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DOI:

[10.1080/09503153.2018.1563588](https://doi.org/10.1080/09503153.2018.1563588)

Document Version

Peer reviewed version

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Citation for published version (APA):

Rapaport, J., Poirier-Baiani, G., & Manthorpe, J. (2019). Social Work in the Canadian province of New Brunswick: reflections on family group conferencing. *Practice. Social Work in Action*, 31(4), 291-302. <https://doi.org/10.1080/09503153.2018.1563588>

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Accepted 5 December 2018 by Practice: Social Work in Action

**Social Work in the Canadian province of New
Brunswick: reflections on family group conferencing**

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Abstract: The Family Group Conference service in New Brunswick has considerably reduced the numbers of children being taken into state care. The initiative has also had a positive impact on social work caseloads and practitioner self esteem. This descriptive account seeks to explain why New Brunswick opted to introduce the Family Group Conference, how the initiative was implemented and what outcomes were achieved. Implications for research and future development with reference to a recent English initiative are also considered.

Key words: Family Group Conference; Family Group Conference coordinator; social worker; systems' change.

Introduction

Imagine being told that your caseload as a children and family social worker was to comprise an average of just seven families. Now imagine hearing that if an 'untoward incident' occurred, your employer would first and foremost anticipate that the fault would most likely lie in a systems' failure, rather than individual

error. This is the general position in respect of child welfare social work in New Brunswick, Canada. The quality of the province's social work workforce and robust implementation of the Family Group Conference (FGC) are cited as contributing to this situation (ANONYMOUS, 2015, a; 2015,b). The social work context and development of the FGC initiative in New Brunswick are described below.

The Family Group Conference: background and development

Social Work matters

The Canadian Association of Social Workers (CASW) represents the unified voice of social work in Canada and works from a national and international perspective to promote the profession. In line with CASW objectives, at provincial level the New Brunswick Association of Social Workers (NBASW) promotes excellence in social work practice and high standards of qualification. It works for social justice and social change. NBASW is also the regulatory body for all social workers who practise in the province. Thus, in contrast to the United Kingdom (UK) and by default, all registered social workers in New Brunswick are members of their professional body. NBASW is authorized to protect the public and to investigate complaints made against members. The provincial government recognizes NBASW as the 'legal' voice of the profession (NBASW, 1989). In the last few years, three social workers, one from New Brunswick, have been awarded the Order of Canada, the second highest national honour, for outstanding professional service.

The high status of this award suggests that the profession is generally well respected.

Social work training programmes vary across Canada. New Brunswick requires graduate or post-graduate achievement as a qualifying minimum. However, New Brunswick is the only officially bilingual Canadian province. English and French speaking social work students are trained at Anglophone and Francophone establishments respectively. A member of NBASW is deputed to supervise newly qualified staff and returnees for an initial period. Child welfare social workers are employed by the Department of Social Development (DoSD). The DoSD has been in charge of its own budget since it split from the health department in 2000. It is able to set its own priorities without competition from the pressing demands of health services.

As in many countries, high profile child-care tragedies have caused public and political outcry in New Brunswick. The case of Juli-Anna in 1996 was the first of such well-publicized cases. There was widespread recognition from within the DoSD that something had to change (Gagnon, 2015). Senior management at that time were strongly influenced by the findings of Dr. W. E. Deming (ANONYMOUS 2015,a), described as a mathematics genius, engineer and eminent management consultant, who, through scientific method and statistical analysis proposed 'The 85 - 15 Rule' as summarized by Walton (1991):

'Everybody works within a system governed by conditions over which the individual has no control ... The 85 – 15 Rule holds that eighty-five percent of what goes wrong is with the system and only fifteen per cent with the individual person or thing'. (Walton, 1991; 20)

The DoSD senior managers held that the child-care tragedies were due to systems' rather than workforce failures (Gagnon, 2015). They decided that a systems' change was necessary to improve the province's child welfare services and set about investigating viable alternatives.

Changing the system

Marc Gagnon, DoSD Director, has described the challenges of finding an evidence-based model that would enhance the wellbeing and safety of families and children and enthuse the child welfare workforce to embrace the ethos of a new system:

'Although pressure for change was enormous we needed to take time to establish the vision and values that would guide this change and lead to this reform with courage and determination and most importantly to find an evidence based model that would create safety and ensure wellbeing for children (Gagnon, 2015;3).

The DoSD commissioned Mike Doolan, then of the University of Christchurch, New Zealand, described as an internationally renowned researcher and academic with expertise in the development of child and family welfare services, including the FGC model. A committed FGC advocate, Doolan (2004) argued that if families are given the right information with appropriate resources and the necessary professional expertise they will be able to make and implement safe and

protective plans for their children. The DoSD decided to implement the FGC model with the twin objectives of improving its child welfare service and reducing the rising numbers of children coming before the courts and into state care. Doolan visited the province to help develop its FGC programme and also advised from a distance. He later returned to provide training and to review progress.

The FGC model is a process led by family members that offers a framework to empower family members to plan and make decisions about a child deemed to be at risk (see Box 1 for New Brunswick's summary of FGC components). It aims to improve engagement, to promote sustained impact and to reduce risks with positive outcomes for children and their families.

BOX 1 – Family Group Conference (FGC) components

The FGC process involves several key stages:

- Point of referral and allocation of a family group coordinator;
- Preparation: identification of the nuclear family, extended family and friends who play an important part in the life of the child or children in question. Coordinator meets the family network to explain the safeguarding concerns and the FGC process;
- Actual conference: coordinator ensures all who attend understand the purpose of the conference and process;
- Private family time: officials and coordinator withdraw to allow attendees to consider possible solutions to the identified concerns and devise a plan;
- Presentation of the plan to the authority: plan is agreed and implemented;
- Review of plan: at a later stage;
- Provision to refresh the review if the plan fails or needs to change (New Brunswick).

Preparations for the introduction of the FGC programme began in 2006. The DoSD received a government budget to initiate the new service. It enlisted media interest from the press and Mike Doolan's visit to the province received positive

news coverage. It also worked with partner agencies such as health, education and the police and a raft of community groups. Standards and monitoring arrangements were devised. A specific training programme, the *Intensive Competency Welfare Training System*, incorporating problem solving, conflict resolution and family therapies, was introduced for all staff working in child welfare. The Family Services Act 2008 provided the legislative framework for the service and established the FGC as a legal entitlement. Arrangements to evaluate the new programme were made with the University of Moncton (ANONYMOUS 2017). A separate FGC department operating within the DoSD was created and in 2009 the initiative was fully implemented.

FGC implementation

Currently (2018) only social workers with five years post-qualifying experience can apply to work in the FGC service. The FGC coordinators and child welfare social workers meet regularly to discuss protocols, practice and feedback on cases. The coordinators carry three to five cases at any one time. The service promotes a no-blame and no-shame culture (ANONYMOUS, 2017). The focus is on finding solutions to family problems and what the child wants. Where court proceedings are underway, in contrast to the situation in England where specified time limits apply (Children and Families Act 2014), there is no time pressure to force the pace of FGC proceedings.

Social workers are mandated to offer the FGC in accordance with the law. If the child and family accept the offer, the social worker provides the coordinator with

a full social history and risk assessment. The coordinator introduces him or herself, ascertains who should attend the meeting, explains the process and objectives and asks about venue and menu preferences. The coordinator facilitates the meeting and reminds all who attend that the objectives are to find a solution to keep the child safe. During the private family time both the coordinator and social worker are in another room. The social worker is available for advice about support services that the family might want to know about such as treatment options, care and custody legalities and healthcare benefits when finalizing the plan. A FGC supervisor is available to call by mobile phone if the coordinator or social worker requires support. When the family presents its agreed plan the social worker is ultimately responsible to ensure the identified safeguarding objectives are met. The plan must be signed by the social worker, coordinator and all the family and other attendees for it to be authorized. A review takes place at a later date. The coordinator facilitates this review meeting and the social worker participates. If the plan fails or needs to change another FGC meeting can be held. Plans can be reinforced or changed.

Outcomes

Within the first year of implementation there was an almost twenty percent reduction in the numbers of children before the courts and in state care (ANONYMOUS, 2015,a). By 2014 this reduction had risen to around twenty-five percent and was still the case in 2017 (ANONYMOUS, 2017). This development resulted in considerable financial savings for the DoSD. These were reinvested to increase the size of the workforce. Social work caseloads reduced dramatically

(Gagnon, 2015) from about fifteen families to an average of seven (Innes, 2014; ANONYMOUS 2015,a; ANONYMOUS, 2017). As a consequence, social workers were able to work with families more intensively with better outcomes for children and families. As at 2017, approximately twenty-per cent of families opt for the FGC. Feedback from families using the specially designed service user 'FGC Feedback' form suggests those who experience the FGC are highly satisfied with the service (Gagnon, 2015). Mike Doolan has accredited New Brunswick's progress as a 'shining light' in FGC development (Innes, 2014). However, the reasons for the eighty percent refusal rate have not to date been investigated.

Six case anonymized studies compiled by coordinators and social workers involved with the FGC (ANONYMOUS, 2015,b) have been constructed to convey an impression of typical service referrals who choose to participate in FGCs (see Table 1). Certain personal and situational characteristics have been changed to safeguard anonymity.

Table 1: Illustrative case examples using Family Group Conferences

Case Study	Summary of main concerns and outcomes
One	Children in care, heading for long-term care and eventual adoption. Parents with addiction and relationship problems. FGC: extended family persuaded parents to accept treatment and agreed to monitor their attendance. As per plan, children were gradually returned to parental care. Social worker continued to review until deemed no longer necessary.
Two	Unexplained injury. Parents needed treatment and help with self-care. FGC: extended family agreed to support child-care, help parents with self-care and to accept treatment. They agreed to help with access to services and to provide child-care to enable parents to attend appointments. After the review the department was able to withdraw.
Three	Child neglect. Parents had severe drug misuse problems. Child was non-verbal and rocking. FGC: large family gathering. Family agreed to help the child and family with practical support, house cleaning and helping child to access specialist service. Child eventually returned to parents who had worked hard with their treatment plan.

	<p>Following fresh concerns a new FGC was held. The family regrouped and reactivated the support plan. They were reminded that the plan was a 'living plan' that was to continue beyond the department's involvement.</p> <p>Five years later the child was seen in the community with family. The child was talking. There had been no more concerns.</p>
Four	<p>Mother with mental health problems. Concerns about her ability to child-care. FGC: children released to the care and legal custody of their fathers with the long-term plan mother should resume care responsibilities after rehabilitation.</p> <p>Mother was unable to commit to her treatment programme. The children remained with their respective fathers. Five years later there had been no reports of further concerns.</p>
Five	<p>Mother receiving considerable support without any improvement. Concerns about domestic violence and addictions. Grandparents were caring for the child.</p> <p>Two FGCs: Extended family became knowledgeable about the protection concerns, took responsibility for the problem and sought resolution. Mother's health gradually improved. The child was returned to her care with family support.</p>
Six	<p>Mother and children were homeless and moving between friends. Concerns about her ability to care. Children came into care and were heading for long-term care and adoption.</p> <p>FGC: Extended family attended. Grandparents offered to provide child-care. An assessment confirmed they were a safe option. They were granted custody of the children.</p>

These cases suggest the strength of family decision-making and sustained commitment to achieve attainable child welfare objectives once the right information and support had been provided. The FGC review was essential to ensure that the plan was on track and providing the necessary safeguards. Ongoing social work support to help families to succeed was evidently important in most of the case examples. However, the social workers would have been powerless to divert the children away from state care and possibly adoption without the support of these families. Families and social workers are here shown to be working reciprocally maximizing each other's strengths to achieve mutually desired goals. This drives to the heart of social work and is a potential morale booster for the profession. The dynamic of interaction between families and social workers and implications for role theory are further explored elsewhere (ANONYMOUS, 2017).

Implications for future FGC development

United Kingdom (UK)

The UK has also had the experience of high-profile child care tragedies, the case of Baby P being the most well known in recent times. The media and political focus was on professional failings and personal blame (Jones, 2014) rather than first investigating the possibility of systemic failings. Professor Eileen Munro earlier highlighted the limitations of the inquiry process that have contributed to prescriptive and defensive practice:

‘... a readiness, in high profile public inquiries into the death of a child, to focus on professional error without looking deeply enough into its causes; and the undue importance given to performance indicators and targets which provide only part of the picture of practice, and which have skewed attention to process over the quality and effectiveness of help given’. (DfE, 2011;6).

The number of children taken into care has continued to rise in recent years (DfE, 2017), with huge implications for public expenditure. Based on 2012 – 2013 statistics the average cost of a foster care placement was estimated as £29K - £33k annually and that of a residential placement, £131k - £135k (National Audit Office (NAO), 2014).

About three quarters of local authorities in England and Wales claim to offer FGCs (Mercer et al, 2015). Although introduced into the UK in the early 1990s and since

promoted in official guidance (DfE, 2010; FRG, 2011), the initiative appears to date to have had little transformative impact. However, unlike New Brunswick, many FGC services in the UK are outsourced to the voluntary sector and staffed by a range of professionals and non-professionals and only sometimes by social workers. There is no legal entitlement to the service. A recent report found that policies regarding how families access the FGC are not always clear (Mercer et al, 2015). Wilkins (2018) highlights the importance of knowing how the FGC is organized to understand how this affects its true impact. Yet surprisingly, given claims that the initiative has the potential to improve child welfare at reduced public expense (FRG, 2011; Hughes, 2015), little is known about how well FGC services in the UK are performing. This begs two important questions: 1) why has research into FGC efficacy been neglected? and 2) what are the barriers and facilitators to the implementation of FGCs? It may be that there are competing child welfare initiatives and FGC development requires further policy encouragement. However, the answers to both questions may stem from a limited body of research and other evidence about FGC performance and effectiveness.

Research imperatives

Systematic reviews and meta-analyses are designed to provide a complete, exhaustive summary of all available evidence relevant to a particular research question. Two such reviews by Skaale and Christensen (2014) and Dijkstra et al (2016) investigated the available FGC literature. Whilst the former found children were more likely to remain in kinship care as a result of the FGC, the latter found the incidence of out of home placements actually rose, particularly where older

children or those from ethnic minority groups were involved. However, both reviews found no significant reduction in the incidence of maltreatment. Doolan (2004) also acknowledges that children remaining with their families or kinship care may be no worse off. However, he points to the documented downsides of state care, such as the instability of out of home placements, children growing up with a sense of loss and displacement and lack of attention to child-care planning.

However, the authors of both reviews acknowledge a number of weaknesses in the research quality of the studies examined. As one example, Dijkstra et al (ibid) highlight problems in making direct comparisons because of the variety of approaches used and in drawing conclusions from retrospective studies that relied on file data that was sometimes incomplete. A pattern of haphazard and poor recording practices, even regarding crucial FGC objectives, were also observed in the Family Rights Group publication, *Report on the impact of the Public Law Outline on Family group Conference services in England and Wales*:

'Unfortunately however, most local authorities/FGC projects do not have in place information systems for recording when FGCs are being held during the pre proceedings process nor for tracking outcomes of FGCs, including whether care proceedings have been avoided'. (FRG, 2009; 5).

The report additionally notes inconsistencies in social work practice in making FGC referrals and between and within local authorities regarding preparation and timetabling at the pre-court proceedings stage. There was also an apparent lack of consistent follow up support for families and friends that casts doubt on whether

reviews were always taking place. The FGC process was observed in some cases to be regarded as a mere 'tick box' exercise. Whilst several encouraging outcomes were also acknowledged, the report's findings suggest that some local authorities have ignored the importance of obtaining outcome evidence and cost-effectiveness on the FGC position in the recent past. This circumstance may in part help to explain the apparent dissonance between the findings of the above meta-analyses and the positive outcomes now emerging from a series of focused evaluations that provide a comprehensive picture FGC performance (Rodger et al, 2017; Munro et al, 2017 and Mason et al, 2017).

A contemporary evaluation programme

Family Valued (Mason et al, 2017) was a Leeds City Council system change initiative, funded by the Department for Education under its Social Care Innovation Programme. The evaluation took place between March 2015 and December 2016 (*op cit*, 2017). A key element was the expansion of Leeds' existing FGC to a scale unprecedented in the UK, including for families experiencing domestic violence. The evaluation incorporated multiple strands of inquiry: qualitative interviews, observations of practice and surveys of practitioners and families and analysis of administrative data and an impact analysis of outcomes and cost effectiveness.

The Leeds City Council FGC and New Brunswick's initiative have several similarities. Both derive from a systems' change perspective and are located in a wider culture of values-based practice. Both collaborated extensively with allied

organizations in the preparation stage and developed a tailored training programme for FGC staff and social workers, although the focus in Leeds is on restorative practice. Given its funding base, Leeds also benefited from an injection of development money, evaluation focus and central government interest.

Restorative practice and the introduction of an Innovations Team to develop family conferencing for families experiencing domestic violence were key components of this FGC expansion. A new approach that focused on helping perpetrators of violence whilst keeping families safe was established. In contrast to the position in New Brunswick there is no legal entitlement to the FGC in the UK. However, the Leeds' social workers received training to implement the expanded service and were required to offer the FGC to families referred for an initial Child Protection Conference. The restorative practice approach was reported to be liked by social workers because it promoted collaborative work with families and supported them to make important decisions about their lives. Some social workers considered restorative practice to be 'good social work', even in one case 'good old fashioned practice' (Mason, et al, 2017; 13).

Leeds' FGC outcomes show similar trends to those of New Brunswick in terms of the number of looked after children and to a lesser extent the average size of social worker caseloads. Financial savings were also found, with further benefits expected as the longer-term impacts of the programme unfold. Family satisfaction ratings were very high. Both Leeds and New Brunswick examples lend support to the argument that FGC outcomes may be further improved if also combined with additional family therapy (Holland and Rivett, 2008).

Overall, the *Family Valued* evaluation findings suggest improvements in keeping families safe. However, whilst the numbers of repeat domestic violence referrals decreased, the fact that any continued serve as a stark reminder that risk cannot be entirely eradicated. The potential for negative risk was found to remain particularly where the victim continued to feel sympathetic towards the perpetrator. These risks existed whether the perpetrator (usually male) had been totally or partially removed from the family, or had taken responsibility to change his behaviour and was later readmitted to the family network. Even in this last example where the perpetrator had made the most fundamental change, the reality of possible risk to the family, victim and children and reputation of the organizations concerned had to be faced.

Summary and concluding comments

The FGCs in Leeds and New Brunswick suggest positive outcomes in respect of the numbers of children taken into state care, social work caseloads, professional morale, family satisfaction and public expenditure. However, whilst the two systematic reviews painted a less rosy picture, researching the FGC and its efficacy presents many challenges. For a start, as the FGC initiative is implemented in numerous ways (Skaale and Christensen, 2014), there are difficulties in making direct comparisons between services. In terms of objectives, should effectiveness be based on long or short-term outcomes? How should a FGC service be judged if vital support services such as family centres, clinics or transport arrangements are cut? What weight should be given to the subjective feelings and satisfaction

ratings of the families and others involved? How should attitudes, relevant to the way information is provided and received, be accessed?

These variables suggest that any investigation of FGC performance requires multiple lines of inquiry as demonstrated in the *Family Valued* evaluation report. New Brunswick appears to be recognizing the importance of obtaining data on outcome evidence and cost-effectiveness as part of routine practice. However, whilst progress in the UK has been slow, a framework for ongoing evaluation has now been created to investigate short, medium and long-term outcomes. Given the comprehensive cover of the FGC and service developments and the views of families and practitioners, the Leeds' experience is highly relevant and accessible. However, whilst the intention is to keep families and children safe and to improve child welfare services, the evaluation also recognizes that risk is a reality. It may be minimized by good systems and good practice but never entirely eliminated.

Systems' shortcomings were implicated in the deaths of Juli-Anna (Hughes, 2015) in Canada and of Baby Peter (Jones, 2014) in the UK. The FGC systems in New Brunswick and Leeds have led to improved outcomes for some families and children and in so doing, appear to have helped to boost the social work profession. The implementation of FGCs may be taking root in receptive services and among professionals.

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