Street-level bureaucracy and family group decision making in the USA

William Vesneski
Dotoral Student, University of Washington, School of Social Work, Seattle, WA, USA

Correspondence:
William Vesneski,
University of Washington,
School of Social Work,
Box 354900, 1401 – 15th Avenue NE,
Seattle, WA 98105,
USA
E-mail: vesneski@u.washington.edu

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ABSTRACT
Since its official recognition in New Zealand law in 1989, family group decision making (FGDM) has been utilized by a growing number of child welfare workers throughout the world. In the USA, social workers in 35 states utilize FGDM. The seeming popularity of the practice, however, belies its complex position in American child welfare policy. This brief analytic essay examines this position by focusing on the relationship between street-level bureaucracy and FGDM. Specifically, it describes the role of street-level bureaucracy in FGDM’s diffusion throughout the USA during a time of considerable policy skepticism towards family support, and it explains the dilution of the FGDM model through use of street-level bureaucracy theory. The essay concludes by raising important policy questions concerning the use and replication of FGDM in the USA.

INTRODUCTION
Family group decision making (FGDM) in child welfare practice has gained international prominence in recent years. Put briefly, FGDM evolved from the cultural practice of whanau hui among the Maori of New Zealand. Whanau hui refers to a gathering of immediate and extended kin in order to address and resolve a crisis or critical problem facing the family (Love 2000). Today, FGDM meetings in the USA are often sponsored by child welfare social workers and involve an abused or neglected child’s immediate and extended family with the goal of planning for and ensuring the safety of the child.

Since official recognition as a child welfare practice in New Zealand’s Children, Young Persons and their Families Act in 1989, FGDM has been modified and put to use in countries throughout Europe and North America as well as in Australia, Israel and South Africa. In the USA, FGDM is practiced in at least 150 communities in 35 states (Merkel-Holguin 2003). Although generally viewed as a positive development in child welfare practice, the nature of FGDM’s diffusion throughout the USA raises significant questions about child welfare policy and the role of frontline social workers in the shaping of such policy.

This short essay describes FGDM practice in the USA and it identifies the role of street level bureaucracy as a source of the practice’s diffusion and its varied implementation by local child welfare agencies. Written from the perspective of an academic and former child welfare practitioner, the essay’s goal is to reveal the significant policy questions raised by FGDM for child welfare social workers and policy practitioners.

THE NEW ZEALAND MODEL OF FGDM
The New Zealand approach to FGDM has been described as both a ‘gold standard’ (Adams & Chandler 2004) and ‘best practice model’ (Gill et al. 2003). According to the New Zealand model, decision-making meetings have three stages (Walton et al. 2003). First, they begin with a formal gathering of kin, child welfare authorities and professional service providers during which a detailed report on a maltreated child’s circumstances is presented to all attendees. Second, although family members are very likely to differ in their views about the nature, cause of and solution to their child’s maltreatment, they are asked to come together during ‘private time’ to develop a unified comprehensive plan for the child’s care.
(Merkel-Holguin 2000; Pennell 2004). During private time, family members are able to speak honestly, air out differences and find common ground away from the watchful eye of social workers and court personnel. The family’s plan often includes details about the child’s placement (whether with kin or strangers in foster care), the therapeutic services needed by the child and other family members, and the timelines for service completion. Third, the plan is reviewed by all in attendance, and appropriate benchmarks and individual responsibilities for achieving the plan are identified (Lupton 1998).

Because it assumes that families have the resources, abilities and skills to make sound decisions about their children, FGDM places far greater emphasis on the family’s role in ensuring the safety of an abused and neglected child than does ‘service as usual’ child welfare practice in most countries (Nixon 2000). The FGDM approach also reflects the deeply held commitment among many social workers to empowering, family-centred practice. Finally, and most importantly, FGDM addresses a family’s unique needs and, thus, avoids a ‘one size fits all’ strategy in the commissioning and delivery of child welfare services.

## STREET-LEVEL BUREAUCRACY AND THE DIFFUSION OF FGDM IN THE USA

Family group decision making gained popularity in the USA at the same time that federal child welfare policy was shifting, quite markedly, away from family preservation and support to child safety and protection. This shift became most apparent in 1997 when President Clinton signed the Adoption and Safe Families Act (ASFA). Without doubt, ASFA was intended to recalibrate national child welfare policy which, for many practitioners and scholars, had become too focused on safeguarding the rights of parents’ who had maltreated their children (Gelles 1993). To accomplish its policy goals, ASFA encouraged greater state intervention in the lives of families involved with the child welfare system (who are predominantly poor and of colour) than had existed previously under US law (Huntington 2006). For example, the law shortened the amount of time children were legally permitted to spend in foster care before their parental rights were terminated and it provided the states with financial incentives to increase the rate of adoption among children in care.

At the policy level and in historical terms, ASFA is widely viewed as prioritizing child safety and protection (child saving) over family preservation and support (Larner et al. 1998; Barth 1999; Kemp et al. 2005). The fact that FGDM, rooted in an ethic of family support, took root in the USA at generally the same time that ASFA was enacted is not only paradoxical but a testament to the power of front-line social workers and similar ‘street-level bureaucrats’ – through the exercise of their professional knowledge and discretion – to influence the implementation of national child welfare policy (Lipsky 1980).

Unlike New Zealand and Britain, where FGDM use was fostered by legislation and judicial guidance, the practice emerged in the USA largely through the work of a loose network of stakeholders, including child welfare social workers, local agency officials, private foundation representatives and academics. The American Humane Association, a large nongovernmental organization, has played a longstanding role facilitating this network and encouraging the use of FGDM through online and in-person training and technical assistance (American Humane Association 2007).

Clare Huntington (2006, p. 680), writing in the UCLA Law Review, underscores the role that practitioners, like those active within the American Humane Society, have played in shaping FGDM implementation: ‘Notably, in the USA, social workers, rather than lawyers and legislators, have pushed for its [FGDM’s] adoption’. In their push towards FGDM implementation, social workers have relied less on changing state and federal policies, and more on their own individual creativity, initiative and commitment to address local child welfare conditions and stakeholder needs (Adams & Chandler 2004, p. 109).

Empirical support for this view can be found in a survey completed by Paul Nixon et al. (2005). Based upon a convenience sample of FGDM practitioners and stakeholders from throughout the world (where 63.6% of the 225 respondents were from the USA), the authors found that for a ‘significant majority’ of survey takers, ‘Overwhelmingly, in most sites the mandate for FGC was described as a “best practice” one, driven by enthusiastic professionals wanting to change the way things were done in their organization’ (Nixon et al. 2005, p. 45). In short, as US social workers integrated FGDM into their practices over the last 10 years, they simultaneously adopted a de facto family support policy that differs from, and some might argue, subverts the national policy of child safety embodied in ASFA. Similar examples of local street-level policy-making in the face of countervailing national policies can be found in welfare reform.
VARIATION IN FGDM IMPLEMENTATION

As is typical of street-level policies, the implementation of FGDM varies widely across the USA. One consequence of this variation has been the dilution of the New Zealand model. For example, in the state of Oregon, where more than 10 000 children have been placed into care (Oregon Department of Human Services, State of Oregon 2005), social workers are required to ‘consider the use of a family decision-making meeting in each case in which a child is placed in substitute care for more than 30 days’ (Oregon Revised Statute 1997). Yet, Oregon law neither clearly defines nor ties FGDM use to the New Zealand model. This failure to codify the New Zealand model is significant because it means that private time, the most critical phase of a FGDM meeting, need not occur.

Although the preparation demands of FGDM are significant and critical to its success (Crampton 2007), private time remains the intervention’s signature element. Private time, exclusive of state child welfare officials, is essential because it is one of the few points in a child welfare case when the family’s autonomy and decision-making authority is both supported by the state and free of its surveillance. During private time, family members speak candidly to one another without fear that their statements might be used later as evidence against them in a trial to terminate parental rights.

The dilution of the New Zealand model is not only reflected by a failure to ensure that private time occurs, however. Just as important, it appears that in a large majority of US jurisdictions, social workers independently decide which families to refer to FGDM on a case-by-case basis. The effect of this ad hoc implementation scheme is that some social workers may be highly selective when deciding which families qualify for FGDM while others may employ a divergent set of selection criteria (Crampton 2007).

Even though reliance on professional knowledge and discretion is typical of street-level policy-making (and essential to sound social work practice), in the absence of clear policies and guidelines, it nevertheless leads to troubling questions concerning the uniformity of FGDM implementation. These questions have been consistently flagged in both the empirical and practice literatures, yet they continue to loom over FGDM’s use in the USA (see Bell & Wilson 2006; Merkel-Holguin 2000; Walton et al. 2003; Pennell 2004). Among the most pressing is whether social workers refer only ‘easy’ cases – those where families are most likely to achieve positive outcomes – to FGDM. And, if so, what is the fate of families who are at the greatest risk of poor outcomes? Similarly, to what extent are social service supports and funds directed to supporting families’ plans and what impact does funding variation have on differences in outcomes?

CONCLUSION

Family group decision making in the USA stands at the intersection of competing child welfare policy values. Specifically, in the face of ASFA, which called for greater state intervention in the family, FGDM actively supports a family’s ability and freedom to serve as its children’s caregiver. FGDM is a family-centred intervention during a time when the protection of individual children is a paramount US policy priority.

That FGDM implementation would vary across the USA (and the world, for that matter) is to be expected given the social work profession’s respect for practice-derived knowledge and worker wisdom. Additionally, globalizing forces, such as the Internet, have not only contributed to FGDM’s rapid diffusion, but they have helped spur its local adaptation by making research, knowledge and best practice information readily available to front line workers and agency administrators through comprehensive websites (such as http://www.americanhumane.org). Undoubtedly, the New Zealand model, as it is understood today, is in itself an adaptation of an indigenous Maori cultural practice. Nevertheless, the reliance on social worker discretion in FGDM implementation raises important questions about its equitable use in the US child welfare system – a system already characterized by few resources and the disproportionate involvement of children of colour. The lack of uniform implementation illustrates the ambivalence and uncertainty in the USA towards the appropriate balance between child safety and family preservation.

Given this complex policy environment, US social workers must act mindfully when utilizing FGDM. In the absence of larger national and state guidelines, we must critically reflect on the practice’s origins, its
potential disjunctures with federal policy values and the implications these disjunctures have for our work with vulnerable families. At the same time, policy- and lawmakers must grapple with the implications of FGDM’s bottom-up incorporation into social workers’ practice repertoires. At present, there is limited acknowledgment at the policy level that practitioners have a principled and abiding commitment to family-centred practice. This commitment requires that both legislators and agency administrators recognize the limits and possible ineffectiveness of policies that emphasize either child protection or family preservation to the exclusion of the other.

The concerns raised in this essay are not meant to argue against the use of FGDM. FGDM is, potentially, a deeply empowering and emancipatory process that is both consonant with social work values and supported by a growing and generally positive, yet still incomplete, evidence base (e.g. Pennell & Burford 2000; Gunderson et al. 2003; Marsh & Crow 2003; Sundell & Binnerljung 2004). As professionals committed to social change, however, we cannot ignore the troubling policy questions raised by FGDM’s use.

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REFERENCES


