# Chapter 6 A Randomized Controlled Trial on the Effectiveness of Family Group Conferencing in Child Welfare

## *Methods, Results and Methodological Considerations*

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To study the process and effectiveness of Family Group Conferencing (FGC) in Dutch child welfare, we conducted a randomized controlled trial. Over 300 families were randomly assigned to an FGC ($n$ = 229) and a care as usual (CAU; $n$ = 99) group. Only 27% of families in the FGC group completed a conference, seemingly because of unfamiliarity with or ambiguity of the aims of FGC. Overall, FGC was as effective as CAU in improving child safety and reducing child welfare involvement. The positive effects of FGC on empowerment and social support were small and inconsistent and accompanied by a longer duration of child welfare involvement and a marginally higher amount of professional care use. FGC and CAU did not differ in terms of cost-effectiveness. Furthermore, on the basis of the family characteristics that were studied, effectiveness did not differ across subgroups of families. For some outcomes (i.e. parental empowerment, professional service use), FGC generated more positive results at lower levels of completion. The potential of randomized experimentation for studying the effectiveness of FGC and the need to 1) assess programme fidelity, 2) provide information about the practices under study and 3) identify moderators of effectiveness are discussed.

### 6.1 Family Group Conferencing in Child Welfare

To safeguard children's rights to grow up in a secure and protective environment and to be protected from all forms of maltreatment, governments and child welfare agencies are under constant moral, political and societal pressure to offer effective support to families in which child safety is at stake. Yet, despite all efforts, youth care and evidence-based treatment are effective for only a small proportion of the children and families in child welfare (Connell et al., 2007; Weisz et al., 2017; Asscher, 2018). To increase effectiveness, the approach to child welfare support has shifted over the last few decades from a problem-focused approach, with minimal client involvement, to one focusing on strengths and shared decision-making between clients and care providers. This way,

cooperative collaboration and active responsibility of the family and its social network are promoted (Johansson et al., 2008; Hoek, 2010), with the aim of preventing long-term dependency on formal care (Cohen & Ventura, 2016; Van Dam et al., 2018).

In various countries, including the Netherlands, the shift from a problem-focused to a solution-and-strength-focused approach has been accompanied by new policies and laws. Since 2015, Dutch law requires that all families referred to child welfare should first be offered the possibility to make their own care plan, i.e. a family group plan (Art. 4.1.2; Dutch Youth Act). Only if families decline this offer or if urgent threats are posed to the development of the child(ren) in the family may child welfare workers refrain from providing families with this possibility (*Factsheet Familiegroepsplan*, 2017). Through this law, the government directs child welfare agencies to promote active responsibility among citizens. In line with the law, practices to involve and empower families have become central elements in methods adopted by Dutch child welfare agencies to support families.

The decision-making model of family group conferencing (FGC) is one of such practices. Whereas in regular care the child welfare worker is, in collaboration with the family, responsible for the making and implementation of a care plan, in FGC a coordinator helps the family to gather all people important for the family to make their own family group plan. Subsequently, the coordinator places the responsibility for implementation of the plan on the family and the social network (Merkel-Holguin, 1996). Despite the broad implementation of FGC globally and many research efforts into FGC, Frost, Abram and Burgess found, in 2012, after reviewing the literature, that it is not possible to draw conclusions about the effectiveness of FGC owing to a lack of robust research allowing causal inferences, i.e. few (quasi) experimental or longitudinal studies were conducted.

Four years later, in 2016, we conducted a multilevel meta-analytic study based on the 14 available controlled studies, consisting of a total of $N = 88{,}495$ participants, generating 34 effect sizes (Dijkstra et al., 2016). Consistent with the findings of Frost et al. (2014), we found that the number of controlled effectiveness studies was limited. In addition, the quality of the available studies was generally weak, mainly because of their retrospective design, lack of valid instruments and limited information on programme fidelity (i.e., whether FGC is carried out according to the model). The results of this meta-analysis show that FGC was not more effective than CAU in reducing child maltreatment, out-of-home placements and involvement of child welfare. The findings of an experimental trial published after our meta-analytic study are similar (Hollinshead et al., 2017).

## 6.2 Methods of Our Study

To advance research in this area, we conducted a randomized controlled trial (RCT) on the effectiveness of FGC in child welfare. In addition to the effectiveness of FGC and moderators of effectiveness, we studied the process from referral to completion of FGC to gain better insight into the process of FGC. We performed this RCT in collaboration with the *Eigen Kracht Centrale*, the bureau that offers the Dutch version of the original model of FGC (*Eigen Kracht Conferenties*) and *Jeugdbescherming Regio Amsterdam*, a child welfare agency in Amsterdam, The Netherlands. This study was financially supported by the Netherlands Organization for Health Research and Development (ZonMw; grant number: 70-72900-98-13158) as part of a ZonMw programme directed at effectiveness of youth care, subprogramme research into the effectiveness of methods to increase families' strengths. Financial support for this study was granted in the fall of 2013 to Asscher, Creemers, Deković and Stams, who are behavioural scientists in (forensic) child and youth care at the Universities of Amsterdam and Utrecht, and to delegates from the *Eigen Kracht Centrale*, *Jeugdbescherming Regio Amsterdam* and the municipality of Amsterdam. All co-applicants were involved in the development of the research questions and the proposed design to generate answers to these questions. The ZonMw was not involved in this process. In December 2013, Dijkstra was appointed as a PhD student at Forensic Child and Youth Care Sciences (University of Amsterdam) to conduct this study, the study was registered at the Dutch Trial Register (nr. NTR4320) and shortly thereafter, the study protocol was published (Asscher et al., 2014).

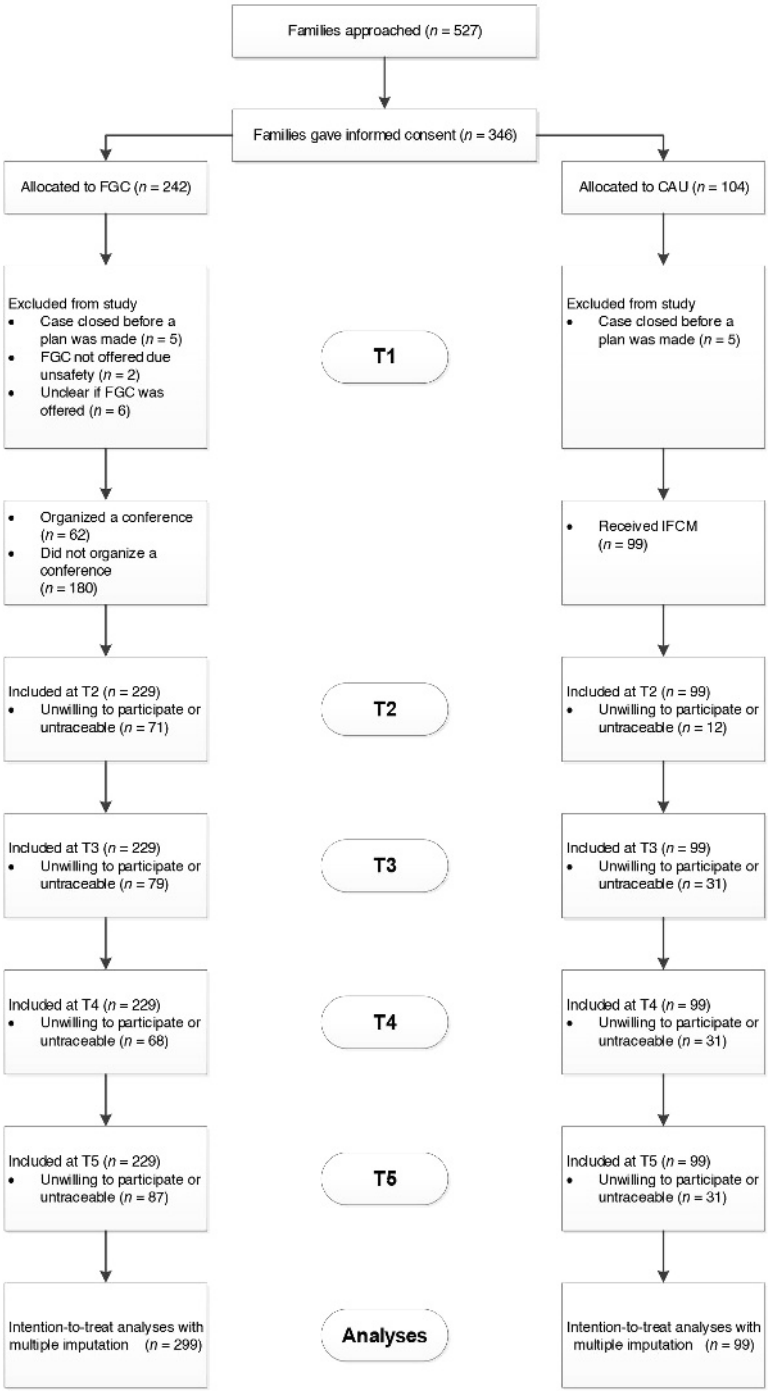
The target group of *Jeugdbescherming Regio Amsterdam* consists of families with multi-complex problems across various domains, such as child maltreatment, mental health problems, alcohol abuse and other drug problems, high-conflict divorce and child behaviour problems. For all families, child safety is at stake, and in most families, risk factors for child maltreatment are present. The care that is offered to the families is compulsory, and in some families a supervision order has been imposed. Since in the Netherlands, decision-making with FGC is believed to be suitable for all families in child welfare, there were no exclusion criteria for participation in this study. All families that were referred to *Jeugdbescherming Regio Amsterdam* in the period January 2014 to December 2014 were approached to participate in the study (Figure 6.1). Of these 527 families, 346 families (66% of total) gave informed consent and were randomly assigned (ratio 2:1) to the FGC group ($n$ = 242) or the control group (Care as Usual (CAU); $n$ = 104). All families (in both the FGC group and the CAU group) received Intensive Family Case Management (IFCM, Busschers et al., 2016), as is the standard procedure of this child welfare agency. This is a supervision and case management method, based on Functional Family Parole Services (Alexander & Robbins, 2010), for engaging, motivating and working with high-risk youth and multi-problem families. Families in the FGC group and the CAU group differed in the decision-making model

that was used to make and instigate their care plan. Families in the CAU group made a care plan in collaboration with the child welfare worker, conforming to IFCM. Families in the FGC group were offered FGC as a decision-making model to make their own care plan with their social network, without the involvement of the child welfare worker.

Of the 346 families, 18 families were excluded from the study because they did not belong to the target group of the child welfare agency, as determined by the child welfare worker (FGC group $n$ = 5; CAU group $n$ = 5) or because the child welfare worker evaluated the risk of unsafety as too high to offer FGC (FGC group $n$ = 2) or because it was unclear whether or not an FGC had been offered (FGC group $n$ = 6). The final sample of 328 families (FGC group $n$ = 229; CAU group $n$ = 99) consisted of 529 children with a mean age of 10 years (M = 10.04, SD = 4.96, range 0-19). More than half of the families had a non-Western background (53%, $n$ = 175). A majority of the biological parents were divorced (76%) and had a low level of education (77%), specifically, only primary education or lower levels of secondary or tertiary education. Almost half of the families were referred to the child welfare agency because of parental problems (49%, i.e. psychopathology or substance abuse), as opposed to child-related problems (24%, i.e. delinquency or school problems) or family-related problems (27%, i.e. child maltreatment). Since families in the FGC group did not differ from families in the CAU group on any of the background characteristics at baseline, randomization of the sample seems to have been successful.

With the use of validated questionnaires (Asscher et al., 2014), data were obtained from parents, child welfare workers and FGC coordinators on five measurement occasions: as soon as possible after referral to the child welfare agency (pre-test, T1) and at assessments 1 month (T2), 3 months (T3), 6 months (T4) and 12 months (T5) after a care plan had been made. In addition, file analyses were conducted. Although at pre-test assessment, complete data were available for almost all families, 25-36% of parents did not complete one or more of the follow-up assessments (Figure 6.1). Child welfare worker reports were not completed for 13-38% of the families, mainly when child welfare workers were no longer involved owing to case closure. Missing data were replaced by multiple imputation (Graham, 2009). When a case was closed during the data collection, missing child welfare worker data were not imputed.

**Figure 6.1 Flow diagram of the study**



## 6.3 Results of Our Study

### 6.3.1 *The Process of FGC*

Our data showed that of the 229 families that were offered FGC, 137 families (60%) accepted the offer and started with the preparation phase. Eventually, 62 families completed a conference, making up 27% of all families that were offered FGC. Parents and child welfare workers were asked why they had declined or discontinued FGC. Reasons for declining the offer and for dropout after starting with FGC were alike and included lack of motivation, high-conflict divorce and a general need for other professional care. Moreover, a small percentage of child welfare workers (9%) reported that they did not see any added value in the FGC approach. Statistical analyses yielded two significant predictors of dropout in the preparation phase; broken and/or newly formed families were less likely to complete a conference once preparation had started, whereas families with indications for child maltreatment were more likely to complete a conference (Dijkstra et al., 2017).

### 6.3.2 *Effectiveness of FGC*

In FGC, families voluntarily decide to accept or decline the offer to pursue a Family Group conference. Since this decision is part of the process of FGC, an intention-to-treat design was applied following the principle of Montori and Guyatt (2001). In other words, all families were included in the analyses, irrespective of their level of completion of the FGC process. Using this approach, potential confounding effects of treatment motivation were eliminated.

We found FGC to be as effective as CAU in improving child safety, reducing indications or risk of child maltreatment and incidence of supervision orders. Although the numbers were small in both groups, FGC resulted in more children placed out of home. In the short term (1, 3- and 6 months' follow-up), FGC was associated with a longer duration of child welfare involvement compared with the case of CAU, which was mostly explained by the long-time families needed to create a care plan. Findings suggest that in the long term, a marginally higher number of professional services was used in the FGC group. The findings for empowerment and social support suggest small positive effects for FGC, although inconsistent over time. Family characteristics, i.e. ethnicity status, complete or broken/newly formed family, education level of parents, parental intellectual disability and referral reason, did not influence the results, indicating that subgroups of families did not benefit more from the FGC approach than others.

**Table 6.1 Programme integrity; key elements and completion**

| Phase | Key elements | Completion: % and *n* families | |
|---|---|---|---|
| Referral | Family want to pursue an Family Group conference and is referred to FGC-coordinator | 60% | 137 of *n* = 229 |
| Preparation | FGC-coordinator has telephone contact with the family for an appointment | 98% | 134 of *n* = 137 |
| | FGC-coordinator visits the family for an informative meeting | 99% | 132 of *n* = 134 |
| | Family agrees with participation and FGC-coordinator starts with preparation after the informative meeting | 68% | 90 of *n* = 132 |
| Conference | Conference takes place | 69% | 62 of *n* = 90 |
| Information part | – Coordinator leads discussion of the purpose of the conference | 100% | 62 of *n* = 62 |
| | – Child welfare worker (and other professionals) shares information on the needs and care options and provides, if necessary, conditions for the plan. Participants can ask questions. | 95% | 59 of *n* = 62 |
| Private part | – FGC-plan is made based on the FGC-format | 97% | 60 of *n* = 62 |
| | – FGC-plan is formulated without FGC-coordinator and professionals | 93% | 56 of *n* = 60 |
| Presentation part | – Family and extended network present the plan to coordinator and professionals. All participants must agree. | 100% | 60 of *n* = 60 |
| | – Participants appoint one or two persons who (safe) guard the implementation of the plan | 82% | 49 of *n* = 60 |
| | – Evaluation date is planned | 65% | 39 of *n* = 60 |
| Implementation | Family and involved persons start working with the FGC-plan | 100% | 60 of *n* = 60 |
| | FGC-plan is the first plan that is made (no other care plan has already been made and implemented) | 37% | 22 of *n* = 60 |
| | FGC-plan (or adapted FGC-plan) is still in use after three months, according to the family and extended network | 57%[1] | 34 of *n* = 54 |
| | FGC-plan (or adapted FGC-plan) is still in use after three months, according to the child welfare worker | 52%[2] | 31 of *n* = 54 |
| | FGC-plan (or adapted FGC-plan) is still in use after six months, according to the family and extended network | 43%[3] | 26 of *n* = 51 |
| | FGC-plan (or adapted FGC-plan) is still in use after six months, according to the child welfare worker | 45%[3] | 27 of *n* = 51 |
| | FGC-plan (or adapted FGC-plan) is still in use after twelve months, according to the family and extended network | 20%[4] | 12 of *n* = 43 |
| | FGC-plan (or adapted FGC-plan) is still in use after twelve months, according to the child welfare worker | 15%[5] | 9 of *n* = 43 |

NB. [1] In 15% of the cases, implementation was unknown (10% case closed). [2] in 18% of the cases, implementation was unknown (10% case closed). [3] In 15% case was closed. [4] In 38% of the cases, implementation was unknown (28% case closed). [5] In 40% of the cases, implementation was unknown (28% case closed).

To get an indication of programme fidelity and its influence on the results, we devised an instrument to assess the level of FGC completion. First, we used the studies of Berzin and colleagues (2007), Marcynyszyn and colleagues (2012), Rauktis and colleagues (2013) and the Guideline for FGDM in Child Welfare (American Humane Association, in Olson, 2009) to determine key elements of FGC. To reach a consensus on the key elements, we organized a Delphi round (Hsu & Sandford, 2007), in which we asked six experts in the field of FGC for their opinions about the included key elements and their importance, on the basis of which we finalized the instrument. This instrument as well as the completion of the key elements in our study can be found in Table 6.1. The average level of FGC completion was relatively low, which could largely be explained by the high dropout rates in the first two phases of the FGC process and – to a lesser extent – by inadequate use of the FGC plans. For instance, at the time of the conference another care plan had already been instigated, no stakeholders had been assigned to monitor the implementation of the plan, no evaluation had been scheduled or the plan was not used or adapted. Higher levels of FGC completion were related to a larger number of different social support sources at T2, T3 and – at trend level – T4. In contrast, higher levels of completion were related – at trend level – to lower levels of parental empowerment at T4 and a larger number of professional services used at T5 (Dijkstra et al., 2019).

### *6.3.3 Cost-effectiveness of FGC*

We examined the cost-effectiveness of FGC in a subsample with complete cost data ($N$ = 69). No significant differences were found between FGC and CAU in terms of costs associated with child welfare involvement at 6 and 12 months after a care plan was made. FGC was not more cost-effective than CAU for all the assessed outcomes. When cost-effectiveness was examined for different levels of FGC completion, results showed that for families that dropped out in the referral phase, the FGC approach was more cost-effective than CAU, whereas FGC was less cost-effective for families that dropped out in the preparation phase or that completed all phases of FGC (Dijkstra et al., 2018).

### *6.3.4 Conclusions*

Overall, we concluded that FGC was neither more nor less effective than CAU in terms of improving child safety and reducing child welfare involvement. Positive effects of FGC for empowerment and social support were small and inconsistent and were accompanied by a longer duration of child welfare involvement and a marginally higher amount of professional care use. FGC and CAU did not differ in terms of cost-effectiveness. Furthermore, on the basis of the family characteristics that were studied, effectiveness did not vary across subgroups of families. Interestingly, our findings indicated that for

some outcomes (i.e. cost-effectiveness, parental empowerment, professional service use), FGC generated more positive results at lower levels of completion. Although further research is needed to better understand the working mechanisms of FGC, these findings may suggest that, in particular, the choice of whether or not to start with FGC, rather than the overall FGC approach, yields positive outcomes. Hypothetically, this choice may provide families with a sense of autonomy and self-direction over the child welfare process and may contribute to setting self-concordant goals, which has been shown to be associated with progress in achieving these goals (Koestner et al., 2002). As perceiving autonomy and experiencing behaviour as self-determined are known to enhance motivation and facilitate psychological functioning (Ryan & Deci, 2000), being allowed to choose whether or not to start with FGC may result in more positive outcomes.

In addition to conclusions on effectiveness, there is empirical evidence showing that the implementation of FGC as a standard procedure in child welfare falls short. Only a small percentage of families completed a family group conference, seemingly because of unfamiliarity with or ambiguity of the aims of FGC. In addition, although the attitude of child welfare workers towards the FGC model was not systematically examined, a small percentage of child welfare workers did report their doubts about using the model, which might have (negatively) influenced the way they introduced it to families. Furthermore, high-conflict divorce partly explained the dropout in the preparation phase. These findings, combined with the long duration of the preparation phase of FGC, suggest that families lack knowledge about the aims of FGC and – when pursuing FGC – need more support throughout the process. An elaborate discussion of our findings and implications for practice is provided in Sharon Dijkstra's dissertation (Dijkstra, 2019).

## 6.4 Methodological Considerations

We conducted this experimental trial in Dutch child welfare on the basis of the conviction that an RCT is the best possible way to test the effectiveness of Family Group Conferencing. Randomized experimentation provides the strongest evidence for causal relations between exposure to method and outcome, because alternative explanations for differences in outcomes between the experimental and control groups, including passage of time and pre-existing differences between the groups, are highly implausible (Cook, 2003). Randomized experimentation is deemed suitable to identify effective methods in everyday practice (in addition to highly structured 'lab' situations), including methods that address a similar problem, but whose delivery varies between participants (e.g., Zwarenstein et al., 2008).

Some have questioned the rigor of the outcomes of FGC evaluated by RCTs. The main criticism is that it is difficult to control the complex social reality of FGC, such as

resistance of families towards professionals and unexpected events that may have a large impact on the results (De Jong et al., 2015). However, randomized allocation optimizes equal distribution of known as well as unknown factors that may influence the results of a method over the experimental and control groups (Dehue, 1997). Consequently, proper randomization results in equivalent levels of resistance towards professionals and an equal likelihood of high-impact events in families in the experimental and control conditions, provided that such factors are not related to the allocated method (also see Creemers et al., 2016). As such, the design controls for the impact of factors other than the studied methods on the results.

Data from RCTs is also valuable for studying the process of FGC. Unlike retrospective studies, which generally focus on the (small) selection of families that succeeded in organizing a family group conference, prospective RCTs also generate data of families that withdraw from pursuing FGC during the process. Furthermore, in RCTs all families in the experimental part of the target group are offered the studied method. Thus, in the case of FGC, child welfare workers offer all families in the experimental group the possibility to make their own family group plan with FGC. This is consistent with Article 4.1.2 of the Dutch Youth Act, which provides that all families in child welfare should be offered the possibility to make such a plan as well as with the belief that FGC is suitable for all families. Because this research design results in a non-selected group of families that are offered FGC, the resulting data allow for examining factors that predict which families are interested in proceeding with FGC and factors that predict the likelihood of FGC completion.

In our RCT, we were able to exceed the targeted number of 300 participating families, allocate them randomly over the FGC and control group and follow the majority of the included families over the course of the research period. These results demonstrate that close collaboration with the child welfare agency and the FGC bureau, in addition to investing time and effort on anticipating practical and logistical challenges, make RCTs in everyday clinical practice feasible. All efforts have resulted in a rich data set that allowed us to provide greater insight into the process and effectiveness of FGC, insight that can contribute to achieving evidence-based social work practice (Gambrill, 2001).

## 6.5 Recommendations for Future Research

In addition to further insights into the process and effectiveness of FGC, our endeavour has resulted in several recommendations for future research. First, there is, to our knowledge, no standardized instrument or checklist to assess FGC programme fidelity. This makes it difficult to establish the extent to which FGC is carried out according to the model. When programme fidelity is not taken into account in effectiveness studies – which is the case in most studies on the effectiveness of FGC – it remains unclear

whether non-significant results can be attributed to an ineffective model or an ineffective implementation (Rauktis et al., 2013). Furthermore, the absence of a standardized checklist and the lack of monitoring of the FGC process according to such a checklist hampers constructive discussion about the results of effectiveness studies, because it makes arguments about faulty or unjustified implementation easy to raise but difficult to prove or empirically support. Although in our own study we did gather information at the family level on how the different phases of FGC were carried out, based on the assessed level of FGC completion and its influence on the results, we believe that more detailed information is needed to better capture the FGC process. This includes, for instance, information on the collaboration between the FGC coordinator and the child welfare worker, which is essential to successfully implement FGC in child welfare. More detailed information is needed not only to better account for treatment fidelity in effectiveness studies, but also to better understand the high likelihood of dropout throughout the FGC process and to guide implementation more effectively and efficiently.

Second, with the general shift from a problem-focused to a solution-focused approach, based on youth and family strengths and shared decision-making between clients and service providers, current standard methods and practices in child welfare include elements that target intermediate goals shared with FGC, i.e. empowerment and active responsibility of the family and its social network. This also pertains to IFCM, the standard practice in this study, in which child welfare workers are trained to activate parents, make shared decisions and involve the extended network. Although the FGC model has some unique elements, including the independent coordinator and the private family time during which the FGC plan is created, it can be questioned whether these unique elements and the way they are carried out sufficiently differentiate FGC from standard practice, such as IFCM. In any case, to further understand the differential effectiveness of FGC in child welfare on the basis of controlled studies, more detailed information on the practices carried out in FGC and control groups is required. This would also be helpful for future meta-analytic studies in this area, as it allows for coding distinguishable programme characteristics that may be included as potential moderators of effectiveness.

Third, although it is important to know which families are more or less likely to benefit from the FGC approach and under what conditions, research in this area is particularly scarce. Our moderator analyses showed no differences in effectiveness between subgroups of families, lending support to the assumption that FGC is not exclusive for a certain type of families. Yet this lack of significant differences among families may have been caused partly by a lack of statistical power to detect moderator effects. Moreover, for dichotomous outcomes (i.e. indications of child maltreatment, out-of-home placement and supervision orders), we could not perform moderator analyses because of lack of data or highly skewed distributions of research participants across

categories. To examine for which families and under what conditions FGC is effective, studies with even larger sample sizes are needed. Such studies should also consider the use of a family-centred approach rather than a traditional variable-centred approach to examine the influence of family characteristics. In studies with a variable-centred approach, family characteristics are treated as single variables in isolation, whereas in practice a particular constellation of family characteristics presents a better context that may affect response to a method or intervention (Pelham et al., 2017). In a family-centred approach, clusters of families are identified on the basis of child-, caregiver-, family- and case factors (Pelham et al., 2017; Leijten et al., 2018). Such studies may generate important information to guide child welfare workers and FGC coordinators in approaching and supporting families and thereby improve clinical practice.

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