One Family's Journey: A Case Study Utilizing Complementary Conferencing Processes

Betty Christenson, MS, LISW, and Scott Maloney, BS

Ms. Christenson and Mr. Maloney are members of the Family Group Decision Making (FGDM) team that is a unique collaborative between Olmsted County Child and Family Services and Family Service Rochester in southeastern Minnesota. The Olmsted County FGDM team consists of six staff members who are cross-trained in a wide variety of family involvement processes, such as family group conferencing, case planning conferences, mediation, circles, wraparound, and victim/offender conferencing.

According to results of an international survey on family group conferencing (FGC) and related practices, there are more than 50 different names for conferencing processes (Nixon, Burford, Quinn, & Edelbaum, 2005). Some communities, while struggling with tight budgets and time restraints, are shifting to processes that significantly minimize the majority of preparation activities and private family time—two cornerstone elements of the FGC model. Often times, these new processes have begun to compete with, rather than complement, family group conferences (Merkel-Holguin & Wilmot, 2005).

Using a case example, this article demonstrates how Olmsted County Social Services uses complementary conferencing processes—the case planning conference (CPC), which is a crisis-oriented conferencing process, and the family group conference, used for comprehensive planning and driven by the family group.

The CPC process originated from an appreciation of the benefits of joining with families to work through case-related information within a shortened time period and to develop next steps in advancing the family's progress toward safety and case closure. The CPC, which supports quick action by the agency and can be done with little or no preparation, infuses family and community involvement at critical points in the family's journey through the child protection system. It enhances safety planning at critical agency decision-making points, such as when a child is at risk of maltreatment and/or placement outside of the family home. In addition to immediate safety planning, CPCs result in engaging kin and relatives in plans for safeguarding children, identifying family as care options and kinship resources, defining community and agency resources to address potential risks or harm to the children, and building a constructive working relationship or partnership with the family.

In comparison to a family group conference, the CPC: (a) typically engages a smaller network of family members because the decisions often occur during crisis points

in the case; (b) does not employ coordinators who engage in thorough identification and preparation of the family group and service providers; (c) is largely attended by relevant service providers and family members who are empowered to make the immediate decisions; (d) while still facilitated by family group conference staff, the CPC facilitator calls for an agenda of items for discussion and summarizes salient points on a white board or note paper, which are typed into a laptop computer by the co-facilitator, resulting in a summary document of the results of the meeting which include the immediate next steps of action for the family and service providers; (e) consists of introductions, agenda building, information sharing, notes, and the development of action steps; (f) takes less time, averaging 60-90 minutes in duration; (g) does not provide the family group with private time; (h) focuses on immediate next steps for one or two pressing issues; and (i) is typically initiated by the social worker and is more service provider driven than the family group conference.

The CPC frequently results in a referral for a family group conference, where the members of the broader family group are engaged as leaders in decision making. Research shows that in comparison to traditionally developed case plans, family group conference plans are more comprehensive and more likely to be implemented because of the knowledge and investment of the family group and service providers working in partnership (Merkel-Holguin, Nixon, & Burford, 2003).

Through a case example, we will illustrate that when families participate in both a CPC and a family group conference, they receive the most comprehensive planning available. In this case, the CPC offered an immediate safety plan and the family group conference resulted in a more detailed ongoing plan that leveraged commitment and knowledge of the family group. The CPC did not compromise nor compete with the family group conference, it complemented it.

> The case planning conference infuses family and community involvement at critical points in the family's journey through the child protection system.

Family scenario

(Note: This family has given the authors permission to present their names and situation in detail.)

Olmsted County Social Services in Rochester, Minnesota, began a preliminary assessment when it was reported to child protective services that a mother, Tabatha, tested positive for methamphetamines following the birth of her child, Dakota. The child also tested positive for methamphetamines. Tabatha admitted to methamphetamine use, while the father, Matt, stated he had maintained sobriety for 6 months. Matt also stated he had been attending Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) three times a week to support his sobriety. Tabatha and Matt were residing with Tabatha's parents at the time.

Figure 1. Case-specific framework

Building Safety and Strengthening Families Practice Framework

Danger/Harm
Hospital reported new mom tested positive for meth, infant also positive for meth. Mom reports a history of drug use, last use day prior to birth.

Risk Statement
Child may be accidentally hurt or fail to thrive without attention to her needs when her caretaker is under the influence of drugs.

Complicating Factors
- History of drug use by both parents back to adolescence
- Absence of information (from AHSW) in regard to the detail around described "concerns" re: maternal grandparents
- Operating assumption by family is that the baby will go home
- Decision around immediate care of baby needs to be made today

GENOGRAM/ECOMAP
- Mom has admitted to the meth use, offered to move out if necessary
- Both mom and dad are distraught
- Conflict appears present between dad and maternal grandmother
- Dad got visibly angry and left the hospital room today
- Dad has a formal diagnosis of bipolar and reports taking medication

NEXT STEPS

(Immediate Progress) Safety/Protection Required
1. Assessors to visit the home
2. Baby care items and schedules of feeding/responding discussed with parents and include public health input
3. Create a crisis case plan to be put in place for the next two days including needs for time-out, questions re: baby care and distress to be discussed with parents
4. Convene a case plan meeting as soon as possible with extended family and supports

Safety

Strengths/Protective Factors
- Dad reports sobriety of 6 months and describes utilizing his support system (AA, NA) 3 times per week basis for the assumed 6-month period
- Maternal grandparents have said they would provide financial and physical care up to 24 hours/day if needed
- Dad has stepped in and talked about his confidence, willingness
- Maternal grandparents and parents have offered daily UA's, they would be willing to come to the office

Purpose/Focus of Meeting
1. Next steps for assessors

Partnering: Action with family in their position: willingness, confidence, capacity (Lohrbach, 2000)

To better explain the case presented, we have included the Building Safety and Strengthening Families Practice Framework, which is utilized throughout Olmsted County Child Protection (Turnell & Edwards, 1999). This framework is also used in CPCs as a means of sharing information. Pertinent family information is illustrated in Figure 1 in a framework that was completed with the family portrayed in this case scenario. It highlights such elements as danger/harm, family strengths, protective factors, complicating factors and risks to the child.

Prior to using CPCs, in a situation like this, Olmsted County would have taken custody of Dakota and placed her in emergency foster care. In the weeks following the placement, the assessment process would have continued and an ongoing child protection case manager would have been assigned. Because of the baby's age, concurrent permanency laws would have mandated that Dakota be in foster care for only up to 6 months. Matt and Tabatha would have worked with the agency to develop both a plan for reunification and a plan for alternative permanency. Because CPCs can involve the family group earlier in the case planning process, we see families' hopefulness, engagement, and efforts increase as they believe in the possibilities of children being returned to their care. These front-end processes can also alleviate family member frustrations that may cause reunification efforts to fail.

In this case, an emergency CPC was convened at the hospital within 24 hours of Tabatha giving birth and prior to her being released from the hospital. Matt, Tabatha, Matt's mother and stepfather, Tabatha's parents, two child protection assessors, a child protection supervisor, the yet-to-be-assigned child protection ongoing case manager, and a social worker from the hospital were present at the CPC. Two coordinators from the Family Group Decision Making (FGDM) team were present; with one serving as lead facilitator and the other using a laptop to capture in document form what the facilitator was writing on easel paper. All parties left the CPC with a document that clearly defined the plan as developed. It was decided at this CPC that Dakota could go home with Matt and Tabatha after the initial safety plan was developed.

Key points of the plan developed in the CPC, which made it possible for Dakota to go home with her parents:

- Other adults will be present when Tabatha is taking care of Dakota
- Dakota's father, Matt, will provide 24-hour/day supervision
- Maternal grandmother will provide 24-hour/day backup supervision
- Matt, Tabatha, and maternal grandparents agree to submit to random drug tests
- Matt and Tabatha agree to, and will expect, daily random drop-in visits from social services staff
- Family members will have access to a list of appropriate contact people and phone numbers for safety purposes
- Tabatha will get a sponsor and begin AA and/or NA meetings
- Matt will continue attending his AA/NA meetings
- If Matt or Tabatha use chemicals, grandparents will:
  - Make sure Dakota is away from them and is safe
  - Contact ongoing social worker
  - In an emergency, contact the police
- A referral will be made for a family group conference

The plan stipulated that Tabatha's parents and Matt would provide around-the-clock

supervision, keeping Dakota within sight and sound. Matt and both of Tabatha's parents suggested they submit random urine samples for analysis. The next-day results from Matt's urinanalysis tested positive for THC or marijuana. At that point, Tabatha's parents refused to submit to urine testing. Because of this change in follow-through, the agency decided the risk to Dakota outweighed the previously recognized protective factors, and Dakota was placed in foster care. Per the plan developed at the CPC, the agency knew that Matt's parents were also willing to care for Dakota. However, they were not included in the original plan as caregivers for Dakota because they lived in another community. After Dakota's 3-day stay in foster care, and an inspection of Matt's parents' home, Dakota was placed in their care. Matt and Tabatha remained in Rochester for a few days before moving to the community where Matt's parents live.

At that point, the ongoing child protection case manager made a referral to the FGDM team. The Olmsted County FGC referral form includes the following four questions to stimulate best practice thinking as it pertains to the case:

- **Reason:** *(Why is child protective services involved?)* Tabatha gave birth to a baby who had methamphetamines in her system. Tabatha tested positive for methamphetamines and the baby's father, Matt, tested positive for THC.
- **Purpose:** *(What is the decision that needs to be made or the plan that needs to be developed?)* A plan of care, protection, and support for Dakota needs to be developed.
- **Risk:** *(What is the agency worried might happen and when is it worried that it may happen?)* Dakota may be accidentally hurt or fail to thrive without attention to her needs while her caretaker(s) is under the influence of drugs.
- **Bottom Lines:** *(What does the agency need to see happen in order to move towards case closure?)* Dakota is to live with a caretaker who is not using chemicals and who can meet her basic, age-specific needs.

Upon receiving the FGC referral, the FGDM team assigned the coordination responsibilities to one of the facilitators who convened the CPC. This was beneficial because the coordinator had already developed rapport with the family. After a few weeks of preparation, a family group conference was held in the other community. Dakota, Matt, Tabatha, Matt's mother and stepfather, Matt's father, Matt's sister, Matt's paternal grandmother, Tabatha's maternal grandmother, two sets of great aunts and uncles, Matt's cousin, and the ongoing child protection case manager participated. Additional service providers were not present at the meeting because family members had assumed supportive roles that would have typically been fulfilled by service providers.

Key points of the plan developed in the family group conference that made it possible for Dakota to remain with her grandparents while increasing parenting time to demonstrate that Matt and Tabatha's home was safe enough for Dakota to live with them:

- Matt will find a job
- Matt and Tabatha will save money for an

apartment

- Matt and Tabatha will continue attending weekly AA/NA meetings
- Family members have reviewed, and will be watchful for, behaviors that would indicate if Matt or Tabatha relapse
- The detailed family safety plan will be used in the event Matt or Tabatha relapse
- Family will continue caring for Dakota in their home
  - Matt and Tabatha will develop a checklist of steps for caring for Dakota
  - Parenting time will increase to 2 hours daily
  - The increase in parenting time will take place initially during daytime hours, and work toward increasing time during evening hours
  - Per family agreement, they will initiate overnight and weekend stays by Dakota with Matt and Tabatha, who will check-in with family during the stays
- The family will have ongoing contact with a social worker, per the established plan
- A follow-up family group conference will be scheduled within 1 month

In accordance with the plan, a follow-up family group conference was held approximately 1 month later, and the same individuals participated. Matt and Tabatha completed the majority of the plan and exceeded plan expectations in other areas during the 30 days following the initial family group conference.

Key accomplishments noted at the follow-up family group conference, which allowed Dakota to return to her parents on a full-time basis:

- Matt is employed and enjoys his job
- All stipulations for increasing time with Dakota have been followed and monitored by family
- Matt and Tabatha have paid deposits and would be moving into an apartment
- According to plan, Dakota will live with Matt and Tabatha in their apartment
- Matt and Tabatha are attending AA/NA on a weekly basis
- Between family, work, and AA/NA, both have strong networks of support
- Family is prepared to follow the safety plan should either parent relapse
- Matt and Tabatha have ongoing contact with a social worker

Matt and Tabatha achieved these accomplishments beyond the plan that was developed at the family group conference:

- Matt continues to keep his job with an employer that conducts random drug screenings of all employees
- Tabatha took a job with work hours that are compatible with Matt's, providing both of them time with Dakota
- Tabatha obtained her driver's license
- The family has adequate transportation
- Matt and Tabatha completed the family economic assistance program in their area and are now financially self-sufficient

Conclusion

If the agency had not conducted a CPC at the front end of this case, the extended family likely would not have been engaged until the family group conference. Dakota probably would have remained in foster care until reunification efforts took place or until alternative permanency plans were implemented. The CPC offered the extended family an opportunity to enter into a respectful partnership with service providers in which they decided to become primary caregivers for the child. It set the stage for a fuller, more robust family-driven family group conference in which families were positioned as leaders in decision making.

> "Empowerment means assisting individuals, families, and communities in discovering and using the resources and tools within and around them." (Kaplan & Gerard, 1994)

It is with greater humility than pride that we share this family's journey. The honor was ours, as coordinators of these processes, to experience the wisdom and willingness to trust that was displayed by the family. We witnessed the optimism of the social worker and the innate beauty of the processes themselves, which combined and complemented each other for the benefit of Dakota and her family. We had a rare opportunity indeed, as we enjoyed the consistent confidence placed in us by our agency leaders who guide and encourage us as we navigate through our own journeys, playing our small parts in the process of system change.

The authors would like to acknowledge the support of their fellow FGDM team members, Kelli DeCook, Rebekah Kirgis, Carla Miller, and Amy Oian; Rob Sawyer, director of Olmsted County's Child and Family Services Division; Sue Lohrbach, program manager of the FGDM team; and Brian D'Agnolo, supervisor of the FGDM team from Family Service Rochester.

References

Kaplan, L., & Gerard, J. (1994) *Strengthening high-risk families: A handbook for practitioners*. New York: Lexington Books.

Lohrbach, S. (2000). *Building safety & strengthening families practice framework*. Olmsted County Family Services, Rochester, MN.

Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Learning with families: A synopsis of FGDM research and evaluation in child welfare. *Protecting Children* 18 (1-2), 2-11.

Merkel-Holguin, L., & Wilmot, L. (2005). Analyzing family involvement approaches and reviewing trends in FGDM. In J. Pennell and G. Anderson (Eds.), *Widening the circle: The practice and evaluation of family group conferencing with children, youth and their families*. Washington, DC: NASW Press.

Nixon, P., Burford, G., & Quinn, A., with Edelbaum, J. (2005). *A survey of international practices, policy & research on family group conferencing and related practices*. Retrieved May 1, 2006, from http://www.americanhumane.org/site/DocServer/FGDM_www_survey.pdf?docID.

Turnell, A., & Edwards, S. (1999). *Signs of safety; A solution and safety oriented approach to child protection casework*, New York: Norton.