Although one will see that only 48% and 46% of responses were coded to reflect goodness of fit with IDHW and personal practice, respectively, a methodological note may illuminate this result. In content analysis a code may only be applied when a statement directly indicates that code. Although many of the other statements made by participants implied a perceived goodness of fit it would be methodologically unsound to treat them as directly reflecting this.

2. What are some of the benefits that you perceive from using Family Group Decision Making?

Table 3. Percent of responses present in FGDM fit with practice questions.

<i>Code Name</i>	<i>Percent of Responses</i>
Goodness of fit - DHW	48%
Goodness of fit - personal	46%
Family centered	30%
Empowering families	20%
Trusting family members as experts	20%
Sharing Power	17%
Identify family strengths	15%
Personal & DHW practice congruity	15%
Child focused for safety, permanency, reunification	13%
Families support systems	11%
Case planning	9%
DHW staff using their own FGDM	9%
Focus on safety	7%
Holding perpetrators accountable	7%
Identify family & child resources	7%
Principles of partnership	7%
Using personal judgement	7%
Contracting Referring as challenge	4%
Contracting Referring as challenge	4%
Preserving families	4%
Prevent foster care placement	4%
Timing of referral in case activities	4%
Children's needs	2%
DHW support of FGDM as positive	2%
Family engagement - client	2%
Family engagement - extended	2%
Family financial issues	2%
Least restrictive & intrusive	2%
Location of FGDM services & meeting	2%
Privacy and confidentiality of family	2%
Timing of referral response	2%

In table 4 both perceived risks and benefits associated with FGDM are included to approximate a holistic understanding of how these rank against each other. When one examines the data in the context of margin of error it becomes clear that no perceived risk or benefit remarkably stands apart from any other that is adjacent to it in the rankings. The approach that is taken here is to identify

the two most frequently cited risks and benefits, to separate out risks and benefits accompanied by a brief discussion, and to encourage the reader to digest these risks and benefits through their own lenses.

Table 4. Percent of responses present in FGDM risks and benefits questions.

<i>Code Name</i>	<i>Percent of Responses</i>
Families support systems	28%
Exacerbate family conflicts	24%
Identify family & child resources	22%
Extended family conflict	17%
Case planning	13%
Child focused for safety, permanency, reunification	13%
Focus on safety	11%
Privacy and confidentiality of family	11%
DHW disagrees with family plan	9%
Children's needs	7%
Extended family appropriateness	7%
Identify family strengths	7%
Prevent foster care placement	7%
Timing of referral in case activities	7%
Children's family bonding	4%
Children's involvement in meeting	4%
DHW support of FGDM as negative	4%
Empowering families	4%
Family preparation for FGDM	4%
Holding perpetrators accountable	4%
Intergenerational abuse	4%
Use of an outside facilitator & neutrality	4%
DHW colleagues & staffings encouraging FGDM	2%
Establishing permanency for children	2%
Family substance abuse	2%
Fictive kin	2%
Parents functioning levels	2%
Sharing Power	2%
Task oriented	2%
Trusting family members as experts	2%

The data in Table 4 identify the two most frequently stated risks as (a) the presence of conflict in the extended family, and (b) exacerbating conflicts within families. Other risks that were stated included; safety risks to children and family members; threats to families' privacy and confidentiality; IDHW staff members

disagreeing with the plan the family arrives at; extended family members may be inappropriate for or in the meeting; lasting effects of intergenerational abuse; family members' substance abuse issues interfering; and parents not being able to function at a level necessary for FGDM because of cognitive disabilities or mental illness.

Although not necessarily a risk, some IDHW staff members discussed the departments' emphasis on using FGDM as a negative thing in the context of time frames allotted to complete key tasks in a case. Specifically, although FGDM can be a powerful case planning tool that most workers would use earlier rather than later in a case, their stated reality is that the time allowed between adjudication and case plan hearings precludes making a FGDM referral and incorporating the resulting family plan into what is presented in court.

The two most frequently stated benefits of FGDM were (a) engaging family support systems, and (b) identifying family and child resources. Other benefits that were stated included; the possibility for more effective case planning; better prospects for child permanency and family reunification; addressing children's needs more fully; identifying families' strengths; preventing foster care placement; empowering families; holding perpetrators of abuse accountable; the neutrality of an outside facilitator; support from colleagues in case staffings; incorporating fictive kin; and a focus on goals and tasks.

Although an approximately equal amount of risks and benefits were stated, almost every IDHW staff member also stated that the benefits outweigh the risks, and that child protection and child welfare practice are never without risks. Some initial codes in Table 4 represent factors that are both risks and benefits, including; children's bonding with family members, which may be enhanced or worsened depending on events in the meeting, which also makes children's direct participation both a risk and benefit. Sharing power and trusting families as their own experts can be very powerful methods for improving family functioning. Sharing power with and trusting the expertise of family members who may behave inappropriately during the meeting could certainly create a risk from a potentially powerful benefit. The overwhelming majority of IDHW staff

members who were interviewed emphasized the importance of thoroughly preparing participants before holding an FGDM meeting can mitigate these risks while augmenting these benefits.

Facilitating Conditions and Barriers

Table 5 displays the percent of responses that corresponded with initial codes present in the FGDM risks and benefits subset of questions. There were 92 responses in this subset and the subset included the questions;

1. What conditions make it easier to use Family Group Decision Making as a practice tool for you?
2. What conditions make it challenging to use Family Group Decision Making as a practice tool for you?
3. What conditions make it easier to use Family Group Decision Making as a tool for the families you work with?
4. What conditions make it challenging to use Family Group Decision Making as a tool for the families you work with?

In table 4 both facilitating conditions and barriers to FGDM implementation are included best understand how these rank against each other.

As one can see in Table 5 both of the most frequently stated considerations were barriers. IDHW staff members reported that locations of FGDM services and meetings and transportation for families were barriers to family participation and for them making referrals for FGDM. Other barriers that were stated included; the FGDM referral process and the timing of responses to referrals; conflict within extended families, intergenerational abuse, and the inappropriateness of some extended family members for FGDM participation; families' financial issues and the availability of child care; family privacy and confidentiality issues; legal issues such as custody disputes, restraining orders, and conditions of probation or parole; parents levels of functioning; and embarrassment of the client family. The IDHW staff members reported that thorough and thoughtful preparation of family members could serve to mitigate several of these barriers.

Table 5. Percent of responses present in facilitating conditions and barriers questions.

<i>Code Name</i>	<i>Percent of Responses</i>
Location of FGDM services & meeting	25%
Transportation for families	18%
Use of an outside facilitator & neutrality	17%
Family engagement - extended	14%
Family understanding of process	13%
Contracting Referring as challenge	12%
Extended family conflict	12%
DHW support of FGDM as positive	11%
Family financial issues	11%
Child care	9%
Family engagement - client	9%
Timing of referral in case activities	9%
Family availability	8%
Families support systems	7%
DHW colleagues & staffings encouraging FGDM	5%
Family preparation for FGDM	5%
Sharing Power	5%
Empowering families	4%
Privacy and confidentiality of family	4%
Community Attitudes	3%
Focus on safety	3%
Identify family & child resources	3%
Legal concerns, restraining orders, custody disputes	3%
Parents functioning levels	3%
Timing of referral response	3%
Case planning	2%
Exacerbate family conflicts	2%
Family centered	2%
Family embarrassment	2%
Fictive kin	2%
Intergenerational abuse	2%
Kinship involvement exists	2%
Culture of family	1%
DHW staff using their own FGDM	1%
Extended family appropriateness	1%
Holding perpetrators accountable	1%

Facilitating conditions that were stated included; the neutrality of an outside facilitator; the engagement of the extended family and fictive kin, including the presence of kinship involvement or placement; the support of the

IDHW and of individual colleagues, supervisors, and chiefs; the local availability of extended family members and other family support system members; and the opportunity to engage in a strengths based and family centered practice.

Some considerations were framed by participants as both facilitating conditions and barriers, and included; the level of client families' engagement with their extended family; sharing power, which was discussed in the preceding section on risks and benefits; and ensuring the safety of children and all FGDM participants. Additionally, identifying family and child resources was discussed as a benefit of FGDM unless there were no such resource people available to a client family. Some IDHW staff members also discussed the fit between FGDM and the client family's culture as something that could either facilitate or obstruct successful FGDM implementation at the case level. The disconnect between using FGDM as a case planning tool and the tension between making FGDM referrals and meeting mandated time frames for case activities with the court was again discussed by several participants.

Open Question

A final "open" question was posed to interview participants. This question was "No evaluator can anticipate all of the conditions and circumstances surrounding any practice; What things have I not asked about that you want me to know about Family Group Decision Making and your practice with families?" Responses to such open questions can be telling because the content requested is not circumscribed by the evaluator and participants are encouraged to talk about things that they may have anticipated discussing in the interview but were not asked about. Table 6 displays the percent of responses that corresponded with initial codes present in the open question.

As one can see in Table 6 there were various responses to the question and these ranged across topics covered in the preceding subsets of questions. The one statement that, given the margin of error, was remarkable focused on the timing of FGDM referrals in the context of other case activities. This was initially identified as an issue in the FGDM risks and benefits subset of questions,

emerged again in the facilitating conditions and barriers questions, and was quite prevalent in response to the open question. Although not remarkable in the context of the obtained margin of error, the issue of community attitudes arose in response to this question and these responses focused on the relationship between IDHW, the county attorney’s office, the court, and local law enforcement. For any child protection and child welfare system to function effectively these relationships are of the utmost importance so although this response may not have been frequent it is salient.

Table 6. Percent of responses present in the open question.

<i>Code Name</i>	<i>Percent of Responses</i>
Timing of referral in case activities	30%
Location of FGDM services & meeting	13%
Community Attitudes	9%
Contracting Referring as challenge	9%
Identify family strengths	9%
Case planning	4%
DHW colleagues & staffings encouraging FGDM	4%
DHW disagrees with family plan	4%
DHW staff using their own FGDM	4%
DHW support of FGDM as positive	4%
Family engagement - extended	4%
Family preparation for FGDM	4%
Family understanding of process	4%
Fictive kin	4%
Focus on safety	4%
Identify family & child resources	4%
Legal concerns, restraining orders, custody disputes	4%
Privacy and confidentiality of family	4%
Timing of referral response	4%
Transportation for families	4%
Use of an outside facilitator & neutrality	4%

Content Themes

When the data include so many categorical codes that occur across different logical subsets a completely frequency based approach would be overly simplistic, and would essential generate no relevant themes because everything becomes a theme. The criteria applied here, in addition to the co-occurrence

across logical subsets one, is that of salience for the Department of Health and Welfare. Salience in this context means that an identified theme is informative to the IDHW about their current policies, procedures, or practices; that it relates to something the IDHW can act upon in some way; and that it identifies an implication for policy or practice that can be described in this evaluation.

Family Centered Staff

The IDHW staff members who were interviewed offered statements that indicated they were family centered in their practice with remarkable consistency. When one examines the frequencies in the preceding data tables this is not readily apparent, but when these responses are viewed in the aggregate what emerges is a portrait of remarkable diffusion of family centered practice values. IDHW staff members in regions 1 and 2 believe in empowering families through identifying their strengths and trusting family members' expertise.

IDHW staff members consistently reported that FGDM was congruous with both the departments family centered practice model and their own preferred approaches to practice. Some IDHW staff members apply methods akin to FGDM meetings independently with families they are serving. Specifically these staff members contact extended and fictive kin and actively engage their support of primary client families, both as individuals and collectively and collaboratively with the client families.

Case Planning Coordination

A theme that very clearly emerged across many logical subsets of questions was the disconnect between the current FGDM implementation process and meeting required mandates for case planning time frames with the courts. IDHW staff members consistently reported that they would make more FGDM referrals if they were able to have the process completed, resulting in a family plan, in a manner that coincided better with mandated case planning time frames, specifically case plan hearings. Although these mandates were developed at the macro-systemic policy level any efforts the IDHW can make to

reconcile this tension is likely to increase the diffusion of FGDM throughout regions 1 and 2.

Conclusions

Strengths and Limitations

The strengths of the evaluation work reported here include the high response rate from participants who were recruited; the use of in person interviews to collect the data, which allowed for probing and clarification of meaning; the use of mixed methods in the content analysis to guard against researcher bias; and discussing the practical implications of the findings as a utilization focus. The weaknesses of this study include limited generalizability to IDHW regions 1 and 2; a margin of error that is slightly higher than is desirable (e.g.; 5%); and the risk of undue subjectivity when the data were analyzed for content themes, which is present in any qualitative research method.

One should bear in mind that this study and report are one part of a larger evaluation effort. Evaluation activities that are concurrently underway include: analyzing data from FGDM providers case files to identify implementation trends; and using data from the FOCUS database and the IDHW data warehouse to analyze system outcomes associated with FGDM implementation. When taken together, these further analyses can inform IDHW administrators, program managers and chiefs, and front line staff about the overall effectiveness of FGDM and case characteristics that have a strong relationship to FGDM outcomes.

Policy and Procedure Implications

The primary implication of these findings for policy and procedure is reconciling the tension between the current procedures for implementing FGDM and mandated time frames for case plan hearings in the courts. Since these mandates were developed at the macro-systemic policy level the IDHW approaching a solution through altering these mandates would require a Herculean effort that might not succeed. This leaves the IDHW with modifying

the current FGDM implementation procedures. These modifications could range from increasing the efficiency of the referral process and improving the timeliness of feedback from FGDM meetings to moving FGDM to a completely in house program.

Any of these modifications will have intended and unintended consequences attached to them and will thus require careful deliberation. Nonetheless thoughtful action is necessary to increase the diffusion of FGDM as a practice tool in IDHW regions 1 and 2. It is apparent that barriers to FGDM implementation are rooted in this practical consideration rather than any values based conflicts within the IDHW so attending to these case pragmatics will likely be fruitful for the department.

Practice Implications

The primary practice implication of these findings is a positive one: Continue activities that diffuse the principles of the family centered practice model. As stated previously, IDHW staff members believe in empowering families through identifying their strengths and trusting family members' expertise. The initial and ongoing training activities that support this practice model diffusion should be continued.

In complex systems policy and practice are intricately interwoven. Fortunately this component of the FGDM evaluation has identified a specific policy and procedure implication that, if acted on, will enhance implementation of FGDM. Such an enhancement is congruous with both IDHW and staff members' orientation to family centered practice and should be seriously considered.

Lessons Learned

In any program evaluation effort unanticipated things happen, and these are appropriately viewed as learning opportunities. This section will briefly describe the lessons learned during the first year of the evaluation, including; establishing access to data; challenges in using students as research staff; and the impact of IDHW staff workloads on evaluation activities.

Data Access

Two areas of data access provide learning opportunities for the IDHW and the evaluator. First, data from the FOCUS database are to be used for the outcome evaluation and accessing these data has been challenging. Challenges have primarily been around the availability of IDHW information technology staff members to work with the evaluator in developing the appropriate queries. Although the evaluator has been in direct contact with IDHW information technology staff members since December 2006 no meetings have been scheduled. During the April 2007 IDHW Evaluation Board meeting this was discussed and a strategy to gain access to FOCUS data was discussed. Part of this strategy included conveying to IDHW information technology staff members that the evaluator wanted to engage in collaborative data sharing through working with them to develop basic queries of the FOCUS system that would enable him to work independently on more complex queries for the outcome evaluation. To date no access to FOCUS data has been granted to the evaluator, and he is turning to the IDHW Evaluation Board and administration for additional help.

Another data access issue arose recently with one of the contract FGDM providers. Specifically, one of the providers has expressed reluctance for the evaluation team to collect data about FGDM implementation from their hard copy files. Although the evaluator provided assurances of ethical protocols being followed, including documented approval from the EWU Institutional Review Board for Human Subjects Research (IRB), the provider remains hesitant to allow access to their files and stated that they were awaiting feedback from the IDHW. It appears that the solution to this data access challenge lies with the IDHW and can be easily implemented. The required data are in hard copy forms that the provider sends copies of to the IDHW regional office where they get referrals from. What is suggested as a solution is for the evaluator to;

1. Travel to the IDHW regional office and make copies of the forms for each case referred for FGDM;

2. Bring those copies to his EWU office and keep them secured in the same way other confidential evaluation documents (e.g.; signed informed consent forms) are maintained;
3. Have the evaluation research assistant enter these data into the electronic database developed for this purpose (which is being used to collect data from another provider);
4. Shred the forms on an ongoing basis as the data are entered.

This approach, in addition to resolving this data access issue, has the benefit of cost savings to the IDHW on the basis of less extensive travel for data entry purposes. Following discussion in the next IDHW Evaluation Board meeting the evaluator will prepare the necessary IRB protocol change before proceeding with this solution.

Students as Research Staff

This program evaluation has always used student employees as research assistants. These employees have been graduate students and as such they have numerous pressures to cope with. Coping strategies of graduate student employees vary considerably and one unfortunate result is that sometimes their work as employees suffers considerably. Although the current graduate student who is the research assistant for this evaluation is doing excellent work the same cannot be said about their predecessor. In conversations with colleagues in academic institutions and public agencies it is clear that this experience is not unique to this evaluation, the IDHW, or EWU. Since the IDHW is committed to using evidence to improve practice an appropriate strategy is to recruit and hire permanent research staff. This has already been implemented at the ICWRTC with one part time employee with promising results. Although research experience is an important part of graduate education, product delivery is also important, so developing core permanent research and evaluation staff is a worthwhile consideration.

IDHW Staff Workloads

Although the IDHW staff who participated in this component of the evaluation were very accommodating and deserving of our gratitude, it is apparent that their workloads would hinder their participation in much program evaluation activity. Willingness to participate was not an issue but availability was. Although the availability issue was exacerbated by the travel considerations involved in conducting interviews, it should be stated here that there is not a great deal of flexibility available to IDHW staff members in fulfilling their workload obligations. It sometimes required weeks of effort to arrive at an interview schedule that would optimally meet participants' needs, and some potential participants were excluded from evaluation interviews because of scheduling and workload issues. It is also quite possible that data access issues around the FOCUS system could be related to workload issues. The IDHW has commissioned a workload study and the extent to which they can apply the results of his study to positively impact staff workloads will surely benefit the department and its employees.

Appendix A: Email Recruitment Message for IDHW Staff

Dear Colleagues,

My name is Ed Byrnes and I am with the EWU School of Social Work. I am working with the Idaho Child Welfare Research & Training Center as the evaluator for the Family Group Decision Making (FGDM) Pilot in regions 1 & 2.

As part of the evaluation I am interviewing IDHW child welfare case managers about this project. It is important for me to interview case managers whether or not they make FGDM referrals. The interview questions are about how you arrive at decisions on whether or not to make an FGDM referral, how FGDM fits with the DHW and your personal practice models, your perceptions of the risks and benefits of FGDM, conditions that help and make it more difficult to use FGDM as a practice tool, and other ideas and experiences you have around FGDM.

Your participation in these interviews is voluntary. The interviews will take between 30 and 45 minutes each. The identities of individuals who participate in the interviews, and their responses, will be kept confidential and I will have sole access to this information. The interview questions, procedures for protecting interviewees' privacy, and the informed consent statement have all been approved by the IDHW and also the EWU Institutional Review Board.

Because I am traveling from Spokane I would prefer it if I can interview all of you at your offices in <Field Office Location> during one day. I would like to interview you on <Proposed Interview Date> in <Field Office Location>. Please reply with any times during either of this day that would be impossible for you to meet during, since with advance notice we can schedule your interview times to fit as well as possible. I will then reply with a suggested interview schedule and travel to <Field Office Location> to meet with you all.

I would like to begin this process as soon as possible so please contact me about this as soon as you can. If you prefer to call me my office phone number is 509-359-2294 and my cell phone number is 509-879-3958.

Please allow me to thank you in advance for helping with this evaluation through participating in these interview meetings. I look forward to meeting each of you in person.

Sincerely,

Ed Byrnes

<Attached v-card>
Edward C. Byrnes, Ph.D.
Associate Professor
School of Social Work
Eastern Washington University
121 Senior Hall
Cheney, WA 99203
(509) 359-2294
ebyrnes@mail.ewu.edu

Appendix B: Informed Consent Document

Consent Form
Evaluation Key Informant Interview: Family Group Decision Making

Principal Investigator

Edward C. Byrnes, Ph.D.
Associate Professor
School of Social Work
Eastern Washington University
121 Senior Hall
Cheney, WA 99004-2441
(509) 359-2294

Introduction

You are invited to participate in this evaluation through an individual interview. This document provides you with information about this evaluation on which to base your decision about participating. Dr. Byrnes will discuss the evaluation with you, and review everything in this document. If you decide to participate in this evaluation interview you will be asked to sign this document, which means that you understand what you are being asked to do and that you are participating voluntarily.

Purpose and Benefits

The purpose of this study is to help the Idaho Department of Health and Welfare understand how Family Group Decision Making is being implemented. The Idaho Department of Health and Welfare will use the results of this evaluation to continue improving services to its clients, through innovations like Family Group Decision Making. The community will benefit from this evaluation because information will be used to guide training and implementation activities around Family Group Decision Making. The only direct benefit to you as a participant is knowing that you have participated in a process that may improve your community.

Procedures

If you decide to participate in this study you will be asked to spend approximately 90 minutes answering questions as part of an individual interview. The questions will be about; (a) your understanding of FGDM, (b) factors that influence your decision to make referrals for FDGM, (c) your perceptions of how FGDM fits with your agency and personal practice (d) conditions that make FGDM easier and challenging to use as a practice tool, and (e) additional information that you want to include about FGDM. You are free to answer only the questions that you want to, and you may stop participating in the interview any time you want to. Your answers to questions will be recorded in writing by Dr. Byrnes.

Evaluation Key Informant Interview: Family Group Decision Making

Risk, Stress or Discomfort

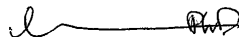
The risk from participating in this evaluation interview is possible violations of your privacy.

No evaluator or researcher can guarantee your absolute privacy. The following steps are being taken to ensure that your privacy is protected;

- 1) The written record of your answers to the questions will be kept in the physical possession of Dr. Byrnes until these written records are placed in a locked file cabinet at Dr. Byrnes' Eastern Washington University office,
- 2) No information that specifically identifies you as an interview participant will be shared with anyone,
- 3) The final evaluation report will not include any information which could possibly identify any interview participant, if you are directly quoted no information that could possibly identify you will accompany the quote, and
- 4) On or before the last day of September 2111, three years after the evaluation is completed, the written records of your answers to the questions will be physically destroyed by Dr. Byrnes.

Other Information

Since Dr. Byrnes will know your identity, your participation in this study is confidential, but you will not remain completely anonymous. If you feel uncomfortable answering any of the questions during the interview you are free to not answer it without offering a reason. You are free to stop participating in this interview at any time without affecting your current or future relationship with Dr. Byrnes, with Eastern Washington University, or with the Idaho Department of Health and Welfare. If it appears to Dr. Byrnes that continuing to participate in this interview exposes you to risks beyond what are described here you may be involuntarily withdrawn from this evaluation. If you have any concerns about your rights as a participant in this evaluation, or have any complaints you wish to make, you may contact Sarah Keller, Chair, Institutional Review Board for Human Subjects Research (509-359-7039) or Ruth Galm, Assistant Vice-President for Grants and Research Development (509-359-7971/6567).



Edward C. Byrnes, Ph.D.

August 2, 2007

Date

The evaluation interview described above has been explained to me, and I voluntarily consent to participate in this interview. I have had an opportunity to ask questions. I understand that by signing this form I am not waiving my legal rights. I understand that I will receive a signed copy of this form.

Signature of Participant

Date