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Family Group Conferencing Worldwide: Part Two in a Series

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Part one in this series can be read at: www.iirp.org/Pages/fgcseries01.html

This is part two in a series about family group conferencing (FGC), a restorative process that empowers families to make decisions, usually made for them by outside officials, concerning the care and support of their children. Part one of this series mainly emphasized FGC in child welfare and contained a brief explanation and history of FGC. In addition to other child welfare FGC programs, parts two and three will address FGCs in adult mental health, youth justice, domestic violence and school applications, as well as FGC theory and philosophy.

FGC began in New Zealand and has spread throughout the world. The key features of the New Zealand FGC model, where it is built into child welfare law, are preparation, information giving, private family time, agreeing on the plan and monitoring and review. The critical criterion for including an FGC program in this series is the use of private family time. Private family time indicates a crucial paradigm shift fully in tune with the International Institute for Restorative Practices's (IIRP's) definition of restorative practices and its goal of building a global alliance for family empowerment. During private family time, after hearing information about the case, the family is left alone to arrive at its own plan to address the concerns at hand. This component of FGC is essential in taking the decision-making process out of the hands of professionals and governments, and putting it back in the hands of those people who are directly affected.

FGC programs are in progress in the Nordic nations of Finland, Norway, Sweden and Denmark. The Nordic FGC Project, coordinated by Tarja Heino, of STAKES (National Research and Development Center for Welfare and Health), Finland has helped implement and conduct evaluations of FGC in those countries, funded by the Nordic Council of Ministers. To view the STAKES website about FGC in the Nordic countries go to: www.stakes.fi/hyvinvointi/NFRS/english/english.htm

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Each Nordic country has approached FGC in a slightly different manner, but in each one the state has been active in importing, developing, exploring and implementing the practice. This series covers programs in Finland and Sweden. Information in this article about the Finnish program is drawn from Heino's paper: *The Focus on Children in Family Group Conferences: Results from the Finnish project on the FGC method, 1997-2000*, which she presented at the Fam-

ily Rights Group Conference, in Manchester, U.K., October, 2002, as well as from a conversation with STAKES FGC researcher and coordinator Sarianna Reinikainen.

The Finnish FGC pilot ran from 1997 through 2000, funded and implemented by STAKES, with help from 26 participating municipalities and five local NGOs. The project developed a Finnish FGC model, a handbook and other training materials. FGCs continue, sponsored by STAKES, in 50 out of 448 municipalities in Finland. FGC is used chiefly in the most difficult child protection situations, where a decision must be made about a child's living arrangements.

The Finnish FGC model is exceptionally child-centered. In child protection cases, the FGC process begins when the social worker holds a meeting to introduce the possibility of an FGC to the client, which is defined as the entire family, including children, even small children. Said Heino: "We know from ... studies among children who have experienced family violence that the children know about the violence between parents and it has an impact on them—and that being well informed helps them to overcome these experiences."

If the family agrees to hold an FGC, each member, children included, signs a written agreement. If a child of 15 or older does not agree to the FGC, it does not occur. The coordinator asks professionals involved in the case to write their views of the situation, instructing them to focus on the children's

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issues. The family receives the reports before the conference so that there are no surprises at the meeting. The coordinator finds someone from the child's network—preferably not a professional—to be his or her advocate. In Helsinki there is an extensive coordinator bank from which to draw. Two coordinators are used for each FGC—one for the children and one for the adults. Reinikainen said that this is especially effective when trying to reach people important to the child. A child's perspective is different from an adult's, she emphasized. Children's coordinators meet with children, as young as possible without parents present, to obtain their point of view.

Five to 20 people from the family network attend each FGC. The child is always present at the conference, even if he or she is very young. She may wander in and out or play if she gets bored, eat if she's hungry, sleep if she's tired. "The child is there to help participants remember who is the focus of the process," said Heino. In the first part of the conference, the professionals read their reports about the child (which the family has already seen). The coordinator helps the professionals refrain from discussing the parents and stay focused on the children. The profes-

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sionals then take questions from the family network. Children, with help from their advocates, are given an equal opportunity to ask questions. Next, the family network has its private meeting. The professionals wait outside, available if needed. If a child has chosen a professional as his or her advocate, the coordinator tries to find someone else to substitute in that function. Families have trouble being honest with professionals around and say things they think the professionals want to hear, said Reinikainen. The family has a concrete set of issues to discuss



A meeting at a Finland FGC seminar: (from left to right) Project Coordinator Tarja Heino from STAKES, Eeva-Liisa Tamski, Sirku Mehtola, Maija Pietiläinen, Monika Possauner, Juha-Pekka Vuorio and Liisa Korhonen

in their private meeting and, focusing on the child's needs, develops a plan to address those issues. The plan must be clear about who does what and when.

The family network then reconvenes with the professionals, telling them what kind of support they might need to fulfill the plan. The child must be able to understand what has been agreed upon for his or her protection. The professionals need to agree to accept the plan as in the child's best interest. A follow-up meeting is arranged, to be held in three months' time or sooner, to ensure that the family network is upholding the plan.

People in Finland are very interested in FGC, said Reinikainen, and the practice has spread to many types of situations. Good results have been obtained with young teens that are acting out and behaving obstinately or skipping school. On Åland Island in West Finland, an FGC project involving parents who couldn't agree on custody and visitation issues worked very well. Still, said Reinikainen, FGC is not in use everywhere, because some social service providers are afraid of giving up responsibility to the family network. Reinikainen believes that FGC should be part of basic social work studies, as well as part of Finnish law. These things have not happened yet, but Reinikainen believes and hopes they will happen in the future. "This [FGC] project is very alive," she said.

FGC began in Sweden in 1995 with several local projects, said Mats Erkers, FGC Project Leader of the Botkyrka Municipality, south of Stockholm. Six months later, he said, the national Swedish FGC project began. The practice got a boost following the legendary 1996 "grandma revolt," when grandmothers took to the streets to protest the state placing their grandchildren in foster care and prohibiting contact. This made for lots of debate, said Erkers, and eventually to a change in laws governing child welfare.

In May 2000, Botkyrka's FGC unit arranged the First Nordic FGC Conference, with about 200 participants from Sweden, Finland, Norway and Denmark, which strengthened the

network between different Nordic groups of FGC practitioners. The network developed the Nordic FGC project, led by Tarja Heino of STAKES, Finland. Erkers is responsible for the Swedish FGC unit of this project. Eva Nyberg of the Department of Social Work, Stockholm University, is in charge of research and development for this unit.

FGC is in practice in 40 out of 240 communities in Sweden. FGCs are voluntary in Sweden, not mandatory, as they are in New Zealand. However, if a child can't stay with his or her parents, social workers are required to investigate whether he or she can be placed with an extended family member or other close person, and the parent does not have the right to prevent such a placement. Parents can choose whether or not to participate in an FGC, but social workers can always involve the extended family, even without the parents' permission.

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The FGC project in Botkyrka is separate and distinct from those in the rest of Sweden, said Erkers. "In my area, we made our own project from the beginning and it is now a

permanent organization,” he said, adding, “We are the most successful area in Scandinavia because we have been working with FGC for many years and have built it into the system. It’s not a project anymore, it’s ordinary work.” In Botkyrka, said Erkers: “We learned from New Zealand and have full-time coordinators who only do FGC.” In other parts of Sweden, he said, professional coordinators are not used, only laypersons.

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In Botkyrka, when a social worker believes a child is at risk or if a child is in a placement situation outside the home, parents may choose an FGC as an alternative way to plan for the child’s future. FGCs are also used in other situations, e.g., with children having difficulties in school or adults with drug or alcohol problems. For the most part, however, FGCs are reserved for children at high risk. Time and resources determine priorities: In preparation for FGCs, coordinators in Botkyrka must sometimes travel 1,000 miles to meet with extended family members and funds must also sometimes be provided for these family members to attend.

After the family makes the plan, they reconvene with the professionals, who review the plan with respect to safety concerns. Most Botkyrka FGC plans place the child with a family member. Usually, the child stays with a parent and receives support from the extended family. Sometimes the child moves from the mother to the father. There is almost always at least one follow-up meeting to make sure that the plan is working. “It’s good to have the opportunity to change things,” said Erkers. There is security in knowing that a follow-up meeting will be held, making it possible for a family to take risks.

Erkers believes that FGC has changed the values of child welfare workers in Sweden. FGCs compel social workers to be clear about their own rules—e.g., why a child is at risk—and to translate their expertise to ordinary people, providing clear information about what kinds of services are available. Social workers used to think it was good to place children outside the home. Now they generally believe that such placements cut children off from their roots. “Now all social workers in Sweden know they have to help children and families be together,” said Erkers.

The struggle between different social work perspectives continues, however. Some professionals still don’t want to give too much power to the extended family because they’re afraid the family doesn’t know what’s best for the child, said Erkers. He believes that private family time is an essential part of transferring power from professionals to families. “Without private family time, it’s not FGC,” he said. During private family time, families must think for themselves. “Families are used to social workers making suggestions about their lives,” he said, “but it’s not good for people when they don’t have to think about their own future.” Said Erkers: “FGC helps family members keep the focus on the child’s future, not on the past, and gives families the resources to help them come together in respectful ways.”

Essex County, U.K. is the site of a unique program using FGC in the area of adult mental health. The North Essex Mental Health Partnership Trust (NEMHPT), a combined trust of health and social care, in partnership with Essex County Council Social Services, developed an FGC pilot study for mental health service users (i.e. patients or clients) not restricted to families with children. This is a new and unusual application for FGC. Information in this article is from the NEMHPT and Essex County Council Social Services publication: *Supporting People Together: FGC in Mental Health Services, Research Finds and Practice Developments*, by Linda Flynn, service manager, mental health, NEMHPT, Chelmsford, N. Essex; Julia Hennessy, service manager, FGC and Family Centres in Essex; Robin Mutter, researcher; and Nuala Judge, researcher, as well

from as a conversation with Linda Flynn. The program’s website is: www.essexcc.gov.uk/socialservices/fgc/FGCMentalHealth.asp

The adult mental health FGC pilot began in 1998, when it was ascertained that a very high percentage of children in child welfare FGCs came from families with mental health difficulties, said Flynn. Supporting People Together emphasizes that FGC is not family therapy, but a planning process with a “practical emphasis designed to increase support, challenge isolation and combat discrimination against individuals ... who have mental health difficulties.” FGC is based on the belief that service users and their families are the people who know most about their difficulties and that service users can and have the right to make informed choices about their lives, their difficulties and their treatment. The 16 service users who took part in the pilot had been diagnosed with personality disorder, bipolar disorder/manic depression, schizophrenia, psychosis and Asperger Syndrome.

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It was important that the pilot have a multi-disciplinary base, said Flynn, so a steering group of representatives from health, children’s and social services; district council; carer and service user groups; voluntary organizations and the local university was enlisted to develop the project. Funding was secured and a methodology for evaluation and analysis was set. Sixteen FGCs were referred between July 2000 and May 2001, and conferences were held between October 2000 and the end of August 2001.

The University of East Anglia (UEA), based in Norwich, Norfolk, U.K., gathered the pilot research, independent of statutory services. UEA’s David Shemmings was project research consultant. Qualitative and

quantitative data were gathered from the first 16 conferences, including questionnaires and interviews with participants and a three-month-plus follow-up with service users. Among pilot participants, 85 percent said they felt empowered by the conference and 90 percent said they were able to obtain the information and resources they needed.

Since the pilot's end, adult mental health FGCs have become a regular part of mental health service in Essex, funded by a joint commission of health and social services. In two-and-a-half years, 74 mental health FGCs have been held (as of March 2003), with extremely good outcomes, said Flynn.

Changes were made to the Essex child welfare FGC model to adapt it to adult mental health. The former focuses on planning for the needs of children. The child's wishes and feelings are very important and are taken into account, but if the child is young it is adults who ultimately make the decisions. In adult mental health FGCs, the service user has the final say in decisions relating to her life:

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whether she wishes to be referred to an FGC, who is invited, what plan is made, etc. An FGC senior practitioner drafts a report outlining the service user's areas of need, which the service user signs, consenting to share information with conference participants, all of whom are given a copy of the report prior to the conference. Children's services FGCs can be held in times of crisis, but adult mental health FGCs are not convened when service users are acutely ill. "You can't empower people if they're psychotic or delusional and believe their family is out to get them," said Flynn, adding that it's better to wait until the service user is stable. Adult mental health FGCs involve two coordinators: a care coor-

ordinator (who oversees the service user's care) and an independent FGC coordinator.

When families get together for a mental health FGC, said Flynn, they want to know: what do the diagnoses mean? What are the effects/side effects, etc. of drugs? What are the warning signs of a mental illness emergency? What do you do/whom do you call to forestall a crisis? Through FGCs, service users and family support groups learn how to recognize warning signs of deterioration, such as when an individual stops taking medication, and what to do and whom to contact in such circumstances. FGCs improve the quality of mental health service in terms of care and planning and help service users engage and plan for themselves. Plans generally focus on concrete proposals involving who does what and when.

FGCs help service users achieve what most want: good quality care in their own homes and communities when it's timely and necessary, instead of waiting until the last moment and risking recurrent hospitalization, said Flynn. The more deterioration and crisis can be averted, the greater the likelihood of improvement, she said. Most service users who took part in the pilot had been sectioned (committed) to the hospital pre-conference. None have been sectioned since. In two years, out of the first 50 mental health FGCs in Essex, 20 people had been admitted to the hospital for mental health reasons pre-FGC. Only two had to be readmitted post-FGC.

Flynn said that FGCs work particularly well with individuals who have personality disorder, whom she described as people who can be difficult to work with and may exhibit chaotic, anti-social or self-harming behavior. FGCs are good for providing structure and setting boundaries, she said, and people with personality disorder tend to operate better when provided with a rigid structure.

There is a powerful stigma attached to mental health problems in the U.K., and individuals with such problems are often considered dangerous, said Flynn. Through FGCs, both families and professionals become much better informed about mental health issues. People can sometimes do embarrassing things when they're unwell, said Flynn. She cited the case of a man with

bipolar disorder living with a wife and teenage daughter. He stopped taking his medication and his wife didn't know what to do. The man turned up at his daughter's school and made disturbing gestures, then lost control at a newspaper stand, whereupon the owner called the police. The man was sectioned to the hospital, his condition stabilized. The family couldn't bear the thought of him coming home, said Flynn.

An FGC was held with the man, his extended family, neighbors and police. Everyone learned about the symptoms of bipolar disorder—what might happen during a manic

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episode—and the support group came up with a crisis plan. They would make sure that the man continued to take his medication. If there were any difficulty they would alert his care coordinator. Asked at the conference why he had stopped taking his medication, the man said he had a problem with side effects, but that no one would ever listen to him about it. In the conference, the professionals listened and the man's medication was changed, making a big difference to him. And because his family, friends and neighbors now understood that his illness had a biological basis—that the man was not a "nut" or a "raving mad-man," he was no longer stigmatized. His daughters' friends, who had been afraid to come to her house, began to visit regularly. Since the FGC, the man hasn't had a manic episode, said Flynn.

The most disturbed people tend not to engage, so "we can't reach them," said Flynn. FGCs give disturbed individuals a way to engage on their own terms. There is often much secrecy concerning mental illness, along with a reluctance to obtain help by both service users and their families

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because of fear, guilt and/or shame. FGCs help service users break through these feelings, which can prevent them from asking for help from family members. Post-FGC, one service user said: "It certainly allowed me to open up more and admit that I needed their support, whereas before I was tending to hide my feelings." FGCs are particularly effective in combating social isolation. Participants contacted up to after 12 months post-FGC reported that the enhanced regular contact initiated by families' plans produced qualitative improvement in service users' relationships with family and friends.

FGCs significantly increase the effectiveness of the support network both by decreasing feelings of fear and shame and by coordinating and integrating how networks, service users and professionals work together. FGCs effectively draw family and friends into the support network and add new members to the network. The collective nature of meeting as a group dispels misunderstandings. After an FGC, one family member said: "Since [service user] has become ill it's been me liaising with them [other family and friends]. ... The story can get a bit distorted from what it actually is. ... [But] with everyone in the room, nobody could go away not understanding what was going on."

FGCs are empowering, putting service-users and support groups in a position of influence over the process. A family member expressed how families sometimes feel excluded from the treatment process: "Officials don't like family getting involved. I think we mess things up for them; and all their good work goes to pot when we go in and say, 'No, that's not right ...' I'm sure the hospital didn't like us, 'cause there was always one of us on the phone saying, 'What's going on? ... We don't think this is right.' ... And a lot of them are quite patronizing, you know ... It's, 'Sorry, but you're not professional, you don't understand.' ... When you live with [service user], you do understand what [service user]'s going through, but suddenly you are being told, 'No, I'm sorry, you don't understand.'" FGC redresses the problem of alienation between family members and professionals by drawing the two groups together in a coordinated complementary support system.

The toughest barrier to break down was the medical model, said Flynn—the one that says, "We'll tell you what's wrong and what to do about it." But now, she said, there are a lot more people on-board with FGCs,



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and mental health legislation in the U.K. is all pointing to involving families, along the themes of empowerment and inclusion. Said Flynn: "The beauty of FGC is that it's so simple. It's all about treating people the way you would want to be treated yourself." She said that everyone she talks to tells the same story: "Somewhere in my family is a significant mental health issue." National statistics in the U.K. indicate that one person in four has a mental health problem at some point in their lives. But, Flynn concluded, "If we carry on with stigmatizing, we'll never get anywhere."

An FGC child welfare program is thriving in San Diego County, California, U.S.A. Elizabeth Quinnett, Acting Chief in Children's Services, Health and Human Services

Agency, County of San Diego, and training consultant on FGC with the Academy for Professional Excellence, San Diego, helped to develop the program. In San Diego, FGC is known as Family Unity Meeting (FUM). More than 800 FUMs have been held in San Diego County since 1999. For the last two years, cases of children under age six where the parents are involved with drugs and alcohol have, by Children's Services mandate, been referred to FUMs. When the FUM program started, the area's presiding judge, the Honorable James Milliken, went to New Zealand and "came back sold on the idea of family conferencing," said Quinnett. Milliken's advocacy and high level of understanding of the process have helped the program's success. All judges in the area are aware of the practice, and others in the judicial system understand it. When they see an FUM plan attached to a child welfare report, they know what they're looking at, said Quinnett.

San Diego FUM is a hybrid of Oregon FUM and New Zealand FGC. The term FUM is used in San Diego because Quinnett and her staff were originally trained in the Oregon FUM model. At first, as in Oregon FUMs, San Diego didn't use private family time. (In San Diego it's called family alone time.) However, once they tried it they liked it so much that they've used it ever since. The name FUM was retained because it was well-known in the community.

In San Diego FUM, exploration of "strengths and concerns" in meetings is very important. Many perpetrators have a very clear idea of what's wrong with them, said Quinnett, and it's very empowering for them to hear their strengths. "A person's whole affect changes," said Quinnett, adding, "It's a powerful tool to build on and keeps the meeting focused." A break follows the strengths portion, during which participants share food together. This is very important, said Quinnett, because it further breaks down the hierarchy in the room between family and professionals and emphasizes that everyone is there out of concern for the children. Afterwards, people bring up painful history and current concerns. (In San Diego FUMs, the term "problem" is deliberately avoided because of its negative implication, replaced by "concern".)

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Co-facilitators are used in San Diego FUMs. "When your buttons get pushed you can back each other up, and it helps with the flow. One person writes on the flip chart, the other facilitates," said Quinnett. There is a large bank of workers in the agency to help co-facilitate. Quinnett would like to see an FUM unit in each of the six regional offices in her area. She would also like to see FUMs in the receiving home where children who have been taken into custody are held, "when the family is in crisis—at the front end."

FUM throws the safety net a lot farther around the child than conventional child welfare practice, because it brings in so many more people, makes much better connections to resources in the community and strengthens connections within the family, said Quinnett. FUM also dramatically improves attitudes toward agency workers, because families feel respected. "We're not saying, 'I am the almighty social worker and you are the lowly bad person.' We're giving responsibility back where it belongs," she said. FUM increases placements within the family—a beneficial outcome, because "the system doesn't make a good parent," said Quinnett. She tells her staff to remember that they're just temporary in people's lives—there to get the family network set up so that when they leave the network is in place.

Now, however, the \$35 billion California budget deficit threatens the existence of San Diego FUM. A federal audit found that many areas needed improvement, but praised FUM, said Quinnett. But she's afraid that as workloads become heavier for social workers, they'll have to cut back to mandated services like investigating child abuse, and programs like FUM will be the first suspended. When the program began they were able to pay facilitators overtime to work evenings and weekends—the most convenient time for families to attend FUMs. Now she is afraid overtime will be cut. Quinnett hopes that FUMs can be part of every child welfare system some day.



Family Unity Meeting staff, County of San Diego Health & Human Services Agency, Children's Services: (bottom row) Dave Roob, Rebecca Slade; (middle row) Bob Kuchta, Joaquin Zavala; (top row) Liz Quinnett, Amy Markin, Mary Sorgdrager

"I never fail to be amazed at what families can come up with," she said, adding, "Child abuse is not the end. Like any crisis, it's also an opportunity."

You may reach Elizabeth Quinnett at marrsquinn@prodigy.net. Quinnett's plenary speech about FUM, delivered at the

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IIRP's 3rd International Conference on Conferencing, Circles and other Restorative Practices, can be read at: www.restorativepractices.org/Pages/mn02_quinnett.html

A child welfare FGC program is ongoing in New South Wales (NSW), Australia, under the auspices of the NGO, UnitingCare Burnside and the NSW Department of Community Services (DoCS). Information in this article is drawn from a conversation with the Patricia Kiely, clinical psychologist and manager of Burnside's family work program, and her paper: *A Longitudinal Evaluation of Family Group Conferencing*, delivered at the Association of Children's Welfare Agencies conference in Bondi Beach, Australia, 2002.

Kiely said that their Family Decision Making project began in 1996 when Burnside invited a New Zealand FGC practitioner to speak in Australia. Burnside negotiated with DoCS, which refers cases to Burnside, to obtain funding for an FGC project. DoCS liked the model because they saw it as a way to place children whose parents had problems with drugs, alcohol or violence within a wider family network, said Kiely. Ultimately, DoCS and Burnside each provided half of the funding for the project. Burnside's website is: www.burnside.org.au/

Outcomes of the 1996–1998 NSW FGC pilot, evaluated by Dr. Judy Cashmore, were very positive, said Kiely. A longitudinal research project that followed up with families for five years has now been completed. The project sample group, drawn from the Cumberland/Prospect area in Sydney, NSW, included a random selection of 30 of the 40 original families referred to the project: 15 who completed FGCs and 15 who were referred to the project, didn't proceed to FGCs and were referred to traditional case planning processes.

The most common risk factors in both groups were domestic violence, drug and alcohol issues and criminal activity. The most striking finding of the study, she said, was the increased percentage of extended family placements provided in the FGC group for their vulnerable children—both respite and foster care. The increased placements

coincided with a decrease in smaller types of kinship supports, such as taking a child to a doctor's appointment or providing monetary aid. Giving a child a place to live is a comprehensive type of support and negates the need to provide as much other kinds of support, said Kiely.

Children under age 12 were more likely to receive kinship placement than were older children. Kinship placement in the older group was more difficult to find because of these children's challenging behavior, said Kiely. Still, FGCs enabled older children to gain knowledge of what was available and retain contact with the family group. In the traditional process group, children did not want to stay with their placements and tended to lose contact with their families.

There were reductions in temporary care orders, reports to statutory services and home visits post-FGC, suggesting a reduced need because children were now living in safe conditions. An increase in longer-term wardship orders was found in the FGC group. Wardship is not always a negative, Kiely explained, citing the case of a mother with a long history of drug and alcohol problems who had been in and out of jail. At the woman's FGC, the family plan stipulated that her child be assigned a court-ordered wardship with a maternal aunt. For the length of the wardship, the family wanted to be able to build a relationship with the mother that did not focus on getting her fit for motherhood right away. A wardship can also provide security for children: Sometimes families want the statutory authority "to be the big stick," said Kiely. A family might opt for a wardship order with an aunt so that she can legally prevent parents from suddenly showing up drunk or drugged and taking their children away.

Kiely emphasized, "FGC is not welfare on the cheap," adding, "The expectation that increased family support would reduce the need for community support was not confirmed." There was an increase in services provided to families who took part in FGCs. Families who have been in the welfare system a long time often receive no services, said Kiely, whereas FGCs facilitate better assessments and targeting of services. Kiely cited the case of a physically abused four-year-old from a family with

a history of severe mental illness. The child had never been assessed until preparations were made for an FGC. But due to those preparations, representatives from various resources were brought to the conference and the family could choose between them. "When representatives of services are invited to FGCs, it's surprising how quickly services are provided," said Kiely. There is normally



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-Patricia Kiely

a seven-year waiting list for public housing in Sydney. But at an FGC where the family group decided that a family member needed a house in order to care for a child, a housing department liaison made a house available. Such stories abound involving FGCs and the availability of speech pathologists, pre-school placements, etc., because at FGCs service liaisons get to know the family, see

everyone working together and want to work with them.

"FGCs changed the way the department worked with families," said Kiely, adding, "It used to be a hostile environment. The professionals didn't believe that families should make decisions, kids would be safe or families would keep their promises. But everything changed after family group conferencing was introduced."

In 2000, legislation in NSW put FGC in place as an alternative dispute resolution model. Burnside will continue to provide FGCs, said Kiely. In addition, she said, Australian Aboriginal FGC practitioners affiliated with DoCS are employing a model with the same philosophical base as New Zealand FGC that fits well with the Aboriginal approach to decision-making.

Another successful FGC pilot program was launched in Hennepin County, Minnesota (which includes the city of Minneapolis and surrounding suburbs), in July 1999. Kathleen Holland, Supervisor of Hennepin County Department of Children, Family and Adult Services (CFASD) said that the program was built on a solid foundation with support from judges, public defenders, county attorneys and child welfare administrators. A dialogue occurred between all these parties to determine how they were going to give families a voice while meeting safety and protection needs. Without those "tough discussions," said Holland, the pilot would not have been successful. Holland especially noted the contributions of CFASD head Dr. David Sanders and Hennepin County Judges Robert Blaeser (a member of the White Earth Band of the Minnesota Chippewa Tribe), and Herbert Lefler, in supporting FGC initiatives in Hennepin County.

The Native American council system's commitment to raising children is a good fit with FGC, as is the old-fashioned American small-town notion of a community coming together to care for its children, said Holland. The FGC pilot program aimed to reestablish connections to those traditions, both of which can be found in Hennepin County. With the integral support of the court, child welfare services and the legal system, CFASD has been able to hold more than 250 con-

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ferences in about three years and is working toward making FGC an integrative practice considered in every child welfare case. "If a case opens in our department," said Holland, "we're willing to talk to the family about the [FGC] process."

Funds for Hennepin County's FGC pilot became available through a federal Department of Human Services court improvement grant as part of a push toward family reunification. Aims of the pilot were somewhat determined by Minnesota's six-month permanence time limit for children under age eight who are in foster care, and 12-month limit for older children, said Holland. The state liked the idea of FGC as a mechanism to encourage reunification. FGCs shorten the timeline in many child welfare cases by eliminating the trial process, which Holland called: "emotionally damaging and expensive." In contrast, FGCs are respectful, improve communication between family members and create a circle of support among families and between families and professionals.

The success rate of plans devised in FGCs is high, said Holland. All plans are reviewed by social service workers, and, if appropriate, by a tribal council, according to the terms of the Indian Child Welfare Act of 1978. If the plan doesn't meet safety and child welfare standards, specific recommendations are made so that the family can address the matter again. The social service worker who refers a case to FGC continues with the case and sees to the implementation of the plan.

Holland named the elements she considers essential to FGC. They must be voluntary. "People must come with the desire to sit down together and solve the problem, not blame each other," she said. Facilitation must be neutral; "People must know that the facilitator has no investment in the outcome." There must be "enough of a support system to re-define the sphere of support." Holland cited the example of a woman who wouldn't let the department involve any family members in her FGC, but invited 26 service providers. "That's not a family," said Holland, adding, "Whenever life's crises come up, we need to be able to go to family—to take care of the kids, for transportation, school and health issues." Holland said that CFASD has been

very effective in bringing fathers into the mix. Often, she said, there are multiple fathers in a family, and all attend the conference. Also, in an FGC, it is important to consider not just the family's problems, but it's strengths. In addition, it is essential to focus exclusively on the needs of the child—to suspend adult issues for the time being and think through the eyes of the child. "This is about kids staying connected to their families," said Holland.



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—Kathleen Holland

By extension, it's about creating a more solid base for our society.

FGC is adaptable to many cultures. Families are asked to share their values and rituals at conferences said Holland. Hennepin County has a diverse pool of community providers to co-facilitate FGCs for non-English speaking families and those of varied ethnic backgrounds. Conferences are held at community sites to provide a neutral setting and encourage community involvement.

One struggle involves determining how to run FGCs effectively when domestic violence is a factor, said Holland. CFASD is partnering with domestic abuse agencies and relying on their expertise. CFASD is also working with

14 community agencies to resolve other types of problems. A new FGC project, "Youth in Transition," has been launched to help children move from the child welfare and foster care system to independence, and another project is in development to help youth in the juvenile justice system transition back into the community. Holland hopes that FGC will someday be used to resolve all sorts of community processes, including helping seniors plan for future needs. The Hennepin County FGC website is: www.co.hennepin.mn.us/cfasd/family_group_conferencing/fgc.htm

A new Children Act passed in the Republic of Ireland in 2001. "Based on the premise that detention should be used only as a last resort and should only be considered after a range of community-based measures have been exhausted, the Act provides for family group conferences and other new provisions to deal with unruly children or those children with special needs," reads a web-page by Ireland's North Western Health Board (NWHB). NWHB Family Group Conference Manager Joe Cullen, who has worked in the foster care field for 22 years, said he thinks that the new law was a long time coming. In 1995, he proposed an FGC pilot, but was unable to raise funding or arouse interest in the idea. Then Frank Fahey, a junior government minister for children, went on a fact-finding mission to New Zealand, met Mike Doolan, and learned about FGC. Impressed with the way the FGC handed decision-making to families and with the number of Maori children it had discharged from state care, Fahey initiated an FGC pilot with the East Coast Area Health Board and John O'Riordan in the greater Dublin area in 1999. The pilot involved families in decision-making and asked how to prevent children from coming into the care system, said Cullen.

Since January 2001, the NWHB has held 25-plus New Zealand model FGCs in the Donegal area in northwest Ireland, which have had "some wonderful outcomes," said Cullen, adding, "This is the model that works." Via FGCs, 14 children were discharged from the care system to the extended family network and six children were prevented from being received into care. "All the situations held," said Cullen. The

families came together and were handed the authority to make their own plans, which were presented to the health boards. The boards were delighted with the outcomes.

However, Cullen said he was worried about the health boards' ability to work with plans that families devise. There is a financial crisis with the health boards in Ireland, which don't have a system of payment for extended families. "The preventative stuff always gets cut," he said. Yet, said Cullen: "We can do [FGCs] at very little cost financially." He said they've "been looking at money for kinship placement, doing it informally," adding, "Social workers have to be creative in trying to put things in place."

Unfortunately, a panel recommended that the same stringent standards apply to relative foster care as apply to stranger foster care. This is "the straw that breaks the camel's back," said Cullen. He cited cases where FGCs placed children with relatives; an assessment of those relatives took place months later, after the children had bonded; the relatives failed the assessment and the children were taken away. Different standards should be available for relative foster-carers, said Cullen.

Pressure on social workers is unbelievable now, said Cullen. New statutory requirements make it increasingly difficult for them to do their work; all they can do is respond to crisis after crisis. Social workers signed up to do FGCs to work in partnership with families, he said, but when social workers are pulled from the partnerships by statutory requirements, it becomes difficult for families to hold up their end. But with the social workers that are committed to FGCs, the results are absolutely wonderful. "This keeps us all plugging away," said Cullen.

Complicating matters further, a new model—Family Welfare Conferencing (FWC)—was introduced with the Children Act 2001, which is far from Fahey's initial vision, as it incorporates significant changes from the New Zealand FGC model, said Cullen. FWCs are not about intervention. Their purpose is to bring families together to consider special care orders. FWCs can be triggered by the health board applying for a special care order for a non-offending, out-of-control child who is a risk to him or



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herself or others, or when a child needs to be detained. The child must be deemed unlikely to receive care or detention unless a court makes the order, and the health board must convene an FWC before making the order. In the future, if a child is charged with an offense before the court, a judge will be able to order an FWC if there are concerns about the child's care and protection because of lack of parental supervision. This part of the law hasn't been enacted yet, said Cullen. In any case, the boards don't have the resources and people aren't yet trained for it, he said. "The board will be inundated with inappropriate referrals," said Cullen, adding, "These are interesting times."

Cullen was concerned that orders for FWCs "come so far down the line in the child's life, when special care orders are required, that these children have burned all their bridges." He is also worried that "we'll get pulled into the statutory piece and won't be allowed to do FGCs" and that resources will be pulled away from FGC by FWC.

Other services and projects are developing and calling themselves FWCs, not FGCs, and a national FWC health board committee has been established. Cullen is on the committee, feeding back to the board to get the message across about "what the likely outcomes will be if we go down this road," he said.

The FGC structure, with private family time and families having decision-making power, has not been written into the law pertaining to FWCs, but Cullen is lobbying for that to happen. He believes that legislators need to be educated that the initial vision was for family group conferencing and that the FGC model should be in the center of FWC. "Families need to be listened to," said Cullen, adding, "The safety net is in the wider family. They've got the expertise and knowledge that we'll never have."

FGC continues to be implemented in many nations as its uses expand to include myriad applications. This is true despite the fact that in numerous locations FGC practice is threatened by cuts in government spending. The next piece in this series, appearing soon on the Restorative Practices eForum, will explore additional locations where FGC is in use, as well as other diverse applications. ☺