

Improving Outcomes by Improving Practice

A Practiced Focused Newsletter

Family Team Conferencing



The Child Welfare Policy and Practice Group

The Child Welfare Policy and Practice Group is a nonprofit technical assistance organization committed to improving outcomes by improving practice. Its work has spanned over twenty states and focuses on the development of front-line practice that is strengths, needs and family team based, individualized and dedicated to safety, stability, permanence and well-being. Its technical assistance includes practice model development, strategic planning for practice model implementation, curriculum development, training and training of trainers, supervisory coaching, practice coaching and practice evaluation.

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Tanya's Story



Tanya is a young mother with four daughters. The oldest child is eight years old and her sisters are five, three and one. The eight year old was in the third grade and her sisters were being cared for by a variety of family members when Tanya was able to work. Terrence is the biological father of all four girls and he is in and out of the home. At the time of the planned family meeting he was seeing Tanya but living with his mother who resided nearby. Tanya was working at two separate temp jobs during which three calls were made to

the central abuse hotline reporting that her eldest daughter was sleeping in school, was very thin and had raw red and bleeding patches on the skin of her arms and neck.

CPS investigators had visited the home after each call and met with Tanya who resented the intrusions and accusations that she was not properly caring for her children. Despite repeated assurances by Tanya that her daughter was getting enough rest and receiving proper care for her allergies and eczema, which she stated led to the red raw patches, the school continued to have concerns.

All of the caretakers, the paternal grandmother and the reporter of the abuse were interviewed and prepared for the planned Family Team Conferencing (FTC). Between preparing for the conference and the conference date, a fourth call was made to the abuse registry with similar complaints. The supervisor of the unit handling the calls made a decision to remove the children until the reasons for the child's continued symptoms could be determined. The caseworker who was facilitating the conference requested that the team meeting be allowed to go forward to see if some other approach could be taken other than removal. The supervisor reluctantly agreed but insisted upon attending the conference to observe what plans might be developed that would address the children's needs.

At the conference, several of Tanya's aunts, her grandmother, Terrence's mother, the worker, the supervisor and the facilitator were in attendance. As Tanya told her story, she included many of the details about the difficulty of caring for her daughter's allergies to several foods and severe eczema. Some of the aunts who cared for the girls did not know these details. They had been serving sandwiches for instance when the child was allergic to wheat. They did not know about only bathing children with eczema in tepid water and using only natural fabric clothing to reduce inflammation. There were several examples of ways that the condition could be improved. All committed to following the routines that Tanya followed based on the advice of her pediatrician.

While Tanya refused to have the school counselor at the first conference, the counselor was invited to the subsequent conferences and was able to learn from the family about the variety of ways to help address the eczema and allergy symptoms that were still occurring but diminishing in school. Without the FTC, it is likely that the girls would have suffered the trauma of removal from their mother and possible separation from each other.

Family Team Conferencing

All families use teams to deal with the challenges they face. A team may be as small and informal as parents conferring on how to discipline a child or a new mother talking with her mother about responding to a child's illness. Or the family's team might be a more formal one, consisting of parents and a teen son who is experiencing poor academic performance meeting with a school guidance counselor. Family teams are routinely used by families to address relatively minor issues like these. However there are times when larger teams are needed, such as when siblings must choose a path of care for a failing parent. In circumstances like this, teams may become more formal, where physicians, hospice professionals, legal professionals and ultimately funeral home staff may be added. Typically, the more complex and urgent a challenge the family is facing the more likely it is that formal team members (usually professionals) will be asked to join the team. It is also likely that the role of formal team members (professionals) is likely to be more episodic, responsive to an escalating problem or specialized issue, than ongoing.

In The Child Welfare Group's (CWG) experience in training and coaching family teaming practice and in conducting over a thousand case reviews in the Qualitative Service Review (QSR)¹ process, it has found that the addition of formal team members to the family team can lessen the family's sense of ownership of the team. Such team meetings are more likely to be experienced by parents as the professionals' team due to their higher status and expertise in selected areas. In its QSR work, CWG always asks families who have been a part of such meetings in child welfare, "Who's team meeting was this?" Not surprisingly many families describe them as the agency's meeting. The power dynamic in such meetings tilts heavily toward professionals. Not only may the meeting be perceived as the agency's, but unfortunately the resultant plan or decision will be viewed as the agency's as well. Supporting full family involvement can not only increase a family's investment in the plan, it also permits their insight to sharpen assessment and individualization of services and supports.

¹The QSR is a practice improvement approach designed to assess current child and family outcomes and system performance in a representative sample of cases by gathering information directly by interviewing families, children and service team members.

Dion's Story

This is a case in which a mom and her young son Dion were in a drug treatment facility several hours away from the city in which her family lived. Her immediate family included her sister, her brother and her mother and father (divorced). Dion's father was not involved in her life or that of their child due to his continued drug involvement. Mom had progressed well in her treatment and was due for release to a halfway house soon.

The Family Team Meeting was held in the home of her brother. Invited to the meeting were her brother's housemate and mom's mother and father. His current wife was not invited. Family dynamics were such that mom wanted to position herself between her sister and the seat she saved for her father. She wanted to face her brother and have her mother sit between her sister and brother, making sure that her mother and father were separated from each other in the meeting. Mom felt that her mother's tendency to blame, control, and create conflict could be managed best in this way. This turned out to be a wise decision. Mom's desired outcome for the meeting was to plan for her future, complete her college education, choose a location for her and Dion to live after her release and to nurture her relationships with Dion and her family, including Dion's cousins.

This mom's informal support system was the key to a successful meeting – it truly was the mom's and her family's meeting and they knew and managed the dynamics better than the meeting facilitator or social worker could have. In addition to facilitating progress in the case, the social worker learned more about mom and the family during the meeting than could have been learned in any other setting.

Mom's brother showed his support for mom by hosting the meeting and encouraging mom to move to the town where he and her sister live, by offering ideas for how she might explore possibilities for getting back in school and by offering to assist mom in finding housing. Mom's brother and his housemate could understand mom's struggles with drugs and support her recovery, as the housemate is a recovering alcoholic and her brother has stood by him through the recovery process. Mom's sister was very supportive of her and forgiving of her decisions and mistakes, as she knew the family history and the losses and stresses mom had experienced due to the parents' divorce. She encouraged mom, holding her hand as she shared feelings that have been difficult to talk about for years (e.g. the pain mom suffered when her parents divorced – her father was her primary emotional support and he was gone from the home).

This healing aspect of the meeting would probably not have been possible without the support of both her siblings. Her sister offered to help with child care while mom pursued her education and attended support group meetings. Dad was loving and supportive, recognizing his daughter's strengths and expressing them to her, which was very important for her to hear. The entire family recognized that dad

would not be able to be as involved as others in helping mom, due to his current wife's feelings toward dad's first family. Mom's mother behaved in a restrained manner during most of the meeting, praising mom for returning to her spiritual roots and encouraging her to stay on the right track. She did attempt to turn the focus on herself once or twice and mom's siblings were able to redirect her.

As in all meetings, a "What Can Go Wrong?" plan was developed. The main thing identified that could go wrong was that mom had outstanding criminal charges in another municipality and might have to go to jail if found guilty. A contingency plan was made for who would take care of Dion, how connections could be maintained between mom and Dion during a separation and other aspects of her possible incarceration. The next meeting was set, with the family agreeing, at the brother's suggestion, to hold the meeting at the drug treatment center, so they could visit mom and support her continued successful recovery.

As it turned out, the follow-up meeting was held at the treatment center and went well. Shortly afterward, mom's court hearing was held and resulted in her incarceration. Mom and the family were disappointed, of course and the good news is that they had a workable contingency plan which they implemented.

This family was swerved by New Jersey's DCF and reflects the role of family teaming in that reform.



The Emergence of Formal Team Meetings

Team meetings have been used in child welfare since its earliest days, beginning with agency staffing of cases. These meetings usually seek to broaden professional input into decision-making and family participation is infrequent. Multi-disciplinary meetings, especially related to cases of severe abuse and neglect, were created to include decision-making input from specialists outside of child welfare, such as medical, law enforcement and mental health professionals. Family involvement was infrequent in these settings as well. In the past several decades, team meeting models have sought to increase family involvement in decision-making and Family Group Decision Making, Family Unity Meetings, Team Decision-Making and other family group conferencing approaches emerged to address this need. In the area of mental health, Wraparound practice employs team meetings to involve families and youth, assess, craft plans, problem-solve and coordinate interventions. All of these approaches recognize the family's expertise about their strengths and needs and lead to improved system responses to those needs.

The Family Team Conferencing Approach

FTC (called Family Team Meetings by some systems) was selected as the topic for this newsletter because of continuing evidence in QSRs that the lack of ongoing, regular teamwork is a major contributor to poor outcomes. As this edition will address again later, even the most competent team decision is largely dependent on the ongoing work that occurs following the team meeting to achieve desired goals. When poor team formation and functioning are present, family involvement diminishes, coordination and vital information sharing declines and accountability recedes. Not surprisingly, outcomes suffer when these vital practice functions are not performed.

The Evolution of Family Team Conferencing

The FTC approach grew out of a child welfare class action settlement agreement in Alabama in the 1990s, involving a case filed by the Washington, DC based Bazelon Center for Mental Health Law, The Alabama Disabilities Advocacy Program, the State ACLU and the Southern Poverty Law Center.

In that case, titled after the named class member, R.C., the original plaintiff class was composed of children in the child welfare system with mental health needs, but later grew to include almost all of the children in the system.² The settlement agreement contained a set of practice principles which the child welfare system committed to fully implement in all of its counties over a multi-year period. Implementation of the principles was intended to create a child welfare system of care. System of Care and Child and Adolescent Service System Program (CASSP) concepts played a significant role in the provisions of the settlement. The practice-related core of the R.C. principles included the following:

Class members and their families shall have access to a comprehensive array of services, including intensive home-based services, designed to enable class members to live with their families and address their physical, emotional, social and educational needs.

Class members and their families shall receive individualized services based on their unique strengths and needs. (Services must be adapted to class members and their families; class members and their families must not be required to adapt to inflexible, pre-existing services that may not be effective.)

Services to class members and their families shall be delivered pursuant to an individualized service plan. (Individualized service plans shall be based on a comprehensive, individualized assessment of the strengths and needs of the class member and his/her family. The “system of care” shall carefully monitor implementation of the individualized service plan and the progress being made toward the goal and objectives of the plan. The goal and the objectives of the individualized service plan will be updated as needed.)

Class members, parents and foster parents shall be encouraged and assisted to articulate their own strengths and needs, the goals they are seeking for themselves and what services they think are required to meet these goals.

Class members, their parents and foster parents shall be involved in the planning and delivery of services.

The “system of care” shall ensure that the services identified in individualized service plans are accessed and delivered in a coordinated and therapeutic manner.

It became apparent to the system’s child welfare leadership that to fully implement these (and other) principles in all sixty-seven counties would require the creation of a new practice culture which existing child welfare approaches could not produce. These principles set the expectation for a high degree of family involvement in planning and decision-making, creation of strength and needs-based, individualized plans, highly coordinated service delivery and services matched to each family’s unique needs.

²Paul Vincent, CWG Director was Alabama’s child welfare director during the first six years of the R.C. reform and several senior CWG consultants held leadership positions there.

Although it was not described as such in the settlement, the principles formed an early version of a practice model that in time family teaming would become an integral part of.³

Staff would need (and ultimately received) training and coaching in all of the practice areas to include engaging and building trusting relationships with families, strength and needs-based assessment and individualized planning, to achieve fidelity with the principles. But because of the expectations for family inclusion and voice, comprehensive assessment, service coordination and individualized planning, it seemed unlikely that the caseworker alone could achieve these objectives. System representatives had visited sites with innovative practices. After seeing how Wraparound child and family team meetings included families, individualized planning and coordinated a high level of services, that concept, with some modifications for the settlement environment, seemed to offer guidance for a process that would integrate application of the principles. This new meeting approach, called at the time Individualized Service Planning (ISP) Meetings, became the foundation for FTC. It was also informed by the individualized planning principles of the Individualized Educational Programs (IEP) process, engagement approaches from intensive family preservation services and the person-centered services philosophy of developmental disabilities practice.

Even in the early, more experimental period of the reform, implementation of the principles, with FTC as a foundation, produced significant improvements in outcomes. Fewer children entered care, lengths of stay declined, reunifications increased, placement disruptions were reduced and the use of congregate care diminished.

How is Family Team Conferencing Different from Other Approaches?

A primary construct underlies the FTC approach – a set of overarching principles of practice within which it operates. These are:

- Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them. The quality of this relationship is essential to engaging the child and family in a process of change.
- Children and families are more likely to pursue a plan or course of action that they have a key role in designing.
- When children and families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change.
- The family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time.

³For more information about practice models see *Adopting a Child Welfare Practice Framework* at <http://childwelfaregroup.org/documents/Framework.pdf>.

- Decisions about child and family interventions are more relevant, comprehensive and effective when the family's team makes them. Families should always be core members of the team with the goal of becoming the driver of the team.
- Family teams should be created to be sustainable supports for the family after the formal system exits.
- Assessments that focus on underlying needs, as opposed to symptoms, provide the best guide to effective intervention and lasting change.
- Plans that are needs-based rather than service-driven are more likely to produce safety, stability, permanency, well-being and adequate parental/caregiver functioning.
- Coordination of the activities of case contributors is essential and works most effectively and efficiently when it occurs in regular face-to-face meetings of the family team.
- Reunification occurs more rapidly and permanently when visiting between parents and children in custody is frequent and in the most normalized environment possible. Office based visits and supervised visits are the least normalized environment.
- Success in school is a reliable predictor of child well-being. When the direction of planning for safety, stability and permanency is fully integrated with school needs and plans, children are more likely to make progress in all of these areas.
- Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time.
- Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports.
- The service array should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are provided in the family's natural setting or for children in custody, the child's current placement. If services are limited to delivery in a particular place, children often have to move to receive them. Services should be flexible enough to be delivered where the child and family reside.

- Many of the services and resources that children and families find most accessible and responsive are those established in their own community, provided within their own neighborhoods and culture.

All teaming approaches share a set of common values: the goals of safety, permanence, stability and well-being for children, involvement of families and their informal supports, shared planning and decision-making and strength-based practice, among others. Teaming approaches differ in their origins and some may give greater emphasis to certain goals than others. The characteristics of FTC, some of which differ from those of other teaming approaches, are as follow:

1. The FTC is part of a larger model of practice, not a free-standing approach. FTC assumes that systems will work concurrently on developing a workforce whose practice is consistent with the principles referenced previously.
2. In addition to the fundamental goal of helping children achieve basic goals, the FTC also seeks to develop a durable team that can sustain the family over time, after formal supports conclude. Too often when professional, formal supports end at case closure, families are not prepared to function independently and have few other options other than re-entering the formal system. A sustainable team which includes informal supports and neighborhood and community resources should be available to the family for the long-term.
3. The family team is formed at the earliest period of system involvement and continues to be active until case closure. Teams meet regularly to assess, plan and adapt interventions based on changing circumstances. Case planning, in addition to key decision-making, is the responsibility of the team. Team meetings include but are not limited to critical decision-making events, like removals or placement disruptions. In FTC, the family's needs determine the frequency of meetings, with the goal of crafting or adjusting strength and needs-based, individualized plans that lead to safety, stability, permanency and well being.
4. Like some other teaming approaches, the team composition is chosen by the family. Families are prepared in person before their first conference, to provide an overview of the teaming process, enlist them in identifying individuals they wish to join their team and prepare them for their role. The preparations meetings are relatively brief, lasting usually an hour or so and may be a part of other normal interaction with the family. Team members new to the process are also prepared in advance, by phone or in person.
5. Facilitation of the FTC is usually led by the caseworker, who has received family engagement and teaming training. The availability of expert full-time facilitators is useful, to assist in coaching staff in facilitation and leading particularly complex conferences. Caseworkers are chosen for this role for practical reasons, because the FTC process is employed with all families and conferences are used for both case planning and decision-making. It is not possible to



assign facilitation responsibility to fulltime facilitators because the volume of conferences is too great when teaming becomes the way all important business gets done across the life of a case. In many situations, a family member or young adult transitioning out of care assumes responsibility for leadership of the team as their capacity to do so is strengthened.

6. In FTC, what happens between conferences is as important as what happens in them. QSR results consistently show that where only event-driven team meetings are provided, their infrequency limits their ability to address poor ongoing functional teaming (sharing vital information, coordinating services and joint problem solving and plan adaptation) between team meetings. Staff tend to go back to their silos and conventional practice after a decision is made. FTC employs regular team conferences to help achieve ongoing and responsive teaming practice.
7. The steps in facilitation of team conferences are similar in most teaming approaches. In FTC, several elements are included to strengthen the process. Team conferences begin by the facilitator asking the family what it wishes the conference to accomplish. Giving the family voice such a priority at the start helps level the balance of power between the family and professionals in the discussion. Agency staff may suggest additional goals, but the conversation begins with the family's objectives. Also early in the conference the family tells its own story, not the professionals. This step also empowers the family and humanizes them to team members who may only see the family's limitations.
8. The size and composition of the FTC may vary depending on the family's needs. Team conferences may be composed only of the caseworker, family and a relative early in the engagement process, but could grow to a large group if multiple complex needs are involved.
9. Conferences conclude with the question, "What could go wrong with this plan?" Such team practice helps identify vulnerabilities in planning that could undermine the achievement of goals.

Conclusion

At its core, FTC functions in a manner that models the approach families use naturally - relying on their own family members, natural allies and informal supports as they reach out to expert help when the complexity of challenges increase. Where families are overwhelmed by current life circumstances FTC provides a process to enable families to engage their informal supports and add professionals when needed to address emerging challenges and shape a lasting team that helps sustain them over time.

FTCs have been employed in many states and as part of foundation supported initiatives. For more information on systems using the approach and their results, contact CWG.⁴

Charlie's Story

Charlie is a 7 year-old whose mom struggles with serious mental health issues and is a heavy user of meth. Because of Charlie's severe acting out behavior, mom felt she could no longer manage him and that the only alternative she knew of was placement in a residential treatment center where he could get the help he needed. The child welfare agency believed Charlie could be helped in a Therapeutic Foster Care placement and so with mom's guidance, they identified a team consisting of mom's father, her brother, Charlie's school teacher, his behavior coach and prospective therapeutic foster-to-adopt parents who were open to adopting or fostering a special needs child.

Mom and her team were prepared for the FTC which involved preparing her to meet the therapeutic foster parents so that she could have a voice in choosing them. The caseworker and mom worked on a list of questions she might ask the foster parents and, as well, Charlie was helped to make a list of questions he too could ask the couple.



⁴CWG's most intensive recent work in assisting systems in developing FTC capacity has been in Community Partnership for Child Protection sites, Utah, Maine, Indiana, Arizona's mental health system and New Jersey.

Following the introductory part of the FTC, Charlie left the room and the mother told the team her story, including her extended family from whom she had been estranged for several months. She talked about how hard life had been without her family and how she did not want to lose her son. She spoke about her fear of her son loving someone more than her if they were providing him a better home. Tearfully her father told her how much he missed her and the foster parents talked about how they know they could never replace her in Charlie's life.

Charlie rejoined the team to ask his questions. His first one was, "Do you ever go to Chucky Cheese to play?" at which time the team broke into laughter. The second question was "Will I have a bed to myself?" and the third and last question was "My mom's birthday is coming up soon so can we have a party for her?"

With three "yeses" Charlie left the room again and the team, with mom's approval and input, developed a transition plan for Charlie to go to the foster home and identified ways to help mom address her needs related to her mental health issues and her use of drugs. Charlie was able to stay in the community, get the help he needed and was able to maintain contact with his mom and extended family. He was also placed in a setting where if return home was not possible, an alternative permanency resource might be offered.

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