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# Family Group Conferencing with BME Families in Scotland

*Katerina Valenti* 

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This article explores the use of family group conferencing (FGC) in social work with children and families from black and minority ethnic (BME) backgrounds living in Scotland. It does so by presenting the views of social work practitioners on issues that are highlighted as significant in the existing literature about the use of FGC with BME families. Eight semi-structured interviews with key informants were carried out as part of the work for a Master of Social Work dissertation, and this is followed by a reflexive discussion from the perspective of the author as a newly qualified social worker working in a statutory children and families' team. The article ends with suggestions for maximising the opportunities for BME families to participate in, and benefit from, FGC.

*Keywords:* family group conferencing; family group decision-making; black and minority ethnic; child welfare; reflexivity

## Introduction

This article discusses family group conferencing (FGC) with black and minority ethnic (BME) families in Scotland. My interest in this area was firstly aroused during my social work training at a Scottish university and particularly during my fieldwork placements, where, as a Master of Social Work student from a white minority ethnic community, I observed that, although legislation, policy and practice guidelines were couched in terms of valuing partnerships between professionals, social workers, service users, extended families and communities, this was rarely achieved in practice. I witnessed many examples of what could be described as institutional and cultural racism, where professionals made decisions about BME service users that seemed to be based on cultural prejudices, where questionable judgements were made about service users' strengths and capabilities and where social workers failed to provide opportunities for service users to become actively involved in decision-making processes. I therefore set out to use the opportunity of research for my Masters' dissertation to find out more, looking for different, more culturally sensitive and inclusive ways of working with families that might also be compatible with

Scottish child welfare policy and came across FGC, which seemed to hold the possibility of a better approach. Since qualifying as a social worker in 2012, I have been working in a local authority children and families' team, supporting a wide range of low income families, some of whom are from a BME background. This has given me the opportunity to test out some of my ideas in practice. This article therefore represents the coming-together of my ideas in practice.

The article begins with an exploration of terminology before introducing the methodology used in the study. I then set the project in the Scottish context, looking at population figures, legislation and relevant policy and practice, before going on to examine what the state of knowledge is on FGC, firstly, presenting evidence from research and secondly, evidence from my own interviews with practitioners, where I asked them specifically about the use of FGC with BME families in Scotland. I end with a reflexive discussion, as I reflect on my dissertation findings in the light of my experience as a statutory social worker working with children and families in a local authority in Scotland.

## Terminology

I must begin by briefly explaining the terms I am using. 'FGC' is a method that originated in New Zealand in social work with Maori families. FGC is a way of working with families that aim to actively involve children and their families in decision-making and counteract institutional racism and the paternalistic professional and organisational practices that are often encountered in child welfare services (Holland and O'Neill 2006). It is led by the family and brings together relatives, friends and professionals involved with a case in a meeting to make decisions about the child's welfare (Connolly 2006a; Crampton 2007; O'Connor et al. 2005; Schmid and Pollack 2009). The term FGC is commonly used in European literature; the term Family Group Decision Making (FGDM) is mainly used in the USA.

As well as outlining FGC, it is also important to give attention to what is meant by 'BME'. In describing findings from my interviews, I will use the term BME to include both white and non-white people from minority groups, because the social workers whom I interviewed used the term broadly, stating that service users from Poland and Italy with whom they worked also experienced racism and negative discrimination on the basis of their ethnicity. However, official statistics that will be presented in relation to BME families limit the term 'BME' to those of 'mixed ethnicity', 'black', 'Asian' and 'other ethnic background' (see Hopton 2010; Scottish Government 2010). There is, in practice, considerable debate about the term 'BME', with some commentators even going so far as to argue that the term is unhelpful and may even be considered to be discriminatory, since it obscures differences between and within different ethnic groups (Cree 2010; Hillen 2013).

## **Methodology**

This article, as already stated, is drawn from work for a Master of Social Work dissertation, with additional reflections from my work as a newly qualified practitioner. The student project had two parts: a review of relevant literature and a series of interviews with key respondents.

### ***Conducting the Literature Review***

I searched for relevant literature using Google Scholar and the ASSIA (Applied Social Sciences Index and Abstracts) search engine. The initial key words and phrases included: FGC, child welfare, BME communities, social work with children and families, FGDM. I began by searching for recent literature (published within the last five years) and identified the material that was most relevant to my study, following up references and expanding my scope to include work published within the last fifteen years. Although there were hundreds of articles on FGC/FGDM, only a small number mentioned BME families, and most studies were from the USA. I also, not unexpectedly, found relevant material from New Zealand in relation to Maori families, because this is where FGC originated. In response to the reviews of an early draft of this article, I expanded the literature to also look at the theme of cultural competence.

### ***Interviews with Respondents***

I used purposive sampling (Babbie 2001) to explore the views of eight professionals with different perspectives on FGC and different experiences of working with BME families; each was chosen because of their specific knowledge and skills. Only participant 6 considered herself to be from a BME background. No service users were interviewed, in line with MSW dissertation's regulations at my university. Ethical approval for the project was given by the Research Committee of the School of Social and Political Science, University of Edinburgh.

### **Coding and Analysis**

I analysed the data using a thematic analysis model developed by Braun and Clarke (2006). Having transcribed the data, I spent time analysing the participants' responses and creating analytical codes by breaking them down and categorising them into themed groups. Most of the codes related to areas of study that emerged from the literature review; however, some were raised by professionals. After categorising the data into codes, I created a thematic map to find relationships between the codes before I selected and discussed my final set of themes.

## The Scottish Context

### *BME Population Figures*

It is difficult to be sure exactly how many BME families are currently living in Scotland, but the size of the minority ethnic population has increased greatly in recent years. This amounted to just over 200,000 or 4% of the total population of Scotland in 2011 (based on the 2011 ethnicity classification); this has doubled since 2001 when just over 100,000 or 2% of the total population of Scotland (based on the 2001 ethnicity classification) were from a minority ethnic group. The Asian population was the largest minority ethnic group (3% of the total population,  $n = 141,000$  people) and has seen an increase of one percentage point since 2001. Just over 1% ( $n = 61,000$ ) of the population recorded their ethnic group as 'White: Polish' (Scottish Government 2011).

Research suggests that there has been a far higher increase of BME children in the care system in Scotland than those of white ethnicity. Scottish Government (2010) statistics reveal that the number of 'looked after' white children increased by 26% between 2002 and 2009; the number of BME children increased over the same period by about 121.5%. Children looked after from black communities increased by 200%, children of mixed ethnicity by 180% and children from Asian communities by 76% (see Table 1).

### *Legislative Framework*

A basic aspect of the legislative framework and policy is that local authorities in the UK should provide culturally appropriate services for BME families. The Children (Scotland) Act (1995) is the current legal framework relating to children's welfare. In particular, Section 2 refers to parents' rights to live with their children or to regulate their children's residence and make decisions about their upbringing. Parents can exercise these rights only if they are in the children's best interests (Anderson et al. 2008; Scottish Executive 2011a). Section 17 of the Act states that local authorities must consider the views of all parties involved when making decisions about the child. Before making a

**Table 1.** Looked after children by ethnicity, Scottish Government (2010).

Ethnicity	2002	2009
White	11,047	13,918
Mixed ethnicity	85	238
Asian	47	83
Black	19	57
Other ethnic background	44	54
Not known/disclosed	At 2005: 1834	938

decision about a child, local authorities should take into consideration the views of the child, the child's parents and anybody else whose views are relevant, such as relatives. Paragraph 4 of this section states that local authorities should also consider the child's 'religious persuasion, racial origin, and cultural and linguistic background [sic]' (Norrie 2004, 53).

Social work practice with families in Scotland is also guided by other legislation, including laws about preventing discrimination in the provision of services and facilities, such as the Race Relations Act 1976 (Scottish Executive 2011b) and the Equality Act 2006 (Scottish Executive 2011c) are frameworks for preventing discrimination on the grounds of personal characteristics such as 'race' and religion.

Practice with children and families is also regulated by the United Nations Convention on the Rights of the Child (UNCRC) (Howe 2010). Article 12 of the UNCRC enshrines the right of children to express their opinions and makes states responsible for providing the conditions for ensuring that children either participate directly or are represented by adults. Moreover, the UNCRC recognises that the family is responsible for the child's upbringing, and the child has the right to have an input in the decision-making about their future. It stipulates that states should support families that have difficulties raising their children (United Nations 2011).

### ***Scottish Policy and Practice***

Scotland has historically taken a very different approach to the rest of the UK in relation to child welfare. This can be traced to the publication of the Kilbrandon Report in 1964 (Scottish Government 2006), which outlined a new direction for working with children and young people. Section 246 of this report recognised the need to have a 'family service' to meet the needs of adults and children in the family, one which would work in close partnership with parents, providing them with the support they needed to face their difficulties and helping them use their resources to improve their children's well-being. Following the Kilbrandon report, Children's Hearings were introduced in the Social Work (Scotland) Act 1968 and first set up in 1971 (Asquith 1995; Guthrie 2011). A central principle of Children's Hearings is that better decisions can be reached through discussion between lay panel members, experts, children and their parents (Anderson et al. 2008). This principle was later repeated in Section 17 of the Children (Scotland) Act 1995, which indicates that before making a decision about a child's care, local authorities should take into consideration the views of the child, the child's parents and anybody else whose views are relevant, such as relatives. However, almost half a century after Children's Hearings were introduced, it seems that practitioners working with children and families still find it difficult to work in partnership with parents to build on families' strengths.

The Scottish review of child protection, *It's Everyone's Job to Make Sure I'm Alright*, published in 2002, found that the needs of BME children and families were not well served by statutory and voluntary agencies (Section 7.54). Its findings revealed a lack of cultural competence among practitioners and a lack of 'racially appropriate services' as well as a 'lack of people with sufficient knowledge of both minority ethnic issues and child welfare and protection in Scotland' (Section 7.55) (Scottish Executive 2002). The review also identified that parents feel that they have very little control over the decisions made by professionals about their children's welfare. The review recommends that services for children and families should focus on building families' strengths and providing 'space for negotiation'. The term 'space of negotiation' refers to the professionals' duty to discuss the views of the children and other relevant people, such as family members and other professionals, before making plans to meet the children's best interests (Section 8.28) (Scottish Executive 2002). Current policy takes this further and introduces new cultural expectations too. *Getting It Right for Every Child* (GIRFEC), notes that practitioners should value and promote diversity; at the same time, it states that children should have the right to be surrounded by others who understand and respect their 'racial, ethnic and cultural heritage'.

## Findings

### *Evidence from Research*

In spite of the good intentions in legislation and policy, there is still a lack of evidence about culturally appropriate services in Scotland. Tisdall (2009) argues that there is little evidence available about BME children's needs and the services that are provided, stressing the lack of research in Scotland into the extent to which local authorities respect children's wishes and their cultural background when making decisions.

A detailed literature search identified that although FGC was created as a tool for responding to families' needs in a culturally appropriate and sensitive way, there has been surprisingly little examination of its use with BME families (Chand and Thoburn 2005; O'Shaughnessy, Collins, and Fatimilehin 2010). Olson (2009) asserts that the implementation of FGC in the USA and Canada has helped to address the child welfare system's failure to respond to families' unique cultural characteristics and the failure of social work professionals to involve families in the process of decision-making. FGC has been transported to many parts of the world including the USA, Brazil, Australia, Scandinavia, Thailand, South Africa, Israel, the UK and Canada (Barnsdale and Walker 2007; Holland and O'Neill 2006; O'Connor et al. 2005; Roujanavong 2005). The data available about the impact of FGC on BME families in the UK are, however, limited and the studies that have been carried out emphasise the need for further research.

Two recent studies have explored the effectiveness of FGC projects with BME families. The first project was carried out by Family Rights Group (FRG) in London in response to concerns that BME families were underrepresented in FGC services (Barn, Das, and Sawyer 2009). The second project took place in Liverpool in 2003 in response to the high proportion of looked after children from BME communities. This project aimed to reduce the number of children from BME communities in care (O'Shaughnessy, Collins, and Fatimilehin 2010). Barn, Das, and Sawyer (2009) gathered information by exploring the views and experiences of Family Rights Group members. For the project in Liverpool, O'Shaughnessy, Collins, and Fatimilehin (2010) examined 72 FGC interventions with BME families between 2003 and 2007. Both studies note that family members stated that they felt that FGC respected their cultural practices, allowed them to voice their opinions and gave them the space to make a plan that would take into account their cultural values. Additionally, both studies concluded that BME families felt empowered by being able to take ownership of the plan and felt that this made its implementation more achievable. Families felt that, compared to traditional child welfare interventions, FGC met their needs more effectively.

## **Findings — Evidence from Interviews with Practitioners**

Three key themes were explored with the practitioners. These were the following: the extent of use of FGC with BME families, the effectiveness of FGC with BME families and any potential issues arising from applying FGC with BME families.

### ***The Extent of Use of FGC with BME Families***

All but one of the informants suggested that BME families were underrepresented in FGC for a variety of reasons including their underrepresentation in social work services generally; social workers' unfamiliarity with FGC; and shortage of information for FGC in different languages. As Participant 7 said, *There are a lot of barriers, I think, for BME families in terms of access to services.* This fits with what is known from wider research that BME families are more likely to be underrepresented in early intervention and preventative services rather than in child protection interventions (Barn 2007; O'Shaughnessy, Collins, and Fatimilehin 2010; Williams and Soydan 2005). Participant 7 also observed the lack of social workers from BME communities and suggested that this needed to change. The shortage of BME professionals in social services has been stressed nationally and internationally (Lombard 2009; Ruiz and Tourse 2011). In the UK, the shortage of BME social workers in social care management has been called a 'major issue [that] need[s] to be tackled' (Lombard 2009). The international literature stressed the advantages of a diverse workforce



within an organisation. It would not only enable organisations to respond effectively to service users from diverse backgrounds but would also help to promote awareness of issues relevant to various ethnic groups within the organisation and promote social and economic justice (Ruiz and Tourse 2011).

There was the general agreement that FGC is not a popular method. As Participant 3 stated, *There are a lot of social workers who do not know about the FGC services. It would not be unusual for social workers who work with BME families not to be aware of [FGC]*. Participants 5 and 6 said that the culture among social work professionals does not promote referrals to FGC. Participant 6 explained:

When a child is at risk of removal [from their house] referral to FGC is mandatory [for the particular council] but often it does not happen. Often the opportunity for FGC is lost and things move on to the point that a mediating action is already underway with the child moving into accommodation and by that point the family is often reluctant to engage ... the timing of the intervention is important and the decision making is a strategic issue in social work in general, not only with BME communities

Participants 5 and 7 were also critical of social workers' reluctance to cooperate and share professional power with the families. They highlighted the need for social workers to shift from 'doing to' to 'doing with' families. Again, my findings are backed up by wider research. Although FGC is well established in some local authorities, research finds that social workers often resist referring families to the service (Barnsdale and Walker 2007). Barnsdale and Walker (2007) note that social workers in Scotland are often reluctant to share power and 'give families more control' (101).

Participant 4 noticed that it would be difficult for a family that does not speak English to refer themselves for FGC because there are no leaflets available in languages other than English. This shortage of information for FGC in different languages might be considered as an example of the structural discrimination that people from BME communities can face. Structural discrimination refers to power relations and social divisions that create barriers that prevent people from accessing services and opportunities on the grounds of personal characteristics such as language (Thompson 2006). Although social workers have an ethical obligation to identify and tackle discrimination to ensure service users' equal access to services (IFSW 2012), this example shows that discrimination is not always identified and tackled.

### ***The Effectiveness of FGC with BME Families***

All interviewees expressed the opinion that FGC would be an effective way to work with BME families. Participant 5, for example, said that in his experience, he could think of an Asian family that had been referred to FGC services. He said: *Asian families are very good to work with because they have very strong*

*sense of family and really thrived on the opportunity to coordinate the family support.* Although he acknowledged that this view is very stereotypical, it nevertheless reflects the wider literature. Barn, Sinclair, and Ferdinand (1997), who examined the services provided to BME communities in 3 different local authorities in England, reveal that family-oriented practice considered being more appropriate from practitioners when working children and families from BME backgrounds.

A qualitative research study conducted in Canada suggested that the South Asian population considered 'family-centred' practice to be better than 'child-centred' approaches. This research revealed that South Asians generally felt that 'child-centred' approaches did not involve them in the decision-making for their children; including the family in decision-making and supporting them with the upbringing of their child was more in line with their cultural values and the outcomes were therefore more effective (Maiter and Stalker 2011).

Participant 4 stated that FGC was 'the ideal vehicle' for working with families whose first language is not English and that are not familiar with the British system. It appears that families who are unfamiliar with the welfare system might find it difficult to seek for advice and get appropriate support due to their lack of awareness regarding potential support by services and the challenges that services face when they work with BME families. This view is also in accordance with what the literature suggests. In particular, O'Shaughnessy, Collins, and Fatimilehin (2010) state that families that are not familiar with how the system works in the UK and that face linguistic, cultural and other barriers to accessing services can benefit from FGC.

Participant 8 shared her own experience of coordinating a FGC for a BME family, when she had to facilitate an FGC for a Pakistani family whose baby had been removed at birth due to domestic abuse. The aim of the meeting was to make a safe plan to bring the baby back home. The family did not want to involve members of the extended family and they also did not want to have interpreters from the same community. Consequently, the meeting took place only with the immediate members of the family and without an interpreter; family members translated for anyone who did not speak English. Participant 8 said that the outcome of the meeting was positive; the family managed to make a safe plan and the baby returned home.

There was the general agreement among three participants that FGC is an effective method when working with families from BME backgrounds, while P1 and P5, who have several years of social work practice experience in New Zealand, said that it made a difference in New Zealand because the law made it mandatory. However, I agree with P5 that any law making FGC mandatory would not 'force' families to participate in FGC. Rather, it is the referrals from professionals that should become mandatory. Making FGC referrals mandatory would give families the opportunity to become actively involved in the decision-making process.

### ***Potential Issues Arising from Applying FGC with BME Families***

Most of the participants expressed similar concerns about the difficulties of using FGC with BME families. The use of interpreters and family dynamics was the two main challenges that the interviewees identified as needing to be overcome when applying FGC with BME families. One of the FGC coordinators referred to a recent experience she had with a Polish family:

... I had to use seven different translators with the same family ... you cannot get the same translator every time you visit the family ... you introduce the whole range of different translators into their [service users'] lives ... then you have the time dilate two times long ... and you are not never totally sure that the translator has completely understood because everything is second hand in conversation. (Participant 4)

She also said that families sometimes refuse to accept interpreters from the same community because of issues of confidentiality, although Participant 7 said that this was not always the case; that sometimes families were happy to work with interpreters they knew through their community. Participant 6 noted that, because the main part of the FGC meeting takes place among the family members, the use of interpreters creates fewer issues in FGC. Again, reviewing the wider literature it seems that the question of interpreters and language difficulties are general challenges, faced when working both with all BME service users or working with any families; moreover, these can be overcome (Connolly 2006b; Dalrymple 2002; Kriz and Skivenes 2010).

The interviewees who have experience working with BME communities all raised concerns about the use of FGC with BME families, particularly in relation to the family dynamics and cultural practices of certain ethnicities, such as the marginalised position of women and young people in some Asian cultures. Participant 6 said that

[FGC] could be seen as an opportunity for the dominant members to reproduce their oppression towards other members ... [FGC] might reinforce the culture stereotype for men to make decisions and women and young people would not have the chance to challenge it

Participants 2, 3, 4 and 5 agreed that it is good practice for the coordinator to ensure that the voices of all family members are heard and taken into consideration when making the plan. They stressed that it is coordinator's job to talk separately with each of the family members individually in the preparation time to take account of all views. When the family presents the plan, it is coordinator's job to make sure that everybody is comfortable with it. Interviewees 2, 3, 4 and 5 also talked about the use of advocates for family members who are not confident enough to express their views. Participant 5 talked about cultures in which the father is more powerful and stressed that the coordinator needs to be aware of this and act appropriately:

We need to make sure that everybody's opinion has been expressed clearly but the father should feel he is the head of the family and the process does not disempower him ... he is maybe in control of the meeting if the family is comfortable with that ... the coordinator might believe that this is not right, but it is not about the coordinators and the social workers; it is about the family.

Participant 7 also advised that family dynamics and some cultural norms should be upheld, not only in FGC but also in every social work intervention that involves BME groups. Again this is an issue explored in the research literature (Connolly 2006b; Dalrymple 2002), which stresses that it is important that FGC coordinators make sure at the preparation stage that they have discussed with all the family members and their voices are represented at the final plan, and at this stage, the coordinator should offer the choice of extra support to any member of the family that needs it, for example a parent with learning disabilities.

In addition, participant's 8 experience, discussed above, shows that although FGC is usually considered to be a preventative method, it may be effective in reversing families' disadvantages and improving their situation. FGC not only can work to prevent the removal of children from their homes but also it can help to reunite them with their families once they have been removed (O'Shaughnessy, Collins, and Fatimilehin 2010).

## Discussion

Both the literature review and the primary research suggested that there is space for improvement in social work policy and practice. Although FGC has been available in Scotland since 1998, BME families remain underrepresented in FGC, in spite of the fact that there is evidence to support its effectiveness. While some councils have made referral to FGC mandatory for families whose children are at risk of removal from home, my own interviews demonstrated that even when this is in place, social workers did not routinely follow the guidance, and BME parents who did not speak English were both less likely to be referred to FGC services and less likely to refer themselves, given the dearth of information about FGC available in languages other than English. This is an example of structural discrimination reducing BME families' opportunities to make an informed choice about the kind of help they received.

In reflecting on the findings of the dissertation that I wrote three years ago, I now believe that there may be more similarities than differences among families of different ethnic backgrounds whose children are at risk of neglect and abuse. In responding to this, FGC is an ideal way of promoting a family's strengths, involving the family members in decision-making and sharing professional power. But it is not always easy to live up to the principles that FGC stands for; real-world practice is complex and difficult at times.

I am pleased to acknowledge that FGC has been institutionalised in my local authority: FGC has to be considered before a child is accommodated and it

would be unusual for any social worker within my local authority not to be aware of FGC. The FGC team is a very busy team and there is a long waiting list. However, FGC coordinators have questioned whether the increased popularity of FGC is related to the potential economic benefits, as the FGC staff has doubled in a climate which is characterised by budget cuts. There have been occasions when children I am working with have been referred to FGC from other services within the local authority due to limited availability of foster placements and young people's units and this raises concerns that referral to FGC might become policy/resource led than needs led.

I have been involved with five FGC processes in my time as a practitioner, and I have made several referrals that have not proceeded to a FGC meeting for a variety of reasons, for example, because there was no extended network to draw on or because the family was reluctant to work with the service. None of these families was of a BME background. I was, however, allocated a family from a BME background who had participated in a FGC meeting before I took on the case. FGC helped the family by enabling extended family members and friends from the community to be identified, and it helped the children to be accommodated with extended family members who would respect their cultural background. My discussions with the parents in this situation showed that the FGC process had increased their participation in, and commitment to, the agreed plan of action; they took ownership of the plan when social control was exercised by the extended network, because they did not want to disappoint their family and their community. In addition, the extended network consisted of people who spoke the same language as them, so the parents also had extra support in understanding the plan. It is this 'value-added' approach that is so important for working in a culturally competent way. Not only do we need to be respectful and responsive to people on an individual basis, but also we need to have an understanding of the wider social and structural context within which BME families are located (Harrison and Turner 2011; O'Hagan 2001). This is the essence of the FGC approach.

Taking sufficient consideration of the views of the child and their families when decisions are made on behalf of a child is not, however, straightforward. It is difficult not to listen to everyone's views when working within the *GIRFEC* framework. But listening to views and taking appropriate action is not the same thing. There have been times when I have had to accommodate children, and although the families' views were heard, actions had to be taken that they were not happy with. Thus, children and families' social work are not always conducive to the empowering practice we aspire to.

## Conclusion

This article set out to review the place of FGC in childcare practice with BME families in Scotland. I have discussed the evidence and research and reflected on my experience of working for three years in a children and families'

practice team. Although there is a lack of research about the use of FGC with BME families, there is enough evidence to suggest that it is a method that can be used effectively with different cultures and my experience confirms these findings. I discussed the potential difficulties of using FGC with BME families, which must be addressed when working with people from different backgrounds regardless of the approach that is used. In fact, FGC can be used to mitigate such concerns.

Future research must look at how social workers can maximise the benefits of FGC when working with families from different backgrounds so the families can receive increased benefit from this approach. Social workers and professionals who work with BME families should also be informed of the benefits of this approach and the availability of the FGC services in order to refer the families. Further research is required in order to unpack this more fully and in particular to explore how BME families can ensure access to FGC and how the coordinators of FGC can ensure maximising benefits while reducing the potential issues of using FGC as identified throughout this paper.

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