



# Using Family Group Conferencing in the Children's Mental Health Context

By Jeanette Schmid

Family group conferencing (FGC), first legislated in New Zealand in 1989 as a decision-making process in child welfare and youth justice, has a growing number of additional applications, including education, children with special needs, and aging populations (American Humane Association website).

In Toronto, FGC was initially used exclusively in child protection. However, it soon became evident that it could be successfully applied in the children's mental health context. The Toronto FGC Project Steering Committee—a collaboration of agencies focusing on child welfare and children's mental health—had an appreciation of FGC philosophies and values, which made the transition to include referrals from clinicians a natural shift. Nevertheless, it became obvious that the model required some adaptation for this different context. This paper provides an overview of issues that need to be considered when using conferencing in a children's mental health context.

The number of mental health referrals to the Toronto FGC Project is small, and they originate from various partner and other agencies. Similar to the experiences in child welfare, it takes time to create a culture in which clinicians routinely use conferencing to complement their work. The project endeavors to build ongoing mechanisms to create awareness and education through presentations at team meetings, training, and newsletters.

### How is conferencing different from therapy?

Counselors and FGC coordinators need to articulate to service providers, family members, and others how

conferencing differs from therapy. When a decision about a child's behavioral, emotional, or special needs must be made, conferencing can be a successful process for positioning the family members as leaders in making that decision. It is a process that is directed by the family rather than the therapist. Conferencing does not focus on the interactions between parties and on communication, though the process of conferencing is likely to impact family member relationships.

The Toronto FGC Project has applied conferencing in the children's mental health context when children are:

- suicidal;
- having significant issues regarding school, e.g., school refusal;
- developmentally delayed;
- having separation anxiety or conduct disorder;
- likely to experience adoption disruption;
- being impacted by a parent's physical or mental health;
- living in out-of-home care and seeking reconnection with their kin; and
- needing a longer term plan for their permanency.

With the above scenarios, there usually is no current child welfare involvement. Although many of those concerns may also be found in child welfare referrals, in those cases, the child protection issue is the focus of the conference.

### Relevant FGC principles and goals

It is important to review how conferencing principles translate into the children's mental health context before examining how the model functions. Typically, in children's mental health, the issues of concern are identified as being located within the individual and/or the immediate family system (Smith, 2002). FGC, however, allows for a holistic, expanded understanding of concerns, seeing the children in the context of their nuclear family, extended family, and community.

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The definition of issues is also frequently deficit-based in traditional interventions (Graybeal, 2001). Conferencing widens the dialogue beyond the challenges, to include family strengths and a broadened kinship system and community, hence offering a different starting point for making a decision and creating a plan.

The notion of “family” is widened beyond the nuclear family, to include kith, kin, community supporters, and anyone with a significant relationship to the child. This contributes to a broader range of perspectives and increases the potential supports available to the family. Without a statutory framework like that found in the New Zealand Children, Young Persons and Their Families Act to guide FGC practice, this expanded definition has implications regarding consent and the sharing of information. The predominant culture is predicated on a more narrow definition of family, embedding the power of decision making in the nuclear family, particularly the parental unit. Conferencing, by resurrecting the lost notion of the child being part of a larger extended family and community, creates the dilemma of who has the right to make decisions about children’s well-being.

A key goal of conferencing is to expand a family’s support network during crises. Traditional therapeutic interventions identify individuals, and sometimes their nuclear families, as the “client,” and focus the work on that unit. While counseling may help people unlock their strengths, the narrow focus can inadvertently sustain isolation. In the extreme, the professionals supporting an individual may become the family substitute for that individual. Over the long term, this can undermine the family’s competency and create a dependency on the service provider.

Oftentimes, family members feel quite burdened by, or ashamed of, the mental health issues they are confronting, which makes it difficult for them to reach out to their family circle. In addition, a common

phenomena in families is the burn-out of those playing a supportive role. Mothers have told FGC coordinators that “they have used up” the people around them. A vicious cycle is set up where these families become increasingly isolated.

Conferencing, by facilitating the larger family system in creating decisions and making plans, guards against the type of therapeutic intervention that isolates children from their larger familial system and context. It promotes professionals working in partnership with the family, rather than working on an isolated, parallel track.

Networks are strengthened through enhancing connections within the family group and through the education that may take place through the FGC preparation process. This process enables the identification and customized use of resources, both within the kinship system and within institutions. Family members have reported, “We feel closer since having the conference.” A grandmother recently stated, “There has been healing here. My son and I have been struggling with issues for a long time. Today I have seen that these are not mountains, but molehills, and we know that as a family we can conquer these challenges.” Her son said, “I thought we were dealing with a huge complex problem. But if each of us commits to doing one simple thing, then the problem becomes simple.” In another, very emotional conference, two grandmothers who had conflict committed to relating to each other in a way that would be supportive of their grandson and promote his best interests.

The issue of connectedness is not only about the family network as a whole. It also speaks to the child’s place within the family. “Belonging” is a key theme in therapeutic work. Both family and culture are inherent to the child’s sense of belonging, which is the context for the child’s sense of self (Love, 2000). Children benefit from having a circle of care and from being

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connected to a network of adult resources (Daniel & Taylor, 1999). When children are placed outside of their family for behavioral reasons precipitated by family-specific stressors, or for safety reasons, they often feel distance from their family. Conferencing reinforces the children's links with their kinship system. One family member who came from far away to attend a conference commented, "My presence here shows Josiah how important he is. It shows him that everyone that is connected to him, whether they are from here or away, had to be here today to work out a way of improving his life." A teenager for whom a plan was being developed stated at the end of a conference, "I will never have to say again that I was abandoned." A final principle that needs to be considered is that of expertise. In the therapeutic context, the focus on the therapist's expertise results in a concomitant lessening of the client's role in decision making. This dynamic is reinforced by clients typically seeing the service providers as experts and deferring to their opinion, and it is underscored by therapists seeing it as their professional imperative to solve problems on behalf of their clients. Even when they support the values of partnership, it can be difficult for therapists to turn over leadership to, or share it with, their clients. Consequently, the voice of clients becomes marginalized and diminished (Waldegrave, 2000).

Conferencing does not undervalue the expertise of service providers, but suggests that it is critical to harness the wisdom, knowledge, and expertise of the broader family system in making decisions. Family private time, a cornerstone and unique element of FGC, positions the family as leaders by leaving the family network alone to caucus and develop the initial plan and recommendations. It signals that the group is sufficiently competent to arrive at a plan, and it demonstrates concretely a respect for the family's privacy.

### Applying FGC in a mental health context

Typically, the FGC coordinator receives the referral

from the clinician, and then meets with the immediate family, relatives, and friends to prepare them for the conference. Other professionals engaged with the family are also invited to participate and prepare for the conference. The three standard stages of the FGC—information giving, private time, and a review of the plan—are followed.

A number of conditions need to be met for a successful referral. First, the crisis needs to be perceived as such by all parties. In child welfare and juvenile justice applications of conferencing, the question of leverage seems to be a central motivator for conference participation. In children's mental health, there are fewer situations where there will be an institutional response if no conference is held. For a conference to materialize, it is important that the family members believe that the situation is sufficiently critical for them to attend and that developing a plan is pivotal to the family's stability. The central question to be addressed at the conference must have meaning to everyone in the family group, and should impact core issues rather than symptoms. The early work of the coordinator is to help the referring clinician, and the family, to identify a clear focus that will function as an anchor for the conference. As many mental health referrals involve a complex range of issues, the coordinator can support the clinician to distill the concerns into one anchoring question to be addressed.

Second, a clear delineation between the coordinator and therapist roles is essential. Therapists serve as information providers, not problem solvers, judges, or arbitrators, and therefore become less central in the process. Although not central to conference preparation with the family, within the context of the broader therapeutic goals, therapists will have conversations with their clients about the conference process. At all times, however, the counselor needs to avoid directing or influencing the plan. In addition, the coordinator clarifies with the referring clinician an additional role of supporting the family in

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implementing the plan, if requested (e.g., accessing other service providers). The clinician should also be aware that the family group may not identify additional therapy as part of the plan.

The coordinator shepherds the FGC process and is not an extension of the therapist. The job of the coordinator remains to prepare the participants for the conference, to widen the circle of invitees, and where necessary, in conjunction with the family, to develop safety plans that enable full participation at the FGC. The coordinator has a relationship with all family members, while the therapist is usually engaged only with the client(s).

Often, family groups expect clinicians to play the role of the expert because of their knowledge and understanding of complex mental health issues. However, therapists need to be cautious about repositioning themselves as the expert decision makers. But it is appropriate for the coordinator to support the clinician's delineation of information and expansion of possible resources.

In sharing information at the FGC, the clinician is not sharing child protection concerns, and therefore can be freer in providing observations. However, while the power differential between the family and child protection worker is explicit and thus more transparent in a child welfare referral, the power dynamic in the mental health context cannot be overlooked. In providing information, the counselor should focus on the needs of the child, rather than advocating for one family member and risking polarizing other family group members. This can be difficult for a clinician who has loyalty to the particular subsystem with whom the clinician has been engaged. The coordinator's challenge is to ensure that the service providers share only the critical information related to the child's needs, and to hold service providers accountable for conducting their role in a way that is congruent with FGC philosophies.

Because counselors fear that they will jeopardize the relationship they have with the client, they often resort to global, positive descriptions of the situation. Clinicians need to be supported by the coordinator in speaking explicitly and honestly, not only to the strengths, but also to the issues that the family group needs to address. When the most critical issues are not presented, the family group is misinformed and ultimately—and perhaps inadvertently—disempowered.

In the third phase of child welfare FGCs, the worker is responsible for accepting or rejecting the plan, if the plan meets the articulated thresholds of safety, permanency, and well-being. However, in the concluding phase of the FGC for mental health referrals, the dynamic is different. In this context, clinicians only “receive” the plan and can, without reserve, commend the family for its hard work and commitment to the child. The process allows the family to be the true “author” of the plan. There may be some negotiation about how the clinician can support the plan, and family members may offer to become part of the counseling contract. This distinction raises the question about how the presence or absence of an external person with approval or authority impacts the concept of empowerment.

Post-conference, the clinician has the role of supporting the family (or particular members) through the implementation of the plan. Although the therapist may help connect the family to other resources, the therapist's support with implementation is more likely to be on an emotional level. It is important that the clinician does not automatically revert to focusing on, or advocating exclusively for, the individual client. Rather, it is hoped that the clinician shifts to focusing on the family group as the client.

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In the Toronto project's experience, the focusing on child mental health issues will be shorter than the 5-hour average typical of child welfare conferences, and the size of the participating family group may be smaller.

## Conclusion

The implementation of FGC in a children's mental health context is a work in progress. However, it is important that practitioners, whether they are prospective referral sources or coordinators, understand the variations in FGC roles and process when applied in this context. The differences between the child welfare and the children's mental health models arise from the fact that the clinician is not in a mandated role vis-à-vis the family; the clinician is tasked to interact with the family in a way that is quite different from the role of the child welfare worker. Reflexive practice is encouraged for any children's mental health center that hopes to incorporate conferencing into its palette of services.

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