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MID-WESTERN HEALTH BOARD

FAMILY GROUP CONFERENCE PILOT PROJECT

EVALUATION REPORT

May 2002

Dr Valerie O’Brien,
Dept of Social Policy and Social Work,
University College Dublin
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Last but not least, to my sons Edward and Peter and partner Sean for all their support and for putting up with an absent mother and wife as the deadlines drew close.
**LIST OF ABBREVIATIONS & COMMON TERMS USED**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>MWHB</td>
<td>Mid-Western Health Board</td>
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<tr>
<td>ERHA</td>
<td>East Region Health Authority</td>
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<tr>
<td>NWHB</td>
<td>North-Western Health Board</td>
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<tr>
<td>HB</td>
<td>Health Board</td>
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<tr>
<td>FGC</td>
<td>Family Group Conference</td>
</tr>
<tr>
<td>FWC</td>
<td>Family Welfare Conference</td>
</tr>
<tr>
<td>Teams</td>
<td>Teams refer to the social work team within the community care structure in the health board,</td>
</tr>
<tr>
<td>Community Care</td>
<td>Community Care refers to the structure within the health board set up to deliver community-based social and health services. The Pilot Project was conducted in the geographical area of the North Tipperary part of the North Tipperary/East Limerick Community Care Area.</td>
</tr>
<tr>
<td>Social Work Staff Structure</td>
<td>There are three grades of social worker in social work teams in community care areas. The first grade refers to a basic social worker, the second grade is a team leader and the senior grade within the structure is the social work manager, who has overall responsibility for the service delivery and who is part of the management structure within each community care structure. The team leader has responsibility for providing support and supervision and running the social work team on a day-to-day basis.</td>
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<tr>
<td>Social Worker</td>
<td></td>
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<tr>
<td>Team leader</td>
<td></td>
</tr>
<tr>
<td>Social Work Manager</td>
<td>The Department in each Community Care area that oversees all local aspects in relation to child welfare and child protection.</td>
</tr>
<tr>
<td>Child Care Department</td>
<td>In this project was the designated Service Manager to receive and negotiate all referrals to the service</td>
</tr>
<tr>
<td>Project Manager</td>
<td>The Co-ordinator is the person who convenes and coordinates the FGC. The Coordinator’s job commences with the allocation of the referral and continues through the preparatory stage to the holding of the FWC and distribution of the plan.</td>
</tr>
<tr>
<td>Co-ordinator</td>
<td>O’Malley Park, Family Resource Centre is a community organisation, which provides a community-based service to families. O’Malley Park, Family Resource Centre provided the coordination service for the F.G.C. pilot project.</td>
</tr>
<tr>
<td>O’Malley Park, Family Resource Centre</td>
<td>These two terms are used interchangeably in the report and refers to the people involved in the FGC process, other than the family members and the co-ordinator. They comprise a group of people, employed in a range of statutory, voluntary and private agencies that are involved in providing services to the families who have agreed to participate in the family group conference process.</td>
</tr>
<tr>
<td>Information-Givers/Professionals</td>
<td>Family member and family members are terms used to refer broadly to people from the child’s family or social network who are involved in the FGC process.</td>
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<td>Family Member/Family Members</td>
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CHAPTER ONE

Part 1 - INTRODUCTION TO FAMILY GROUP CONFERENCES

Part 2 - THE MWHB PILOT PROJECT

Part 1 - INTRODUCTION to FAMILY GROUP CONFERENCES

1.1 Introduction to Report

Family Group Conferencing originated first in New Zealand, as part of the Children and Young Person Act, 1989. The model legislated for in New Zealand has been adopted in a number of countries including Australia, the United Kingdom, Canada, Sweden, France and here in Ireland. The principles and the processes involved were clearly demarcated in the New Zealand legislation. Few countries have included in their own legislation the detail surrounding conferencing laid down in the New Zealand legislation.

The underlying philosophy of partnership, interest in developing "strengths focused" models of work, an increased use of relative placements for children who cannot be looked after by their own birth parents are important context markers in the development of current practice. The benefits of Family Group Conferences have been evaluated internationally and the results have been both positive and encouraging. Family Group Conferencing has a potentially critical contribution to make to the development and delivery of childcare, child protection and child welfare systems. It represents a major new approach for dealing with family crises, as it recognises the crucial significance of the family in relation to securing positive outcomes for children. Family strengths, knowledge and resources are utilised to make decisions, both to protect the child and maximise opportunities for ongoing family commitment and involvement in the life of the child.

The benefits of Family Group Conferences have been evaluated in small-scale Irish studies in the ERHA (2000); NWHB (2002) and many of the benefits seen internationally were also found here.

1.2 Purpose of Report

This report has been commissioned to appraise and draw together the main findings of a small Pilot Project on Family Group Conferences (FGCs) aimed at examining the specific fit between family group conferencing and child protection. This is an aspect that had not been previously pilot-tested specifically in Ireland. The pilot project was conducted in the North Tipperary Community Care Area of the Mid-Western Health Board (MWHB) over the period September 2001 to February 2002. (For demographic profile of North Tipperary and description of the child protection system, see Appendix 1.)

The report first describes the FGC process and the pilot project. It provides details of the Conferences held as part of the Pilot Project, as well as the views of the multiple participants involved. The report analyses and presents findings and recommendations.
in respect of the main research questions regarding the potential fit between family group conferences and child protection.

The report also presents at Appendix 2 and 3 revised and updated versions of ‘Good Practice Guidelines’, which were developed and used in the pilot project, and which takes account of the views of participants and the main findings and recommendations. These guidelines are proposed for use where agencies are intended to implement family group conferences as part of general child welfare services. They also are relevant for ‘family welfare conference’ developments envisaged under the Children Act, 2001.

1.3 The Basis for Family Group Conferencing

Differences in child welfare systems, legislation, service delivery, cultural and political systems will frame the basis for family group conferencing in different countries. Doolan (2001) discusses how FGC can be seen as operating from a number of different bases. The three bases which he categorises are

1. legislative,
2. procedural, and
3. a ‘best practice’ base.

The interest in this new approach has resulted in conferencing being implemented in Ireland as part of the criminal justice and child welfare systems, under statutory requirements laid down in the Children Act, 2001 and as part of a policy direction laid down under ‘Children First’, (Department of Health 1999). To date, however, the implementation of FGC practice in the pilot projects has operated primarily from a ‘best practice’ model. All pilot projects to date, including this one have operated without specific legislative or procedural mandates. There is now reference to the possibilities that FGC may offer in the ‘Children First’ (Department of Health 1999). Likewise, there is provision for conferencing in the Children Act, 2001 which will introduce a legislative basis for conferencing in certain prescribed circumstances, when the relevant sections of the Act are enabled. At the time of this study, the relevant sections of the Children Act, 2001 which places statutory responsibility on various agencies, had not been brought into operation.

The latter legislation uses a number or terms where it refers to conferencing. The use of different terms for what is in essence the same approach appears to be an attempt to distinguish responsibility for convening the conference for young people at different stages of their care and/ or criminal careers. ‘Family Welfare Conferencing’ is the term given to the conference that the Health board has statutory responsibility to convene under both Section 7 and 77 of the Children Act, 2001. This is one of three types of conference referred to the in the Act. The other types are ‘Conferencing’, which the Juvenile Liaison Officer service has responsibility to provide (Sections 29 to 43), and the ‘family conference’, which the probation service have responsibility to convene on referral from the courts (Sections 78 to 87). The use of three separate labels for conferences is viewed as potentially confusing, and a weakness in the legislative framework. There are no major differences in the principles on which all versions of conferencing are based, or in the actual process of convening the various categories of conferences. Further discussion of the similarities and differences of these types is presented in Appendix 4.
There is similar potential for confusion in the terminology regarding FGCs used in ‘Children First’. This document suggests that “a family support meeting is a useful venue for drawing up a plan and for consolidating any informal undertakings made. The family would attend this meeting, any other members of the neighbourhood/community networks, and any professionals involved in delivering a service or offering support. The family should be assisted to set the agenda for this meeting. Tasks, including the person(s) responsible for carrying them out, can be identified and an outline plan agreed and recorded. A family group conference model may also be a useful mechanism for drawing up a family support plan” (Children First, 1999, pg 62).

The principles underpinning conferencing and the process by which they are to be organised are not stated in detail in the legislation or in Children First. This provides Health Boards, and other services, with the flexibility and opportunity to introduce conferencing by incorporating the best practice lessons learned from other jurisdictions and the three pilot projects here in Ireland. In support of this opportunity, the Children First document cautions that “areas adopting this model must ensure that adequate resources, preparation and training are in place, and that established protocols are observed at all times”.

While the distinctions between family welfare conference, family conference and conference are important, in order to minimise confusion, the term ‘Family Group Conference’ is the name used to describe the type of conference piloted in this study. It is intended that this pilot will go some distance in helping to develop the fit between child protection systems and conferencing.

1.4 Legislative Basis in Ireland

While the purpose of this report is to present the findings regarding the potential fit of family group conferencing in the child protection system, it is important to set out the future legislative responsibilities for health boards in respect of conferencing. Notwithstanding the differences in naming family group conference, family welfare conferences, family conferences and conferences, the legislative requirements placed on health boards when Children Act, 2001 is implemented are set out below.

The Children Act, 2001 sees the Family Welfare Conference as a mechanism for early intervention at an inter-agency level for children at risk. The family welfare conference can be triggered in two ways:

(1) On a direction from the court

Section 77 where a court considers a child (aged 12-18), before it on a criminal charge, may be in need of care or protection

Referral of case to Health Board:

- The court may adjourn proceedings where a child charged with an offence (because it considers that it may be appropriate for a care or supervision order to
be made under the Child Care Act, 1991) and direct the Health Board (Section 77 (1) (a)) to convene a Family Welfare Conference (FWC) in respect of the child.

- Having held an FWC, the Health Board may apply to the Court for a care order, a supervision order or a special care order (Section 77 (2) (a)). If the Board decides not to apply for any such order in respect of the child, it shall inform the court (Section 77 (2) (b)) of:
  (i) its reasons for so deciding;
  (ii) any service or assistance which it has provided or intends to provide for the child and his/her family, and
  (iii) any action it has taken or intends to take in respect of the child.
- A Health Board is of the view that a child requires special care and protection, which he/she is unlikely to receive unless a special care order is made (Section 23 (a))

(2) On the Health Board's own initiative,
Where it appears to a health Board that a child (of any age) who resides or is found in its area may require special care or protection which the child is unlikely to receive unless a court makes an order in respect of him or her…. (Section 7(1) (b)) the health board shall appoint a person to convene on its behalf a family welfare conference in respect of the child.

Before applying for a special care order under the amended Act of 1991 Part IV A (Section 23A(2)(a)) the health board shall
Arrange for the convening of a family welfare conference (within the meaning of the Children Act, 2001) in respect of the child

Nobody other than the court can order the health board to hold a family welfare conference. However, a ‘parent my request a health board to apply for a special care order in respect of his or her child’ (Section 23A (3)). If this request is acceded to, then the health board will be obligated to hold a family welfare conference as part of this process. If the ‘Health Board decides not to do so, it shall inform the parent in writing of the reasons for its decision (Section 23A (3))

(3) Health Board involvement in other types of conferences stipulated by Children Act, 2001
The only other involvement stipulated for health board is under Section 32 (3) which states that the facilitator (Garda liaison officer) shall invite any other persons who in his or her opinion would make a positive contribution to the conference including one or more representatives from any of the following bodies
(a) the health board for the area in which the child normally resides.

A number of health boards, while striving to meet their statutory requirements, also want to avail of the benefits of conferencing as a method of intervention for families that require either family support or child protection services.

1.5 Fit with other Policy Developments
Family Group Conferencing shares core values with the operational principles guiding the vision and values of The National Children’s Strategy, (Dept of Health and Children, 2000) namely that service actions and interventions should be:

- **Child-Centred**: the best interests of the child shall be a primary consideration and children’s wishes and feelings should be given due regard.
- **Family-Focused**: the family generally affords the best environment for raising children and external intervention should be to support and empower families within the community.
- **Equitable**: children should have equality of opportunity in relation to access to and participation in the services delivered and have the necessary levels of quality support to achieve this.
- **Inclusive**: the diversity of children’s experiences, cultures and lifestyles must be recognised and given expression.
- **Action Orientated**: service delivery needs to be clearly focused on achieving specified results to agreed standards in a targeted and cost effective manner.
- **Integrated**: measures should be taken in partnership with and between relevant players, i.e. the state, the voluntary/community sector and families.

The FGC is seen to fit with the current requirement to consider the “best interests of the child” as emphasised in the Child Care Act, 1991. FGCs are seen as:

- Safeguarding children and promoting their welfare;
- Taking account of parental responsibility;
- Taking account of race, culture, class, language, religion and disability;
- Working in partnership:
- Supporting children’s contact with their family;
- Providing services to children in need;
- Reuniting children with their families wherever possible (O’Brien 1999)

### 1.6 The Principles Underpinning Family Group Conferences

The following are the general principles underpinning the operation of FGCs:

- The **child’s interests** are paramount, and FGC is the primary decision-making forum for the child;
- Children are **best looked after** within their own family, and family is defined **widely**;
- Working in **partnership** is beneficial to children;
- **Independent co-ordinator** facilitates the involvement of the family, agency and professionals in the process.
- Family are given time to **plan in private**.
- **Plan is accepted** and resourced by agency and professionals unless it places child at further risk.

### 1.7 Operation of the Family Group Conference

There are a number of defined stages to the family group conference process, the first being the preparatory stage before the FGC, and three stages within the actual conference itself. These stages are described briefly as comprised of
(1) The information-giving stage in which information pertaining to the agency concerns regarding the child is shared with the family;
(2) Private family time in which the family deliberate about the concerns and construct a plan to respond to the concerns regarding the child highlighted in the information giving stage; and
(3) The final stage is where the plan is presented to the professionals. This plan is accepted unless it places the child at further risk. A review system and monitoring structures to address the concerns and to support the plan is addressed at this point.

Fuller detail of the various stages is provided in Appendix 5.

PART 2 - THE MWHB PILOT PROJECT

1.8  Introduction to MWHB Pilot Project

1.8.1  Impetus for the Pilot Project
The impetus and key direction of the MWHB Pilot Project stemmed from a finding and recommendation in a previous FGC Pilot Project. The difficulty in giving an accurate portrayal of the fit between the FGC model and child protection protocols was a major finding in ERHA pilot project (O’Brien 2000). The high level of both internal and external change that was occurring in the system at the time was identified as a factor in this finding. The research showed that, in a number of cases, the referrals received in that project clearly fell into a child protection category. The cases were considered as being on the lower scale of risks, rather than involving severe child protection issues. A key recommendation of the report was:
‘While this evaluation report draws clear conclusions about the place and applicability of the FGC in practice, a more extensive study of its potential to meet statutory requirements, and the adoption of a defined FGC method as a standard protocol for given circumstances is urgently needed. This project can make a significant contribution to a co-ordinated and coherent future policy direction’ (O’Brien 2000 p. 75)

In looking to develop its childcare services, the MWHB also noted the potential of the FGC in the child protection sphere, and decided to commission a project specifically to examine and develop this issue.

1.8.2  Purpose and Goal of the Pilot Project
The purpose of the Pilot Project therefore was to examine the applicability of the Family Group Conference as a means of improving the management of child protection concerns.

The project goals were to establish, by 28th March 2002, if the use of Family Group Conferences with selected families can

- Strengthen families’ capacities to respond to and be involved in the resolution of child protection concerns;
- Satisfy statutory and/or professional concerns about the young people and children involved;
1.8.3 Phasing of the Pilot Project
It was agreed that the pilot project would comprise the following key aspects:

i. Appoint Project Manager and Management Committee
ii. Recruit and train two FGC co-ordinators from an independent agency;
iii. Design referral and case management guidelines for MWHB staff;
iv. Do preparatory training for staff to be involved;
v. Hold six Family Group Conferences by March, 2002;
vi. Evaluation Report on the extent to which FGCs could be successfully used during the course of the pilot.

1.9 Terms of Reference for Evaluation
The terms of reference for the evaluation of the project were developed between the Project Management Committee, the Project Manager and the Project Consultant.

These were as follows:

- To evaluate the six Family Group Conferences scheduled for completion by March 2002;
- To explore and establish the level of family participation and sense of ownership of the FGC process;
- To test how the FGC fits alongside current professional processes of investigation, assessment, case conferencing, and review the experience from the perspective of the various stakeholders;
- To consider the implications of extending conferencing service to the management of family support and child protection cases on a regional basis

1.10 Evaluation Methodology

1.10.1 Philosophy underpinning Evaluation
The purpose and aim of this project lent itself to a research methodology based on action research, similar to previous pilot study (O’Brien, 2000). Action research seeks to capture the processes, as they are evolving, and aims to use findings to point and direct the project in ways that are both relevant and appropriate. Action based research emphasises local descriptions in so far as it takes account of the processes evolving in a particular context.

In this evaluation a mixture of both qualitative and quantitative research is used, but qualitative research, with its emphasis on local knowledge, interpretation, and importance of multiple perspectives, is more relevant to address the aims of the evaluation brief above.

A further distinction that needs to be made in regard to research design is the difference between formative and summative evaluation. Formative evaluation is designed to help programme managers, practitioners and planners improve design of a
programme in the developmental phase. Summative evaluation is designed to provide information at the end of a programme about whether it should be continued, dismantled or drastically overhauled. While the terms of reference for this research involves both, this distinction between formative and summative evaluation brings clarity to demands upon the evaluation. Both process and outcome data can be helpful for formative evaluation purposes.

The focus on action-based research, drawing on a predominantly formative evaluation model which embraces a combination of quantitative and qualitative methodology, fits with the role of the evaluation as part of the process rather than a methodology that seeks to take an observer position where the processes and actors were objectified.

1.10.2 Ethical Issues
Evaluators are obliged to conduct the evaluation with the highest possible attention to ethics. Ethical issues during planning must be honest and respectful to those who co-operate in providing information. Written consent was obtained from each person involved, and guarantees given that identifying information would not be published as part of the report.

All family members and information-givers were told at the outset of the project that research was an integral part of the project, and their co-operation was sought on this basis. Inclusion in the pilot project was not, however, dependent on the participants agreeing to co-operate. All interview schedules were posted from the project manager’s office to family members and information-givers following the conference. Family members were offered assistance by the project manager’s office in filling up the schedule if they so chose. This offer was accepted by a number of family members. Written questionnaires were designed and circulated to all management committee members, the project manager and the child care manager.

1.10.3 Data Collection Methods and Tools
A data spread across participants was acquired, reflecting the importance of the different perspectives. The research instruments, which were developed as part of ERHA project (O’Brien 2000), were used where applicable. These instruments were built on previous FGC evaluations (Smith & Hennessy, 1999; Lupton et al, 1998; Crow & Marsh (1996). There is particular value in adapting previously developed research tools as it allowed for a degree of validity and reliability, and allows for the possibility for comparative views to be taken. It also reduces the time that would be involved if the tools had to be developed from scratch.

The methodologies used to collect data ranged through formal and informal interviews, using structured and unstructured questionnaires, and are contained in Appendix 6.

1.10.4 Documentary analysis and Focus Group Discussions
The research methodology also involved document analysis, including minutes of Management Committee meetings, progress reports of the Project Manager, and agency policy statements, as well as the evaluation feedback forms of all staff who received training as part of the project.
Close liaison was maintained with the Project Manager during the course of the project. The evaluator’s membership of the Management Committee enabled practice developments over the course of the project to be informed by data collection and research findings. In this regard the formative evaluation research framework contributed greatly to the project. Finally, ongoing liaison with colleagues in the North/South Forum, other pilots projects and service developments in Ireland and international liaisons augmented the various data methods outlined above and also strengthened the development of the project review.

1.10.5 The Data Sample

Baseline data was obtained on the six referrals received by the project. Summary information is presented in Table 3.1, entitled ‘Profile of Six Cases Referred for an FGC in the MWHB Project’. The data on the three conferences which were completed within the pilot project evaluation time frame is analysed in depth. This includes 13 family members, 14 information givers and two co-ordinators. Additional information was obtained from 12 management committee members. Several of the management committee members were heads of services and key personnel from external agencies, and also included the project manager, and the child care manager (See Appendix 7).

1.10.6 Limitation of the Evaluation

The actual referral rate of cases was slower than anticipated, and therefore the evaluation is based on a smaller number of conferences than originally envisaged. The phenomenon of slowness in referrals to pilot projects is noted in Crow & Marsh, 1996. This means three rather than the six intended conferences were available for evaluation in the pilot project. The small number involved is a major limitation, especially on the quantitative side. However, the numbers did allow for in-depth examination of the cases involved and to that end assisted in examining the primary project objective of the potential for application of the FGC in the child protection system. The short time scale of the project did not allow for outcomes to be examined over time. Instead the project provides a snap shot of how family group conferencing interfaced with cases at a certain point in time.

The failure to interview the three children (all over seven) is a limitation. Circumstances did not permit the interviews. The NWHB pilot study, which included children’s voices, makes a major contribution to the field in this regard.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction to Literature Review
In this chapter the relevant aspects of the literature are presented. This is done under a number of headings, giving a summary view of literature findings on the FGC first, and then going on to look at decision-making in child protection under a number of sub-headings including the crucial issue of parental participation. The next part deals with the literature relating to introduction and the use of FGCs in a child protection context. The place and practice of child protection in the host organisation for this pilot project, the MWHB, is then considered. The plans to broaden the child protection framework to include family support in the MWHB are presented. In the final part the impact of the national framework for child protection, Children First is discussed.

2.2 Summary of findings on FGCs
The key messages from research on FGCs are to be found in Lupton’s (2000 p. 36-38) review of the literature. They are as follows:
- the majority of family members, extended as well as close, like the ideal of a family meeting and agree to participate; neutral venues and flexibility of arrangements are particularly appreciated;
- in contrast with traditional child protection meetings, children appear more inclined to attend FGCs and, once there, appear to participate more extensively; children seem particularly to appreciate the family-only part of the meeting;
- the majority from the family network felt well prepared in advance of the FGC and knew what to expect, some arrived without being clear of the ‘terms and conditions’; it is important that written information for children is provided in appropriate language;
- families and professionals see the FGC as more enabling of family participation than traditional ways of working, with the majority of family members indicating that they would use a FGC again, should future problems arise; more evidence is needed however on the extent to which families also experience the FGC process as empowering;
- the role played by professionals within the meeting may require attention, with consideration being given to making the information-giving session more interactive and with written reports being available before the meeting; some thought could be given to the idea of a family ‘pre-meeting’ before the professionals arrive;
- the great majority of family groups produced a plan and most of these plans appear to be agreed ‘in principle’ by the agencies concerned; more detailed information is however required on the extent to which plans are implemented fully as agreed and the reasons why not, if not;
- FGCs appear to mobilise family support, but they may not thereby reduce the demands on agency/ professional resources; in the main plans appear to be realistic in terms of the support requested;
- the early indications are that FGCs may be no less effective than traditional approaches in ensuring the care and protection of children; more extensive evidence however is needed on this vital question.
2.2 Decision-making in Child Protection
2.3.1 Complexity in Decision-Making
The complexity involved in decision-making in the child protection sphere is widely acknowledged in the literature. This is, perhaps, best summed up in the comment by Cleaver and Freeman (1995), when they acknowledge the inherent difficulty in decision-making for professionals in the following terms:

“Decision-making requires the skills of Machiavelli, the wisdom of Solomon, the compassion of Augustine and the hide of a tax-inspector. Making decisions proves to be something of a balancing act for professionals. Taking into account parental perspectives involves surrendering a degree of control to the powerless”.

Larner (et all, 1998) further suggests the decisions that caseworkers have to make would:

“Challenge King Solomon, yet most of them lack Solomon’s wisdom, few enjoy his credibility with the public and none command his resources”

2.3.2 The Place of the Case Conference
The case conference has been the traditional decision-making forum in child protection issues. Hayes (2000) (See Section 2.5 for details of this study) views the case conference as only one phase of child protection work, with often more difficult and challenging phases of intervention and investigation preceding the case conference. Ferguson (2000) (See Section 2.6 for details of Ferguson’s work in the MWHB) suggests the need for clear criteria for calling case conferences. Ferguson’s research found the following:

- A significant number of high-risk substantiated cases that could, or perhaps should, have reached a case conference did not do so. A full 67% of substantiated high-risk referrals did not have a conference. (Ferguson, 2000 Pg 151)
- A key finding is the relatively minor role played by case conferences in managing new cases and referrals, being largely concerned with cases with a history of health board involvement. (Ferguson, 2000 Pg 167)
- The criteria should include specifying who is responsible for calling case conferences, the role of the C.P.N system in this and the relationship between decision-making and planning at C.P.N meetings and case conferences. (Ferguson, 2000 Pg 149)

2.3.3 Parental & Children’s Participation in Case Conferences
Hayes (2000) writes about degrees of partnership operating along a continuum of power relationships. He sees partnership as including:

- ‘participation’ in key decision-making meetings,
- ‘involvement’ in identifying problems and goals and objectives for work,
- ‘consultation’ before decisions are made or actions taken, and
- ‘keeping fully informed’ about services, powers and duties of social services, likely action, rights, etc.)

Philips and Evans (1986) warn that partnership should not be seen as mere attendance but rather: “…Understand the process which they are going through and both they
and the professionals feel that they have made a useful contribution to the plan of action” (Philips and Evans, 1986 Pg 12).
FIGURE 2.1 - DECISION MAKING FORUMS FOR CHILD PROTECTION PLANNING

No Family Participation

Entry onto C.P.N.S. (Internal to H.B)

Liaison – Management Team Meeting (Garda/Social Work)

Strategy Meeting (inter-professional)
At outset to share all available and relevant info.
Convene at any time following preliminary enquiries and submission to C.P.N.
Garda involvement essential

Referral

Child Protection Conference (Inter-professional and family involved)
Initial enquires completed
When decisions of a serious nature are being considered
Facilitate sharing, outline child protection plan and identify tasks
Not all Child Protection cases warrant a C.P. conference
Each community care area develops its own protocol

Family Group Conference
Family involved and inter-professional
Accesses expert family knowledge
Extensive Family Participation

Source, Suggested in Children First, Adapted McClure (2001), Unpublished
While there has been some research into parental participation at case conferences there has been little empirical research into parental participation in other “emergency phases” of the child protection process. Ferguson showed that Irish practices on the inclusion of parents or guardians in case conferences fell far short of what is regarded internationally as best practice. (Ferguson, 2000 Pg 144). In the MWHB parents were invited to attend in just over half of the conferences, with 54% (n = 14) of the parents invited actually attending for part of the conference. In only one case did the parents attend for the whole conference. (Ferguson, 2000 Pg 156)

Ferguson warns that the lack of an invitation to what are perceived as non-cooperative parents may alienate them further and intensify their hostility. He goes on to suggest that the challenge to professionals is in developing a fully inclusive practice to engage with hostile clients at case conferences in a system which operates in a subjective, arbitrary manner which no longer accords to best practice. (Ferguson, 2000 Pg 157).

An evaluation of Children First in 2001 shows an increased level of parental participation at case conferences (HEBE, 2001).

Ferguson’s research identified a need for more information and better listening. Writing of the general Child Protection care system Ferguson found that one of the main criticisms, voiced by many children, was they felt they were denied information. The children in care were especially critical of a lack of information from social workers as to why they were being placed in care. (Ferguson, 2000 Pg 218). In summary, what clearly emerges from the interviews with children is the poor communication and quality of information given to children, especially in relation to plans for children in care. (Ferguson, 2000 Pg 224)

Some practitioners would argue the current child protection structure and meetings cited in Children First militate against children participating to their full capacity.

2.4 Introduction of FGCs into Child Protection Practice

When looking at the introduction of the FGC internationally there is need to examine the context and environment in which the model was introduced. Doolan (2001) identifies three approaches:

1. Legislative - The legislative basis is such that the model is enshrined in law, and there are procedures specified/ regulated to ensure that the principles are set out to guide the practice.
2. Procedural - The guiding principles are enshrined in procedural requirements to behave in a certain way.
3. Best Practice - The principles are introduced to staff who are encouraged to carry out their duties and responsibilities within a re-focused practice paradigm. In this approach the professionals act as ‘gatekeepers’.

Doolan sees potential problems with all three approaches. With a legislative mandate, the “philosophical underpinnings of the approach can be underpinned by the legislation” with solicitors possibly advising their clients “not to engage, or their use of other legislation to thwart the intentions of child welfare law”. On the other hand, Doolan sees the procedural approach as running the risk of “instability in the face of changing fads about what is the right thing to do… or colonisation of the concept of empowerment practice by pre-setting the professional agenda”. The development of the ‘Best Practice’ approach relies on enthusiasts trying to make inroads. (Doolan, 2001, pp 5-6).
A number of Public Inquiries into child abuse in the U.K. in the 1970’s and 1980’s led to the development of what has been characterised as a pre-dominantly legalistic and procedural response to child abuse allegations and investigations. These responses have since been criticised as defensive and reactive in nature by Cooper (1994;) and Parton (1997). These legislative and procedural models of practice led to a system which has been criticised for its exclusion of parents and children (Nixon 2000, Thoburn et al, 1995, Ryburn & Atherton, 1996)

With its emphasis not just on parental and children’s participation in decision-making, but the wider family network also, the FGC has been viewed as a valuable antidote to the exclusionary system. In the U.K. the FGC has been introduced as a “good practice” rather than a legal construct, with the “grassroots” level challenging rather than complimenting existing practice. Nixon (1999) saw change being brought forward through winning over people’s “hearts and minds” to this way of working, rather than through legislation or procedural change. This differentiation has critical implications for the implementation and development of FGC/ FWC. Nixon sees the FGC practice being shaped by its “proximate social, organisational and political contexts” (Nixon, 2001 pg 6).

In Ireland, in anticipation of the legislative changes, a number of Pilot Projects were undertaken (ERHA, NWHB and MWHB). FWCs are now included in legislation in limited circumstances, however the MWHB is committed to introducing the FGC/ FWC as a model of best practice on a wider basis.

A key issue of importance in the introduction of FGC is how the model can be incorporated/ accommodated into the current Child Protection system, taking into account policy and procedures. Writing of the U.K. Nixon (2000) describes a system of a “procedural and legal context”. He remains critical of the approach to “fit FGCs within the procedures, time scales and assumptions of the state bureaucracies” which he believes have “relegated FGCs to a secondary planning forum or a ‘rubber-stamp’ for professional ideas. The net effect is that FGC principles and philosophy are watered down to fit into mainstream orthodox practice”(Nixon, 2000 pg 7).

In New Zealand, FGC advocates have been seeking to change the paradigm from child protection, through professional intervention and decision-making, to a paradigm of a family support approach to child protection. (Doolan 2001). Doolan is optimistic “that core statutory social work can deliver on the state requirements that children be protected by embracing the family support paradigm, and through that process, need responsive services identified by families can be provided for them.” He sees the “tension between family support (a needs-based approach) and child protection (a risk-based approach) is eased by an effective partnership mechanism, such as the Family Group Conference”. (Doolan, 2001, Pg 5). This model of practice is no less committed to child protection. Doolan sees the need for different thinking in relation to some aspects of child protection definitions, and on how to manage the process at the post-inquiry and assessment stages. The classic child protection approach is professional deliberation, court involvement and care. The family support approach engages the wider family as the change agent, as participants and as decision-makers through the mechanism of the Family Group Conference.
2.5 Use of FGC in Child Protection

Nixon is one of the leading advocates of the benefits and place of the FGC approach in decision-making in child protection. Nonetheless, he is critical of the development of the field, and the manner in which the approach may be used. He notes that it is somehow ironic that:

“the idea that families would make better decisions than professionals came from families and communities, not from the professionals. Yet it is professionals who have designed the service, driven it, constructed it, inset the standards, and in so doing to some extent at least, may have colonised these ideas and diluted the spirit of FGCs, or certainly modified them” (Nixon, 1999 pg 4)

Nixon says that there is a tendency for professionals in the U.K. to refer cases to the FGC service when they want to:

- Use the FGC as a rubber stamp for their ideas
- Squeeze resources out of families
- Use the Conference as an intervention of ‘last resort’ (Nixon, 1999 Pg 4)

Hamill (1996) notes that child protection is probably the one area where family participation leads to most anxiety for professionals. She identifies two major concerns in relation to the introduction of FGCs in child protection:

(a) the relationship between the FGC and local child protection procedures, and
(b) the ‘safety’ of FGC in the complex area of child protection.

It should be noted that the FGC process is unlikely to be occurring in a vacuum. Other services are likely to be involved, are likely to become involved or will remain involved post-FGC. Therefore there is a need for the FGC service/ practice to interface with a number of other services, both statutory and voluntary.

Hayes’s (2000) research was undertaken to explore professionals’ views on the possible use of FGCs in Child Protection. In the course of his research Hayes evaluated three groups of staff: practitioners, managers and non-social work members of the North and West Belfast Health and Social Services Trust in Northern Ireland. Fifty-five percent of Hayes sample agreed that FGC “should be used in Child Protection work”. Only 7% disagreed, and 38% were not sure.

Hayes (2000) concludes

“it is both desirable and feasible to use FGC in child protection work. However, this is based on the realisation that the FGC model will not be appropriate for all families in which child protection concerns exist and that there are difficulties with the model that need to be addressed in practice.”

2.6 Child Protection in MWHB

In the mid to late 1990s, Ferguson undertook a research project to evaluate the work of the Mid-Western Health Board’s child care and protection system, as it actually processed cases over a specified period. This research aimed to learn more about how
the Child Care system works, identifying what aspects are done well, and how professionals actually operate on a day-to-day basis to protect children.

Ferguson’s research pre-dated the introduction of Children First. Following the introduction of Children First, the MWHB, as did most Health Boards, introduced a formalised Child Protection Notification system. This had interdisciplinary management groups meeting regularly to process ‘notified’ referrals and cases. This is an initiative which represents perhaps the most significant organisational change as community care shifted its primary concern to child abuse. Ferguson was critical of a system which he saw was influenced more by managers, bureaucracy and accountability. Ferguson suggests that need, rather than the decision-making process itself, should drive responses to children and families (Ferguson, 2000 Pg 153).

Ferguson also found the Health Board’s professional systems to be chronically enmeshed with certain types of cases and families, which posed particular challenges. The cases coming to the attention of Health Boards were characterised as tending to involve reconstituted families or lone parents (usually mothers) who live in poverty, often suffering addiction problems, and other adversities such as a violent partner, who may or may not be the father of the children. As the children grow older and enter their teenage years, they tend to become out of control; they have to deal, not only with the legacy of years of adversity and child abuse, but also with a view of them as threats to themselves and/ or social order. (Ferguson, 2000 Pg 266)

The MWHB “Child Welfare and Family Support Strategy Statement 2002-2005” sets out an organisational framework for the development a Child Welfare System within the MWHB that provides for the delivery of early intervention and family support services to children and families in need. It is acknowledged that, under the auspices of the MWHB, many initiatives exist that seek to safeguard children and, if at all possible, to keep them out of the Child Protection system and state care. However it is recognised within the MWHB that more could be done to promote the welfare of children and to provide services that could alleviate family problems before they deteriorate to the point at which child protection and alternative care options are considered (MWHB, McClure, 2001, Pg 2). This strategy provides a management model for the development of a Child Welfare System that sets out clear objectives, procedures and structures for the delivery of services in a context of prevention and support.

2.7 Broadening of ‘Child Protection Concern’ to include Family Support in MWHB

One of the key findings and recommendations made by Ferguson was the need for Health Boards to design a strategy for working with cases which are immensely demanding of energy and resources (Ferguson, 2000 Pg 266). Such a strategy requires a fundamental change in the way childcare services are conceptualised and delivered. The system needs to stop trying to fit cases into a ‘child protection concern’ frame and approach child welfare on the basis of assessed need, regardless of the presenting problem. (Ferguson, 2000 Pg 266)
Re-focusing children’s social work requires an acknowledgement of the specific, yet inter-linked, sub-systems of child protection, childcare and family support. For each sub-system staff should be given specific responsibilities to discharge key roles and tasks in the case management process. At the same time, however, there must be an acknowledgement that these sub-systems can and do inter-link and inter-act as the needs of children and their families evolve. Children who require protection may need to be brought into the child care system, albeit for a short period. Children in the care system may need an infrastructure of support to be put in place in the family and local community so that they may safely leave the care system.
Scoping the parameters of these sub-systems, agreeing their interfaces and developing protocols for the various team members to operate dynamically and effectively is a key challenge to successfully refocused practice. (Giller, 2001 “Responding to the Implications of the Ferguson Report: Options for the Mid-Western Health Board”)

In light of the findings internationally described above, and Ferguson’s conclusions in the MWHB, the board has been endeavouring to find ways to fit family welfare and child protection together. The FGC is seen to have a potentially pivotal role in integrating systems and moving processes in the right direction, and hence the proposal for this pilot project.

2.8 National Developments – Children First
Children First - the National Guidelines for the Protection and Welfare of Children was launched in 1999. The objectives of the Guidelines are stated as:
1. To improve the identification, reporting, assessment, treatment and management of child abuse cases.
2. To facilitate effective child protection work by emphasising the importance of family support services and the need for clarity of responsibility between professionals.
3. To maximise the capacity of staff in organisation to protect children by virtue of the guidelines relevance and comprehensiveness.
4. To consolidate inter-agency co-operation based on clarity of responsibility, partnership and co-ordination of information.

The Guidelines provide details for parts of the child protection system including handling the referral, screening and initial assessment, the Child Protection Notification system, and different types of planning meetings. This document, although it does not embrace the FGC as such recognises and defines a Child Protection Conference as an:

“inter-agency and inter-professional meeting, which is convened by the Child Care Manager/designate. It normally takes place when initial enquiries and, if relevant, emergency action have taken place. It may take place during the early stages of enquiry, or at any time when concerns arise about a child’s care and protection. The Child’s parents/ carers and the child should be included where appropriate”. (Children First, 1999 p78, par. 8.19.1)

The Guidelines contain significant pointers regarding inclusiveness:

- Parents/carers normally have more information than any professional about their child and can make valuable contributions to assessment and planning;

- Plans made at Conferences are more likely to succeed if negotiated while parents/carers are present;

- The experience of parents/carers waiting outside a room while a Child Protection Conference is in progress can be extremely distressing and unhelpful. For this reason, parents/careers should participate in the whole conference. If their presence at the whole Conference is not permitted, then
arrangements should be made to minimise any potential discomfort likely to be experienced by them (tea, coffee, etc.)

- Parents/carers are likely to feel nervous, under scrutiny and, in some cases, hostile to the professionals present. Sensitivity and preparation are required in order to reduce tension and facilitate useful discussion;

- Parents/Carers should be permitted to bring a support person to the Child Protection Conference, whose identity will be clarified by the Chairperson to the other participants;

- The purpose of involving parents/carers in a Child Protection Conference, as with any other participant, is to hear his or her contribution and agree conclusions and recommendations. The Child Care Conference should not be used as venue for making assessments of characters, behaviours or abilities of parents/carers, nor should parents/carers be re-interviewed or interrogated at a Child Protection Conference (Children First, 1999 pg 150-151)

The Guidelines go on to delineate certain circumstances when the exclusion of parents/carers may be justified. The MWHB Protocol clearly outlines the Child Protection Conference Agenda, which provides an opportunity for “Family Members Contribution” (MWHB, 2001 (B) Pg 18). The Guidelines state “it is appropriate to hold a Child Protection Conference when decisions of a serious nature are being considered which require the input of professionals from different disciplines and agencies (MWHB, 2001, Pg 78, par. 8.19.2).

In anticipation of Children First, the MWHB designed Child Protection Guidelines within the Board, which recognised Child Care and Protection as a “corporate responsibility requiring a commitment from all personnel without exception across the entire Health Board Services” (MWHB, 1998, pg 1, par.3). Following the introduction of Children First, and in line with recommendations therein (Children First, Pg 79, 8.19) the MWHB’s Child Care and Family Support Services developed a “Child Protection Conference Protocol” (November 2001). This protocol identified a number of objectives: the most relevant for this research being the objective “To maximise involvement of appropriate individuals, particularly parents, children and young people” (MWHB, 2001 Pg 4)

The MWHB’s policy is to maximise parental involvement, while maintaining the care and protection needs of the child as the first priority. The Board has a commitment to inviting parents to participate in Child Protection Conferences, unless there are clear grounds for exclusion. (MWHB, 2001 Pg 11). The Board also has a clear policy on the preparation of parents to participate in a Child Protection Conference.
CHAPTER THREE
PART 1- GENERAL INFORMATION ON THE CONFERENCES
PART 2 - FAMILY MEMBERS VIEWS OF THE CONFERENCE STAGES

3.1 Introduction

This chapter is divided into two parts. Part one summarises information on referrals received in the project. In part two, the family members’ views of the different stages of the conferences are presented.

The project time-frame extended for six months from September 2001 to the end of February 2002. During that time, six referrals were made to the project. Three of these referrals ended with family group conferences, one referral was withdrawn during the late preparation stage, and two referrals were withdrawn earlier. All six referrals are used to provide base-line information in this report. The findings in part two of this chapter are based predominantly on the views of the participants in the three completed conferences, as well as the one referral withdrawn. Where applicable, general observations relating to the other two cases are included, as the formative evaluation methodology used enabled the researcher to remain close to the processes as they were developing.

In part one, the profile of the six cases referred for conferences is presented, briefly giving key characteristics. The data on the three conferences, which were completed within the evaluation time-frame, is analysed in depth in later sections of the report. Summary information is presented in Table 3.1, entitled ‘Profile of Six Cases Referred for an FGC in the MWHB Project’.

For comparative purposes, the Lupton (1995) FGC evaluation comprised of 19 families, with 22 FGCs being held. Of those 19 families, 11 were researched in depth. In the ERHA Phase One Study (O’Brien 1999), 8 conferences were held and 8 families were researched in depth. 19 family members, 8 information givers and 3 coordinators provided the research data in that case. In the NWHB Study (2000) 15 referrals were received into the Project from January-June 2001, 10 were completed and 5 did not go to Conference. 61.5% of these were included in the research data, 7 of whom were children. In Hayes’s (2000) study in Northern Ireland, 8 families were involved, and research data was obtained on the 8 conferences.
TABLE 3.1
Profile of Six Cases Referred for an FGC

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age of child</th>
<th>Child attend</th>
<th>Gender</th>
<th>Completed: C Terminated: T</th>
<th>Plan made &amp; acc</th>
<th>No. of Family members</th>
<th>No. of Prof.</th>
<th>Persons excluded from conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3 months</td>
<td>Y</td>
<td>F</td>
<td>C</td>
<td>Y</td>
<td>Invited 8</td>
<td>Attended 8</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>8 years</td>
<td>Y</td>
<td>F</td>
<td>C</td>
<td>Y</td>
<td>Invited 3</td>
<td>Attended 3</td>
<td>Yes Paternal aunt on Mother’s insistence</td>
</tr>
<tr>
<td>3</td>
<td>14 months</td>
<td>No</td>
<td>M</td>
<td>T</td>
<td></td>
<td>Invited 5</td>
<td>Attended 2</td>
<td>No Family members excluded themselves</td>
</tr>
<tr>
<td>4</td>
<td>10 years 7 years</td>
<td>Y</td>
<td>M M</td>
<td>C</td>
<td>Y</td>
<td>Invited 9</td>
<td>Attended 8</td>
<td>No N/A</td>
</tr>
<tr>
<td>5</td>
<td>11 years 16 years</td>
<td>M</td>
<td>F</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>15 years</td>
<td>F</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>
3.2 Status of Participants in Cases 1 - 4

3.2.1 Marital Status of Parents
Examination of the marital status of the parents show that in one family the parents were “married but separated”, in two families the parents were cohabiting, and in the remaining case the father was a widower.

3.2.2 Age & Gender Profile of Children
The age profile of the 5 children involved in the project ranged between the ages of three month to 10 years. A gender analysis shows three (60%) were male, while females represented two (40%) of the children included in this study.

3.2.3 History of Contact with the Health Board
The results show that there was a significant history of family contact with the Health Board. This involvement was divided into two categories. Firstly, four of the five children in respect of whom the conference was being called had been involved with the Health Board in the past. Secondly, 66% of other family members had had substantial prior involvement with the Health Board, compared to 75% in the ERHA project.

3.3 Connection with the Pilot Project

3.3.1 Reasons and Route of Referrals
The referrals sought by the project were families who were involved in the child protection system, as distinct from families that were viewed in the agency as falling within the remit of family support. Referrals were sent to the project manager’s office from the community care team. The project manager attended the child protection notification meetings. This provided the project manager with an overview of cases entering the child protection system. Potential cases could be discussed at this early stage between the project manager and the staff of the child protection notification system.

The decision-making body designated for accepting referrals into the project was a referral committee. The referral committee was comprised of the Child Care Manager, Principal Social Worker and Project Manager. Their role was to assess and make a decision on the referrals. On acceptance for the project, the case was assigned to a coordinator, whose task was to introduce and explain the process, and to prepare the participants for the FGC. It was to prove beneficial that the members of this committee had an overview of, and positions of responsibility in, the child protection system.

3.3.2 Factors influencing the Referral Rates
The rate of referral of cases to the pilot project was initially slow, a finding which is similar to other projects. The short lead-in time, combined with the short life span of the project (6 months) meant that the project was under pressure in achieving its targets from the start. The location of the project in one small geographical area, together with the shared personnel in child protection and on the referral committee, assisted in the referral process. Another factor, which influenced the decision to set up
the project in that area was the need to work with a management team who had a history of working together. The social work team had undergone major changes of personnel, but many of the other inter-disciplinary team members involved in child protection were in place for some time.

Four of the six referrals were received in the period December 2001 to February 2002. Yet, only one of these cases ended with a family group conference. In many respects this illustrates that as the project was entering its second three-month period, efforts were made to find ‘suitable cases’. Two of families approached and asked to consider an FGC did not share the agency’s enthusiasm for this new approach at that point in time. With the slow trend of referrals, key people in the voluntary sector were also contacted. It was intended initially that the pilot would examine the applicability of the FGC model to cases where domestic violence and child protection were issues. No cases emerged in the time period involved, and at the later stage of the project, it was thought that the voluntary sector might provide such a referral. While this was investigated, it was deemed unlikely that a case that would fall into the child protection referral criteria would have been managed solely by the voluntary sector. The other hope was that the voluntary sector might bring a case where they were working alongside the statutory services, and which might have been overlooked in the agency. Despite the efforts, no such case was found.

3.4 The Conferences
The stages in the conference process are discussed in detail in Appendix 2.

3.4.1 Preparation and Participation
Contacting Invitees: The primary means used by the co-ordinator to make the necessary arrangements with family members for the conference was a combination of telephone calls, with a follow-up personal home-visit. A similar method was utilised for contacting the professionals. The difficulties of contacting people were amplified by the rural setting of the pilot project. Significant travel hours were involved in each case.

Family & Professionals in Attendance: The number of family members who attended the FGCS averaged five, with a range from two to eight. Those who failed to attend were divided into three categories. Firstly, there were those who could not attend due to particular circumstance. Secondly, there were those who chose not to attend and thirdly those who could not attend as other key family members excluded them. Professional attendance was high and averaged seven persons, varying from six to nine. In all 86% of professionals invited to a conference attended.

In the ERHA project, the average number of family members who attended was also five. The NWHB project had an average family attendance of nine, ranging from five to twenty. The high rate of attendance reported above is indicative of the readiness of people in families and their social networks to become involved when invited to help protect vulnerable children. It also shows, however, that when extended family members are invited, significant difficulties can arise from the birth parents perspective, as more people are aware now of the child protection difficulties.
3.4.2 Time Scales involved in the FGCs

**Referral:** It was found that 2 of the cases referred to the pilot were accepted within one week of the referral being made, and the remaining case was accepted within a three week period.

**Acceptance to Pilot:** The period between acceptance of the referral and the holding of the FGC was three weeks in one case, five weeks in the second and ten weeks in the third.

The time between referral and holding a conference in the ERHA study averaged six weeks, the shortest was three weeks and the longest was ten weeks. In the Essex project (Smith & Hennessy, 1999) the average was five weeks, the shortest 1 week and the longest 14 weeks.

**Preparation:** The average length the co-ordinators spent working at preparation between the referral and the holding of the FGC was 48 hours, compared to 30 hours in the ERHA project. The inner and outer times in the ERHA project ranged from 25 to 35 hours while in this project it ranged from 36 to 48 hours. The NWHB experience was 73.35 hours average, the inner and outer times ranged from 37 to 100 hours. As was the experience in the ERHA, the main issue accounting for this difference was the amount of travel involved. In one conference, 18 of the 36 hours (50%) was spent on travel and in another, 17 of the 48 hours (35%) was spent on travel. The NWHB project found face-to-face interaction accounted for an average of 31.4 hours and travel averaged at 42.6 hours per Conference with a maximum of 85 hours. This finding points to serious implications for the delivery of co-ordination (and other) services in rural settings.

**Information-Giving:** The average length of time for the information-giving stage of the actual conference was 45 minutes, a finding similar to the ERHA experience. These figures are marginally higher than the NWHB experience of 33 minutes.

**Private Family Time:** On withdrawal of the professionals from the meeting, private family time ranged from a maximum of three hours in one very complex meeting to thirty minutes in the second, and fifteen minutes in the third. It is interesting to note that the families that needed longer to plan in private needed less time for discussing and presenting their plan. In the ERHA project the average length of private family time was 60 minutes, ranging from 90 down to 15 minutes. The NWHB found private time averaged at 2 hours 28.5 minutes, with an inner and outer limits ranging from one hour to 5 hours. Lupton (1995) found that private family time was 2 hours and 15 minutes at longest, ranging down to 15 minutes.

**Presentation of Plan:** The average time for presentation of the plan for review and ratification by the professionals took on average one hour and fifteen minutes, compared to 50 minutes in the ERHA project. However, this average figure does not illustrate the major differences in this sub-stage. In the case of the conferences with the fifteen minutes private family time, the plan presentation stage took three hours. In another case, the presentation of the plan took 45 minutes, while the family needed thirty minutes to devise their plan.
Duration of FGC: The entire conference process in the pilot took an average three and three-quarter hours, compared to two and a half hours in the ERHA.

Referral to Completion: The total number of hours the co-ordinator worked in facilitating the conference between the referral stage and the completion averaged 49 hours. The inner and outer times ranged between 42 and 53 hours. The average of 49 hours compares to 33 hours in the ERHA project. In the Essex study, the time commitment of the co-ordinators in preparation for and holding of the conference was 29 hours, with the limits being between 12 and 48 hours. The Lupton study (1995) average was 23 hours, with variation from 8 to 51 hours.

Geographical location, cases involving large numbers of invitees and complex family situations contribute to the variation in time scales. The extent to which the time commitment involved was connected with the high-risk, child protection cases involved is discussed further in Chapter five. The level of time commitment has serious implications for the resource requirements for FGCs, when they are implemented on a broader level.

It should also be noted that considerable effort in terms of project manager’s and co-ordinator’s time were used on the referrals which did not end with conferences.

Time Conference was Held: All of the FGC’s were held on a weekday, with two of the conferences during office hours. In the other case, the FGC was held in the evening to accommodate working members of the family network. Seventy percent of the NWHB FGCs were held during the week, with 43% occurring in the evening. Thirty percent were held at the weekend with one third during the day and a further one third in the evening. The high level of employment in Ireland indicates that evening meetings will continue to be desired, especially if wider family membership is to be attracted to the conferences. From the agency perspective, evening and weekend meetings have major implications for the agency’s work practice agreements. A balance will need to be worked out with staff if FGCs are to be held at a time convenient for some families.

Venue: In one case, the location chosen for the FGC was a community centre, as it was deemed to be a neutral venue for all participants:

The fact that it was on neutral ground was of benefit to both families as it meant no advantage to either side

It also facilitated the practicalities of a sizeable group meeting. In the other two cases, the family members chose a health board premises. No conference was held in the families’ own home, which was also the case in the Essex and Lupton study findings. In the ERHA, one conference was held in the family’s own home. The availability of suitable venues is a real issue in a rural context. Privacy, availability of venues in general, and suitable space are the main issues. As one family member said

‘Where else would we go?’

Another non-family attendee at a conference said when asked about the venue chosen

‘I was very comfortable because it was an environment I was used to. However, although it was a Health Board premise, the family also appeared comfortable with it. There were plenty of empty rooms available and I would recommend access to at least 2 rooms for any future conference.’
A family member who attended this conference has a slightly different view when they said

‘it was all right but for ...the child’s sake, I would have preferred the hotel.’

In another case the response from another information-giver to the use of a community resource in a rural area was

‘The venue was very poor, inadequate. It was ...small, cramped, lacked confidentiality

Local community hall........ it would not have worked if more family had attended.’

One family member at the same conference saw it differently, and described the venue

‘......as a grand place’.

3.4.3 Presenting the Plan

Reaction to Plan: In all three cases, the plan as presented was accepted by the health board. However, it is important to stress that in two of the three cases, significant details of the plan were worked out when the family members and the professionals were sitting down together after the private family time. In both these instances, the co-ordinator played a key role in facilitating the end result.

Review Date: The place of the review emerged as significant issue in this pilot project. The main issue centres on the place of the FGC and the review alongside other decision-making forums. This issue is elaborated further in Chapter five.

Monitoring Of Plan: There was explicit reference to the monitoring of plans in all of cases, and this was seen to be the remit of the designated social worker.

PART 2 - FAMILY’S VIEWS ON THE FGCs

3.5 Introduction to Qualitative Research

In Part 2 of this chapter and in Chapter four the views of the participants are presented, drawing on both qualitative and quantitative data. Those included were fourteen family members (n = 14), eleven information givers (n = 11), the co-ordinators (n = 2) and the management committee (n = 12) and project manager (n = 1).

There are two aspects in which the views and feelings of the participants are ascertained. Firstly, the four stages of the FGC process are examined in relation to their specific conference, i.e. Referral stage, Information-Giving Stage, Private Family Time and Presenting the Plan. Secondly, a more general overview of the process is obtained by reflecting broadly on the model.

3.6 Family views on the Four Stages of the Conference

3.6.1 Before the Conference - The Referral and Preparation Stage
A number of key issues, pertinent to the referral stage, are discussed here. These address the following questions:

- Was the information clear?
- Did they feel adequately prepared?
- Did they know what would be achieved?
- Was there any conflict regarding attendance?
- Were those people considered to be helpful contacted and facilitated to attend?
- Did the family have different views regarding who should attend? and
- Did they consider the right professionals were in attendance?

**TABLE 3.2**
Summary Table of Family Members Perspective on Level of Preparation prior to FGC (n = 14)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>In parts</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was information clear prior to conference</td>
<td>78% (11)</td>
<td>22% (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you adequately prepared</td>
<td>35% (5)</td>
<td>35% (5)</td>
<td>21% (3)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Any conflict re attendance</td>
<td>28% (4)</td>
<td>36% (5)</td>
<td>22% (3)</td>
<td>14% (2)</td>
</tr>
<tr>
<td>Were helpful people facilitated to attend</td>
<td>72% (10)</td>
<td>21% (3)</td>
<td>7% (1)</td>
<td></td>
</tr>
<tr>
<td>Were the right Professionals invited</td>
<td>86% (12)</td>
<td></td>
<td>14% (2)</td>
<td></td>
</tr>
</tbody>
</table>

Clarity of information: The referring worker outlined the concern of the agency in writing to the project manager in the referral. This concern formed the basis for the holding of the FGC. The ‘why’ of the concern determined the scope and brief of the FGC for the participants. The co-ordinator was generally the first person in contact with prospective attendees (except birth parents, who would have already given permission to the agency to proceed with an FGC). At this juncture, the process and reason for peoples’ participation being requested was explained. The great majority of families (78%) responded positively saying there was clarity of information from the co-ordinators, describing both the process and the purpose of the FGC, while the remainder (22%) expressed some uncertainty. The NWHB study reported a higher (91.7%) level of satisfaction with the clarity of information received prior to the conference, with the reminder feeling that the information was clear only in parts.

Many of the families’ fears were resolved when the co-ordinators explained the concepts that lay behind the process and the steps that would occur at the various stages of the meeting. One family member said that initially:

‘I had no understanding of FGC.... initially I thought it was a family court’.

When the family members were asked about what other information would have been helpful at the initial stage, one birth parent said she would have liked:
More information on the reports that were going to be given by the professionals. At least then I would have known what to expect from all of them and not to be worried about them.

Overall, the brochures used to introduce conferencing were viewed as being particularly helpful and easy to read.

What would be achieved
In reviewing the family’s understanding of the reason for the conference, the family members showed a good understanding of why such a meeting was needed. It also showed they were conversant with what the health board was saying about what would need to change in the family to put a safer living situation in place for the children. It is necessary to bear in mind that the understanding captured in the evaluation evolved over the course of the FGC process itself, rather than being present so clearly at the beginning. However when the family were asked about what would be achieved at the outset, some family members wanted to know more about the extent of the neglect and abuse inflicted on the children. Others wanted to use the conference to make more definite decisions, like making a more permanent care plan, or getting the parents to change their ways. There was limited evidence of caution or suspicion as to why the agency was now inviting participants in, as was evident in the ERHA project.

However, in one case there was a total lack of understanding among the family members as to why such a meeting was being arranged. This person’s view represents the frustration that family members experienced when they perceived that they already had given as much as they could.

There was a complete lack of understanding about the conference and everyone was a little frustrated when the exact mission of the conference was revealed. My own view is that unless the problematic person is helped, it is very hard to expect the family to continue picking up the pieces considering we’ve done it for years.

This comment also reflects a view that if the agency is too prescriptive about what the FGC can achieve, such problems may emerge.

A key component, which contributed to the success of this initial preparation stage, was the personal visit by the co-ordinator to those invited to attend. This was a finding which emerged also in the ERHA project. Interestingly the co-ordinators views of this stage is somewhat different. Their experience was that this stage represented major work for them in respect of clarifying and reclarifying the reasons for the conference, the agency concerns, who was to be involved etc.

Overall Adequacy of Preparation: There was a difference between the family members knowing the reason for the FGC and what they hoped would be achieved, and the extent to which the family felt prepared for the totality of the experience. Only a portion (35%) of family members felt they were adequately prepared in all aspects of the FGC in advance of the conference, while 52% felt some gaps remained for them. Three people felt they were not adequately prepared at all. This overall adequacy of preparation was less in the MWHB, compared to the ERHA project where 74 % (n =14) reported that they were very well prepared. Nonetheless, when the family were asked what worked for them in the preparation stage they said:
the on going talks with the co-ordinator……the continuous explanations
……the previous notice which …..gave time to organise domestic
arrangements
These factors all contributed to the overall preparation at this stage.

Conflict re attendance: There was conflict regarding who was to attend in the
preparation stage in the four conferences. The main cause of conflict hinged on
exclusions. In one instance the birth mother refused to attend if members of the
paternal side were to attend. Unfortunately, in this case, the birth mother herself had a
very small family and social network and therefore the possibilities for the child were
diminished. In another situation the difficulties centred more on the family’s
suspicions of the process and the fear that this meeting, regardless of all the re-
assurances, would be unable to deliver in the way that was being promised. It is of
note that in this instance that a parental alcohol problem was central to the protection
issues for the child, and the family members generally felt let down by the statutory
services interventions in their lives.

When family members were asked in detail about the reasons for conflict, it was seen
to be associated more with past difficulties in the family as indicated in this quote:

“I would prefer not to mention names but the conflict (about attendance) was
not a direct result of the conference, it goes back to other family problems.”

Helpful attendees: family Despite the views expressed above about family
attendance, eleven family members (72%) felt all appropriate people were contacted
and three people felt that, in part at least, the right ones were facilitated to attend. One
person had no view. When family members were asked if, on reflection, they had a
different view regarding who should have attended, no other people were identified.

Right Professionals: The vast majority of family members said that the right
professionals were invited, and two people said they did not know. This was also the
finding in the NWHB study where 88.3% of respondents felt that the right
professionals were invited to the meeting. When this subject was explored further an
interesting observation about feeling overwhelmed by professionals emerged:

“I didn’t think there should be all these professionals present as it felt very
uncomfortable at times with everyone staring at us.”

Others indicated that they would have liked different professionals to attend, such as
the local doctor.

3.6.2 The Information-Giving Stage

In Table 3.3 the question of adequacy of information provided to participants, the
opportunity for family to speak, the extent to which the family members had their
questions answered and their level of comfort during this time is presented.
TABLE 3.3
Summary of Participants Experience at the Information-Giving Stage

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Some</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate information to make a decision</td>
<td>36% (5)</td>
<td>50% (7)</td>
<td>7% (1)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Chance to speak if you wished</td>
<td>93% (13)</td>
<td></td>
<td></td>
<td>7% (1)</td>
</tr>
<tr>
<td>Answered your questions</td>
<td>36% (5)</td>
<td>36% (5)</td>
<td>7% (1)</td>
<td>21% (3)</td>
</tr>
<tr>
<td>Felt comfortable</td>
<td>36% (5)</td>
<td>14% (2)</td>
<td>36% (5)</td>
<td>14% (2)</td>
</tr>
</tbody>
</table>

(N = 14)

The majority felt the information-giving stage was handled well, with some 36% (5) of family members feeling they got adequate information at this point to enable them make a decision. Half the people (50%) found some gaps in the information shared, and one person felt they did not get adequate information at all. Up to 50% indicated that they felt uncomfortable at the meeting to some degree. All said, however, they were given a chance to talk if they wanted, and they also felt listened to by all. For over half the family members, they felt there were some inadequacies in the answers given by the professionals to their questions. In many of these instances, the nature of the cases and the stage they were at in the child protection process accounted for this. The challenge remains to develop a context to enable these unasked questions to be asked.

Many of the reasons people stated they were satisfied with the information given is reflected in the following view:

‘the openness, honesty, and the.... collective concern for the child really showed. The availability of tea, the warm surroundings and the atmosphere really helped.’

This however did not take away from the pain experienced when the enormity of what was happening for the children was illustrated.

On the other hand, hearing the details of what happened made some people uncomfortable, for others it brought back pain from events that happened at an earlier stage of the child protection assessment and investigation. One person noted that she found it hard to listen to what was reported, as she kept thinking that if the parent only stopped drinking, then all would be fine.

For others, the meeting and how the information was shared was such a new experience, the impact was expressed:

‘I was never involved in the likes of that before.’

Interestingly, no comments emerged about the style of reports or language used by the information-givers during either the information-giving stage, or the presentation of the plan. In the ERHA report, family members commented on the ‘big words’ used by the social workers and the sense that participants didn’t understand what the professionals were saying half the time. (O’Bien, 2000 p.46).
A number of people expressed surprise that the information being shared was affirming and positive in many aspects, while also being challenging and revealing. This reflects the importance of the inclusion of a strengths’ perspective to the assessment of protection issues.

Overall the family members indicate that they were pleased with the way in which the information was shared. However, when the processes surrounding the presentation of plan were examined, it became clear that the great majority of family members would have liked more information, especially about resources and options. Issues of information-giving therefore need to be interpreted cautiously. This comment sums up the point:

‘Even though I was well informed I feel that more information into the outcomes and backup options should the plan have failed and what other outcomes were available if problems should arise from the plan.’

The co-ordinator played a pivotal role in setting the tone for the information flow at the conference. The co-ordinator was viewed by family members as someone with whom a bond had been forged through the home visit. The family members spoke by and large of the great help, reassurance and support received from the co-ordinators. One family member only felt they were not facilitated to participate as much as they would have liked.

3.6.3 Private Family Time
Table 3.4 presents the family members view of the key processes that occurred during private family time stage of the conference. The processes examined are as follows:

The extent to which the family had a clear idea of what needed to happen when the professionals left?
The extent the family felt listened to?
The extent others felt listened to?
Any difficulties that may have arisen in the absence of the professionals? and
The extent available resources were pointed out to the family to facilitate plan?

### TABLE 3.4
Summary of Family Member’s View of Private Family Time (PFT)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Quite a bit</th>
<th>A little bit</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was made clear what needed to happened when professionals left</td>
<td>65 % (9)</td>
<td>21% (3)</td>
<td>14% (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extent you felt listened to</td>
<td>65 % (9)</td>
<td>7% (1)</td>
<td>14% (2)</td>
<td>7% (1)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Extent others listened to</td>
<td>65% (9)</td>
<td>28 (4)</td>
<td></td>
<td>7% (1)</td>
<td></td>
</tr>
<tr>
<td>Any difficulties emerge in PFT</td>
<td>7% (1)</td>
<td>29% (4)</td>
<td>43% (6)</td>
<td>21% (3)</td>
<td></td>
</tr>
<tr>
<td>Extent it was easier to talk</td>
<td>43% (6)</td>
<td>29% (4)</td>
<td>14% (2)</td>
<td>14% (2)</td>
<td></td>
</tr>
</tbody>
</table>
In Table 3.4 the summary picture of family members' views of private family time are presented. The majority of family members had a clear understanding of what needed to happen when the professionals left the meeting, while three members (21%) were somewhat confused, and two people had no view (14%). Within the private family time, nine people (65%) felt listened to. Four people felt they could have been listened to more. It is not surprising that it was generally the birth parents that had the experience of not being listened to enough.

Generally, the informants indicate that no major difficulties emerged during this part of any of the three conferences. That is not to say there was not some tension. In one instance the father:  

‘threatened to leave the FGC. He did not see any point in the FGC. After some talking to he decided to stay.  

In another instance, the view was expressed that it was clear that parent and child  

….. ‘did not get on with each other. My opinion is that if both were on their own they would have been shouting at each other.’  

Families reported that while there was a lot of tension, sometimes between members of the same family, and other times between the child’s paternal and maternal side, a range of conflict resolution skills were drawn on to handle the mounting tensions and differences.

This suggests while the process of FGC was experienced as generally positive by the family, it can be a painful experience for some individuals when discussing a family problem, and yet, families found ways of handling these difficulties.

**Professionals Leaving**

Discussions in the absence of the professionals were easier for the most part (53%) but a sizeable number (42%) experienced no significant difference due to professionals leaving. In the NWHB study, 29.2% felt it was easier with most people (66.7%) saying that it made no difference. Some people commented on the difference as being attributed to being alone as family:

‘It was different because it was only the two families that were there’

For others they saw it as pragmatic in a different way:

‘I would say that they gave us a job to do to the best of our ability for…..(the child’s) future and safety and to draw up a plan with our own freedom of speech which I thought was very fair in this situation.’

The ease of being alone is also reflected in this experience, when a family member said:

‘I got a chance to say everything I wanted, to bring out into the open…’

The private family time was more difficult for some rather than others, and again the vulnerability of the parents, while still a factor, was lessened after the professionals left. This is reflected in the following comments from two parents:

‘There was less tension and I was not as nervous’  

(N = 14)
Undoubtedly, the experience of family coming together under circumstances where a state agency has a major issue in respect of one of their children is likely to evoke a wide mixture of emotions. When the family were asked about how participating in the FGC impacted on their relationship, eleven people (79%) said there was no impact, two didn’t know and one did not answer.

It is important to note that, despite the challenges and tensions, no family members commented that the process might have been easier if an outsider had to sit in with them. This is different to the ERHA experience where in almost equal measure, family members totally opposed and supported the idea of an outsider staying with them for the private family time. Those opposed saw that it would work against the family making the decision (O’Brien, 2000), while those that supported it thought it would help family work faster through the planning stage and/or would reduce family tensions. 25% of respondents in the NWHB study reported that problems did arise during private family time due to the absence of the professionals and the authors suggest that in such situations the presence of the coordinator may facilitate discussions.

Devising a Plan

When the family were asked about their experience of devising a plan, a number of interesting points emerged. The difficulty of the task of trying to devise a suitable plan was compounded by the lack of more specific knowledge of the actual risk involved in either the child going home or having unsupervised access while still in care, or being safe at home if still living there. The difficulties of the task facing the family members in trying to devise a plan in these circumstances is captured in the following views:

‘I felt like I knew nothing yet had all the information in front of me. I’m not quite sure what more could have been added but something was missing.

I just wanted to know about certain injuries which could not be answered in order to be sure of the safety of ... ’...the child’.I just wanted to know who to trust in the future.

An issue that emerged for the family, especially for birth parents in one FGC was their need to have some private family time for themselves within the private family time. This was seen as a space possibly to help them compose themselves, reflect on what had been said or simply to sort out where they stood in relation to what was emerging for their child and themselves.

The challenges facing the family in drawing up a plan are many. Two of the main issues are lack of information regarding resources which has potential to hamper, and the lack of certainty as to the risk involved if certain courses were taken. This may, of course, reflect the stage the child protection assessment is at, and what aspect of decision-making is needed at that time, and the part the family can play in that.
3.6.4 Presenting the Plan
Table 3.5 presents the key findings of family member’s experience of the process of presenting the plan. It is examined under the following headings:
- The extent to which the family recollect the plan?
- The degree it was different from what they thought may have been reached?
- If the plan was accepted? and
- If a date for review was set?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Quite a bit</th>
<th>In between</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of happiness with plan</td>
<td>21% (3)</td>
<td>36% (5)</td>
<td>7% (1)</td>
<td>29% (4)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Level of difference from what family thought might constitute plan</td>
<td>29% (4)</td>
<td>21% (3)</td>
<td>14% (2)</td>
<td>36% (5)</td>
<td></td>
</tr>
<tr>
<td>Success in resolving the problems at time</td>
<td>29% (4)</td>
<td>14% (2)</td>
<td>43% (6)</td>
<td>14% (2)</td>
<td></td>
</tr>
<tr>
<td>Levels of satisfaction regarding plan at time of research</td>
<td>37% (5)</td>
<td>14% (2)</td>
<td>21% (3)</td>
<td>14% (2)</td>
<td>14% (2)</td>
</tr>
</tbody>
</table>

(N = 14)

3.6.5 Reflections on the plan and outcomes
It is important to note that examination of the outcome of the plan after a lapse of time was not possible, given the time constraints of the pilot project and the need to have FGC’s up to a month before the pilot ended. A number of interesting views emerged when the family members were asked to reflect on the plans made and their view of the outcomes.

Only three people (21%) were very happy with the plan while seven people (49%) felt that it contributed positively to the situation the families faced. One third were not happy, or did not have a view. As time went on, it appears that the number of people who were happy with the plans diminished. Questions were raised about additional help needed after drawing up of the plan, by way of examining the impact of plan. Three family members (21%) said additional help was required outside the plan.

However, the majority (79%) did not know if the plan required subsequent help. It is necessary to look behind the small quantitative data presented to understand what may be behind the figures for discontentment with the plan. Some family members commented on how the changed care arrangements since the FGC were much better for the child, and commented that she was visibly happier. For others, they felt that the plan had a negative effect on them personally. This was especially the view for birth parents and carers, who either lost that status as a result of events following the FGC or had their access cut as a result of the family plan. It is very evident that when
the plans are examined the dynamic and complex nature of the processes following the FGC impact on the outcome of the plan, and how it is perceived.

3.6.6 Families overall impression of the FGC
The family members were asked for general comments about the FGC process, and what surprised them most about it. The following comments give a flavour of the answers to these questions. For some the newness was evident:

*The whole process was a surprise really, as it is not like anything I’ve ever experienced*

For the parents it was particularly difficult, as would be understood when cases are involved in the child protection system:

*People (family members) were saying things that were hurtful and they were very selfish in parts. Everything was to suit them and they made most of the decisions for us.*

Overall people welcomed the opportunity for a number of reasons:

*The FGC has answered a lot of unanswered questions on the safety of the child. ....*

*The FGC has provided the foundation for a happy environment’*

‘Very well organised, easy people to speak to and the freedom of speech, privacy, no aggressive behaviour’

‘It’s good because it brings all family members together to sort out any differences that they may have’.

‘The FGC helps to bring everything out into the open.’

‘I feel that all professionals involved did what they could to help’.

Lastly, but of central importance is the way the family saw the FGC impacting on the children who were present at the conference. The children present ranged in ages from 3 months to ten years (4 children). The family members who attended the FGC for the small baby felt that her presence kept them extremely focused, though it was difficult for the parents. They were afraid of having to handle her if she needed attention, as they did not want to be in the limelight. For the older child, one family member’s view was:

*The child was there and she wasn’t there if you know what I mean. She played ...In the other room to take the pressure off her.*

When the impact of the meeting was explored, some felt that it lifted a weight off the child. In this instance she was to remain in her extended family. Another family
member thought it frightened her but when this was further explored it appeared that
the trauma of what had been happening to the child was much more the issue. Yet
another family member said they did not know what the impact was as she felt:

*It is hard to know what they are actually thinking*

---

3.7 Conclusion

This chapter was divided into two parts. In part one the profile of the families referred to the
conference, attendance of participants and duration of FGC from referral to completion was presented.
In part two, the family views were presented. This part predominantly sought to address the extent to
which family members participate in and have a sense of ownership of the FGC process.

Many of the findings were similar to the findings which emerged in the ERHA project
(O’Brien, 2000 p79-82) in Ireland and which are also features of international pilot
studies Lupton et al, 1995; Lupton & Stevens, 1997; Crow and Marsh, 1996 and

- The overall finding was the family members did participate in meetings organised
to address concerns relating to the children in their networks. There was
overwhelming appreciation for the co-ordinators preparatory work, how they
imparted the information and their general demeanour.

- The family members participated from both maternal and paternal sides.

- The family members who participated averaged five per conference (excluding
children), and a large majority of those who were invited to attend did so.

- Family members described the home visit from the co-ordinator as extremely
positive, and this visit helped to set the scene for the meeting. The social workers
in many of the cases also played a key role in encouraging the birth parents of the
children to allow the meeting go ahead.

- Family members expressed the opinion that their views were heard and respected. Some family
members who had no experience of prior meetings felt it was good and those that had prior contact
with professional networks felt the process was better than their previous experience.

- When the private stage and presenting of the plan was examined it emerged that
the family had limited knowledge of the resources available to them. This has
implications for participation, as if family members are not given adequate
information to address the concerns, then the extent to which participation can be
achieved is affected.
MID-WESTERN HEALTH BOARD

FAMILY GROUP CONFERENCE PILOT PROJECT

EVALUATION REPORT

May 2002

Dr Valerie O’Brien,
Dept of Social Policy and Social Work,
University College Dublin
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ACKNOWLEDGEMENTS

The author wishes to acknowledge with sincere gratitude the people who contributed to this study. The pilot project could not have happened without the participation and co-operation of a great number of individuals and organisations, and the evaluation report could not have been undertaken without the assistance of family members, information-givers and the co-ordinators involved in the pilot conferences. They have given generously of their time and direct experience, for which I am very grateful.

Among the individuals who have assisted the author on this project are:

Ita O’Brien: Director of Child Care Services, who commissioned and supported the project. Through her vision, the window of opportunity to explore the application of FGC to the area of child protection has been completed, before the proposed legislative changes and implementation of Children First are written in stone.

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Last but not least, to my sons Edward and Peter and partner Sean for all their support and for putting up with an absent mother and wife as the deadlines drew close.
# LIST OF ABBREVIATIONS & COMMON TERMS USED

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<th>Description</th>
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<td>MWHB</td>
<td>Mid-Western Health Board</td>
</tr>
<tr>
<td>ERHA</td>
<td>East Region Health Authority</td>
</tr>
<tr>
<td>NWHB</td>
<td>North-Western Health Board</td>
</tr>
<tr>
<td>HB</td>
<td>Health Board</td>
</tr>
<tr>
<td>FGC</td>
<td>Family Group Conference</td>
</tr>
<tr>
<td>FWC</td>
<td>Family Welfare Conference</td>
</tr>
<tr>
<td>Teams</td>
<td>Teams refer to the social work team within the community care structure in the health board.</td>
</tr>
<tr>
<td>Community Care</td>
<td>Community Care refers to the structure within the health board set up to deliver community-based social and health services. The Pilot Project was conducted in the geographical area of the North Tipperary part of the North Tipperary/East Limerick Community Care Area.</td>
</tr>
<tr>
<td>Social Work Staff Structure</td>
<td>There are three grades of social worker in social work teams in community care areas. The first grade refers to a basic social worker, the second grade is a team leader and the senior grade within the structure is the social work manager, who has overall responsibility for the service delivery and who is part of the management structure within each community care structure. The team leader has responsibility for providing support and supervision and running the social work team on a day-to-day basis.</td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
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<tr>
<td>Team leader</td>
<td></td>
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<tr>
<td>Social Work Manager</td>
<td></td>
</tr>
<tr>
<td>Child Care Department</td>
<td>The Department in each Community Care area that oversees all local aspects in relation to child welfare and child protection.</td>
</tr>
<tr>
<td>Project Manager</td>
<td>In this project was the designated Service Manager to receive and negotiate all referrals to the service</td>
</tr>
<tr>
<td>Co-ordinator</td>
<td>The Co-ordinator is the person who convenes and coordinates the FGC. The Coordinator’s job commences with the allocation of the referral and continues through the preparatory stage to the holding of the FWC and distribution of the plan.</td>
</tr>
<tr>
<td>O’Malley Park, Family Resource Centre</td>
<td>O’Malley Park, Family Resource Centre is a community organisation, which provides a community based service to families. O’Malley Park, Family Resource Centre provided the coordination service for the F.G.C. pilot project.</td>
</tr>
<tr>
<td>Information-Givers/Professionals</td>
<td>These two terms are used interchangeably in the report and refers to the people involved in the FGC process, other than the family members and the co-ordinator. They comprise a group of people, employed in a range of statutory, voluntary and private agencies that are involved in providing services to the families who have agreed to participate in the family group conference process.</td>
</tr>
<tr>
<td>Family Member/Family Members</td>
<td>Family member and family members are terms used to refer broadly to people from the child’s family or social network who are involved in the FGC process.</td>
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CHAPTER ONE

Part 1 - INTRODUCTION TO FAMILY GROUP CONFERENCES

Part 2 - THE MWHB PILOT PROJECT

Part 1 - INTRODUCTION to FAMILY GROUP CONFERENCES

1.1 Introduction to Report
Family Group Conferencing originated first in New Zealand, as part of the Children and Young Person Act, 1989. The model legislated for in New Zealand has been adopted in a number of countries including Australia, the United Kingdom, Canada, Sweden, France and here in Ireland. The principles and the processes involved were clearly demarcated in the New Zealand legislation. Few countries have included in their own legislation the detail surrounding conferencing laid down in the New Zealand legislation.

The underlying philosophy of partnership, interest in developing "strengths focused" models of work, an increased use of relative placements for children who cannot be looked after by their own birth parents are important context markers in the development of current practice. The benefits of Family Group Conferences have been evaluated internationally and the results have been both positive and encouraging. Family Group Conferencing has a potentially critical contribution to make to the development and delivery of childcare, child protection and child welfare systems. It represents a major new approach for dealing with family crises, as it recognises the crucial significance of the family in relation to securing positive outcomes for children. Family strengths, knowledge and resources are utilised to make decisions, both to protect the child and maximise opportunities for ongoing family commitment and involvement in the life of the child.

The benefits of Family Group Conferences have been evaluated in small-scale Irish studies in the ERHA (2000); NWHB (2002) and many of the benefits seen internationally were also found here.

1.2 Purpose of Report
This report has been commissioned to appraise and draw together the main findings of a small Pilot Project on Family Group Conferences (FGCs) aimed at examining the specific fit between family group conferencing and child protection. This is an aspect that had not been previously pilot-tested specifically in Ireland. The pilot project was conducted in the North Tipperary Community Care Area of the Mid-Western Health Board (MWHB) over the period September 2001 to February 2002. (For demographic profile of North Tipperary and description of the child protection system, see Appendix 1.)

The report first describes the FGC process and the pilot project. It provides details of the Conferences held as part of the Pilot Project, as well as the views of the multiple participants involved. The report analyses and presents findings and recommendations.
in respect of the main research questions regarding the potential fit between family group conferences and child protection.

The report also presents at Appendix 2 and 3 revised and updated versions of ‘Good Practice Guidelines’, which were developed and used in the pilot project, and which takes account of the views of participants and the main findings and recommendations. These guidelines are proposed for use where agencies are intended to implement family group conferences as part of general child welfare services. They also are relevant for ‘family welfare conference’ developments envisaged under the Children Act, 2001.

1.3 The Basis for Family Group Conferencing

Differences in child welfare systems, legislation, service delivery, cultural and political systems will frame the basis for family group conferencing in different countries. Doolan (2001) discusses how FGC can be seen as operating from a number of different bases. The three bases which he categorises are

(4) legislative,
(5) procedural, and
(6) a ‘best practice’ base.

The interest in this new approach has resulted in conferencing being implemented in Ireland as part of the criminal justice and child welfare systems, under statutory requirements laid down in the Children Act, 2001 and as part of a policy direction laid down under ‘Children First’, (Department of Health 1999). To date, however, the implementation of FGC practice in the pilot projects has operated primarily from a ‘best practice’ model. All pilot projects to date, including this one have operated without specific legislative or procedural mandates. There is now reference to the possibilities that FGC may offer in the ‘Children First’ (Department of Health 1999). Likewise, there is provision for conferencing in the Children Act, 2001 which will introduce a legislative basis for conferencing in certain prescribed circumstances, when the relevant sections of the Act are enabled. At the time of this study, the relevant sections of the Children Act, 2001 which places statutory responsibility on various agencies, had not been brought into operation.

The latter legislation uses a number of terms where it refers to conferencing. The use of different terms for what is in essence the same approach appears to be an attempt to distinguish responsibility for convening the conference for young people at different stages of their care and/ or criminal careers. ‘Family Welfare Conferencing’ is the term given to the conference that the Health board has statutory responsibility to convene under both Section 7 and 77 of the Children Act, 2001. This is one of three types of conference referred to in the Act. The other types are ‘Conferencing’, which the Juvenile Liaison Officer service has responsibility to provide (Sections 29 to 43), and the ‘family conference’, which the probation service have responsibility to convene on referral from the courts (Sections 78 to 87). The use of three separate labels for conferences is viewed as potentially confusing, and a weakness in the legislative framework. There are no major differences in the principles on which all versions of conferencing are based, or in the actual process of convening the various categories of conferences. Further discussion of the similarities and differences of these types is presented in Appendix 4.
There is similar potential for confusion in the terminology regarding FGCs used in ‘Children First’. This document suggests that “a family support meeting is a useful venue for drawing up a plan and for consolidating any informal undertakings made. The family would attend this meeting, any other members of the neighbourhood/community networks, and any professionals involved in delivering a service or offering support. The family should be assisted to set the agenda for this meeting. Tasks, including the person(s) responsible for carrying them out, can be identified and an outline plan agreed and recorded. A family group conference model may also be a useful mechanism for drawing up a family support plan” (Children First, 1999, pg 62).

The principles underpinning conferencing and the process by which they are to be organised are not stated in detail in the legislation or in Children First. This provides Health Boards, and other services, with the flexibility and opportunity to introduce conferencing by incorporating the best practice lessons learned from other jurisdictions and the three pilot projects here in Ireland. In support of this opportunity, the Children First document cautions that “areas adopting this model must ensure that adequate resources, preparation and training are in place, and that established protocols are observed at all times”.

While the distinctions between family welfare conference, family conference and conference are important, in order to minimise confusion, the term ‘Family Group Conference’ is the name used to describe the type of conference piloted in this study. It is intended that this pilot will go some distance in helping to develop the fit between child protection systems and conferencing.

1.4 Legislative Basis in Ireland

While the purpose of this report is to present the findings regarding the potential fit of family group conferencing in the child protection system, it is important to set out the future legislative responsibilities for health boards in respect of conferencing. Notwithstanding the differences in naming family group conference, family welfare conferences, family conferences and conferences, the legislative requirements placed on health boards when Children Act, 2001 is implemented are set out below.

The Children Act, 2001 sees the Family Welfare Conference as a mechanism for early intervention at an inter-agency level for children at risk. The family welfare conference can be triggered in two ways:

(3) On a direction from the court

Section 77 where a court considers a child (aged 12-18), before it on a criminal charge, may be in need of care or protection

Referral of case to Health Board:

- The court may adjourn proceedings where a child charged with an offence (because it considers that it may be appropriate for a care or supervision order to
be made under the Child Care Act, 1991) and direct the Health Board (Section 77 (1) (a)) to convene a Family Welfare Conference (FWC) in respect of the child.

- Having held an FWC, the Health Board may apply to the Court for a care order, a supervision order or a special care order (Section 77 (2) (a)). If the Board decides not to apply for any such order in respect of the child, it shall inform the court (Section 77 (2) (b)) of
  (i) its reasons for so deciding;
  (iv) any service or assistance which it has provided or intends to provide for the child and his/her family, and
  (v) any action it has taken or intends to take in respect of the child.

- A Health Board is of the view that a child requires special care and protection, which he/she is unlikely to receive unless a special care order is made (Section 23 (a))

**On the Health Boards own initiative,**

Where it appears to a health Board that a child (of any age) who resides or is found in its area may require special care or protection which the child is unlikely to receive unless a court makes an order in respect of him or her ....(Section 7(1) (b)) the health board shall appoint a person to convene on its behalf a family welfare conference in respect of the child.

Before applying for a special care order under the amended Act of 1991 Part IV A (Section 23A(2)(a)) the health board shall

Arrange for the convening of a family welfare conference (within the meaning of the Children Act, 2001) in respect of the child

Nobody other than the court can order the health board to hold a family welfare conference. However, a ‘parent may request a health board to apply for a special care order in respect of his or her child’ (Section 23A (3)). If this request is acceded to, then the health board will be obligated to hold a family welfare conference as part of this process. If the ‘Health Board decides not to do so, it shall inform the parent in writing of the reasons for its decision (Section 23A (3))

**Health Board involvement in other types of conferences stipulated by Children Act, 2001**

The only other involvement stipulated for health board is under Section 32 (3) which states that the facilitator (Garda liaison officer) shall invite any other persons who in his or her opinion would make a positive contribution to the conference including one or more representatives from any of the following bodies

(b) the health board for the area in which the child normally resides.

A number of health boards, while striving to meet their statutory requirements, also want to avail of the benefits of conferencing as a method of intervention for families that require either family support or child protection services.

**1.5 Fit with other Policy Developments**
Family Group Conferencing shares core values with the operational principles guiding the vision and values of The National Children’s Strategy, (Dept of Health and Children, 2000) namely that service actions and interventions should be:

- **Child-Centred**: the best interests of the child shall be a primary consideration and children’s wishes and feelings should be given due regard.
- **Family-Focused**: the family generally affords the best environment for raising children and external intervention should be to support and empower families within the community.
- **Equitable**: children should have equality of opportunity in relation to access to and participation in the services delivered and have the necessary levels of quality support to achieve this.
- **Inclusive**: the diversity of children’s experiences, cultures and lifestyles must be recognised and given expression.
- **Action Orientated**: service delivery needs to be clearly focused on achieving specified results to agreed standards in a targeted and cost effective manner.
- **Integrated**: measures should be taken in partnership with and between relevant players, i.e. the state, the voluntary/community sector and families.

The FGC is seen to fit with the current requirement to consider the “best interests of the child” as emphasised in the Child Care Act, 1991. FGCs are seen as:

- Safeguarding children and promoting their welfare;
- Taking account of parental responsibility;
- Taking account of race, culture, class, language, religion and disability;
- Working in partnership:
- Supporting children’s contact with their family;
- Providing services to children in need;
- Reuniting children with their families wherever possible (O’Brien 1999)

### 1.6 The Principles Underpinning Family Group Conferences

The following are the general principles underpinning the operation of FGCs:

- The **child’s interests** are paramount, and FGC is the primary decision-making forum for the child;
- Children are **best looked after** within their own family, and family is defined widely;
- Working in **partnership** is beneficial to children;
- **Independent co-ordinator** facilitates the involvement of the family, agency and professionals in the process.
- Family are given time to **plan in private**.
- **Plan is accepted** and resourced by agency and professionals unless it places child at further risk.

### 1.7 Operation of the Family Group Conference

There are a number of defined stages to the family group conference process, the first being the preparatory stage before the FGC, and three stages within the actual conference itself. These stages are described briefly as comprised of
(1) The information-giving stage in which information pertaining to the agency concerns regarding the child is shared with the family;
(2) Private family time in which the family deliberate about the concerns and construct a plan to respond to the concerns regarding the child highlighted in the information giving stage; and
(3) The final stage is where the plan is presented to the professionals. This plan is accepted unless it places the child at further risk. A review system and monitoring structures to address the concerns and to support the plan is addressed at this point.

Fuller detail of the various stages is provided in Appendix 5.

PART 2 - THE MWHB PILOT PROJECT

1.8 Introduction to MWHB Pilot Project

1.8.1 Impetus for the Pilot Project
The impetus and key direction of the MWHB Pilot Project stemmed from a finding and recommendation in a previous FGC Pilot Project. The difficulty in giving an accurate portrayal of the fit between the FGC model and child protection protocols was a major finding in ERHA pilot project (O’Brien 2000). The high level of both internal and external change that was occurring in the system at the time was identified as a factor in this finding. The research showed that, in a number of cases, the referrals received in that project clearly fell into a child protection category. The cases were considered as being on the lower scale of risks, rather than involving severe child protection issues. A key recommendation of the report was:

‘While this evaluation report draws clear conclusions about the place and applicability of the FGC in practice, a more extensive study of its potential to meet statutory requirements, and the adoption of a defined FGC method as a standard protocol for given circumstances is urgently needed. This project can make a significant contribution to a co-ordinated and coherent future policy direction’ (O’Brien 2000 p. 75)

In looking to develop its childcare services, the MWHB also noted the potential of the FGC in the child protection sphere, and decided to commission a project specifically to examine and develop this issue.

1.8.2 Purpose and Goal of the Pilot Project
The purpose of the Pilot Project therefore was to examine the applicability of the Family Group Conference as a means of improving the management of child protection concerns.

The project goals were to establish, by 28th March 2002, if the use of Family Group Conferences with selected families can

- Strengthen families’ capacities to respond to and be involved in the resolution of child protection concerns;
- Satisfy statutory and/or professional concerns about the young people and children involved;
1.8.3 Phasing of the Pilot Project
It was agreed that the pilot project would comprise the following key aspects:

vii. Appoint Project Manager and Management Committee
viii. Recruit and train two FGC co-ordinators from an independent agency;
ix. Design referral and case management guidelines for MWHB staff;
x. Do preparatory training for staff to be involved;
xi. Hold six Family Group Conferences by March, 2002;
xii. Evaluation Report on the extent to which FGCs could be successfully used during the course of the pilot.

1.9 Terms of Reference for Evaluation
The terms of reference for the evaluation of the project were developed between the Project Management Committee, the Project Manager and the Project Consultant.

These were as follows:

- To evaluate the six Family Group Conferences scheduled for completion by March 2002;
- To explore and establish the level of family participation and sense of ownership of the FGC process;
- To test how the FGC fits alongside current professional processes of investigation, assessment, case conferencing, and review the experience from the perspective of the various stakeholders;
- To consider the implications of extending conferencing service to the management of family support and child protection cases on a regional basis

1.10 Evaluation Methodology

1.10.1 Philosophy underpinning Evaluation
The purpose and aim of this project lent itself to a research methodology based on action research, similar to previous pilot study (O’Brien, 2000). Action research seeks to capture the processes, as they are evolving, and aims to use findings to point and direct the project in ways that are both relevant and appropriate. Action based research emphasises local descriptions in so far as it takes account of the processes evolving in a particular context.

In this evaluation a mixture of both qualitative and quantitative research is used, but qualitative research, with its emphasis on local knowledge, interpretation, and importance of multiple perspectives, is more relevant to address the aims of the evaluation brief above.

A further distinction that needs to be made in regard to research design is the difference between formative and summative evaluation. Formative evaluation is designed to help programme managers, practitioners and planners improve design of a
programme in the developmental phase. Summative evaluation is designed to provide information at the end of a programme about whether it should be continued, dismantled or drastically overhauled. While the terms of reference for this research involves both, this distinction between formative and summative evaluation brings clarity to demands upon the evaluation. Both process and outcome data can be helpful for formative evaluation purposes.

The focus on action-based research, drawing on a predominantly formative evaluation model which embraces a combination of quantitative and qualitative methodology, fits with the role of the evaluation as part of the process rather than a methodology that seeks to take an observer position where the processes and actors were objectified.

1.10.2 Ethical Issues
Evaluators are obliged to conduct the evaluation with the highest possible attention to ethics. Ethical issues during planning must be honest and respectful to those who co-operate in providing information. Written consent was obtained from each person involved, and guarantees given that identifying information would not be published as part of the report.

All family members and information-givers were told at the outset of the project that research was an integral part of the project, and their co-operation was sought on this basis. Inclusion in the pilot project was not, however, dependent on the participants agreeing to co-operate. All interview schedules were posted from the project manager’s office to family members and information-givers following the conference. Family members were offered assistance by the project manager’s office in filling up the schedule if they so chose. This offer was accepted by a number of family members. Written questionnaires were designed and circulated to all management committee members, the project manager and the child care manager.

1.10.3 Data Collection Methods and Tools
A data spread across participants was acquired, reflecting the importance of the different perspectives. The research instruments, which were developed as part of ERHA project (O’Brien 2000), were used where applicable. These instruments were built on previous FGC evaluations (Smith & Hennessy, 1999; Lupton et al, 1998; Crow & Marsh (1996). There is particular value in adapting previously developed research tools as it allowed for a degree of validity and reliability, and allows for the possibility for comparative views to be taken. It also reduces the time that would be involved if the tools had to be developed from scratch.

The methodologies used to collect data ranged through formal and informal interviews, using structured and unstructured questionnaires, and are contained in Appendix 6.

1.10.4 Documentary analysis and Focus Group Discussions
The research methodology also involved document analysis, including minutes of Management Committee meetings, progress reports of the Project Manager, and agency policy statements, as well as the evaluation feedback forms of all staff who received training as part of the project.
Close liaison was maintained with the Project Manager during the course of the project. The evaluator’s membership of the Management Committee enabled practice developments over the course of the project to be informed by data collection and research findings. In this regard the formative evaluation research framework contributed greatly to the project. Finally, ongoing liaison with colleagues in the North/South Forum, other pilots projects and service developments in Ireland and international liaisons augmented the various data methods outlined above and also strengthened the development of the project review.

1.10.5 The Data Sample

Baseline data was obtained on the six referrals received by the project. Summary information is presented in Table 3.1, entitled ‘Profile of Six Cases Referred for an FGC in the MWHB Project’. The data on the three conferences which were completed within the pilot project evaluation time frame is analysed in depth. This includes 13 family members, 14 information givers and two co-ordinators. Additional information was obtained from 12 management committee members. Several of the management committee members were heads of services and key personnel from external agencies, and also included the project manager, and the child care manager (See Appendix 7).

1.10.6 Limitation of the Evaluation

The actual referral rate of cases was slower than anticipated, and therefore the evaluation is based on a smaller number of conferences than originally envisaged. The phenomenon of slowness in referrals to pilot projects is noted in Crow & Marsh, 1996. This means three rather than the six intended conferences were available for evaluation in the pilot project. The small number involved is a major limitation, especially on the quantitative side. However, the numbers did allow for in-depth examination of the cases involved and to that end assisted in examining the primary project objective of the potential for application of the FGC in the child protection system. The short time scale of the project did not allow for outcomes to be examined over time. Instead the project provides a snap shot of how family group conferencing interfaced with cases at a certain point in time.

The failure to interview the three children (all over seven) is a limitation. Circumstances did not permit the interviews. The NWHB pilot study, which included children’s voices, makes a major contribution to the field in this regard.
CHAPTER TWO

LITERATURE REVIEW

2.3 Introduction to Literature Review
In this chapter the relevant aspects of the literature are presented. This is done under a number of headings, giving a summary view of literature findings on the FGC first, and then going on to look at decision-making in child protection under a number of sub-headings including the crucial issue of parental participation. The next part deals with the literature relating to introduction and the use of FGCs in a child protection context. The place and practice of child protection in the host organisation for this pilot project, the MWHB, is then considered. The plans to broaden the child protection framework to include family support in the MWHB are presented. In the final part the impact of the national framework for child protection, Children First is discussed.

2.2 Summary of findings on FGCs
The key messages from research on FGCs are to be found in Lupton’s (2000 p. 36-38) review of the literature. They are as follows:

- the majority of family members, extended as well as close, like the ideal of a family meeting and agree to participate; neutral venues and flexibility of arrangements are particularly appreciated;
- in contrast with traditional child protection meetings, children appear more inclined to attend FGCs and, once there, appear to participate more extensively; children seem particularly to appreciate the family-only part of the meeting;
- the majority from the family network felt well prepared in advance of the FGC and knew what to expect, some arrived without being clear of the ‘terms and conditions’; it is important that written information for children is provided in appropriate language;
- families and professionals see the FGC as more enabling of family participation than traditional ways of working, with the majority of family members indicating that they would use a FGC again, should future problems arise; more evidence is needed however on the extent to which families also experience the FGC process as empowering;
- the role played by professionals within the meeting may require attention, with consideration being given to making the information-giving session more interactive and with written reports being available before the meeting; some thought could be given to the idea of a family ‘pre-meeting’ before the professionals arrive;
- the great majority of family groups produced a plan and most of these plans appear to be agreed ‘in principle’ by the agencies concerned; more detailed information is however required on the extent to which plans are implemented fully as agreed and the reasons why not, if not;
- FGCs appear to mobilise family support, but they may not thereby reduce the demands on agency/ professional resources; in the main plans appear to be realistic in terms of the support requested;
- the early indications are that FGCs may be no less effective than traditional approaches in ensuring the care and protection of children; more extensive evidence however is needed on this vital question.
2.4 Decision-making in Child Protection

2.3.1 Complexity in Decision-Making

The complexity involved in decision-making in the child protection sphere is widely acknowledged in the literature. This is, perhaps, best summed up in the comment by Cleaver and Freeman (1995), when they acknowledge the inherent difficulty in decision-making for professionals in the following terms:

“Decision-making requires the skills of Machiavelli, the wisdom of Solomon, the compassion of Augustine and the hide of a tax-inspector. Making decisions proves to be something of a balancing act for professionals. Taking into account parental perspectives involves surrendering a degree of control to the powerless”.

Larner (et al., 1998) further suggests the decisions that caseworkers have to make would:

“Challenge King Solomon, yet most of them lack Solomon’s wisdom, few enjoy his credibility with the public and none command his resources”

2.3.4 The Place of the Case Conference

The case conference has been the traditional decision-making forum in child protection issues. Hayes (2000) (See Section 2.5 for details of this study) views the case conference as only one phase of child protection work, with often more difficult and challenging phases of intervention and investigation preceding the case conference. Ferguson (2000) (See Section 2.6 for details of Ferguson’s work in the MWHB) suggests the need for clear criteria for calling case conferences. Ferguson’s research found the following:

- A significant number of high-risk substantiated cases that could, or perhaps should, have reached a case conference did not do so. A full 67% of substantiated high-risk referrals did not have a conference. (Ferguson, 2000 Pg 151)
- A key finding is the relatively minor role played by case conferences in managing new cases and referrals, being largely concerned with cases with a history of health board involvement. (Ferguson, 2000 Pg 167)
- The criteria should include specifying who is responsible for calling case conferences, the role of the C.P.N system in this and the relationship between decision-making and planning at C.P.N meetings and case conferences. (Ferguson, 2000 Pg 149)

2.3.5 Parental & Children’s Participation in Case Conferences

Hayes (2000) writes about degrees of partnership operating along a continuum of power relationships. He sees partnership as including:

- ‘participation’ in key decision-making meetings,
- ‘involvement’ in identifying problems and goals and objectives for work,
- ‘consultation’ before decisions are made or actions taken, and
- ‘keeping fully informed’ about services, powers and duties of social services, likely action, rights, etc.)

Philips and Evans (1986) warn that partnership should not be seen as mere attendance but rather: “…Understand the process which they are going through and both they
and the professionals feel that they have made a useful contribution to the plan of action” (Philips and Evans, 1986 Pg 12).
FIGURE 2.1 - DECISION MAKING FORUMS FOR CHILD PROTECTION PLANNING

- Entry onto C.P.N.S. (Internal to H.B)
- Liaison - Management Team Meeting (Garda/Social Work)
- Strategy Meeting (inter-professional)
  - At outset to share all available and relevant info.
  - Convene at any time following preliminary enquiries and submission to C.P.N.
  - Garda involvement essential
- Referral
  - Child Protection Conference (Inter-professional and family involved)
    - Initial enquires completed
    - When decisions of a serious nature are being considered
    - Facilitate sharing, outline child protection plan and identify tasks
    - Not all Child Protection cases warrant a C.P. conference
    - Each community care area develops its own protocol
- No Family Participation
  - Family Group Conference
    - Family involved and inter-professional
    - Accesses expert family knowledge
Extensive Family Participation

Source, Suggested in Children First, Adapted McClure (2001), Unpublished
While there has been some research into parental participation at case conferences there has been little empirical research into parental participation in other “emergency phases” of the child protection process. Ferguson showed that Irish practices on the inclusion of parents or guardians in case conferences fell far short of what is regarded internationally as best practice. (Ferguson, 2000 Pg 144). In the MWHB parents were invited to attend in just over half of the conferences, with 54% (n = 14) of the parents invited actually attending for part of the conference. In only one case did the parents attend for the whole conference. (Ferguson, 2000 Pg 156)

Ferguson warns that the lack of an invitation to what are perceived as non-cooperative parents may alienate them further and intensify their hostility. He goes on to suggest that the challenge to professionals is in developing a fully inclusive practice to engage with hostile clients at case conferences in a system which operates in a subjective, arbitrary manner which no longer accords to best practice. (Ferguson, 2000 Pg 157). An evaluation of Children First in 2001 shows an increased level of parental participation at case conferences (HEBE, 2001).

Ferguson’s research identified a need for more information and better listening. Writing of the general Child Protection care system Ferguson found that one of the main criticisms, voiced by many children, was they felt they were denied information. The children in care were especially critical of a lack of information from social workers as to why they were being placed in care. (Ferguson, 2000 Pg 218). In summary, what clearly emerges from the interviews with children is the poor communication and quality of information given to children, especially in relation to plans for children in care. (Ferguson, 2000 Pg 224)

Some practitioners would argue the current child protection structure and meetings cited in Children First militate against children participating to their full capacity.

2.4 Introduction of FGCs into Child Protection Practice

When looking at the introduction of the FGC internationally there is need to examine the context and environment in which the model was introduced. Doolan (2001) identifies three approaches:

4. Legislative - The legislative basis is such that the model is enshrined in law, and there are procedures specified/ regulated to ensure that the principles are set out to guide the practice.
5. Procedural - The guiding principles are enshrined in procedural requirements to behave in a certain way.
6. Best Practice - The principles are introduced to staff who are encouraged to carry out their duties and responsibilities within a re-focused practice paradigm. In this approach the professionals act as ‘gatekeepers’.

Doolan sees potential problems with all three approaches. With a legislative mandate, the “philosophical underpinnings of the approach can be underpinned by the legislation” with solicitors possibly advising their clients “not to engage, or their use of other legislation to thwart the intentions of child welfare law”. On the other hand, Doolan sees the procedural approach as running the risk of “instability in the face of changing fads about what is the right thing to do… or colonisation of the concept of empowerment practice by pre-setting the professional agenda”. The development of the ‘Best Practice’ approach relies on enthusiasts trying to make inroads. (Doolan, 2001, pp 5-6).
A number of Public Inquiries into child abuse in the U.K. in the 1970’s and 1980’s led to the development of what has been characterised as a pre-dominantly legalistic and procedural response to child abuse allegations and investigations. These responses have since been criticised as defensive and reactive in nature by Cooper (1994;) and Parton (1997). These legislative and procedural models of practice led to a system which has been criticised for its exclusion of parents and children (Nixon 2000, Thoburn et al, 1995, Ryburn & Atherton, 1996)

With its emphasis not just on parental and children’s participation in decision-making, but the wider family network also, the FGC has been viewed as a valuable antidote to the exclusionary system. In the U.K. the FGC has been introduced as a “good practice” rather than a legal construct, with the “grassroots” level challenging rather than complimenting existing practice. Nixon (1999) saw change being brought forward through winning over people’s “hearts and minds” to this way of working, rather than through legislation or procedural change. This differentiation has critical implications for the implementation and development of FGC/ FWC. Nixon sees the FGC practice being shaped by its “proximate social, organisational and political contexts” (Nixon, 2001 pg 6).

In Ireland, in anticipation of the legislative changes, a number of Pilot Projects were undertaken (ERHA, NWHB and MWHB). FWCs are now included in legislation in limited circumstances, however the MWHB is committed to introducing the FGC/ FWC as a model of best practice on a wider basis.

A key issue of importance in the introduction of FGC is how the model can be incorporated/ accommodated into the current Child Protection system, taking into account policy and procedures. Writing of the U.K. Nixon (2000) describes a system of a “procedural and legal context”. He remains critical of the approach to “fit FGCs within the procedures, time scales and assumptions of the state bureaucracies” which he believes have “relegated FGCs to a secondary planning forum or a ‘rubber-stamp’ for professional ideas. The net effect is that FGC principles and philosophy are watered down to fit into mainstream orthodox practice”(Nixon, 2000 pg 7).

In New Zealand, FGC advocates have been seeking to change the paradigm from child protection, through professional intervention and decision-making, to a paradigm of a family support approach to child protection. (Doolan 2001). Doolan is optimistic “that core statutory social work can deliver on the state requirements that children be protected by embracing the family support paradigm, and through that process, need responsive services identified by families can be provided for them.” He sees the “tension between family support (a needs-based approach) and child protection (a risk-based approach) is eased by an effective partnership mechanism, such as the Family Group Conference”. (Doolan, 2001, Pg 5). This model of practice is no less committed to child protection. Doolan sees the need for different thinking in relation to some aspects of child protection definitions, and on how to manage the process at the post-inquiry and assessment stages. The classic child protection approach is professional deliberation, court involvement and care. The family support approach engages the wider family as the change agent, as participants and as decision-makers through the mechanism of the Family Group Conference.
2.5 Use of FGC in Child Protection

Nixon is one of the leading advocates of the benefits and place of the FGC approach in decision-making in child protection. Nonetheless, he is critical of the development of the field, and the manner in which the approach may be used. He notes that it is somehow ironic that:

“the idea that families would make better decisions than professionals came from families and communities, not from the professionals. Yet it is professionals who have designed the service, driven it, constructed it, inset the standards, and in so doing to some extent at least, may have colonised these ideas and diluted the spirit of FGCs, or certainly modified them” (Nixon, 1999 pg 4)

Nixon says that there is a tendency for professionals in the U.K. to refer cases to the FGC service when they want to:

- Use the FGC as a rubber stamp for their ideas
- Squeeze resources out of families
- Use the Conference as an intervention of ‘last resort’ (Nixon, 1999 Pg 4)

Hamill (1996) notes that child protection is probably the one area where family participation leads to most anxiety for professionals. She identifies two major concerns in relation to the introduction of FGCs in child protection:

(c) the relationship between the FGC and local child protection procedures, and
(d) the ‘safety’ of FGC in the complex area of child protection.

It should be noted that the FGC process is unlikely to be occurring in a vacuum. Other services are likely to be involved, are likely to become involved or will remain involved post-FGC. Therefore there is a need for the FGC service/practice to interface with a number of other services, both statutory and voluntary.

Hayes’s (2000) research was undertaken to explore professionals’ views on the possible use of FGCs in Child Protection. In the course of his research Hayes evaluated three groups of staff: practitioners, managers and non-social work members of the North and West Belfast Health and Social Services Trust in Northern Ireland. Fifty-five percent of Hayes sample agreed that FGC “should be used in Child Protection work”. Only 7% disagreed, and 38% were not sure.

Hayes (2000) concludes

“it is both desirable and feasible to use FGC in child protection work. However, this is based on the realisation that the FGC model will not be appropriate for all families in which child protection concerns exist and that there are difficulties with the model that need to be addressed in practice.”

2.6 Child Protection in MWHB

In the mid to late 1990s, Ferguson undertook a research project to evaluate the work of the Mid-Western Health Board’s child care and protection system, as it actually processed cases over a specified period. This research aimed to learn more about how
the Child Care system works, identifying what aspects are done well, and how professionals actually operate on a day-to-day basis to protect children.

Ferguson’s research pre-dated the introduction of Children First. Following the introduction of Children First, the MWHB, as did most Health Boards, introduced a formalised Child Protection Notification system. This had interdisciplinary management groups meeting regularly to process ‘notified’ referrals and cases. This is an initiative which represents perhaps the most significant organisational change as community care shifted its primary concern to child abuse. Ferguson was critical of a system which he saw was influenced more by managers, bureaucracy and accountability. Ferguson suggests that need, rather than the decision-making process itself, should drive responses to children and families (Ferguson, 2000 Pg 153).

Ferguson also found the Health Board’s professional systems to be chronically enmeshed with certain types of cases and families, which posed particular challenges. The cases coming to the attention of Health Boards were characterised as tending to involve reconstituted families or lone parents (usually mothers) who live in poverty, often suffering addiction problems, and other adversities such as a violent partner, who may or may not be the father of the children. As the children grow older and enter their teenage years, they tend to become out of control; they have to deal, not only with the legacy of years of adversity and child abuse, but also with a view of them as threats to themselves and/ or social order. (Ferguson, 2000 Pg 266)

The MWHB “Child Welfare and Family Support Strategy Statement 2002-2005” sets out an organisational framework for the development a Child Welfare System within the MWHB that provides for the delivery of early intervention and family support services to children and families in need. It is acknowledged that, under the auspices of the MWHB, many initiatives exist that seek to safeguard children and, if at all possible, to keep them out of the Child Protection system and state care. However it is recognised within the MWHB that more could be done to promote the welfare of children and to provide services that could alleviate family problems before they deteriorate to the point at which child protection and alternative care options are considered (MWHB, Mcclure, 2001, Pg 2). This strategy provides a management model for the development of a Child Welfare System that sets out clear objectives, procedures and structures for the delivery of services in a context of prevention and support.

2.7 Broadening of ‘Child Protection Concern’ to include Family Support in MWHB

One of the key findings and recommendations made by Ferguson was the need for Health Boards to design a strategy for working with cases which are immensely demanding of energy and resources (Ferguson, 2000 Pg 266). Such a strategy requires a fundamental change in the way childcare services are conceptualised and delivered. The system needs to stop trying to fit cases into a ‘child protection concern’ frame and approach child welfare on the basis of assessed need, regardless of the presenting problem. (Ferguson, 2000 Pg 266)
Re-focusing children’s social work requires an acknowledgement of the specific, yet inter-linked, sub-systems of child protection, childcare and family support. For each sub-system staff should be given specific responsibilities to discharge key roles and tasks in the case management process. At the same time, however, there must be an acknowledgement that these sub-systems can and do inter-link and inter-act as the needs of children and their families evolve. Children who require protection may need to be brought into the child care system, albeit for a short period. Children in the care system may need an infrastructure of support to be put in place in the family and local community so that they may safely leave the care system.
Scoping the parameters of these sub-systems, agreeing their interfaces and developing protocols for the various team members to operate dynamically and effectively is a key challenge to successfully refocused practice. (Giller, 2001 “Responding to the Implications of the Ferguson Report: Options for the Mid-Western Health Board”)

In light of the findings internationally described above, and Ferguson’s conclusions in the MWHB, the board has been endeavouring to find ways to fit family welfare and child protection together. The FGC is seen to have a potentially pivotal role in integrating systems and moving processes in the right direction, and hence the proposal for this pilot project.

2.8 National Developments – Children First

Children First - the National Guidelines for the Protection and Welfare of Children was launched in 1999. The objectives of the Guidelines are stated as:

5. To improve the identification, reporting, assessment, treatment and management of child abuse cases.

6. To facilitate effective child protection work by emphasising the importance of family support services and the need for clarity of responsibility between professionals.

7. To maximise the capacity of staff in organisation to protect children by virtue of the guidelines relevance and comprehensiveness.

8. To consolidate inter-agency co-operation based on clarity of responsibility, partnership and co-ordination of information.

The Guidelines provide details for parts of the child protection system including handling the referral, screening and initial assessment, the Child Protection Notification system, and different types of planning meetings. This document, although it does not embrace the FGC as such recognises and defines a Child Protection Conference as an:

“inter-agency and inter-professional meeting, which is convened by the Child Care Manager/designate. It normally takes place when initial enquiries and, if relevant, emergency action have taken place. It may take place during the early stages of enquiry, or at any time when concerns arise about a child’s care and protection. The Child’s parents/ carers and the child should be included where appropriate”. (Children First, 1999 p78, par. 8.19.1)

The Guidelines contain significant pointers regarding inclusiveness:

- **Parents/carers normally have more information than any professional about their child and can make valuable contributions to assessment and planning;**

- **Plans made at Conferences are more likely to succeed if negotiated while parents/carers are present;**

- **The experience of parents/carers waiting outside a room while a Child Protection Conference is in progress can be extremely distressing and unhelpful. For this reason, parents/careers should participate in the whole conference. If their presence at the whole Conference is not permitted, then**
arrangements should be made to minimise any potential discomfort likely to be experienced by them (tea, coffee, etc.)

- Parents/carers are likely to feel nervous, under scrutiny and, in some cases, hostile to the professionals present. Sensitivity and preparation are required in order to reduce tension and facilitate useful discussion;

- Parents/Carers should be permitted to bring a support person to the Child Protection Conference, whose identity will be clarified by the Chairperson to the other participants;

- The purpose of involving parents/carers in a Child Protection Conference, as with any other participant, is to hear his or her contribution and agree conclusions and recommendations. The Child Care Conference should not be used as venue for making assessments of characters, behaviours or abilities of parents/carers, nor should parents/carers be re-interviewed or interrogated at a Child Protection Conference (Children First, 1999 pg 150-151)

The Guidelines go on to delineate certain circumstances when the exclusion of parents/carers may be justified. The MWHB Protocol clearly outlines the Child Protection Conference Agenda, which provides an opportunity for “Family Members Contribution” (MWHB, 2001 (B) Pg 18). The Guidelines state “it is appropriate to hold a Child Protection Conference when decisions of a serious nature are being considered which require the input of professionals from different disciplines and agencies (MWHB, 2001, Pg 78, par. 8.19.2).

In anticipation of Children First, the MWHB designed Child Protection Guidelines within the Board, which recognised Child Care and Protection as a “corporate responsibility requiring a commitment from all personnel without exception across the entire Health Board Services” (MWHB, 1998, pg 1, par.3). Following the introduction of Children First, and in line with recommendations therein (Children First, Pg 79, 8.19) the MWHB’s Child Care and Family Support Services developed a “Child Protection Conference Protocol” (November 2001). This protocol identified a number of objectives: the most relevant for this research being the objective “To maximise involvement of appropriate individuals, particularly parents, children and young people”(MWHB, 2001 Pg 4)

The MWHB’s policy is to maximise parental involvement, while maintaining the care and protection needs of the child as the first priority. The Board has a commitment to inviting parents to participate in Child Protection Conferences, unless there are clear grounds for exclusion. (MWHB, 2001 Pg 11). The Board also has a clear policy on the preparation of parents to participate in a Child Protection Conference.
CHAPTER THREE
PART 1- GENERAL INFORMATION ON THE CONFERENCES
PART 2 - FAMILY MEMBERS VIEWS OF THE CONFERENCE STAGES

3.1 Introduction
This chapter is divided into two parts. Part one summarises information on referrals received in the project. In part two, the family members’ views of the different stages of the conferences are presented.

The project time-frame extended for six months from September 2001 to the end of February 2002. During that time, six referrals were made to the project. Three of these referrals ended with family group conferences, one referral was withdrawn during the late preparation stage, and two referrals were withdrawn earlier. All six referrals are used to provide base-line information in this report. The findings in part two of this chapter are based predominantly on the views of the participants in the three completed conferences, as well as the one referral withdrawn. Where applicable, general observations relating to the other two cases are included, as the formative evaluation methodology used enabled the researcher to remain close to the processes as they were developing.

In part one, the profile of the six cases referred for conferences is presented, briefly giving key characteristics. The data on the three conferences, which were completed within the evaluation time-frame, is analysed in depth in later sections of the report. Summary information is presented in Table 3.1, entitled ‘Profile of Six Cases Referred for an FGC in the MWHB Project’.

For comparative purposes, the Lupton (1995) FGC evaluation comprised of 19 families, with 22 FGCs being held. Of those 19 families, 11 were researched in depth. In the ERHA Phase One Study (O’Brien 1999), 8 conferences were held and 8 families were researched in depth. 19 family members, 8 information givers and 3 coordinators provided the research data in that case. In the NWHB Study (2000) 15 referrals were received into the Project from January-June 2001, 10 were completed and 5 did not go to Conference. 61.5% of these were included in the research data, 7 of whom were children. In Hayes’s (2000) study in Northern Ireland, 8 families were involved, and research data was obtained on the 8 conferences.
### TABLE 3.1
Profile of Six Cases Referred for an FGC

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age of child</th>
<th>Child attend</th>
<th>Gender</th>
<th>Completed: C</th>
<th>Plan made &amp; acc</th>
<th>No. of Family members</th>
<th>No. of Prof.</th>
<th>Persons excluded from conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3 months</td>
<td>Y</td>
<td>F</td>
<td>C</td>
<td>Y</td>
<td>Invited 8</td>
<td>Attended 8</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Invited 7</td>
<td>Attended 6</td>
<td>Paternal aunt on Mother’s insistence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No report</td>
<td>submitted</td>
<td>Paternal uncle due to alcohol problem</td>
</tr>
<tr>
<td>2</td>
<td>8 years</td>
<td>Y</td>
<td>F</td>
<td>C</td>
<td>Y</td>
<td>Invited 3</td>
<td>Attended 3</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Invited 6</td>
<td>Attended 6</td>
<td>Paternal aunt on Mother’s insistence</td>
</tr>
<tr>
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<td></td>
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<td>No report</td>
<td>submitted</td>
<td>Paternal uncle due to alcohol problem</td>
</tr>
<tr>
<td>3</td>
<td>14 months</td>
<td>No</td>
<td>M</td>
<td>T</td>
<td></td>
<td>Invited 5</td>
<td>Attended 2</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Invited 9</td>
<td>Attended 8</td>
<td>Family members excluded themselves</td>
</tr>
<tr>
<td>4</td>
<td>10 years 7 years</td>
<td>Y</td>
<td>M</td>
<td>M</td>
<td>Y</td>
<td>Invited 9</td>
<td>Attended 8</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No report</td>
<td>submitted</td>
<td>Family members excluded themselves</td>
</tr>
<tr>
<td>5</td>
<td>11 years 16 years</td>
<td>M</td>
<td>F</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>15 years</td>
<td>F</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>
3.2 Status of Participants in Cases 1 - 4

3.2.1 Marital Status of Parents
Examination of the marital status of the parents show that in one family the parents were “married but separated”, in two families the parents were cohabiting, and in the remaining case the father was a widower.

3.2.2 Age & Gender Profile of Children
The age profile of the 5 children involved in the project ranged between the ages of three month to 10 years. A gender analysis shows three (60%) were male, while females represented two (40%) of the children included in this study.

3.2.4 History of Contact with the Health Board
The results show that there was a significant history of family contact with the Health Board. This involvement was divided into two categories. Firstly, four of the five children in respect of whom the conference was being called had been involved with the Health Board in the past. Secondly, 66% of other family members had had substantial prior involvement with the Health Board, compared to 75% in the ERHA project.

3.3 Connection with the Pilot Project

3.3.1 Reasons and Route of Referrals
The referrals sought by the project were families who were involved in the child protection system, as distinct from families that were viewed in the agency as falling within the remit of family support. Referrals were sent to the project manager’s office from the community care team. The project manager attended the child protection notification meetings. This provided the project manager with an overview of cases entering the child protection system. Potential cases could be discussed at this early stage between the project manager and the staff of the child protection notification system.

The decision-making body designated for accepting referrals into the project was a referral committee. The referral committee was comprised of the Child Care Manager, Principal Social Worker and Project Manager. Their role was to assess and make a decision on the referrals. On acceptance for the project, the case was assigned to a coordinator, whose task was to introduce and explain the process, and to prepare the participants for the FGC. It was to prove beneficial that the members of this committee had an overview of, and positions of responsibility in, the child protection system.

3.3.2 Factors influencing the Referral Rates
The rate of referral of cases to the pilot project was initially slow, a finding which is similar to other projects. The short lead-in time, combined with the short life span of the project (6 months) meant that the project was under pressure in achieving its targets from the start. The location of the project in one small geographical area, together with the shared personnel in child protection and on the referral committee, assisted in the referral process. Another factor, which influenced the decision to set up
the project in that area was the need to work with a management team who had a
history of working together. The social work team had undergone major changes of
personnel, but many of the other inter-disciplinary team members involved in child
protection were in place for some time.

Four of the six referrals were received in the period December 2001 to February 2002.
Yet, only one of these cases ended with a family group conference. In many respects
this illustrates that as the project was entering its second three-month period, efforts
were made to find ‘suitable cases’. Two of families approached and asked to consider
an FGC did not share the agency’s enthusiasm for this new approach at that point in
time. With the slow trend of referrals, key people in the voluntary sector were also
contacted. It was intended initially that the pilot would examine the applicability of
the FGC model to cases where domestic violence and child protection were issues. No
cases emerged in the time period involved, and at the later stage of the project, it was
thought that the voluntary sector might provide such a referral. While this was
investigated, it was deemed unlikely that a case that would fall into the child
protection referral criteria would have been managed solely by the voluntary sector.
The other hope was that the voluntary sector might bring a case where they were
working alongside the statutory services, and which might have been overlooked in
the agency. Despite the efforts, no such case was found.

3.4 The Conferences
The stages in the conference process are discussed in detail in Appendix 2.

3.4.1 Preparation and Participation
Contacting Invitees: The primary means used by the co-ordinator to make the
necessary arrangements with family members for the conference was a combination
of telephone calls, with a follow-up personal home-visit. A similar method was
utilised for contacting the professionals. The difficulties of contacting people were
amplified by the rural setting of the pilot project. Significant travel hours were
involved in each case.

Family & Professionals in Attendance: The number of family members who attended
the FGCs averaged five, with a range from two to eight. Those who failed to attend
were divided into three categories. Firstly, there were those who could not attend due
to particular circumstance. Secondly, there were those who chose not to attend and
thirdly those who could not attend as other key family members excluded them.
Professional attendance was high and averaged seven persons, varying from six to
nine. In all 86% of professionals invited to a conference attended.

In the ERHA project, the average number of family members who attended was also
five. The NWBH project had an average family attendance of nine, ranging from five
to twenty. The high rate of attendance reported above is indicative of the readiness of
people in families and their social networks to become involved when invited to help
protect vulnerable children. It also shows, however, that when extended family
members are invited, significant difficulties can arise from the birth parents
perspective, as more people are aware now of the child protection difficulties.
3.4.3 Time Scales involved in the FGCs

Referral: It was found that 2 of the cases referred to the pilot were accepted within one week of the referral being made, and the remaining case was accepted within a three week period.

Acceptance to Pilot: The period between acceptance of the referral and the holding of the FGC was three weeks in one case, five weeks in the second and ten weeks in the third.

The time between referral and holding a conference in the ERHA study averaged six weeks, the shortest was three weeks and the longest was ten weeks. In the Essex project (Smith & Hennessy, 1999) the average was five weeks, the shortest 1 week and the longest 14 weeks.

Preparation: The average length the co-ordinators spent working at preparation between the referral and the holding of the FGC was 48 hours, compared to 30 hours in the ERHA project. The inner and outer times in the ERHA project ranged from 25 to 35 hours while in this project it ranged from 36 to 48 hours. The NWHB experience was 73.35 hours average, the inner and outer times ranged from 37 to 100 hours. As was the experience in the ERHA, the main issue accounting for this difference was the amount of travel involved. In one conference, 18 of the 36 hours (50%) was spent on travel and in another, 17 of the 48 hours (35%) was spent on travel. The NWHB project found face-to-face interaction accounted for an average of 31.4 hours and travel averaged at 42.6 hours per Conference with a maximum of 85 hours. This finding points to serious implications for the delivery of co-ordination (and other) services in rural settings.

Information-Giving: The average length of time for the information-giving stage of the actual conference was 45 minutes, a finding similar to the ERHA experience. These figures are marginally higher than the NWHB experience of 33 minutes.

Private Family Time: On withdrawal of the professionals from the meeting, private family time ranged from a maximum of three hours in one very complex meeting to thirty minutes in the second, and fifteen minutes in the third. It is interesting to note that the families that needed longer to plan in private needed less time for discussing and presenting their plan. In the ERHA project the average length of private family time was 60 minutes, ranging from 90 down to 15 minutes. The NWHB found private time averaged at 2 hours 28.5 minutes, with an inner and outer limits ranging from one hour to 5 hours. Lupton (1995) found that private family time was 2 hours and 15 minutes at longest, ranging down to 15 minutes.

Presentation of Plan: The average time for presentation of the plan for review and ratification by the professionals took on average one hour and fifteen minutes, compared to 50 minutes in the ERHA project. However, this average figure does not illustrate the major differences in this sub-stage. In the case of the conferences with the fifteen minutes private family time, the plan presentation stage took three hours. In another case, the presentation of the plan took 45 minutes, while the family needed thirty minutes to devise their plan.
Duration of FGC: The entire conference process in the pilot took an average three and three-quarter hours, compared to two and a half hours in the ERHA.

Referral to Completion: The total number of hours the co-ordinator worked in facilitating the conference between the referral stage and the completion averaged 49 hours. The inner and outer times ranged between 42 and 53 hours. The average of 49 hours compares to 33 hours in the ERHA project. In the Essex study, the time commitment of the co-ordinators in preparation for and holding of the conference was 29 hours, with the limits being between 12 and 48 hours. The Lupton study (1995) average was 23 hours, with variation from 8 to 51 hours.

Geographical location, cases involving large numbers of invitees and complex family situations contribute to the variation in time scales. The extent to which the time commitment involved was connected with the high-risk, child protection cases involved is discussed further in Chapter five. The level of time commitment has serious implications for the resource requirements for FGCs, when they are implemented on a broader level.

It should also be noted that considerable effort in terms of project manager’s and co-ordinator’s time were used on the referrals which did not end with conferences.

Time Conference was Held: All of the FGC’s were held on a weekday, with two of the conferences during office hours. In the other case, the FGC was held in the evening to accommodate working members of the family network. Seventy percent of the NWHB FGCs were held during the week, with 43% occurring in the evening. Thirty percent were held at the weekend with one third during the day and a further one third in the evening. The high level of employment in Ireland indicates that evening meetings will continue to be desired, especially if wider family membership is to be attracted to the conferences. From the agency perspective, evening and weekend meetings have major implications for the agency’s work practice agreements. A balance will need to be worked out with staff if FGCs are to be held at a time convenient for some families.

Venue: In one case, the location chosen for the FGC was a community centre, as it was deemed to be a neutral venue for all participants:

> The fact that it was on neutral ground was of benefit to both families as it meant no advantage to either side

It also facilitated the practicalities of a sizeable group meeting. In the other two cases, the family members chose a health board premises. No conference was held in the families’ own home, which was also the case in the Essex and Lupton study findings. In the ERHA, one conference was held in the family’s own home. The availability of suitable venues is a real issue in a rural context. Privacy, availability of venues in general, and suitable space are the main issues. As one family member said

> ‘Where else would we go?’

Another non-family attendee at a conference said when asked about the venue chosen

> ‘I was very comfortable because it was an environment I was used to.
However, although it was a Health Board premise, the family also appeared comfortable with it. There were plenty of empty rooms available and I would recommend access to at least 2 rooms for any future conference.’
A family member who attended this conference has a slightly different view when they said

‘it was all right but for ...the child’s sake, I would have preferred the hotel.’

In another case the response from another information-giver to the use of a community resource in a rural area was

‘The venue was very poor, inadequate. It was ...small, cramped, lacked confidentiality

Local community hall……... it would not have worked if more family had attended.’

One family member at the same conference saw it differently, and described the venue

‘……as a grand place’.

3.4.3 Presenting the Plan

Reaction to Plan: In all three cases, the plan as presented was accepted by the health board. However, it is important to stress that in two of the three cases, significant details of the plan were worked out when the family members and the professionals were sitting down together after the private family time. In both these instances, the co-ordinator played a key role in facilitating the end result.

Review Date: The place of the review emerged as significant issue in this pilot project. The main issue centres on the place of the FGC and the review alongside other decision-making forums. This issue is elaborated further in Chapter five.

Monitoring Of Plan: There was explicit reference to the monitoring of plans in all of cases, and this was seen to be the remit of the designated social worker.

PART 2 - FAMILY’S VIEWS ON THE FGCs

3.5 Introduction to Qualitative Research

In Part 2 of this chapter and in Chapter four the views of the participants are presented, drawing on both qualitative and quantitative data. Those included were fourteen family members (n = 14), eleven information givers (n = 11), the co-ordinators (n = 2) and the management committee (n = 12) and project manager (n = 1).

There are two aspects in which the views and feelings of the participants are ascertained. Firstly, the four stages of the FGC process are examined in relation to their specific conference, i.e. Referral stage, Information-Giving Stage, Private Family Time and Presenting the Plan. Secondly, a more general overview of the process is obtained by reflecting broadly on the model.

3.6 Family views on the Four Stages of the Conference

3.6.1 Before the Conference - The Referral and Preparation Stage
A number of key issues, pertinent to the referral stage, are discussed here. These address the following questions:

Was the information clear?
Did they feel adequately prepared?
Did they know what would be achieved?
Was there any conflict regarding attendance?
Were those people considered to be helpful contacted and facilitated to attend?
Did the family have different views regarding who should attend? and
Did they consider the right professionals were in attendance?

**TABLE 3.2**
Summary Table of Family Members Perspective on Level of Preparation prior to FGC (n = 14)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>In parts</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was information clear prior to conference</td>
<td>78% (11)</td>
<td>22% (3)</td>
<td></td>
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</tr>
<tr>
<td>Were you adequately prepared</td>
<td>35% (5)</td>
<td>35% (5)</td>
<td>21% (3)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Any conflict re attendance</td>
<td>28% (4)</td>
<td>36% (5)</td>
<td>22% (3)</td>
<td>14% (2)</td>
</tr>
<tr>
<td>Were helpful people facilitated to attend</td>
<td>72% (10)</td>
<td>21% (3)</td>
<td></td>
<td>7% (1)</td>
</tr>
<tr>
<td>Were the right Professionals invited</td>
<td>86% (12)</td>
<td></td>
<td>14% (2)</td>
<td></td>
</tr>
</tbody>
</table>

(N=14)

**Clarity of information:** The referring worker outlined the concern of the agency in writing to the project manager in the referral. This concern formed the basis for the holding of the FGC. The ‘why’ of the concern determined the scope and brief of the FGC for the participants. The co-ordinator was generally the first person in contact with prospective attendees (except birth parents, who would have already given permission to the agency to proceed with an FGC). At this juncture, the process and reason for peoples’ participation being requested was explained. The great majority of families (78%) responded positively saying there was clarity of information from the co-ordinators, describing both the process and the purpose of the FGC, while the remainder (22%) expressed some uncertainty. The NWHB study reported a higher (91.7%) level of satisfaction with the clarity of information received prior to the conference, with the reminder feeling that the information was clear only in parts.

Many of the families’ fears were resolved when the co-ordinators explained the concepts that lay behind the process and the steps that would occur at the various stages of the meeting. One family member said that initially:

‘I had no understanding of FGC…. initially I thought it was a family court’.

When the family members were asked about what other information would have been helpful at the initial stage, one birth parent said she would have liked:
More information on the reports that were going to be given by the professionals. At least then I would have known what to expect from all of them and not to be worried about them.

Overall, the brochures used to introduce conferencing were viewed as being particularly helpful and easy to read.

What would be achieved
In reviewing the family’s understanding of the reason for the conference, the family members showed a good understanding of why such a meeting was needed. It also showed they were conversant with what the health board was saying about what would need to change in the family to put a safer living situation in place for the children. It is necessary to bear in mind that the understanding captured in the evaluation evolved over the course of the FGC process itself, rather than being present so clearly at the beginning. However when the family were asked about what would be achieved at the outset, some family members wanted to know more about the extent of the neglect and abuse inflicted on the children. Others wanted to use the conference to make more definite decisions, like making a more permanent care plan, or getting the parents to change their ways. There was limited evidence of caution or suspicion as to why the agency was now inviting participants in, as was evident in the ERHA project.

However, in one case there was a total lack of understanding among the family members as to why such a meeting was being arranged. This person’s view represents the frustration that family members experienced when they perceived that they already had given as much as they could.

There was a complete lack of understanding about the conference and everyone was a little frustrated when the exact mission of the conference was revealed. My own view is that unless the problematic person is helped, it is very hard to expect the family to continue picking up the pieces considering we’ve done it for years.

This comment also reflects a view that if the agency is too prescriptive about what the FGC can achieve, such problems may emerge.

A key component, which contributed to the success of this initial preparation stage, was the personal visit by the co-ordinator to those invited to attend. This was a finding which emerged also in the ERHA project. Interestingly the co-ordinators views of this stage is somewhat different. Their experience was that this stage represented major work for them in respect of clarifying and reclarifying the reasons for the conference, the agency concerns, who was to be involved etc.

Overall Adequacy of Preparation: There was a difference between the family members knowing the reason for the FGC and what they hoped would be achieved, and the extent to which the family felt prepared for the totality of the experience. Only a portion (35%) of family members felt they were adequately prepared in all aspects of the FGC in advance of the conference, while 52% felt some gaps remained for them. Three people felt they were not adequately prepared at all. This overall adequacy of preparation was less in the MWHB, compared to the ERHA project where 74% (n =14) reported that they were very well prepared. Nonetheless, when the family were asked what worked for them in the preparation stage they said:
the on going talks with the co-ordinator......the continuous explanations
......the previous notice which .....gave time to organise domestic
arrangements
These factors all contributed to the overall preparation at this stage.

**Conflict re attendance:** There was conflict regarding who was to attend in the preparation stage in the four conferences. The main cause of conflict hinged on exclusions. In one instance the birth mother refused to attend if members of the paternal side were to attend. Unfortunately, in this case, the birth mother herself had a very small family and social network and therefore the possibilities for the child were diminished. In another situation the difficulties centred more on the family’s suspicions of the process and the fear that this meeting, regardless of all the re-assurances, would be unable to deliver in the way that was being promised. It is of note that in this instance that a parental alcohol problem was central to the protection issues for the child, and the family members generally felt let down by the statutory services interventions in their lives.

When family members were asked in detail about the reasons for conflict, it was seen to be associated more with past difficulties in the family as indicated in this quote:

*I would prefer not to mention names but the conflict (about attendance) was not a direct result of the conference, it goes back to other family problems.*

**Helpful attendees: family** Despite the views expressed above about family attendance, eleven family members (72%) felt all appropriate people were contacted and three people felt that, in part at least, the right ones were facilitated to attend. One person had no view. When family members were asked if, on reflection, they had a different view regarding who should have attended, no other people were identified.

**Right Professionals:** The vast majority of family members said that the right professionals were invited, and two people said they did not know. This was also the finding in the NWHB study where 88.3% of respondents felt that the right professionals were invited to the meeting. When this subject was explored further an interesting observation about feeling overwhelmed by professionals emerged:

*I didn’t think there should be all these professionals present as it felt very uncomfortable at times with everyone staring at us.*

Others indicated that they would have liked different professionals to attend, such as the local doctor.

### 3.6.2 The Information-Giving Stage

In Table 3.3 the question of adequacy of information provided to participants, the opportunity for family to speak, the extent to which the family members had their questions answered and their level of comfort during this time is presented.
TABLE 3.3
Summary of Participants Experience at the Information-Giving Stage

<table>
<thead>
<tr>
<th></th>
<th>Yes (N = 14)</th>
<th>Some (N = 14)</th>
<th>No (N = 14)</th>
<th>Don't know (N = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate information to make a decision</td>
<td>36% (5)</td>
<td>50% (7)</td>
<td>7% (1)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Chance to speak if you wished</td>
<td>93% (13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answered your questions</td>
<td>36% (5)</td>
<td>36% (5)</td>
<td>7% (1)</td>
<td>21% (3)</td>
</tr>
<tr>
<td>Felt comfortable</td>
<td>36% (5)</td>
<td>14% (2)</td>
<td>36% (5)</td>
<td>14% (2)</td>
</tr>
</tbody>
</table>

(N = 14)

The majority felt the information-giving stage was handled well, with some 36% (5) of family members feeling they got adequate information at this point to enable them make a decision. Half the people (50%) found some gaps in the information shared, and one person felt they did not get adequate information at all. Up to 50% indicated that they felt uncomfortable at the meeting to some degree. All said, however, they were given a chance to talk if they wanted, and they also felt listened to by all. For over half the family members, they felt there were some inadequacies in the answers given by the professionals to their questions. In many of these instances, the nature of the cases and the stage they were at in the child protection process accounted for this. The challenge remains to develop a context to enable these unasked questions to be asked.

Many of the reasons people stated they were satisfied with the information given is reflected in the following view:

‘the openness, honesty, and the…. collective concern for the child really showed. The availability of tea, the warm surroundings and the atmosphere really helped.’

This however did not take away from the pain experienced when the enormity of what was happening for the children was illustrated.

On the other hand, hearing the details of what happened made some people uncomfortable, for others it brought back pain from events that happened at an earlier stage of the child protection assessment and investigation. One person noted that she found it hard to listen to what was reported, as she kept thinking that if the parent only stopped drinking, then all would be fine.

For others, the meeting and how the information was shared was such a new experience, the impact was expressed:

‘I was never involved in the likes of that before.’

Interestingly, no comments emerged about the style of reports or language used by the information-givers during either the information-giving stage, or the presentation of the plan. In the ERHA report, family members commented on the ‘big words’ used by the social workers and the sense that participants didn’t understand what the professionals were saying half the time. (O’Brien, 2000 p.46).
A number of people expressed surprise that the information being shared was affirming and positive in many aspects, while also being challenging and revealing. This reflects the importance of the inclusion of a strengths’ perspective to the assessment of protection issues.

Overall the family members indicate that they were pleased with the way in which the information was shared. However, when the processes surrounding the presentation of plan were examined, it became clear that the great majority of family members would have liked more information, especially about resources and options. Issues of information-giving therefore need to be interpreted cautiously. This comment sums up the point:

‘Even though I was well informed I feel that more information into the outcomes and backup options should the plan have failed and what other outcomes were available if problems should arise from the plan.’

The co-ordinator played a pivotal role in setting the tone for the information flow at the conference. The co-ordinator was viewed by family members as someone with whom a bond had been forged through the home visit. The family members spoke by and large of the great help, reassurance and support received from the co-ordinators. One family member only felt they were not facilitated to participate as much as they would have liked.

3.6.3 Private Family Time
Table 3.4 presents the family members view of the key processes that occurred during private family time stage of the conference. The processes examined are as follows:

The extent to which the family had a clear idea of what needed to happen when the professionals left?
The extent the family felt listened to?
The extent others felt listened to?
Any difficulties that may have arisen in the absence of the professionals? and
The extent available resources were pointed out to the family to facilitate plan?

**TABLE 3.4**

Summary of Family Member’s View of Private Family Time (PFT)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Quite a bit</th>
<th>A little bit</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was made clear what needed to happened when professionals left</td>
<td>65% (9)</td>
<td>21% (3)</td>
<td>14% (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extent you felt listened to</td>
<td>65% (9)</td>
<td>7% (1)</td>
<td>14% (2)</td>
<td>7% (1)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Extent others listened to</td>
<td>65% (9)</td>
<td>28 (4)</td>
<td></td>
<td></td>
<td>7% (1)</td>
</tr>
<tr>
<td>Any difficulties emerge in PFT</td>
<td>7% (1)</td>
<td>29% (4)</td>
<td>43% (6)</td>
<td>21% (3)</td>
<td></td>
</tr>
<tr>
<td>Extent it was easier to talk</td>
<td>43% (6)</td>
<td>29% (4)</td>
<td>14% (2)</td>
<td></td>
<td>14% (2)</td>
</tr>
</tbody>
</table>
In Table 3.4 the summary picture of family members views of private family time are presented. The majority of family members had a clear understanding of what needed to happen when the professionals left the meeting, while three members (21%) were somewhat confused, and two people had no view (14%). Within the private family time, nine people (65%) felt listened to. Four people felt they could have been listened to more. It is not surprising that it was generally the birth parents that had the experience of not being listened to enough.

Generally, the informants indicate that no major difficulties emerged during this part of any of the three conferences. That is not to say there was not some tension. In one instance the father:

‘threatened to leave the FGC. He did not see any point in the FGC. After some talking to he decided to stay.

In another instance, the view was expressed that it was clear that parent and child

….. ‘did not get on with each other. My opinion is that if both were on their own they would have been shouting at each other.’

Families reported that while there was a lot of tension, sometimes between members of the same family, and other times between the child’s paternal and maternal side, a range of conflict resolution skills were drawn on to handle the mounting tensions and differences.

This suggests while the process of FGC was experienced as generally positive by the family, it can be a painful experience for some individuals when discussing a family problem, and yet, families found ways of handling these difficulties.

Professionals Leaving
Discussions in the absence of the professionals were easier for the most part (53%) but a sizeable number (42%) experienced no significant difference due to professionals leaving. In the NWHB study, 29.2% felt it was easier with most people (66.7%) saying that it made no difference. Some people commented on the difference as being attributed to being alone as family:

‘It was different because it was only the two families that were there’

For others they saw it as pragmatic in a different way:

‘I would say that they gave us a job to do to the best of our ability for…..(the child’s) future and safety and to draw up a plan with our own freedom of speech which I thought was very fair in this situation.’

The ease of being alone is also reflected in this experience, when a family member said:

‘I got a chance to say everything I wanted, to bring out into the open…’

The private family time was more difficult for some rather than others, and again the vulnerability of the parents, while still a factor, was lessened after the professionals left. This is reflected in the following comments from two parents:

‘There was less tension and I was not as nervous’…
Undoubtedly, the experience of family coming together under circumstances where a state agency has a major issue in respect of one of their children is likely to evoke a wide mixture of emotions. When the family were asked about how participating in the FGC impacted on their relationship, eleven people (79%) said there was no impact, two didn’t know and one did not answer.

It is important to note that, despite the challenges and tensions, no family members commented that the process might have been easier if an outsider had to sit in with them. This is different to the ERHA experience where in almost equal measure, family members totally opposed and supported the idea of an outsider staying with them for the private family time. Those opposed saw that it would work against the family making the decision (O’Brien, 2000), while those that supported it thought it would help family work faster through the planning stage and/or would reduce family tensions. 25% of respondents in the NWHB study reported that problems did arise during private family time due to the absence of the professionals and the authors suggest that in such situations the presence of the coordinator may facilitate discussions.

Devising a Plan

When the family were asked about their experience of devising a plan, a number of interesting points emerged. The difficulty of the task of trying to devise a suitable plan was compounded by the lack of more specific knowledge of the actual risk involved in either the child going home or having unsupervised access while still in care, or being safe at home if still living there. The difficulties of the task facing the family members in trying to devise a plan in these circumstances is captured in the following views:

‘I felt like I knew nothing yet had all the information in front of me. I’m not quite sure what more could have been added but something was missing.

I just wanted to know about certain injuries which could not be answered in order to be sure of the safety of ... ’...the child’..I just wanted to know who to trust in the future.

An issue that emerged for the family, especially for birth parents in one FGC was their need to have some private family time for themselves within the private family time. This was seen as a space possibly to help them compose themselves, reflect on what had been said or simply to sort out where they stood in relation to what was emerging for their child and themselves.

The challenges facing the family in drawing up a plan are many. Two of the main issues are lack of information regarding resources which has potential to hamper, and the lack of certainty as to the risk involved if certain courses were taken. This may, of course, reflect the stage the child protection assessment is at, and what aspect of decision-making is needed at that time, and the part the family can play in that.
3.6.5 Presenting the Plan
Table 3.5 presents the key findings of family member’s experience of the process of presenting the plan. It is examined under the following headings:
- The extent to which the family recollect the plan?
- The degree it was different from what they thought may have been reached?
- If the plan was accepted? and
- If a date for review was set?

TABLE 3.5

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Quite a bit</th>
<th>In between</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of happiness with plan</td>
<td>21% (3)</td>
<td>36% (5)</td>
<td>7% (1)</td>
<td>29% (4)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Level of difference from what family thought might constitute plan</td>
<td>29% (4)</td>
<td>21% (3)</td>
<td>14% (2)</td>
<td>36% (5)</td>
<td></td>
</tr>
<tr>
<td>Success in resolving the problems at time</td>
<td>29% (4)</td>
<td>14% (2)</td>
<td>43% (6)</td>
<td></td>
<td>14% (2)</td>
</tr>
<tr>
<td>Levels of satisfaction regarding plan at time of research</td>
<td>37% (5)</td>
<td>14% (2)</td>
<td>21% (3)</td>
<td>14% (2)</td>
<td>14% (2)</td>
</tr>
</tbody>
</table>

(N = 14)

3.6.5 Reflections on the plan and outcomes
It is important to note that examination of the outcome of the plan after a lapse of time was not possible, given the time constraints of the pilot project and the need to have FGC’s up to a month before the pilot ended. A number of interesting views emerged when the family members were asked to reflect on the plans made and their view of the outcomes.

Only three people (21%) were very happy with the plan while seven people (49%) felt that it contributed positively to the situation the families faced. One third were not happy, or did not have a view. As time went on, it appears that the number of people who were happy with the plans diminished. Questions were raised about additional help needed after drawing up of the plan, by way of examining the impact of plan. Three family members (21%) said additional help was required outside the plan.

However, the majority (79%) did not know if the plan required subsequent help. It is necessary to look behind the small quantitative data presented to understand what may be behind the figures for discontentment with the plan. Some family members commented on how the changed care arrangements since the FGC were much better for the child, and commented that she was visibly happier. For others, they felt that the plan had a negative effect on them personally. This was especially the view for birth parents and carers, who either lost that status as a result of events following the FGC or had their access cut as a result of the family plan. It is very evident that when
the plans are examined the dynamic and complex nature of the processes following
the FGC impact on the outcome of the plan, and how it is perceived.

3.6.6 Families overall impression of the FGC
The family members were asked for general comments about the FGC process, and
what surprised them most about it. The following comments give a flavour of the
answers to these questions. For some the newness was evident:

*The whole process was a surprise really, as it is not like anything I’ve ever
experienced*

For the parents it was particularly difficult, as would be understood when cases are
involved in the child protection system:

*People (family members) were saying things that were hurtful and they were very
selfish in parts. Everything was to suit them and they made most of the decisions
for us.*

Overall people welcomed the opportunity for a number of reasons:

*The FGC has answered a lot of unanswered questions on the safety of the child. ....
The FGC has provided the foundation for a happy environment’*

‘Very well organised, easy people to speak to and the freedom of speech, privacy,
no aggressive behaviour’

‘It’s good because it brings all family members together to sort out any differences
that they may have’.

‘The FGC helps to bring everything out into the open.’

‘I feel that all professionals involved did what they could to help’.

Lastly, but of central importance is the way the family saw the FGC impacting on the
children who were present at the conference. The children present ranged in ages from
3 months to ten years (4 children). The family members who attended the FGC for the
small baby felt that her presence kept them extremely focused, though it was difficult
for the parents. They were afraid of having to handle her if she needed attention, as
they did not want to be in the limelight. For the older child, one family member’s
view was:

*The child was there and she wasn’t there if you know what I mean. She played
...In the other room to take the pressure off her.*

When the impact of the meeting was explored, some felt that it lifted a weight off the
child. In this instance she was to remain in her extended family. Another family
member thought it frightened her but when this was further explored it appeared that the trauma of what had been happening to the child was much more the issue. Yet another family member said they did not know what the impact was as she felt:

*It is hard to know what they are actually thinking*

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3.7 Conclusion

This chapter was divided into two parts. In part one the profile of the families referred to the conference, attendance of participants and duration of FGC from referral to completion was presented. In part two, the family views were presented. This part predominantly sought to address the extent to which family members participate in and have a sense of ownership of the FGC process.

Many of the findings were similar to the findings which emerged in the ERHA project (O’Brien, 2000 p79-82) in Ireland and which are also features of international pilot studies Lupton et al, 1995; Lupton & Stevens, 1997; Crow and Marsh, 1996 and Smith & Hennessy, 1998.

- The overall finding was the family members did participate in meetings organised to address concerns relating to the children in their networks. There was overwhelming appreciation for the co-ordinators preparatory work, how they imparted the information and their general demeanour.
- The family members participated from both maternal and paternal sides.
- The family members who participated averaged five per conference (excluding children), and a large majority of those who were invited to attend did so.
- Family members described the home visit from the co-ordinator as extremely positive, and this visit helped to set the scene for the meeting. The social workers in many of the cases also played a key role in encouraging the birth parents of the children to allow the meeting go ahead.
- Family members expressed the opinion that their views were heard and respected. Some family members who had no experience of prior meetings felt it was good and those that had prior contact with professional networks felt the process was better than their previous experience.
- When the private stage and presenting of the plan was examined it emerged that the family had limited knowledge of the resources available to them. This has implications for participation, as if family members are not given adequate information to address the concerns, then the extent to which participation can be achieved is affected.
CHAPTER FIVE
APPLICATION OF FAMILY GROUP CONFERENCES IN CHILD PROTECTION

5.1 Introduction

This chapter considers the applicability of the FGC model in the child protection system. The discussion is set against the research findings and current model of child protection outlined in Chapter Two. It builds on the findings presented in Chapters Three and Four and draws substantially on the views of the management committee and the project manager. Members of the project management committee are also key stakeholders in the child protection system.

In the first part of Chapter Five, the impact of participation in the FGC pilot project is examined. Particular attention is focused on how participation in the pilot project impacted on the role of the professionals involved. This provides an important marker for understanding how the key stakeholders/professionals envisage ways in which the FGC approach may fit with protocols in child protection system into the future. The other emphasis is a consideration of the uses, challenges and possibilities which FGCs are seen to have in child protection. The implications of the agency having statutory responsibilities under the Children Act, 2001 and its wish to incorporate the FGC more into mainstream services are addressed.

5.2 Significant Changes in the Operating Environment

Major developments in childcare policy and practice are underway in the agency in which this pilot project was carried out. Timing of developments is an important issue in the board, as when reviewing the MWBH protocols, a management committee member provided information that:

'The Mid-Western Health Board is due to publish a new protocol for its Child Protection Conference process. It has been written ... without consideration for how the FGC model will impact on the Child Protection Conference process and makes no reference to FGCs.'

This is indicative of the fragmented approach to service development that can arise out of competing demands on services. Alongside this, staff shortages and staff retention, especially in the social work department, were major issues that impacted on referrals, and staff availability to work on cases.

On a national level, despite the interest and developments in Family Group and Family Welfare Conferences, there has been no detailed consideration of how FGCs can be more fully integrated into the current child protection system, or the new system proposed by ‘Children First’ and legislated for in the Children Act, 2001. This, according to one member of the project management committee is:
FGC represents one element of a number of new structures and processes that are being proposed to modernise and improve the Irish child protection and welfare systems. At present there is limited information on how these structures and processes will work in reality and whether the potential envisaged will be actualised. The Children Act, 2001 neither prescribes a family empowerment model (as in New Zealand) or a restorative Justice model. The Act does not make a philosophical position explicit to inform the future practice of conferencing in any of the three contexts where it calls up conferencing (Health Boards, the Gardaí and Probation and Welfare Service). There has been criticism of the fact that the legislation does not define Family Welfare Conference, nor does it makes specific allowance for “private family time”. The private family time represents the singularly most obvious element of a family empowerment model and transfer of power from the professionals to the family. It is to be hoped that the integrity of the model is not lost in the application of FWC called up under the legislation. It appears that the potentially beneficial ways of working which conferencing allows are recognised, as the Minister with responsibility for children in the Department of Health and Children, Ms Mary Hannifin, T.D. expressed the view that:

“New FGC ideas (contained in the legislation) does not prevent Health Boards from convening FGCs in relation to children who may be in need of care and protection at a much earlier stage”. (Minister Mary Hannifin 28/11/2000)

5.3 Management Perspectives

The management committee

The eleven members of the management committee (excluding the project manager, child care manager and project consultant) saw many functions arising from their membership of the management committee. These ranged from representing their department or staff group, being part of consultation on development of the pilot project, being supportive of innovative concepts, advising on the development of the FGC model from the viewpoint of ‘Children First’ and facilitating resource requirements between the project and other departments.

How did membership of FGC management committee affect positioning in the organisation?

The management committee had members who were key players in the child protection system and members who had a more peripheral responsibility for child protection, but were key players in the delivery of community services. Many members reported that as a result of their membership they were:

‘More informed regarding the model and had an opportunity to analyse and reflect on complexities involved in its implementation’.

Overall, they have been exposed to some of the pitfalls, limitations and difficulties in trying to make conferencing ‘fit’ into the existing child protection system. At the end of the pilot, they still expressed a:

‘Confusion vis-a-vis the perceived expectation that FGC and Case Conference (traditional) could work together’

However, the opportunity of working on the pilot project gave enhanced knowledge of the dynamics in the family and multi-disciplinary spheres, which is essential in the management of child welfare/protection. They reported to be especially struck by:

‘How the different groups/professionals viewed the Child Protection System’

Overall, they expressed satisfaction to have been

‘enabled to contribute to the organisation’s understanding and readiness for working in context of Family Group Conferences’.

To what extent has the use of FGC’s affected other professionals’ roles in their work with family members?

The impact of the FGCs was evident in how the key management committee members saw the process impacting on other professionals’ roles. In this domain, the participants were talking predominantly from their positions as managers and supervisors in the organisation. Many reported a change in how professionals began to talk about families, and how the FGC offered the possibilities for a different participation of extended family in the child protection system. They welcomed the shift in:
‘the balance from decision-making to that of partnership/ collaboration and even to accepting ‘direction’ from family members’.

Their view was that for staff directly involved:

‘It meant closer working with family members and sometimes extended family members’ ....

...and they were

‘engaged with families on a different, more open and sometimes more challenging level, particularly where previously contact would have been limited to one/two family members and perhaps in the professionals’ domain rather than in venue/setting of family’s choosing’.

There was also evidence of greater enthusiasm:

‘What I have noticed is the enthusiasm of agency workers to get a family conference off the ground as opposed to organising a case conference’.

However, given the limited number of cases involved in the pilot, many of the participants emphasised the need for caution as it is

‘it is difficult to say if the outcomes of FGC will be different, but the process and emphasis are very different’.

There was evidence of growing confidence arising from the possibilities that the pilot project offered, as much criticism of the existing system centred on the extent to which the protocols in place are ‘system driven rather than needs driven’. In the words of another participant:

‘The FGC provides a new model for working with families. Traditionally processes have been imposed on families with little consideration for their needs as defined by themselves or their capacity to meet them without recourse to authoritative or intrusive state interventions’.

Another participant did not see evidence of a major shift such as outlined above by others as:

‘The people involved with the conference that I was part of already had a more consultative approach and were very comfortable with the consultative process’

The implications of the major change was evident to managers, and this indicated that workers would need ongoing support and/or structured supervision in terms of the increased work load on the referrer and those responsible for carrying out the plan, and support in terms of resources and commitment to plans made and agreed etc.

5.4  Fitting the FGC approach with existing protocols in the child protection system

This section presents findings arising from questions as to how the FGC approach fits with existing protocols in the child protection system, and if the FGC model of practice has application across the child protection spectrum as it currently operates? The findings are divided into a number of sub-sections, and reference is only made briefly if the point has been elaborated in a previous section.

In previous discussions outlined, there was evidence that the information-givers saw some differences between FGC’s and other decision-making structures in the child protection system. The principal differences discussed were the active participation of the extended family, the greater presence and participation of the child, the less intimidating atmosphere and the diminished agency control. Combined with this was a realisation that the FGC lends itself to greater exposure of the individual
professional. There was a view that in the case conference context there is more of a shared or collective responsibility. However, it may be that the more the active participation of the extended family where they can question the individual worker in front of their colleagues gives rise to the sense of greater exposure in the FGC context. In the case conference context, any questioning (usually by the small number of family in attendance) is focused more on the group of professionals.

### 5.5 FGCs and/or Case Conferences

Given a choice, would you be more inclined to use traditional child protection protocols over protocols that include FGC?

When this question was asked, participants were inclined to interpret ‘traditional child protection protocols’ as referring to case conferences. As highlighted in Chapter Two, case conferences are only one part of the child protection decision-making system. Parental participation to date has been developed predominantly in this domain and therefore it is not surprising that the participants interpreted it in this way.

Many people felt that:

*The FGC distributes the power more evenly between the professionals and family than the case conference process and the circumstances in which it can fit better are urgently required.*

Participants were divided on how the FGC could potentially fit with case conferences. Some thought they will not replace case conferences altogether, but could give options and alternatives that may involve families in a more pro-active way.

The FGC was seen as having the potential to complement and inform the case conference process. The ways in which this may work out were not clear. However, views were expressed that it was important to avoid a situation where the FGC was seen to be reporting to or accountable to case conference structure. Also, having both systems happening on the same case was seen as potentially very cumbersome.

It was considered essential that case conference participants should have an understanding of the FGC model, and understand the different roles and functions, in order to maximise the possibilities which the FGC could offer. The need for clear policy guidelines to be in place where a case conference was going to be suspended in a serious child protection case to allow for an FGC was highlighted.

A number of members of the management committee felt that the FGC could have application across a range of cases. They also saw its potential relevance in other decision-making processes, including opportunity in the family support domain. In summary there was a sense that FGC should not only be used in more serious end of child protection but should also be available in family support.

Likewise it was felt that the FGC provides opportunity and mechanism to move beyond a ‘social control’ model that can sometimes pervade child protection systems, and would help to reduce some of the adversarial attitudes in both workers and families.

Despite this positive disposition towards the FGC process, the managers recognised a number of issues which need to be addressed for its successful application.
There remains a desire for a guarantee that it
‘did not increase risk or likelihood of increased risk’.

There was a sense that
‘both options need to be available depending on the case and degree of risk involved. All in all, there is a place for both’.

Another member stressed that
‘they would like to choose a protocol that would include FGC. In theory, it would be the better practice for both social worker and service user. However, you have to consider the work involved.’

A view expressed strongly was that:
‘Traditional protocols continually fail to deliver quality services’ so we should not be intent on using different outcome measures for the FGC than traditional methods.’

Another member felt that
‘Traditional methods have been shown too often not to work in children’s best interests in the longer term. There is a powerful argument to begin to find more humane and respectful ways of dealing with family problems. The FGC model provides one possible approach that could help families to take ownership of their problems and find ‘organic’ solutions without recourse to state approaches’.

Reasons cited for the choice of FGC centred on:
‘An enabling approach to the family; A respectful and open way of working; It puts responsibility on the family, while at the same times gives them power. Traditional system can cause more damage to the family and therefore put the child at further risk.’

5.6 Domains in which FGC may be particularly applicable

In this part, situations which may lend themselves to successful application of FGCs are identified. These parameters are not intended as an exhaustive list of domains and circumstances required to hold a FGC. As discussed above the participants were of the view that the FGC may be useful for both child protection and statutory welfare responsibilities. It is suggested that the following features and situations need careful attention:

- The agency is in a position to state clearly what the child protection concern is and what parameters are required to ensure that the child is protected and cared for. In Chapter Four, it was evident that this continues to be a challenge for practitioners. This may be attributed to the dynamic and complex nature of the cases in which timing, co-operation and planning are core factors.
- Where children are being returned to family or extended family setting for care. There were strong views expressed that FGC should not only be used in the more serious end of child protection, but should also be available in family support.

Other factors that needed to be in place to optimise the opportunities for a successful FGC outcome was where
- There is a good level of formal, and more importantly informal and ongoing, social network support.
- There are family members identified who might be able to carry through a care plan.
When the family is approached and they agree to be involved in devising a plan via the FGC, it is important the professionals involved do not make a judgement alone about the existence or abilities of such networks prior to the family being offered the opportunity to be involved in the process. This would require the case to be sent to a co-ordinator in all instances once the family gives initial permission, and the Referral Committee has accepted the case.

5.7 **Circumstances not to proceed with an FGC**

Some information emerged in the pilot which throws light on those situations that are less likely to benefit from an FGC. These parameters are not intended as an exhaustive list of circumstances which would contra-indicate holding an FGC, but the issues would warrant very careful consideration. These include:

- The time-scales involved would automatically exclude ‘life and limb’ situations that require immediate attention. There is no reason, however, why an FGC may not assist in the medium to longer term planning and decision-making required after the initial crisis.
- The most important contra-indicator is where the agency is in the process of assessment and it is not able to clearly define its concern at this point in time. If the FGC goes ahead in the midst of such confusion, it is likely that greater misunderstandings and longer-term problems will occur in the professional-family network.
- Where issues/concerns are of long-standing and where parental circumstances are unlikely to change easily/quickly. This was viewed as an appropriate basis to have a FGC in the pilot, but the evidence shows that if a child’s situation is of long-standing, eg living with the effects of alcohol, suddenly deciding to have an FGC is unlikely to have positive outcomes. Failure may occur because the system has entered a certain equilibrium and unless there is a crisis that brings this chronic long-term situation to the fore, it is unlikely that an FGC would be successful to adequately mediate change for the children.
- Likewise, if the agency system does not afford flexibility and decides ‘to put the family through more traditional processes’ it should not expect or try use the family group conference to merely rubber-stamp or copper-fasten its pre-conceived plan. The purpose of the FGC is to offer a real opportunity for the extended family group to be informed, to devise a safe plan and to have a major input into the decision-making.
- A small number of participants expressed a view that they would have concerns regarding appropriateness of using the model where there is domestic abuse, or coercion in relationships. Such a case did not feature in the pilot. However, the literature e.g. Pennell & Burford (1997) showed very positive outcomes using FGCs for situations involving domestic violence and child protection concerns. There is a need to look further at the issues impacting on the applicability of this approach to these cases here in Ireland.

Further debate is needed about the types of families/child protection concerns that are likely to be dealt with effectively through using the FGC model, as opposed to any other approach. It is important to remember that research to date shows the vast majority of extended families will make safe plans for their vulnerable children. The
question is if there are families that have such limited resources that they need additional assistance in order to be involved in planning?

It is also important that major emphasis is placed on looking at specific applications in the Irish cultural and systems context. Lessons can be learned from other contexts, but it is important to examine the potential application of those findings within the changing Irish system.

5.8 Weaknesses that emerged in fitting FGCs with the current child protection system?

A number of challenges were identified in the pilot about fitting the FGC into the child protection protocols. Again, the conceptual and hypothetical orientation of many of these issues was striking, as the cases in the pilot provided evidence on a somewhat limited range of situations.

The first challenge raised was that the process in which this new practice was explored was ‘only a pilot’, and therefore it may be difficult to draw inferences for the larger picture. The limited experience of applying FGC in Ireland in the child protection context is a particular challenge to the project’s goal. The ERHA project was based pre-dominantly on the family support or the very low risk child protection category. Likewise, in the NWHB Pilot Project, 50% of the family group conferences were focused only on family support issues, and 10% were related only to issues of family break down. The remaining forty percent of conferences had work focused in two areas. However family support again featured predominantly. Family support was cited as a focus of work in conjunction with issues of ‘child in care’ (10%), an ‘alternative to admission to care’ (10%) and ‘Family breakdown’ (10%). The focus of work for the remaining FGC was ‘child protection’ and ‘child in care’ (10%). Thus a dominant focus of work throughout all conferences was family support.

Confusion existed in the pilot around the best circumstances for holding an FGC. Confusion was seen also with the difficulties surrounding the lack of clarity or lack of understanding regarding child protection concerns. The confusion was also centred on the place of FGC alongside the other decision-making processes. This was evidenced in a number of situations where decision-making reverted back to a more professional ‘expert-position’ approach, as happened when a review meeting was cancelled. This occurred because of the view that certain circumstances had arisen. There was a counter-view, however, that these circumstances were more parental issues and the child still had a strong need to have key decisions made about them.

Challenges related to value-base, workload, resources and responsibility

The FGC operates from a definite value base, which may be quite challenging to families and workers experience.

The workload involved was seen as an issue, as it was felt that the FGC model requires a lot of time for mediation, negotiation and facilitation, which may not be available or allowable where acute risks are involved.
Availability of resources is a major issue that is seen potentially to work against the FGC approach. The resources required in terms of staff time, facilitation skills and appropriate family supports are significant. The additional workload for already overloaded area social workers emerged as a major feature. Contrary to expectations, the FGC did not lighten their work-load, at least in the short term, whatever about creating more satisfactory work practice.

Another major finding from the social workers involved in the pilot project was the sense that they considered that responsibility rested with them to agree the final plan. This was a change from the present situation where, at the Case Conferences chaired by C.C.M. or a Head of Department, the decision-making is very much collegiate.

Families
A number of issues were identified from the family’s perspective that would pose challenges for incorporating FGC into the child protection system:

- The model depends on engaging family participation and commitment, which can be difficult in long-standing child protection cases. It may be presupposed that all key family members are committed to the process, although individual and/or family may not be willing to participate.
- Even though the model allows each family member a voice, family dynamics can at times pose major difficulties to realising this ideal.
- The FGC system may serve to isolate an individual within the family system. In one of the conferences it was reported that the parent found it very difficult. While one of the aims should be to minimise trauma for the participants (perhaps by identifying advocates or support for vulnerable attendees) it is important to remember in child protection cases that the children’s interest need to be the primary concern, and privileged over other issues.
- The process could raise family’s expectations of resources being made available or changes happening, that may not materialise.
- There may be uncertainty about the families’ ability to protect the vulnerable member.

5.9 The model’s innate strengths in managing child protection concerns
The pilot project served to illustrate the widely-acknowledged strengths of the FGC process. These include:

Participation
- Makes wider family more aware of agency concerns for the child
- It gives families the opportunity to take a level of ownership of the whole issue and to make their own decisions for welfare/care of the children within the process.
- Involves the family centrally in making plan/decisions
- Taps into the families own resources, some of which may not otherwise be activated.

Outcome
- Opportunity for fuller information to be gathered and shared.
- If the plan is agreed, the child remains within family circle.
• Less adversarial, and focuses efforts on the common purpose of the best interests of the child
• Less intrusive, less traumatic, less impositional.
• Transparency surrounding decision-making.
• Accountability for and by users and providers.
• When applied and resourced will promotes equity, respect, responsibility and ownership.

**Professional / Family relationships**

• Fosters collaboration/partnership between family and professionals as families are no longer passive recipients of a service approach imposed upon them.
• Independent co-ordinator will have established a relationship with the family, and may take a broader view than an internal chairperson, thereby enhancing the interface between the family and the agency systems.

5.10 **Safety features that need to be built into the model?**

A number of safety features were identified, which if built into an evolving model, would help to address concerns identified in the pilot. These include:

• Adequate training and preparation for all participants.
• A strong care plan is central, if the child is in the care system.
• Adequate resourcing of plans so that families or workers are not “set up to fail”.
• Alternatives to be identified in case of breakdown, and come-back routes if unanticipated/unrecognized risks or flaws emerge.
• Ensure strong family and agency commitment to plan.
• Review mechanism, opportunity to reflect on plan
• Consideration should be given to reducing the workload for period up to and shortly after FGC.
• Referral and initial groundwork undertaken in supervision so that team leader and social worker shared case issues.
• If a perpetrator of abuse is to be present – the aspect of exclusion and presence needs careful handling and planning.
5.11 Conclusion

Many of the strengths identified for FGCs indicate that the participants have a high level of commitment to the ethos and value base of the FGC process. The positives that they associate with FGC reflect this conceptual nature and include increased partnership, family participation, and transparency in decision-making. There was evidence of many of these positive processes in the FGCs that occurred as part of the pilot project. The pilot also provided evidence which showed how the FGC can optimise family placement for children, and tap into family's ability to draw up a protective plan for children and also offer much from their own resources. However, the use of the FGC approach needs to take full account of the perceived weaknesses and barriers that may impede its successful introduction within the broader system.

The positioning of the FGC as a complementary approach within the current professional and professional/ family decision-making processes is the key to working out the fit between the FGC and child protection system. It is not envisaged that they can develop or be used as two separate or exclusive processes. Instead, it is imperative to urge caution about going down the UK route in this regard. Under UK Dept of Health guidelines, it is simply not permitted for a case conference to be suspended to facilitate use of an FGC. At this point, it is important that flexibility is maintained until possibilities are further explored. The task is to see the FGC integrated into the Child Protection System and consideration being given to a systematic process for deciding how the innovative FGC method will be convened alongside other decision-making mechanisms. It is crucial that the FGC is not seen as a ‘once-off” event but as part of the ongoing process.

A proposal to this end is developed further in Chapter Six.
CHAPTER SIX

PROPOSAL FOR FITTING FGCS INTO CHILD PROTECTION

6.1 Introduction
In this chapter, an option which may assist agencies who wish to incorporate the principles and methodology of FGC into their child protection system is presented and discussed. For the purpose of achieving ‘joined-up’ services, where appropriate, linkages are also made with agency’s statutory responsibilities to provide a family welfare conference service under the Children Act, 2001 as well as agencies interested in mainstreaming family group conference as part of their family support and general child welfare services.

However, the primary focus of this chapter remains to discuss the project objective of where and how the FGC has potential to fit into the child protection system. The proposal is tentative, and it is hoped it will contribute to the necessary debate about where Family Group Conferencing may fit with and enhance the child protection management system outlined in Children First. The difficulties arising in Health Boards from major structural changes and staff shortages are acknowledged. The different options put forward in this proposal are based on understanding that many of these changes are being managed currently and solutions and plans are in place to address a number of priority areas.

6.2 Developing The Proposal
In Chapter Five, it was noted that the majority of management committee members interpreted the question about the fit between as FGC and ‘traditional child protection protocols’ as referring to case conferences. This was understandable as:
(a) there were written protocols in the agency for case conferences, and
(b) many of the other procedures underpinning Children First are perhaps not seen as such explicit procedures, as this change was being implemented in the agency on a phased basis.

There are a number of key issues that need clarification if the fit between case conferences and FGCs is be worked out.

- Both are decision-making forums, and if both are used, what principles of the two models are at variance?
  - One key difference is the principle that the family, as opposed to the professionals, are privileged in the making of the protection plan in the FGC, while the agency retains the power to decide if this plan safeguards the child?
  - Another key difference is the role of the independent coordinator. In the case conference forum, a person that has statutory responsibility for the output normally conducts the chairing
- What are the criteria required to hold a child protection case conference, and are these the same criteria that need to be used to initiate a family group conference?
- Is it likely that the information-givers at the FGC will be similar to the participants at the case conference? It is difficulty to see how they would be different as the focus in both is on devising a child protection plan.
- Parental involvement is now part of case conferences, and how different is it when extended family are involved in FGCs?

In the UK, the Department of Health Guidance (1999) stipulates that an FGC cannot replace a case conference, when the criteria for holding a case conference exist. In a recent research study conducted by Brown (2002), few families who were in the case conference system opted for an FGC also, as they saw this as unnecessary duplication, and they felt they had limited power to influence the professional viewpoint. It is suggested that if we follow the UK approach in Ireland, the potential of the FGC in the child protection system, and its widely recognised benefits will be seriously compromised. Lessons may also be learnt from the home of the FGC, New Zealand, where the FGC is used as the main child protection decision-making forum and, in the event of not reaching a decision acceptable to the agency, the case is referred then to court.

6.3 A Salutory Lesson
An example may illustrate the kind of difficulties involved in mixing FGCs in the Child Protection system, without having a very clear framework.

The infant of a young couple was admitted to hospital with injuries, and NAI was confirmed. The child was admitted to care on an emergency basis, and it was planned to have a FGC to consider the child protection plan required. A very successful FGC was held and it was decided that the child would remain in care, and the agency would continue working with the parents to assess the situation. Early indicators in the case, according to the agency (not shared at the conference) were that is was likely that reunification would occur. Some time later, a case conference was held, and the decision was made for the child to be returned to his parents.

A review FGC conference was held. The purpose was to explore with the family how they could assist the young couple care for the child.

Some time later, the child was injured again, and the child was admitted to care again in an emergency.

A third FGC was held to draw up a new child protection plan, and a plan was made.

Given the seriousness of the case, the service manager conducted a series of interviews with the participants. His conclusion was that the main mistake made was the agency failed to involve the family sufficiently in the decision-making. A case conference was held after the first FGC and at this conference the agency decided to return the child. Family members said they were wary of this decision but, as the agency had made it, they did not feel they were in a position to challenge it. If they had done so, (and in what forum could they have done that?), or if they had to raise their concerns about the decision at the subsequent FGC, which was set up to support the agency plan, it was likely that they would have alienated the young parents.

The key lesson of this case, which was relayed by a colleague from the UK, was the extended family should have been more involved in the assessment process. What is indicated is a need to have complementary decision-making fora, rather than having
one damage the possibility of the other. It is also necessary to see FGCs as an on-going process, and not as a single event. This may involve having a number of FGCs until such time as a safe care and protection plan is in place for the child. This undoubtedly will have major implications, as the fit between the FGC and other decision-making structures in CPN have to be very carefully worked out.

In conclusion, it is a major challenge in finding the fit between FGC and case conferences, while seeking to adhere to the widely-prized principles of extended family involvement, independence of co-ordinators, private family time and privileging family decision-making. This challenge is attempted in the remaining sections of this Chapter.

6.4 Concepts Underpinning The Proposals

The following are the concepts which inform the proposal contained in the following sections:

- The positioning of the FGC as a complementary and process-enhancing approach within the current professional and professional/ family decision-making process is key to working out the fit between the FGC and child protection system;
- The different legislative, procedural and ‘best practice’ basis from which FGC can operate, as outlined in Chapter Two. Distinction needs to be drawn between processes that are legislatively (i.e. reviews), procedurally (i.e. child protection conference) and best practice (i.e. supervision) derived;
- The FGC is only one of a number of decision-making processes operating in the child protection and care system. Findings arising from the implementation of ‘Children First’ (HEBE, 2001) relating to referrals, assessment, child protection notification, and case conferences are outlined in Chapter Two;
- The desire and preference for greater child-centred and parental involvement, enshrined in both legislative and policy initiatives;
- The constitutional and cultural implications of extending beyond parental participation, to extended family involvement, in managing and addressing child protection;
- A desire to minimise the confusion arising in Ireland presently in relation to terminology used in respect of family group conferencing, family welfare conferencing, conferencing and family conferencing which, as outlined earlier can be seen in relation to the need to distinguish services providers and service users,
rather than being a reflection of different methodologies or principles underlying the models. The term FGC is used to define the overall conferencing service in the health board, with different labels such as FWC fitting with this;

- A desire for efficient use of limited resources and provision of quality-driven services, to be achieved by developing a service based on readily understood approach, methods and techniques.

### 6.4 Activating Conferences within the Health Board

In this section the different potential routes from the various points in the child care system to a conferencing service are summarised. These routes are described and considered in detail in the subsequent section 6.6. Figure 6.1 shows different routes possible, four of which will utilise a (procedural and/or best practice derived) family group conference service and one, which will utilise a family welfare conference (legislative).

- Route One is where it is clear from the start that the referral is of a child welfare or family support nature, (procedural and/or best practice basis). These cases lie outside the child protection system.
- Routes Two to Four is where the referral contains a recognised child protection concern. The left-hand side of the figure outlines the junctures in the child protection system, which may trigger a referral for a family group conference. The decision to refer to the FGC may be made at three points within the child protection system. It also outlines the various linkages back into the child protection and child welfare systems arising from the referral.
- Route Five is where the court directs, or the health board’s application for a special care order prompts the referral (legislative basis).

**FIGURE 6.1 – Routes to FGC in Child Protection and Related Systems**
6.6 Triggering Family Group Conference Referrals in the Health Board.

6.6.1 Different Junctures - Different Referral Options

In this part, the different referral options and reasons for using a family group conference are presented. Each option is presented in tabular form, using a number of categorisations to highlight the issues involved in finding a suitable fit in the CP system. The categories used to describe the options include:

(i) A description of the situation;
(ii) Criteria set down for making a referral;
(iii) Potential constraints;
(iv) CP case management implications;
(v) Linkages required in system.

The findings presented in Chapters Three, Four and Five inform this typology.

In examining the different routes by which a referral may be made for a family group conference, five possible routes are identified. Route 1 refers to the child welfare/support realm, and Route 5 refers to the statutory requirement for a family welfare conference. They are included to enable the totality of the system to be seen, but the emphasis is primarily on Routes 2 to 4, which have most implications for the (procedural/best practice) family group conferencing and the child protection system.

A key distinction between the provision of family welfare conferences and an FGC service in child protection is the probability that the complexity of the family problems suggests substantial prior involvement with the statutory services. Depending on this experience, the impact of the FWC may be diminished. This may result from an FWC being introduced at the end of many other processes, while FGC may be introduced at an earlier stage in the statutory interventions. Nevertheless, the referral for a FWC will be one route into the conferencing system provided by the health board. As such, it will also intersect with the child protection system, and therefore there are implications for how FWC fits with the child protection system. It will also have implications for the care system and the regulations that govern that sphere, but that is beyond the scope of this project.
Routes 2 - 4 can be triggered as all cases have been notified to CPN system and a plan is required to address the child protection concerns. Cases all fall within the remit of the child protection system at the time of referral. Referrals may be initiated at different stages of child protection process i.e. post-assessment, multi-disciplinary planning or review. All referrals via routes 2 - 4 require the child protection plan to be reviewed at six monthly intervals by the CPN system (sitemap check), so long as case is seen by agency as meeting active child protection criteria. Case management responsibility remains with the multi-disciplinary team members involved in working with the case throughout this process.

6.6.2 Route 1

Referral from CPN system to family support/ child welfare services following notification. Decision that no further child protection action required. Referral made in conjunction with referring social worker. No other child protection decision-making process initiated or involved. This may be either a new or existing case.
<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>Referral falls within a child welfare/family support concern Either known or new case.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRITERIA FOR REFERRAL</td>
<td>No ongoing child protection issue</td>
</tr>
<tr>
<td></td>
<td>Need for agency to be clear as to purpose of meeting</td>
</tr>
<tr>
<td></td>
<td>Family in agreement with referral</td>
</tr>
<tr>
<td>POTENTIAL CONSTRAINTS</td>
<td>Low priority in agency and may not be prioritised for family group conference</td>
</tr>
<tr>
<td></td>
<td>Agency concern not shared as issue within extended family and wider family participation may be affected.</td>
</tr>
<tr>
<td>CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS</td>
<td>Need to ensure that plan does not place child/ren at risk</td>
</tr>
<tr>
<td>LINKAGES REQUIRED IN SYSTEM</td>
<td>Referrer and FGC referral committee</td>
</tr>
<tr>
<td></td>
<td>Coordinator, referrer and their line manager, and the service manager</td>
</tr>
<tr>
<td></td>
<td>Coordinator and service manager (FGC service)</td>
</tr>
<tr>
<td></td>
<td>Service manager and other heads of disciplines to give feedback re service and clinical issues that may need attention</td>
</tr>
</tbody>
</table>
6.6.3 Route 2
Referral from a professional meeting for a family group conference to assist in drawing up a child protection plan

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE TWO: REFERRAL FROM PROFESSIONAL MEETING</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Referral from a professional meeting for a family group conference to assist in drawing up a child protection plan</td>
</tr>
</tbody>
</table>
| CRITERIA FOR REFERRAL     | - Child’s immediate safety concerns met  
- Case meets criteria for staying open within the CPN system  
- Case not envisaged to progress to child protection case conference at this stage  
- At point of referral to FGC service clarity needed as to what child protection concern is and what needs attention  
- Clear mandate from major stakeholders in child protection system |
| POTENTIAL CONSTRAINTS     | - What safety features required by system?  
- Extent that parent/s accept the basis for agency concerns and if family members are willing to share responsibility for protection issue and willing to be involved in devising solutions. |
| CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS | - Some professionals may be more anxious to progress to case conference as they may not want to take too many risks  
- Criteria needs to be developed to assist risk taking involved in not going to case conference  
- Identified triggers required if child protection system needs to be reactivated during process |
| KEY LINKAGES REQUIRED IN SYSTEM | - Clear information from CPN system and case managers in respect of care protection plan needed  
- Clear lines of communication to ensure accountability criteria met  
- If child in care, need to ensure that regulations that govern care planning are adhered to and fit with decision making structures of FGC process  
- Need to ensure that FGC plan if agreed is circulated to key people and monitoring and review system in place |
6.6.4 Route 3

Referral from the CPN system in conjunction with case managers for a FGC, **instead** of holding a child protection case conference. Child protection needs assessed and bottom line (relatively) clear.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE THREE: IN PLACE OF A CASE CONFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Referral from the CPN system in conjunction with case managers for a FGC <strong>instead</strong> of holding a child protection case conference. Child protection needs assessed and bottom line (relatively) clear.</td>
</tr>
</tbody>
</table>
| CRITERIA FOR REFERRAL | - Child’s immediate safety concerns met  
- Case meets criteria for staying open within the CPN system  
- At point of referral to FGC service clarity needed as to what child protection concern is and what needs attention i.e. parameters of clear child protection plan identified  
- Clear mandate from major stakeholders in child protection system to proceed in this direction  
- Indication that the family would like to be involved |
| POTENTIAL CONSTRAINTS | - Multiple personnel from agencies involved, need for very clear communication and structures  
- Ensure all key players know sequence of processes proposed  
- Despite decision taken, certain key professionals may feel anxious or uncertain about sharing risks to this extent with family  
- Family tensions associated with past history may impact on participation of key players and exclusions have to be negotiated…potential to heighten professional tensions  
- Family members may have difficulty becoming involved due to past history with birth parents or family want to take over and just take child and not involve agency |
| CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS | - Agreed time frame required within which FGC needs to be held and monitoring system required in lead up to FGC  
- Need to ensure protection / safety needs of child in place  
- Manage multiple visitors to family member as intense contact from co-ordinators and regular agency staff likely at this stage  
- Some professionals may be more anxious to progress to case conference due to view that risks too high  
- Identified triggers required if child protection system needs to be reactivated during process |
| KEY LINKAGES REQUIRED IN SYSTEM | - Clear information from CPN system and case managers in respect of care protection plan needed  
- Clear lines of communication to ensure accountability criteria met  
- If child in care, need to ensure that regulations that govern care planning are adhered to and fit with decision-making structures of FGC process  
- Need to ensure that FGC plan if agreed is circulated to key people and monitoring and review system in place |
6.6.5 Routes 4A and 4B

There are two possibilities for referrals to FGC where it is likely that a child protection case conference is indicated. In both instances, the purpose of the FGC is to assist in the assessment of the child protection concerns and to involve the family in devising a plan. This will inform the fuller child protection plan required and the role of the child protection case conference in the process. The variation in the two possibilities is that:

1. In the first, the purpose of the child protection case conference is to discuss the child protection issues and plans in light of the new information arising from the FGC.
2. In the second, the FGC is convened to address the child protection concerns and to devise a plan but the case conference forum is required to ratify this plan.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE 4A: WHERE CASE CONFERENCE INDICATED AND FGC ASSISTS WITH DECISION-MAKING BEFORE CASE CONFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Referral for a FGC to assist in the assessment of the child protection concern as part of child protection case conference process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CRITERIA FOR REFERRAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child’s immediate safety and protection needs met</td>
<td></td>
</tr>
<tr>
<td>• Significant assessment of protection needs and history needed which family can assist in.</td>
<td></td>
</tr>
<tr>
<td>• Clear specification as to what aspect of child protection issue at this stage needs attention at FGC and what the focus of the case conference will be</td>
<td></td>
</tr>
<tr>
<td>• Readiness of agency to share mid to long term plans envisaged based on current information available</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POTENTIAL CONSTRAINTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of clarity between purpose of FGC and Case conference, may confuse, alienate and enrage participants.</td>
<td></td>
</tr>
<tr>
<td>• Essential that co-ordinators has extremely clear brief and knows the different systems</td>
<td></td>
</tr>
<tr>
<td>• Lack of specificity as to aspect of decisions that needs to be focused on at FGC</td>
<td></td>
</tr>
<tr>
<td>• Timing of processes may be at variance with expectations</td>
<td></td>
</tr>
<tr>
<td>• Costly due to partial duplication</td>
<td></td>
</tr>
<tr>
<td>• Many of constraints in Option 2 and 3 also relevant</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify the aspects of the FGC plan that can be ratified outside the case conference (short term) and what aspects need to be held over until case conference appraises the information</td>
<td></td>
</tr>
<tr>
<td>• Manage the sequencing of different decision-making</td>
<td></td>
</tr>
<tr>
<td>• How to explain different agency procedures re extended family participation in FGC and case conference models</td>
<td></td>
</tr>
<tr>
<td>• How to avoid overlap and contradictory decision making</td>
<td></td>
</tr>
<tr>
<td>• Manage emotional field of participants; tensions, mistrust and hope</td>
<td></td>
</tr>
<tr>
<td>• Writing style of reports to different contexts</td>
<td></td>
</tr>
<tr>
<td>• Many of case management implications indicated in Option 2 and 3 also relevant</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KEY LINKAGES REQUIRED IN SYSTEM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Linkages very important to avoid confusion between child protection stakeholders and FGC information givers</td>
<td></td>
</tr>
<tr>
<td>• Likely that many information givers will attend both FGC and child protection system</td>
<td></td>
</tr>
<tr>
<td>• Essential to link with care planning decision-making required under regulation (if applicable).</td>
<td></td>
</tr>
</tbody>
</table>
The variation in the Route whereby the FGC can link with the case conference system is where the FGC occurs, and agency stipulates that this plan needs to be then ratified at the case conference.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE 4B: WHERE CASE CONFERENCE INDICATED AND FGC CONVENED AND FINAL DECISION MAKING OCCURS AT CASE CONFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Referral for a FGC is to assist in the assessment of the child protection concern as part of child protection case conference process. Decision is made at case conference convened after the FGC.</td>
</tr>
</tbody>
</table>
| CRITERIA FOR REFERRAL | Criteria are similar as outlined in 4A  
- Child’s immediate safety and protection needs met  
- Significant assessment of protection needs and history needed.  
- Clear specification as to what aspect of child protection issue needs attention at FGC at this stage and what the focus of the Case conference will be  
- Readiness of agency to share mid to long term plans envisaged based on current information available  
Decision to use this option would occur if the agency was unable to delegate decision-making powers to FGC context (with safeguards) as has occurred in UK. |
| POTENTIAL CONSTRAINTS | Lack of clarity between purpose of FGC and case conference for participants of both held, it may confuse, alienate and enrage.  
- Likely that family members will refuse to attend FGC as it would be clear duplication (as has occurred in UK)  
- If referral made, essential that co-ordinator has extremely clear brief and knows the different systems  
- Lack of specificity as to aspect of decisions that needs to be focused on at FGC  
- Timing of processes may be at variance with professional / family expectations  
- Costly due to partial duplication  
- Many of constraints in Routes 2 and 3 also relevant |
| CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS | Identify if any aspects of the child protection plan can be ratified outside the case conference (short term) and what aspects need to be held over until case conference appraises the plan  
- Importance of holding the follow up case conference very quickly afterwards  
- Manage the sequencing and processes of different decision making structures  
- How to negotiate extended family participation in FGC and parental involvement only or predominantly in case conference  
- How to avoid overlap and contradictory decision making  
- Manage emotional field for participants; tensions, mistrust yet hope for different outcomes  
- Many of case management implications indicated in Option 2 and 3 also relevant |
| KEY LINKAGES REQUIRED IN SYSTEM | Linkages very important to avoid confusion between child protection stakeholders and FGC information givers  
- Likely that many information givers will attend both FGC and child protection system  
- Essential to like with care planning decision making required under regulation. |

Options 4A and 4B highlight the core issue of the fit between the child protection system and the FGC decision-making system. Selecting Option 4A may have been the key to the solving the problems in the example described in Section 6.3 above.
6.6.6 Route 5

Referral from the court under Section 77 of the Children Act, 2001 for a family welfare conference. It is highly likely that this referral will be brought to the attention of the CPNS and decisions will then need to be made in conjunction with relevant case managers. (This option is briefly presented, as it is not the focus of this report)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE 5 : REFERRAL FROM COURT FOR FAMILY WELFARE CONFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Court mandated referral or Requirement for HB to convene if applying for a special care order Section 77 Children Act, 2001</td>
</tr>
<tr>
<td>CRITERIA FOR REFERRAL</td>
<td>Decision of Court and must meet criteria laid out in legislation If agency applying for a special care order, they must as soon as possible hold an FWC If court makes referral, FWC must be held</td>
</tr>
<tr>
<td>POTENTIAL CONSTRAINTS</td>
<td>• Timing of case management: in some situations crisis plans will need to be put in place which may impact on FWC • Extended families may not be motivated to participate as the young person may be a the end of a long sequence of difficulties • Tolerance for young person may be low among family members and professionals</td>
</tr>
<tr>
<td>CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS</td>
<td>Referrals from court may not fit with child protection criteria in use in agency, but legislative mandate means FWC must occur anyway</td>
</tr>
<tr>
<td>KEY LINKAGES REQUIRED IN SYSTEM</td>
<td>Need for liaison between court service, probation service, education and health boards (joined-up agency work) Procedures and regulations required Linkages internally in HB</td>
</tr>
</tbody>
</table>
6.7 Managing the Referral Network

In Figure 6.2 a model is presented which may assist in managing the referral process. The key components to this process are the following:

1. Service manager of family group conference service
2. Referral committee comprising of child care manager, principal social worker and service manager. The key position of the first two in the child protection system facilitates joined-up thinking and management strategies
3. Clear criteria regarding the function of the CPN system is required to ensure that the distinction between the child protection system and child welfare system meets the needs for the children and families rather than being system-led.
FIGURE 6.2 - THE REFERRAL PROCESS (Adapted Lynch, 2002)

Referral

S.W. Department conducts initial assessment of referral

Child Protection Concern

Child Welfare Concern

Other services provided or NFA

Referral to Family Group Conference Service

Assessed by Referral Committee:
Child Care Manager
Principal Social Worker
Service Manager

Referral unsuitable

Referral accepted: link to CPNS referral dependent

Service Manager allocates case to Coordinator

Service Manager convenes meeting with Referring S.W., S.W.T.L., and Coordinator

Family Welfare Conference convened

No family plan devised

Family plan devised

Accepted by Referral Committee or in consultation with CPNS and case manager depending on route of referral (see Fig 6.1)

Plan breaks down

Plan implemented

Plan to be reviewed

Other interventions or NFA
6.8 The Implications of Change

The FGC is not a simple solution that will resolve a complex issue quickly, but it does offer a model to put into practice the spirit of partnership and inclusivity to truly involve individuals and families in child welfare and protection work. Among the reasons for striving to make this work are the following potential benefits for families:

- A FGC is not a professional framework that families attend, but rather a family process that professionals support;
- The approach strengthens relationships within and between family members and with the statutory services;
- Where there is an entrenched way of working, convening an FGC can offer an alternative way of working;
- The FGC helps the family to work with the Health Board, sharing responsibility and risks, while also identifying supports;
- The FGC helps promote self-determination of family decision-making to its fullest extent, while enabling the statutory services to discharge their duties.

It is worth re-iterating some of the key issues which impact on the approach:

- Children and matters relating to their care and protection are the primary focus of Family Group Conference. The focus of the FGC must be on the child/children and not the broader family;
- The nature and extent of family participation in an FGC needs to be clearly and succinctly defined and understood by both the family and the professionals attending;
- Extended family members attendance at FGC’s must be encouraged and facilitated as far is possible and practicable;
- Families’ reluctance to participate does not necessarily reflect an unwillingness to participate. Families’ fears need to be recognised and worked through;
- Families’ vulnerabilities need to be recognised and sensitively managed in the FGC process (taking account of literacy, language and cultural differences).

From a staffing perspective, there are also key issues:

- This model’s values and principles fits with the way many professionals wish to work with families;
- Training is needed for all staff on the philosophy, principles and theory of FGC to ensure the delivery of an effective, consistent and quality service;
- Professionals of all disciplines need to engage in a more participatory practice with families, and to be aware of the impact of ‘expert identities’ to this process;
- Professionals need to adopt a stance of curiosity towards their practice and to develop receptivity to new and creative ideas;
- Professionals will need to continue to focus on solutions and strengths if the family empowerment objective of FGC is to be achieved;
- The introduction of FGC’s and FWC’s to Irish childcare practice in general will involve a major shift in both professional thinking and practice;
Both the practical and emotional demands placed on all parties involved in the FGC process needs to be acknowledged. An appropriate support and supervision structure needs to be in place for co-ordinators and frontline workers involved in the FGC. Supervision should allow the opportunity to reflect on the impact of FGC and to improve to improve practice skills, whilst also allowing an opportunity to debrief.

6.9 Implications at National Level

The different components required to successfully implement a family group conferencing service are expanded in Appendix Three. The development of a single, flexible model of conferencing for different practices across all 10 Health Boards would minimise the individualisation of conferencing and reduce diverging practices. Given the inter-agency and cross-area working involved, this is considered an essential national objective. It is suggested that there is a need for a National Committee/ Forum to oversee the development and implementation of FGC and FWC in the health board context.

Attention is needed as to how the implementation of conferencing in the Children Act, 2001 will impact on service provision and service users. The Act neither prescribes a family empowerment model (New Zealand) or a restorative justice model. The Act does not make explicit a philosophical position to inform the future practice of conferencing in any of the three contexts (Health Boards, the Gardai and Probation and Welfare Services). There has not been criticism of the fact that the legislation neither defines the various types of conferences contained within it, nor makes specific allowance for “private family time”. The private family time represents the singularly most obvious element of a family empowerment model and transfer of power from the professionals to the family. It is essential that the integrity of the model is not lost in the application of FWC model prescribed under legislation. It is also considered that practice needs a chance to develop, especially in the areas and with the client groups involved, before regulation, which it is understood are in the course of preparation, are finalised.

Partnership in all areas of work is deemed to be a desirable aspiration, and there is no area where the benefits of this are more obvious than in the principle of working collaboratively in the area of childcare. It is to be hoped that the ethos behind the whole concept of a Family Welfare Conference will incorporate the principles and practices of partnership with the inclusion of the empowerment (New Zealand) model of Family Group Conferences as an essential element of intervention with families.

6.10 Concluding Remarks

It is the author’s hope that the Pilot Project on Family Group Conference in the North Tipperary Community Care Area, and the resulting evaluation and development work contained in this report, go towards informing the future development of policy and practice in Family Group Conferencing and the Family Welfare Conference Model as legislated for in the Children Act, 2001 in the Mid-Western Health Board. As a model, the FGC undoubtedly will continue to evolve. It is hoped that the proposal contained in this report, and the recommendations contained in the Guidance in the Appendices will go some way towards unlocking the model’s potential, and the professionals undoubted commitment to this way of working. This model is one
practical way of joining the family and agency systems to ensure that children are afforded the best possible outcomes.
MID-WESTERN HEALTH BOARD

FAMILY GROUP CONFERENCE PILOT PROJECT

EVALUATION REPORT

May 2002

Dr Valerie O’Brien,
Dept of Social Policy and Social Work,
University College Dublin
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Last but not least, to my sons Edward and Peter and partner Sean for all their support and for putting up with an absent mother and wife as the deadlines drew close.
## LIST OF ABBREVIATIONS & COMMON TERMS USED

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>MWHB</td>
<td>Mid-Western Health Board</td>
</tr>
<tr>
<td>ERHA</td>
<td>East Region Health Authority</td>
</tr>
<tr>
<td>NWHB</td>
<td>North-Western Health Board</td>
</tr>
<tr>
<td>HB</td>
<td>Health Board</td>
</tr>
<tr>
<td>FGC</td>
<td>Family Group Conference</td>
</tr>
<tr>
<td>FWC</td>
<td>Family Welfare Conference</td>
</tr>
<tr>
<td>Teams</td>
<td>Teams refer to the social work team within the community care structure in the health board,</td>
</tr>
<tr>
<td>Community Care</td>
<td>Community Care refers to the structure within the health board set up to deliver community-based social and health services. The Pilot Project was conducted in the geographical area of the North Tipperary part of the North Tipperary/East Limerick Community Care Area.</td>
</tr>
<tr>
<td>Social Work Staff Structure</td>
<td>There are three grades of social worker in social work teams in community care areas. The first grade refers to a basic social worker, the second grade is a team leader and the senior grade within the structure is the social work manager, who has overall responsibility for the service delivery and who is part of the management structure within each community care structure. The team leader has responsibility for providing support and supervision and running the social work team on a day-to-day basis.</td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Team leader</td>
<td></td>
</tr>
<tr>
<td>Social Work Manager</td>
<td></td>
</tr>
<tr>
<td>Child Care Department</td>
<td>The Department in each Community Care area that oversees all local aspects in relation to child welfare and child protection.</td>
</tr>
<tr>
<td>Project Manager</td>
<td>In this project was the designated Service Manager to receive and negotiate all referrals to the service</td>
</tr>
<tr>
<td>Co-ordinator</td>
<td>The Co-ordinator is the person who convenes and coordinates the FGC. The Coordinator’s job commences with the allocation of the referral and continues through the preparatory stage to the holding of the FWC and distribution of the plan.</td>
</tr>
<tr>
<td>O’Malley Park, Family Resource Centre</td>
<td>O’Malley Park, Family Resource Centre is a community organisation, which provides a community based service to families. O’Malley Park, Family Resource Centre provided the coordination service for the F.G.C. pilot project.</td>
</tr>
<tr>
<td>Information-Givers/Professionals</td>
<td>These two terms are used interchangeably in the report and refers to the people involved in the FGC process, other than the family members and the co-ordinator. They comprise a group of people, employed in a range of statutory, voluntary and private agencies that are involved in providing services to the families who have agreed to participate in the family group conference process.</td>
</tr>
<tr>
<td>Family Member/Family Members</td>
<td>Family member and family members are terms used to refer broadly to people from the child’s family or social network who are involved in the FGC process.</td>
</tr>
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CHAPTER ONE

Part 1 - INTRODUCTION TO FAMILY GROUP CONFERENCES

Part 2 - THE MWHB PILOT PROJECT

Part 1 - INTRODUCTION to FAMILY GROUP CONFERENCES

1.1 Introduction to Report
Family Group Conferencing originated first in New Zealand, as part of the Children and Young Person Act, 1989. The model legislated for in New Zealand has been adopted in a number of countries including Australia, the United Kingdom, Canada, Sweden, France and here in Ireland. The principles and the processes involved were clearly demarcated in the New Zealand legislation. Few countries have included in their own legislation the detail surrounding conferencing laid down in the New Zealand legislation.

The underlying philosophy of partnership, interest in developing "strengths focused" models of work, an increased use of relative placements for children who cannot be looked after by their own birth parents are important context markers in the development of current practice. The benefits of Family Group Conferences have been evaluated internationally and the results have been both positive and encouraging. Family Group Conferencing has a potentially critical contribution to make to the development and delivery of childcare, child protection and child welfare systems. It represents a major new approach for dealing with family crises, as it recognises the crucial significance of the family in relation to securing positive outcomes for children. Family strengths, knowledge and resources are utilised to make decisions, both to protect the child and maximise opportunities for ongoing family commitment and involvement in the life of the child.

The benefits of Family Group Conferences have been evaluated in small-scale Irish studies in the ERHA (2000); NWHB (2002) and many of the benefits seen internationally were also found here.

1.2 Purpose of Report
This report has been commissioned to appraise and draw together the main findings of a small Pilot Project on Family Group Conferences (FGCs) aimed at examining the specific fit between family group conferencing and child protection. This is an aspect that had not been previously pilot-tested specifically in Ireland. The pilot project was conducted in the North Tipperary Community Care Area of the Mid-Western Health Board (MWHB) over the period September 2001 to February 2002. (For demographic profile of North Tipperary and description of the child protection system, see Appendix 1.)

The report first describes the FGC process and the pilot project. It provides details of the Conferences held as part of the Pilot Project, as well as the views of the multiple participants involved. The report analyses and presents findings and recommendations.
in respect of the main research questions regarding the potential fit between family group conferences and child protection.

The report also presents at Appendix 2 and 3 revised and updated versions of ‘Good Practice Guidelines’, which were developed and used in the pilot project, and which takes account of the views of participants and the main findings and recommendations. These guidelines are proposed for use where agencies are intended to implement family group conferences as part of general child welfare services. They also are relevant for ‘family welfare conference’ developments envisaged under the Children Act, 2001.

1.3 The Basis for Family Group Conferencing

Differences in child welfare systems, legislation, service delivery, cultural and political systems will frame the basis for family group conferencing in different countries. Doolan (2001) discusses how FGC can be seen as operating from a number of different bases. The three bases which he categorises are

- (7) legislative,
- (8) procedural, and
- (9) a ‘best practice’ base.

The interest in this new approach has resulted in conferencing being implemented in Ireland as part of the criminal justice and child welfare systems, under statutory requirements laid down in the Children Act, 2001 and as part of a policy direction laid down under ‘Children First’, (Department of Health 1999). To date, however, the implementation of FGC practice in the pilot projects has operated primarily from a ‘best practice’ model. All pilot projects to date, including this one have operated without specific legislative or procedural mandates. There is now reference to the possibilities that FGC may offer in the ‘Children First’ (Department of Health 1999). Likewise, there is provision for conferencing in the Children Act, 2001 which will introduce a legislative basis for conferencing in certain prescribed circumstances, when the relevant sections of the Act are enabled. At the time of this study, the relevant sections of the Children Act, 2001 which places statutory responsibility on various agencies, had not been brought into operation.

The latter legislation uses a number or terms where it refers to conferencing. The use of different terms for what is in essence the same approach appears to be an attempt to distinguish responsibility for convening the conference for young people at different stages of their care and/ or criminal careers. ‘Family Welfare Conferencing’ is the term given to the conference that the Health board has statutory responsibility to convene under both Section 7 and 77 of the Children Act, 2001. This is one of three types of conference referred to in the Act. The other types are ‘Conferencing’, which the Juvenile Liaison Officer service has responsibility to provide (Sections 29 to 43), and the ‘family conference’, which the probation service have responsibility to convene on referral from the courts (Sections 78 to 87). The use of three separate labels for conferences is viewed as potentially confusing, and a weakness in the legislative framework. There are no major differences in the principles on which all versions of conferencing are based, or in the actual process of convening the various categories of conferences. Further discussion of the similarities and differences of these types is presented in Appendix 4.
There is similar potential for confusion in the terminology regarding FGCs used in ‘Children First’. This document suggests that “a family support meeting is a useful venue for drawing up a plan and for consolidating any informal undertakings made. The family would attend this meeting, any other members of the neighbourhood/community networks, and any professionals involved in delivering a service or offering support. The family should be assisted to set the agenda for this meeting. Tasks, including the person(s) responsible for carrying them out, can be identified and an outline plan agreed and recorded. A family group conference model may also be a useful mechanism for drawing up a family support plan” (Children First, 1999, pg 62).

The principles underpinning conferencing and the process by which they are to be organised are not stated in detail in the legislation or in Children First. This provides Health Boards, and other services, with the flexibility and opportunity to introduce conferencing by incorporating the best practice lessons learned from other jurisdictions and the three pilot projects here in Ireland. In support of this opportunity, the Children First document cautions that “areas adopting this model must ensure that adequate resources, preparation and training are in place, and that established protocols are observed at all times”.

While the distinctions between family welfare conference, family conference and conference are important, in order to minimise confusion, the term ‘Family Group Conference’ is the name used to describe the type of conference piloted in this study. It is intended that this pilot will go some distance in helping to develop the fit between child protection systems and conferencing.

1.4 Legislative Basis in Ireland

While the purpose of this report is to present the findings regarding the potential fit of family group conferencing in the child protection system, it is important to set out the future legislative responsibilities for health boards in respect of conferencing. Notwithstanding the differences in naming family group conference, family welfare conferences, family conferences and conferences, the legislative requirements placed on health boards when Children Act, 2001 is implemented are set out below.

The Children Act, 2001 sees the Family Welfare Conference as a mechanism for early intervention at an inter-agency level for children at risk. The family welfare conference can be triggered in two ways:

(5) On a direction from the court

Section 77 where a court considers a child (aged 12-18), before it on a criminal charge, may be in need of care or protection

Referral of case to Health Board:

- The court may adjourn proceedings where a child charged with an offence (because it considers that it may be appropriate for a care or supervision order to
be made under the Child Care Act, 1991) and direct the Health Board (Section 77 (1) (a)) to convene a Family Welfare Conference (FWC) in respect of the child.

- Having held an FWC, the Health Board may apply to the Court for a care order, a supervision order or a special care order (Section 77 (2) (a)). If the Board decides not to apply for any such order in respect of the child, it shall inform the court (Section 77 (2) (b)) of
  (i) its reasons for so deciding;
  (vi) any service or assistance which it has provided or intends to provide for the child and his/her family, and
  (vii) any action it has taken or intends to take in respect of the child.

- A Health Board is of the view that a child requires special care and protection, which he/she is unlikely to receive unless a special care order is made (Section 23 (a))

(6) On the Health Boards own initiative,
Where it appears to a health Board that a child (of any age) who resides or is found in its area may require special care or protection which the child is unlikely to receive unless a court makes an order in respect of him or her…. (Section 7(1) (b)) the health board shall appoint a person to convene on its behalf a family welfare conference in respect of the child.

Before applying for a special care order under the amended Act of 1991 Part IV A (Section 23A(2)(a)) the health board shall
Arrange for the convening of a family welfare conference (within the meaning of the Children Act, 2001) in respect of the child

Nobody other than the court can order the health board to hold a family welfare conference. However, a 'parent may request a health board to apply for a special care order in respect of his or her child' (Section 23A (3)). If this request is acceded to, then the health board will be obligated to hold a family welfare conference as part of this process. If the 'Health Board decides not to do so, it shall inform the parent in writing of the reasons for its decision (Section 23A (3))

(3) Health Board involvement in other types of conferences stipulated by Children Act, 2001
The only other involvement stipulated for health board is under Section 32 (3) which states that the facilitator (Garda liaison officer) shall invite any other persons who in his or her opinion would make a positive contribution to the conference including one or more representatives from any of the following bodies
  (c) the health board for the area in which the child normally resides.

A number of health boards, while striving to meet their statutory requirements, also want to avail of the benefits of conferencing as a method of intervention for families that require either family support or child protection services.

1.5 Fit with other Policy Developments
Family Group Conferencing shares core values with the operational principles guiding the vision and values of The National Children’s Strategy, (Dept of Health and Children, 2000) namely that service actions and interventions should be:

- **Child-Centred**: the best interests of the child shall be a primary consideration and children’s wishes and feelings should be given due regard.
- **Family-Focused**: the family generally affords the best environment for raising children and external intervention should be to support and empower families within the community.
- **Equitable**: children should have equality of opportunity in relation to access to and participation in the services delivered and have the necessary levels of quality support to achieve this.
- **Inclusive**: the diversity of children’s experiences, cultures and lifestyles must be recognised and given expression.
- **Action Orientated**: service delivery needs to be clearly focused on achieving specified results to agreed standards in a targeted and cost effective manner.
- **Integrated**: measures should be taken in partnership with and between relevant players, i.e. the state, the voluntary/community sector and families.

The FGC is seen to fit with the current requirement to consider the “best interests of the child” as emphasised in the Child Care Act, 1991. FGCs are seen as:

- Safeguarding children and promoting their welfare;
- Taking account of parental responsibility;
- Taking account of race, culture, class, language, religion and disability;
- Working in partnership:
- Supporting children’s contact with their family;
- Providing services to children in need;
- Reuniting children with their families wherever possible (O’Brien 1999)

1.6 **The Principles Underpinning Family Group Conferences**

The following are the general principles underpinning the operation of FGCs:

- The **child’s interests** are paramount, and FGC is the primary decision-making forum for the child;
- Children are **best looked after** within their own family, and family is defined widely;
- Working in **partnership** is beneficial to children;
- **Independent co-ordinator** facilitates the involvement of the family, agency and professionals in the process.
- Family are given time to **plan in private**.
- **Plan is accepted** and resourced by agency and professionals unless it places child at further risk.

1.7 **Operation of the Family Group Conference**

There are a number of defined stages to the family group conference process, the first being the preparatory stage before the FGC, and three stages within the actual conference itself. These stages are described briefly as comprised of
(1) The information-giving stage in which information pertaining to the agency concerns regarding the child is shared with the family;

(2) Private family time in which the family deliberate about the concerns and construct a plan to respond to the concerns regarding the child highlighted in the information giving stage; and

(3) The final stage is where the plan is presented to the professionals. This plan is accepted unless it places the child at further risk. A review system and monitoring structures to address the concerns and to support the plan is addressed at this point.

Fuller detail of the various stages is provided in Appendix 5.

PART 2 - THE MWHB PILOT PROJECT

1.8 Introduction to MWHB Pilot Project

1.8.1 Impetus for the Pilot Project
The impetus and key direction of the MWHB Pilot Project stemmed from a finding and recommendation in a previous FGC Pilot Project. The difficulty in giving an accurate portrayal of the fit between the FGC model and child protection protocols was a major finding in ERHA pilot project (O’Brien 2000). The high level of both internal and external change that was occurring in the system at the time was identified as a factor in this finding. The research showed that, in a number of cases, the referrals received in that project clearly fell into a child protection category. The cases were considered as being on the lower scale of risks, rather than involving severe child protection issues. A key recommendation of the report was:

‘While this evaluation report draws clear conclusions about the place and applicability of the FGC in practice, a more extensive study of its potential to meet statutory requirements, and the adoption of a defined FGC method as a standard protocol for given circumstances is urgently needed. This project can make a significant contribution to a co-ordinated and coherent future policy direction’ (O’Brien 2000 p. 75)

In looking to develop its childcare services, the MWHB also noted the potential of the FGC in the child protection sphere, and decided to commission a project specifically to examine and develop this issue.

1.8.2 Purpose and Goal of the Pilot Project
The purpose of the Pilot Project therefore was to examine the applicability of the Family Group Conference as a means of improving the management of child protection concerns.

The project goals were to establish, by 28th March 2002, if the use of Family Group Conferences with selected families can

- Strengthen families’ capacities to respond to and be involved in the resolution of child protection concerns;
- Satisfy statutory and/or professional concerns about the young people and children involved;
1.8.3 Phasing of the Pilot Project

It was agreed that the pilot project would comprise the following key aspects:

- Appoint Project Manager and Management Committee
- Recruit and train two FGC co-ordinators from an independent agency;
- Design referral and case management guidelines for MWHB staff;
- Do preparatory training for staff to be involved;
- Hold six Family Group Conferences by March, 2002;
- Evaluation Report on the extent to which FGCs could be successfully used during the course of the pilot.

1.9 Terms of Reference for Evaluation

The terms of reference for the evaluation of the project were developed between the Project Management Committee, the Project Manager and the Project Consultant.

These were as follows:

- To evaluate the six Family Group Conferences scheduled for completion by March 2002;
- To explore and establish the level of family participation and sense of ownership of the FGC process;
- To test how the FGC fits alongside current professional processes of investigation, assessment, case conferencing, and review the experience from the perspective of the various stakeholders;
- To consider the implications of extending conferencing service to the management of family support and child protection cases on a regional basis.

1.10 Evaluation Methodology

1.10.1 Philosophy underpinning Evaluation

The purpose and aim of this project lent itself to a research methodology based on action research, similar to previous pilot study (O’Brien, 2000). Action research seeks to capture the processes, as they are evolving, and aims to use findings to point and direct the project in ways that are both relevant and appropriate. Action based research emphasises local descriptions in so far as it takes account of the processes evolving in a particular context.

In this evaluation a mixture of both qualitative and quantitative research is used, but qualitative research, with its emphasis on local knowledge, interpretation, and importance of multiple perspectives, is more relevant to address the aims of the evaluation brief above.

A further distinction that needs to be made in regard to research design is the difference between formative and summative evaluation. Formative evaluation is designed to help programme managers, practitioners and planners improve design of
programme in the developmental phase. Summative evaluation is designed to provide information at the end of a programme about whether it should be continued, dismantled or drastically overhauled. While the terms of reference for this research involves both, this distinction between formative and summative evaluation brings clarity to demands upon the evaluation. Both process and outcome data can be helpful for formative evaluation purposes.

The focus on action-based research, drawing on a predominantly formative evaluation model which embraces a combination of quantitative and qualitative methodology, fits with the role of the evaluation as part of the process rather than a methodology that seeks to take an observer position where the processes and actors were objectified.

1.10.2 Ethical Issues
Evaluators are obliged to conduct the evaluation with the highest possible attention to ethics. Ethical issues during planning must be honest and respectful to those who cooperate in providing information. Written consent was obtained from each person involved, and guarantees given that identifying information would not be published as part of the report.

All family members and information-givers were told at the outset of the project that research was an integral part of the project, and their co-operation was sought on this basis. Inclusion in the pilot project was not, however, dependent on the participants agreeing to co-operate. All interview schedules were posted from the project manager’s office to family members and information-givers following the conference. Family members were offered assistance by the project manager’s office in filling up the schedule if they so chose. This offer was accepted by a number of family members. Written questionnaires were designed and circulated to all management committee members, the project manager and the child care manager.

1.10.3 Data Collection Methods and Tools
A data spread across participants was acquired, reflecting the importance of the different perspectives. The research instruments, which were developed as part of ERHA project (O’Brien 2000), were used where applicable. These instruments were built on previous FGC evaluations (Smith & Hennessy, 1999; Lupton et al, 1998; Crow & Marsh (1996). There is particular value in adapting previously developed research tools as it allowed for a degree of validity and reliability, and allows for the possibility for comparative views to be taken. It also reduces the time that would be involved if the tools had to be developed from scratch.

The methodologies used to collect data ranged through formal and informal interviews, using structured and unstructured questionnaires, and are contained in Appendix 6.

1.10.4 Documentary analysis and Focus Group Discussions
The research methodology also involved document analysis, including minutes of Management Committee meetings, progress reports of the Project Manager, and agency policy statements, as well as the evaluation feedback forms of all staff who received training as part of the project.
Close liaison was maintained with the Project Manager during the course of the project. The evaluator’s membership of the Management Committee enabled practice developments over the course of the project to be informed by data collection and research findings. In this regard the formative evaluation research framework contributed greatly to the project. Finally, ongoing liaison with colleagues in the North/South Forum, other pilots projects and service developments in Ireland and international liaisons augmented the various data methods outlined above and also strengthened the development of the project review.

1.10.5 The Data Sample

Baseline data was obtained on the six referrals received by the project. Summary information is presented in Table 3.1, entitled ‘Profile of Six Cases Referred for an FGC in the MWHB Project’. The data on the three conferences which were completed within the pilot project evaluation time frame is analysed in depth. This includes 13 family members, 14 information givers and two co-ordinators. Additional information was obtained from 12 management committee members. Several of the management committee members were heads of services and key personnel from external agencies, and also included the project manager, and the child care manager (See Appendix 7).

1.10.6 Limitation of the Evaluation

The actual referral rate of cases was slower than anticipated, and therefore the evaluation is based on a smaller number of conferences than originally envisaged. The phenomenon of slowness in referrals to pilot projects is noted in Crow & Marsh, 1996. This means three rather than the six intended conferences were available for evaluation in the pilot project. The small number involved is a major limitation, especially on the quantitative side. However, the numbers did allow for in-depth examination of the cases involved and to that end assisted in examining the primary project objective of the potential for application of the FGC in the child protection system. The short time scale of the project did not allow for outcomes to be examined over time. Instead the project provides a snap shot of how family group conferencing interfaced with cases at a certain point in time.

The failure to interview the three children (all over seven) is a limitation. Circumstances did not permit the interviews. The NWHB pilot study, which included children’s voices, makes a major contribution to the field in this regard.
CHAPTER TWO

LITERATURE REVIEW

2.5 Introduction to Literature Review
In this chapter the relevant aspects of the literature are presented. This is done under a number of headings, giving a summary view of literature findings on the FGC first, and then going on to look at decision-making in child protection under a number of sub-headings including the crucial issue of parental participation. The next part deals with the literature relating to introduction and the use of FGCs in a child protection context. The place and practice of child protection in the host organisation for this pilot project, the MWHB, is then considered. The plans to broaden the child protection framework to include family support in the MWHB are presented. In the final part the impact of the national framework for child protection, Children First is discussed.

2.2 Summary of findings on FGCs
The key messages from research on FGCs are to be found in Lupton’s (2000 p. 36-38) review of the literature. They are as follows:

- the majority of family members, extended as well as close, like the ideal of a family meeting and agree to participate; neutral venues and flexibility of arrangements are particularly appreciated;
- in contrast with traditional child protection meetings, children appear more inclined to attend FGCs and, once there, appear to participate more extensively; children seem particularly to appreciate the family-only part of the meeting;
- the majority from the family network felt well prepared in advance of the FGC and knew what to expect, some arrived without being clear of the ‘terms and conditions’; it is important that written information for children is provided in appropriate language;
- families and professionals see the FGC as more enabling of family participation than traditional ways of working, with the majority of family members indicating that they would use a FGC again, should future problems arise; more evidence is needed however on the extent to which families also experience the FGC process as empowering;
- the role played by professionals within the meeting may require attention, with consideration being given to making the information-giving session more interactive and with written reports being available before the meeting; some thought could be given to the idea of a family ‘pre-meeting’ before the professionals arrive;
- the great majority of family groups produced a plan and most of these plans appear to be agreed ‘in principle’ by the agencies concerned; more detailed information is however required on the extent to which plans are implemented fully as agreed and the reasons why not, if not;
- FGCs appear to mobilise family support, but they may not thereby reduce the demands on agency/ professional resources; in the main plans appear to be realistic in terms of the support requested;
- the early indications are that FGCs may be no less effective than traditional approaches in ensuring the care and protection of children; more extensive evidence however is needed on this vital question.
2.6 Decision-making in Child Protection

2.3.1 Complexity in Decision-Making

The complexity involved in decision-making in the child protection sphere is widely acknowledged in the literature. This is, perhaps, best summed up in the comment by Cleaver and Freeman (1995), when they acknowledge the inherent difficulty in decision-making for professionals in the following terms:

“Decision-making requires the skills of Machiavelli, the wisdom of Solomon, the compassion of Augustine and the hide of a tax-inspector. Making decisions proves to be something of a balancing act for professionals. Taking into account parental perspectives involves surrendering a degree of control to the powerless”.

Larner (et al, 1998) further suggests the decisions that caseworkers have to make would:

“Challenge King Solomon, yet most of them lack Solomon’s wisdom, few enjoy his credibility with the public and none command his resources”

2.3.6 The Place of the Case Conference

The case conference has been the traditional decision-making forum in child protection issues. Hayes (2000) (See Section 2.5 for details of this study) views the case conference as only one phase of child protection work, with often more difficult and challenging phases of intervention and investigation preceding the case conference. Ferguson (2000) (See Section 2.6 for details of Ferguson’s work in the MWHB) suggests the need for clear criteria for calling case conferences. Ferguson’s research found the following:

- A significant number of high-risk substantiated cases that could, or perhaps should, have reached a case conference did not do so. A full 67% of substantiated high-risk referrals did not have a conference. (Ferguson, 2000 Pg 151)
- A key finding is the relatively minor role played by case conferences in managing new cases and referrals, being largely concerned with cases with a history of health board involvement. (Ferguson, 2000 Pg 167)
- The criteria should include specifying who is responsible for calling case conferences, the role of the C.P.N system in this and the relationship between decision-making and planning at C.P.N meetings and case conferences. (Ferguson, 2000 Pg 149)

2.3.7 Parental & Children’s Participation in Case Conferences

Hayes (2000) writes about degrees of partnership operating along a continuum of power relationships. He sees partnership as including:

- ‘participation’ in key decision-making meetings,
- ‘involvement’ in identifying problems and goals and objectives for work,
- ‘consultation’ before decisions are made or actions taken, and
- ‘keeping fully informed’ about services, powers and duties of social services, likely action, rights, etc.)

Philips and Evans (1986) warn that partnership should not be seen as mere attendance but rather: “...Understand the process which they are going through and both they
and the professionals feel that they have made a useful contribution to the plan of action” (Philips and Evans, 1986 Pg 12).
FIGURE 2.1 - DECISION MAKING FORUMS FOR CHILD PROTECTION PLANNING

No Family Participation

Entry onto C.P.N.S. (Internal to H.B)

Liaison –Management Team Meeting (Garda/Social Work)

Strategy Meeting (inter-professional)
At outset to share all available and relevant info.
Convene at any time following preliminary enquiries and submission to C.P.N.
Garda involvement essential

Referral

Child Protection Conference

(Inter-professional and family involved)
Initial enquires completed
When decisions of a serious nature are being considered
Facilitate sharing, outline child protection plan and identify tasks
Not all Child Protection cases warrant a C.P. conference
Each community care area develops its own protocol

Family Group Conference
Family involved and inter-professional
Accesses expert family knowledge
Extensive Family Participation

Source, Suggested in Children First, Adapted McClure (2001), Unpublished
While there has been some research into parental participation at case conferences there has been little empirical research into parental participation in other “emergency phases” of the child protection process. Ferguson showed that Irish practices on the inclusion of parents or guardians in case conferences fell far short of what is regarded internationally as best practice. (Ferguson, 2000 Pg 144). In the MWHB parents were invited to attend in just over half of the conferences, with 54% (n = 14) of the parents invited actually attending for part of the conference. In only one case did the parents attend for the whole conference. (Ferguson, 2000 Pg 156)

Ferguson warns that the lack of an invitation to what are perceived as non-cooperative parents may alienate them further and intensify their hostility. He goes on to suggest that the challenge to professionals is in developing a fully inclusive practice to engage with hostile clients at case conferences in a system which operates in a subjective, arbitrary manner which no longer accords to best practice. (Ferguson, 2000 Pg 157). An evaluation of Children First in 2001 shows an increased level of parental participation at case conferences (HEBE, 2001).

Ferguson’s research identified a need for more information and better listening. Writing of the general Child Protection care system Ferguson found that one of the main criticisms, voiced by many children, was they felt they were denied information. The children in care were especially critical of a lack of information from social workers as to why they were being placed in care. (Ferguson, 2000 Pg 218). In summary, what clearly emerges from the interviews with children is the poor communication and quality of information given to children, especially in relation to plans for children in care. (Ferguson, 2000 Pg 224)

Some practitioners would argue the current child protection structure and meetings cited in Children First militate against children participating to their full capacity.

2.4 Introduction of FGCs into Child Protection Practice
When looking at the introduction of the FGC internationally there is need to examine the context and environment in which the model was introduced. Doolan (2001) identifies three approaches:

7. Legislative - The legislative basis is such that the model is enshrined in law, and there are procedures specified/ regulated to ensure that the principles are set out to guide the practice.
8. Procedural - The guiding principles are enshrined in procedural requirements to behave in a certain way.
9. Best Practice - The principles are introduced to staff who are encouraged to carry out their duties and responsibilities within a re-focused practice paradigm. In this approach the professionals act as ‘gatekeepers’.

Doolan sees potential problems with all three approaches. With a legislative mandate, the “philosophical underpinnings of the approach can be underpinned by the legislation” with solicitors possibly advising their clients “not to engage, or their use of other legislation to thwart the intentions of child welfare law”. On the other hand, Doolan sees the procedural approach as running the risk of “instability in the face of changing fads about what is the right thing to do... or colonisation of the concept of empowerment practice by pre-setting the professional agenda”. The development of the ‘Best Practice’ approach relies on enthusiasts trying to make inroads. (Doolan, 2001, pp 5-6).
A number of Public Inquiries into child abuse in the U.K. in the 1970’s and 1980’s led to the development of what has been characterised as a pre-dominantly legalistic and procedural response to child abuse allegations and investigations. These responses have since been criticised as defensive and reactive in nature by Cooper (1994;) and Parton (1997). These legislative and procedural models of practice led to a system which has been criticised for its exclusion of parents and children (Nixon 2000, Thoburn et al, 1995, Ryburn & Atherton, 1996)

With its emphasis not just on parental and children’s participation in decision-making, but the wider family network also, the FGC has been viewed as a valuable antidote to the exclusionary system. In the U.K. the FGC has been introduced as a “good practice” rather than a legal construct, with the “grassroots” level challenging rather than complimenting existing practice. Nixon (1999) saw change being brought forward through winning over people’s “hearts and minds” to this way of working, rather than through legislation or procedural change. This differentiation has critical implications for the implementation and development of FGC/ FWC. Nixon sees the FGC practice being shaped by its “proximate social, organisational and political contexts” (Nixon, 2001 pg 6).

In Ireland, in anticipation of the legislative changes, a number of Pilot Projects were undertaken (ERHA, NWHB and MWHB). FWCs are now included in legislation in limited circumstances, however the MWHB is committed to introducing the FGC/ FWC as a model of best practice on a wider basis.

A key issue of importance in the introduction of FGC is how the model can be incorporated/ accommodated into the current Child Protection system, taking into account policy and procedures. Writing of the U.K. Nixon (2000) describes a system of a “procedural and legal context”. He remains critical of the approach to “fit FGCs within the procedures, time scales and assumptions of the state bureaucracies” which he believes have “relegated FGCs to a secondary planning forum or a ‘rubber-stamp’ for professional ideas. The net effect is that FGC principles and philosophy are watered down to fit into mainstream orthodox practice”(Nixon, 2000 pg 7).

In New Zealand, FGC advocates have been seeking to change the paradigm from child protection, through professional intervention and decision-making, to a paradigm of a family support approach to child protection. (Doolan 2001). Doolan is optimistic “that core statutory social work can deliver on the state requirements that children be protected by embracing the family support paradigm, and through that process, need responsive services identified by families can be provided for them.” He sees the “tension between family support (a needs-based approach) and child protection (a risk-based approach) is eased by an effective partnership mechanism, such as the Family Group Conference”. (Doolan, 2001, Pg 5). This model of practice is no less committed to child protection. Doolan sees the need for different thinking in relation to some aspects of child protection definitions, and on how to manage the process at the post-inquiry and assessment stages. The classic child protection approach is professional deliberation, court involvement and care. The family support approach engages the wider family as the change agent, as participants and as decision-makers through the mechanism of the Family Group Conference.
2.5 Use of FGC in Child Protection

Nixon is one of the leading advocates of the benefits and place of the FGC approach in decision-making in child protection. Nonetheless, he is critical of the development of the field, and the manner in which the approach may be used. He notes that it is somehow ironic that:

“the idea that families would make better decisions than professionals came from families and communities, not from the professionals. Yet it is professionals who have designed the service, driven it, constructed it, inset the standards, and in so doing to some extent at least, may have colonised these ideas and diluted the spirit of FGCs, or certainly modified them” (Nixon, 1999 pg 4)

Nixon says that there is a tendency for professionals in the U.K. to refer cases to the FGC service when they want to:

- Use the FGC as a rubber stamp for their ideas
- Squeeze resources out of families
- Use the Conference as an intervention of ‘last resort’ (Nixon, 1999 Pg 4)

Hamill (1996) notes that child protection is probably the one area where family participation leads to most anxiety for professionals. She identifies two major concerns in relation to the introduction of FGCs in child protection:

(e) the relationship between the FGC and local child protection procedures, and
(f) the ‘safety’ of FGC in the complex area of child protection.

It should be noted that the FGC process is unlikely to be occurring in a vacuum. Other services are likely to be involved, are likely to become involved or will remain involved post-FGC. Therefore there is a need for the FGC service/practice to interface with a number of other services, both statutory and voluntary.

Hayes’s (2000) research was undertaken to explore professionals’ views on the possible use of FGCs in Child Protection. In the course of his research Hayes evaluated three groups of staff: practitioners, managers and non-social work members of the North and West Belfast Health and Social Services Trust in Northern Ireland. Fifty-five percent of Hayes sample agreed that FGC “should be used in Child Protection work”. Only 7% disagreed, and 38% were not sure.

Hayes (2000) concludes

“it is both desirable and feasible to use FGC in child protection work. However, this is based on the realisation that the FGC model will not be appropriate for all families in which child protection concerns exist and that there are difficulties with the model that need to be addressed in practice.”

2.6 Child Protection in MWHB

In the mid to late 1990s, Ferguson undertook a research project to evaluate the work of the Mid-Western Health Board’s child care and protection system, as it actually processed cases over a specified period. This research aimed to learn more about how
the Child Care system works, identifying what aspects are done well, and how professionals actually operate on a day-to-day basis to protect children.

Ferguson’s research pre-dated the introduction of Children First. Following the introduction of Children First, the MWHB, as did most Health Boards, introduced a formalised Child Protection Notification system. This had interdisciplinary management groups meeting regularly to process ‘notified’ referrals and cases. This is an initiative which represents perhaps the most significant organisational change as community care shifted its primary concern to child abuse. Ferguson was critical of a system which he saw was influenced more by managers, bureaucracy and accountability. Ferguson suggests that need, rather than the decision-making process itself, should drive responses to children and families (Ferguson, 2000 Pg 153).

Ferguson also found the Health Board’s professional systems to be chronically enmeshed with certain types of cases and families, which posed particular challenges. The cases coming to the attention of Health Boards were characterised as tending to involve reconstituted families or lone parents (usually mothers) who live in poverty, often suffering addiction problems, and other adversities such as a violent partner, who may or may not be the father of the children. As the children grow older and enter their teenage years, they tend to become out of control; they have to deal, not only with the legacy of years of adversity and child abuse, but also with a view of them as threats to themselves and/or social order. (Ferguson, 2000 Pg 266)

The MWHB “Child Welfare and Family Support Strategy Statement 2002-2005” sets out an organisational framework for the development a Child Welfare System within the MWHB that provides for the delivery of early intervention and family support services to children and families in need. It is acknowledged that, under the auspices of the MWHB, many initiatives exist that seek to safeguard children and, if at all possible, to keep them out of the Child Protection system and state care. However it is recognised within the MWHB that more could be done to promote the welfare of children and to provide services that could alleviate family problems before they deteriorate to the point at which child protection and alternative care options are considered (MWHB, McClure, 2001, Pg 2). This strategy provides a management model for the development of a Child Welfare System that sets out clear objectives, procedures and structures for the delivery of services in a context of prevention and support.

2.7 Broadening of ‘Child Protection Concern’ to include Family Support in MWHB

One of the key findings and recommendations made by Ferguson was the need for Health Boards to design a strategy for working with cases which are immensely demanding of energy and resources (Ferguson, 2000 Pg 266). Such a strategy requires a fundamental change in the way childcare services are conceptualised and delivered. The system needs to stop trying to fit cases into a ‘child protection concern’ frame and approach child welfare on the basis of assessed need, regardless of the presenting problem. (Ferguson, 2000 Pg 266)
Re-focusing children’s social work requires an acknowledgement of the specific, yet inter-linked, sub-systems of child protection, childcare and family support. For each sub-system staff should be given specific responsibilities to discharge key roles and tasks in the case management process. At the same time, however, there must be an acknowledgement that these sub-systems can and do inter-link and inter-act as the needs of children and their families evolve. Children who require protection may need to be brought into the child care system, albeit for a short period. Children in the care system may need an infrastructure of support to be put in place in the family and local community so that they may safely leave the care system.
Scoping the parameters of these sub-systems, agreeing their interfaces and developing protocols for the various team members to operate dynamically and effectively is a key challenge to successfully refocused practice. (Giller, 2001 “Responding to the Implications of the Ferguson Report: Options for the Mid-Western Health Board”)

In light of the findings internationally described above, and Ferguson’s conclusions in the MWHB, the board has been endeavouring to find ways to fit family welfare and child protection together. The FGC is seen to have a potentially pivotal role in integrating systems and moving processes in the right direction, and hence the proposal for this pilot project.

2.8 National Developments – Children First

Children First - the National Guidelines for the Protection and Welfare of Children was launched in 1999. The objectives of the Guidelines are stated as:

9. To improve the identification, reporting, assessment, treatment and management of child abuse cases.
10. To facilitate effective child protection work by emphasising the importance of family support services and the need for clarity of responsibility between professionals.
11. To maximise the capacity of staff in organisation to protect children by virtue of the guidelines relevance and comprehensiveness.
12. To consolidate inter-agency co-operation based on clarity of responsibility, partnership and co-ordination of information.

The Guidelines provide details for parts of the child protection system including handling the referral, screening and initial assessment, the Child Protection Notification system, and different types of planning meetings. This document, although it does not embrace the FGC as such recognises and defines a Child Protection Conference as an:

“inter-agency and inter-professional meeting, which is convened by the Child Care Manager/designate. It normally takes place when initial enquiries and, if relevant, emergency action have taken place. It may take place during the early stages of enquiry, or at any time when concerns arise about a child’s care and protection. The Child’s parents/ carers and the child should be included where appropriate”. (Children First, 1999 p78, par. 8.19.1)

The Guidelines contain significant pointers regarding inclusiveness:

- Parents/carers normally have more information than any professional about their child and can make valuable contributions to assessment and planning;
- Plans made at Conferences are more likely to succeed if negotiated while parents/carers are present;
- The experience of parents/carers waiting outside a room while a Child Protection Conference is in progress can be extremely distressing and unhelpful. For this reason, parents/careers should participate in the whole conference. If their presence at the whole Conference is not permitted, then
arrangements should be made to minimise any potential discomfort likely to be experienced by them (tea, coffee, etc.)

- Parents/carers are likely to feel nervous, under scrutiny and, in some cases, hostile to the professionals present. Sensitivity and preparation are required in order to reduce tension and facilitate useful discussion;

- Parents/Carers should be permitted to bring a support person to the Child Protection Conference, whose identity will be clarified by the Chairperson to the other participants;

- The purpose of involving parents/carers in a Child Protection Conference, as with any other participant, is to hear his or her contribution and agree conclusions and recommendations. The Child Care Conference should not be used as venue for making assessments of characters, behaviours or abilities of parents/carers, nor should parents/carers be re-interviewed or interrogated at a Child Protection Conference (Children First, 1999 pg 150-151)

The Guidelines go on to delineate certain circumstances when the exclusion of parents/carers may be justified. The MWHB Protocol clearly outlines the Child Protection Conference Agenda, which provides an opportunity for “Family Members Contribution” (MWHB, 2001 (B) Pg 18). The Guidelines state “it is appropriate to hold a Child Protection Conference when decisions of a serious nature are being considered which require the input of professionals from different disciplines and agencies (MWHB, 2001, Pg 78, par. 8.19.2).

In anticipation of Children First, the MWHB designed Child Protection Guidelines within the Board, which recognised Child Care and Protection as a “corporate responsibility requiring a commitment from all personnel without exception across the entire Health Board Services” (MWHB, 1998, pg 1, par.3). Following the introduction of Children First, and in line with recommendations therein (Children First, Pg 79, 8.19) the MWHB’s Child Care and Family Support Services developed a “Child Protection Conference Protocol” (November 2001). This protocol identified a number of objectives: the most relevant for this research being the objective “To maximise involvement of appropriate individuals, particularly parents, children and young people” (MWHB, 2001 Pg 4)

The MWHB’s policy is to maximise parental involvement, while maintaining the care and protection needs of the child as the first priority. The Board has a commitment to inviting parents to participate in Child Protection Conferences, unless there are clear grounds for exclusion. (MWHB, 2001 Pg 11). The Board also has a clear policy on the preparation of parents to participate in a Child Protection Conference.
CHAPTER THREE

PART 1 - GENERAL INFORMATION ON THE CONFERENCES

PART 2 - FAMILY MEMBERS VIEWS OF THE CONFERENCE STAGES

3.1 Introduction

This chapter is divided into two parts. Part one summarises information on referrals received in the project. In part two, the family members’ views of the different stages of the conferences are presented.

The project time-frame extended for six months from September 2001 to the end of February 2002. During that time, six referrals were made to the project. Three of these referrals ended with family group conferences, one referral was withdrawn during the late preparation stage, and two referrals were withdrawn earlier. All six referrals are used to provide base-line information in this report. The findings in part two of this chapter are based predominantly on the views of the participants in the three completed conferences, as well as the one referral withdrawn. Where applicable, general observations relating to the other two cases are included, as the formative evaluation methodology used enabled the researcher to remain close to the processes as they were developing.

In part one, the profile of the six cases referred for conferences is presented, briefly giving key characteristics. The data on the three conferences, which were completed within the evaluation time-frame, is analysed in depth in later sections of the report. Summary information is presented in Table 3.1, entitled ‘Profile of Six Cases Referred for an FGC in the MWHB Project’.

For comparative purposes, the Lupton (1995) FGC evaluation comprised of 19 families, with 22 FGCs being held. Of those 19 families, 11 were researched in depth. In the ERHA Phase One Study (O’Brien 1999), 8 conferences were held and 8 families were researched in depth. 19 family members, 8 information givers and 3 coordinators provided the research data in that case. In the NWHB Study (2000) 15 referrals were received into the Project from January-June 2001, 10 were completed and 5 did not go to Conference. 61.5% of these were included in the research data, 7 of whom were children. In Hayes’s (2000) study in Northern Ireland, 8 families were involved, and research data was obtained on the 8 conferences.
TABLE 3.1
Profile of Six Cases Referred for an FGC

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age of child</th>
<th>Child attend</th>
<th>Gender</th>
<th>Completed: C Terminated: T</th>
<th>Plan made &amp; acc</th>
<th>No. of Family members</th>
<th>No. of Prof.</th>
<th>Persons excluded from conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3 months</td>
<td>Y</td>
<td>F</td>
<td>C</td>
<td>Y</td>
<td>Invited 8, Attended 8</td>
<td>Invited 7, 6 Reports submitted</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>8 years</td>
<td>Y</td>
<td>F</td>
<td>C</td>
<td>Y</td>
<td>Invited 3, Attended 3</td>
<td>Invited 6, Attended 6</td>
<td>Yes Paternal aunt on Mother’s insistence Paternal uncle due to alcohol problem</td>
</tr>
<tr>
<td>3</td>
<td>14 months</td>
<td>No</td>
<td>M</td>
<td>T</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>10 years 7 years</td>
<td>Y</td>
<td>M</td>
<td>M M</td>
<td>C</td>
<td>Y</td>
<td>Invited 5, Attended 2</td>
<td>Invited 9, Attended 8</td>
</tr>
<tr>
<td>5</td>
<td>11 years 16 years</td>
<td>M</td>
<td>F</td>
<td>T</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>15 years</td>
<td>F</td>
<td>T</td>
<td>T</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
3.2 Status of Participants in Cases 1 - 4

3.2.1 Marital Status of Parents
Examination of the marital status of the parents show that in one family the parents were “married but separated”, in two families the parents were cohabiting, and in the remaining case the father was a widower.

3.2.2 Age & Gender Profile of Children
The age profile of the 5 children involved in the project ranged between the ages of three month to 10 years. A gender analysis shows three (60%) were male, while females represented two (40%) of the children included in this study.

3.2.5 History of Contact with the Health Board
The results show that there was a significant history of family contact with the Health Board. This involvement was divided into two categories. Firstly, four of the five children in respect of whom the conference was being called had been involved with the Health Board in the past. Secondly, 66% of other family members had had substantial prior involvement with the Health Board, compared to 75% in the ERHA project.

3.3 Connection with the Pilot Project

3.3.1 Reasons and Route of Referrals
The referrals sought by the project were families who were involved in the child protection system, as distinct from families that were viewed in the agency as falling within the remit of family support. Referrals were sent to the project manager’s office from the community care team. The project manager attended the child protection notification meetings. This provided the project manager with an overview of cases entering the child protection system. Potential cases could be discussed at this early stage between the project manager and the staff of the child protection notification system.

The decision-making body designated for accepting referrals into the project was a referral committee. The referral committee was comprised of the Child Care Manager, Principal Social Worker and Project Manager. Their role was to assess and make a decision on the referrals. On acceptance for the project, the case was assigned to a co-ordinator, whose task was to introduce and explain the process, and to prepare the participants for the FGC. It was to prove beneficial that the members of this committee had an overview of, and positions of responsibility in, the child protection system.

3.3.2 Factors influencing the Referral Rates
The rate of referral of cases to the pilot project was initially slow, a finding which is similar to other projects. The short lead-in time, combined with the short life span of the project (6 months) meant that the project was under pressure in achieving its targets from the start. The location of the project in one small geographical area, together with the shared personnel in child protection and on the referral committee, assisted in the referral process. Another factor, which influenced the decision to set up
the project in that area was the need to work with a management team who had a history of working together. The social work team had undergone major changes of personnel, but many of the other inter-disciplinary team members involved in child protection were in place for some time.

Four of the six referrals were received in the period December 2001 to February 2002. Yet, only one of these cases ended with a family group conference. In many respects this illustrates that as the project was entering its second three-month period, efforts were made to find ‘suitable cases’. Two of families approached and asked to consider an FGC did not share the agency’s enthusiasm for this new approach at that point in time. With the slow trend of referrals, key people in the voluntary sector were also contacted. It was intended initially that the pilot would examine the applicability of the FGC model to cases where domestic violence and child protection were issues. No cases emerged in the time period involved, and at the later stage of the project, it was thought that the voluntary sector might provide such a referral. While this was investigated, it was deemed unlikely that a case that would fall into the child protection referral criteria would have been managed solely by the voluntary sector. The other hope was that the voluntary sector might bring a case where they were working alongside the statutory services, and which might have been overlooked in the agency. Despite the efforts, no such case was found.

3.4 The Conferences

The stages in the conference process are discussed in detail in Appendix 2.

3.4.1 Preparation and Participation

Contacting Invitees: The primary means used by the co-ordinator to make the necessary arrangements with family members for the conference was a combination of telephone calls, with a follow-up personal home-visit. A similar method was utilised for contacting the professionals. The difficulties of contacting people were amplified by the rural setting of the pilot project. Significant travel hours were involved in each case.

Family & Professionals in Attendance: The number of family members who attended the FGCs averaged five, with a range from two to eight. Those who failed to attend were divided into three categories. Firstly, there were those who could not attend due to particular circumstance. Secondly, there were those who chose not to attend and thirdly those who could not attend as other key family members excluded them. Professional attendance was high and averaged seven persons, varying from six to nine. In all 86% of professionals invited to a conference attended.

In the ERHA project, the average number of family members who attended was also five. The NWHB project had an average family attendance of nine, ranging from five to twenty. The high rate of attendance reported above is indicative of the readiness of people in families and their social networks to become involved when invited to help protect vulnerable children. It also shows, however, that when extended family members are invited, significant difficulties can arise from the birth parents perspective, as more people are aware now of the child protection difficulties.
3.4.4 Time Scales involved in the FGCs

**Referral:** It was found that 2 of the cases referred to the pilot were accepted within one week of the referral being made, and the remaining case was accepted within a three week period.

**Acceptance to Pilot:** The period between acceptance of the referral and the holding of the FGC was three weeks in one case, five weeks in the second and ten weeks in the third.

The time between referral and holding a conference in the ERHA study averaged six weeks, the shortest was three weeks and the longest was ten weeks. In the Essex project (Smith & Hennessy, 1999) the average was five weeks, the shortest 1 week and the longest 14 weeks.

**Preparation:** The average length the co-ordinators spent working at preparation between the referral and the holding of the FGC was 48 hours, compared to 30 hours in the ERHA project. The inner and outer times in the ERHA project ranged from 25 to 35 hours while in this project it ranged from 36 to 48 hours. The NWHB experience was 73.35 hours average, the inner and outer times ranged from 37 to 100 hours. As was the experience in the ERHA, the main issue accounting for this difference was the amount of travel involved. In one conference, 18 of the 36 hours (50%) was spent on travel and in another, 17 of the 48 hours (35%) was spent on travel. The NWHB project found face-to-face interaction accounted for an average of 31.4 hours and travel averaged at 42.6 hours per Conference with a maximum of 85 hours. This finding points to serious implications for the delivery of co-ordination (and other) services in rural settings.

**Information-Giving:** The average length of time for the information-giving stage of the actual conference was 45 minutes, a finding similar to the ERHA experience. These figures are marginally higher than the NWHB experience of 33 minutes.

**Private Family Time:** On withdrawal of the professionals from the meeting, private family time ranged from a maximum of three hours in one very complex meeting to thirty minutes in the second, and fifteen minutes in the third. It is interesting to note that the families that needed longer to plan in private needed less time for discussing and presenting their plan. In the ERHA project the average length of private family time was 60 minutes, ranging from 90 down to 15 minutes. The NWHB found private time averaged at 2 hours 28.5 minutes, with an inner and outer limits ranging from one hour to 5 hours. Lupton (1995) found that private family time was 2 hours and 15 minutes at longest, ranging down to 15 minutes.

**Presentation of Plan:** The average time for presentation of the plan for review and ratification by the professionals took on average one hour and fifteen minutes, compared to 50 minutes in the ERHA project. However, this average figure does not illustrate the major differences in this sub-stage. In the case of the conferences with the fifteen minutes private family time, the plan presentation stage took three hours. In another case, the presentation of the plan took 45 minutes, while the family needed thirty minutes to devise their plan.
Duration of FGC: The entire conference process in the pilot took an average three and three-quarter hours, compared to two and a half hours in the ERHA.

Referral to Completion: The total number of hours the co-ordinator worked in facilitating the conference between the referral stage and the completion averaged 49 hours. The inner and outer times ranged between 42 and 53 hours. The average of 49 hours compares to 33 hours in the ERHA project. In the Essex study, the time commitment of the co-ordinators in preparation for and holding of the conference was 29 hours, with the limits being between 12 and 48 hours. The Lupton study (1995) average was 23 hours, with variation from 8 to 51 hours.

Geographical location, cases involving large numbers of invitees and complex family situations contribute to the variation in time scales. The extent to which the time commitment involved was connected with the high-risk, child protection cases involved is discussed further in Chapter five. The level of time commitment has serious implications for the resource requirements for FGCs, when they are implemented on a broader level.

It should also be noted that considerable effort in terms of project manager’s and co-ordinator’s time were used on the referrals which did not end with conferences.

Time Conference was Held: All of the FGC’s were held on a weekday, with two of the conferences during office hours. In the other case, the FGC was held in the evening to accommodate working members of the family network. Seventy percent of the NWHB FGCs were held during the week, with 43% occurring in the evening. Thirty percent were held at the weekend with one third during the day and a further one third in the evening. The high level of employment in Ireland indicates that evening meetings will continue to be desired, especially if wider family membership is to be attracted to the conferences. From the agency perspective, evening and weekend meetings have major implications for the agency’s work practice agreements. A balance will need to be worked out with staff if FGCs are to be held at a time convenient for some families.

Venue: In one case, the location chosen for the FGC was a community centre, as it was deemed to be a neutral venue for all participants:

The fact that it was on neutral ground was of benefit to both families as it meant no advantage to either side

It also facilitated the practicalities of a sizeable group meeting. In the other two cases, the family members chose a health board premises. No conference was held in the families’ own home, which was also the case in the Essex and Lupton study findings. In the ERHA, one conference was held in the family’s own home. The availability of suitable venues is a real issue in a rural context. Privacy, availability of venues in general, and suitable space are the main issues. As one family member said

‘Where else would we go?’

Another non-family attendee at a conference said when asked about the venue chosen

‘I was very comfortable because it was an environment I was used to. However, although it was a Health Board premise, the family also appeared comfortable with it. There were plenty of empty rooms available and I would recommend access to at least 2 rooms for any future conference.’
A family member who attended this conference has a slightly different view when they said

‘it was all right but for the child’s sake, I would have preferred the hotel.’

In another case the response from another information-giver to the use of a community resource in a rural area was

‘The venue was very poor, inadequate. It was small, cramped, lacked confidentiality

Local community hall........ it would not have worked if more family had attended.’

One family member at the same conference saw it differently, and described the venue

‘......as a grand place’.

3.4.3 Presenting the Plan

Reaction to Plan: In all three cases, the plan as presented was accepted by the health board. However, it is important to stress that in two of the three cases, significant details of the plan were worked out when the family members and the professionals were sitting down together after the private family time. In both these instances, the co-ordinator played a key role in facilitating the end result.

Review Date: The place of the review emerged as significant issue in this pilot project. The main issue centres on the place of the FGC and the review alongside other decision-making forums. This issue is elaborated further in Chapter five.

Monitoring Of Plan: There was explicit reference to the monitoring of plans in all of cases, and this was seen to be the remit of the designated social worker.

PART 2 - FAMILY’S VIEWS ON THE FGCs

3.5 Introduction to Qualitative Research

In Part 2 of this chapter and in Chapter four the views of the participants are presented, drawing on both qualitative and quantitative data. Those included were fourteen family members (n = 14), eleven information givers (n = 11), the co-ordinators (n = 2) and the management committee (n = 12) and project manager (n = 1).

There are two aspects in which the views and feelings of the participants are ascertained. Firstly, the four stages of the FGC process are examined in relation to their specific conference, i.e. Referral stage, Information-Giving Stage, Private Family Time and Presenting the Plan. Secondly, a more general overview of the process is obtained by reflecting broadly on the model.

3.6 Family views on the Four Stages of the Conference

3.6.1 Before the Conference - The Referral and Preparation Stage
A number of key issues, pertinent to the referral stage, are discussed here. These address the following questions:

- Was the information clear?
- Did they feel adequately prepared?
- Did they know what would be achieved?
- Was there any conflict regarding attendance?
- Were those people considered to be helpful contacted and facilitated to attend?
- Did the family have different views regarding who should attend? and
- Did they consider the right professionals were in attendance?

TABLE 3.2
Summary Table of Family Members Perspective on Level of Preparation prior to FGC (n = 14)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>In parts</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was information clear prior to conference</td>
<td>78% (11)</td>
<td>22% (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you adequately prepared</td>
<td>35% (5)</td>
<td>35% (5)</td>
<td>21% (3)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Any conflict re attendance</td>
<td>28% (4)</td>
<td>36% (5)</td>
<td>22% (3)</td>
<td>14% (2)</td>
</tr>
<tr>
<td>Were helpful people facilitated to attend</td>
<td>72% (10)</td>
<td>21% (3)</td>
<td>7% (1)</td>
<td></td>
</tr>
<tr>
<td>Were the right Professionals invited</td>
<td>86% (12)</td>
<td></td>
<td>14% (2)</td>
<td></td>
</tr>
</tbody>
</table>

Clarity of information: The referring worker outlined the concern of the agency in writing to the project manager in the referral. This concern formed the basis for the holding of the FGC. The ‘why’ of the concern determined the scope and brief of the FGC for the participants. The co-ordinator was generally the first person in contact with prospective attendees (except birth parents, who would have already given permission to the agency to proceed with an FGC). At this juncture, the process and reason for peoples’ participation being requested was explained. The great majority of families (78%) responded positively saying there was clarity of information from the co-ordinators, describing both the process and the purpose of the FGC, while the remainder (22%) expressed some uncertainty. The NWHB study reported a higher (91.7%) level of satisfaction with the clarity of information received prior to the conference, with the reminder feeling that the information was clear only in parts.

Many of the families’ fears were resolved when the co-ordinators explained the concepts that lay behind the process and the steps that would occur at the various stages of the meeting. One family member said that initially:

‘I had no understanding of FGC.... initially I thought it was a family court’.

When the family members were asked about what other information would have been helpful at the initial stage, one birth parent said she would have liked:
'More information on the reports that were going to be given by the professionals. At least then I would have known what to expect from all of them and not to be worried about them.

Overall, the brochures used to introduce conferencing were viewed as being particularly helpful and easy to read.

What would be achieved
In reviewing the family’s understanding of the reason for the conference, the family members showed a good understanding of why such a meeting was needed. It also showed they were conversant with what the health board was saying about what would need to change in the family to put a safer living situation in place for the children. It is necessary to bear in mind that the understanding captured in the evaluation evolved over the course of the FGC process itself, rather than being present so clearly at the beginning. However when the family were asked about what would be achieved at the outset, some family members wanted to know more about the extent of the neglect and abuse inflicted on the children. Others wanted to use the conference to make more definite decisions, like making a more permanent care plan, or getting the parents to change their ways. There was limited evidence of caution or suspicion as to why the agency was now inviting participants in, as was evident in the ERHA project.

However, in one case there was a total lack of understanding among the family members as to why such a meeting was being arranged. This person’s view represents the frustration that family members experienced when they perceived that they already had given as much as they could.

There was a complete lack of understanding about the conference and everyone was a little frustrated when the exact mission of the conference was revealed. My own view is that unless the problematic person is helped, it is very hard to expect the family to continue picking up the pieces considering we’ve done it for years.

This comment also reflects a view that if the agency is too prescriptive about what the FGC can achieve, such problems may emerge.

A key component, which contributed to the success of this initial preparation stage, was the personal visit by the co-ordinator to those invited to attend. This was a finding which emerged also in the ERHA project. Interestingly the co-ordinators views of this stage is somewhat different. Their experience was that this stage represented major work for them in respect of clarifying and reclarifying the reasons for the conference, the agency concerns, who was to be involved etc.

Overall Adequacy of Preparation: There was a difference between the family members knowing the reason for the FGC and what they hoped would be achieved, and the extent to which the family felt prepared for the totality of the experience. Only a portion (35%) of family members felt they were adequately prepared in all aspects of the FGC in advance of the conference, while 52% felt some gaps remained for them. Three people felt they were not adequately prepared at all. This overall adequacy of preparation was less in the MWHB, compared to the ERHA project where 74% (n=14) reported that they were very well prepared. Nonetheless, when the family were asked what worked for them in the preparation stage they said:
the on going talks with the co-ordinator……..the continuous explanations
……..the previous notice which .....gave time to organise domestic
arrangements

These factors all contributed to the overall preparation at this stage.

Conflict re attendance: There was conflict regarding who was to attend in the preparation stage in the four conferences. The main cause of conflict hinged on exclusions. In one instance the birth mother refused to attend if members of the paternal side were to attend. Unfortunately, in this case, the birth mother herself had a very small family and social network and therefore the possibilities for the child were diminished. In another situation the difficulties centred more on the family’s suspicions of the process and the fear that this meeting, regardless of all the re-assurances, would be unable to deliver in the way that was being promised. It is of note that in this instance that a parental alcohol problem was central to the protection issues for the child, and the family members generally felt let down by the statutory services interventions in their lives.

When family members were asked in detail about the reasons for conflict, it was seen to be associated more with past difficulties in the family as indicated in this quote:

I would prefer not to mention names but the conflict (about attendance) was not a direct result of the conference, it goes back to other family problems.

Helpful attendees: family Despite the views expressed above about family attendance, eleven family members (72%) felt all appropriate people were contacted and three people felt that, in part at least, the right ones were facilitated to attend. One person had no view. When family members were asked if, on reflection, they had a different view regarding who should have attended, no other people were identified.

Right Professionals: The vast majority of family members said that the right professionals were invited, and two people said they did not know. This was also the finding in the NWHB study where 88.3% of respondents felt that the right professionals were invited to the meeting. When this subject was explored further an interesting observation about feeling overwhelmed by professionals emerged:

I didn’t think there should be all these professionals present as it felt very uncomfortable at times with everyone staring at us.

Others indicated that they would have liked different professionals to attend, such as the local doctor.

3.6.2 The Information-Giving Stage

In Table 3.3 the question of adequacy of information provided to participants, the opportunity for family to speak, the extent to which the family members had their questions answered and their level of comfort during this time is presented.
TABLE 3.3
Summary of Participants Experience at the Information-Giving Stage

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Some</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate information to make a decision</td>
<td>36% (5)</td>
<td>50% (7)</td>
<td>7% (1)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Chance to speak if you wished</td>
<td>93% (13)</td>
<td></td>
<td></td>
<td>7% (1)</td>
</tr>
<tr>
<td>Answered your questions</td>
<td>36% (5)</td>
<td>36% (5)</td>
<td>7% (1)</td>
<td>21% (3)</td>
</tr>
<tr>
<td>Felt comfortable</td>
<td>36% (5)</td>
<td>14% (2)</td>
<td>36% (5)</td>
<td>14% (2)</td>
</tr>
</tbody>
</table>

(N = 14)

The majority felt the information-giving stage was handled well, with some 36% (5) of family members feeling they got adequate information at this point to enable them make a decision. Half the people (50%) found some gaps in the information shared, and one person felt they did not get adequate information at all. Up to 50% indicated that they felt uncomfortable at the meeting to some degree. All said, however, they were given a chance to talk if they wanted, and they also felt listened to by all. For over half the family members, they felt there were some inadequacies in the answers given by the professionals to their questions. In many of these instances, the nature of the cases and the stage they were at in the child protection process accounted for this. The challenge remains to develop a context to enable these unasked questions to be asked.

Many of the reasons people stated they were satisfied with the information given is reflected in the following view:

‘the openness, honesty, and the…. collective concern for the child really showed. The availability of tea, the warm surroundings and the atmosphere really helped.’

This however did not take away from the pain experienced when the enormity of what was happening for the children was illustrated.

On the other hand, hearing the details of what happened made some people uncomfortable, for others it brought back pain from events that happened at an earlier stage of the child protection assessment and investigation. One person noted that she found it hard to listen to what was reported, as she kept thinking that if the parent only stopped drinking, then all would be fine.

For others, the meeting and how the information was shared was such a new experience, the impact was expressed:

‘I was never involved in the likes of that before.’

Interestingly, no comments emerged about the style of reports or language used by the information-givers during either the information-giving stage, or the presentation of the plan. In the ERHA report, family members commented on the ‘big words’ used by the social workers and the sense that participants didn’t understand what the professionals were saying half the time. (O’Brien, 2000 p.46).
A number of people expressed surprise that the information being shared was affirming and positive in many aspects, while also being challenging and revealing. This reflects the importance of the inclusion of a strengths’ perspective to the assessment of protection issues.

Overall the family members indicate that they were pleased with the way in which the information was shared. However, when the processes surrounding the presentation of plan were examined, it became clear that the great majority of family members would have liked more information, especially about resources and options. Issues of information-giving therefore need to be interpreted cautiously. This comment sums up the point:

‘Even though I was well informed I feel that more information into the outcomes and backup options should the plan have failed and what other outcomes were available if problems should arise from the plan.’

The co-ordinator played a pivotal role in setting the tone for the information flow at the conference. The co-ordinator was viewed by family members as someone with whom a bond had been forged through the home visit. The family members spoke by and large of the great help, reassurance and support received from the co-ordinators. One family member only felt they were not facilitated to participate as much as they would have liked.

### 3.6.3 Private Family Time

Table 3.4 presents the family members view of the key processes that occurred during private family time stage of the conference. The processes examined are as follows:

- The extent to which the family had a clear idea of what needed to happen when the professionals left?
- The extent the family felt listened to?
- The extent others felt listened to?
- Any difficulties that may have arisen in the absence of the professionals? and
- The extent available resources were pointed out to the family to facilitate plan?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Quite a bit</th>
<th>A little bit</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was made clear what needed to happened when professionals left</td>
<td>65 % (9)</td>
<td>21% (3)</td>
<td>14% (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extent you felt listened to</td>
<td>65 % (9)</td>
<td>7% (1)</td>
<td>14% (2)</td>
<td>7% (1)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Extent others listened to</td>
<td>65% (9)</td>
<td>28 (4)</td>
<td>7% (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any difficulties emerge in PFT</td>
<td>7% (1)</td>
<td>29% (4)</td>
<td>43% (6)</td>
<td>21% (3)</td>
<td></td>
</tr>
<tr>
<td>Extent it was easier to talk</td>
<td>43% (6)</td>
<td>29% (4)</td>
<td>14% (2)</td>
<td>14% (2)</td>
<td></td>
</tr>
</tbody>
</table>
without Professionals

<table>
<thead>
<tr>
<th>Extent resources were pointed out</th>
<th>43% (6)</th>
<th>36% (5)</th>
<th>21% (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N = 14)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Table 3.4 the summary picture of family members views of private family time are presented. The majority of family members had a clear understanding of what needed to happen when the professionals left the meeting, while three members (21%) were somewhat confused, and two people had no view (14%). Within the private family time, nine people (65%) felt listened to. Four people felt they could have been listened to more. It is not surprising that it was generally the birth parents that had the experience of not being listened to enough.

Generally, the informants indicate that no major difficulties emerged during this part of any of the three conferences. That is not to say there was not some tension. In one instance the father:

‘threatened to leave the FGC. He did not see any point in the FGC. After some talking to he decided to stay.

In another instance, the view was expressed that it was clear that parent and child

..... ‘did not get on with each other. My opinion is that if both were on their own they would have been shouting at each other.’

Families reported that while there was a lot of tension, sometimes between members of the same family, and other times between the child’s paternal and maternal side, a range of conflict resolution skills were drawn on to handle the mounting tensions and differences.

This suggests while the process of FGC was experienced as generally positive by the family, it can be a painful experience for some individuals when discussing a family problem, and yet, families found ways of handling these difficulties.

Professionals Leaving

Discussions in the absence of the professionals were easier for the most part (53%) but a sizeable number (42%) experienced no significant difference due to professionals leaving. In the NWHB study, 29.2% felt it was easier with most people (66.7%) saying that it made no difference. Some people commented on the difference as being attributed to being alone as family:

‘It was different because it was only the two families that were there’

For others they saw it as pragmatic in a different way:

‘I would say that they gave us a job to do to the best of our ability for…..(the child’s) future and safety and to draw up a plan with our own freedom of speech which I thought was very fair in this situation.’

The ease of being alone is also reflected in this experience, when a family member said:

‘I got a chance to say everything I wanted, to bring out into the open....’

The private family time was more difficult for some rather than others, and again the vulnerability of the parents, while still a factor, was lessened after the professionals left. This is reflected in the following comments from two parents:

‘There was less tension and I was not as nervous’...and
Undoubtedly, the experience of family coming together under circumstances where a state agency has a major issue in respect of one of their children is likely to evoke a wide mixture of emotions. When the family were asked about how participating in the FGC impacted on their relationship, eleven people (79%) said there was no impact, two didn’t know and one did not answer.

It is important to note that, despite the challenges and tensions, no family members commented that the process might have been easier if an outsider had to sit in with them. This is different to the ERHA experience where in almost equal measure, family members totally opposed and supported the idea of an outsider staying with them for the private family time. Those opposed saw that it would work against the family making the decision (O’Brien, 2000), while those that supported it thought it would help family work faster through the planning stage and /or would reduce family tensions. 25% of respondents in the NWHB study reported that problems did arise during private family time due to the absence of the professionals and the authors suggest that in such situations the presence of the coordinator may facilitate discussions.

Devising a Plan
When the family were asked about their experience of devising a plan, a number of interesting points emerged. The difficulty of the task of trying to devise a suitable plan was compounded by the lack of more specific knowledge of the actual risk involved in either the child going home or having unsupervised access while still in care, or being safe at home if still living there. The difficulties of the task facing the family members in trying to devise a plan in these circumstances is captured in the following views:

‘I felt like I knew nothing yet had all the information in front of me. I’m not quite sure what more could have been added but something was missing.

I just wanted to know about certain injuries which could not be answered in order to be sure of the safety of ... ‘...the child’.I just wanted to know who to trust in the future.

An issue that emerged for the family, especially for birth parents in one FGC was their need to have some private family time for themselves within the private family time. This was seen as a space possibly to help them compose themselves, reflect on what had been said or simply to sort out where they stood in relation to what was emerging for their child and themselves.

The challenges facing the family in drawing up a plan are many. Two of the main issues are lack of information regarding resources which has potential to hamper, and the lack of certainty as to the risk involved if certain courses were taken. This may, of course, reflect the stage the child protection assessment is at, and what aspect of decision-making is needed at that time, and the part the family can play in that.
3.6.6 Presenting the Plan
Table 3.5 presents the key findings of family member’s experience of the process of presenting the plan. It is examined under the following headings:
- The extent to which the family recollect the plan?
- The degree it was different from what they thought may have been reached?
- If the plan was accepted? and
- If a date for review was set?

### TABLE 3.5

<table>
<thead>
<tr>
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<td>Success in resolving the problems at time</td>
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(N = 14)

3.6.5 Reflections on the plan and outcomes
It is important to note that examination of the outcome of the plan after a lapse of time was not possible, given the time constraints of the pilot project and the need to have FGC’s up to a month before the pilot ended. A number of interesting views emerged when the family members were asked to reflect on the plans made and their view of the outcomes.

Only three people (21%) were very happy with the plan while seven people (49%) felt that it contributed positively to the situation the families faced. One third were not happy, or did not have a view. As time went on, it appears that the number of people who were happy with the plans diminished. Questions were raised about additional help needed after drawing up of the plan, by way of examining the impact of plan. Three family members (21%) said additional help was required outside the plan.

However, the majority (79%) did not know if the plan required subsequent help. It is necessary to look behind the small quantitative data presented to understand what may be behind the figures for discontentment with the plan. Some family members commented on how the changed care arrangements since the FGC were much better for the child, and commented that she was visibly happier. For others, they felt that the plan had a negative effect on them personally. This was especially the view for birth parents and carers, who either lost that status as a result of events following the FGC or had their access cut as a result of the family plan. It is very evident that when
the plans are examined the dynamic and complex nature of the processes following the FGC impact on the outcome of the plan, and how it is perceived.

3.6.6 Families overall impression of the FGC
The family members were asked for general comments about the FGC process, and what surprised them most about it. The following comments give a flavour of the answers to these questions. For some the newness was evident:

*The whole process was a surprise really, as it is not like anything I’ve ever experienced*

For the parents it was particularly difficult, as would be understood when cases are involved in the child protection system:

*People (family members) were saying things that were hurtful and they were very selfish in parts. Everything was to suit them and they made most of the decisions for us.*

Overall people welcomed the opportunity for a number of reasons:

*The FGC has answered a lot of unanswered questions on the safety of the child. ....*  
*The FGC has provided the foundation for a happy environment’*  
*‘Very well organised, easy people to speak to and the freedom of speech, privacy, no aggressive behaviour’*  
*‘It’s good because it brings all family members together to sort out any differences that they may have’.*  
*‘The FGC helps to bring everything out into the open.’*  
*‘I feel that all professionals involved did what they could to help’.*  

Lastly, but of central importance is the way the family saw the FGC impacting on the children who were present at the conference. The children present ranged in ages from 3 months to ten years (4 children). The family members who attended the FGC for the small baby felt that her presence kept them extremely focused, though it was difficult for the parents. They were afraid of having to handle her if she needed attention, as they did not want to be in the limelight. For the older child, one family member’s view was:

*The child was there and she wasn’t there if you know what I mean. She played ...In the other room to take the pressure off her.*

When the impact of the meeting was explored, some felt that it lifted a weight off the child. In this instance she was to remain in her extended family. Another family
member thought it frightened her but when this was further explored it appeared that the trauma of what had been happening to the child was much more the issue. Yet another family member said they did not know what the impact was as she felt:

It is hard to know what they are actually thinking

3.7 Conclusion

This chapter was divided into two parts. In part one the profile of the families referred to the conference, attendance of participants and duration of FGC from referral to completion was presented. In part two, the family views were presented. This part predominantly sought to address the extent to which family members participate in and have a sense of ownership of the FGC process.

Many of the findings were similar to the findings which emerged in the ERHA project (O’Brien, 2000 p79-82) in Ireland and which are also features of international pilot studies Lupton et al, 1995; Lupton & Stevens, 1997; Crow and Marsh, 1996 and Smith & Hennessy, 1998.

- The overall finding was the family members did participate in meetings organised to address concerns relating to the children in their networks. There was overwhelming appreciation for the co-ordinators preparatory work, how they imparted the information and their general demeanour.
- The family members participated from both maternal and paternal sides.
- The family members who participated averaged five per conference (excluding children), and a large majority of those who were invited to attend did so.
- Family members described the home visit from the co-ordinator as extremely positive, and this visit helped to set the scene for the meeting. The social workers in many of the cases also played a key role in encouraging the birth parents of the children to allow the meeting go ahead.
- Family members expressed the opinion that their views were heard and respected. Some family members who had no experience of prior meetings felt it was good and those that had prior contact with professional networks felt the process was better than their previous experience.
- When the private stage and presenting of the plan was examined it emerged that the family had limited knowledge of the resources available to them. This has implications for participation, as if family members are not given adequate information to address the concerns, then the extent to which participation can be achieved is affected.
MID-WESTERN HEALTH BOARD

FAMILY GROUP CONFERENCE PILOT PROJECT

EVALUATION REPORT

May 2002

Dr Valerie O’Brien,
Dept of Social Policy and Social Work,
University College Dublin
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ACKNOWLEDGEMENTS

The author wishes to acknowledge with sincere gratitude the people who contributed to this study. The pilot project could not have happened without the participation and co-operation of a great number of individuals and organisations, and the evaluation report could not have been undertaken without the assistance of family members, information-givers and the co-ordinators involved in the pilot conferences. They have given generously of their time and direct experience, for which I am very grateful.

Among the individuals who have assisted the author on this project are:

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Last but not least, to my sons Edward and Peter and partner Sean for all their support and for putting up with an absent mother and wife as the deadlines drew close.
# LIST OF ABBREVIATIONS & COMMON TERMS USED

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>MWHB</td>
<td>Mid-Western Health Board</td>
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<tr>
<td>ERHA</td>
<td>East Region Health Authority</td>
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<tr>
<td>NWHB</td>
<td>North-Western Health Board</td>
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<td>HB</td>
<td>Health Board</td>
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<td>FGC</td>
<td>Family Group Conference</td>
</tr>
<tr>
<td>FWC</td>
<td>Family Welfare Conference</td>
</tr>
<tr>
<td>Teams</td>
<td>Teams refer to the social work team within the community care structure in the health board,</td>
</tr>
<tr>
<td>Community Care</td>
<td>Community Care refers to the structure within the health board set up to deliver community-based social and health services. The Pilot Project was conducted in the geographical area of the North Tipperary part of the North Tipperary/East Limerick Community Care Area.</td>
</tr>
<tr>
<td>Social Work Staff Structure</td>
<td>There are three grades of social worker in social work teams in community care areas. The first grade refers to a basic social worker, the second grade is a team leader and the senior grade within the structure is the social work manager, who has overall responsibility for the service delivery and who is part of the management structure within each community care structure. The team leader has responsibility for providing support and supervision and running the social work team on a day-to-day basis.</td>
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<tr>
<td>Social Worker</td>
<td></td>
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<tr>
<td>Team leader</td>
<td></td>
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<tr>
<td>Social Work Manager</td>
<td>The Department in each Community Care area that oversees all local aspects in relation to child welfare and child protection.</td>
</tr>
<tr>
<td>Child Care Department</td>
<td>In this project was the designated Service Manager to receive and negotiate all referrals to the service</td>
</tr>
<tr>
<td>Project Manager</td>
<td>The Co-ordinator is the person who convenes and coordinates the FGC. The Coordinator’s job commences with the allocation of the referral and continues through the preparatory stage to the holding of the FWC and distribution of the plan.</td>
</tr>
<tr>
<td>Co-ordinator</td>
<td>O’Malley Park, Family Resource Centre is a community organisation, which provides a community based service to families. O’Malley Park, Family Resource Centre provided the coordination service for the F.G.C. pilot project.</td>
</tr>
<tr>
<td>O’Malley Park, Family Resource Centre</td>
<td>These two terms are used interchangeably in the report and refers to the people involved in the FGC process, other than the family members and the co-ordinator. They comprise a group of people, employed in a range of statutory, voluntary and private agencies that are involved in providing services to the families who have agreed to participate in the family group conference process.</td>
</tr>
<tr>
<td>Information-Givers/Professionals</td>
<td>Family member and family members are terms used to refer broadly to people from the child’s family or social network who are involved in the FGC process.</td>
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<td>Family Member/Family Members</td>
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CHAPTER ONE

Part 1 - INTRODUCTION TO FAMILY GROUP CONFERENCES

Part 2 - THE MWHB PILOT PROJECT

Part 1 - INTRODUCTION to FAMILY GROUP CONFERENCES

1.1 Introduction to Report

Family Group Conferencing originated first in New Zealand, as part of the Children and Young Person Act, 1989. The model legislated for in New Zealand has been adopted in a number of countries including Australia, the United Kingdom, Canada, Sweden, France and here in Ireland. The principles and the processes involved were clearly demarcated in the New Zealand legislation. Few countries have included in their own legislation the detail surrounding conferencing laid down in the New Zealand legislation.

The underlying philosophy of partnership, interest in developing "strengths focused" models of work, an increased use of relative placements for children who cannot be looked after by their own birth parents are important context markers in the development of current practice. The benefits of Family Group Conferences have been evaluated internationally and the results have been both positive and encouraging. Family Group Conferencing has a potentially critical contribution to make to the development and delivery of childcare, child protection and child welfare systems. It represents a major new approach for dealing with family crises, as it recognises the crucial significance of the family in relation to securing positive outcomes for children. Family strengths, knowledge and resources are utilised to make decisions, both to protect the child and maximise opportunities for ongoing family commitment and involvement in the life of the child.

The benefits of Family Group Conferences have been evaluated in small-scale Irish studies in the ERHA (2000); NWHB (2002) and many of the benefits seen internationally were also found here.

1.2 Purpose of Report

This report has been commissioned to appraise and draw together the main findings of a small Pilot Project on Family Group Conferences (FGCs) aimed at examining the specific fit between family group conferencing and child protection. This is an aspect that had not been previously pilot-tested specifically in Ireland. The pilot project was conducted in the North Tipperary Community Care Area of the Mid-Western Health Board (MWHB) over the period September 2001 to February 2002. (For demographic profile of North Tipperary and description of the child protection system, see Appendix 1.)

The report first describes the FGC process and the pilot project. It provides details of the Conferences held as part of the Pilot Project, as well as the views of the multiple participants involved. The report analyses and presents findings and recommendations
in respect of the main research questions regarding the potential fit between family group conferences and child protection.

The report also presents at Appendix 2 and 3 revised and updated versions of ‘Good Practice Guidelines’, which were developed and used in the pilot project, and which takes account of the views of participants and the main findings and recommendations. These guidelines are proposed for use where agencies are intended to implement family group conferences as part of general child welfare services. They also are relevant for ‘family welfare conference’ developments envisaged under the Children Act, 2001.

1.3 The Basis for Family Group Conferencing

Differences in child welfare systems, legislation, service delivery, cultural and political systems will frame the basis for family group conferencing in different countries. Doolan (2001) discusses how FGC can be seen as operating from a number of different bases. The three bases which he categorises are

1. Legislative,
2. Procedural, and

The interest in this new approach has resulted in conferencing being implemented in Ireland as part of the criminal justice and child welfare systems, under statutory requirements laid down in the Children Act, 2001 and as part of a policy direction laid down under ‘Children First’, (Department of Health 1999). To date, however, the implementation of FGC practice in the pilot projects has operated primarily from a ‘best practice’ model. All pilot projects to date, including this one have operated without specific legislative or procedural mandates. There is now reference to the possibilities that FGC may offer in the ‘Children First’ (Department of Health 1999). Likewise, there is provision for conferencing in the Children Act, 2001 which will introduce a legislative basis for conferencing in certain prescribed circumstances, when the relevant sections of the Act are enabled. At the time of this study, the relevant sections of the Children Act, 2001 which places statutory responsibility on various agencies, had not been brought into operation.

The latter legislation uses a number or terms where it refers to conferencing. The use of different terms for what is in essence the same approach appears to be an attempt to distinguish responsibility for convening the conference for young people at different stages of their care and/or criminal careers. ‘Family Welfare Conferencing’ is the term given to the conference that the Health board has statutory responsibility to convene under both Section 7 and 77 of the Children Act, 2001. This is one of three types of conference referred to in the Act. The other types are ‘Conferencing’, which the Juvenile Liaison Officer service has responsibility to provide (Sections 29 to 43), and the ‘family conference’, which the probation service have responsibility to convene on referral from the courts (Sections 78 to 87). The use of three separate labels for conferences is viewed as potentially confusing, and a weakness in the legislative framework. There are no major differences in the principles on which all versions of conferencing are based, or in the actual process of convening the various categories of conferences. Further discussion of the similarities and differences of these types is presented in Appendix 4.
There is similar potential for confusion in the terminology regarding FGCs used in ‘Children First’. This document suggests that

“a family support meeting is a useful venue for drawing up a plan and for consolidating any informal undertakings made. The family would attend this meeting, any other members of the neighbourhood/community networks, and any professionals involved in delivering a service or offering support. The family should be assisted to set the agenda for this meeting. Tasks, including the person(s) responsible for carrying them out, can be identified and an outline plan agreed and recorded. A family group conference model may also be a useful mechanism for drawing up a family support plan” (Children First, 1999, pg 62).

The principles underpinning conferencing and the process by which they are to be organised are not stated in detail in the legislation or in Children First. This provides Health Boards, and other services, with the flexibility and opportunity to introduce conferencing by incorporating the best practice lessons learned from other jurisdictions and the three pilot projects here in Ireland. In support of this opportunity, the Children First document cautions that “areas adopting this model must ensure that adequate resources, preparation and training are in place, and that established protocols are observed at all times”.

While the distinctions between family welfare conference, family conference and conference are important, in order to minimise confusion, the term ‘Family Group Conference’ is the name used to describe the type of conference piloted in this study. It is intended that this pilot will go some distance in helping to develop the fit between child protection systems and conferencing.

1.4 Legislative Basis in Ireland

While the purpose of this report is to present the findings regarding the potential fit of family group conferencing in the child protection system, it is important to set out the future legislative responsibilities for health boards in respect of conferencing. Notwithstanding the differences in naming family group conference, family welfare conferences, family conferences and conferences, the legislative requirements placed on health boards when Children Act, 2001 is implemented are set out below.

The Children Act, 2001 sees the Family Welfare Conference as a mechanism for early intervention at an inter-agency level for children at risk. The family welfare conference can be triggered in two ways:

(7) **On a direction from the court**

Section 77 where a court considers a child (aged 12-18), before it on a criminal charge, may be in need of care or protection

Referral of case to Health Board:

- The court may adjourn proceedings where a child charged with an offence (because it considers that it may be appropriate for a care or supervision order to
be made under the Child Care Act, 1991) and direct the Health Board (Section 77 (1) (a)) to convene a Family Welfare Conference (FWC) in respect of the child.

- Having held an FWC, the Health Board may apply to the Court for a care order, a supervision order or a special care order (Section 77 (2) (a)). If the Board decides not to apply for any such order in respect of the child, it shall inform the court (Section 77 (2) (b)) of
  - (i) its reasons for so deciding;
  - (viii) any service or assistance which it has provided or intends to provide for the child and his/her family, and
  - (ix) any action it has taken or intends to take in respect of the child.
- A Health Board is of the view that a child requires special care and protection, which he/she is unlikely to receive unless a special care order is made (Section 23 (a))

(8) **On the Health Board’s own initiative**, Where it appears to a health Board that a child (of any age) who resides or is found in its area may require special care or protection which the child is unlikely to receive unless a court makes an order in respect of him or her …(Section 7(1) (b)) the health board shall appoint a person to convene on its behalf a family welfare conference in respect of the child.

Before applying for a special care order under the amended Act of 1991 Part IV A (Section 23A(2)(a)) the health board shall
Arrange for the convening of a family welfare conference (within the meaning of the Children Act, 2001) in respect of the child.

Nobody other than the court can order the health board to hold a family welfare conference. However, a ‘parent may request a health board to apply for a special care order in respect of his or her child’ (Section 23A (3)). If this request is acceded to, then the health board will be obligated to hold a family welfare conference as part of this process. If the ‘Health Board decides not to do so, it shall inform the parent in writing of the reasons for its decision (Section 23A (3))

(3) **Health Board involvement in other types of conferences stipulated by Children Act, 2001**
The only other involvement stipulated for health board is under Section 32 (3) which states that the facilitator (Garda liaison officer) shall invite any other persons who in his or her opinion would make a positive contribution to the conference including one or more representatives from any of the following bodies
  - (d) the health board for the area in which the child normally resides.

A number of health boards, while striving to meet their statutory requirements, also want to avail of the benefits of conferencing as a method of intervention for families that require either family support or child protection services.

1.5 **Fit with other Policy Developments**
Family Group Conferencing shares core values with the operational principles guiding the vision and values of The National Children’s Strategy, (Dept of Health and Children, 2000) namely that service actions and interventions should be:

- **Child-Centred**: the best interests of the child shall be a primary consideration and children’s wishes and feelings should be given due regard.
- **Family-Focused**: the family generally affords the best environment for raising children and external intervention should be to support and empower families within the community.
- **Equitable**: children should have equality of opportunity in relation to access to and participation in the services delivered and have the necessary levels of quality support to achieve this.
- **Inclusive**: the diversity of children’s experiences, cultures and lifestyles must be recognised and given expression.
- **Action Orientated**: service delivery needs to be clearly focused on achieving specified results to agreed standards in a targeted and cost effective manner.
- **Integrated**: measures should be taken in partnership with and between relevant players, i.e. the state, the voluntary/community sector and families.

The FGC is seen to fit with the current requirement to consider the “best interests of the child” as emphasised in the Child Care Act, 1991. FGCs are seen as:

- Safeguarding children and promoting their welfare;
- Taking account of parental responsibility;
- Taking account of race, culture, class, language, religion and disability;
- Working in partnership:
- Supporting children’s contact with their family;
- Providing services to children in need;
- Reuniting children with their families wherever possible (O’Brien 1999)

### 1.6 The Principles Underpinning Family Group Conferences

The following are the general principles underpinning the operation of FGCs:

- The **child’s interests** are paramount, and FGC is the primary decision-making forum for the child;
- Children are **best looked after** within their own family, and **family** is defined **widely**;
- Working in **partnership** is beneficial to children;
- **Independent co-ordinator** facilitates the involvement of the family, agency and professionals in the process.
- Family are given time to **plan in private**.
- **Plan is accepted** and resourced by agency and professionals unless it places child at further risk.

### 1.7 Operation of the Family Group Conference

There are a number of defined stages to the family group conference process, the first being the preparatory stage before the FGC, and three stages within the actual conference itself. These stages are described briefly as comprised of
(1) The information-giving stage in which information pertaining to the agency concerns regarding the child is shared with the family;
(2) Private family time in which the family deliberate about the concerns and construct a plan to respond to the concerns regarding the child highlighted in the information giving stage; and
(3) The final stage is where the plan is presented to the professionals. This plan is accepted unless it places the child at further risk. A review system and monitoring structures to address the concerns and to support the plan is addressed at this point.

Fuller detail of the various stages is provided in Appendix 5.

PART 2 - THE MWHB PILOT PROJECT

1.8 Introduction to MWHB Pilot Project

1.8.1 Impetus for the Pilot Project

The impetus and key direction of the MWHB Pilot Project stemmed from a finding and recommendation in a previous FGC Pilot Project. The difficulty in giving an accurate portrayal of the fit between the FGC model and child protection protocols was a major finding in ERHA pilot project (O’Brien 2000). The high level of both internal and external change that was occurring in the system at the time was identified as a factor in this finding. The research showed that, in a number of cases, the referrals received in that project clearly fell into a child protection category. The cases were considered as being on the lower scale of risks, rather than involving severe child protection issues. A key recommendation of the report was:

‘While this evaluation report draws clear conclusions about the place and applicability of the FGC in practice, a more extensive study of its potential to meet statutory requirements, and the adoption of a defined FGC method as a standard protocol for given circumstances is urgently needed. This project can make a significant contribution to a co-ordinated and coherent future policy direction’ (O’Brien 2000 p. 75)

In looking to develop its childcare services, the MWHB also noted the potential of the FGC in the child protection sphere, and decided to commission a project specifically to examine and develop this issue.

1.8.2 Purpose and Goal of the Pilot Project

The purpose of the Pilot Project therefore was to examine the applicability of the Family Group Conference as a means of improving the management of child protection concerns.

The project goals were to establish, by 28th March 2002, if the use of Family Group Conferences with selected families can

- Strengthen families’ capacities to respond to and be involved in the resolution of child protection concerns;
- Satisfy statutory and/or professional concerns about the young people and children involved;
Assist with preparing the Board to meet its statutory responsibilities to provide a conferencing service under the provision of the Children Act, 2001.

1.8.3 Phasing of the Pilot Project
It was agreed that the pilot project would comprise the following key aspects:

xix. Appoint Project Manager and Management Committee
xx. Recruit and train two FGC co-ordinators from an independent agency;
xxi. Design referral and case management guidelines for MWHB staff;
xxii. Do preparatory training for staff to be involved;
xxiii. Hold six Family Group Conferences by March, 2002;
xxiv. Evaluation Report on the extent to which FGCs could be successfully used during the course of the pilot.

1.9 Terms of Reference for Evaluation
The terms of reference for the evaluation of the project were developed between the Project Management Committee, the Project Manager and the Project Consultant.

These were as follows:

- To evaluate the six Family Group Conferences scheduled for completion by March 2002;
- To explore and establish the level of family participation and sense of ownership of the FGC process;
- To test how the FGC fits alongside current professional processes of investigation, assessment, case conferencing, and review the experience from the perspective of the various stakeholders;
- To consider the implications of extending conferencing service to the management of family support and child protection cases on a regional basis

1.10 Evaluation Methodology

1.10.1 Philosophy underpinning Evaluation
The purpose and aim of this project lent itself to a research methodology based on action research, similar to previous pilot study (O’Brien, 2000). Action research seeks to capture the processes, as they are evolving, and aims to use findings to point and direct the project in ways that are both relevant and appropriate. Action based research emphasises local descriptions in so far as it takes account of the processes evolving in a particular context.

In this evaluation a mixture of both qualitative and quantitative research is used, but qualitative research, with its emphasis on local knowledge, interpretation, and importance of multiple perspectives, is more relevant to address the aims of the evaluation brief above.

A further distinction that needs to be made in regard to research design is the difference between formative and summative evaluation. Formative evaluation is designed to help programme managers, practitioners and planners improve design of a
programme in the developmental phase. Summative evaluation is designed to provide information at the end of a programme about whether it should be continued, dismantled or drastically overhauled. While the terms of reference for this research involves both, this distinction between formative and summative evaluation brings clarity to demands upon the evaluation. Both process and outcome data can be helpful for formative evaluation purposes.

The focus on action-based research, drawing on a predominantly formative evaluation model which embraces a combination of quantitative and qualitative methodology, fits with the role of the evaluation as part of the process rather than a methodology that seeks to take an observer position where the processes and actors were objectified.

1.10.2 Ethical Issues
Evaluators are obliged to conduct the evaluation with the highest possible attention to ethics. Ethical issues during planning must be honest and respectful to those who co-operate in providing information. Written consent was obtained from each person involved, and guarantees given that identifying information would not be published as part of the report.

All family members and information-givers were told at the outset of the project that research was an integral part of the project, and their co-operation was sought on this basis. Inclusion in the pilot project was not, however, dependent on the participants agreeing to co-operate. All interview schedules were posted from the project manager’s office to family members and information-givers following the conference. Family members were offered assistance by the project manager’s office in filling up the schedule if they so chose. This offer was accepted by a number of family members. Written questionnaires were designed and circulated to all management committee members, the project manager and the child care manager.

1.10.3 Data Collection Methods and Tools
A data spread across participants was acquired, reflecting the importance of the different perspectives. The research instruments, which were developed as part of ERHA project (O’Brien 2000), were used where applicable. These instruments were built on previous FGC evaluations (Smith & Hennessy, 1999; Lupton et al, 1998; Crow & Marsh (1996). There is particular value in adapting previously developed research tools as it allowed for a degree of validity and reliability, and allows for the possibility for comparative views to be taken. It also reduces the time that would be involved if the tools had to be developed from scratch.

The methodologies used to collect data ranged through formal and informal interviews, using structured and unstructured questionnaires, and are contained in Appendix 6.

1.10.4 Documentary analysis and Focus Group Discussions
The research methodology also involved document analysis, including minutes of Management Committee meetings, progress reports of the Project Manager, and agency policy statements, as well as the evaluation feedback forms of all staff who received training as part of the project.
Close liaison was maintained with the Project Manager during the course of the project. The evaluator’s membership of the Management Committee enabled practice developments over the course of the project to be informed by data collection and research findings. In this regard the formative evaluation research framework contributed greatly to the project. Finally, ongoing liaison with colleagues in the North/South Forum, other pilots projects and service developments in Ireland and international liaisons augmented the various data methods outlined above and also strengthened the development of the project review.

1.10.5 The Data Sample

Baseline data was obtained on the six referrals received by the project. Summary information is presented in Table 3.1, entitled ‘Profile of Six Cases Referred for an FGC in the MWHB Project’. The data on the three conferences which were completed within the pilot project evaluation time frame is analysed in depth. This includes 13 family members, 14 information givers and two co-ordinators. Additional information was obtained from 12 management committee members. Several of the management committee members were heads of services and key personnel from external agencies, and also included the project manager, and the child care manager (See Appendix 7).

1.10.6 Limitation of the Evaluation

The actual referral rate of cases was slower than anticipated, and therefore the evaluation is based on a smaller number of conferences than originally envisaged. The phenomenon of slowness in referrals to pilot projects is noted in Crow & Marsh, 1996. This means three rather than the six intended conferences were available for evaluation in the pilot project. The small number involved is a major limitation, especially on the quantitative side. However, the numbers did allow for in-depth examination of the cases involved and to that end assisted in examining the primary project objective of the potential for application of the FGC in the child protection system. The short time scale of the project did not allow for outcomes to be examined over time. Instead the project provides a snap shot of how family group conferencing interfaced with cases at a certain point in time.

The failure to interview the three children (all over seven) is a limitation. Circumstances did not permit the interviews. The NWHB pilot study, which included children’s voices, makes a major contribution to the field in this regard.
CHAPTER TWO

LITERATURE REVIEW

2.7 Introduction to Literature Review
In this chapter the relevant aspects of the literature are presented. This is done under a number of headings, giving a summary view of literature findings on the FGC first, and then going on to look at decision-making in child protection under a number of sub-headings including the crucial issue of parental participation. The next part deals with the literature relating to introduction and the use of FGCs in a child protection context. The place and practice of child protection in the host organisation for this pilot project, the MWHB, is then considered. The plans to broaden the child protection framework to include family support in the MWHB are presented. In the final part the impact of the national framework for child protection, Children First is discussed.

2.2 Summary of findings on FGCs
The key messages from research on FGCs are to be found in Lupton’s (2000 p. 36-38) review of the literature. They are as follows:

- the majority of family members, extended as well as close, like the ideal of a family meeting and agree to participate; neutral venues and flexibility of arrangements are particularly appreciated;
- in contrast with traditional child protection meetings, children appear more inclined to attend FGCs and, once there, appear to participate more extensively; children seem particularly to appreciate the family-only part of the meeting;
- the majority from the family network felt well prepared in advance of the FGC and knew what to expect, some arrived without being clear of the ‘terms and conditions’; it is important that written information for children is provided in appropriate language;
- families and professionals see the FGC as more enabling of family participation than traditional ways of working, with the majority of family members indicating that they would use a FGC again, should future problems arise; more evidence is needed however on the extent to which families also experience the FGC process as empowering;
- the role played by professionals within the meeting may require attention, with consideration being given to making the information-giving session more interactive and with written reports being available before the meeting; some thought could be given to the idea of a family ‘pre-meeting’ before the professionals arrive;
- the great majority of family groups produced a plan and most of these plans appear to be agreed ‘in principle’ by the agencies concerned; more detailed information is however required on the extent to which plans are implemented fully as agreed and the reasons why not, if not;
- FGCs appear to mobilise family support, but they may not thereby reduce the demands on agency/ professional resources; in the main plans appear to be realistic in terms of the support requested;
- the early indications are that FGCs may be no less effective than traditional approaches in ensuring the care and protection of children; more extensive evidence however is needed on this vital question.
2.8 Decision-making in Child Protection
2.3.1 Complexity in Decision-Making
The complexity involved in decision-making in the child protection sphere is widely acknowledged in the literature. This is, perhaps, best summed up in the comment by Cleaver and Freeman (1995), when they acknowledge the inherent difficulty in decision-making for professionals in the following terms:

“Decision-making requires the skills of Machiavelli, the wisdom of Solomon, the compassion of Augustine and the hide of a tax-inspector. Making decisions proves to be something of a balancing act for professionals. Taking into account parental perspectives involves surrendering a degree of control to the powerless”.

Larner (et al, 1998) further suggests the decisions that caseworkers have to make would:

“Challenge King Solomon, yet most of them lack Solomon’s wisdom, few enjoy his credibility with the public and none command his resources”

2.3.8 The Place of the Case Conference
The case conference has been the traditional decision-making forum in child protection issues. Hayes (2000) (See Section 2.5 for details of this study) views the case conference as only one phase of child protection work, with often more difficult and challenging phases of intervention and investigation preceding the case conference. Ferguson (2000) (See Section 2.6 for details of Ferguson’s work in the MWHB) suggests the need for clear criteria for calling case conferences. Ferguson’s research found the following:

- A significant number of high-risk substantiated cases that could, or perhaps should, have reached a case conference did not do so. A full 67% of substantiated high-risk referrals did not have a conference. (Ferguson, 2000 Pg 151)
- A key finding is the relatively minor role played by case conferences in managing new cases and referrals, being largely concerned with cases with a history of health board involvement. (Ferguson, 2000 Pg 167)
- The criteria should include specifying who is responsible for calling case conferences, the role of the C.P.N system in this and the relationship between decision-making and planning at C.P.N meetings and case conferences. (Ferguson, 2000 Pg 149)

2.3.9 Parental & Children’s Participation in Case Conferences
Hayes (2000) writes about degrees of partnership operating along a continuum of power relationships. He sees partnership as including:

- ‘participation’ in key decision-making meetings,
- ‘involvement’ in identifying problems and goals and objectives for work,
- ‘consultation’ before decisions are made or actions taken, and
- ‘keeping fully informed’ about services, powers and duties of social services, likely action, rights, etc.)

Philips and Evans (1986) warn that partnership should not be seen as mere attendance but rather: “…Understand the process which they are going through and both they
and the professionals feel that they have made a useful contribution to the plan of action” (Philips and Evans, 1986 Pg 12).
FIGURE 2.1 - DECISION MAKING FORUMS FOR CHILD PROTECTION PLANNING

No Family Participation

Entry onto C.P.N.S. (Internal to H.B)

Liaison –Management Team Meeting (Garda/Social Work)

Strategy Meeting (inter-professional)
At outset to share all available and relevant info.
Convene at any time following preliminary enquiries and submission to C.P.N. Garda involvement essential

Referral

Child Protection Conference (Inter-professional and family involved)
Initial enquiries completed
When decisions of a serious nature are being considered
Facilitate sharing, outline child protection plan and identify tasks
Not all Child Protection cases warrant a C.P. conference
Each community care area develops its own protocol

Family Group Conference
Family involved and inter-professional
Accesses expert family knowledge
Extensive Family Participation

Source, Suggested in Children First, Adapted McClure (2001), Unpublished
While there has been some research into parental participation at case conferences there has been little empirical research into parental participation in other “emergency phases” of the child protection process. Ferguson showed that Irish practices on the inclusion of parents or guardians in case conferences fell far short of what is regarded internationally as best practice. (Ferguson, 2000 Pg 144). In the MWHB parents were invited to attend in just over half of the conferences, with 54% (n = 14) of the parents invited actually attending for part of the conference. In only one case did the parents attend for the whole conference. (Ferguson, 2000 Pg 156)

Ferguson warns that the lack of an invitation to what are perceived as non-cooperative parents may alienate them further and intensify their hostility. He goes on to suggest that the challenge to professionals is in developing a fully inclusive practice to engage with hostile clients at case conferences in a system which operates in a subjective, arbitrary manner which no longer accords to best practice. (Ferguson, 2000 Pg 157).

An evaluation of Children First in 2001 shows an increased level of parental participation at case conferences (HEBE, 2001).

Ferguson’s research identified a need for more information and better listening. Writing of the general Child Protection care system Ferguson found that one of the main criticisms, voiced by many children, was they felt they were denied information. The children in care were especially critical of a lack of information from social workers as to why they were being placed in care. (Ferguson, 2000 Pg 218). In summary, what clearly emerges from the interviews with children is the poor communication and quality of information given to children, especially in relation to plans for children in care. (Ferguson, 2000 Pg 224)

Some practitioners would argue the current child protection structure and meetings cited in Children First militate against children participating to their full capacity.

2.4 Introduction of FGCs into Child Protection Practice

When looking at the introduction of the FGC internationally there is need to examine the context and environment in which the model was introduced. Doolan (2001) identifies three approaches:

10. Legislative - The legislative basis is such that the model is enshrined in law, and there are procedures specified/regulated to ensure that the principles are set out to guide the practice.
11. Procedural - The guiding principles are enshrined in procedural requirements to behave in a certain way.
12. Best Practice - The principles are introduced to staff who are encouraged to carry out their duties and responsibilities within a re-focused practice paradigm. In this approach the professionals act as ‘gatekeepers’.

Doolan sees potential problems with all three approaches. With a legislative mandate, the “philosophical underpinnings of the approach can be underpinned by the legislation” with solicitors possibly advising their clients “not to engage, or their use of other legislation to thwart the intentions of child welfare law”. On the other hand, Doolan sees the procedural approach as running the risk of “instability in the face of changing fads about what is the right thing to do... or colonisation of the concept of empowerment practice by pre-setting the professional agenda”. The development of the ‘Best Practice’ approach relies on enthusiasts trying to make inroads. (Doolan, 2001, pp 5-6).
A number of Public Inquiries into child abuse in the U.K. in the 1970’s and 1980’s led to the development of what has been characterised as a pre-dominantly legalistic and procedural response to child abuse allegations and investigations. These responses have since been criticised as defensive and reactive in nature by Cooper (1994;) and Parton (1997). These legislative and procedural models of practice led to a system which has been criticised for its exclusion of parents and children (Nixon 2000, Thoburn et al, 1995, Ryburn & Atherton, 1996)

With its emphasis not just on parental and children’s participation in decision-making, but the wider family network also, the FGC has been viewed as a valuable antidote to the exclusionary system. In the U.K. the FGC has been introduced as a “good practice” rather than a legal construct, with the “grassroots” level challenging rather than complimenting existing practice. Nixon (1999) saw change being brought forward through winning over people’s “hearts and minds” to this way of working, rather than through legislation or procedural change. This differentiation has critical implications for the implementation and development of FGC/ FWC. Nixon sees the FGC practice being shaped by its “proximate social, organisational and political contexts” (Nixon, 2001 pg 6).

In Ireland, in anticipation of the legislative changes, a number of Pilot Projects were undertaken (ERHA, NWHB and MWHB). FWCs are now included in legislation in limited circumstances, however the MWHB is committed to introducing the FGC/ FWC as a model of best practice on a wider basis.

A key issue of importance in the introduction of FGC is how the model can be incorporated/ accommodated into the current Child Protection system, taking into account policy and procedures. Writing of the U.K. Nixon (2000) describes a system of a “procedural and legal context”. He remains critical of the approach to “fit FGCs within the procedures, time scales and assumptions of the state bureaucracies” which he believes have “relegated FGCs to a secondary planning forum or a ‘rubber-stamp’ for professional ideas. The net effect is that FGC principles and philosophy are watered down to fit into mainstream orthodox practice”(Nixon, 2000 pg 7).

In New Zealand, FGC advocates have been seeking to change the paradigm from child protection, through professional intervention and decision-making, to a paradigm of a family support approach to child protection. (Doolan 2001). Doolan is optimistic “that core statutory social work can deliver on the state requirements that children be protected by embracing the family support paradigm, and through that process, need responsive services identified by families can be provided for them.” He sees the “tension between family support (a needs-based approach) and child protection (a risk-based approach) is eased by an effective partnership mechanism, such as the Family Group Conference”. (Doolan, 2001, Pg 5). This model of practice is no less committed to child protection. Doolan sees the need for different thinking in relation to some aspects of child protection definitions, and on how to manage the process at the post-inquiry and assessment stages. The classic child protection approach is professional deliberation, court involvement and care. The family support approach engages the wider family as the change agent, as participants and as decision-makers through the mechanism of the Family Group Conference.
2.5 Use of FGC in Child Protection

Nixon is one of the leading advocates of the benefits and place of the FGC approach in decision-making in child protection. Nonetheless, he is critical of the development of the field, and the manner in which the approach may be used. He notes that it is somehow ironic that:

“the idea that families would make better decisions than professionals came from families and communities, not from the professionals. Yet it is professionals who have designed the service, driven it, constructed it, inset the standards, and in so doing to some extent at least, may have colonised these ideas and diluted the spirit of FGCs, or certainly modified them” (Nixon, 1999 pg 4)

Nixon says that there is a tendency for professionals in the U.K. to refer cases to the FGC service when they want to:

- Use the FGC as a rubber stamp for their ideas
- Squeeze resources out of families
- Use the Conference as an intervention of ‘last resort’ (Nixon, 1999 Pg 4)

Hamill (1996) notes that child protection is probably the one area where family participation leads to most anxiety for professionals. She identifies two major concerns in relation to the introduction of FGCs in child protection:

(g) the relationship between the FGC and local child protection procedures, and
(h) the ‘safety’ of FGC in the complex area of child protection.

It should be noted that the FGC process is unlikely to be occurring in a vacuum. Other services are likely to be involved, are likely to become involved or will remain involved post-FGC. Therefore there is a need for the FGC service/ practice to interface with a number of other services, both statutory and voluntary.

Hayes’s (2000) research was undertaken to explore professionals’ views on the possible use of FGCs in Child Protection. In the course of his research Hayes evaluated three groups of staff: practitioners, managers and non-social work members of the North and West Belfast Health and Social Services Trust in Northern Ireland. Fifty-five percent of Hayes sample agreed that FGC “should be used in Child Protection work”. Only 7% disagreed, and 38% were not sure.

Hayes (2000) concludes

“it is both desirable and feasible to use FGC in child protection work. However, this is based on the realisation that the FGC model will not be appropriate for all families in which child protection concerns exist and that there are difficulties with the model that need to be addressed in practice.”

2.6 Child Protection in MWHB

In the mid to late 1990s, Ferguson undertook a research project to evaluate the work of the Mid-Western Health Board’s child care and protection system, as it actually processed cases over a specified period. This research aimed to learn more about how
the Child Care system works, identifying what aspects are done well, and how professionals actually operate on a day-to-day basis to protect children.

Ferguson’s research pre-dated the introduction of Children First. Following the introduction of Children First, the MWHB, as did most Health Boards, introduced a formalised Child Protection Notification system. This had interdisciplinary management groups meeting regularly to process ‘notified’ referrals and cases. This is an initiative which represents perhaps the most significant organisational change as community care shifted its primary concern to child abuse. Ferguson was critical of a system which he saw was influenced more by managers, bureaucracy and accountability. Ferguson suggests that need, rather than the decision-making process itself, should drive responses to children and families (Ferguson, 2000 Pg 153).

Ferguson also found the Health Board’s professional systems to be chronically enmeshed with certain types of cases and families, which posed particular challenges. The cases coming to the attention of Health Boards were characterised as tending to involve reconstituted families or lone parents (usually mothers) who live in poverty, often suffering addiction problems, and other adversities such as a violent partner, who may or may not be the father of the children. As the children grow older and enter their teenage years, they tend to become out of control; they have to deal, not only with the legacy of years of adversity and child abuse, but also with a view of them as threats to themselves and/or social order. (Ferguson, 2000 Pg 266)

The MWHB “Child Welfare and Family Support Strategy Statement 2002-2005” sets out an organisational framework for the development a Child Welfare System within the MWHB that provides for the delivery of early intervention and family support services to children and families in need. It is acknowledged that, under the auspices of the MWHB, many initiatives exist that seek to safeguard children and, if at all possible, to keep them out of the Child Protection system and state care. However it is recognised within the MWHB that more could be done to promote the welfare of children and to provide services that could alleviate family problems before they deteriorate to the point at which child protection and alternative care options are considered (MWHB, McClure, 2001, Pg 2). This strategy provides a management model for the development of a Child Welfare System that sets out clear objectives, procedures and structures for the delivery of services in a context of prevention and support.

2.7 Broadening of ‘Child Protection Concern’ to include Family Support in MWHB

One of the key findings and recommendations made by Ferguson was the need for Health Boards to design a strategy for working with cases which are immensely demanding of energy and resources (Ferguson, 2000 Pg 266). Such a strategy requires a fundamental change in the way childcare services are conceptualised and delivered. The system needs to stop trying to fit cases into a ‘child protection concern’ frame and approach child welfare on the basis of assessed need, regardless of the presenting problem. (Ferguson, 2000 Pg 266)
Re-focusing children’s social work requires an acknowledgement of the specific, yet inter-linked, sub-systems of child protection, childcare and family support. For each sub-system staff should be given specific responsibilities to discharge key roles and tasks in the case management process. At the same time, however, there must be an acknowledgement that these sub-systems can and do inter-link and inter-act as the needs of children and their families evolve. Children who require protection may need to be brought into the child care system, albeit for a short period. Children in the care system may need an infrastructure of support to be put in place in the family and local community so that they may safely leave the care system.
Scoping the parameters of these sub-systems, agreeing their interfaces and developing protocols for the various team members to operate dynamically and effectively is a key challenge to successfully refocused practice. (Giller, 2001 “Responding to the Implications of the Ferguson Report: Options for the Mid-Western Health Board”)

In light of the findings internationally described above, and Ferguson’s conclusions in the MWHB, the board has been endeavouring to find ways to fit family welfare and child protection together. The FGC is seen to have a potentially pivotal role in integrating systems and moving processes in the right direction, and hence the proposal for this pilot project.

2.8 National Developments – Children First

Children First - the National Guidelines for the Protection and Welfare of Children was launched in 1999. The objectives of the Guidelines are stated as:
13. To improve the identification, reporting, assessment, treatment and management of child abuse cases.
14. To facilitate effective child protection work by emphasising the importance of family support services and the need for clarity of responsibility between professionals.
15. To maximise the capacity of staff in organisation to protect children by virtue of the guidelines relevance and comprehensiveness.
16. To consolidate inter-agency co-operation based on clarity of responsibility, partnership and co-ordination of information.

The Guidelines provide details for parts of the child protection system including handling the referral, screening and initial assessment, the Child Protection Notification system, and different types of planning meetings. This document, although it does not embrace the FGC as such recognises and defines a Child Protection Conference as an:

“ inter-agency and inter-professional meeting, which is convened by the Child Care Manager/designate. It normally takes place when initial enquiries and, if relevant, emergency action have taken place. It may take place during the early stages of enquiry, or at any time when concerns arise about a child’s care and protection. The Child’s parents/ carers and the child should be included where appropriate”. (Children First, 1999 p78, par. 8.19.1)

The Guidelines contain significant pointers regarding inclusiveness:

- Parents/carers normally have more information than any professional about their child and can make valuable contributions to assessment and planning;
- Plans made at Conferences are more likely to succeed if negotiated while parents/carers are present;
- The experience of parents/carers waiting outside a room while a Child Protection Conference is in progress can be extremely distressing and unhelpful. For this reason, parents/careers should participate in the whole conference. If their presence at the whole Conference is not permitted, then
arrangements should be made to minimise any potential discomfort likely to be experienced by them (tea, coffee, etc.)

- Parents/carers are likely to feel nervous, under scrutiny and, in some cases, hostile to the professionals present. Sensitivity and preparation are required in order to reduce tension and facilitate useful discussion;

- Parents/Carers should be permitted to bring a support person to the Child Protection Conference, whose identity will be clarified by the Chairperson to the other participants;

- The purpose of involving parents/carers in a Child Protection Conference, as with any other participant, is to hear his or her contribution and agree conclusions and recommendations. The Child Care Conference should not be used as venue for making assessments of characters, behaviours or abilities of parents/carers, nor should parents/carers be re-interviewed or interrogated at a Child Protection Conference (Children First, 1999 pg 150-151)

The Guidelines go on to delineate certain circumstances when the exclusion of parents/carers may be justified. The MWHB Protocol clearly outlines the Child Protection Conference Agenda, which provides an opportunity for “Family Members Contribution” (MWHB, 2001 (B) Pg 18). The Guidelines state “it is appropriate to hold a Child Protection Conference when decisions of a serious nature are being considered which require the input of professionals from different disciplines and agencies (MWHB, 2001, Pg 78, par. 8.19.2).

In anticipation of Children First, the MWHB designed Child Protection Guidelines within the Board, which recognised Child Care and Protection as a “corporate responsibility requiring a commitment from all personnel without exception across the entire Health Board Services” (MWHB, 1998, pg 1, par.3). Following the introduction of Children First, and in line with recommendations therein (Children First, Pg 79, 8.19) the MWHB’s Child Care and Family Support Services developed a “Child Protection Conference Protocol” (November 2001). This protocol identified a number of objectives: the most relevant for this research being the objective “To maximise involvement of appropriate individuals, particularly parents, children and young people” (MWHB, 2001 Pg 4)

The MWHB’s policy is to maximise parental involvement, while maintaining the care and protection needs of the child as the first priority. The Board has a commitment to inviting parents to participate in Child Protection Conferences, unless there are clear grounds for exclusion. (MWHB, 2001 Pg 11). The Board also has a clear policy on the preparation of parents to participate in a Child Protection Conference.
CHAPTER THREE
PART 1- GENERAL INFORMATION ON THE CONFERENCES
PART 2 - FAMILY MEMBERS VIEWS OF THE CONFERENCE STAGES

3.1 Introduction
This chapter is divided into two parts. Part one summarises information on referrals received in the project. In part two, the family members’ views of the different stages of the conferences are presented.

The project time-frame extended for six months from September 2001 to the end of February 2002. During that time, six referrals were made to the project. Three of these referrals ended with family group conferences, one referral was withdrawn during the late preparation stage, and two referrals were withdrawn earlier. All six referrals are used to provide base-line information in this report. The findings in part two of this chapter are based predominantly on the views of the participants in the three completed conferences, as well as the one referral withdrawn. Where applicable, general observations relating to the other two cases are included, as the formative evaluation methodology used enabled the researcher to remain close to the processes as they were developing.

In part one, the profile of the six cases referred for conferences is presented, briefly giving key characteristics. The data on the three conferences, which were completed within the evaluation time-frame, is analysed in depth in later sections of the report. Summary information is presented in Table 3.1, entitled ‘Profile of Six Cases Referred for an FGC in the MWHB Project’.

For comparative purposes, the Lupton (1995) FGC evaluation comprised of 19 families, with 22 FGCs being held. Of those 19 families, 11 were researched in depth. In the ERHA Phase One Study (O’Brien 1999), 8 conferences were held and 8 families were researched in depth. 19 family members, 8 information givers and 3 coordinators provided the research data in that case. In the NWHB Study (2000) 15 referrals were received into the Project from January-June 2001, 10 were completed and 5 did not go to Conference. 61.5% of these were included in the research data, 7 of whom were children. In Hayes’s (2000) study in Northern Ireland, 8 families were involved, and research data was obtained on the 8 conferences.
### TABLE 3.1
Profile of Six Cases Referred for an FGC

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age of child</th>
<th>Child attend</th>
<th>Gender</th>
<th>Completed: C Terminated: T</th>
<th>Plan made &amp; acc</th>
<th>No. of Family members</th>
<th>No. of Prof.</th>
<th>Persons excluded from conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3 months</td>
<td>Y</td>
<td>F</td>
<td>C</td>
<td>Y</td>
<td>Invited 8 Attended 8</td>
<td>Invited 7</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Attended 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 reports submitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>8 years</td>
<td>Y</td>
<td>F</td>
<td>C</td>
<td>Y</td>
<td>Invited 3 Attended 3</td>
<td>Invited 6</td>
<td>Yes Paternal aunt on Mother’s insistence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Attended 6</td>
<td>Paternal uncle due to alcohol problem</td>
</tr>
<tr>
<td>3</td>
<td>14 months</td>
<td>No</td>
<td>M</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>10 years 7 years</td>
<td>Y</td>
<td>M</td>
<td>M</td>
<td>Y</td>
<td>Invited 5 Attended 2</td>
<td>Invited 9</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Attended 8</td>
<td>Family members excluded themselves</td>
</tr>
<tr>
<td>5</td>
<td>11 years 16 years</td>
<td>M</td>
<td>F</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>15 years</td>
<td>F</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>
3.2 Status of Participants in Cases 1 - 4

3.2.1 Marital Status of Parents
Examination of the marital status of the parents show that in one family the parents were “married but separated”, in two families the parents were cohabiting, and in the remaining case the father was a widower.

3.2.2 Age & Gender Profile of Children
The age profile of the 5 children involved in the project ranged between the ages of three month to 10 years. A gender analysis shows three (60%) were male, while females represented two (40%) of the children included in this study.

3.2.6 History of Contact with the Health Board
The results show that there was a significant history of family contact with the Health Board. This involvement was divided into two categories. Firstly, four of the five children in respect of whom the conference was being called had been involved with the Health Board in the past. Secondly, 66% of other family members had had substantial prior involvement with the Health Board, compared to 75% in the ERHA project.

3.3 Connection with the Pilot Project

3.3.1 Reasons and Route of Referrals
The referrals sought by the project were families who were involved in the child protection system, as distinct from families that were viewed in the agency as falling within the remit of family support. Referrals were sent to the project manager’s office from the community care team. The project manager attended the child protection notification meetings. This provided the project manager with an overview of cases entering the child protection system. Potential cases could be discussed at this early stage between the project manager and the staff of the child protection notification system.

The decision-making body designated for accepting referrals into the project was a referral committee. The referral committee was comprised of the Child Care Manager, Principal Social Worker and Project Manager. Their role was to assess and make a decision on the referrals. On acceptance for the project, the case was assigned to a co-ordinator, whose task was to introduce and explain the process, and to prepare the participants for the FGC. It was to prove beneficial that the members of this committee had an overview of, and positions of responsibility in, the child protection system.

3.3.2 Factors influencing the Referral Rates
The rate of referral of cases to the pilot project was initially slow, a finding which is similar to other projects. The short lead-in time, combined with the short life span of the project (6 months) meant that the project was under pressure in achieving its targets from the start. The location of the project in one small geographical area, together with the shared personnel in child protection and on the referral committee, assisted in the referral process. Another factor, which influenced the decision to set up the project in that area.
was the need to work with a management team who had a history of working together. The social work team had undergone major changes of personnel, but many of the other inter-disciplinary team members involved in child protection were in place for some time.

Four of the six referrals were received in the period December 2001 to February 2002. Yet, only one of these cases ended with a family group conference. In many respects this illustrates that as the project was entering its second three-month period, efforts were made to find ‘suitable cases’. Two of families approached and asked to consider an FGC did not share the agency’s enthusiasm for this new approach at that point in time. With the slow trend of referrals, key people in the voluntary sector were also contacted. It was intended initially that the pilot would examine the applicability of the FGC model to cases where domestic violence and child protection were issues. No cases emerged in the time period involved, and at the later stage of the project, it was thought that the voluntary sector might provide such a referral. While this was investigated, it was deemed unlikely that a case that would fall into the child protection referral criteria would have been managed solely by the voluntary sector. The other hope was that the voluntary sector might bring a case where they were working alongside the statutory services, and which might have been overlooked in the agency. Despite the efforts, no such case was found.

3.4 The Conferences

The stages in the conference process are discussed in detail in Appendix 2.

3.4.1 Preparation and Participation

Contacting Invitees: The primary means used by the co-ordinator to make the necessary arrangements with family members for the conference was a combination of telephone calls, with a follow-up personal home-visit. A similar method was utilised for contacting the professionals. The difficulties of contacting people were amplified by the rural setting of the pilot project. Significant travel hours were involved in each case.

Family & Professionals in Attendance: The number of family members who attended the FGCs averaged five, with a range from two to eight. Those who failed to attend were divided into three categories. Firstly, there were those who could not attend due to particular circumstance. Secondly, there were those who chose not to attend and thirdly those who could not attend as other key family members excluded them. Professional attendance was high and averaged seven persons, varying from six to nine. In all 86% of professionals invited to a conference attended.

In the ERHA project, the average number of family members who attended was also five. The NWHB project had an average family attendance of nine, ranging from five to twenty. The high rate of attendance reported above is indicative of the readiness of people in families and their social networks to become involved when invited to help protect vulnerable children. It also shows, however, that when extended family members are invited, significant difficulties can arise from the birth parents perspective, as more people are aware now of the child protection difficulties.
3.4.5 Time Scales involved in the FGCs

Referral: It was found that 2 of the cases referred to the pilot were accepted within one week of the referral being made, and the remaining case was accepted within a three week period.

Acceptance to Pilot: The period between acceptance of the referral and the holding of the FGC was three weeks in one case, five weeks in the second and ten weeks in the third.

The time between referral and holding a conference in the ERHA study averaged six weeks, the shortest was three weeks and the longest was ten weeks. In the Essex project (Smith & Hennessy, 1999) the average was five weeks, the shortest 1 week and the longest 14 weeks.

Preparation: The average length the co-ordinators spent working at preparation between the referral and the holding of the FGC was 48 hours, compared to 30 hours in the ERHA project. The inner and outer times in the ERHA project ranged from 25 to 35 hours while in this project it ranged from 36 to 48 hours. The NWHB experience was 73.35 hours average, the inner and outer times ranged from 37 to 100 hours. As was the experience in the ERHA, the main issue accounting for this difference was the amount of travel involved. In one conference, 18 of the 36 hours (50%) was spent on travel and in another, 17 of the 48 hours (35%) was spent on travel. The NWHB project found face-to-face interaction accounted for an average of 31.4 hours and travel averaged at 42.6 hours per Conference with a maximum of 85 hours. This finding points to serious implications for the delivery of co-ordination (and other) services in rural settings.

Information-Giving: The average length of time for the information-giving stage of the actual conference was 45 minutes, a finding similar to the ERHA experience. These figures are marginally higher than the NWHB experience of 33 minutes.

Private Family Time: On withdrawal of the professionals from the meeting, private family time ranged from a maximum of three hours in one very complex meeting to thirty minutes in the second, and fifteen minutes in the third. It is interesting to note that the families that needed longer to plan in private needed less time for discussing and presenting their plan. In the ERHA project the average length of private family time was 60 minutes, ranging from 90 down to 15 minutes. The NWHB found private time averaged at 2 hours 28.5 minutes, with an inner and outer limits ranging from one hour to 5 hours. Lupton (1995) found that private family time was 2 hours and 15 minutes at longest, ranging down to 15 minutes.

Presentation of Plan: The average time for presentation of the plan for review and ratification by the professionals took on average one hour and fifteen minutes, compared to 50 minutes in the ERHA project. However, this average figure does not illustrate the
major differences in this sub-stage. In the case of the conferences with the fifteen minutes private family time, the plan presentation stage took three hours. In another case, the presentation of the plan took 45 minutes, while the family needed thirty minutes to devise their plan.

**Duration of FGC:** The entire conference process in the pilot took an average three and three-quarter hours, compared to two and a half hours in the ERHA.

**Referral to Completion:** The total number of hours the co-ordinator worked in facilitating the conference between the referral stage and the completion averaged 49 hours. The inner and outer times ranged between 42 and 53 hours. The average of 49 hours compares to 33 hours in the ERHA project. In the Essex study, the time commitment of the co-ordinators in preparation for and holding of the conference was 29 hours, with the limits being between 12 and 48 hours. The Lupton study (1995) average was 23 hours, with variation from 8 to 51 hours.

Geographical location, cases involving large numbers of invitees and complex family situations contribute to the variation in time scales. The extent to which the time commitment involved was connected with the high-risk, child protection cases involved is discussed further in Chapter five. The level of time commitment has serious implications for the resource requirements for FGCs, when they are implemented on a broader level.

It should also be noted that considerable effort in terms of project manager’s and co-ordinator’s time were used on the referrals which did not end with conferences.

**Time Conference was Held:** All of the FGC’s were held on a weekday, with two of the conferences during office hours. In the other case, the FGC was held in the evening to accommodate working members of the family network. Seventy percent of the NWHB FGCs were held during the week, with 43% occurring in the evening. Thirty percent were held at the weekend with one third during the day and a further one third in the evening. The high level of employment in Ireland indicates that evening meetings will continue to be desired, especially if wider family membership is to be attracted to the conferences. From the agency perspective, evening and weekend meetings have major implications for the agency’s work practice agreements. A balance will need to be worked out with staff if FGCs are to be held at a time convenient for some families.

**Venue:** In one case, the location chosen for the FGC was a community centre, as it was deemed to be a neutral venue for all participants:

*The fact that it was on neutral ground was of benefit to both families as it meant no advantage to either side*

It also facilitated the practicalities of a sizeable group meeting. In the other two cases, the family members chose a health board premises. No conference was held in the families’ own home, which was also the case in the Essex and Lupton study findings. In the ERHA, one conference was held in the family’s own home. The availability of suitable
venues is a real issue in a rural context. Privacy, availability of venues in general, and suitable space are the main issues. As one family member said

‘Where else would we go?’

Another non-family attendee at a conference said when asked about the venue chosen

‘I was very comfortable because it was an environment I was used to. However, although it was a Health Board premise, the family also appeared comfortable with it. There were plenty of empty rooms available and I would recommend access to at least 2 rooms for any future conference.’

A family member who attended this conference has a slightly different view when they said

‘it was all right but for …the child’s sake, I would have preferred the hotel.’

In another case the response from another information-giver to the use of a community resource in a rural area was

‘The venue was very poor, inadequate. It was …small, cramped, lacked confidentiality

Local community hall……….. it would not have worked if more family had attended.’

One family member at the same conference saw it differently, and described the venue

‘……as a grand place’.

3.4.3 Presenting the Plan

Reaction to Plan: In all three cases, the plan as presented was accepted by the health board. However, it is important to stress that in two of the three cases, significant details of the plan were worked out when the family members and the professionals were sitting down together after the private family time. In both these instances, the co-ordinator played a key role in facilitating the end result.

Review Date: The place of the review emerged as significant issue in this pilot project. The main issue centres on the place of the FGC and the review alongside other decision-making forums. This issue is elaborated further in Chapter five.

Monitoring Of Plan: There was explicit reference to the monitoring of plans in all of cases, and this was seen to be the remit of the designated social worker.

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PART 2 - FAMILY’S VIEWS ON THE FGCs

3.5 Introduction to Qualitative Research

In Part 2 of this chapter and in Chapter four the views of the participants are presented, drawing on both qualitative and quantitative data. Those included were fourteen family members (n = 14), eleven information givers (n = 11), the co-ordinators (n = 2) and the management committee (n = 12) and project manager (n = 1).

There are two aspects in which the views and feelings of the participants are ascertained. Firstly, the four stages of the FGC process are examined in relation to their specific
conference, i.e. Referral stage, Information-Giving Stage, Private Family Time and Presenting the Plan. Secondly, a more general overview of the process is obtained by reflecting broadly on the model.

3.6 Family views on the Four Stages of the Conference

3.6.1. Before the Conference - The Referral and Preparation Stage

A number of key issues, pertinent to the referral stage, are discussed here. These address the following questions:

- Was the information clear?
- Did they feel adequately prepared?
- Did they know what would be achieved?
- Was there any conflict regarding attendance?
- Were those people considered to be helpful contacted and facilitated to attend?
- Did the family have different views regarding who should attend? and
- Did they consider the right professionals were in attendance?

TABLE 3.2
Summary Table of Family Members Perspective on Level of Preparation prior to FGC (n = 14)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>In parts</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was information clear prior to</td>
<td>78% (11)</td>
<td>22% (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>conference</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you adequately prepared</td>
<td>35% (5)</td>
<td>35% (5)</td>
<td>21% (3)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Any conflict re attendance</td>
<td>28% (4)</td>
<td>36% (5)</td>
<td>22% (3)</td>
<td>14% (2)</td>
</tr>
<tr>
<td>Were helpful people facilitated to</td>
<td>72% (10)</td>
<td>21% (3)</td>
<td>7% (1)</td>
<td></td>
</tr>
<tr>
<td>attend</td>
<td></td>
<td></td>
<td></td>
<td>(N=14)</td>
</tr>
<tr>
<td>Were the right Professionals invited</td>
<td>86% (12)</td>
<td></td>
<td>14% (2)</td>
<td></td>
</tr>
</tbody>
</table>

Clarity of information: The referring worker outlined the concern of the agency in writing to the project manager in the referral. This concern formed the basis for the holding of the FGC. The ‘why’ of the concern determined the scope and brief of the FGC for the participants. The co-ordinator was generally the first person in contact with prospective attendees (except birth parents, who would have already given permission to the agency to proceed with an FGC). At this juncture, the process and reason for peoples’ participation being requested was explained. The great majority of families (78%) responded positively saying there was clarity of information from the co-ordinators, describing both the process and the purpose of the FGC, while the remainder (22%) expressed some uncertainty. The NWHB study reported a higher (91.7%) level of satisfaction with the clarity of information received prior to the conference, with the reminder feeling that the information was clear only in parts.
Many of the families’ fears were resolved when the co-ordinators explained the concepts that lay behind the process and the steps that would occur at the various stages of the meeting. One family member said that initially:

‘I had no understanding of FGC… initially I thought it was a family court’.

When the family members were asked about what other information would have been helpful at the initial stage, one birth parent said she would have liked:

'More information on the reports that were going to be given by the professionals. At least then I would have known what to expect from all of them and not to be worried about them.'

Overall, the brochures used to introduce conferencing were viewed as being particularly helpful and easy to read.

What would be achieved
In reviewing the family’s understanding of the reason for the conference, the family members showed a good understanding of why such a meeting was needed. It also showed they were conversant with what the health board was saying about what would need to change in the family to put a safer living situation in place for the children. It is necessary to bear in mind that the understanding captured in the evaluation evolved over the course of the FGC process itself, rather than being present so clearly at the beginning. However when the family were asked about what would be achieved at the outset, some family members wanted to know more about the extent of the neglect and abuse inflicted on the children. Others wanted to use the conference to make more definite decisions, like making a more permanent care plan, or getting the parents to change their ways. There was limited evidence of caution or suspicion as to why the agency was now inviting participants in, as was evident in the ERHA project.

However, in one case there was a total lack of understanding among the family members as to why such a meeting was being arranged. This person’s view represents the frustration that family members experienced when they perceived that they already had given as much as they could.

‘There was a complete lack of understanding about the conference and everyone was a little frustrated when the exact mission of the conference was revealed. My own view is that unless the problematic person is helped, it is very hard to expect the family to continue picking up the pieces considering we’ve done it for years.’

This comment also reflects a view that if the agency is too prescriptive about what the FGC can achieve, such problems may emerge.

A key component, which contributed to the success of this initial preparation stage, was the personal visit by the co-ordinator to those invited to attend. This was a finding which emerged also in the ERHA project. Interestingly the co-ordinators views of this stage is somewhat different. Their experience was that this stage represented major work for them in respect of clarifying and reclarifying the reasons for the conference, the agency concerns, who was to be involved etc.
Overall Adequacy of Preparation: There was a difference between the family members knowing the reason for the FGC and what they hoped would be achieved, and the extent to which the family felt prepared for the totality of the experience. Only a portion (35%) of family members felt they were adequately prepared in all aspects of the FGC in advance of the conference, while 52% felt some gaps remained for them. Three people felt they were not adequately prepared at all. This overall adequacy of preparation was less in the MWHB, compared to the ERHA project where 74% (n =14) reported that they were very well prepared. Nonetheless, when the family were asked what worked for them in the preparation stage they said:

*the on going talks with the co-ordinator……the continuous explanations …..the previous notice which ….gave time to organise domestic arrangements*

These factors all contributed to the overall preparation at this stage.

Conflict re attendance: There was conflict regarding who was to attend in the preparation stage in the four conferences. The main cause of conflict hinged on exclusions. In one instance the birth mother refused to attend if members of the paternal side were to attend. Unfortunately, in this case, the birth mother herself had a very small family and social network and therefore the possibilities for the child were diminished. In another situation the difficulties centred more on the family’s suspicions of the process and the fear that this meeting, regardless of all the re-assurances, would be unable to deliver in the way that was being promised. It is of note that in this instance that a parental alcohol problem was central to the protection issues for the child, and the family members generally felt let down by the statutory services interventions in their lives.

When family members were asked in detail about the reasons for conflict, it was seen to be associated more with past difficulties in the family as indicated in this quote:

*I would prefer not to mention names but the conflict (about attendance) was not a direct result of the conference, it goes back to other family problems.*

Helpful attendees: family Despite the views expressed above about family attendance, eleven family members (72%) felt all appropriate people were contacted and three people felt that, in part at least, the right ones were facilitated to attend. One person had no view. When family members were asked if, on reflection, they had a different view regarding who should have attended, no other people were identified.

Right Professionals: The vast majority of family members said that the right professionals were invited, and two people said they did not know. This was also the finding in the NWHB study where 88.3% of respondents felt that the right professionals were invited to the meeting. When this subject was explored further an interesting observation about feeling overwhelmed by professionals emerged:

*I didn’t think there should be all these professionals present as it felt very uncomfortable at times with everyone staring at us.*

Others indicated that they would have liked different professionals to attend, such as the local doctor.
3.6.2 The Information-Giving Stage

In Table 3.3 the question of adequacy of information provided to participants, the opportunity for family to speak, the extent to which the family members had their questions answered and their level of comfort during this time is presented.

TABLE 3.3
Summary of Participants Experience at the Information-Giving Stage

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Some</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate information to make a decision</td>
<td>36%</td>
<td>50%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Chance to speak if you wished</td>
<td>93%</td>
<td>7%</td>
<td></td>
<td>7%</td>
</tr>
<tr>
<td>Answered your questions</td>
<td>36%</td>
<td>36%</td>
<td>7%</td>
<td>21%</td>
</tr>
<tr>
<td>Felt comfortable</td>
<td>36%</td>
<td>14%</td>
<td>36%</td>
<td>14%</td>
</tr>
</tbody>
</table>

(N = 14)

The majority felt the information-giving stage was handled well, with some 36% (5) of family members feeling they got adequate information at this point to enable them make a decision. Half the people (50%) found some gaps in the information shared, and one person felt they did not get adequate information at all. Up to 50% indicated that they felt uncomfortable at the meeting to some degree. All said, however, they were given a chance to talk if they wanted, and they also felt listened to by all. For over half the family members, they felt there were some inadequacies in the answers given by the professionals to their questions. In many of these instances, the nature of the cases and the stage they were at in the child protection process accounted for this. The challenge remains to develop a context to enable these unasked questions to be asked.

Many of the reasons people stated they were satisfied with the information given is reflected in the following view:

‘the openness, honesty, and the.... collective concern for the child really showed. The availability of tea, the warm surroundings and the atmosphere really helped.’

This however did not take away from the pain experienced when the enormity of what was happening for the children was illustrated.

On the other hand, hearing the details of what happened made some people uncomfortable, for others it brought back pain from events that happened at an earlier stage of the child protection assessment and investigation. One person noted that she found it hard to listen to what was reported, as she kept thinking that if the parent only stopped drinking, then all would be fine.

For others, the meeting and how the information was shared was such a new experience, the impact was expressed:

‘I was never involved in the likes of that before.’
Interestingly, no comments emerged about the style of reports or language used by the information-givers during either the information-giving stage, or the presentation of the plan. In the ERHA report, family members commented on the ‘big words’ used by the social workers and the sense that participants didn’t understand what the professionals were saying half the time. (O’Brien, 2000 p.46).

A number of people expressed surprise that the information being shared was affirming and positive in many aspects, while also being challenging and revealing. This reflects the importance of the inclusion of a strengths’ perspective to the assessment of protection issues.

Overall the family members indicate that they were pleased with the way in which the information was shared. However, when the processes surrounding the presentation of plan were examined, it became clear that the great majority of family members would have liked more information, especially about resources and options. Issues of information-giving therefore need to be interpreted cautiously. This comment sums up the point:

‘Even though I was well informed I feel that more information into the outcomes and backup options should the plan have failed and what other outcomes were available if problems should arise from the plan.’

The co-ordinator played a pivotal role in setting the tone for the information flow at the conference. The co-ordinator was viewed by family members as someone with whom a bond had been forged through the home visit. The family members spoke by and large of the great help, reassurance and support received from the co-ordinators. One family member only felt they were not facilitated to participate as much as they would have liked.

### 3.6.3 Private Family Time

Table 3.4 presents the family members view of the key processes that occurred during private family time stage of the conference. The processes examined are as follows:

- The extent to which the family had a clear idea of what needed to happen when the professionals left?
- The extent the family felt listened to?
- The extent others felt listened to?
- Any difficulties that may have arisen in the absence of the professionals? and
- The extent available resources were pointed out to the family to facilitate plan?

<table>
<thead>
<tr>
<th>TABLE 3.4</th>
</tr>
</thead>
</table>

#### Summary of Family Member’s View of Private Family Time (PFT)

<table>
<thead>
<tr>
<th>It was made clear what</th>
<th>Yes</th>
<th>Quite a bit</th>
<th>A little bit</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>65% (9)</td>
<td>21% (3)</td>
<td>14% (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In Table 3.4 the summary picture of family members views of private family time are presented. The majority of family members had a clear understanding of what needed to happen when the professionals left the meeting, while three members (21%) were somewhat confused, and two people had no view (14%). Within the private family time, nine people (65%) felt listened to. Four people felt they could have been listened to more. It is not surprising that it was generally the birth parents that had the experience of not being listened to enough.

Generally, the informants indicate that no major difficulties emerged during this part of any of the three conferences. That is not to say there was not some tension. In one instance the father:

‘threatened to leave the FGC. He did not see any point in the FGC. After some talking to he decided to stay.

In another instance, the view was expressed that it was clear that parent and child

….. ‘did not get on with each other. My opinion is that if both were on their own they would have been shouting at each other.’

Families reported that while there was a lot of tension, sometimes between members of the same family, and other times between the child’s paternal and maternal side, a range of conflict resolution skills were drawn on to handle the mounting tensions and differences.

This suggests while the process of FGC was experienced as generally positive by the family, it can be a painful experience for some individuals when discussing a family problem, and yet, families found ways of handling these difficulties.

Professionals Leaving

Discussions in the absence of the professionals were easier for the most part (53%) but a sizeable number (42%) experienced no significant difference due to professionals leaving. In the NWLB study, 29.2% felt it was easier with most people (66.7%) saying that it made no difference. Some people commented on the difference as being attributed to being alone as family:

‘It was different because it was only the two families that were there’
For others they saw it as pragmatic in a different way:

‘I would say that they gave us a job to do to the best of our ability for.....(the child’s) future and safety and to draw up a plan with our own freedom of speech which I thought was very fair in this situation.’

The ease of being alone is also reflected in this experience, when a family member said:

‘I got a chance to say everything I wanted, to bring out into the open...’

The private family time was more difficult for some rather than others, and again the vulnerability of the parents, while still a factor, was lessened after the professionals left. This is reflected in the following comments from two parents:

‘There was less tension and I was not as nervous’...and

‘I wasn’t as nervous as before...’

Undoubtedly, the experience of family coming together under circumstances where a state agency has a major issue in respect of one of their children is likely to evoke a wide mixture of emotions. When the family were asked about how participating in the FGC impacted on their relationship, eleven people (79%) said there was no impact, two didn’t know and one did not answer.

It is important to note that, despite the challenges and tensions, no family members commented that the process might have been easier if an outsider had to sit in with them. This is different to the ERHA experience where in almost equal measure, family members totally opposed and supported the idea of an outsider staying with them for the private family time. Those opposed saw that it would work against the family making the decision (O’Brien, 2000), while those that supported it thought it would help family work faster through the planning stage and/or would reduce family tensions. 25% of respondents in the NWHB study reported that problems did arise during private family time due to the absence of the professionals and the authors suggest that in such situations the presence of the coordinator may facilitate discussions.

Devising a Plan

When the family were asked about their experience of devising a plan, a number of interesting points emerged. The difficulty of the task of trying to devise a suitable plan was compounded by the lack of more specific knowledge of the actual risk involved in either the child going home or having unsupervised access while still in care, or being safe at home if still living there. The difficulties of the task facing the family members in trying to devise a plan in these circumstances is captured in the following views:

‘I felt like I knew nothing yet had all the information in front of me. I’m not quite sure what more could have been added but something was missing.

I just wanted to know about certain injuries which could not be answered in order to be sure of the safety of ... ‘the child’...I just wanted to know who to trust in the future.'
An issue that emerged for the family, especially for birth parents in one FGC was their need to have some private family time for themselves within the private family time. This was seen as a space possibly to help them compose themselves, reflect on what had been said or simply to sort out where they stood in relation to what was emerging for their child and themselves.

The challenges facing the family in drawing up a plan are many. Two of the main issues are lack of information regarding resources which has potential to hamper, and the lack of certainty as to the risk involved if certain courses were taken. This may, of course, reflect the stage the child protection assessment is at, and what aspect of decision-making is needed at that time, and the part the family can play in that.

3.6.7 Presenting the Plan

Table 3.5 presents the key findings of family member’s experience of the process of presenting the plan. It is examined under the following headings:

- The extent to which the family recollect the plan?
- The degree it was different from what they thought may have been reached?
- If the plan was accepted? and
- If a date for review was set?

| TABLE 3.5 Summary of Family Members Views of the Process of Presenting the Plan |
|---------------------------------|------------|-----------|--------------|--------|----------------|
|                                 | Yes        | Quite a   | In between   | No     | Don’t know     |
| Level of happiness with plan    | 21% (3)    | 36% (5)   | 7% (1)       | 29% (4)| 7% (1)         |
| Level of difference from what   | 29% (4)    | 21% (3)   | 14% (2)      | 36% (5)|               |
| family thought might constitute|            |           |              |        |                |
| plan                           |            |           |              |        |                |
| Success in resolving the        | 29% (4)    | 14% (2)   | 43% (6)      | 14% (2)|               |
| problems at time               |            |           |              |        |                |
| Levels of satisfaction          | 37% (5)    | 14% (2)   | 21% (3)      | 14% (2)| 14% (2)        |
| regarding plan at time of      |            |           |              |        |                |
| research                       |            |           |              |        |                |
| (N = 14)                       |            |           |              |        |                |

3.6.5 Reflections on the plan and outcomes

It is important to note that examination of the outcome of the plan after a lapse of time was not possible, given the time constraints of the pilot project and the need to have FGC’s up to a month before the pilot ended. A number of interesting views emerged when the family members were asked to reflect on the plans made and their view of the outcomes.
Only three people (21%) were very happy with the plan while seven people (49%) felt that it contributed positively to the situation the families faced. One third were not happy, or did not have a view. As time went on, it appears that the number of people who were happy with the plans diminished. Questions were raised about additional help needed after drawing up of the plan, by way of examining the impact of plan. Three family members (21%) said additional help was required outside the plan.

However, the majority (79%) did not know if the plan required subsequent help. It is necessary to look behind the small quantitative data presented to understand what may be behind the figures for discontentment with the plan. Some family members commented on how the changed care arrangements since the FGC were much better for the child, and commented that she was visibly happier. For others, they felt that the plan had a negative effect on them personally. This was especially the view for birth parents and carers, who either lost that status as a result of events following the FGC or had their access cut as a result of the family plan. It is very evident that when the plans are examined the dynamic and complex nature of the processes following the FGC impact on the outcome of the plan, and how it is perceived.

3.6.6 Families overall impression of the FGC
The family members were asked for general comments about the FGC process, and what surprised them most about it. The following comments give a flavour of the answers to these questions. For some the newness was evident:

The whole process was a surprise really, as it is not like anything I’ve ever experienced

For the parents it was particularly difficult, as would be understood when cases are involved in the child protection system:

People (family members) were saying things that were hurtful and they were very selfish in parts. Everything was to suit them and they made most of the decisions for us.

Overall people welcomed the opportunity for a number of reasons:

The FGC has answered a lot of unanswered questions on the safety of the child. ....

The FGC has provided the foundation for a happy environment’

‘Very well organised, easy people to speak to and the freedom of speech, privacy, no aggressive behaviour’

‘It’s good because it brings all family members together to sort out any differences that they may have’.
‘The FGC helps to bring everything out into the open.’

‘I feel that all professionals involved did what they could to help’.

Lastly, but of central importance is the way the family saw the FGC impacting on the children who were present at the conference. The children present ranged in ages from 3 months to ten years (4 children). The family members who attended the FGC for the small baby felt that her presence kept them extremely focused, though it was difficult for the parents. They were afraid of having to handle her if she needed attention, as they did not want to be in the limelight. For the older child, one family member’s view was:

The child was there and she wasn’t there if you know what I mean. She played ...In the other room to take the pressure off her.

When the impact of the meeting was explored, some felt that it lifted a weight off the child. In this instance she was to remain in her extended family. Another family member thought it frightened her but when this was further explored it appeared that the trauma of what had been happening to the child was much more the issue. Yet another family member said they did not know what the impact was as she felt:

It is hard to know what they are actually thinking

3.7 Conclusion
This chapter was divided into two parts. In part one the profile of the families referred to the conference, attendance of participants and duration of FGC from referral to completion was presented. In part two, the family views were presented. This part predominantly sought to address the extent to which family members participate in and have a sense of ownership of the FGC process.

Many of the findings were similar to the findings which emerged in the ERHA project (O’Brien, 2000 p79-82) in Ireland and which are also features of international pilot studies Lupton et al, 1995; Lupton & Stevens, 1997; Crow and Marsh, 1996 and Smith & Hennessy, 1998.

- The overall finding was the family members did participate in meetings organised to address concerns relating to the children in their networks. There was overwhelming appreciation for the co-ordinators preparatory work, how they imparted the information and their general demeanour.
- The family members participated from both maternal and paternal sides.
- The family members who participated averaged five per conference (excluding children), and a large majority of those who were invited to attend did so.
- Family members described the home visit from the co-ordinator as extremely positive, and this visit helped to set the scene for the meeting. The social workers in many of the cases also played a key role in encouraging the birth parents of the children to allow the meeting go ahead.
- Family members expressed the opinion that their views were heard and respected. Some family members who had no experience of prior meetings felt it was good and those that had prior contact with professional networks felt the process was better than their previous experience.
- When the private stage and presenting of the plan was examined it emerged that the family had limited knowledge of the resources available to them. This has
implications for participation, as if family members are not given adequate information to address the concerns, then the extent to which participation can be achieved is affected.
CHAPTER FIVE
APPLICATION OF FAMILY GROUP CONFERENCES IN CHILD PROTECTION

5.1 Introduction

This chapter considers the applicability of the FGC model in the child protection system. The discussion is set against the research findings and current model of child protection outlined in Chapter Two. It builds on the findings presented in Chapters Three and Four and draws substantially on the views of the management committee and the project manager. Members of the project management committee are also key stakeholders in the child protection system.

In the first part of Chapter Five, the impact of participation in the FGC pilot project is examined. Particular attention is focused on how participation in the pilot project impacted on the role of the professionals involved. This provides an important marker for understanding how the key stakeholders/professionals envisage ways in which the FGC approach may fit with protocols in child protection system into the future. The other emphasis is a consideration of the uses, challenges and possibilities which FGCs are seen to have in child protection. The implications of the agency having statutory responsibilities under the Children Act, 2001 and its wish to incorporate the FGC more into mainstream services are addressed.

5.2 Significant Changes in the Operating Environment

Major developments in childcare policy and practice are underway in the agency in which this pilot project was carried out. Timing of developments is an important issue in the board, as when reviewing the MWHB protocols, a management committee member provided information that:

‘The Mid-Western Health Board is due to publish a new protocol for its Child Protection Conference process. It has been written ... without consideration for how the FGC model will impact on the Child Protection Conference process and makes no reference to FGCs.’

This is indicative of the fragmented approach to service development that can arise out of competing demands on services. Alongside this, staff shortages and staff retention, especially in the social work department, were major issues that impacted on referrals, and staff availability to work on cases.

On a national level, despite the interest and developments in Family Group and Family Welfare Conferences, there has been no detailed consideration of how FGCs can be more fully integrated into the current child protection system, or the new system proposed by
‘Children First’ and legislated for in the Children Act, 2001. This, according to one member of the project management committee is:

‘in part a consequence of the problems that have arisen in implementing the new national guidelines and the current lack of infrastructure within the health Boards to implement the Children Act.’

FGC represents one element of a number of new structures and processes that are being proposed to modernise and improve the Irish child protection and welfare systems. At present there is limited information on how these structures and processes will work in reality and whether the potential envisaged will be actualised. The Children Act, 2001 neither prescribes a family empowerment model (as in New Zealand) or a restorative Justice model. The Act does not make a philosophical position explicit to inform the future practice of conferencing in any of the three contexts where it calls up conferencing (Health Boards, the Gardaí and Probation and Welfare Service). There has been criticism of the fact that the legislation does not define Family Welfare Conference, nor does it make specific allowance for ‘private family time’. The private family time represents the singularly most obvious element of a family empowerment model and transfer of power from the professionals to the family. It is to be hoped that the integrity of the model is not lost in the application of FWC called up under the legislation. It appears that the potentially beneficial ways of working which conferencing allows are recognised, as the Minister with responsibility for children in the Department of Health and Children, Ms Mary Hannifin, T.D. expressed the view that:

“New FGC ideas (contained in the legislation) does not prevent Health Boards from convening FGCs in relation to children who may be in need of care and protection at a much earlier stage”. (Minister Mary Hannifin 28/11/2000)

5.3 Management Perspectives

The management committee

The eleven members of the management committee (excluding the project manager, child care manager and project consultant) saw many functions arising from their membership of the management committee. These ranged from representing their department or staff group, being part of consultation on development of the pilot project, being supportive of innovative concepts, advising on the development of the FGC model from the viewpoint of ‘Children First’ and facilitating resource requirements between the project and other departments.

How did membership of FGC management committee affect positioning in the organisation?

The management committee had members who were key players in the child protection system and members who had a more peripheral responsibility for child protection, but were key players in the delivery of community services. Many members reported that as a result of their membership they were:

‘More informed regarding the model and had an opportunity to analyse and reflect on complexities involved in its implementation’.

Overall, they have been exposed to some of the pitfalls, limitations and difficulties in trying to make conferencing ‘fit’ into the existing child protection system. At the end of the pilot, they still expressed a:

‘Confusion vis-à-vis the perceived expectation that FGC and Case Conference (traditional) could work together’

However, the opportunity of working on the pilot project gave enhanced knowledge of the dynamics in the family and multi-disciplinary spheres, which is essential in the management of child welfare/protection. They reported to be especially struck by:

‘How the different groups/professionals viewed the Child Protection System’

Overall, they expressed satisfaction to have been

‘enabled to contribute to the organisation’s understanding and readiness for working in context of Family Group Conferences’.

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May 2002 Dr Valerie O’Brien, Dept of Social Policy and Social Work, UCD 117
To what extent has the use of FGC’s affected other professionals’ roles in their work with family members?

The impact of the FGCs was evident in how the key management committee members saw the process impacting on other professionals’ roles. In this domain, the participants were talking predominantly from their positions as managers and supervisors in the organisation. Many reported a change in how professionals began to talk about families, and how the FGC offered the possibilities for a different participation of extended family in the child protection system. They welcomed the shift in:

‘the balance from decision-making to that of partnership/collaboration and even to accepting ‘direction’ from family members’.

Their view was that for staff directly involved:

‘It meant closer working with family members and sometimes extended family members’ ....

and they were

‘engaged with families on a different, more open and sometimes more challenging level, particularly where previously contact would have been limited to one/two family members and perhaps in the professionals’ domain rather than in venue/settling of family’s choosing’.

There was also evidence of greater enthusiasm:

‘What I have noticed is the enthusiasm of agency workers to get a family conference off the ground as opposed to organising a case conference’.

However, given the limited number of cases involved in the pilot, many of the participants emphasised the need for caution as it is

‘it is difficult to say if the outcomes of FGC will be different, but the process and emphasis are very different’.

There was evidence of growing confidence arising from the possibilities that the pilot project offered, as much criticism of the existing system centred on the extent to which the protocols in place are ‘system driven rather than needs driven’. In the words of another participant:

‘The FGC provides a new model for working with families. Traditionally processes have been imposed on families with little consideration for their needs as defined by themselves or their capacity to meet them without recourse to authoritative or intrusive state interventions’.

Another participant did not see evidence of a major shift such as outlined above by others as:

‘The people involved with the conference that I was part of already had a more consultative approach and were very comfortable with the consultative process’.

The implications of the major change was evident to managers, and this indicated that workers would need ongoing support and/or structured supervision in terms of the increased work load on the referrer and those responsible for carrying out the plan, and support in terms of resources and commitment to plans made and agreed etc.

5.4 Fitting the FGC approach with existing protocols in the child protection system

This section presents findings arising from questions as to how the FGC approach fits with existing protocols in the child protection system, and if the FGC model of practice has application across the child protection spectrum as it currently operates? The findings are divided into a number of sub-sections, and reference is only made briefly if the point has been elaborated in a previous section.
In previous discussions outlined, there was evidence that the information-givers saw some differences between FGC’s and other decision-making structures in the child protection system. The principal differences discussed were the active participation of the extended family, the greater presence and participation of the child, the less intimidating atmosphere and the diminished agency control. Combined with this was a realisation that the FGC lends itself to greater exposure of the individual professional. There was a view that in the case conference context there is more of a shared or collective responsibility. However, it may be that the more the active participation of the extended family where they can question the individual worker in front of their colleagues gives rise to the sense of greater exposure in the FGC context. In the case conference context, any questioning (usually by the small number of family in attendance) is focused more on the group of professionals.

5.6 FGCs and/or Case Conferences
Given a choice, would you be more inclined to use traditional child protection protocols over protocols that include FGC?

When this question was asked, participants were inclined to interpret ‘traditional child protection protocols’ as referring to case conferences. As highlighted in Chapter Two, case conferences are only one part of the child protection decision-making system. Parental participation to date has been developed predominantly in this domain and therefore it is not surprising that the participants interpreted it in this way.

Many people felt that:
‘The FGC distributes the power more evenly between the professionals and family than the case conference process and the circumstances in which it can fit better are urgently required.’

Participants were divided on how the FGC could potentially fit with case conferences. Some thought they will not replace case conferences altogether, but could give options and alternatives that may involve families in a more pro-active way.

The FGC was seen as having the potential to complement and inform the case conference process. The ways in which this may work out were not clear. However, views were expressed that it was important to avoid a situation where the FGC was seen to be reporting to or accountable to case conference structure. Also, having both systems happening on the same case was seen as potentially very cumbersome.

It was considered essential that case conference participants should have an understanding of the FGC model, and understand the different roles and functions, in order to maximise the possibilities which the FGC could offer. The need for clear policy guidelines to be in place where a case conference was going to be suspended in a serious child protection case to allow for an FGC was highlighted.

A number of members of the management committee felt that the FGC could have application across a range of cases. They also saw its potential relevance in other decision-making processes, including opportunity in the family support domain.
summary there was a sense that FGC should not only be used in more serious end of child protection but should also be available in family support.

Likewise it was felt that the FGC provides opportunity and mechanism to move beyond a ‘social control’ model that can sometimes pervade child protection systems, and would help to reduce some of the adversarial attitudes in both workers and families.

Despite this positive disposition towards the FGC process, the managers recognised a number of issues which need to be addressed for its successful application.

There remains a desire for a guarantee that it

‘*did not increase risk or likelihood of increased risk*’.

There was a sense that

‘*both options need to be available depending on the case and degree of risk involved. All in all, there is a place for both*’.

Another member stressed that

‘*they would like to choose a protocol that would include FGC. In theory, it would be the better practice for both social worker and service user. However, you have to consider the work involved.*’

A view expressed strongly was that:

‘*Traditional protocols continually fail to deliver quality services*’ so we should not be intent on using different outcome measures for the FGC than traditional methods.’

Another member felt that

‘*Traditional methods have been shown too often not to work in children’s best interests in the longer term. There is a powerful argument to begin to find more humane and respectful ways of dealing with family problems. The FGC model provides one possible approach that could help families to take ownership of their problems and find ‘organic’ solutions without recourse to state approaches’.*

Reasons cited for the choice of FGC centred on:

‘*An enabling approach to the family; A respectful and open way of working; It puts responsibility on the family, while at the same times gives them power. Traditional system can cause more damage to the family and therefore put the child at further risk.*’

5.6 **Domains in which FGC may be particularly applicable**

In this part, situations which may lend themselves to successful application of FGCs are identified. These parameters are not intended as an exhaustive list of domains and circumstances required to hold a FGC. As discussed above the participants were of the view that the FGC may be useful for both child protection and statutory welfare responsibilities. It is suggested that the following features and situations need careful attention:

- The agency is in a position to state clearly what the child protection concern is and what parameters are required to ensure that the child is protected and cared for. In Chapter Four, it was evident that this continues to be a challenge for practitioners.
This may be attributed to the dynamic and complex nature of the cases in which timing, co-operation and planning are core factors.

- Where children are being returned to family or extended family setting for care. There were strong views expressed that FGC should not only be used in the more serious end of child protection, but should also be available in family support.

Other factors that needed to be in place to optimise the opportunities for a successful FGC outcome was where

- There is a good level of formal, and more importantly informal and ongoing, social network support.
- There are family members identified who might be able to carry through a care plan.
- When the family is approached and they agree to be involved in devising a plan via the FGC, it is important the professionals involved do not make a judgement alone about the existence or abilities of such networks prior to the family being offered the opportunity to be involved in the process. This would require the case to be sent to a co-ordinator in all instances once the family gives initial permission, and the Referral Committee has accepted the case.

5.7 **Circumstances not to proceed with an FGC**

Some information emerged in the pilot which throws light on those situations that are less likely to benefit from an FGC. These parameters are not intended as an exhaustive list of circumstances which would contra-indicate holding an FGC, but the issues would warrant very careful consideration. These include:

- The time-scales involved would automatically exclude ‘life and limb’ situations that require immediate attention. There is no reason, however, why an FGC may not assist in the medium to longer term planning and decision-making required after the initial crisis.
- The most important contra-indicator is where the agency is in the process of assessment and it is not able to clearly define its concern at this point in time. If the FGC goes ahead in the midst of such confusion, it is likely that greater misunderstandings and longer-term problems will occur in the professional-family network.
- Where issues/ concerns are of long-standing and where parental circumstances are unlikely to change easily/quickly. This was viewed as an appropriate basis to have a FGC in the pilot, but the evidence shows that if a child’s situation is of long-standing, e.g. living with the effects of alcohol, suddenly deciding to have an FGC is unlikely to have positive outcomes. Failure may occur because the system has entered a certain equilibrium and unless there is a crisis that brings this chronic long-term situation to the fore, it is unlikely that an FGC would be successful to adequately mediate change for the children.
- Likewise, if the agency system does not afford flexibility and decides ‘to put the family through more traditional processes’ it should not expect or try use the family group conference to merely rubber-stamp or copper-fasten its pre-conceived plan.
The purpose of the FGC is to offer a real opportunity for the extended family group to be informed, to devise a safe plan and to have a major input into the decision-making.

- A small number of participants expressed a view that they would have concerns regarding appropriateness of using the model where there is domestic abuse, or coercion in relationships. Such a case did not feature in the pilot. However, the literature e.g. Pennell & Burford (1997) showed very positive outcomes using FGCs for situations involving domestic violence and child protection concerns. There is a need to look further at the issues impacting on the applicability of this approach to these cases here in Ireland.

Further debate is needed about the types of families/child protection concerns that are likely to be dealt with effectively through using the FGC model, as opposed to any other approach. It is important to remember that research to date shows the vast majority of extended families will make safe plans for their vulnerable children. The question is if there are families that have such limited resources that they need additional assistance in order to be involved in planning?

It is also important that major emphasis is placed on looking at specific applications in the Irish cultural and systems context. Lessons can be learned from other contexts, but it is important to examine the potential application of those findings within the changing Irish system.

5.8 Weaknesses that emerged in fitting FGCs with the current child protection system?
A number of challenges were identified in the pilot about fitting the FGC into the child protection protocols. Again, the conceptual and hypothetical orientation of many of these issues was striking, as the cases in the pilot provided evidence on a somewhat limited range of situations.

The first challenge raised was that the process in which this new practice was explored was ‘only a pilot’, and therefore it may be difficult to draw inferences for the larger picture. The limited experience of applying FGC in Ireland in the child protection context is a particular challenge to the project’s goal. The ERHA project was based predominantly on the family support or the very low risk child protection category. Likewise, in the NWGB Pilot Project, 50% of the family group conferences were focused only on family support issues, and 10% were related only to issues of family breakdown. The remaining forty percent of conferences had work focused in two areas. However family support again featured predominantly. Family support was cited as a focus of work in conjunction with issues of ‘child in care’ (10%), an ‘alternative to admission to care’ (10%) and ‘Family breakdown’ (10%). The focus of work for the remaining FGC was ‘child protection’ and ‘child in care’ (10%). Thus a dominant focus of work throughout all conferences was family support.

Confusion existed in the pilot around the best circumstances for holding an FGC. Confusion was seen also with the difficulties surrounding the lack of clarity or lack of understanding regarding child protection concerns. The confusion was also centred on the
place of FGC alongside the other decision-making processes. This was evidenced in a number of situations where decision-making reverted back to a more professional ‘expert-position’ approach, as happened when a review meeting was cancelled. This occurred because of the view that certain circumstances had arisen. There was a counter-view, however, that these circumstances were more parental issues and the child still had a strong need to have key decisions made about them.

**Challenges related to value-base, workload, resources and responsibility**

The FGC operates from a definite value base, which may be quite challenging to families and workers experience.

The workload involved was seen as an issue, as it was felt that the FGC model requires a lot of time for mediation, negotiation and facilitation, which may not be available or allowable where acute risks are involved.

Availability of resources is a major issue that is seen potentially to work against the FGC approach. The resources required in terms of staff time, facilitation skills and appropriate family supports are significant. The additional workload for already overloaded area social workers emerged as a major feature. Contrary to expectations, the FGC did not lighten their work-load, at least in the short term, whatever about creating more satisfactory work practice.

Another major finding from the social workers involved in the pilot project was the sense that they considered that responsibility rested with them to agree the final plan. This was a change from the present situation where, at the Case Conferences chaired by C.C.M. or a Head of Department, the decision-making is very much collegiate.

**Families**

A number of issues were identified from the family’s perspective that would pose challenges for incorporating FGC into the child protection system:

- The model depends on engaging family participation and commitment, which can be difficult in long-standing child protection cases. It may be presupposed that all key family members are committed to the process, although individual and/or family may not be willing to participate.
- Even though the model allows each family member a voice, family dynamics can at times pose major difficulties to realising this ideal.
- The FGC system may serve to isolate an individual within the family system. In one of the conferences it was reported that the parent found it very difficult. While one of the aims should be to minimise trauma for the participants (perhaps by identifying advocates or support for vulnerable attendees) it is important to remember in child protection cases that the children’s interest need to be the primary concern, and privileged over other issues.
- The process could raise family’s expectations of resources being made available or changes happening, that may not materialise.
- There may be uncertainty about the families’ ability to protect the vulnerable member.
5.9 The model’s innate strengths in managing child protection concerns

The pilot project served to illustrate the widely-acknowledged strengths of the FGC process. These include:

Participation

- Makes wider family more aware of agency concerns for the child
- It gives families the opportunity to take a level of ownership of the whole issue and to make their own decisions for welfare/care of the children within the process.
- Involves the family centrally in making plan/decisions
- Taps into the families own resources, some of which may not otherwise be activated.

Outcome

- Opportunity for fuller information to be gathered and shared.
- If the plan is agreed, the child remains within family circle.
- Less adversarial, and focuses efforts on the common purpose of the best interests of the child
- Less intrusive, less traumatic, less impositional.
- Transparency surrounding decision-making.
- Accountability for and by users and providers.
- When applied and resourced will promotes equity, respect, responsibility and ownership.

Professional / Family relationships

- Fosters collaboration/ partnership between family and professionals as families are no longer passive recipients of a service approach imposed upon them.
- Independent co-ordinator will have established a relationship with the family, and may take a broader view than an internal chairperson, thereby enhancing the interface between the family and the agency systems.

5.10 Safety features that need to be built into the model?

A number of safety features were identified, which if built into an evolving model, would help to address concerns identified in the pilot. These include:

- Adequate training and preparation for all participants.
- A strong care plan is central, if the child is in the care system.
- Adequate resourcing of plans so that families or workers are not “set up to fail”.
- Alternatives to be identified in case of breakdown, and come-back routes if unanticipated/ unrecognized risks or flaws emerge.
- Ensure strong family and agency commitment to plan.
- Review mechanism, opportunity to reflect on plan
• Consideration should be given to reducing the workload for period up to and shortly after FGC.
• Referral and initial groundwork undertaken in supervision so that team leader and social worker shared case issues.
• If a perpetrator of abuse is to be present – the aspect of exclusion and presence needs careful handling and planning.

5.11 Conclusion

Many of the strengths identified for FGCs indicate that the participants have a high level of commitment to the ethos and value base of the FGC process. The positives that they associate with FGC reflect this conceptual nature and include increased partnership, family participation, and transparency in decision-making. There was evidence of many of these positive processes in the FGCs that occurred as part of the pilot project. The pilot also provided evidence which showed how the FGC can optimise family placement for children, and tap into family’s ability to draw up a protective plan for children and also offer much from their own resources. However, the use of the FGC approach needs to take full account of the perceived weaknesses and barriers that may impede its successful introduction within the broader system.

The positioning of the FGC as a complementary approach within the current professional and professional/ family decision-making processes is the key to working out the fit between the FGC and child protection system. It is not envisaged that they can develop or be used as two separate or exclusive processes. Instead, it is imperative to urge caution about going down the UK route in this regard. Under UK Dept of Health guidelines, it is simply not permitted for a case conference to be suspended to facilitate use of an FGC. At this point, it is important that flexibility is maintained until possibilities are further explored. The task is to see the FGC integrated into the Child Protection System and consideration being given to a systematic process for deciding how the innovative FGC method will be convened alongside other decision-making mechanisms. It is crucial that the FGC is not seen as a “once-off” event but as part of the ongoing process.

A proposal to this end is developed further in Chapter Six.
CHAPTER SIX
PROPOSAL FOR FITTING FGCS INTO CHILD PROTECTION

6.1 Introduction
In this chapter, an option which may assist agencies who wish to incorporate the principles and methodology of FGC into their child protection system is presented and discussed. For the purpose of achieving ‘joined-up’ services, where appropriate, linkages are also made with agency’s statutory responsibilities to provide a family welfare conference service under the Children Act, 2001 as well as agencies interested in mainstreaming family group conference as part of their family support and general child welfare services.

However, the primary focus of this chapter remains to discuss the project objective of where and how the FGC has potential to fit into the child protection system. The proposal is tentative, and it is hoped it will contribute to the necessary debate about where Family Group Conferencing may fit with and enhance the child protection management system outlined in Children First. The difficulties arising in Health Boards from major structural changes and staff shortages are acknowledged. The different options put forward in this proposal are based on understanding that many of these changes are being managed currently and solutions and plans are in place to address a number of priority areas.

6.2 Developing The Proposal
In Chapter Five, it was noted that the majority of management committee members interpreted the question about the fit between as FGC and ‘traditional child protection protocols’ as referring to case conferences. This was understandable as:

(c) there were written protocols in the agency for case conferences, and
(d) many of the other procedures underpinning Children First are perhaps not seen as such explicit procedures, as this change was being implemented in the agency on a phased basis.

There are a number of key issues that need clarification if the fit between case conferences and FGCS is be worked out.

- Both are decision-making forums, and if both are used, what principles of the two models are at variance?
  - One key difference is the principle that the family, as opposed to the professionals, are privileged in the making of the protection plan in the FGC, while the agency retains the power to decide if this plan safeguards the child?
  - Another key difference is the role of the independent coordinator. In the case conference forum, a person that has statutory responsibility for the output normally conducts the chairing
- What are the criteria required to hold a child protection case conference, and are these the same criteria that need to be used to initiate a family group conference?
• Is it likely that the information-givers at the FGC will be similar to the participants at the case conference? It is difficulty to see how they would be different as the focus in both is on devising a child protection plan.
• Parental involvement is now part of case conferences, and how different is it when extended family are involved in FGCs?

In the UK, the Department of Health Guidance (1999) stipulates that an FGC cannot replace a case conference, when the criteria for holding a case conference exist. In a recent research study conducted by Brown (2002), few families who were in the case conference system opted for an FGC also, as they saw this as unnecessary duplication, and they felt they had limited power to influence the professional viewpoint. It is suggested that if we follow the UK approach in Ireland, the potential of the FGC in the child protection system, and its widely recognised benefits will be seriously compromised. Lessons may also be learnt from the home of the FGC, New Zealand, where the FGC is used as the main child protection decision-making forum and, in the event of not reaching a decision acceptable to the agency, the case is referred then to court.

6.3 A Salutory Lesson
An example may illustrate the kind of difficulties involved in mixing FGCs in the Child Protection system, without having a very clear framework.

The infant of a young couple was admitted to hospital with injuries, and NAI was confirmed. The child was admitted to care on an emergency basis, and it was planned to have a FGC to consider the child protection plan required. A very successful FGC was held and it was decided that the child would remain in care, and the agency would continue working with the parents to assess the situation. Early indicators in the case, according to the agency (not shared at the conference) were that is was likely that reunification would occur. Some time later, a case conference was held, and the decision was made for the child to be returned to his parents.

A review FGC conference was held. The purpose was to explore with the family how they could assist the young couple care for the child.

Some time later, the child was injured again, and the child was admitted to care again in an emergency.

A third FGC was held to draw up a new child protection plan, and a plan was made.

Given the seriousness of the case, the service manager conducted a series of interviews with the participants. His conclusion was that the main mistake made was the agency failed to involve the family sufficiently in the decision-making. A case conference was held after the first FGC and at this conference the agency decided to return the child. Family members said they were wary of this decision but, as the agency had made it, they did not feel they were in a position to challenge it. If they had done so, (and in what forum could they have done that?), or if they had to raise their concerns about the
decision at the subsequent FGC, which was set up to support the agency plan, it was likely that they would have alienated the young parents.

The key lesson of this case, which was relayed by a colleague from the UK, was the extended family should have been more involved in the assessment process. What is indicated is a need to have complementary decision-making fora, rather than having one damage the possibility of the other. It is also necessary to see FGCs as an on-going process, and not as a single event. This may involve having a number of FGCs until such time as a safe care and protection plan is in place for the child. This undoubtedly will have major implications, as the fit between the FGC and other decision-making structures in CPN have to be very carefully worked out.

In conclusion, it is a major challenge in finding the fit between FGC and case conferences, while seeking to adhere to the widely-prized principles of extended family involvement, independence of co-ordinators, private family time and privileging family decision-making. This challenge is attempted in the remaining sections of this Chapter.

6.5 Concepts Underpinning The Proposals

The following are the concepts which inform the proposal contained in the following sections:

- The positioning of the FGC as a complementary and process-enhancing approach within the current professional and professional/ family decision-making process is key to working out the fit between the FGC and child protection system;
- The different legislative, procedural and ‘best practice’ basis from which FGC can operate, as outlined in Chapter Two. Distinction needs to be drawn between processes that are legislatively (i.e. reviews), procedurally (i.e. child protection conference) and best practice (i.e. supervision) derived;
- The FGC is only one of a number of decision-making processes operating in the child protection and care system. Findings arising from the implementation of ‘Children First’ (HEBE, 2001) relating to referrals, assessment, child protection notification, and case conferences are outlined in Chapter Two;
6.5 Activating Conferences within the Health Board

In this section the different potential routes from the various points in the child care system to a conferencing service are summarised. These routes are described and considered in detail in the subsequent section 6.6. Figure 6.1 shows different routes possible, four of which will utilise a (procedural and /or best practice derived) family group conference service and one, which will utilise a family welfare conference (legislative).

- Route One is where it is clear from the start that the referral is of a child welfare or family support nature, (procedural and /or best practice basis). These cases lie outside the child protection system.
- Routes Two to Four is where the referral contains a recognised child protection concern. The left-hand side of the figure outlines the junctures in the child protection system, which may trigger a referral for a family group conference. The decision to refer to the FGC may be made at three points within the child protection system. It also outlines the various linkages back into the child protection and child welfare systems arising from the referral.
- Route Five is where the court directs, or the health board’s application for a special care order prompts the referral (legislative basis).

**FIGURE 6.1 – Routes to FGC in Child Protection and Related Systems**
6.6 Triggering Family Group Conference Referrals in the Health Board.

6.6.1 Different Junctures - Different Referral Options

In this part, the different referral options and reasons for using a family group conference are presented. Each option is presented in tabular form, using a number of categorisations to highlight the issues involved in finding a suitable fit in the CP system. The categories used to describe the options include:

(vi) A description of the situation;
(vii) Criteria set down for making a referral;
(viii) Potential constraints;
(ix) CP case management implications;
(x) Linkages required in system.

The findings presented in Chapters Three, Four and Five inform this typology.

In examining the different routes by which a referral may be made for a family group conference, five possible routes are identified. Route 1 refers to the child welfare/support realm, and Route 5 refers to the statutory requirement for a family welfare conference. They are included to enable the totality of the system to be seen, but the emphasis is primarily on Routes 2 to 4, which have most implications for the (procedural/best practice) family group conferencing and the child protection system.

A key distinction between the provision of family welfare conferences and an FGC service in child protection is the probability that the complexity of the family problems suggests substantial prior involvement with the statutory services. Depending on this experience, the impact of the FWC may be diminished. This may result from an FWC being introduced at the end of many other processes, while FGC may be introduced at an earlier stage in the statutory interventions. Nevertheless, the referral for a FWC will be one route into the conferencing system provided by the health board. As such, it will also
intersect with the child protection system, and therefore there are implications for how FWC fits with the child protection system. It will also have implications for the care system and the regulations that govern that sphere, but that is beyond the scope of this project.

Routes 2 - 4 can be triggered as all cases have been notified to CPN system and a plan is required to address the child protection concerns. Cases all fall within the remit of the child protection system at the time of referral. Referrals may be initiated at different stages of child protection process i.e. post-assessment, multi-disciplinary planning or review. All referrals via routes 2 - 4 require the child protection plan to be reviewed at six monthly intervals by the CPN system (sitemap check), so long as case is seen by agency as meeting active child protection criteria. Case management responsibility remains with the multi-disciplinary team members involved in working with the case throughout this process.
6.6.2 Route 1

Referral from CPN system to family support/child welfare services following notification. Decision that no further child protection action required. Referral made in conjunction with referring social worker. No other child protection decision-making process initiated or involved. This may be either a new or existing case.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE ONE: FAMILY SUPPORT /CHILD WELFARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Referral falls within a child welfare/family support concern Either known or new case.</td>
</tr>
<tr>
<td>CRITERIA FOR REFERRAL</td>
<td>No ongoing child protection issue Need for agency to be clear as to purpose of meeting Family in agreement with referral</td>
</tr>
<tr>
<td>POTENTIAL CONSTRAINTS</td>
<td>Low priority in agency and may not be prioritised for family group conference Agency concern not shared as issue within extended family and wider family participation may be affected.</td>
</tr>
<tr>
<td>CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS</td>
<td>Need to ensure that plan does not place child/ren at risk</td>
</tr>
<tr>
<td>LINKAGES REQUIRED IN SYSTEM</td>
<td>Referrer and FGC referral committee Coordinator, referrer and their line manager, and the service manager Coordinator and service manager (FGC service) Service manager and other heads of disciplines to give feedback re service and clinical issues that may need attention</td>
</tr>
</tbody>
</table>
6.6.3 Route 2
Referral from a professional meeting for a family group conference to assist in drawing up a child protection plan

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE TWO: REFERRAL FROM PROFESSIONAL MEETING</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Referral from a professional meeting for a family group conference to assist in drawing up a child protection plan</td>
</tr>
</tbody>
</table>
| CRITERIA FOR REFERRAL | • Child’s immediate safety concerns met  
• Case meets criteria for staying open within the CPN system  
• Case not envisaged to progress to child protection case conference at this stage  
• At point of referral to FGC service clarity needed as to what child protection concern is and what needs attention  
• Clear mandate from major stakeholders in child protection system |
| POTENTIAL CONSTRAINTS | • What safety features required by system?  
• Extent that parent/s accept the basis for agency concerns and if family members are willing to share responsibility for protection issue and willing to be involved in devising solutions. |
| CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS | • Some professionals may be more anxious to progress to case conference as they may not want to take too many risks  
• Criteria needs to be developed to assist risk taking involved in not going to case conference  
• Identified triggers required if child protection system needs to be reactivated during process |
| KEY LINKAGES REQUIRED IN SYSTEM | • Clear information from CPN system and case managers in respect of care protection plan needed  
• Clear lines of communication to ensure accountability criteria met  
• If child in care, need to ensure that regulations that govern care planning are adhered to and fit with decision making structures of FGC process  
• Need to ensure that FGC plan if agreed is circulated to key people and monitoring and review system in place |
6.6.4 Route 3

Referral from the CPN system in conjunction with case managers for a FGC, instead of holding a child protection case conference. Child protection needs assessed and bottom line (relatively) clear.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE THREE: IN PLACE OF A CASE CONFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DESCRIPTION</strong></td>
<td>Referral from the CPN system in conjunction with case managers for a FGC instead of holding a child protection case conference. Child protection needs assessed and bottom line (relatively) clear.</td>
</tr>
</tbody>
</table>
| **CRITERIA FOR REFERRAL** | • Child’s immediate safety concerns met  
• Case meets criteria for staying open within the CPN system  
• At point of referral to FGC service clarity needed as to what child protection concern is and what needs attention i.e. parameters of clear child protection plan identified  
• Clear mandate from major stakeholders in child protection system to proceed in this direction  
• Indication that the family would like to be involved |
| **POTENTIAL CONSTRAINTS** | • Multiple personnel from agencies involved, need for very clear communication and structures  
• Ensure all key players know sequence of processes proposed  
• Despite decision taken, certain key professionals may feel anxious or uncertain about sharing risks to this extent with family  
• Family tensions associated with past history may impact on participation of key players and exclusions have to be negotiated…potential to heighten professional tensions  
• Family members may have difficulty becoming involved due to past history with birth parents or family want to take over and just take child and not involve agency |
| **CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS** | • Agreed time frame required within which FGC needs to be held and monitoring system required in lead up to FGC  
• Need to ensure protection / safety needs of child in place  
• Manage multiple visitors to family member as intense contact from co-ordinators and regular agency staff likely at this stage  
• Some professionals may be more anxious to progress to case conference due to view that risks too high  
• Identified triggers required if child protection system needs to be reactivated during process |
| **KEY LINKAGES REQUIRED IN SYSTEM** | • Clear information from CPN system and case managers in respect of care protection plan needed  
• Clear lines of communication to ensure accountability criteria met  
• If child in care, need to ensure that regulations that govern care planning are adhered to and fit with decision-making structures of |

May 2002  Dr Valerie O’Brien, Dept of Social Policy and Social Work, UCD
6.6.5 Routes 4A and 4B

There are two possibilities for referrals to FGC where it is likely that a child protection case conference is indicated. In both instances, the purpose of the FGC is to assist in the assessment of the child protection concerns and to involve the family in devising a plan. This will inform the fuller child protection plan required and the role of the child protection case conference in the process. The variation in the two possibilities is that:

(3) In the first, the purpose of the child protection case conference is to discuss the child protection issues and plans in light of the new information arising from the FGC.

(4) In the second, the FGC is convened to address the child protection concerns and to devise a plan but the case conference forum is required to ratify this plan.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE 4A: WHERE CASE CONFERENCE INDICATED AND FGC ASSISTS WITH DECISION-MAKING BEFORE CASE CONFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Referral for a FGC to assist in the assessment of the child protection concern as part of child protection case conference process</td>
</tr>
</tbody>
</table>
| CRITERIA FOR REFERRAL | • Child’s immediate safety and protection needs met  
• Significant assessment of protection needs and history needed which family can assist in.  
• Clear specification as to what aspect of child protection issue at this stage needs attention at FGC and what the focus of the case conference will be  
• Readiness of agency to share mid to long term plans envisaged based on current information available |
| POTENTIAL CONSTRAINTS | • Lack of clarity between purpose of FGC and Case conference, may confuse, alienate and enrage participants.  
• Essential that co-ordinators has extremely clear brief and knows the different systems  
• Lack of specificity as to aspect of decisions that needs to be focused on at FGC  
• Timing of processes may be at variance with expectations  
• Costly due to partial duplication  
• Many of constraints in Option 2 and 3 also relevant |
| CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS | • Identify the aspects of the FGC plan that can be ratified outside the case conference (short term) and what aspects need to be held over until case conference appraises the information  
• Manage the sequencing of different decision-making  
• How to explain different agency procedures re extended family participation in FGC and case conference models  
• How to avoid overlap and contradictory decision making  
• Manage emotional field of participants; tensions, mistrust and hope  
• Writing style of reports to difference contexts  
• Many of case management implications indicated in Option 2 and 3 also relevant |
| KEY LINKAGES | • Linkages very important to avoid confusion between child protection |
### Required in System

<table>
<thead>
<tr>
<th>Stakeholders and FGC information givers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely that many information givers will attend both FGC and child protection system</td>
</tr>
<tr>
<td>Essential to link with care planning decision-making required under regulation (if applicable).</td>
</tr>
</tbody>
</table>

The variation in the Route whereby the FGC can link with the case conference system is where the FGC occurs, and agency stipulates that this plan needs to be then ratified at the case conference.

### Category

**ROUTE 4B: WHERE CASE CONFERENCE INDICATED AND FGC CONVENED AND FINAL DECISION MAKING OCCURS AT CASE CONFERENCE**

### Description

Referral for a FGC is to assist in the assessment of the child protection concern as part of child protection case conference process. Decision is made at case conference convened after the FGC.

### Criteria for Referral

Criteria are similar as outlined in 4A

- Child’s immediate safety and protection needs met
- Significant assessment of protection needs and history needed.
- Clear specification as to what aspect of child protection issue needs attention at FGC at this stage and what the focus of the Case conference will be
- Readiness of agency to share mid to long term plans envisaged based on current information available

Decision to use this option would occur if the agency was unable to delegate decision-making powers to FGC context (with safeguards) as has occurred in UK.

### Potential Constraints

- Lack of clarity between purpose of FGC and case conference for participants of both held, it may confuse, alienate and enrage.
- Likely that family members will refuse to attend FGC as it would be clear duplication (as has occurred in UK)
- If referral made, essential that co-ordinator has extremely clear brief and knows the different systems
- Lack of specificity as to aspect of decisions that needs to be focused on at FGC
- Timing of processes may be at variance with professional / family expectations
- Costly due to partial duplication
- Many of constraints in Routes 2 and 3 also relevant

### Child Protection Case Management Implications

- Identify if any aspects of the child protection plan can be ratified outside the case conference (short term) and what aspects need to be held over until case conference appraises the plan
- Importance of holding the follow up case conference very quickly afterwards
- Manage the sequencing and processes of different decision making structures
- How to negotiate extended family participation in FGC and parental involvement only or predominantly in case conference
- How to avoid overlap and contradictory decision making
- Manage emotional field for participants; tensions, mistrust yet hope for different outcomes
- Many of case management implications indicated in Option 2 and 3 also relevant

### Key Linkages

- Linkages very important to avoid confusion between child protection...
Options 4A and 4B highlight the core issue of the fit between the child protection system and the FGC decision-making system. Selecting Option 4A may have been the key to solving the problems in the example described in Section 6.3 above.

## 6.6.6 Route 5

Referral from the court under Section 77 of the Children Act, 2001 for a family welfare conference. It is highly likely that this referral will be brought to the attention of the CPNS and decisions will then need to be made in conjunction with relevant case managers. (This option is briefly presented, as it is not the focus of this report)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ROUTE 5 : REFERRAL FROM COURT FOR FAMILY WELFARE CONFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>Court mandated referral or Requirement for HB to convene if applying for a special care order Section 77 Children Act, 2001</td>
</tr>
<tr>
<td>CRITERIA FOR REFERRAL</td>
<td>Decision of Court and must meet criteria laid out in legislation If agency applying for a special care order, they must as soon as possible hold an FWC If court makes referral, FWC must be held</td>
</tr>
<tr>
<td>POTENTIAL CONSTRAINTS</td>
<td>• Timing of case management: in some situations crisis plans will need to be put in place which may impact on FWC • Extended families may not be motivated to participate as the young person may be at the end of a long sequence of difficulties • Tolerance for young person may be low among family members and professionals</td>
</tr>
<tr>
<td>CHILD PROTECTION CASE MANAGEMENT IMPLICATIONS</td>
<td>Referrals from court may not fit with child protection criteria in use in agency, but legislative mandate means FWC must occur anyway</td>
</tr>
<tr>
<td>KEY LINKAGES REQUIRED IN SYSTEM</td>
<td>Need for liaison between court service, probation service, education and health boards (joined-up agency work) Procedures and regulations required Linkages internally in HB</td>
</tr>
</tbody>
</table>
6.7 Managing the Referral Network

In Figure 6.2 a model is presented which may assist in managing the referral process. The key components to this process are the following:

(4) service manager of family group conference service
(5) referral committee comprising of child care manager, principal social worker and service manager. The key position of the first two in the child protection system facilitates joined-up thinking and management strategies
(6) Clear criteria regarding the function of the CPN system is required to ensure that the distinction between the child protection system and child welfare system meets the needs for the children and families rather than being system-led.
FIGURE 6.2 - THE REFERRAL PROCESS (Adapted Lynch, 2002)

Referral

S.W. Department conducts initial assessment of referral

Child Welfare Concern

Child Protection System

Other services provided or NFA

Child Welfare System

Referral accepted: link to CPNS referral dependent

Assessed by Referral Committee:
Child Care Manager
Principal Social Worker
Service Manager

Referral unsuitable

Service Manager allocates case to Coordinator

Service Manager convenes meeting with Referring S.W., S.W.T.L., and Coordinator

Family Welfare Conference convened

No family plan devised

Accepted by Referral Committee or in consultation with CPNS and case manager depending on route of referral (see Fig 6.1)

Family plan devised

Plan breaks down

Plan implemented

Plan to be reviewed

Other interventions or NFA
6.8 The Implications of Change

The FGC is not a simple solution that will resolve a complex issue quickly, but it does offer a model to put into practice the spirit of partnership and inclusivity to truly involve individuals and families in child welfare and protection work. Among the reasons for striving to make this work are the following potential benefits for families:

- A FGC is not a professional framework that families attend, but rather a family process that professionals support;
- The approach strengthens relationships within and between family members and with the statutory services;
- Where there is an entrenched way of working, convening an FGC can offer an alternative way of working;
- The FGC helps the family to work with the Health Board, sharing responsibility and risks, while also identifying supports;
- The FGC helps promote self-determination of family decision-making to its fullest extent, while enabling the statutory services to discharge their duties.

It is worth re-iterating some of the key issues which impact on the approach:

- Children and matters relating to their care and protection are the primary focus of Family Group Conference. The focus of the FGC must be on the child/children and not the broader family;
- The nature and extent of family participation in an FGC needs to be clearly and succinctly defined and understood by both the family and the professionals attending;
- Extended family members attendance at FGC’s must be encouraged and facilitated as far is possible and practicable;
- Families’ reluctance to participate does not necessarily reflect an unwillingness to participate. Families’ fears need to be recognised and worked through;
- Families’ vulnerabilities need to be recognised and sensitively managed in the FGC process (taking account of literacy, language and cultural differences).

From a staffing perspective, there are also key issues:

- This model’s values and principles fits with the way many professionals wish to work with families;
- Training is needed for all staff on the philosophy, principles and theory of FGC to ensure the delivery of an effective, consistent and quality service;
- Professionals of all disciplines need to engage in a more participatory practice with families, and to be aware of the impact of ‘expert identities’ to this process;
- Professionals need to adopt a stance of curiosity towards their practice and to develop receptivity to new and creative ideas;
- Professionals will need to to continue to focus on solutions and strengths if the family empowerment objective of FGC is to be achieved;
• The introduction of FGC’s and FWC’s to Irish childcare practice in general will involve a major shift in both professional thinking and practice;

• Both the practical and emotional demands placed on all parties involved in the FGC process needs to be acknowledged. An appropriate support and supervision structure needs to be in place for co-ordinators and frontline workers involved in the FGC. Supervision should allow the opportunity to reflect on the impact of FGC and to improve to improve practice skills, whilst also allowing an opportunity to debrief.

6.9 Implications at National Level

The different components required to successfully implement a family group conferencing service are expanded in Appendix Three. The development of a single, flexible model of conferencing for different practices across all 10 Health Boards would minimise the individualisation of conferencing and reduce diverging practices. Given the inter-agency and cross-area working involved, this is considered an essential national objective. It is suggested that there is a need for a National Committee/ Forum to oversee the development and implementation of FGC and FWC in the health board context.

Attention is needed as to how the implementation of conferencing in the Children Act, 2001 will impact on service provision and service users. The Act neither prescribes a family empowerment model (New Zealand) or a restorative justice model. The Act does not make explicit a philosophical position to inform the future practice of conferencing in any of the three contexts (Health Boards, the Gardai and Probation and Welfare Services). There has not been criticism of the fact that the legislation neither defines the various types of conferences contained within it, nor makes specific allowance for “private family time”. The private family time represents the singularly most obvious element of a family empowerment model and transfer of power from the professionals to the family. It is essential that the integrity of the model is not lost in the application of FWC model prescribed under legislation. It is also considered that practice needs a chance to develop, especially in the areas and with the client groups involved, before regulation, which it is understood are in the course of preparation, are finalised.

Partnership in all areas of work is deemed to be a desirable aspiration, and there is no area where the benefits of this are more obvious than in the principle of working collaboratively in the area of childcare. It is to be hoped that the ethos behind the whole concept of a Family Welfare Conference will incorporate the principles and practices of partnership with the inclusion of the empowerment (New Zealand) model of Family Group Conferences as an essential element of intervention with families.

6.10 Concluding Remarks

It is the author’s hope that the Pilot Project on Family Group Conference in the North Tipperary Community Care Area, and the resulting evaluation and development work contained in this report, go towards informing the future development of policy and practice in Family Group Conferencing and the Family Welfare Conference Model as legislated for in the Children Act, 2001 in the Mid-Western Health Board. As a model, the FGC undoubtedly will continue to evolve. It is hoped that the proposal contained in this report, and the recommendations contained in the Guidance in the Appendices will...
go some way towards unlocking the model’s potential, and the professionals undoubted commitment to this way of working. This model is one practical way of joining the family and agency systems to ensure that children are afforded the best possible outcomes.
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APPENDIX TWO

PRACTICE GUIDELINES FOR FGC PROCESS

COMPILED BY

VALERIE O’BRIEN AND BREDA LYNCH
PRACTICE GUIDELINES FOR DIFFERENT STAGES
IN FGC PROCESS

Introduction

The guidelines and practice protocols required for the implementation of FGCs are contained in the following sections. It builds on guidance provided in the ERHA evaluation report (O’Brien 2000). The participants in this pilot project who have contributed in the research and training to the development of these practice protocols fits with the spirit of the FGC model, and is acknowledged. The work of the pioneering spirits internationally who have shared their experiences, learning and reflections, especially colleagues in the USA working in the area of family decision-making, Hampshire (UK) and New Zealand (FGCs), is also acknowledged. Much of this work has been developed from a study of family/ professional networks, as part of a relative care project (O’Brien 1999; 2000; 2001).

The FGC is not a simple solution that will resolve a complex issue quickly, but it does offer a model to put into practice the spirit of partnership and inclusively to truly involve individuals and families in child welfare and protection work. As a model it is evolving and undoubtedly will continue to evolve. It is hoped that the guidance and recommendations contained in these summary notes will go some way towards unlocking the model’s potential and the professionals undoubted commitment to this way of working.

FGC’s: An Overview

- Different purpose of meetings will influence the process/ direction
- The FGC helps families work with agency to share responsibility (risks) and to identify supports
- It helps to promote self-determination of family decision-making to the fullest extent possible
- The FGC helps the family co-operate together and not against one another, while taking the statutory role/ responsibility of the agency into account
- The FGC helps the agency and the family co-operate together
- The language of concern is preferable to the language of problems: concerns are what most people agree on while problems are what most people fight about

Circumstances for referring a case for an FGC.

- Child protection issues clear and agency bottom line worked out and defined
- Agency willing to name its’ concerns openly (why are we involved in this family’s life?)
- Worker sees strengths in the family and has hope for change (listen; locate strengths; trust; hope)
Family and agency share a purpose to come together (share does not necessarily mean total agreement regarding issues and it may be helpful for worker to ask ‘what would motivate family to get involved?’)

Agency willing to give family’s ideas a chance

Circumstances for not referring a case or refusing a referral (Read in conjunction with Chapter Five.)

- The family is unable to see the need for change or fails to recognise the concerns of the Health Board
- Cases where there is a lack of extended family
- Extremely high degree of hostility between family members
- Very “dysfunctional” family with similar problems within the extended network
- Parents/Family with chronic alcohol/drug problem
- Parents and/or family suffer serious mental or learning disabilities needs to be clear of the purpose of the FGC and be realistic as to what can be achieved
- Where confidentiality would be unreasonably compromised by involving extended family members
- Families where manipulation is prevalent or where certain family members are very domineering
- If the agency has already made up it’s mind what it wants done for the child
- If the agency fails to see any strengths in the family
- If the worker or agency has given up on the family and are only going through the motions
- If the workers or management do not agree with the ideas behind the meetings, or if the management of other key professionals holds a similar view (and have top heavy management structure)
- If the child needs alternative care but if the reason for care is inter-generational abuse and many issues have not yet been resolved. In this circumstance it may be important to have a meeting and to identify the child’s social network more so than the family network
- If birth parents are adamant that they do not want to involve their families. However if a child is in the care of the Health Board, and if it appears that child will be in care for a very long time, then the implications of excluding the parents and mobilising the child’s network needs to be considered. On only very rare occasions should parents’ wishes be overruled, but this must not be confused with not putting a very strong case to parents as to how this meeting can help the child’s situation.
- If the child is close to adulthood, and is adamant that he/she does not want an FGC, their wishes should be respected. If the child is younger and is not co-operating, then the care status, current situation and future plans need to determine if a FGC should be held.
- Requirements under Children Act, 2001 and any forthcoming regulations will need to be ascertained
In a number of situations an FGC is not appropriate: cases of organised abuse, cases of inter-generational abuse, in any situation where the safety of the child is prejudiced, placed at risk or compromised, where the child does not want the FGC to occur and where the Health Board or other statutory agency assess that it would be inappropriate to hold a FGC at that time.
STAGES OF THE FAMILY WELFARE CONFERENCE

The following are the key stages and sub-stages in a Family Welfare Conference. Each of these is considered in detail in the subsequent sections.

**STAGE ONE**  
*Referral and Preparation*

**STAGE TWO**  
*Information giving*  
- Convening and introductions  
- Clarifying the concerns, issues and resources

**STAGE THREE**  
*Private family time*  
- Private time

**STAGE FOUR**  
*Presenting the plan*  
- Presenting and considering the plans  
- Reviewing arrangements

**REFERRAL STAGE**

(This needs to be read in conjunction with the REFERRAL ELEMENT in Appendix 3)

In many ways, the referral defines the terms of the FGC. Clarity at this early stage is essential. It is important to continue to distinguish that the FGC is about “Family Decision-Making” and not “Family Support”. Clarity about the reasons for the FGC provides the mandate and impetus for the family and professionals to be brought together.

**Pre-Referral Stage**

- Referrer needs to consult with other key professionals that are involved in the case prior to making the referral. Other professionals may be opposed and if so, this information needs to be placed against the agency concerns.
- Agency making the referral must be very clear with family about purpose of conference, issues to be addressed and agency’s statutory responsibility (bottom line). (It is important that the meeting per se is not used by the agency to assess the concern …… equally the agency concern should not necessarily be up for negotiation at the actual meeting).
- Ensure the issues to be addressed at FGC have mandate from other agencies and/ or participants if required – e.g. potential rehabilitation home of a child in long-term care may need to be first made as part of child-care review meeting.
- Clear approval of line manager is essential
**Negotiate the referral prior to accepting it**

- Meet with parents (give leaflet explaining the concept)
- If limited contact between both parents, check legal status of child’s relationship with both and ensure both are visited
- If permission not forthcoming to contact other family members, consider the legal status, reasons for care, length of time care needed for and emphasise the importance of child-centred decision-making
- Introduce the concept: child focus
- Explain the rationale for having meeting
- Obtain permission (keep in mind agency mandate for taking measures/ working co-operatively

Do not be surprised if parents are initially opposed to idea. The following are suggestions as to topics that can be discussed to help parents give permission.

- Ask if it was their niece rather than their child, how much contact/ involvement they would want
- Broaden the idea of family (many initially see it as nuclear rather than extended)
- Parents' usual fear is associated with the imagined anger and disapproval of family for what is happening to them and their child
- Elaborate and discuss the idea of how child’s needs can be met in the family
- Emphasise the importance of developing all the resources in the family to ensure the child’s needs are met
- Be patient if response is slow at first: keep trying while paying attention to continuum between taking measures and co-operation
- If someone in family/ network has shown interest in concept and he or she has an o.k. relationship with parents, enlist their help to involve the parents

A key question remains in what circumstances, if any, should parents’ wishes be overruled? It is very important to work co-operatively with parents and in last instance if parents are still resistant to idea, then the care and protection status of the child, care plan for the child, ongoing relationship between child and parent, and parental ability and willingness to take on board the ideas and issues need to be weighed up.

**Formal Referral**

Following the successful negotiation of permission from the Parent/ Guardian a referral form is completed and forwarded to the Service Manager, who convenes a referral committee meeting (comprising Service Manager, Principal Social Worker and Child Care Manager). The purpose of this meeting is to assess the appropriateness of the referral and will clarify:

- Is there enough information on the referral form?
  - Is it apparent that the child is in need of care and protection?
- Why has it reached this point?
  - What efforts have been made thus far?
- What are the parameters and the bottom line
• Criteria needs to be explicit as to reasons why referral not acceptable

Once the referral is accepted as appropriate, the Service Manager allocates it to a Coordinator. It is at this point that a four-way meeting takes place.

**Four-way meeting**

A four-way meeting comprising, service manager, team leader, social worker, and co-ordinator at an early stage may be beneficial. This would allow the co-ordinator and referrer the opportunity to clarify:

• That the referring agency will accept the FGC plan, unless it places the child at risk of harm
• Where the FGC will fit in relation to other decision-making processes (e.g. Child Protection Case Conferences, legal proceedings and statutory child in care reviews)
• How the co-ordinator, referrer and other agencies will work together, communicate, resolve difficulties during the FGC and how information will be fed back.
• The Referrer and co-ordinator need to clarify who is going to do what in preparing family and professionals for FGC.
• Whether there are any issues of danger for the co-ordinator from family members
  • Identify any outstanding issues that need to be resolved prior to proceeding
  • What are the agency’s concerns?

**Preparing for the Conference**

The Co-ordinator meets the family for the first time.

• Determine interested parties from parent’s and child’s perspectives i.e. use sociogram/ genogram and Ecomap. Some questions that may help to identify key people are as follows:

  Who is the child called after?
  Who would want to be involved if they knew of the current crisis in child’s life?
  Who gets together sometimes?
  Who has been involved to date in helping the family?
  Who has been successful in the family?
  Anyone economically better off? What about godparents?

• If co-ordinator has limited knowledge of particular cultural or ethnic group, it is important to identify resource people to assist in the preparation while preserving confidentiality i.e ask the family who may be of assistance to the coordinator.

• Discuss if certain people are to be excluded: if so, why? Exclusion should only be as a last resort.

• The arguments for and against the inclusion of older siblings should be considered. This may be decided on the basis of age if they are very young. Otherwise it is a matter for discussion by the family and the child concerned.

• Use a Genogram to construct family tree.

• Involve and prepare other professionals.
It is important they are told about the principles and value base of meeting Purpose for professionals to share concerns – not solutions – though it is o.k. to share options which the family may want to consider Important they are reminded of strengths perspective of family Important that they listen as much as speak

- Location (cup of tea and something nice to eat is good for all of us). What would we want for own family if meeting under similar circumstances?
- Venue chosen by family: be creative, while taking account of security/ confidentiality issues
- Children's limited concentration span needs to be acknowledged: Organise two rooms to allow children to dip in and out.
- Confirm date and time
- Make sure haste does not keep key people away
- Draft agenda (give out outline of what will be covered and how it may be covered ahead of meeting)
- Invite participants, preferably by calling directly
- Think of the phone if geographical spread is large: keep in mind the family’s own network will also be in action once the first person is invited.
- Obtain the views of family members unable to attend if appropriate (these views are then put before conference by family members, advisable it should not be co-ordinator)
- Identify advocate, if required, and remind them their role is for the person they are advocating for (may be child or adult)
- If someone in the family is at risk of ‘blowing their top’ and yet are an important resource, ask them to give someone else permission to ‘check’ them
- Sensitivity required to issue of literacy levels
- Obtain the views of professionals unable to attend if appropriate (these views are then put before conference by other professional, advisable it should not be co-ordinator)
- Professionals to make reports available prior to conference (days not hours)
- Prepare other professionals about their role and the process (if not prepared they may argue over the process and family issues get lost)
- Ascertain what ground rules may be important prior to individual participation, and then at beginning of meeting

Factors that may need attention prior to Conference

- Make sure that the referral/ agency concern is clear
- Make sure that the purpose of the FGC is clear to all participants
- Make sure that the values underpinning the process informs conversations with all participants
- Arising from initial conversation and before the meeting, the following factors may need to be noted
  - Seriousness of abuse/ neglect and child’s situation
  - Depth of any expressed anger about who is proposing to care for the child
  - Past unresolved issues that may be relevant to current childcare issue
Current unresolved issues that may be relevant to current childcare issue e.g. domestic violence
Past unresolved issues that are not relevant to current childcare issue
Resistance to the involvement of either of the parents’ families

STAGE TWO – THE CONFERENCE

Ground Rules for Conference and values that should guide the process

- Need for respect for difference
- Accessible information
- Information shared in non-judgemental way
- Consensus
- Agency states concerns/issues that need to be addressed and bottom line, if applicable
- Family understand the constraints imposed by mandates of agency
- Wish to alleviate crises
- Self determination for family decision-making as far as possible
- Advocate

Beginning and introductions of FGC.

- Formal introduction and welcome (family and non-family). Ask people to introduce themselves and state their relationship to the child.
- Purpose of meeting: clarification of why everyone is there
- Outline of meeting (everyone’s role described and defined). Remember complicated language alienates and excludes people.
- Confirm ground rules. Remind people of ground rules that were identified as important in preparation stage
- Commitment of goal to be child-focused
- If family have not met for long time, acknowledgement/ritual may be important
- Child’s needs: builds plan
- It is family’s own meeting
- Co-ordinator’s job is to facilitate, record and distribute material in writing
- Ensure that supports and resources available are presented. It may be very important that written material is given to participants explaining exactly what is and what is not available, including the requirements the agency must work under.

Information giving

Professionals involved share information regarding care and protection issues for children (concerns need to be specifically spelt out in clear language in writing).

- Role clarified
- Written reports (made available prior to conference) to family member in clear, jargon free language containing bullet points rather than social history
- Purpose of this stage is to share information and to encourage dialogue
• What will be done with reports afterwards – needs clarification?
• Put forward the absent members’ views
• Consider putting main concerns on flip-chart in addition to written reports
• Co-ordinator’s role at this stage is to listen, to clarify and to invite family to ask questions/seek information to help them make sound decisions
• Co-ordinator makes sure language understood and questions can be asked
• It may be useful to record the strengths identified in family network alongside the concerns as this may act as prompt to family in their deliberations
• If plan begins to emerge at this stage in too detailed a way, this is the moment for co-ordinator to organise private time
• ‘Now that we have identified the concerns and some of the strengths in the family, we would like to leave you alone to consider what ideas you have about a plan(s) to resolve these issues’ and leave.
• Spell out parameters to be covered in family’s plan.

STAGE THREE – PRIVATE FAMILY TIME

Private family time
Prior to breaking into private family time
• Co-ordinator makes observations regarding clarifying issues and outlines criteria against which plan will be considered.
• Check that all family members have adequate information regarding concerns and resources
• Help professionals leave meeting – this may be difficult for a number of reasons
  - family afraid of being left alone especially if there is a lot of conflict
  - family may think it is discourteous to expect professionals to leave
  - individuals may want individual professionals to stay – picking advocate from social network rather than professional network
  - professional may think people vulnerable, not able…
  - if family numbers are small, temptation may be to stay
  - this level of respect for family’s privacy is new for professional
  - are there rare circumstances for non-family to stay?
  - maybe need for different rooms for different families to meet

• Sentence such as ‘Now that we have identified the concerns and strengths in the family. I would like to leave you as a family group to make a plan. I will be in the room X, and the workers will be down the hall, and if there is anything you need to clarify, please don’t hesitate to call me. If you don’t need to clarify anything, just give me a shout when you are finished’

How to manage unrelated family issues that may take over?
• Pre-empt the problem by discussing it before the family go into private family time
• Ask to focus on child and leave out unrelated adult issues
Intervene if loud voices can be heard from outside for prolonged time?
If someone wants to leave… use the opportunity to intervene?

STAGE FOUR – PRESENTING THE PLAN

Presenting plan and Review decisions
(Specific guidance marked ** to ** based on Hampshire project experience)

**This is a very important stage in the FGC process because it defines the outcome of the FGC for the child. It is important to take ample time on this stage.

- Invite the family to relay their plan
- Clarify and understand each point of the plan. Invite clarifying questions if necessary regarding concerns and resources
- The co-ordinator makes sure that everyone is clear about the plan that is being presented
- The decision should be read back and recorded by co-ordinator to ensure everyone is crystal clear about plan. This can be done by writing each point on a flip chart in front of the family, using the family’s terms, language, phrases etc. and by checking that all the members agree to the plan. By recording all the words of the plan in front of the family on the flip chart. It is easier to check that the plan written up is the plan they have all agreed.
- If agency is not in a position to accept plan either because of legal issues or failure to address safety issue, than a discussion and adjustment may resolve this. The family may then need to go back into private family time. If time is an issue and key people are required to mandate the plan, consideration may be given to making a commitment that agency will revert within 24 hours. (This option is not to be recommended as it sets up other difficulties with the process).
- Once the plan is re-negotiated there is a need to establish the following:
  - Who is doing each specific thing, when will it be done and how is it to be resourced? Establish who will monitor the plan to make sure it is working. This needs to be explicitly recorded on the flip chart.
  - It is important to stress that all parts of the plan are important and are part of the package.
  - One person may have overall responsibility, yet it is important that all involved take responsibility for its’ success.
  - Review action plans and next steps (who does what, and in what time frame)
- The possibility of having to reconvene the meeting should be discussed. Establish in what circumstances is this likely to happen. What will happen if the plan breaks down? Have the family produced contingency plans?
- Professionals must not agree to the plan if it places the child at risk of harm. They must explain their concerns and why they cannot agree. The family should then be asked to reconsider their plan in light of what the professionals have said. They may need more private time. If after these efforts, the family and professionals still cannot agree the matter must be referred to the Project Manager who in turn will refer it back
to the Referral Agency outlining the reasons in writing why the plan was rejected. The co-ordinator will need to be sensitive particularly to the child’s feelings and indications and also to their support people.

- It must be established whether or not the family are comfortable with their plan. If the family have not fully agreed the plan they must be given more time to resolve it, or if necessary reconvene the meeting at a later point.

When the plan is agreed the Coordinator:

- Will tell people explicitly what they (i.e. Coordinator) will do with the plan and who it will be sent to.
- Will invite the referrers comment on the timescales of resources becoming available and how the family will access them.
- May facilitate a discussion on how the family and professionals will work together.
- Will record the dates of future reviews or meetings.

**Closing the meeting**

- Make clear that each participant will get the plan in writing within agreed time frame
- End with positive focus on child and the family
- Thank the participants
- Family may decide to close with a closing ritual if appropriate

**Circulating the plan**

Reviews and follow up meetings are important to ensure that the FGC plan is monitored, supported and implemented. The Coordinator will:

- Ensure that the initial FGC plan is written up and circulated to all family members and professionals within the next two working days.
- Contact any professionals involved who were unable to remain at the FGC the next working day to let them know the plan.

**Post conference**

*The co-ordinator has built a relationship with the family and ‘letting go’ of this may be difficult for them or for the family. If a family member contacts the coordinator post-FGC, they should respond in a positive way and try to link them back to the Referrer or Social Work Department, as appropriate. However, they do not have a responsibility or mandate for any ongoing work with any family member after the work of the FGC is completed, other than setting up the reviews needed.*

**Reviews and Follow up meetings**

The reviews are very important as they offer the family a chance to return to their decisions, talk about how they are working out with the professionals and consider any changes or adjustments that may be needed.

Attention must also be paid to other decision-making forums, like children in care reviews or the Court process, to ensure that FGC plans for the child inform and
`dovetail’ with other decision-making forums. The timing of the review FGC may depend on these other decision-making forums and will certainly depend upon the nature of the plan for the child. The review FGC will be convened by the co-ordinator in the same way as the initial FGC was, but it is likely that far less preparation will be needed. However, private time for families at this point may be shorter than at the initial FGC.**

All notes generated during the course of the preparation for and during the actual FGC by either the Project Manager or the Co-ordinator to be destroyed when FGC is completed. The only permanent form of record to be kept of the family’s participation in the FGC is the referral form and the plan.
APPENDIX FOUR

ANALYSIS OF DIFFERENT FORMS OF CONFERENCING CONTAINED IN IRISH LEGISLATION
**Under Children Act 2001.** (Adapted from Murhpy 2001 in which he examined how JLO experience may assist Probation service in setting up a Family Conferencing Service)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Health Board</th>
<th>Gardai</th>
<th>Probation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislation</td>
<td><em>Section 7 and Section 77</em></td>
<td>Section 29</td>
<td>Section 79</td>
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<td>Meeting known as</td>
<td><em>Family Welfare Conference</em></td>
<td>Conference</td>
<td>Family Conference</td>
</tr>
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<td>Legal Status</td>
<td>Statutory basis</td>
<td>Statutory basis</td>
<td>Statutory basis</td>
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<td>Referral</td>
<td>Referral from Court, family referral or on Health Board’s application for a Special Care Order or possibly in a “child’s best interests”</td>
<td>Discretion of arresting Garda</td>
<td>Direction of Court</td>
</tr>
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<td>Co-ordinator</td>
<td>In-house or out-house</td>
<td>In-house: Juvenile Liaison Officer</td>
<td>In-house: convened by Probation and Welfare Officer</td>
</tr>
<tr>
<td>Processes : Research findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Focus</td>
<td>To resolve a care and protection issue for a child before the courts on criminal matter or as a preventative strategy with a child</td>
<td>Ending the child’s cycle of offending, the causes of involvement in crime and making restitution to the victim</td>
<td>Ending the child’s cycle of offending, the causes of involvement in crime and making restitution to the victim</td>
</tr>
<tr>
<td>Preparation</td>
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<td>Essential</td>
<td>Essential</td>
</tr>
<tr>
<td>Information Giving Stage</td>
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<td>Quality information</td>
<td>Quality information</td>
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<tr>
<td>Private Family Time</td>
<td>Essential component</td>
<td>Variable use</td>
<td>Essential component</td>
</tr>
<tr>
<td>Family Plan</td>
<td>Formulated by the family and agreed by those present and accepted by the Health Board</td>
<td>Formulated by the family in the presence of the J.L.O and agreed by those present</td>
<td>Formulated by the family and agreed by those present. Ratified by the Court</td>
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<tr>
<td>Victim present at “conference”</td>
<td>Presence not relevant</td>
<td>Shall be invited</td>
<td>Presence important</td>
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</table>
APPENDIX FIVE

DETAILS OF FGC STAGES
Details of FGC Stages

There are four stages to the family group conference, the preparatory stage before the FGC, and three stages within the actual conference itself (O’Brien 2001 adapted from Morris 1994.

The Preparatory Stage is where the family agrees to the necessity for an FGC, after which the case is referred by the agency to an independent co-ordinator. The independent co-ordinator has no casework or management involvement in the matter. The role of the independent co-ordinator is to negotiate attendance at and facilitation of the FGC process. In consultation with the child and their immediate carers, the co-ordinator identifies the family network. This is a crucial step as the process needs to be explained thoroughly to the family so there is no confusion, and they can assume their role and responsibilities. The co-ordinator has the power, in consultation with the family, to exclude individuals from participation in the FGC if their presence is considered inappropriate. Exclusion is used as a last resort. The co-ordinator also contacts the professional network and organises their attendance while ensuring they have clarified their concerns.

Then comes the FGC meeting itself. The proceedings of the conference can be divided into three distinct stages:

The Information-Giving Stage: This is the start of the FGC meeting and is chaired by the independent co-ordinator. The professionals share factually and free from conjecture all relevant and pertinent information with the family, outlining their concerns, statutory duties (bottom line) and available resources. It is important that this stage be as interactive as possible, with the family members being actively encouraged to ask for information and clarification as the reports are presented.

The Private Family Time Stage is the period when the family plan in private. The professionals and co-ordinator leave the meeting unless either is requested to remain at the behest of the family, though this should only happen in extreme situations. The co-ordinator is available to them if they wish to clarify issues. The co-ordinator can mobilise the professionals if the family has specific information they wish to be clarified. The task is to agree a plan, within protective limits, that will ensure the safety, welfare and development of the child. The plan ought to include a review date and thought should be given to a contingency plan in the event of significant developments.

In the Presenting the Plan Stage, when the family have agreed their plan, the co-ordinator and professionals are invited to rejoin the meeting. The plan is presented and if acceptable to the agency, the plan is agreed and the resources are discussed. The only grounds for rejecting a plan is if it places the child at further risk of significant harm. In such an event, the family can reconsider their plan or the case goes through traditional child protection channels.

After the conference, the co-ordinator withdraws from the case, and the family and the referrer continue putting their parts of the plan into operation.
APPENDIX SIX

COSTS OF INDIVIDUAL CONFERENCES IN MWHB PILOT
Costs of Running FGC in Pilot

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
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<td>€99.94</td>
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<td>Miscellaneous</td>
<td>€125 flight cost from U.K.</td>
<td>€58.50 Childcare costs</td>
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<td>Total</td>
<td>€155</td>
<td>€158.44</td>
<td>N/A</td>
<td>€45</td>
</tr>
</tbody>
</table>

Compiled by Breda Lynch, Project Managers Office MWHB
APPENDIX SEVEN

MEMBERSHIP OF PILOT PROJECT MANAGEMENT COMMITTEE
MEMBERSHIP OF MANAGEMENT COMMITTEE

Bill Meagher, Child Care Manager
Blair McClure, Implementation Officer: Children First
Breda Lynch, Project Leader FGC
Dr Miriam Toohey, Senior A.M.O
Dr. Valerie O’Brien, Department of Social Policy and Social Work, UCD
Fiona O’Leary, Co-ordinator
Fionnuala Kenny, Senior Community Worker

Frances Minahin, Coordinator
Garda Deirdre Darcy, J.L.O.
Joanna Gallwey, Senior Clinical Psychologist
Margaret Rogers, Barnardos
Mary Liston, Superintendent Public Health Nurse
Peter O’Dwyer, Superintendent Community Welfare Officer
Rena Heffernan, Social Worker

Tim Hanley, Principal Social Worker
Trish Moloney, Social Work Team Leader,

Committee met on a monthly basis to provide direction and focus to the work of the Pilot project
APPENDIX NINE

DIFFERENCES BETWEEN CASE CONFERENCES AND FAMILY GROUP CONFERENCES
Some differences between an FGC and Case Conference

While both the FGC and Case Conference forums involve professional staff and family representatives who meet to discuss issues surrounding a child, the essential differences are who makes those decisions and how those decisions are made.

In case conferences while there is often input from family members, the Health Board ultimately makes the decisions under its statutory powers. The courts of course are the ultimate arbitrators of all decisions.

In FGC, professionals are not part of the decision-making process but participate primarily in an information-giving role. In situations where there are safety concerns for the child the Health Board may set some non-negotiable parameters, e.g. where a child cannot be placed (with a known perpetrator is residing) but otherwise the family plan is determined by themselves.

<table>
<thead>
<tr>
<th>Case Conference</th>
<th>Family Welfare Conference</th>
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<tr>
<td>● Children First defines a Child Protection Conference as an:</td>
<td>● The “power” is devolved to family who act as decision-makers devising their own plan, which is then put to the Health Board and is accepted if it does not place the child/children at further risk.</td>
</tr>
<tr>
<td>● “inter-agency and inter-professional meeting, which is convened by the Child Care Manager/designate. It normally takes place when initial enquiries and relevant, emergency action have taken place. It may take place during the early stages of enquiry, or at any time when concerns arise about a child’s care and protection. The Child’s parents/carers and the child should be included where appropriate”.</td>
<td>● Fewer professionals involved whose role it is to be sources of information, advise and resources</td>
</tr>
<tr>
<td>● Chairperson is not independent of Health Board</td>
<td>● Less formal, the time and venue is designed to suit the family not the professionals</td>
</tr>
<tr>
<td>● The time and venue for Case Conference is at the convenience of Health Board Personnel 1.</td>
<td>● Empowering</td>
</tr>
<tr>
<td>● No recognised involvement of extended family</td>
<td>● Involvement of extended family</td>
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<tr>
<td></td>
<td>● Independent Coordinator</td>
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<td></td>
<td>● Private-time, switches roles, where families were once “excluded” professionals may now feel they are “excluded”.</td>
</tr>
</tbody>
</table>

Compiled by Breda Lynch, Project Managers Office MWHB