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## **Exploring approaches to child welfare in contexts of domestic violence and abuse: family group conferences**

This article sets out to explore service provision for families affected by domestic violence and abuse (DVA). For most families where there are child protection concerns, there are possibilities for intervention from child welfare agencies and domestic abuse services but these have been criticised as having distinct and disconnected practice cultures and orientation. Recognising this divergence, in this paper we advocate for safeguarding children affected by DVA using the family group conference (FGC) model. This offers possibilities for a coherent response which integrates both child- and women-centred concerns in a holistic approach to family safety and wellbeing. Furthermore, it is well documented that safeguarding work involves professionally-led decision-making which is pre-occupied with the management of risk. Family group conferences, however, promote a partnership approach which engages families in a more democratic decision-making process. As such, FGCs offer families the opportunity to develop their own safety and support plans for the protection and care of children recognising the family's inherent strengths.

**Key words:** child abuse, domestic violence and abuse, family group conferences, child protection, strengths

### **Introduction**

This discussion paper explores the benefits and limitations of current service provision and family group conferences (FGCs) for children and families affected by domestic violence and abuse (DVA). The interplay of DVA and the experiences of children has received considerable attention in recent years. Despite this, statutory services have struggled to develop effective responses to families experiencing DVA (Hester 2011) and services appear overwhelmed by the sheer enormity of the problem in terms of its prevalence, impacts and structural roots (Stark 2007; Peckover 2014). Allen (2013) suggests that the need to safeguard children and young people living with DVA is the most contentious issue in social work (hereafter we use 'children' to refer to those up to age 18). Moreover, as mainstream social care has become preoccupied with the identification and control of risk (Featherstone *et al.* 2014), so too has DVA praxis (Peckover 2014). In children's social care this has led to a narrow, surveillant practice approach which focuses on the child's safety rather than that of the woman, child and parent-child relationships (Lapierre 2008; Hester 2011).

Throughout this paper, the UK government's definition of DVA is employed as an umbrella term encompassing a wide range of abuses. This definition states that DVA is:

[...] any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological; physical; sexual; financial; emotional. (Home Office 2013: online)

This definition reflects the Government's acknowledgment of coercive control (Stark, 2007) as a central dynamic of DVA as well as recognition that the relationships of young people

under the age of 18 are affected by DVA. However, research suggests that the Government does not go far enough in terms of this age boundary (Barter *et al.* 2009). Notwithstanding, the broadening of the definition in 2013 demonstrates the Government's attempts to delineate DVA as a social problem which is widespread affecting people regardless of certain boundaries (such as sexuality and gender, but only to some extent, age). What this definition lacks is an accompanying model for practice in the context of safeguarding children. So, the question that has been raised through scholarship is how can we best support families affected by DVA (Hester 2011)? This paper seeks to explore this question by examining the value of FGCs. In doing so, an argument will be made for social work interventions to move away from prescriptive, surveillant practice to integrate more strengths-based interventions which help to engender feelings of safety, empowerment and self-determination within families (Featherstone *et al.* 2014).

The paper will begin with a discussion centring on DVA, its impacts on children and, more specifically, upon the mother-child relationship. Whilst acknowledging the diversity of family configuration in contemporary society, we focus on the dominant family type which assumes that a family is characterised by male and female parental figures, as well as children. Exploring the impact that DVA has on children helps to illuminate the complexity of the problem facing the social work profession. This is followed by an exposition of the tensions in the field of children's safeguarding within the context of service responses to DVA. A solution to the tensions and disconnect in service delivery is then proposed through a discussion of the FGC model.

### **Children and DVA: prevalence and impact**

It is suggested that one in four children in the UK will experience DVA by the time they reach 18 (Radford *et al.* 2011). In addition, it is estimated that six per cent of all children will be exposed to severe levels of DVA, occurring between the adults in their homes, at some point during their childhood (Radford *et al.* 2011). Of concern is the estimate that 130,000 children live in UK households where DVA is perceived to be high risk; that is, where there is a significant risk of harm or death (CAADA 2012) (CAADA - formerly Co-ordinated Action Against Domestic Abuse, now SafeLives). However, many more children live with low-medium levels on a daily basis and these experiences range from directly witnessing acts of abuse to hearing violence being perpetrated in other parts of the house.

In a recent study, CAADA (2014) analysed a dataset containing a total of 877 children's case records from frontline child protection services (and which was supplemented by data collected directly from 331 children). CAADA found that 62 per cent of children living with DVA had experienced direct harm. This finding adds to a growing body of research which demonstrates the link between and co-occurrence of DVA and child abuse supporting the claim that the fear and distress caused by men's violence is a 'simultaneous abuse of women and children' (Kelly 1994: 47). Moreover, children who experience DVA in the home, directly or indirectly, 'are rarely passive observers... they experience it from the position of subjects and not objects' (Clarke & Wydall 2015: 181).

The impacts on children are wide-ranging and include: physical and health-related conditions; emotional/psychological trauma; relationship problems; disruptions to education; and behavioural issues to name a few (CAADA 2014). In research, children have

depicted the fear that overwhelms them daily when DVA is present as well as describing the controls that perpetrators place upon their lives in terms of play, education, freedom of movement and over friendships and relationships (Houghton 2015). What is important within the discourse which describes these impacts is that children's voices are heard in order to more effectively gain a picture of how *children* construct and make sense of the lived experience of DVA (Lombard 2015).

### **DVA and the mother-child relationship**

It is useful to focus on just one of the impacts of DVA in order to illuminate the workings of coercive and controlling behaviour in relation to children's experiences. Thus, we focus on the harms that can be done to the relational bond between those who are victims within the family setting (Corvo 2006). This section summarises some of the possible disruptions within the mother-child relationship as this is especially pertinent in the context of a 'whole family' approach to social work (SCIE 2009). The mother-child relationship is, however, as Humphreys & Bradbury-Jones (2015: 231) note, a 'significant but marginalised area of inquiry and practice'.

A recent study by Katz (2015) found that, within the home, a key strategy of DVA is the control of time, movement and activities with the intention of separating a child from their mother. Outside of the home, Katz (2015) reported on the ways in which the control of women severely restricted children's lives by preventing their engagement with extended family, friends and extra-curricular activities. This study highlighted classic strategies of coercive control (Stark 2007) which can limit a child's resilience and ability to cope. In effect, Katz describes 'maternal alienation'; the strategy used by male perpetrators to deliberately undermine and destroy relationships between mothers and their children (Morris 2009: 416). The concept of maternal alienation also explains the long-lasting estrangement that can occur in the mother-child relationship. By exploiting maternal alienation, perpetrators can ensure that women's and children's experiential knowledge and meaning-making is 'denied, invalidated and forced underground' (Kelly & Radford 1996: 20). This is an effective form of coercive control that serves to isolate and disempower victims.

In addition, whilst deliberately drawing on particular narratives and stereotypes, an effect of the self-serving techniques employed by male perpetrators, Morris (2009) argues, is the portrayal of mothers as 'irrational, lying, monstrous and unloving, and culpable for all problems in the family' (2009: 417). This can lead to women taking the blame for the problems in the family and for their lack of ability to protect their children. Moulding *et al.* (2015: 249) highlight additional consequences of victim-blaming discourse in terms of children and adults (who grew up with violence) blaming their mothers. They also highlight the difficulty of disentangling women and children from further abuse. This is the challenge for social work, and Smith *et al.* (2015) advocate one approach as being to increase strengths by bolstering maternal protectiveness and enhancing the mother-child relationship.

### **Locating the problem in practice: the preoccupation with risk**

Undisputedly, the presence of DVA in children's lives presents multiple risks to well-being and this has become a firm priority for policy and practice across the health and social care sectors (Humphreys & Bradbury-Jones 2015). Indeed, a preoccupation with risk is

considered to have had a far-reaching spread in modern society *per se* (Beck 1992). Over the decades, for social work practice this has triggered a paradigm shift to one which has embedded risk as the central focus of the work (Cottam 2011). This shift has had influence throughout the multi-agency field and the DVA sector has integrated this approach to risk into its policy and practices. This exemplifies what Walby *et al.* (2014) explore as the mainstreaming of DVA services. Not all commentators view the preoccupation with risk as positive and it is has led to a call for what Featherstone *et al.* (2014) name as a return to more humane social work with families.

Nowadays it is acknowledged that DVA features in some of the most challenging social work cases. However, a single-agency response has limited results (Cleaver *et al.* 2007).

Responding to this, in the 1990s the New Labour Government adopted the Co-ordinated Community Response (CCR) model which incorporates a multi-agency approach to working with adult victims/survivors, perpetrators *and* children. The implementation of the CCR model has seen the growth of individual structures designed to address different aspects of risk; for example, multi-agency risk assessment conferences (MARACs) who manage high risk cases as well as new requirements for Local Safeguarding Children Boards (LSCBs) to treat DVA as a priority area (Hester 2011). The continued growth of these individual structures within the CCR model reflects the endurance and dominance of a risk management perspective. The multi-agency approach, however, has attracted criticism as Humphreys & Stanley (2006: 9) identify 'a profound separation in the discourses of child abuse and women abuse which underpins structural and organisational barriers to an integrated response'.

### **Safeguarding practice with families affected by DVA**

Safeguarding practices are shaped by the Children Act 1989 and statutory guidance, such as 'Working Together to Safeguard Children' (DoE 2015). These are commonly interpreted within the confines of the risk management perspective (Featherstone *et al.* 2014). In safeguarding cases for families affected by DVA this usually requires the eradication of the risk, achieved by removing the perpetrator (male) from the family home. Mostly, the responsibility for ensuring that this happens is placed with the mother (the victim/survivor). In this scenario women are often pathologised for their lack of ability to safeguard their children with the onus placed upon them to make up for this failure (Lapierre 2008).

Lapierre (2008: 453) argues that through this 'deficit model of mothering' the construction of abused women as inadequate mothers is commonplace in children's safeguarding work. Yet placing the primary responsibility for parenting and safeguarding children with the mother results in the neglect of the abusive partner (Buzawa *et al.* 2009). Moreover, this approach is antithetical to the majority of DVA praxis which sees the structural and systemic roots of DVA as located in patriarchy and gender inequality (Stark 2007). More importantly for children, the neglect of fathers obscures the consequences of DVA which affect the 'whole family' (SCIE 2009). Devaney (2008) suggests reframing professional interventions to focus on the risk that men present rather than the risk that children are at. Practitioners are more likely to include work with fathers in this way.

Yet, it is widely acknowledged that fathers generally are not readily engaged in child protection processes and planning for the safety of their children (see Scourfield 2006).

Indeed, research suggests that fathers are excluded from planning processes when they have been perpetrators of DVA, the underlying assumption appearing to be that they do not have a right to be engaged in this way (Featherstone & Peckover 2007) or that they would represent a threat to their partners or professionals if they attended planning meetings (Stanley & Humphreys 2015).

Children's social care is only one agency involved in addressing DVA through the CCR. Often mothers are referred on or signposted to specialist DVA agencies. Many of these agencies integrate an empowerment model of practice which seeks to equip women with the knowledge, confidence and reflexive ability to recognise male power and control, and to live safe, independent lives. This outcome is particularly cogent if mothers separate from the perpetrators of DVA but children still have contact with their fathers. However, the disconnect between the approaches of children's social care, the domestic abuse sector (who work with victims and perpetrators) and agencies concerned with child contact has been criticised by Hester (2011) in her conceptual 'three planets' model. Hester delineates the disparate and conflicting cultures, histories, perspectives and drivers of each sector. In actuality, Hester argues, for families who come into contact with each of these sectors, the experience is disconnected, ambiguous and even conflicting.

This paper does not seek to argue that risk should not be responded to or managed through statutory social work systems, or within the CCR model. Rather, we wish to propose that risk and need can be managed in different ways involving children and their families who would benefit from empowering processes that build on existing strengths and capacities (for example, the family group conference). FGCs can run in tandem with safeguarding frameworks (that is, alongside the child protection systems currently in place).

### **Family Group Conferences**

Although much has been written about FGCs and safeguarding children, it is useful to provide an overview of the model to enable the reader to consider how FGCs work with cases of DVA. A FGC is a family-led, decision-making process which enable families to develop their own plans for the care and protection of children (Frost *et al.* 2014a). FGCs originated in New Zealand in the late 1980s in response to the over-representation of children of Maori origin subject to child protection processes and/or in state care (Ashley & Nixon 2007). Their use has spread across the globe and they have been implemented in Australia, North America, South America, the UK and Europe (Ashley & Nixon 2007).

The model represents a cultural shift in the child protection paradigm. In recent years, approaches to protecting children have tended to be professionally-led and driven, the underlying belief being that professionals, the 'experts', are best placed to make safety plans for children (Featherstone *et al.* 2014). Families have been penalised if they do not adhere to these plans. In contrast, one of the underlying philosophies of the FGC approach is that families are the 'experts' on their own situation and should be actively involved in and share decision-making about children in the family, drawing upon their existing strengths and resources (Frost *et al.* 2014a). It is solution-focussed in that families develop solutions to the problems that they face, being supported to do so by an Independent FGC Co-ordinator (Frost *et al.* 2014a). The model is viewed by many professionals and policy

makers as best practice in partnership-working with families in child protection (Ashley & Nixon 2007).

Since the inception of FGCs in the late 1980s, when applied in different countries, the model has been subject to various adaptations reflecting differing legislative, policy and practice landscapes. For example, in the USA and Canada, FGCs are referred to as Family Group Decision Making (FGDM) and in Hawaii, FGCs are referred to as Ohana conferencing ('Ohana' meaning family) (Litchfield *et al.* 2003; Heino 2009). Hence the model of FGCs is not homogenous and can be adapted to meet the needs of different jurisdictions across the globe, and even between the different states and regions within a country. Some countries use FGCs in a restorative justice context, others in a child protection context, and some in both fields. FGCs are becoming more widely used in planning for vulnerable adults (Tapper 2010), further demonstrating the adaptability of the model.

### **The Research Evidence**

There is a large, growing body of international literature that focuses on the positive outcomes that FGCs can achieve for children engaged in child protection processes (Fox 2008). Other studies find that FGCs are no more successful or, indeed, less successful than other approaches (Frost *et al.* 2014b). Therefore, the evidence is inconclusive, inconsistent and contradictory. There are few comparative studies that compare outcomes from FGCs and existing child protection processes and these do not demonstrate that FGCs are more effective than other approaches (Sundell & Vinnerljung 2004; Frost *et al.* 2014b). The authors of the studies do highlight their limitations, commenting on the juxtaposition between the FGC approach and existing child protection cultures. Questions are raised about whether FGCs can be successful if they are implemented as part of a process that undermines the empowering ideology of FGCs (Sundell & Vinnerljung 2004). Furthermore, even where the studies have found neutral or negative results, the authors still recommend their use and further research into the efficacy of the FGC model (Frost *et al.* 2014b).

What is meant by outcomes in safeguarding children, however, can be problematic to define. Clearly there are marked differences in definitions of child abuse, child protection and what constitutes positive outcomes for children across the globe, reflecting different cultural, societal and the economic contexts (Gilbert *et al.* 2011.) Despite these variations, there appears to be a consensus in the research that FGCs can result in:

- Less children entering state care/more children remaining in the care of their families;
- Improved contact arrangements between children in care and their families;
- Families developing safe plans for children;
- Children and families feeling more engaged in the process;
- More fathers being engaged than in traditional child protection processes. (Ashley & Nixon 2007; Ashley 2011)

In addition to research about child protection outcomes more generally, there appears to be an emerging body of more focused research on the use of FGCs specifically to address safeguarding concerns for children in DVA cases. In these circumstances, the use of FGCs has long been a contentious issue with concerns raised about the appropriateness of bringing a

family together in a FGC where there is violence within the family. Critics have tended to express concern for the safety of survivors of DVA in meetings where the survivor and the perpetrator are both present with the potential for 'revictimisation', exacerbating the victim's experiences of being abused (Mills *et al.* 2006; Kohn 2010).

These concerns are not reflected in the research evidence, rather this highlights that FGCs can enable women to feel empowered and in control of their lives, whilst perpetrators take responsibility for their behaviour and take steps to address it (Kohn 2010; Pennell 2006). Indeed, FGCs and other restorative approaches are starting to be used more readily within the field of DVA as increasingly 'whole family approaches' are increasingly being viewed as best practice with children and families in this area (SCIE 2009). There appears to be a consensus emerging that children are better protected when families are engaged in decision-making and solution-finding which addresses abusive behaviour (Sidebotham *et al.* 2016).

A distinction needs to be made here between the use of FGCs as a restorative approach to mediate between 'victim' and 'perpetrator' and those FGCs that are focused on safety planning for children. Much of the research has tended to focus on FGCs as a restorative process, as this is where they are most widely used within the field of DVA (Pennell 2006; Liebmann & Wooton 2010). Again, it is important to note that the breadth and scope of the use of FGCs in restorative processes to address DVA is variable and reflects local legislative, policy and practice contexts; and thus, it is difficult to make comparisons (Drost *et al.* 2013).

There is some that FGCs are helpful in safety planning. A study conducted in Newfoundland and Labrador, Canada, compared outcomes from FGCs (known locally as FGDM) and traditional case planning approaches to DVA finding a marked reduction in indicators of both child abuse/neglect and abuse of mothers/partners following the FGDM (Pennell & Burford 2000). One year after the FGDM, the incidents of abuse/neglect were 50 per cent less compared to the year before, while incidents increased significantly for 31 families in the control group who did not participate in a FGDM (Mills *et al.* 2006). Additionally, whilst there is an absence of supporting research (which focuses on FGCs and safety planning), there is a growing body of evidence from service evaluations exemplifying successful practice in this area (Inglis 2007). More recently, the UK's Department for Education, through Innovation Funding, has funded FGC services to focus specifically on DVA. For example, the Leeds 'Family Valued' Service replaces initial child protection conferences with FGCs in DVA cases (Leeds City Council 2013). An outcome evaluation for this service has not yet been published but early findings are reported to be positive (Leeds City Council 2013).

### **FGCs and Current Gaps in Service Provision**

We now focus on how FGCs can address some of the practice tensions highlighted earlier. Perhaps one of the most fundamental aspects of the FGC, is the involvement of a child's family in decision-making processes. The principle of involving the 'whole family' is a considerable shift away from the deficit model of mothering discussed earlier (Lapierre 2008; SCIE 2009) but rather than centring on the role of the mother, as criticised by Lapierre, we consider the involvement of fathers and children.

### **Involving Fathers**

The FGC process ensures that the locus of responsibility for a child's safety is shared with a child's family or significant others, including the father. The non-involvement of fathers in planning and decision-making to safeguard children has been evidenced above, not least within the area of DVA. When fathers are not involved, the underlying message is twofold: that fathers are not responsible for the well-being of their children; and that they do not have a right to be involved in decision-making about their children as abusers within the family (Featherstone & Peckover 2007). The FGC model advocates for an alternative where fathers are routinely involved in and responsible for making decisions about their children.

Scourfield (2006) has argued that whilst abusive men are at the centre of most child protection situations, many of these have something positive to offer their children. In addition, if we consider children's rights, it is important to acknowledge that children have a right to foster a relationship with their fathers if they choose to do so (Morrison 2009). This should be facilitated and supported by child protection processes. One of the concerns raised about men engaging within the FGC process where DVA is a feature is that the abusive male will dominate and, subsequently, reinforce the abuse already experienced by children and their mothers (Kohn 2010). Yet, the evidence for FGCs appears to contradict this concern and instead highlights the potential for men to make positive contributions without them dominating or using the meeting as a further mechanism for control and abuse (Inglis 2007).

Inglis (2007) cites early findings from a study of a UK-based FGC service which addressed DVA claiming that all FGCs were violence-free and women reported feeling empowered in the process and family members reporting that they preferred a FGC to a child protection conference. The notion that women feel empowered in the FGC process was also found in the Canadian study mentioned above (Pennell and Burford, 2002). Using evidence from the Newfoundland and Labrador FGDM service, they asserted that the FGC process enabled women to take a leadership role and 'take back' control over their lives and those of their children.

As stated previously, the use of FGCs in DVA has tended to focus on restorative justice, encouraging perpetrators to understand and take responsibility for their actions. In this paper, we primarily consider the possibilities offered by FGCs from a safety planning perspective. However, the FGC process does involve some reparation for the perpetrator as when the focus is on welfare planning for safeguarding children, it appears that a restorative process, to some extent, is also taking place when a male perpetrator is confronted with the impact that DVA has had on the family children. Moreover, Pennell & Burford (2000) found that incidences of DVA in those families who were subject to a FGDM decreased considerably, whilst those in a comparison group who were subject to established child protection processes increased substantially.

### **Involving children**

Despite the implications for so many children growing up with DVA, to-date the opportunities and support for children to talk about their experiences has been limited and subject to ethical debate (Morris *et al.* 2015). Yet, children have a right to have their views heard and be involved in decision-making (UN Convention of the Rights of the Child, Articles 3 and 12). This principle is clear in child protection legislation and policy (such as the

Children Act 1989 and the 'Working Together to Safeguard Children' guidance (DoE 2015)). Furthermore, where opportunities have been made available for children to discuss their experiences, these have been found to be beneficial to safety and well-being (Morris *et al.* 2015). Yet Houghton (2015: 236) argues that there is a dominant 'adult-centric approach' to children's safeguarding and DVA which requires a re-focus towards children's agency, participation and rights. This is not straightforward, however, and Iversen (2014: 27) highlights the ease at which tensions between the principle and practice of participation can arise. Iversen notes how social workers can easily fall into the trap of categorising children (as competent or problematic for example) producing an order of 'predetermined participation' as children's wishes or views 'may be disregarded by those who claim to know more' (Ivesen (2014: 286). Nonetheless, research indicates that children being heard and empowered to participate in decision-making processes are critical to 'coping and surviving' in the face of DVA (Houghton 2015: 237).

Research on children's involvement at FGCs has evidenced the potential for children to feel that their voices have been heard (Holland & O'Neill 2006) with the overwhelming consensus that children should attend their FGC where possible (Ashley & Nixon 2007). In their study of children's involvement, Bell & Wilson (2006) found that they felt empowered by the experience of being consulted and listened to, welcoming the opportunity for their family to discuss issues without the presence of professionals (during private family time - part of the FGC structure). In their research into the participation of children in FGCs in Wales, Holland & O'Neill (2006) emphasise the positive impact for children who participate in their FGC, finding that the majority of children talked about being attended to and about their contributions to decision-making. However, Holland and O'Neill identified potential pitfalls at a FGC being that adults may tend to bully and dominate the meeting, leaving children feeling unheard and powerless (Dalrymple 2002; Holland & O'Neill 2005; Frost *et al.* 2014a).

Hence, the potential for children to be heard and involved in decision-making processes needs careful consideration in order to ensure that children are supported to meaningfully participate in the FGC process. The use of advocates is suggested as a means to support children to represent their views and be meaningfully engaged as well as helping to reduce the risk of children feeling disempowered, or disillusioned, with the process (Bell & Wilson 2005; Frost *et al.* 2014a; Holland & O'Neill 2005). Advocates may help a FGC to gain a clearer picture of how *children* construct and make sense of the lived experience of DVA (Lombard 2015).

### **Discussion and conclusions**

To return to Hester's (2011) argument which exposes the disconnect between the different professions working within the context of DVA, it is proposed that research from FGCs highlights the potential to address this prolific problem. One of the benefits of FGCs is that not only do they bring together the key family members in a child's life but also the relevant professionals. These professionals are invited to contribute to the 'information sharing' part of the FGC and are instrumental in considering whether a family's plan adequately safeguards the child/ren who are the focus of the FGC. In effect, all of the key people come together at the same time to plan with a family for the safety of children in the family. This may include child protection social workers, police, domestic abuse services and family

support services. This enables a 'family approach' (SCIE 2009), with the needs of all parties (that is, the children as well as the survivor, and the perpetrator where appropriate) potentially being addressed at the FGC (Pennell 2000; Inglis 2007).

We have shown how the FGC works with the strengths of families to encourage a partnership approach between child protection services, domestic abuse services and families and in doing so FGCs can work to minimise the risk to women and children and ensure that children are adequately protected (Kohn 2010; Sidebotham *et al.* 2016). Whilst emphasising the benefits of FGCs, it is also important to state that not all cases will be suitable for a FGC; for example, in those instances where risks to children and/or mother is significant. Hence, we are not suggesting that FGCs replace existing responses to DVA in high risk cases, rather we suggest that a more pragmatic approach is taken to planning in low to medium risk cases and that a focus is placed on working alongside the family to address risk and uncertainty.

Research evidence has highlighted that not only do relationships between professionals and families improve as a result of a FGC, but also the relationship between professionals themselves (Litchfield *et al.* 2003; Pennell 2000). Moreover, Pennell (2000) states that FGCs have the potential to enable collaborative professional relationships. This is substantiated by Litchfield *et al.* (2003) who found that, in their evaluation of the Hawai'i FGC service, social workers reported that the FGC process encouraged better partnerships between professionals as well as between professionals and families. One social worker is reported to have said 'the collaborative nature of Ohana conferencing and information sharing almost "force us to work together"' (Litchfield *et al.* 2003: 79).

One of the key themes emerging from the research on FGCs and DVA, and safeguarding children more generally (Browne Olson 2009), is the concept and processes of the conference serving to 'unify' the family, and thus strengthening fragmented family relationships (Pennell and Burford 2000). Clearly, FGCs hold potential for repairing the mother-child relationship when this has been negatively impacted by the presence of DVA. The unifying nature of FGCs is significant when considering the future safety of children. After all it is widely acknowledged that strong family relationships are a protective factor for children. Despite the indications of the research evidence as summarised here, further evidence is needed which explores the effectiveness and appropriateness of the use of FGCs with families affected by DVA.

In this paper we have traversed thorny ground by raising difficult questions about the nature of current service responses to safeguarding children exposed to DVA. We have explored the extent to which a 'whole family' approach offers an effective model for working with families affected by DVA (SCIE 2009). We set out our argument by illuminating the insidiousness of risk discourses in that risk has come to dominate the increasingly multi-disciplinary framework for managing families deemed to be at risk from DVA. On that note, we end this paper by returning to our main argument which advocates for a more dedicated focus on family strengths and which enables the meaningful contribution of families to their safety plans, bringing together families and services in a more democratic multi-agency model.

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