Multiple Family Group Therapy for Families with Children Placed in Out-Of-Home Care in a Chinese Context

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Published online: 05 Nov 2014.

To cite this article: Mooly M. C. Wong, Joyce L. C. Ma & Londy C. L. Chan (2014): Multiple Family Group Therapy for Families with Children Placed in Out-Of-Home Care in a Chinese Context, Social Work with Groups, DOI: 10.1080/01609513.2014.921882

To link to this article: http://dx.doi.org/10.1080/01609513.2014.921882

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Multiple Family Group Therapy for Families with Children Placed in Out-Of-Home Care in a Chinese Context

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Since the 1980s, the family-centered approach has been widely adopted in the west (e.g., the United States) as an approach to serving children living in an out-of-home care context. In comparison, in Hong Kong, out-of-home care services tend to be child-centered and child-protection oriented. This article (1) examines the child welfare service, specifically out-of-home care services, in Hong Kong and (2) makes the case for integrating family-centered out-of-home care services for children. Three vignettes are presented that demonstrate the use of Multiple Family Group Therapy (MFGT) to promote family-centered practice. The article concludes with a discussion of challenges and recommendations related to a shift to family-centered practice.

KEYWORDS child welfare services, child-centered, family-centered, multiple family group therapy, out-of-home care children, Chinese context, Hong Kong

Received January 9, 2014; Revised April 28, 2014; Accepted May 3, 2014.
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INTRODUCTION

The traditional models for serving out-of-home care children in a child protection context in Hong Kong are child centered. Consequently, out-of-home care services are offered as a substitute for parental care (Ainsworth, 1997). The assumption is that children placed in out-of-home care will quickly forget their biological birth parents and become psychologically attached to their new caregivers; the belief being that psychological parenthood is the most important aspect of parenting (Ainsworth, 1997).

As family-oriented theories of treatment proliferated in the late 1950s and 1960s, increasing numbers of practitioners adopted concepts that put children’s symptoms in the context of the family. The family-centered approach then became more relevant, and the child-centered approach was seen as pragmatically and morally insufficient (Keith-Lucas, 2000). Pragmatically, children who had intense conflict with their families were unable to resolve issues without the involvement of their families. Morally, people who were so eager to rescue children, while ignoring their parents, held a belief that “children can change, but not their parents” (Keith-Lucas, 2000).

By the 1980s and 1990s, increasing numbers of child-welfare agencies in the West (e.g. United States) had taken small steps to change their practice from “child rescuers” to “family preservers.” New models had been proposed, for example, the model of family-centered group care developed by Ainsworth (1997, 1998) and Ainsworth and Small (1995). This change was partly due to the increased evidence that staying connected to natural families could likely yield positive impacts on children’s mental health and interpersonal relationships (Andersson, 2005; Attar-Schwartz, 2008; Chapman, Wall, & Barth, 2004; Dunn, Culhane, & Taussig, 2010). Improved family connectedness could also promote family reunification (Bullock, Gooch, & Little, 1998; Bullock, Little, & Millham, 1993; Jones, 1998; Maluccio, Fein, & Davis, 1994; Maluccio, Warsh, & Pine, 1993).

Despite compelling evidence for family-centered intervention for out-of-home care services in the West, little of this approach has been tried in Hong Kong. In this article, the authors examine Hong Kong’s child welfare services, specifically the residential child care service, and explore an alternative intervention approach, Multiple Family Group Therapy (MFGT), to help meet the needs of families with out-of-home care children. Group characteristics and implementation are highlighted.

CHALLENGES AND NEEDS OF FAMILIES WITH OUT-OF-HOME CARE CHILDREN

Joanne (pseudonym), who was born in mainland China, married a man from Hong Kong and gave birth to two children. She migrated to Hong Kong with
her children. The family lived in a public-housing estate in a district described
as a “city of sadness,” due to its high frequency of family tragedies. Joanne’s
family of origin remained in mainland China, and her husband worked on
the mainland, returning to Hong Kong only weekly or biweekly. Joanne was
the sole caregiver for their children.

The second child, who attended elementary school, was hyperactive. He
was unable to comply with the rules and regulations in the classroom,
and the teachers complained about him. Joanne gave birth to a third child
who was born prematurely. The baby had to stay in the hospital with Joanne
during a period of intensive care. Without close supervision, the two older
children caused trouble. One of them stole snacks from a convenience store.
Joanne flew into a rage when the police called her. She punished the children
by keeping them away from home. Instead, they stayed in the common
areas near the housing estate. Neighbors called the police, and Joanne was
charged with neglecting her children. They were taken away by a child-
protection worker and were placed in a small group home. This was reported
in the media. Joanne was so scared that she hid at home for a few days.
The husband was informed and returned home from the mainland a few
days later. Because Joanne was not clear about Hong Kong’s child-protection
policies, she did not know how to get her children back, even though she
did not want to be separated from them. She felt so ashamed that she was
afraid to tell her own family. She lied to her mother and said the children
were at boarding school.

Families with out-of-home care children face many challenges. For
example, parents may have to cope with the difficulties related to their chil-
dren’s physical disabilities and or mental health problems (Harden, 2004).
Moreover, the prevalence of mental health problems in out-of-home care
children is higher than for the general population. Most of their problems
occur before admittance to care facilities (Attar-Schwarz, 2008; Dimigen,
Priore, Butler, Evans, & Ferguson, 1999; Egelund & Lausten, 2009; Minnis,
Everett, Pelosi, Dunn, & Knapp, 2006).

As in Joanne’s case, many parents are overwhelmed and cannot respond
to their children’s developmental needs. The family is a system moving in
time through its own stages of development across two dimensions: (1) the
vertical axis, which includes family history, attitudes, taboos, expectations
and labels and (2) the horizontal axis, which refers to the flow of family
through time, coping with changes and transitions (Carter & McGoldrick,
1989). The interaction of vertical and horizontal variables and flow in a
system produces stress and anxiety for the family. The greater the anx-
iety generated at any transition point, the more difficult, or potentially
dysfunctional, the transitions will be.

Very often, families with out-of-home care children face strains on the
vertical axis, that is, the residual unresolved issues in the family such as mar-
ital discord and parents’ own childhood trauma, which have overwhelmed
parents to such an extent that their ability to take proper care of their child is limited. Joanne, for example, experienced tension with her husband—she did not feel supported by him because he was rarely at home. When her youngest was born, Joanne was so isolated that she was unable to handle the demands of the family. Removal of the children from her home further increased the family’s stress and impeded her mothering.

The family system is disrupted by professional intervention (Minuchin, Colapinto, & Minuchin, 1998), for example, the child protection workers in Joanne’s case. The family appeared to be disorganized and chaotic; therefore, it became necessary to reorganize by establishing clearer boundaries and roles. Restructuring is particularly important for preparing children to be reunited with their families (Bullock et al., 1998; Pine, Warsh, & Maluccio, 1993).

Joanne’s family was socially isolated. In a Chinese society such as in Hong Kong, parents are likely to feel ashamed and guilty when their children are removed from the home; they perceive it as a failure of parental care, and many prefer not to tell others what has happened. Consequently, families with out-of-home care children are in need of support for taking care of children with either normative or special developmental needs, for coping with family stresses or strains, for reorganizing the family system and for preventing social isolation.

RESIDENTIAL CHILD CARE SERVICES IN HONG KONG

Child welfare services for children and families in Hong Kong began as early as the 19th century with the establishment of the first orphanage in 1848 (Ting, 1997). With a decreasing number of orphans in society the services were transformed to support children whose families were in crisis. In its 1991 white paper, the government stated the objectives of child welfare services as,

> to support and strengthen families so that they may provide a suitable environment for the physical, emotional and social development of their children, and to provide assistance to those disadvantaged and vulnerable children who are not adequately looked after by the families. (Hong Kong Government, 1991, p. 22)

Hence, the primary purpose of the services is to provide temporary care to children until they return to their families or have a suitable alternative living environment (Social Welfare Department, 2012). Currently, most out-of-home care services are provided in a family-like setting. This may include small group homes or foster care in a community-based setting as opposed to an institution (Shek, 2004). The other types of services include
children’s homes, boys and girls hostels with/without schools (Social Welfare Department, n.d.). Children are placed in the services either voluntarily, by agreement between the caregiver and social workers from various social services (e.g., family service and child protection service), or involuntarily, by court order.

Social work practitioners of residential child care services in Hong Kong tend to approach their work from a child-rescued, child-centered and professional-driven care context. Many believe that the children’s problems are the consequence of their parents’ inability to competently and safely care for their children (Dunst, Johanson, Trivette, & Hamby, 1991). To protect the children from the “pathological” influence of their parents, the practitioners in residential child care services confine parental involvement to daily matters such as giving pocket money and arranging home leave. In addition, the parents are usually treated as service recipients rather than strategic partners. Many residential child care social workers do not have a comprehensive picture of family circumstances, nor do they understand the children’s difficulties contextually. The service orientation has become “professional” or “expert driven” rather than client driven, which results in standardization and inflexibility (Pufahi, 2007).

These families also have limited resources. Although regular contact through family activities is an important way to rebuild their attachment, the majority of these families receive welfare and are barely getting by. They seldom have enough money for leisure time activities. Furthermore, there is a lack of specialized services such as mental health care for out-of-home care children and their families in the local context. The waiting list for child and adolescent psychiatry is so long that many children have to wait up to one year before receiving psychiatric assessment (Lai, 2006).

The services tend to be child focused and piecemeal. The efficacy of the service model in Hong Kong in meeting children and families’ needs is questionable at best. Services are focused on providing care and protection to the children by placing them in care facilities. The holistic needs of the family are ignored. We argue that family-centered practice is applicable to out-of-home care services for children in Hong Kong.

APPLICATION OF MFGT TO OUT-OF-HOME CARE SERVICES FOR CHILDREN IN HONG KONG

MFGT originates from the work of Laqueur (1972), for families of patients with schizophrenia in the United States in the 1960s (Laqueur, 1972). MFGT is a group approach that brings together a number of families with a common problem and helps them to resolve their difficulties using their own resources. It also helps families to decrease their isolation by developing social networks (Asen, 2002; Asen, Dawson, & McHugh, 2001).
The application of MFGT in Chinese context is still regarded as an innovative family intervention model. The previous applications included divorced families (Lau, 1998), families with members suffering from psychosis (Ma, 1986), autism (Ma, 1987), schizophrenia (Chien & Chan, 2004), and other mental illnesses (Ma, Wan, & Wong, 2012; Ma, Wong, Wan, & Wong, 2011).

The application of MFGT to Hong Kong’s residential child care services is the first step in shifting the orientation of the service paradigm from “child centered” to “family centered.” These families are often perceived as problematic, an image further reinforced by professional intervention that marginalizes parents (Minuchin et al., 1998). The removal of a child from home breaks up not just the family structure but also the emotional ties between parents and children. The situation is further intensified if there is no continuity of connectedness during the placement period. As a result, the family is always regarded as the source of the children’s problems, and family strengths and resources are undermined. MFGT uses the family resilience perspective, which affirms that a family has its own resources and can heal itself (Walsh, 1998). It also believes that family strengths and resiliency can be multiplied when troubled families are grouped together in a potentially supportive context (Asen, 2002).

GROUP INFORMATION

MFGT was conducted under the auspices of a family project that was jointly organized by an academic department of our university (hereafter the University) and Sheng Kung Hui St. Christopher’s Home (hereafter the Home) (Sheng Kung Hui St. Christopher’s Home, 2013). The project included two phases. The first phase was developed in 2010 and lasted for one year. It focused on developing MFGT for the families. The second stage was a 2-year family project named “Walking Together – Family Support Project for Children in Residential Care” that was launched in 2012. Qualitative research was conducted with the focus on identifying the subjective experiences of participants in MFGT. This article focuses on the characteristics and the implementation of MFGT in the first phase of the project.

Group Objectives

We formulated three group objectives, based on the needs of the families, (1) to generate new and multiple perspectives on the problems the families were facing, (2) to empower and improve the self-efficacy of parents, and (3) to build mutual support among families. MFGT can help families, in the short term, to improve communication among members, promote healthier
interaction and coping behaviors, use their own strengths to resolve problems, lower parenting stress, overcome social isolation, and expand social supportive networks. In the long run, MFGT can achieve two interrelated outcomes—enhance the connectedness among family members and facilitate the family’s postreunification adjustment.

Group Composition

In the first phase, three groups were conducted. A total of 13 families (including 14 parents and 25 children) were recruited; 18 out of 25 children were living in care facilities, whether in out-of-home care homes or facilities run by other agencies. The rest of the children lived with their families at home. The families joined the groups voluntarily upon referral by the supervising residential care social workers. The group workers conducted pregroup interviews with each family to (1) assess participants’ motivation in seeking help and identify which family members seemed most committed to being helped, (2) explore the focus of the work that would be most beneficial to the family, (3) explain group-related information, and (4) obtain the commitment of the family by written consent.

Group Structure

The group started with a 2-hour psychoeducation talk, aimed at orientating families to the group and establishing relationships between participants. This was followed by 4 days of intensive group sessions. The major activities were intra- and interfamilial activities as well as parallel groups for children and parents. A mutual support group was formed among families after the completion of the group sessions to monitor family changes, enhance mutual aid among families and foster family volunteering for the Home.

Group Activity

We referenced the activities of the day center of Marlborough (London) day center (Asen et al., 2001) and modified them to match with the needs and cultural characteristics of these families. For instance, the long-term separation of parents and children had negative impacts on both parties, resulting in a lack of communication. We developed an intrafamilial activity, namely “heart connection,” to enhance mutual understanding between parents and children. Parents thought of three grocery items that they wanted their children to buy for the family. Children had to think of three yes/no questions (e.g., “Is it placed in the bathroom?” or “Is it round?”) that would draw some clues about the items. After children got these hints, they went to buy the items. When they returned, a debriefing session was held. The
group worker focused on the participants’ experience in the activity, such as parent–child communication, rather than on the outcome, i.e. the number of correct items.

Moreover, we adopted different activities according to the group development stages. In the beginning stage, most families were more likely to focus on their own family issues. Thus, we organized activities such as “family story” to provide an opportunity for families to narrate their family experience. The group worker asked each family member to either draw a picture or take a photo of their own perspective of family life at different points on a family timeline. Sharing with the group at-large was done afterwards. At the end of the group, the family was asked to add one more picture or photo about their wish for the family in 2 years’ time. This helped them to share about their hope for future family life.

In the middle stage, we increased activities to facilitate interfamily interaction, communication, and cooperation. One such activity was the “joint meal.” It aimed at encouraging cross-family negotiations and planning, as well as experiencing mutual support and surrogate parenting. Two groups with a mixture of parents and children from different families were formed. A budget was given to each group, with the assignment of preparing lunch for the whole group. Each group was required to share jobs equally among its members. The discussion process was video-taped. Then, each group would go shopping, and then the group would have lunch together. Debriefing occurred afterwards. The goal was to create an atmosphere of mutual support.

An activity called “group album” was initiated to connect families and enhance group cohesion. Family/group photos that were taken during the group sessions by our helpers were put in an album to symbolize the group. Each group member said one thing that she or he treasured about the group and then passed the album to another person; the process continued until the album had been passed to all participants. Each family received a copy of the album after the completion of the group.

Staffing, Roles, and Facilitating Skills

The organizers of this project worked in a team, with clear division of labor among the team members. The first author conducted the groups, with the assistance of two social workers from the Home and a part-time master of social work student from the University. Undergraduate social work students were recruited as helpers to handle logistical issues and take photos and videos of the group process. A debriefing group of all team members was held after each group session to review the group process and modify the subsequent group sessions.

The group workers acted as either observers or catalysts as the group progressed through its developmental stages. As observers we commented
on intra- and interfamilial interactions throughout the group process. We reinforced the “client-driven” qualities of the group by validating family strengths and empathic connections. As catalysts, we took a more active role in facilitating the intra- and the interfamilial interactions among the participants in the initial phase of the group. In the later phase of the group we stepped back and became more peripheral to encourage self-help and mutual support (Asen & Scholz, 2010). The alternating roles of observer and catalyst were used throughout the group process.

Because MFGT blends family therapy and group therapy, techniques in family therapy such as joining, reframing, enactment, focusing, and reconstructing (Minuchin & Fishman, 1981) and group work skills such as active listening, reflection, clarification, and summarizing (Johnson & Johnson, 2009) were used at different times depending on the phase of group development and context. We also adopted the five-step technique proposed by Asen and Scholz (2010) to facilitate inter- and intrafamilial interactions, that included observing and “punctuating” problematic interactions and communications, checking perceptions, inviting evaluation, determining the will to change, and encouraging experimentation and action.

GROUP VIGNETTES

The following three group vignettes illustrate the implementation of MFGT and how it helped its participants to (1) shed new light on understanding the problems that families faced, (2) to increase parental-efficacy, and (3) to build support networks. The illustrations will show a progression, on a continuum, of group participation ranging from observational to interactional.

Vignette 1: Couple without Communication

Joanne joined the group with her husband and three children. Two children were living in the care facility after Joanne was accused of neglect. Her husband was working in the mainland most of the time and returned home biweekly. In the “family story” activity, Joanne took a photo of her youngest child’s playtime. Her husband took a photo of a metal sculpture of a bird. The group workers asked them to share the meaning of the photos. Joanne said she was longing for more family time, and her husband said that the sculpture represented him at work, moving around constantly, like a bird flying from place to place. He hoped that he could work hard and support the family continuously.

After the husband shared his thoughts, the group workers observed that Joanne kept quiet, and that was not her usual behavior as an outspoken woman. The group worker then turned to Joanne and showed curiosity about her response. Joanne shared her worry that, sooner or later, her
husband might leave the home like the bird in his photo. The group worker reflected on Joanne’s worry and invited her husband to respond. Her husband said that he chose this bird because it had huge wings that could carry the whole family. He also acknowledged his wife’s contributions to the family. The group worker continued to facilitate the couple’s communication, for example, letting Joanne share her difficulties as the children’s sole caregiver. This activity had a positive impact on the couple’s relationship.

The illumination of new and multiple perspectives of the family members is illustrated in this vignette. The activity provided an opportunity for family members to exchange views. Like Joanna and her husband, most of the families were saturated with problems. Their views were constrained by their symptoms. The new group created a context for the families to do some reframing and consider alternative perspectives to their family problems.

In this illustration the emphasis was on the interaction between the group worker and the parents in one family, whereas the other families in the group observed. Group workers must decide when to invite full participation and when to stay focused on one couple or family for a period of time, as was the case in this illustration. Soliciting feedback from the multiple family group after an intervention focused on one family is also an option. In the final two vignettes the group worker chooses to reach beyond the parents and children in a particular family and seeks the active participation and support of others.

Vignette 2: Father with an Uncontrollable Son

Donald (pseudonym) was a single father who had two sons. The younger son was living in the care facility due to sibling violence, and Donald, who had a chronic physical problem, was too exhausted to discipline the children. In the group session, the elder son teased the younger brother frequently. Donald shouted at him, with no effect. The group worker observed the interaction of the family members and noticed that Donald had reservations about disciplining his son. On one occasion during the family activity, the boy was playing with a toy gun, which provoked his younger brother. The group worker “punctuated” the scene and asked the father for feedback.

The father said he knew his son would not listen to him, but he felt he had no other alternative. The group worker invited input from other participants after seeking Donald’s consent. The other participants brainstormed different methods; however, the father did not feel very comfortable using those methods at that moment. The group worker did not push him but let him to imagine the consequences if the situation remained unchanged and Donald realized that the sibling violence would intensify. In the next group session, the son did the same thing. This time, the father took away the toy gun and put it into his bag. The son ignored the father and tried
Multiple Family Group Therapy

Vignette 3: “We are all in the same boat”

Mary (pseudonym) was in the same group as Donald. She had become a single mother after her divorce a few years earlier. She had two children approaching adolescence. Her youngest child manifested behavioral problems such as truancy and stealing. The children also displayed sibling rivalry. The youngest child had been placed in the care facility a year earlier to relieve Mary’s parenting burden.

In a multiple family group session, the group worker led an intrafamilial activity that emphasized the co-operation between family members. Mary’s younger child left the room during a conflict with the elder one. The group worker stopped the activity and asked the intention of mother in letting him go. The mother suggested continuing the activity because she believed that the child would come back very soon. After a while, the child came back and wanted to continue the activity.

The group worker provided time for Mary to handle the sibling conflict. Mary behaved patiently and let the teenage children talk to each other. The group facilitator noticed that she allowed her children autonomy, letting them resolve their conflicts themselves. Mary shared with the group that she had previously had no confidence that the children could handle conflict independently. However, she noticed that they had gradually learned to compromise with each other. The group workers invited feedback from Donald and facilitated a dialogue between him and Mary. As a result, an atmosphere of mutual support and learning was fostered in the group.

The group facilitators activated the multiple family group members to become “consultants” and “helpers.” There are always untapped resources in families, especially those from marginalized groups in society whose voices are typically unheard. If they have the opportunity to tell their stories in a safe environment, their experiences become testaments of their resiliency to get the gun back. The father then talked to the son patiently. The son did not respond directly, but he did not insist on getting back the gun. The group worker highlighted the scene immediately and invited feedback from the group. Group members showed appreciation for the father’s way of handling the incident.

MFGT can enhance participants’ parenting competencies through the group process. Like Donald, many parents with children placed in out-of-home care, experience a strong sense of failure and inferiority about disciplining their children. Such a mentality might hinder their relationships with their children. Many of these parents have a poor sense of self-efficacy in parenting and thus delegate their authority to alternative caregivers such as house parents and foster-care parents. MFGT sought to help the parents to increase their sensitivity and responsiveness to the needs of their children and attempt alternative ways of parenting in a safe environment.
and resources to help themselves and others. This example shows that the group encouraged the families share and learn from one another. Moreover, the group facilitated them in breaking their isolation by establishing support networks with other families. Hence, MFGT encouraged families to make contact outside the group meetings.

These group vignettes illustrate the intervention strategies of the group workers as well as the benefits the families gained through the MFGT. However, despite the overall positive feedback, there were a number of challenges in shifting the orientation of out-of-home care service from child centered to family centered.

**CHALLENGES**

There were two main challenges—at the organizational and the practical levels—when transforming out-of-home care services model for children through the launch of MFGT.

At the organizational level, the previous service model of out-of-home care services for children was “child-centered,” reflecting the focus on “child protection” as the overall focus of service. Although the welfare and the protection of children must be emphasized, additional attention must be given to the family. In other words, the needs of children should be put into the context of the family. In the development of MFGT in out-of-home services model, it was clear that families needed additional services (such as family-centered counselling and tangible services) to sustain change, because group work was only one of the intervention modalities for these families. Consequently the scope of the project was expanded. However, other gaps (such as the group home’s intake and operation) remained.

There is a clear division of responsibility between out-of-home care social workers and family social workers in Hong Kong’s welfare system. Whereas the former focuses on the welfare of children, the latter provides support to families. It is essential that the two parties cooperate. However, this is difficult to achieve due to different perspectives on, and assessments of, family needs. Therefore, we believe that the paradigm shift from “child-centered” to “family-centered” will take time. Reforms must begin at the organizational level.

At the practical level, this project faces staffing difficulties. MFGT is a family-focused intervention strategy that requires a strong family perspective from the group facilitator. However, most social workers in Hong Kong lack a broad range of theoretical knowledge and skills, or even a value orientation that respects and encourages family participation in the process of change. With the increased number of educational institutions that offer basic and postqualification professional training in family-centered practice in the local context, more intensive training and high-quality supervision can be provided to practitioners.
DISCUSSION

Shifting the paradigm from “child centered” to “family centered” care for out-of-home care services for children in Hong Kong is not easy. We have four recommendations for social workers and policy makers regarding residential care services for children.

First of all, a pilot project should be implemented. For example, launching MFGT in an agency can encourage staff to acquire confidence and competence for adopting a family perspective in service provision. Once they observe the approach’s effectiveness, they will be more motivated to try it in other areas. Hence, the group could be treated as an “add-on” rather than a competitor to existing services (Asen & Scholz, 2010). The agency could choose families with high motivation for the pilot project, with later expansion to more complicated families. In doing so, practice-based wisdom can be accumulated. Team work is crucial when developing a new approach in the agency, since the team can provide multiple perspectives for modifying the services.

Second, a vicarious learning and a “learning-by-doing” approach should be adopted in training staff to use the family-centered approach when working with families. For instance, because MFGT requires many clinical judgments in the process of intervention, our project found that vicarious learning was the most effective way of acquiring practical knowledge and skills. We worked as a team, and the group was led by one experienced group facilitator (the first author) in the initial stage, with other staff members playing the role of observers until they could lead the group independently. This principle could be applied to training for family-oriented case workers, with one therapist as the key person and the other as the coleader.

Third, we suggest keeping detailed documentation regarding the agency’s change process. This would enable the accumulation of practical wisdom as the work approach is transformed. The means of documentation should be multiple (audio/video tape, notes, etc.), depending on the resources of the agency. For instance, in our project, we videotaped the group process and reviewed the tape periodically to improve intervention strategies. The team also met at the end of each group session to share observations and modify the group accordingly. The modification process was recorded for further reference.

Last but not least, it is necessary to have empirical evidence if a new approach is adopted. This is particularly true for out-of-home care services for children in Hong Kong, because most local studies are still focused on children alone. Research studies on the family are woefully lacking in Hong Kong. In this project, we developed a research study, which is the first step in building evidence-based practice to understand the effectiveness of MFGT for these families.
CONCLUSION

Family-centered care practice is a promising service model for families with out-of-home care children. Because children’s issues are often related to their families, it is important to put the needs of the children in the context of their families. In Hong Kong, the development of family-centered practice in social services in general, and out-of-home care services for children in particular, is still at the beginning stage. The application of MFGT to out-of-home care services for children is the first step towards changing our intervention approach.

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