

Research Review: Family group decision-making: a promising practice in need of more programme theory and research

David Crampton

Assistant Professor, Mandel School of Applied Social Sciences, Case Western Reserve University, Cleveland, OH, USA

Correspondence:

David Crampton,
Mandel School of Applied Social
Sciences,
Case Western Reserve University,
10900 Euclid Avenue,
Cleveland,
OH 44106-7164,
USA
E-mail: david.crampton@case.edu

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ABSTRACT

The use of family group decision-making (FGDM) in child protection is rapidly increasing throughout the world. This paper provides a brief overview of the research evidence from 1996 to 2005 and proposes future directions for both practice and research. The purpose of the review is to help move the discussion of FGDM from a promising practice to an evidence-based practice. The research review considers what is known about the child welfare outcomes of FGDM. The paper then turns to research concerning which families are offered FGDM and which FGDM processes appear to be important. The paper concludes with specific suggestions for developing FGDM programmes that can improve child protection practice and then testing these specific programmes in rigorous trials.

INTRODUCTION

More than 150 communities worldwide are experimenting with family group decision-making (FGDM¹) in child welfare practice (Merkel-Holguin 2003). A 2004 web-based survey of family group conferencing (FGC) practice received 225 responses from 16 countries (Nixon *et al.* 2005). The focus of FGDM or FGC is a plan for the care and protection of children developed through a meeting of the children's extended family in cases of confirmed child abuse and neglect. This paper reviews what is known about the child welfare outcomes of FGDM, which families are offered FGDM and which FGDM processes appear to be important. The paper concludes with specific suggestions for developing FGDM programmes that can improve child protection practice.

Although child welfare practitioners are eagerly implementing FGDM programmes, researchers are more cautious. For example, Whittaker asks: 'While enthusiasm runs high, many questions remain: Will family group conferencing meet the ultimate test of empirical validation in rigorous studies with appropriate controls?' (Whittaker 1999, p. xv). Although clearly stating his preference for rigorous clinical tri-

als, Barth concedes that 'the assumptions of family group conferencing are so compelling that variations on this practice will undoubtedly continue to develop without evaluation endorsements' (Barth 2002, p. 201).

Although it is true there are few outcome studies of FGDM to date, there is a considerable amount of research on the FGDM process. This literature is fairly consistent in describing how FGDM works and what the participants think makes it work well. Burford (2001) summarizes this research as demonstrating that family members come to FGDM meetings when they are given an opportunity; they participate appropriately and develop plans that are child-centred; both family members and child welfare professionals believe these meetings improve child protection work; and children placed through meetings are more likely to be placed with members of their extended families.

Given the enthusiasm from the field for FGDM and some positive results of preliminary FGDM research, a logical next step might be to begin randomized trials of FGDM programmes. Two recent examples of these efforts suggest a need for some caution before making these attempts. An English study involving randomly assigned families to either FGC or more traditional

decision-making meetings was cancelled because of an inability to recruit a sufficient number of subjects (Brown 2001). More recently, a California study experienced considerable difficulty in implementing a randomized experiment also because of the challenges of recruiting families into the study (Thomas *et al.* 2003).

Part of the challenge of implementing research trials is to take the 'compelling assumptions' of FGDM and turn them into a specific programme model, or what Weiss (1998) calls *programme theory*. According to Weiss, the programme theory should include the 'assumptions about the chain of interventions and participant responses that lead to program outcomes' (p. 335). Before beginning an FGDM programme and a randomized evaluation of that programme, the conveners should carefully consider which child welfare outcomes they expect FGDM to improve. Next, they must articulate how FGDM can improve these outcomes and which families are likely to benefit from FGDM. As there are several variations in FGDM practice, they must also consider which FGDM practices will be most beneficial for achieving their desired outcomes. Fortunately, there is some empirical work that can be used to inform these decisions about which families will be referred to FGDM and what key FGDM processes should be included. The purpose of this paper is to review each of these issues in order to help communities that are developing FGDM programmes articulate a specific FGDM programme theory that can then be appropriately evaluated.

WHAT IS FGDM?

The focus of FGDM is a plan for the care and protection of the children developed through a meeting of the children's extended family. According to the National Center on Family Group Decision Making at the American Humane Association, 'FGDM is characterized as a practice which is family-centered, family strengths-oriented, culturally based, and community-based. It recognizes that families have the most information about themselves to make well-informed decisions and that individuals can find security and a sense of belonging within their families. It emphasizes that, first and foremost, families have the responsibility to not only care for, but also to provide a sense of identity for, their children' (Merkel-Holguin nd). A typical case example of an FGDM meeting looks something like this:

The setting is a conference room of a non-profit agency which is contracted to provide FGDM services for a subset of cases

from the public child welfare system. The case concerns two girls, 11 months and 10 years old, who were found home alone by the police. Their mother has a long history of substance abuse and numerous previous substantiated incidents of child neglect. The Child Protective Services (CPS) worker now wants to remove her children from her care. The meeting includes the mother, the maternal grandmother, the grandmother's sister, the maternal grandfather (via speaker phone), the CPS worker, who investigated the police report, and the FGDM facilitator. The facilitator has met the family in the process of preparing for the meeting. The facilitator begins the meeting by reviewing its purpose and introducing the CPS worker, who then presents her concerns about the case. Next, the professionals leave the room while the family members develop their plan. The family decides to place the two children with their grandmother, with their aunt's family playing a supportive role. The grandmother agrees to take the children for only 6 months, during which time she expects her daughter to make progress in substance abuse treatment. In the event that the grandmother can no longer care for the children, the grandfather will take them. The mother commits to becoming sober in 6 months' time, and she is clearly encouraged by the support of her family and her concerns about her children being placed in foster care. The professionals are called back into the room and agree to the plan. They all agree to meet again within 3 months to evaluate progress in the case, with the understanding that the grandmother will call the FGDM facilitator if she has any concerns.

In this particular case, the mother made rapid progress in her treatment, and her children were eventually returned to her care. In talking about her experience, she emphasized how the support from her family helped her focus on the needs of her children. This is a compelling account of an individual family. The rest of this paper will describe what we know about how well FGDM works across a larger number of families, communities and countries.

SELECTIONS OF STUDIES UNDER REVIEW

Literature searches using the terms 'Family Group Decision Making' and 'Family Group Conferencing' were conducted using Academic Search Premier, Current Contents/Social & Behavioural Sciences, PsychInfo, Social Sciences Citation Index, and Social Work Abstracts. These efforts produced a small number of papers from the peer-reviewed literature. In order to more fully review the state of the relatively new area of FGDM, additional studies were selected from edited books and the National Center on Family Group Decision Making (http://www.americanhumane.org/site/PageServer?pagename=pc_fgdm). Studies were selected to review current knowledge about FGDM outcomes and key processes.

What are the outcomes of FGDM?

Weiss (1998), following the logic of backward mapping from Elmore (1980), suggests beginning with the outcomes a programme hopes to achieve. However, this is not an easy task for FGDM. While many child welfare practitioners express an interest in bringing together a child's extended family to discuss the child's welfare, why exactly do they think the meeting will help? The limited theory concerning how FGDM can improve child welfare may be part of the reason there is still a limited amount of information about FGDM outcomes. For example, in New Zealand, where the practice began in 1989, there is still little information about the outcomes of FGDM. Robertson (1996) reports that "there are no follow-up data on outcomes, and, in fact research indicates that there is little monitoring of family group conferences' decisions" (p. 62). Similarly, a more recent book about New Zealand practices suggests that 'There is a pressing need for long-term studies that look at the qualitative and enduring nature of decisions that impact critically on the lives of children and families involved. New Zealand has been in a good position to undertake such research but has been hampered by a lack of funds and the state's reluctance to put resources into outcome evaluation' (Connolly & McKenzie 1999, p. 125).

Marsh & Crow (1998) report from England that 'Indicators such as registration on the at-risk register, re-abuse rates, and estimates of "what might have been" all suggest that the plans both protect and benefit the children' (p. 163). Lupton & Nixon (1999), reviewing some of this same research on FGCs, are less convinced and suggest a need for research 'on the outcomes of much larger numbers of FGCs and on more systematic and controlled comparison with those from traditional meetings (case consultations that are part of regular CPS) over a longer period of time if it is effectively to establish that the FGC approach is able to ensure the care and protection of the children involved in the longer term' (p. 177).

There are few FGDM outcome studies. Most lack an equivalent control group. Several studies have attempted to create a matched comparison group, and these studies have demonstrated both positive and neutral results. The Newfoundland and Labrador Family Group Decision Making Project was one of the earliest and most comprehensive evaluations of FGDM. The project included 32 families from three culturally distinct regions of the province. Of the 37

meetings held in 1994 and 1995, 32 were first-time meetings and five were reconvened meetings. Although the number of meetings was small, 472 people participated in these conferences, and 115 of them were interviewed as part of the evaluation. The study used several different sources of data to examine family violence after the conferences (Pennell & Burford 2000). For example, CPS files of the FGDM cases were compared with the same information for a comparison group selected by CPS workers under the direction of an independent evaluation consultant. The FGDM project families started with more CPS events prior to the conferences and had fewer events subsequently compared with the matched cases (Pennell & Burford 2000). Follow-up interviews reinforced the finding from the comparative case file review that children in the FGDM project suffered less abuse and that their parents were providing better care compared with the children from the comparison cases (Burford & Pennell 1995; Pennell & Burford 1999, 2000).

A Michigan study included an outcome analysis of referrals received from 1996 to 1998. During this time, the FGC received 257 referrals, 96 of which proceeded with a family meeting. The analysis compared the outcomes after 2 years of the cases that held family meetings with those that did not. The two groups were compared in terms of additional contact with CPS, number of out-of-home placements and long-term placements with parents or relatives (Crampton 2003). Overall, the cases served by the FGDM programme compared favourably with those served through regular foster care services. Children placed through the FGDM programme were less likely to have additional contact with CPS; they moved less between temporary homes; they were less likely to be placed in an institutional setting and were more likely to remain placed with their extended family members in a legal guardianship (Crampton & Jackson in press).

Recently, a Swedish study compared 97 children involved in an FGDM meeting with 142 children served by traditional CPS (Sundell & Vinnerljung 2004). After controlling for the child's age, gender, family background, and type and severity of problem, they found that the children served through FGDM experienced higher rates of re-referral to CPS (for abuse but not neglect), were in out-of-home placements longer, but over time experienced less intrusive involvement with CPS. However, the researchers emphasized that the impact of FGDM accounted for less than 7% of the variance in the outcome variables.

This means that when other case characteristics were taken into account, the FGDM programme demonstrated limited positive impact.

The first successful randomized trial of FGDM was recently completed in two California communities (Center for Social Services Research 2004). As already noted, the researchers experienced considerable difficulty in recruiting subjects for their study. Nevertheless, a comparison of the FGDM and comparison groups in terms of age, ethnicity, gender, initial placement and initial risk scores showed no statistically significant differences between the two groups, suggesting that the randomization was successful. Overall, they found that FGDM improved collaboration between family members and service providers in the initial phase of involvement, but that FGDM was unable to maintain the family's involvement beyond the conference plan. While staff and family members both said they collaborated more through FGDM, community support was difficult to mobilize through FGDM. A cost study of one of the two programmes suggested that including FGDM in a programme to prevent placement of children in foster care does not increase the overall cost of services. While it may be positive that FGDM did not prove to be more expensive, the researchers also did not find any differences in outcomes. Specifically, they found no statistically significant differences between the comparison and FGDM groups in terms of substantiated maltreatment, number of placement moves or type of exit from services. Overall, the researchers stated that they were impressed by the ability of FGDM to facilitate collaborative relationships between families and staff, but that the FGDM programmes were not able to integrate into other agency and community activities. It is possible, although not definite, that the programmes' inability to sustain and support change accounts for the failure of the FGDM programmes to produce positive child welfare outcomes.

These studies suggest mixed results for FGDM, but perhaps more importantly, they demonstrate the significant challenges of finding appropriate comparison groups for studying FGDM. These ongoing challenges with attempting matched comparison studies suggest we may need to move to randomized trials. However, before a randomized trial is attempted, we need to be clear about what the desired outcomes are, which families are likely to participate and which FGDM processes are needed to produce the desired outcomes.

Which families participate in FGDM?

One of the key steps in understanding which families are likely to benefit from FGDM is finding out which families are offered FGDM services and which families accept FGDM services. Programme evaluation can provide some information about 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 will reveal how child welfare professionals and families view the potential benefits of FGDM.

Thus far, few FGDM studies have examined these questions. In a typical example, a pilot study of 20 family meetings in New South Wales, Australia showed that the process was used for a wide variety of child care concerns (Cashmore & Kiely 2000). Similarly, a study from Santa Clara County, California found that FGDM is used in a wide variety of cases and at any point in the process of a case, from intake to case closure, including family preservation, foster care and adoption cases (Walter R. McDonald and Associates 2000). In a study in Washington State, there were no specific referral criteria for the meetings; social workers were simply asked to refer families they thought would benefit from the process. The cases referred to a family meeting appeared to be similar to other child welfare cases in Washington, except that there was a higher percentage of ethnic minority children in the family meeting cases compared with the overall child welfare population (Vesneski & Kemp 2000). Although this FGC selection process has not been fully explored in British studies of FGCs, researchers from England suggest that there is evidence 'that professionals retain considerable control over whether and which families are offered the choice of a FGC' (Lupton & Nixon 1999, p. 119).

A Swedish FGDM study is one of the few that examined the referral process (Sundell 2000). The referral process study found that only 35% 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. In order to begin to understand why so few referrals were made, interviews were conducted with 19 social workers. These interviews suggested

that the social workers not using FGDM were distrustful of the use of extended family, or they had fear of losing control in FGDM. This study and the others reviewed in this paper suggest that any community implementing an FGDM programme should carefully track whether social workers are making referrals to the FGDM programme and whether there is any bias in their referral making. On the other hand, a survey of social workers in Sweden and the UK found that most were very supportive of FGDM, but few made referrals to FGDM programmes (Sundell *et al.* 2001). The authors speculated that the social workers may have felt insufficient support from their organizations to try FGDM with their cases. Communities implementing FGDM may need not only to review potential bias against FGDM among referring workers, but also to consider whether the organization itself is sufficiently supportive of FGDM utilization.

Of the families offered an FGDM meeting, only about one quarter accepted (Sundell 2000). 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. Interviews with 18 family members who chose not to try FGDM suggested that there were no extended families who could participate, the parents did not have faith in the extended family, the parents did not want to reveal their problems to the extended family, or the parents knew what they wanted and therefore were not interested in alternative services (Sundell 2000).

A Michigan study looked at 593 referrals to an FGDM programme from 1996 to 2000 (Crampton 2003). Of these 593 referrals, only 173 had a family meeting. This study included information about which families were selected for FGDM and which families decided to try FGDM. All of the referral files were reviewed to determine the occurrence of 40 case characteristics related to the children, parents, families and types of child maltreatment. Referrals to the FGDM programme were less likely to be accepted by social workers when the parents' parental rights were terminated during a previous referral to the child welfare system, and were more likely to be accepted when the case mentioned special needs of the children, improper supervision or parental substance abuse. Families were more likely to agree to try the FGDM programme in cases that mentioned improper supervision, special needs of the children, parental substance abuse, relatives willing to care for the children, parents' mental-health concerns, homelessness and

previous involvement with the child welfare system. It seemed that child welfare professionals and family members were more willing to try FGDM in uncertain cases of child maltreatment, and that FGDM works well when it creates an opportunity for diverse participants to share their concerns and suggestions in cases of child maltreatment in which a clear course of action is not yet apparent. In addition, the study found very few case characteristics that were negatively associated with decisions to try FGDM, suggesting that FGDM was perceived to be potentially useful in a wide variety of cases of child maltreatment.

A study of FGC in London noted that compulsory referrals increased the use of FGCs and that in voluntary programmes a substantial minority of social workers, despite their stated support of the process, do not refer families (Marsh & Crow 2003). The study authors suggest that FGC referral criteria seem to work better when there is a clear and automatic 'trigger' to make an FGDM referral.

While most FGDM studies simply report that FGDM is used in a wide range of cases, there is some evidence that social workers are deciding which cases can benefit from FGDM and that some families are deciding not to try FGDM. For communities developing an FGDM programme, it would be useful to understand how they are making these determinations in order to develop an FGDM programme theory. A clear programme theory about referral criteria (and perhaps automatic referral criteria or a 'trigger') may help ensure an adequate number of referrals to the FGDM programme. For communities attempting a randomized trial of FGDM, explicit referral criteria would also help the evaluators plan for sufficient time and resources to recruit an adequate number of participants into the study.

Which processes in FGDM are important?

Most of the FGDM literature primarily describes the FGDM process. Some of this process literature includes information on the participants' satisfaction with FGDM. A consistent theme voiced by FGDM participants is that extensive preparation time and resources are needed in FGDM; however, so far the resources employed have not been linked to FGDM outcomes. Interviews with FGDM participants have been conducted in New Zealand, the UK and the USA. The American Bar Association's Center on Children and the Law conducted field interviews in New Zealand in 1993 and published a book that explains New Zealand laws and best practices in

detail, but does not include evaluation data (Hardin *et al.* 1996). There are several studies of FGDM in England and Wales involving six sites, and the results of these studies are summarized in two recent books (Marsh & Crow 1998; Lupton & Nixon 1999). While there is some variation in the time and resources involved in these studies, most of them included interviews with family members and professionals and documented how the meetings were carried out. Both of these books report that the participants were satisfied with the process, felt the preparation and organization of the meetings was sufficient, and that they would like to see FGDM practice continue. In a Washington State study, the analysis of family plans demonstrated considerable attention to family-centred practices, that is, approaches that validated the knowledge and strengths of the families (Vesneski & Kemp 2000). Oregon's version of FGDM began in 1990 and is now widely used, with over 4000 meetings held in 1998 (Keys & Rockhill 2000). A study of 26 meetings held in Oregon between January 1998 and March 1999 included interviews with 163 participants and was designed to explore elements of successful meetings that engaged families in decision-making (Rockhill & Rodgers 1999). The study suggests that family involvement can be enhanced with adequate preparation time and increased attendance of family members. Clarification of the goal of the meeting, discussions of family strengths, allotment of sufficient time to develop a plan, trust between participants, skilful facilitation and the use of a series of meetings were also shown to help increase family involvement. Similar to these evaluations, a pilot study in New South Wales, Australia found that preparation time averaged 20 hours, and that family members were generally positive about the meeting and able to develop a plan (Cashmore & Kiely 2000). A Canadian pilot study of 23 family meetings in Calgary, Alberta conducted in 1997 demonstrated extensive preparation time, that all the families developed a plan, and that the family members were highly satisfied with the process (Sieppert *et al.* 2000).

Some FGDM advocates are understandably concerned that there will be attempts to start FGDM programmes with insufficient resources, that these programmes will then not produce the potential benefits of FGDM, and that therefore the reputation of FGDM will suffer. One way they attempt to ensure programme integrity is by insisting that FGDM must include quality preparation time, which is described as 20–25 hours on average per case (Mirsky 2003). Preparation time is a key distinction between these

models: 'Without thorough and intensive preconference planning, the FGC approach reflects more traditional case-planning methods' (Merkel-Holguin & Ribich 2001, p. 203). As demonstrated in the studies reviewed earlier, FGDM research suggests that preparation time is often extensive and that FGDM clients are highly satisfied with the process. There is also some evidence that participants believe that preparation time is important for exploring family resources and beginning to change the relationships between family members and child welfare professionals (Marsh & Crow 1998). To date, there is no research which demonstrates that preparation time produces these benefits or that preparation time improves outcomes for children and families. A Michigan study showed that expanding the population served by an FGDM programme without a corresponding increase in programme resources prevented the staff from fully exploring family resources and therefore limited the effectiveness of the programme (Crampton 2003). Clearly, programme resources are important in making family meetings work. However, we do not yet have evidence that would suggest preparation time must be set at a certain level. Communities developing FGDM programmes should consider how much preparation time they can afford and the trade-offs involved in serving more clients at the expense of preparation time. Evaluators of FGDM programmes should consider whether their research design could include an attempt to systematically review preparation time in order to inform the field about this important topic.

IMPLICATIONS FOR FGDM PRACTICE AND RESEARCH

While the FGDM research to date cannot answer the concerns about the effectiveness of FGDM, the studies reviewed here can contribute to conversations in communities considering implementing FGDM programmes. Returning to Weiss's concept of programme theory, communities who wish to try FGDM should consider their 'assumptions about the chain of interventions and participant responses that lead to program outcomes' (Weiss 1998, p. 335), specifically in terms of the questions reviewed in this paper:

1 What are the outcomes of FGDM? Carefully consider why the community wants to adopt FGDM practices and which outcomes are desired. While prescribing the outcomes of an FGDM meeting is not consistent with a family empowerment framework (Merkel-Holguin 2000), communities implementing

FGDM need to have a common understanding of what they are trying to achieve (Crampton 2004). Once these goals are established, the community can work backwards in designing their programme. Given that the community wants to achieve these outcomes (e.g. a reduction in the re-occurrence of substantiated child maltreatment), which families are likely to improve on this outcome through FGDM? Which FGDM practices are most likely to help? Evaluators should consider how to identify a comparison group that can be used to demonstrate differences in the desired outcomes between families who received FGDM services and those who did not.

2 Which families participate in FGDM? As already discussed, FGDM can and is used in a wide variety of cases. However, communities should be cautious about leaving the decision to make a referral to FGDM exclusively at the discretion of a social worker. FGDM research suggests that some social workers can be highly selective in making referrals and that social worker discretion to refer can hamper implementation of the programme and is also contradictory to the empowerment approach to FGDM. Communities should consider adopting trigger criteria that would automatically require certain families to be referred to FGDM, and those families can then decide whether they want to proceed with FGDM. Evaluators should carefully monitor the referral process to see if families meeting the referral criteria are actually referred.

3 Which processes in FGDM are important? FGDM can be a powerful way to engage families and communities in the helping process, but without follow-up and support, the long-term benefits may be minimal. Communities developing FGDM programmes should consider how much preparation time they can afford and the trade-offs involved in serving more clients at the expense of preparation time. Evaluators of FGDM programmes should consider whether their research design could include an attempt to systematically review preparation time in order to inform the field about this important topic.

If communities follow this concrete advice, FGDM will be more likely to succeed. Likewise, rigorous evaluations of FGDM should not be attempted unless these recommendations are followed. Poorly implemented FGDM programmes are likely to have limited success and show little benefit in a randomized trial.

Lupton & Nixon (1999) point out that empowerment is frequently discussed in the FGDM field without a clear understanding of what empowerment means. They further suggest that 'Clarity around the

parameters of professionally led empowerment is vital if service users are not to be encouraged unrealistically to raise their expectations and if hard-pressed social workers working in cash-limited organizations are not to be criticized unfairly for failing to change the world' (p. 29). The FGDM field can begin to provide this clarity by clearly stating which outcomes FGDM should achieve, which families should participate in FGDM and which FGDM processes should be used, drawing upon the research reviewed in this paper. When a clear programme theory for the use of FGDM is developed, it should then be tested using a rigorous research design.

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NOTE

1 Although the term 'family group conferences' or 'family group conferencing' (FGC) is typically used in the UK, in this paper I use the broader term family group decision-making to include FGCs and related practices, such as community conferencing and family unity meetings. The Nixon *et al.* (2005) survey uncovered more than 50 different names for these practices.