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EVALUATION REPORT

ON

PHASE ONE

OF THE

FAMILY GROUP CONFERENCE

PILOT PROJECT

FOR THE

EAST COAST AREA HEALTH BOARD

August 2000

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EVALUATION REPORT

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LIST OF ABBREVIATIONS & COMMON TERMS USED

ERHA	**East Region Health Authority**
EHB	**Eastern Health Board, which was divided into ten separate community care areas, and was replaced by the ERHA in March 2000. The ERHA is comprised of three Health Board Areas.**
ECAHB	**East Coast Area Health Board, is one of the three areas of the ERHA, and is the health board area in which the pilot project is being managed.**
HB	**Health Board**
FGC	**Family Group Conference**
Teams	**Teams refer to the social work team in the health board located within the community care structure.**
Community Care	**Community Care refers to the structure within the health board set up to deliver community based social and health services. The first year of the pilot project was conducted in three community care areas of the EHB - Area 2, Area 5 and Area 10.**
Social Work Staff Structure **Social Worker** **Team leader** **Social Work Manager**	**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 supervision and running the social work team on a day to day basis.**
Hesed House	**Hesed House is a voluntary organisation, which provides a community based counselling, support and family therapy service. Hesed House provided the coordination service for the FGC pilot project .**
Information Givers / Professionals	**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.**
Family Member / Family Members	**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.**

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EXECUTIVE SUMMARY

Introduction
This report provides an overall assessment of Phase One of a three-year Pilot Project, which aimed 'to examine the applicability of the Family Group Conference, as a means of improving the management of troubled and troublesome young persons in the Irish context.' The overall project goals were identified as being to establish whether the use of Family Group Conferences with selected families can:

- Strengthen families' capacities to provide for and manage their troubled or troublesome young persons.
- Satisfy statutory and /or professional concerns about the young persons involved.
- Result in outcomes unlikely to have been achieved with traditional provision.
- Be cost effective.

Methodology
The aim of the evaluation was to examine the role and contribution of FGCs in child welfare, to review practice as it evolved during the life of the pilot, and to make recommendations which would help in taking the project forward. The methodology was chosen to capture the dynamic nature of the processes and outcomes as they happened. The evaluation aims to reflect the project at different stages over its lifetime, and while the findings are local in nature, the international literature provides a backdrop against which the trends arising in the Irish context can be examined and analysed.

The report draws on the experience and views of the participants, as described in Sections Four, Five and Six. It is based on extensive interviews and questionnaires with key participants, as well as information gathered through the provision of training and consultations to health board teams and the co-ordinators. The project manager, and participation in the Project Management Committee during the course of the project, also provided major inputs to the evaluation.

Scope of Pilot Project

By the end of the first year, a total of 19 referrals had been received, from which a total of 10 conferences were completed by mid-July 2000. Three of the referrals made to the project were not approved for conferencing, and conferences were at the preparation stage for six referrals. This report provides baseline material on all 19 conferences, and in-depth analysis on the eight conferences completed by June 2000. It was unfortunate that more of the 19 conferences were not completed by the end of year one, as this would have provided a larger data set for the analysis. However, attempts have been made to include the broad themes emerging in these later conferences by continuing conversations with the co-ordinators, Project Management Committee, community care teams and the project manager up to the time of writing.

KEY FINDINGS

In this section the key findings to emerge in the operation of the pilot project are presented. These are grouped according to the four stages of the conference process, as well as context areas such as general and organisational issues. These findings, primarily from Sections Four, Five and Six together with the analysis in Section Seven form the basis for the recommendations for taking this project forward.

General

- Major developments in child care policy and practice are underway in the agency in which this pilot project was carried out. The change from one Health Board to three Health Boards areas in March 2000 was a significant organisational change, with consequences in terms of staff deployment, arrangements for service delivery, geographical boundaries, organisational and management arrangements. This created a context of uncertainty, in which the pilot was conducted.

- Nineteen referrals were accepted into the pilot project within the period October 1999 to end of June 2000. Three cases were withdrawn during the preparation stage, eight were completed and eight were ongoing at the time of the evaluation.

- The nineteen cases were primarily referred from Community Care Areas 2, 5, and 10. In one case Area 5 shared a case with Area 9. Area 2 referred five cases, Area 5 referred six, one of which was jointly shared with Area 9 and Area 10 made three referrals. Of the nineteen referrals, fifteen came from the Health Boards and four from voluntary agencies.

- The cases referred would be considered as being on the lower scale of risks, rather than dealing with severe child protection issues. (The term 'scale of risk' is used generally, as there is no agreed scale of risk in existence within the agency in which the research was conducted).

- The age profile of the ten children involved in the project ranged between the ages of 0-7 years (40%), 8-15 years (50%) and 16 years + (10 %). A gender analysis shows males as representing 60% while females represented 40% of the children included in this study.

- The basis for Health Board involvement with individual families ranged from Child Protection concerns [inclusive of Family Support Service as a secondary service] (63%) to a child being in care on a voluntary basis (37%).

- All the children in respect of whom the conference was being called had been involved with the Health Board in the past.

- 75% of other family members had had prior substantial involvement with the Health Board, with the remaining 25% categorised as unknown.

- It was found that 80% of these cases referred to the pilot were accepted within two weeks of the referral being made, and the remaining 20% took a further week.

- The period between acceptance of the referral and the holding of the FGC was three weeks in 75% of cases and four weeks for the remaining 25%.

- The average length the co-ordinators spent in preparation from referral to the holding of the FGC was 30 hours. The inner and outer times ranged between 25 - 35 hours. The entire conference generally took an average two and a half-hours.

- The total number of hours the co-ordinator worked in facilitating the conference from referral stage to completion averaged 33 hours. Geographical location, cases involving large numbers of invitees and complex family situations contributed to the variation in time scales. The time commitment involved has major implications for the resource requirements for FGC if it is implemented on a broader level. It can also be expected to impact on the system of payments, as fixed price contracts may not take account of the evident variation.

- In almost 90% of cases the FGC was held on a weekday, with the remainder at the weekend. The preferred time for three of the FGCs was the evening, which generally accommodated working members of the family network, while the others took place during day time, generally in the afternoons.

- In 95% of cases the preferred location for the FGC was a community or parish centre, as it was deemed to be a neutral venue for all participants. It also facilitated the practicalities of a sizeable group meeting. The small number held in the families own home was also a feature.

General Training

- During initial training, the workers were not slow at identifying some of the potential pitfalls of the project. They wondered if some families with major difficulties may be too damaged, and questioned if they would have any resources to offer. They cited anxieties that too much would be expected of families, and that the process might be risky for staff, in terms of families not protecting the child adequately.

- The staff wondered if the project would simply mean more work for them, especially as they were already feeling very overworked, in a context of big changes in organisational structure, and with frequent staff turnover.

- On a practice level staff wondered if they had the ability to sell the ideas to families, and they expressed concerns also for individual family members who may be left feeling vulnerable as a result of the process.

- Most co-ordinators felt that the training had equipped them well for their work, but in the absence of previous Irish experience of applying the FGC model to family situations, a lot of decisions had to be made as different situations

presented. Many of the questions raised initially in training could not be answered definitively at that stage, and the co-ordinators were able to negotiate many of these issues in their practice.

- The co-ordinators raised the need to have joint training with the social workers. This was avoided initially as it was felt the co-ordinators needed to have greater certainty of their own role and authority, which would come from direct work experience. It was felt that premature co-training may have increased mistrust between the two groups, which would not have helped the progress of the project.

- A second round of training was initially planned during phase one for the team members. This did not happen as a decision was made that it was more important to engage the team leaders and managers. On reflection, if the training had been provided in conjunction with the workers with direct experience, the teams may have had a greater sense of ownership of the project and may have increased the flow of referrals at an earlier stage.

Referral and Preparation

- The social workers played a key role in encouraging the birth parents of the children to allow the meeting go ahead in many of the cases.

- Co-ordinators experienced frustration in trying to get people, who were considered important to the process but were reluctant to get involved for whatever reason, to attend. They also experienced difficulty in making contact with family members and information givers who had often changed address or work setting. Mobile phone and landline numbers provided at the referral stage were not always in service, which added to the difficulties experienced during the preparation stage.

- Co-ordinators were surprised at the extent to which the idea had to be sold to families.

- The lack of clarity regarding the agency concerns made the job of co-ordinator difficult. In a number of cases the family view and understanding of the agency concern differed from the agency view as expressed to the co-ordinator at the time of referral.

- The lack of clarity surrounding agency concerns resulted in complex negotiations between the referrer, project manager, co-ordinators and family members, as it became clearer that the mandate for the FGC was not agreed by all involved. This points to a need for greater consultation among the referrers themselves, and between the project manager's office and referrers, prior to the case been passed on to the co-ordinator.

- Large numbers of professionals from non-Health Board agencies had limited understanding of FGCs as they had not had access to training. This meant that the

individual co-ordinator was involved in an induction role at a time when they were extremely busy with other issues.

- The co-ordinators were in full agreement about those in attendance in a quarter (25%) of the cases, and expressed a partially different view in half (50%) the cases.

- Enthusiasm in training does not necessarily lead to major change, as reflected in the limited number of cases where the FGC was seen as applicable by the teams, and as demonstrated by the slow rate of referrals.

- The actual slow rate of referrals needs to be seen against the major reorganisation, as well as staff turn-over and shortages, that were ongoing in the health board. This may also explain the failure of the project to access the team leaders adequately. They were seen as pivotal through their supervisory roles.

- The lack of formal information sharing at team meetings by the social workers that made referrals during the course of the project meant that opportunities were lost to engage other potential referrers in the teams.

- Arranging the conferences posed great challenges and frustrations for the co-ordinators. In over half of the cases the co-ordinators found arranging the FGC as being quite difficult. The difficulties revolved around the clarifying of agency concerns, waiting to make contact with families, waiting to make contact with social workers and dealing with misunderstandings between the family and professionals at the referral stage.

- Having access to a flexible expenses budget to enable the co-ordinators to facilitate participation, and to remove practical and perceived barriers to attendance, was essential during the preparation stage.

Attendance

- The number of family members who attended the FGCs averaged five, varying from three to seven.

- A very positive aspect of the pilot was the extent to which family members were located and contacted, and in most instances they also attended the conferences.

- It was reported that in 50% of cases the social worker and child worked together with the co-ordinator to negotiate attendance of the wider family. The mother and co-ordinator were the primary negotiators in a further 25% of cases, and the social worker and co-ordinator in the remaining 25% of cases.

- In terms of the professionals attending, the mother invited them in 38% of cases, the child in 25% of cases, the mother and child jointly in a further 25% and another person in 12% of cases. Those with statutory responsibility such as Health

Board social workers and team leaders were automatically invited and could not be excluded.

- Attendance of Professionals was high, with 95% of those who were invited present at the conference.

- There was full agreement, with no conflict, regarding who should attend in over half (53%) of the families. Just under a third (31%) experienced minimal conflict while the remaining group (15%) were able to resolve their conflicts through negotiation. Families were quite adamant in many cases that invitations should not extend beyond family into social networks, to maintain the privacy of the situation.

- Tension regarding the intra and extra familial attendance related to sibling rivalry, strained relationships among extended family and a desire to contain the problem within confines of the family and away from the family's social network. This may have implications for children choosing who attends and a possible clash of rights of parents, legal guardians and the rights of the child(ren) to have their wishes heard.

- When asked about the appropriate professionals to attend, the majority of information-givers considered the right professionals were in attendance.

- 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.

- A very small number of exclusions occurred based on family's decision to exclude a person with a drug problem. In another instance a family member chose not to attend and, due to his position of power within the network, that also had an impact on the willingness of other family members to attend.

- The great majority of families (80%) 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 (20%) expressed some uncertainty.

- Many of the families' fears were dissolved 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.

- The greater portion (74%) of family members felt they were adequately prepared in all aspects of the FGC in advance of the conference, while a small number (5%) felt some gaps remained for them. Others (21%) considered they were not adequately prepared. This was due in part to people being invited where there was insufficient time for the co-ordinator to prepare them more fully for attendance.

- Some family were of the view that 'the leaflets were helpful in describing how it worked', though in a smaller number of cases the family members had not been given the information by the referrers. This omission was an issue, considering leaflets were available.

- Families generally felt hopeful and optimistic about what would be achieved by attending the conference, as the process was something novel.

- There is a need for greater guidance for the co-ordinators on whom to privilege when there is a dispute over attendance. There is also a need for guidance on the involvement of children, especially if parents have a different view from the children and the children are young adults.

- Slightly less than two-thirds (62%) of the family thought the right professionals were in attendance while the remainder either did not know (21%) or did not agree with those invited (16%).

- When considering family member attendance, half the professionals were of the view that the wrong family members were invited, while three were of the opinion the right family members were invited.

- In view of the many one-parent families involved, it is positive that the paternal family was so involved. This can be difficult in practice, as the breakdown of the adult relationship often can leave the child vulnerable to losing contact with one side of its family.

- If there is conflict between the maternal and paternal side, which, if either, side should be privileged remains an open question? In what instances (if any) should two separate FGCs be held and if so, how are potentially different plans to be resolved? When there are differences between family and child members in respect of who should attend how can these differences be reconciled, and whose interests should prevail? These are key questions that will continue to challenge the stakeholders involved in the process.

Information Giving

- The co-ordinator played a pivotal role in setting the tone of the conference. They were viewed by family members as being neutral, and a bond had been forged between family and the co-ordinator through the home visit.

- The average length of time for the information giving stage of the actual conference was 45 minutes.

- The majority of family members felt the information giving stage was handled well, with some 85% of family members feeling they got adequate information at this point to enable them make a decision.

- In many cases families said that there was nothing new in what was being said, but it was still useful for the concerns to be heard as a group. Other family members commented that it was the first time the truth had come out all at once and they now felt they could do something about it.

- Families felt there was a need to make a distinction between outlining options and discussing the advantages and disadvantages of the various options and being non-directive.

- The co-ordinators generally had a positive view regarding the quality of information presented by the professionals to the family to enable them to make a decision. It ranged from being sufficient in all parts for slightly under two-thirds (63%), to the remainder being sufficient in some parts (37%).

- Fifty-five percent of the information-givers felt the information shared was complete and comprehensive, while (22%) felt it was complete and comprehensive in part. The remaining (22%) of the information givers did not indicate their views.

- Almost half the family members (47%) felt the available resources were pointed out to them, while others (32%) would have liked more information.

- The majority of information givers (88%) felt the available resources were pointed out to the family sufficiently prior to private family time.

- The overall view of the co-ordinators was that all family members had the opportunity to speak if they wished.

- Thirty-three percent of information-givers considered there was a significant difference in the information produced for the FGC when compared with a case conference, while 12% though there was slight variation. 33% deemed the information produced for the two types of meetings to be the same. 22% did not indicate their view.

- Seventy-seven percent of information-givers rated the conference as being child focused and the remainder (22%) did not indicate a view.

- The information givers, especially from external agencies, found they were not always given the information necessary to ensure they understood exactly what their role was. In the majority of cases, the information givers had received the explanatory booklet prepared especially for professionals, but felt this did not equip them satisfactorily.

- The greater number of family members (79%) felt the professionals listened to them very successfully. A further group (11%) felt successfully listened to. Almost everyone (95%) felt they had the opportunity to speak if they wished and over two thirds had whatever questions they had answered. Family members (21%) felt most of their questions were answered while a similar proportion (21%) had outstanding questions remaining. The challenge is to have a context to enable these unasked questions to be asked.

- *Information-givers need to use clear language in their reports. The concerns of the agency should be presented alongside the strengths of the family to avoid an overly negative description. Family members should receive copies of the reports presented to enable them to proceed with their work during the private family time.*

Private Family Time

- On the withdrawal of the professionals from the meeting, private family time was found to be on average 60 minutes long, ranging from 90 minutes down to fifteen.

- It was found that when children were present, there was greater attention and sensitivity to how things were said, and every attempt was made to make it clear to the children that the situation was not of their making.

- The impact on the child attending private family time was found to be positive, and there was consensus that the advocate system worked. In cases of the young people who stayed, some left when the tension and emotion got too much. This was seen as an appropriate way for the young person to exercise control over the process.

- A number of family members commented that the process might have been easier if someone had to sit in with them. In almost equal measure, family members totally opposed the idea of an outsider and saw that it would work against the family making the decision. Undoubtedly, the experience of family coming together under circumstances where a state agency has an issue in respect of one of their children is likely to evoke a wide mixture of emotions.

- While the greater number of family members (47%) experienced no difficulties or abusive behaviour as a result of the professionals not being there, of those that did, most found it manageable (42%) with two out of nineteen people experiencing abusive behaviour.

- While the process is being experienced as positive by the family, coming together to discuss a family problem can be a painful experience for some individuals.

- The issue of professionals staying with the family during private family time must be examined from the perspective of what assistance the family needs from an outsider. When this question was addressed, it became clearer that the difficulties were associated more with the difficulties of having to make a plan with limited information regarding available resources, rather than needing someone to help with conflictual processes. In other words help was required with the task rather than the family dynamics.

- Discussions in the absence of the professionals were easier for family members for the most part (53%) and a sizeable number (42%) experienced no significant difference due to professionals leaving. It is important not to confuse this finding with the importance families placed on the benefits of having the time to address the issues in private, even though in many instances this was not easy and some families did get stuck.

Presentation of the Plan

- The presentation of the plan for review and ratification by the professionals took on average 50 minutes.

- The processes surrounding the presentation of the plan by the family warrants special attention. The finding that the details of many of the plans had to be further negotiated after the private family time is an issue. This finding may reflect that the passivity of the professionals during the information giving stage was seen by some family members as connected with the difficulties of coming up with a plan. Some family members felt that the information given was not always as clear as it could be in addressing the long-standing issues that had resulted in the current crisis.

- The ambivalence that family members felt towards the attendance of professionals was seen later at the presentation of the plan. A number of family members questioned why all the professionals did not attend this stage. The family members thought they could have made the effort to remain to hear what the family came up with, and to be available to help the family with their decision-making if there were issues.

- The co-ordinators in half the FGCs (4) did not have a pre-conceived plan in mind before going into the FGC while in two FGCs the plan that emerged was very similar to their expectations.

- Upon reflection, the majority of family members (41%) would still choose the same plan, while a lesser number (32%) would only make minor changes. Three out of the nineteen respondents would have liked a totally different plan while two did not know.

- Just less than three quarters of the family members remembered the plan in its totality while another group (16%) could recall quite a bit of the plan. Almost half (47%) had very similar ideas regarding the plan reached, prior to attending the conference. In the majority of FGCs (74%) the plan was accepted as presented and in the remainder (26%) with only minor modifications.

- Over half (53%) of the family members were very satisfied with the FGC plan in resolving the problem at the time, while a further group (16%) were quite satisfied.

- A review was scheduled for two-thirds of the plans, and omitted from one-third of plans.

- There was explicit reference to the monitoring of plans in 88% of cases, and this was seen to be the remit of the designated social worker. In the remaining case, no overt reference was made to the monitoring of the plan.

- Families overall impression of the FGC was positive. The majority (74%) found it good in parts. Just over one-third (37%) considered the child's situation to have

improved while similar percentages (26%) considered it remained the same as before or had got worse. Two of the nineteen respondents did not know.

Outcomes

- The lack of a specific review date or the long duration between review date and FGC emerged as an issue for family members. This was clearly connected with their being unsure as to what was to happen if the plan began to disintegrate. Similarly, there was confusion among family members as to the composition of future reviews. The issues requiring clarification are as follows: Who would organise the review? Who would be invited and by whom? Where would they take place, and what would be the role of the co-ordinator?

- The place of reviews is a central issue that needs clarification, and it is important not to confuse the need to have a second conference around the concerns, as distinct from having review meetings to examine the progress and the need to make necessary changes.

- Approximately half of family members (48%) reported an improvement in family relationships as a direct consequence of the FGC. Many who considered the FGC had no effect commented that the family already enjoyed good relationships and good communication, prior to holding the FGC.

- Almost three-quarters of the family would choose the FGC process at a future date if faced with similar difficulties. 21% of the families showed a preference for the health board to deal with it using conventional means, while (5%) said they would prefer to sort it out themselves.

- Almost half (47%) the respondents were unaware that the co-ordinator was not an employee of the Health Board, while others (32%) were aware of their independence and yet a further group (21%) selected no option.

- No examples were cited of creative or innovative conference plans. Nonetheless, there was, subject to some discussion, a high degree of acceptance of the family plans as proposed. In this context the fact that there were no innovative or challenging plans may be viewed positively, in that too radical or challenging plans at this point may well have been a "change overload".

Organisational Issues

- Despite a short lead-in and implementation period (compared to other pilot projects) the project management committee was flexible enough to cope with the changing context. Relationships between most of the participant bodies worked well, which again indicates a successful project structure.

- The structural relationship between the project manager's office and the community care teams is an area that requires attention. The structure, whereby

the project manager worked to the project management committee with no formal line to the social work managers and other key management staff, was seen to impact on the referral rates and the way in which practice and agency issues surrounding the referrals could be dealt with.

- It is difficult to give an accurate portrayal of the fit between FGC model and the child protection protocols, given the high level of both internal and external change that is occurring in the child-care system. The urgent need to take account of the inter-linkages between each of the developments is important, especially at national level.

- One aspect of the originally intended project structure which was not put in place was the national committee. This committee was intended to have a role in terms of liaison at both inter-departmental and interagency level, and was intended to be under the aegis of the Department of Health and Children. While the absence of this committee did not impinge on the actual operation of the pilot, it obviously has consequences in terms of giving wider exposure to the concept of family group conferencing and the place of the FGC model in future service delivery. It also contributed somewhat to difficulties for the external members of the management committee, in terms of the mandate of the pilot project and expectations from their own organisation, and their organisations future participation and use of the FGC model.

The Co-ordinator

- The co-ordinator's skills that were identified at the training of the various participants and when the participants were asked to reflect on their experience of participating in the FGC are given below. The main skills are those of negotiation, diplomacy, tactfulness, and having an ability to resolve conflict. Knowledge of the statutory organisations, families and inter-agency collaboration was seen as vital. The job is seen as very demanding. For co-ordinators coming from a counselling background, there is a need to avoid slipping into the therapeutic role, and retaining a focus instead on negotiation.

- Over the course of the year of the pilot project, the knowledge, skills and understanding of the FGC process and the complexity involved in family-professional relationship in the child welfare system, grew among the co-ordinators.

- Over the course of the year, they helped refine the role of co-ordinator in an Irish context. Yet there are issues at the different stages which still need clarification**.** These issues centre predominantly on the following questions:

  Are there a number of critical steps between identifying a potential referral; seeking parental permission, clarifying agency concerns and ensuring all other statutory and best practice issues are attended to?
  Is the resolution of these issues essential prior to commencing the preparation of family members, or is it likely that key unidentified issues will continue to emerge during preparation?

Who takes responsibility for preparing family members and other professionals at the preparation stage?
What structures are needed between the co-ordinator, the project manager and the referring agency to address issues of best practice?

What formal level of information is required at the referral stage?

To what extent does the co-ordinator need to facilitate more discussion in the information-giving stage?

Is there a potential role for the co-ordinator in the private family time?

- The resolution of these role issues would enhance working relationships between the co-ordinator and social worker and other information-givers.

- The key challenges facing the co-ordinators in the pilot were:

To show the Health Board staff that they, as outsiders, can be trusted to deliver a process, which is designed to enhance family decision-making;
To show that the role of co-ordinator is not in competition with, or is not a privatisation of the role of social worker and information giver;
To convince Health Board staff that the independence of the role can free up the social worker to do other vital work;
To exercise authority in the role, given that the co-ordinator has no statutory basis at present and the professionals and family members may feel that their statutory position outweighs the co-ordinators;
To maintain a position of neutrality and curiosity in the face of often competing discourses, stories and aspirations;
To be persuasive without being coercive of the family;
To let the family know they have power without being disrespectful of the agency and vice versa.

:

Costs

- The base line information on the costs of service provision was not available in a format that would be necessary to do a comparative cost analysis.

- To facilitate this exercise, a number of performance indicators and output measures need to be agreed, built on both quantitative and qualitative measures.

- A total of £674 was paid out in relation to the actual convening of the seven conferences, which averages at £96, ranging from £75 to £150. This cost is comparable to the Northern Ireland and UK experience (Interim Report 2000).

Conclusions

- It is clear from the results of this pilot project that the FGC is a most effective means to include and facilitate families in planning for, and thereby strengthening their capacities to provide for, and manage their troubled and troublesome young persons and children. The unequivocal experience in this project was that families were willing to be involved, and were capable of coming up with acceptable plans while operating within the principles of the FGC. The respondents reported over-whelmingly that they had felt listened to, and there-by had more ownership of what emerged.

- It is equally clear that, although it is a new way of working, and requires a major shift for workers involved, that the experience was that the plans developed by families using the FGCs were deemed acceptable in all cases to the statutory agencies. The FGC is a vehicle that is based on partnership and inclusion, and fits with both current and proposed legislative principles, as well as good professional practice. It is further concluded that the FGC model required very little adaptation for use in an Irish context, though the challenges lay in finding the fit between the model and the context in which it was applied.

- It is less clear however, and it is a limitation with a short duration pilot project, that the plans will continue to work into the future. The major difficulty of explicating outcomes (See Section 1.5) in very complex family/ professional networks as a result of introduction and implementation of FGCs has been acknowledged as a major issue (Stevens, 2000). The challenge for all involved is to continue with efforts needed to develop methodologies through which this can be achieved.

- In overall conclusion, it may be stated that the FGC was valued by participants in this study, in terms of its partnership and inclusiveness ethos. It is suitable for use in an Irish context, it is effective in terms of getting a widely accepted plan developed, and it has clear potential to improve the management of troubled and troublesome young persons and children. While the difficulties associated with bringing the FGC into mainstream practice are acknowledged and enumerated in this report, its fit with the values and principles being increasingly deployed across public services, makes the effort of extending the practice not just desirable, but essential, in this era of openness and accountability.

Taking FGCs into a More Extensive Application

- FGCs' have a straightforward structure that is clearly delineated into separate stages. Within this model, the roles of the different participants are relatively clear-cut. Despite the simplicity and relative clarity, the model is a huge shift from traditional ways of working with families, and associated attitudes and values. The main difference in the FGC approach is the formalising of a wide definition of family members and the use of private family time. The independence of the co-

ordinator introduces recognition of the importance of facilitation between what may be two disparate systems.

- As part of the process of initiating this project, the application of the model was systematically reviewed, and this experience resulted in protocols being developed for the different stages. Much has been learned through the experience of the pilot project, and a series of updated summary practice protocols are outlined in Section Eight of the report.

- It was concluded as a result of the pilot that the model per se required little adaptation for use in an Irish context, and that the challenge was to enhance the fit between the model and Irish child welfare practices. In moving forward to Phase Two, it is vital to build on the experiences gained through Phase One of the project. A series of key recommendations are developed in response to the analysis of each of the evaluation questions posed. These recommendations provide the basis for going forward.

RECOMMENDATIONS

Referral/ Preparation stage

- Flexibility is needed around the issue of attendance of the children at the FGC. While clear benefits of attendance have emerged, the age of the children, their developmental stage and capacities, the availability of an advocate and the expressed wish of the child should continue to be used to guide practice. This also applies to the place of children in the private family time.
- The issue of practice difficulties surrounding exclusions requires careful attention, and tactful negotiation.
- Greater attention needs to be paid to assessing both the social networks as well as the family network.
- Consideration should be given to giving family members a copy of the professionals' reports before the meetings so they can be prepared in advance. Families should have copies of all reports left with them.
- Further attention needs to be given to the provision of a standard type of information to the co-ordinator, which will addresses the concerns of the agency and points to any key information that has a direct bearing on the issue under consideration.
- Information packs needs to be given to all family members and attempts made to ensure that family are fully prepared for the conference.
- Co-ordinators and professionals making referrals may need more training and guidance on the extent and nature of the advance preparation to be given to families.
- The key issue of who is the family needs further attention and who in the family on behalf of the child can exclude others especially if this may result in the child potentially losing contact with one side of their family.

Role of Co-ordinator

- The independent position of the co-ordinators should be maintained for Phase Two.
- The role of the co-ordinator in the project should be in accordance with the Practice Guidance Notes in Section 8
- It will be necessary to ensure that an adequate cohort of suitable co-ordinators are available as the project enters Phase Two. This is particularly the case if there is to be an expansion of the project into more community care areas, and the types of cases expand from welfare only cases to cases which incorporate a welfare and justice focus.
- In seeking organisations or individuals to provide co-ordinator services, based on the experience of the pilot project, the following points should be considered for inclusion as criteria:

Commitment to the needs of the child as paramount;

Commitment to the principles of participation, social justice and community empowerment;

Knowledge of the child care services, and organisations operating therein;

Highly trained and skilled staff, experienced with inter-agency, family/ professional systems, skilled in negotiation and conflict resolution, with a commitment to professionalism and ethics;

Capable of providing full support service.

- Co-ordinators support group should be formalised
- The system of collaboration and communication between co-ordinators and Project Manager should be maintained

Information-Giving Stage

- Co-ordinators need to consider how information-giving session may be more interactive and less reliant on professionals merely reading out reports. This will require careful facilitation if it is to avoid getting into a renewed problem definition/ assessment session or a therapy encounter.
- More information needs to be provided to family members on resources and options available for solutions.
- Information givers need to keep personal information to the minimum to avoid undue embarrassment.
- The information needs to be clearly presented, and the resources available to support the family made explicit.
- There is a need to consider facilitating more discussion of the options after the information giving stage.

Private Family Time Stage

- The private family time may be enhanced if the co-ordinators stay after the information givers leave to help the family make the transition. This needs delicate handling and it is important that the advocates are checked with, in particular to ensure that the vulnerable family members are ok.

Plan Presentation Stage

- There is a need to establish and convey to the family a set of criteria against which the proposed plan will be assessed. This should include a clear system for monitoring the plan, and an early warning system in place to alert the key people in the event of this not happening. The failure of the plans may not have immediate impact on the protection of the child, but in medium term it is important to alert the key players before the situation deteriorates further. The on-going communication of developments in relation to the child within the family should also be included, although this has to be balanced with privacy issues. The arrangements for reviewing the plan should be included.
- There is a need to construct key performance indicators and output measures that can be used for comparative purposes. These could include:
  No of plans (%) accepted without amendment
  No of plans (%) accepted after further discussion
  No of plans rejected

General

- 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 report can make a significant contribution to a co-ordinated and coherent future policy across the organisation.
- Further work is required to monitor cases longitudinally and to compare the outcomes of the FGCs that have been held.
- The model of the FGC as applied in the Pilot Project does not require any significant adjustment to operate satisfactorily in an Irish context. Such minor modifications as may be required will flow from the context and use proposed for the FGC.
- The project structure put in place for Phase One of the Pilot Project was effective in ensuring good relationships generally between the participant groups, and in seeing the required deliverables completed on time. Significant organisational changes have occurred since the project commenced, but it is recommended that a similar structure, expanded and developed to take account of the scale of project chosen, is created to deliver and oversee Phase Two. Consideration should be given to upgrading the position of project manager from a Team Leader grade to a social work manager grade, given the projected expanded volume of work and scale of the office for later phases. This could also facilitate better liaison between the project office and the social work managers, which was an issue in the pilot project.
- There is a need to examine how team accountability regarding the referrals made can be built into the job of project manager while avoiding an over rigidity, which could have the effect of diminishing referral rate.
- There is a need for greater multi-disciplinary and inter-agency involvement in the structure, provided the brief of the project is clear in terms of receiving referrals from all sectors.
- There is a need to incorporate the option of an FGC explicitly into case discussion at allocation meetings. If a decision is being made not to refer, the reason should

be listed. Equally at different stages of case management review, the option of FGC should be raised and a similar exercise of setting out reasons for not using FGC should be noted. (The attitude to FGCs would undoubtedly also change if their use was underpinned by legislation as proposed in the Children's Bill, 1999.)

- There is a need to take account of the impact of the mainstreaming of the family group conference.

Training

- *The success or otherwise of an initiative such as introducing FGCs is dependent on developing the interest and enthusiasm of the workers involved. The provision of training, which introduces the subject and facilitates workers to contribute to its development, is perhaps the most tangible and direct way of achieving this. Notwithstanding the practical difficulties, it is recommended that training along the lines developed for the pilot project be provided for all social work staff in areas that are going to use the method. Tailored training needs to be extended to other disciplines within the area Health Board and to organisations that interface with the services provided and who need to understand the principles and operation of conferences.*
- It is recommended that the first group of workers who have referred cases and worked in the conferences should be utilised in training.

Costs

- Given the focus on quality services and value for money, appropriate service and financial output measures and performance indicators need to be developed for FGCs. It is suggested that the following be considered as an initial guide
  - No of cases referred to Project Office as a % of cases entering the system
  - Referrals approved for conferences as a % of overall referrals
  - No of referrals decided upon within 2 weeks of receipt
  - No of conferences held within 2, 3, 4, 5, 6, >6 weeks of approval to hold

- There is a need to put systems in place to collate base line information required for assessing costs of FGC project.
- There is a need to put systems in place to collate base line information required for assessing costs of traditional service provision.

1.1 Introduction to Report

This report has been commissioned to appraise and draw together the main findings of Phase One of a Pilot Project on Family Group Conferences (FGCs) in Ireland. The pilot project was conducted in three community care areas of the Eastern Health Board (EHB), now the East Region Health Authority (ERHA), over the period May 1999 to June 2000[1]

The project was concerned with introducing and operating Family Group Conferences (FGCs), as originally developed and used in New Zealand and now in more widespread use, in an Irish legal, organisational and professional context.

The report describes the FGC process and the pilot project in depth. It contains 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 evaluation questions set by the Project Management Committee. The report also presents a revised and updated version of Good Practice Guidelines which were developed and used in the training phase of the pilot, and which take account of the views of participants and the main findings and recommendations. These are proposed for use if the Project is extended into Phase Two, as originally envisaged.

1.2 Introduction to Family Group Conferences

1.2.1 Emergence of FGCs

The convergence of a number of trends in child care in the 1990's has led to the development and implementation of "Family Group Conferences" as an innovative practice for working with families in the area of family support, child protection and child placement. The trends that influence this development are:

- A renewed emphasis on the importance of children's families of origin for their developing identity, and a realization that over 80% of children return to their family of origin on leaving care (Milham et al 1986; Dept of Health 1992; Thoburn 1989).
- Partnership, and participation of families in decision-making, is now recognized as an important principle in child-care thinking. Partnership points to the increased participation of birth families in child care decision making. Partnership as a concept is welcomed, but is ill defined, meaning different things to different people. Research shows however that unless birth parents are helped to engage fully in the process of participation, opportunities are lost to maximize the benefit of increased participation. (Thorn 1995).
- Greater focus on the potential of children's extended families and social networks to offer support and care in times of crisis.
- An increase in the number of children requiring care has resulted in a large increase in the use of relative care placements as a care option, due in part to the shortage of foster care placements, and the shift away from residential care. An increasing percentage of children are in the care system on the basis of court orders.
- Social workers are seeking opportunities to develop models of practice that are geared towards working in collaboration with individuals and families, as practice based solely on child protection leads to disillusionment, burn-out and a high turn over of staff.
- Recent legislative change places greater emphasis on taking account "of the interests of the child".

[1] See abbreviations and definitions of terms on pg. iv.

These shifts in child-care thinking and practice may in part be attributed to a negativity linked to State intervention in families, which is seen as hostile and uncaring. In the current climate of "professional as expert" the risk assessment models of practice seldom invite any direct involvement of wider family networks in the assessment process. The risk assessments treat people as "objects of assessment", resulting in a checklist mentality that leaves little space for class and cultural difference.

1.2.2 Development of FGCs in New Zealand

Family group conferences originated in New Zealand in 1989. The context of development and change there included:

- Children's legislation: reflected a Justice model rather than a Welfare model
- Extreme criticism of existing services by indigenous people
- Need for greater family involvement in decision-making
- Flexible attitude to funding and severe economic retrenchment
- Closure of many residential institutions

Since the development of the FGC in New Zealand, projects have been set up in many countries, either within their existing legal framework or new legal frameworks. Projects which have occurred internationally include the United Kingdom (Lupton & Nixon, 2000; Marsh and Crow, 1998); Australia (Swain, 1993); Canada (Pennell & Burford, 1995); Sweden, South Africa, France, Holland ……

One explanation for this growth in international interest has been that the concepts of partnership and empowerment that underpin the model are equally acceptable to the political agendas of the right and left (Lupton 1998).

1.2.3 The Principles Underpinning Family Group Conferences

The FGC is seen to fit with the current requirement to consider the "best interests of the child". 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 whenever possible.

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

- The child's interests are paramount;
- Children are best looked after within own family;
- Working in partnership is beneficial to children;
- FGC is the primary decision-making forum for the child;
- Independent co-ordinator facilitates the involvement of the family and professionals in the process

1.2.4 Operation of FGCs

According to Morris (1994:1-2) FGCs are operated on the following principles:

- The term family is interpreted widely;
- The family always has the opportunity to plan in private;

- The professionals agree the family's plan unless, and only unless, the plan places the child further at risk.

There are four stages to the family group conference, the preparatory stage before the FGC, and three stages within the actual conference itself.

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 as 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 mobilize 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.

1.2.5 Applicability of Family Group Conferences in Ireland?

A number of the international trends discussed in Section 1.2.1 are reflected in current Irish child-care. The "best interests of the child" and the focus on "family support" are enshrined in the Child Care Act, 1991. The underlying philosophy of partnership, interest in developing "strengths focused" models of work, and an increased number of relative care placements for children who can not be looked after by their own birth parents are important context markers in current practice.

The concept of partnership is now ubiquitous throughout Irish society, from National Pay Agreements that have brought unprecedented economic success to Community Development Projects that have helped rejuvenate disadvantaged areas (Murphy, 2000). Training for participation in workplace partnership is now becoming a norm. The principle of working collaboratively in the pursuit of mutually agreed goals has underpinned such enterprises. It seems a natural progression for the principles of partnership to find expression within the Child Welfare arena in a model of good practice and inclusivity. The Family Group Conference is one vehicle and venue to facilitate the process of bridging the gap between espousing the value of partnership in theory and its achievement in practice. The FGC has moved families from the sidelines as passive recipients of social services to active participants in decision-making processes that directly relate to the well being its members.

The principles of the FGC fit with the ethos enunciated in the relevant current Irish legislation, the Child Care Act, 1991. It also fits with current professional thinking in child care, as well as Eastern Health Board policy as enunciated in the First Report on Child Care and Family Support Services, Consultative Planning Group (Internal Report 1994) and the Children and Families Programme Service Plans 1998 (Internal Report 1997).

The findings of a research project on relative care in the Eastern Health Board, (O'Brien, 1997) suggest that the family group conference approach combined with family therapy/ systemic thinking offered distinct possibilities for working with relative care networks.

1.3 Introduction to Pilot Project

1.3.1 Impetus for the Pilot Project

In 1998, Minister of State at the Department of Health and Children, Mr. Frank Fahy, TD made a visit to New Zealand, where he was introduced to the concept of the FGC by New Zealand's Chief Social Work Inspector, Mr. Mike Doolan. On the Minister's return to Ireland conversations started between the Dept of Health and Children and the Eastern Health Board about the possibility of setting up a pilot project in Ireland. It was decided, in anticipation of the legislation which would put responsibility for providing Family Group Conferences for young people and their families with health boards, to initiate a three year pilot project in the then EHB (now ECAHB). It was decided to incorporate and expand the scope of a smaller scale project (described in Section 3.1.1), and to run the pilot project for the first year in Community Care Areas 2, 5 and 10 (see abbreviations pg. iv) and then to extend it to other areas.

1.3.2 Purpose and Goal of the Pilot Project

The purpose of the pilot project is to examine the applicability of the Family Group Conference, as a means of improving the management of troubled and troublesome young persons, in the Irish context.

The project goals are to establish, by 31st July 2000, whether the use of Family Group Conferences with selected families can

- Strengthen families' capacities to provide for and manage their troubled or troublesome young persons;
- Satisfy statutory and / or professional concerns about the young persons involved;
- Result in outcomes unlikely to have been achieved with traditional provision;
- Be cost effective.

1.3.3 Phasing of Pilot Project

It was decided that the pilot project would run in three phases. In Phase One (May 1999 to June 2000), the subject of this evaluation report, it was intended that the Pilot Project would have the following key components:

(i) Recruiting and training up to three FGC co-ordinators from an independent agency;
(ii) Designing referral and case management guidelines for EHB staff;
(iii) Holding 18 Family Group Conferences by 30th June, 2000;
(iv) Evaluation to test the extent to which the goal and objectives of FGCs could be met during the course of the pilot.

Following Phase One of the pilot, and subject to the evaluation results, it was proposed to extend the use of FGC's during Year 2 as follows:

(i) Consider extension to first protection referrals;
(ii) Plan for extending project to other community care areas;
(iii) Consider the structure necessary to integrate Welfare & Justice;
(iv) Commence regionalisation process of welfare cases in second half of year two of pilot.
(v) Evaluate results.

After the second year of operation, it is intended to extend the project further and to commence taking referrals of welfare/justice overlap cases, with a final project evaluation report to be completed for 31st July, 2002

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1.4 Terms of Reference for Evaluation

The terms of reference for the evaluation of the project were developed between May and October 1999, with a view to conducting a formative evaluation for Phase One. These were as follows:

- To evaluate 18 Family Group Conferences scheduled for completion by 30th June 2000;

- To explore and establish the level of family participation and sense of ownership of the FGC process;

- To establish if the principles of the FGC were applied in practice by social work managers, team leaders, social workers and co-ordinators;

- To test how the FGC fits alongside current professional processes of investigation, assessment, case conferencing, and review from the perspective of the child care manager, social work manager, team leader, social worker and other key professionals;

- To test the participation of current 'stakeholders', social workers, legal professionals, courts and service providers;

- To establish the effectiveness of FGC Management Committee structures that were set up to deliver the FGC Pilot Project;

- To identify and quantify resource requirements for the successful operation of the Family Group Conference;

- To examine the costs of FGC plans as against traditional service provision;

- To identify innovative Family Group Conference outcomes and examples of creative conferencing;

- To identify what modifications of the standard Family Group Conference (New Zealand model) might be necessary in the Irish context;

- To identify operating principles and guidelines for any fuller implementation of the process.

1.5 Evaluation Methodology

1.5.1 Philosophy underpinning Evaluation

The traditional role of the evaluator is seen as a dispassionate observer and reporter on things as they are. Current thinking sees a range of possible alternatives for conducting evaluation research. Most evaluators are aware that there is no single truth. A premise gaining increasing importance is that people in different positions see the world from different perspectives and define their interests in different ways - they even construe knowledge differently – the evaluator is advised to gather a range of viewpoints in the study. (Weiss, 1998)

The purpose and aim of this project lends itself to a research methodology based on action research. 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 emphasizes local descriptions in so far as it takes account of the processes evolving in a particular context.

The second philosophical view places the research on the continuum between quantitative and qualitative research designs. Quantitative research is generally better where data is available in numerical form. There are accepted methods of analysis, with a known degree of confidence in the extent and distribution of phenomena. There is also a benefit in comparability of quantitative data. Qualitative research can span a wide spectrum – there is a flexibility of inquiry, attention is given to the meanings and perspectives of programme participants and a dynamic account of developments over time is available. Qualitative research also tends to provide a richness of detail and anecdotes or quotes

that capture the essence of phenomena under study. 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.

A further distinction that needs to be made in regard to the 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 program 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.

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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 evaluation as part of the process rather than a methodology that seeks to take an observer position where the processes and actors were objectified.

This positioning has implications in so far as the biases and values base of the evaluator has to be made clear, and it is acknowledged that the evaluator has had multiple roles throughout the course of the pilot project. The evaluator positioning was enhanced by having several research assistants on the project, who had a different perspective from which to ask questions, and they also had a distance from the evolution of the project. They were also involved in collecting a great deal of the data, which enhanced the validity. As researcher, the author was very aware of the tension as highlighted by Weiss between "protecting rights of practitioners and program managers whilst also reporting fully and honestly" and the need to "provide cues to improvement but candor should not be sacrificed" (Weiss, 1998).

1.5.2 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 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 was not, however, dependent on the participants agreeing to co-operate. All family members and a number of information givers were contacted again by the co-ordinators in the weeks before the data was collected. It was concluded that contact from the co-ordinators would enhance the level of co-operation, as distinct from introducing new researchers to contact the family members directly. In many instances, it was felt that the passage of time would have impacted.

1.5.3 Data Collection Methods and Tools

A data spread across participants was acquired, reflecting the importance of the different perspectives. This required the development of several research instruments. Measurement, data collection and analysis are all expensive and time consuming. Careful review of earlier FGC evaluations gave good clues about which characteristics of the programme and its surroundings were worth measuring. The experience of the Essex project (Smith & Hennessy, 1999) and the Hampshire projects (Lupton, 1995, 1998) were used as prototypes in developing research tools, with changes being made to address the particular aims of the pilot project evaluation. The main tool used to gather baseline data was adapted from the tool used in a number of pilot projects in the UK, as reported in Marsh and Crow (1998). 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. Informants were met individually, and as part of formal and informal groups. These meetings took place over the duration of the one-year of the project.

Written questionnaires were designed to obtain information from the various categories of participant, and a number of the research participants were asked to overview them. Changes were made accordingly. The questionnaires that were used by the researchers changed slightly over time, with more questions being added to refine research findings and to test information as it emerged.

A difficulty emerged early in the project with the overall project goal of examining outcomes of conferences. The short time frame of Phase One of the pilot, and the small numbers of conferences taken from a cross-section of cases prevented clear outcome measures being put in place. The difficulty with measuring outcomes has emerged in many projects as reported by Stevens, when he refers to 'A stronger consensus on the ultimate outcomes of the FGC approach may still need to be pursued at a national level.' Additional to this is the difficulty in achieving a clear perspective of outcomes, as there are many other issues going on in these situations which prove difficult to control. The importance of developing outcome measures for FGCs will be further expanded in Section Two.

A literature review was not specified as an essential aspect of the evaluation brief. Nontheless a brief literature review is presented in Section Two to facilitate an exploration and anlaysis of the issues that emerged in this project.

1.5.4 The Data Sample

In total questionnaires were sent to 36 information givers, and thirty-nine family members. These were the participants of the eight conferences that were actually completed as part of the pilot project. Replies were received from nine staff, five from the Health Boards and four from other agencies; nineteen interviews were conducted with family members. Despite vigourous attempts to obtain the co-operation of both information-givers and family members, no further data was available before the writing of the report had to commence. Non-availability associated with annual and parental leave, illness, other work pressures, and a lack of desire or inability to meet with the research team were given as reasons for the limited response. No interviews were conducted with family member in two of the FGC's. This accounted for a total of six people, out of the original total of 39 family members in the sample.

It was originally intended to interview all children over the age of seven years. There was a total of ten children connected with the eight completed FGCs, six of whom

were aged seven or under (see details in Section Four), and therefore outside the sample. Only one young person, aged seventeen, of the remaining four children, was actually interviewed. The remaining three young people, two aged thirteen and one aged fifteen, were not contactable. It was a regrettable aspect of the research that more views of children could not be established first hand. In response to this trend, considerable attention was given to establishing the other participants' views as to how the process may have impacted on the children.

The total number of family interviews were nineteen. Of the thirty-nine family members (excluding the children) who attended the FGCs, Table 1.1 below gives a breakdown of the participants who were not interviewed. Details of those that were interviewed are presented in Section Four.

1.5.5 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 feed-back forms of all staff who received training as part of the project.

Focus group discussions were held with co-ordinators and the community care area teams where the pilot project took place. 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 and international liaisons augmented the various data methods outlined above and also strengthened the development of the project review.

1.5.6 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 new referrals to pilot projects is noted in Marsh and Crow, 1998. This means that eight conferences rather than eighteen conferences were available for evaluation in Phase One of the Pilot Project. The separation of the three year project into phases dictated that Phase One evaluation had to be completed within the original time frame (July 2000) as it was necessary to incorporate the findings into Phase Two which had to be put out to tender.

There was a high level of co-operation from staff and family members involved, but there was difficulty contacting some people, and this resulted in some networks being partially interviewed only, and taking limited part in the evaluation. Many birth parents that participated were not available, and out of the eight conferences only two were interviewed. While it would have been possible to have contemporary evaluation at the time of holding the conference, and this may have increased the numbers involved in the data collection, one of the main interests in the research was in the outcomes of the conference. These could only be examined when a period of time had passed.

Access was obtained to most of the health board information givers through their involvement in different focus groups and training courses during the project. While written questionnaires were useful, in-depth conversations with more information givers would have been valuable, especially information givers employed outside the Health Board. Time limitations prevented this occurring.

1.6 Outline Structure of Evaluation Report

This evaluation report is presented in eight principal sections, as described below, together with an executive summary of the main findings and recommendations, and appendices.

Section One describes the background and aims of the pilot project. It provides an overview of the FGC model and its underlying philosophy, as well as the methodology involved in the pilot project evaluation.

Section Two places the EHB pilot project in context, by examining key international research findings against which the findings and conclusions of the Irish study can be examined

Section Three describes in detail the initiation and evolution of the pilot project, and includes a review of the training and preparation arranged for professional staff and co-ordinators

Sections Four, Five and Six details the information on the conferences held, and the views and experiences of those participating in the FGCs.

Section Seven presents the analysis and the main findings in light of the evaluation questions, as well as recommendations for enhancement of process and practice

Section Eight presents a revised and significantly updated version of Good Practice Guidelines which were developed and used in the training phase of the pilot, and which take account of the views of participants and the main findings and recommendations. These will be used if the Project is extended into Phase Two as originally envisaged.

The Appendices contain documents describing the methods used in the evaluation and other documents developed in relation to the FGC work.

SECTION 2 – LITERATURE REVIEW

The literature is presented to place a number of the key issues and processes in context. This is not an exhaustive literature review, and draws extensively from Murphy (2000) and Lupton (2000).

2.1 Origins of the Family Group Conference

The FGC finds its genesis in an enquiry that endeavoured to locate the cause of the over representation of the Maori, the indigenous people of Aotearon/ New Zealand, in the state care system and to offer alternative means of working with families where child protection and/ or juvenile justice concerns were present. This enquiry culminated in the passing into New Zealand legislation of the Children, Young Persons and Their Families Act, 1989, thus giving a legal basis to the FGC. The Act committed the State to work in partnership with families for the protection of children, young people and their families.

2.2 The FGC as an Inclusive Approach

Ryburn & Atherton (1996) contend this Act, though novel in terms of legislation, was ancient in its discovered emphasis on family decision-making. Swain (1993) suggests this technique is not culturally specific, but rather is an application of an age-old work practice of empowering consumers to manage professional services to meet their own needs. The renewed interest in partnership, as evidenced by its underpinning in modern Child Welfare Acts, stresses the importance of the State and families working collaboratively. This interest in partnership signals a significant move away from an intrusive State, intervening in the lives of families experiencing difficulty, and ushers in a more empowering model of family involvement. The principle of partnership and the value of collaboration are indispensable elements to FGC and good practice. However, both are contested terms, and there is a lack of consensus on definition.

It is difficult to apportion culpability for the systematic exclusion of families from the decision making process over time. Social, political and cultural influences, adjoined to the professionalisation of social interventions, engendered the notion of the expert who had specialist knowledge and expertise to diagnose a problem and prescribe the appropriate solution. This served to reinforce a deficit notion of families and compounded a family's sense of inadequacy and failure. It is against this background that partnership, strengths-based approaches, quality service, transparency surrounding decision making and accountability by and for users and providers has emerged to challenge the exclusion of families and individuals from decision making.

2.3 The FGC Model

The traditional model of practice is seen to be professionally dominated, with the consultation of families occurring in an ad-hoc manner. Families were more frequently informed of decisions rather than being consulted about the proposed plans. The FGC model ushers in a new paradigm, where professionals rescind and relinquish some of their power and control over family processes and work collaboratively with families, while not abdicating their responsibility to ensure the safety, welfare and development of children. The professionals' role moves away from dominant decision-maker and evolves more into a resource to families in the decision-making process by providing pertinent and comprehensive information, making available resources and sharing expertise. Equipped with this knowledge and access to agency resources, the family produces an action plan that will endeavour to ensure a child's safety, welfare and development by drawing on internal resources, frequently invisible

to professionals, from within the kinship network. Corby et al (1994) has found that the families which children are born into are the most important and often the most neglected resource in their lives when professionals are involved in formal child protection investigations, either at best, through indifference, or at worst through deliberate exclusion.

Ryburn (1993 b) suggests that the FGC model compensates for the fact that very often the professionals' view of a particular family will be a deficit view. This deficit view arises because contact with the family has come about in relation to its least coping member. It is easy for this view to ignore the strengths and capacities that may be present in the wider family. FGC operates out of a strengths' perspective, offering support and services to families where needed, to maintain a child within their natural context so long as it does not place them at serious or immediate risk. Hudson et al (1996) claims that FGC hinges on the rights of both the child(ren) and family to be involved in making decisions that affect them. It confers a duty on Health Boards to work collaboratively with families as the executive guardians of decisions taken where children are deemed to be at risk, while attempting to strike a balance between the rights of a child to be cared for within its family, the natural rights conferred by virtue of parenthood and the duty of the State to protect such children.

Ryburn & Atherton (1996) hold the fundamental belief that, given the mechanisms to do so, extended families are capable of making effective decisions about their young people's lives. This raises the issue of whether a family which is failing to provide care and protection for its members are best situated to formulate plans to extricate themselves from the difficulty while ensuring the safety, welfare and development of the child. Barabour (1991) and Paterson & Harvey (1991) found that in over 90% of conferences agreement was reached on the family plans. Ryburn & Atherton (1996) point to the heart of this debate as being a restricted and nuclear definition of what constitutes the family. They further claim that the model clearly recognises that many people may be important to children, other than those who have clearly assignable relationships to them, and that any of these people can play a potentially valuable role in children's lives and the process itself. This broad interpretation of the "family" moves away from pathological definitions of families as abusing, and is a statement of the principle that it is not families but individuals members within families who sometimes harm their children or place them at risk. This process helps to removes the shroud of silence that hangs over abuse and brings it out into the open, thus drawing back the cloak that conceals abusers' presence and actions.

Ryburn (1996) has found that the FGC model provides a means to good practice in child care and protection, but is not a substitute for it. Lupton (2000) says that in examining the role of FGCs in child protection in New Zealand and in the UK 'this vital issue is currently partial and inconclusive' (p. 38). She states that the studies that have addressed this issue each reveal only a limited piece of the picture. However, the picture emerging is looking hopeful, using indicators such as registration and deregistration of children and a re-abuse rate. It is important to stress when examining the role of the FGC and child protection that the FGC process is only one of many interventions required in the child protection system, and therefore it is difficult to examine outcomes when so many other variables are involved.

The greatest strength of the FGC lies in the fact that it offers a clearly defined way to involve families and help them assume responsibility effectively where children/young people are deemed to be at risk. Therefore, it asserts kinship as the most valuable resource in child care and protection. This process shatters traditional roles assumed by the main stakeholders. The family move from the passive periphery to centre stage as experts in their own right with power to make decisions, while professionals have their role redefined in terms of being a resource to the process, while maintaining statutory functions.

The FGC model needs to be flexible and fluid rather than rigid and fixed. Ryburn (1996) holds the view that the family decision making model is one in which there should be an opportunity for family members to work together to renegotiate and reformulate plans if it proves necessary. Rather then viewing the family as a failure, reconvening a FGC offers a more constructive view of the family as being in need of additional supports to (re)negotiate persisting and new challenges to their network. This is in keeping with Morris & Tunnard's (1996) contention that the FGC is a continuing process rather than a one-off event, since it is clear that one meeting may not be enough to make far-reaching decisions about a child's life.

2.4 Length of Time

The average length of time the FGC process takes differs from study to study. Caution is needed when averages are presented as the variation can be very wide. In Lupton (1995) it ranged between 8 hours and 51 hours. In Smith and Hennessy (1998) in the Australian study, co-ordinators took on average 10 hours and 36 minutes in preparation stage. Preparation ranged from 3 hours to 30 hours. Paterson & Harvey (1991) found that 89% of FGC were held during the week and less than 1/5 started after 4:35 PM. Two thirds of FGC were convened within 5 weeks of referral date, 1/6 took over 2 months (average 36 days) to bring from referral to conference.

2.5 Family Participation in the FGC Process

The FGC process is seen to be far more successful in encouraging the participation of family members than existing care planning processes, resulting in greater family as opposed to professional attendance at the meetings (Lupton and Stevens, 1997). It offers a greater sense of ownership to families of both the process and outcomes (Lupton et al. 1995; Rosen, 1994). Case planning meetings were seen to inhibit real family participation, particularly through the presentation of reports focusing on past issues and the department's control of the agenda and solutions (Lupton and Stevens, 1997).

2.5.1 Preparation

Co-ordinators highlight the importance of the preparation period for engaging family members and clarifying which family members can attend. Wiffin (1998) contends that there should be a presumption that all family members are invited to FGC and if exclusion occurs the individual has the right to be notified in writing as to the reasons for the exclusion. The preparation stage is of vital importance to ensure families understand the aims of the FGC and the part that the other attendees are to play in it (Lupton, 2000) Lupton et al (1995), Barker & Barker (1995) and Simmonds et al (1998) reported that the majority of the family members interviewed felt they were adequately prepared.

The issue of attendance is slightly more controversial. Barker & Barker (1995) found that the single biggest issue likely to cause division within the family group was deciding on whom to invite. Marsh and Crow (1997) found that in four out of every ten conferences one person was excluded. Family members were then usually happy that the right people were invited. Once the attendance was agreed the level of family participation was high. The great majority of people invited actually attended (Crow & Marsh, 1997)

2.5.2 Information Giving

Lupton et al (1995) consider further thought may need to be given to improving the quality and quantity of information provided to families in advance of the FGC so that they are clear about the 'terms & conditions' of the meeting & their role within it. It also places greater responsibility upon professionals to be clear and precise regarding the agency concerns and for their presentation to be made in a coherent and easily understandable manner. Lupton et al (1995) cautions information-givers to refrain from indicating to families their views of appropriate outcomes to the FGC. Ryburn (1992) points to the key task of the co-ordinator to ensure that information is presented in ways that can be understood by family members, that is factual and free from conjecture. To engage in coercion or collusion would undermine the integrity of the process and compromise the distinctive roles of the various stakeholders as envisaged in the model.

2.5.3 Private Family Time

The principle of private family time has raised some issues in practice. Lupton et al (1996) addressed the question whether the co-ordinator should remain during the private family planning time, if invited. Although this is normative in the Victoria model in Australia, it is viewed as an exception in the New Zealand model. Arguments in favour of their presence revolved around ensuring that the views of less powerful family members, particularly those of the child(ren) are effectively heard. This would have the effect of changing the family dynamic and planning process significantly and is not seen as necessary if a person within the kinship group was designated the role of advocate, to ensure the voice of the less powerful is heard.

A related criticism levelled against FGC is that the model replaces paternalism (the State deciding) with patriarchy, since in many families in different cultures men exercise decision-making power over women and children. This has implications specifically for private family time. Ban (1993) & Connolly (1994) raise a similar issue of family decision-making and gender roles and question if traditional roles and inequities are being reinforced?

Lupton (2000) in a recent review of the literature, said based on the available data, 'families are generally very positive about the family only stage' (p. 23). She asserted, as does Barker and Barker (1995), that despite many finding it a distressing experience, family members in the main welcomed the opportunity to discuss the issues without the professionals being present. A minority of those interviewed in both these studies said they did not feel the absence of the professionals made any difference to the meeting.

Concern that the dominance of a few powerful individuals within the family may militate against the best interest of the child is evident in international literature. Few studies, with a number of notable exceptions, including Lutpon & Stevens (1997), Smith (1998) have interviewed children directly. Yet, evidence (Lutpon & Stevens, 1997; Smith, 1998) from FGC and traditional meetings (Thoburn et al 1995) indicates that more children attend FGC and, once there, they appear to participate more extensively. Marsh & Crow (1997) show that the vast majority of children invited to attend did so. Children found the information giving hard to understand and to listen to (Lupton & Stevens, 1997). More studies are needed to establish children's views, their experience of FGC and to indicate what changes are needed.

2.6 Professionals' Participation

Morris & Tunnard (1996) found that once the child's network holds responsibility for the planning process, the role of professional shifts from decision-maker to facilitator and enabler. Though professionals may have expertise and knowledge of family patterns and functioning in general, it is claimed they can never be experts on any one family in particular.

FGC juxtaposes professionals and the family thus altering the traditional paradigm from a uni-directional approach to a greater sense of mutuality, equity and equality. Ryburn & Atherton (1996) maintain that the model is rooted in attitude to, and values about, families and their way of life. It is insufficient simply to train people on a practical level or show them the mechanisms of how the model operates. It needs people committed to the principles, with the enthusiasm to make it work and trust in the ability of families to make safe plans for their future. Morris & Tunnard (1996) make a similar point in stating that it is impossible to use FGC's successfully in areas that attach little value to partnership practice, or where staff feel that existing practices are adequate and change unnecessary.

Morris & Tunnard (1996) claim professionals can cope with relinquishing some of their traditional power and that families have a great deal more to offer than other models of practice have been willing or able to explore or accept. It would appear simplistic to accept that professionals would willingly relinquish power which has by and large been unquestioned and indeed jealously guarded for so long without undergoing huge attitudinal change and reconstructing their professional roles. Pennell & Burford (1997) reinforce this view citing the greatest barrier to change as the attitudes among some professionals. Professionals face a dualism in role identity, having to reconcile formal child protection investigation as an alternative intervention to FGC with non-co-operating families and possibly formal child protection investigations running in tandem with co-operative families where child protection concerns may emerge during the process. This raises questions around confidentiality and privilege, and to what extent both can be exercised and co-exist within the process?

2.6.1 Attendance

So what is the professionals' experience? Normally the ratio of family members to professionals was on average 6 to 2, with professionals outnumbering family members in only two of the pilot FGCs (Crow & Marsh 1997). The evidence suggests, indeed that the problem may rather be, as in New Zealand, of getting the relevant professionals to attend the FGC and in convincing them of the merits of the FGC approach. Many of the pilot studies identified concerns on the part of the professionals about

the implications of greater family control over the decision-making process (Thomas, 1994; Lupton et al., 1995; Smith, 1998; Crow and Marsh, 1997).

2.6.2 Information-Giver

Where there is evidence of the views of those professionals attending FGC's (Thomas, 1994; Baker and Baker, 1995; Lupton et al, 1995; Smith, 1998; Simmonds et al, 1998) it seems that the majority were comfortable with (if a bit anxious) about the role of information-giver. Simmonds et al, (1998) report that the great majority of the professionals involved felt that the purpose of the meeting had been set out well or 'well enough'. Smith, (1998) and Lupton et al., (1995) indicate that professionals had attempted to provide their reports in plain and accessible language.

There is evidence however that some professionals, particularly, but not exclusively, from agencies other than SSD's questioned the legitimacy of the FGC proceedings and expressed concerns about the confidentiality of the information to be discussed (Smith, 1998; Lupton et al., 1995). Despite assurances that they were clear about the distinctive nature of the information-giving role, moreover, four out of ten professionals in Lupton et al.'s (1995) study revealed that they had told the family group conference what they felt the outcome of the meeting should be. There is evidence from another site of professionals setting 'bottom lines' to the family decision-making (Smith & Hennessy 1998).

2.6.3 Clarity Needed

According to Lupton et al. (1996) there needs to be far more explicit and formal demarcation of the roles of the social worker and co-ordinator and of their respective tasks in the period between referral and convening of the FGC. Also, clearer guidelines need to be given to information-givers regarding their role in the FGC and the quality and quantity of information to be provided. Lutpon et al (1996) cites the lack of referrals to FGCs as an indication that more attention may need to be paid to communicating the value of the FGC approach in organisations, particularly if it is desired that these agencies contribute staff time and possibly resources to the FGC initiative.

The creativity of an action plan will reflect a family's unique ability to be innovative and address their particular situation with the oversight of the referring agent. It can be demanding for professionals to stretch their boundaries, as it may fit uneasily into a culture of social work practice that places a heavy emphasis on standard procedures and weighty administration.

2.7 Costing FGCs versus Traditional Models

Lupton & Stevens (1997) hold that FGC's do not appear to draw less on agency support/ resources and cannot therefore be viewed as a generally less costly alternative to traditional meetings. The availability and accessibility of resources may cause considerable frustration to both the family and professionals due to bureaucratic constraints which could possible undermine the family plan altogether. The FGC has to be seen as a vehicle for good practice, with the ultimate goal of ensuring the welfare and protection of children, rather than as a cost saving exercise.

Overall, the FGC operates in ways that are consistent with good practice and offers a radically new way of empowering families to make safe decisions for their members with the support of State agencies. It offers new opportunities and possibilities in working with families while challenging conventional practices. If the outcomes desired are too cost orientated and fail to take account of the broader savings, an opportunity will be lost. This has begun to happen in respect of an expectation that FGCs lead to a reduction of children entering care. Lupton (2000) in reviewing the New Zealand experience, provides evidence that this has begun to happen. The other cost saving put forward by proponents of the FGC model is where the FGC may result in a child being placed in a kinship home, thus freeing up scarce foster homes. A reduction of numbers entering care and more children cared for within their own family network are positive moves but there are also inherent dangers. If FGC results in a situation where care is care on the cheap, and fails to adequately support the family members (O'Brien 1997) or if alternative care is further stigmatising for children, (O'Brien 1999), then the potential may be jeopardised.

2.8 Conclusion

In conclusion – the key messages from research based on Lupton's (2000 p. 36-38) review of the literature 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 participants 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, if not;
- FGCs appear to mobilise family support, but they may not thereby reduce the demands to 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.

SECTION 3: THE EVOLUTION OF THE PILOT PROJECT

In Section 2 the key research findings relating to FGCs in the literature were presented. The outline of literature helps to place this FGC pilot project in context. In this section, the initiation and development of the pilot project is described. The project structure is presented. The objectives of the three phases of the pilot, the training provided for professional staff and co-ordinators, and referral criteria and outcomes are described. The Project Manager's Interim Report (2000) provided important summary information for this section

3.1 The Initiation of the Pilot Project

3.1.1 Preliminary Interest in Family Group Conferences

There was interest in working with families in innovative ways, and many of the ideas underpinning the FGC model had existed among several community care teams in the Eastern Health Board. In 1998, the Eastern Health Board had planned to commence a small scale project using Family Group Conferences with 'welfare' referrals initially, with a view to extending it to 'protection' referrals. This arose following informal conversations over a number of years between Mr John Quin, then Senior Social Worker in EHB Area 2 and Dr. Valerie O'Brien, University College Dublin, who shared an interest in the FGC model and were keen to examine its applicability in an Irish context. The informal conversations led to a mandate being given for a limited pilot project to examine the feasibility of developing a family group conference model, including training and implementation at an operational level. This work had involved the following steps:

- John Quin (EHB) and Valerie O'Brien (UCD) attended a two-day International Conference on Family Group Conferences in England in June 1998, aimed at drawing together current research and practice developments in the field.
- Development of an FGC model geared to an Irish setting, drawing on systemic thinking and current research findings.
- Preparation for training of staff and implementation of pilot project in selected areas, and for evaluation of pilot project.

As a result of this mandate, a number of further stages were identified which included negotiating resources, identifying personnel and agencies that could provide a co-ordinator service and discussions at community care area social work team level to raise awareness of the potential of this model. Sr. Jo Kennedy from Hesed House had agreed in principle to provide the co-ordination service for the four FGCs intended to be held in EHB Community Care Area 2. The Senior Social Worker would be involved in identifying suitable cases, and UCD would provide a consultation/ training role.

3.1.2 Political Interest in FGCs

At the same time in 1998, Minister of State at the Department of Health and Children, Mr Frank Fahy, TD made a visit to New Zealand. Minister Fahy's visit and interest in family group conferences was a turning point for family group conferencing in Ireland. The Minister extended an invitation to New Zealand's Chief Social Work Inspector, Mr Mike Doolan to visit Ireland for an extended period. On the Minister's return to Ireland conversations started between key stakeholders both within the Dept. of Health and Children and the Eastern Health Board about the possibility of setting up an FGC pilot project in Ireland.

3.1.3 The Children Bill

The other major impetus for this pilot project was the new Children Bill, sponsored by the Minister for Justice, Equality and Law Reform. In 1998, in the context of work on the new Bill, consideration was being given to the introduction of Family Group Conferences in respect of three target groups of vulnerable young people:

- Those diverted from prosecution by the Gardai;
- Those appearing before a criminal court, in certain circumstances;

- Those exhibiting behaviours or distress of such difficulty that informal means of assistance have proved ineffective.

The latter group has traditionally had low levels of service until problems became so severe and intractable that statutory proceedings are instituted to gain control of their situation. Family Group Conferences were mooted as a means of earlier intervention, to engage family ownership and resolution to manage the situation, and to institute inter-agency plans to assist families to do so.

3.1.4 Initiation of this Pilot Project

It was decided, in anticipation of the legislation which would put responsibility for providing Family Group Conferences for these young people and their families with Health Boards, to initiate a pilot project in the then Eastern Health Board (EHB) and now the East Region Health Authority (ERHA). It was decided to incorporate and expand the scope of the smaller scale project referred to in Section 3.1.1 above, and to extend the pilot over three years. The pilot was to commence in the first year in Community Care Areas 2, 5 and 10 of the Eastern Health Board.

It was decided that the pilot project would run in three phases. In year one, the subject of this evaluation report, it was intended that the Pilot Project would have the following key components:

(v) Recruiting and training up to three FGC co-ordinators from an independent agency;
(vi) Designing referral and case management guidelines for EHB staff;
(vii) Holding 18 Family Group Conferences by 30th June, 2000;
(viii) Evaluation to test the extent to which the goal and objectives of FGCs could be met during the course of the pilot.

Following the first phase of the pilot, and subject to the evaluation results, it was proposed to extend the use of FGC's during Year 2 as follows:

(vi) Consider extension to first protection referrals;
(vii) Plan for extending project to other Community Care areas as part of the ERHA regionalisation process;
(viii) Consider the structure necessary to integrate Welfare & Justice;
(ix) Commence regionalisation process of welfare cases in second half of year two of pilot.
(x) Evaluate results.

After the second year of operation, it is envisaged extending the project and to commence taking referrals of welfare/justice overlap cases, with a final project evaluation report to be completed for 31st July, 2002

3.1.5 Principles on which the Irish Project would be Built

From the preliminary work which had already been undertaken, it was agreed that the principles on which the Pilot project would be built would be based on the New Zealand model of FGC and would include the following:

- Children are generally best looked after within own families
- The vast majority of families will make safe plans for children
- Independence of co-ordinator
- Private family time for planning
- Family plans will be accepted unless it puts the children at greater risk.

3.1.6 Contracts for Training and Evaluation Roles

When the decision to proceed with the pilot project was made, it was imperative that progress was made in a short time-frame, and it was anticipated that the project would commence in June 1999. Based on the previous work that had been done on the limited pilot project, a contract for Training and Evaluation of Phase One of the Pilot Project was negotiated between the EHB and the Dept of Social Policy and Social Work, UCD. The Project Leader in UCD was Dr Valerie O'Brien. The developments that had taken place during the earlier pilot project development enabled UCD to offer services to deliver the project requirements of Phase One in the short time-scales envisaged. Similarly, the work with Sr. Jo Kennedy during the earlier pilot provided the ground-work in terms of identifying a potential independent co-ordinator resource. The preliminary work in acquiring knowledge of the process was already partly completed.

3.2 Project Structure

A structure was put in place to oversee and run the pilot project. The project sponsor is the Minister of State at the Department of Health and Children, formerly Mr. Frank Fahy TD, and now Ms Mary Hanafin, TD. The project commissioner was Ms. Brid Clarke, Programme Manager, Children and Families, Eastern Health Board, and is now Mr. Michael Lyons, C.E.O., East Coast Area Health Board in the revised structure.

A Management Committee was set up to manage Phase One of the project, and included the following people:

Mr John Quin, Child Care Manager, Community Care Area 10, (Chairperson);
Ms Michelle Clear, Child Care Manager, Community Care Area 5;
Ms Diane McHugh, Child Care Manager, Community Care Area 2;
Dr Valerie O'Brien, Department of Social Policy & Social Work, UCD;
Sr. Jo Kennedy, Family Therapist, Hesed House, Inchicore;
Ms Marilyn Roantree, Social Work Manager, Community Care Area 2;
Ms Mary Coyle, Educational Psychologist, Department of Education & Science;
Inspector Bart Faulkner, Garda Siochana, Ballyfermot.

A project manager was appointed, reporting to the Management Committee. This was filled by confined competition within the EHB at Social Work Team Leader level. The job description of the project manager is contained in Appendix Two.

It was intended that a National Committee, which would overview the project with a view to national policy and implementation, would be established. This committee was to have a key role in terms of liaison at both inter-departmental and interagency level, and was to be set up by the Department of Health and Children. While the absence of this committee did not impinge on the actual operation of the pilot, it obviously has consequences in terms of giving wider exposure to the concept of family group conferencing and the place of the FGC model in future service delivery. It also contributed somewhat to difficulties for the external members of the management committee in terms of the mandate and expectations from their own organisation in relation to the project.

3.3 Training - Preparing for the Road Ahead

3.3.1 Approach to Training

It was envisaged that a significant training programme would be required as a pre-requisite to implementing the FGC Pilot Project. Three main target groups were identified:

- the social work teams involved in the project,
- key multi-disciplinary players at an intra and inter-agency level, and
- the independent co-ordinators.

The main purpose of the training was to introduce and give an understanding of the ideal FGC, but had as its focus an appraisal of the ideal within the Irish context. The training programmes drew extensively on the programme devised by the Family Rights Group in the UK and material forwarded from New Zealand by Mr Mike Doolan.

It was inevitable that the application of the model into a different national context would involve change, and the pilot project had to adapt the New Zealand model. The brief also involved looking at what further adaptation would be required for the wider implementation of the model. While conceding the inevitability for the local variations, the Family Rights Group in the UK see the following three conditions are essential to a FGC:

- The term "family" is interpreted widely,
- The family always has the opportunity to plan in private,
- The family's plan is agreed by the professionals unless, and only unless, the plan places the child further at risk.

The approach and methodology used in the training involved active participation of trainees, and participants were encouraged to act as consultants to the emerging FGC process. The protocols that were eventually put in place emerged from the discussions during the training of social work teams and co-ordinators, with subsequent consultation with the project manager, and final approval by the Management Committee. The identification of the existence of grey areas in the operation of the original model, and the need to resolve many of these through practice experience was a similar experience with other pilots (Lupton 1995).

In the course of training and development, two processes were occurring simultaneously. The first was a focus on the organisational features such as referral categories, decision-making on selection of families for the project, role clarification and skills required. The second was a focus on the process issues involved in the actual holding of the three different stages of the conferences.

Contemporary evaluation of the training courses provided as part of the project was received from all staff. Each of the training days was evaluated, and the feedback data helped to inform the plan for the subsequent day's training. The following questions were used for evaluation purposes:

- What was most helpful in relation to the training received?
- What was least helpful?
- What changes would you propose?

The majority of suggestions were taken on in subsequent training events and, overall, the evaluations were extremely positive.

3.3.2 Preparing Co-ordinators for the Project

The overall aims and learning objectives for the training of the co-ordinators were as follows:

- To understand the philosophy of the model
- To develop a working knowledge of the model
- To understand the role of co-ordinators
- To develop relevant practice skills for co-ordinators and to offer opportunities for the development of future mutual support
- To identify the supervision issues required for accountability and professional development purposes

- To understand the role of other professionals
- To respond to specific training needs of the group

In the course of the training with the co-ordinators, the following issues emerged, many of which mirrored the aims and objectives outlined above. They were as follows:

- To be open to one's own biases and possibilities
- To support others who are directly involved in working as co-ordinators
- To learn as much as possible about the role so that families will know that co-ordinators are different from other professionals working in child welfare
- To know how to present the model in a positive way to other professionals and the public who may be sceptical about families capacity to protect their own children
- To understand the models applicability in Irish context
- To learn how to empower families so they can maximise their participation through power sharing
- To distinguish issues that may be central to their own agency, Hesed House, as distinct from the issues that may be more central to this contract and work surrounding co-ordinators role and service provision.

The reasons the co-ordinators gave for wishing to be associated with the project were as follows:

- New and different
- Helpful to families
- Fits with systemic positioning of the organisation
- Fits with the direction that Hesed House is going, in terms of community and empowerment practices
- Provides a tool to put ethical position into practice
- Fits with the historical context of Inchicore, this area had a long history of project work in which a number of the co-ordinators and staff in the agency were involved
- Excited, as it provides an opportunity to be part of something that can be viewed as a gift and it provides an opportunity to redress past injustices to families and communities

Initially there were many questions that also had to be addressed. The questions are as follows, and this list captures the issues facing this group of co-ordinators at the beginning of the project:

- How to manage the difference between therapeutic and co-ordination role?
- What are the parameters of confidentiality?
- What knowledge of legislation and child care is necessary to do the job of co-ordinators?
- What referral process is / will be in place?
- What criteria are in place for selecting the family?
- Is there a client, and who is it?
- What are the rights and responsibilities of the different participants?
- Are there videos and case examples available for training?
- Who are the caregivers that the family may use?
- What time frame are the co-ordinators working within?
- Is there a pre-conceived agenda in the agency at the time of referral?

This list, combined with the list below gives a very good indication of the level of information that existed, and that which required to be developed. It also shows the skill development that was needed to prepare the co-ordinators to take on the task of facilitating FGC's. The list below indicates the trainees' view of what they needed to know in order to do the job:

- How to support and encourage and not influence unduly?
- Will the family know it is a new way of working?
- What are the expectations of co-ordinators role?
- What skills are needed to initiate the conference?
- What is the co-ordinator supposed to do?
- What is the co-ordinator accountable for and where does responsibility begin and end?
- What are the steps in the process?
- Are family members sometimes excluded and if so on what basis?

- Are there particularly useful or necessary conversations to have with some people as part of process?
- Are there grounds sometimes to work solo or should joint work be considered?

The co-ordinators availed of a total of five days of formal training. Regular consultation on issues emerging was also a feature of the preparation/ development process.

3.3.3 Preparing Social Workers and their Managers

The possibility of co-training co-ordinators and social workers was raised at an early stage, but it was decided that trust needed to be built up, and if there was too much uncertainty in the training context surrounding key issues, this would impact on the potential for trusting relationships to develop. It was decided therefore that the social work team in each of the three community care areas would be trained separately initially. It was hoped that this would have the effect of building a safe context in which the practices involved could be explored. The three social work teams were seen as key players in Phase One of the project, as it was intended that the referrals would be made from these areas. It was expected that this approach would involve the social work team having a good grasp of the principles of the FGC, and would open up the potential of this novel way of working, as well as providing them with the skills for making referrals and information-giving. It was the intention that many of the protocols would be developed out of the training, using a facilitation style, which would give rise to a sense of ownership of the method among the three teams.

Each of the three community care teams was given two days training prior to the project commencing. This was followed by one day's training for managers early in the project operation. The staff involved, and their managers, were brought together half way through the project to discuss their learning experience. This was a very important punctuation, as it helped to consider where the project was up to, and to decide what changes needed to be made to the future direction.

The aims/ learning objectives of the training for the social work managers and their teams were as follows:

- To provide an understanding of the FGC model.
- To provide and understanding of the background and philosophy.
- To examine key issues involved in using FGC's in child welfare.
- To develop relevant practice skills particularly around providing good quality information.
- To have an understanding of the local implementation strategy.
- To have an understanding of the roles and responsibilities in FGC's.

The programme for the two days training was generally as follows:

Day One	**Day Two**
Welcome, introductions, and aims; Professional and family exercise; Background context and model; Issues and anxieties; Providing information to the family; Who would you refer to FGC? Finish and prepare for day two.	Warm up; Putting the FGC into practice; Role play and feedback; Agreeing to, carrying out and monitoring plan; Attitudes to families; Future training needs and developing the initiative; Outstanding issues and finishing; Evaluation.

The specific aim of the training for the managers was to provide an opportunity for them to examine the supervision and management issues arising from implementing Family Group Conferences, and to construct useful solutions. The objectives were:

- To examine the support /supervision model as a framework to locate the issues.
- To identify the management issues at key stages of referral, preparation, information giving, presenting the plan and review arrangements.
- To highlight the management perspective and experience arising from the conferences held to date.
- To provide updated information on the project.

This session provided useful guidance to managers as well as providing a framework for examining concerns. It also helped to create a context in which those practitioners who had been involved in a FGC could present their experience and learning.

3.3.4 Preparing Key Players in Multi-Disciplinary Teams in Community Care, (at an intra and inter-agency level)

The key players in the multi disciplinary groups in each of the teams were invited to training. Multi-disciplinary in this context refers to formal and informal teams of professionals situated within health boards and other statutory and voluntary sector agencies, who have responsibility for delivering child welfare services. The objective was as follows:

- To provide an understanding of the FGC model and an opportunity to discuss the application of the model to practice;
- To provide participants with a basic knowledge of the FGC process;
- To provide an opportunity to learn about the local initiative;
- To provide an opportunity to consider FGC as a response to child welfare procedures.

There was quite a lot of variation in the numbers invited and attending. In one of the teams there were ten in attendance, while in another over thirty people came. This reflected the different priorities that had to be attended to in each area. This training was the only opportunity to get the information disseminated. There was much similarity in the issues identified in the discussion with the multi-disciplinary teams as with both the co-ordinators and the social work teams. Notwithstanding this training, a lack of multi-disciplinary involvement emerged later in the project,

It was intended initially to provide further training between October and December 1999. However, this did not happen on a team basis. Instead, in response to the practice issues which were emerging and the slower than anticipated rate of referral, it was decided to target the managers in an attempt to examine the referral and supervision processes. Meetings were held at the time with social workers who had been involved in the FGC's, both through making the referrals or in an information-giving role.

3.3.5 Response to the Training

Generally, the initial response to the concept of FGC's in the training sessions was extremely positive. Many questions were raised relating to organisational, procedural and practice issues. Some concerns were expressed over:

- The viability of the model with certain families where they were dealing with multiple and complex issues;
- The impact on vulnerable family members of being confronted with the larger family group;
- The issue of confidentiality and sharing of personal information within the family group, and the assumption that the families have resources within their network that previously lay untapped;
- A fundamental issue was raised concerning the higher expectation on families to sort out what many thought needed state help.

3.4 Establishing Referral Criteria and Exclusions

3.4.1 Referral Criteria

Taking account of the FGC Pilot Project objectives, the Management Committee put in place the following criteria for referral of cases:

a) Concern by a professional for the care, protection, welfare, or placement of a child**.**

b) Concern shared by some family members regarding the care, protection, welfare or placement of a child.

c) Child is not at immediate risk of life and limb.

d) The family agrees to participate in a Family Group Conference and are aware of the nature and purpose of the referral.

This was a broad remit, and the only circumstances excluded were where life or limb considerations applied. Workers were told that referrals would be considered within the three categories of

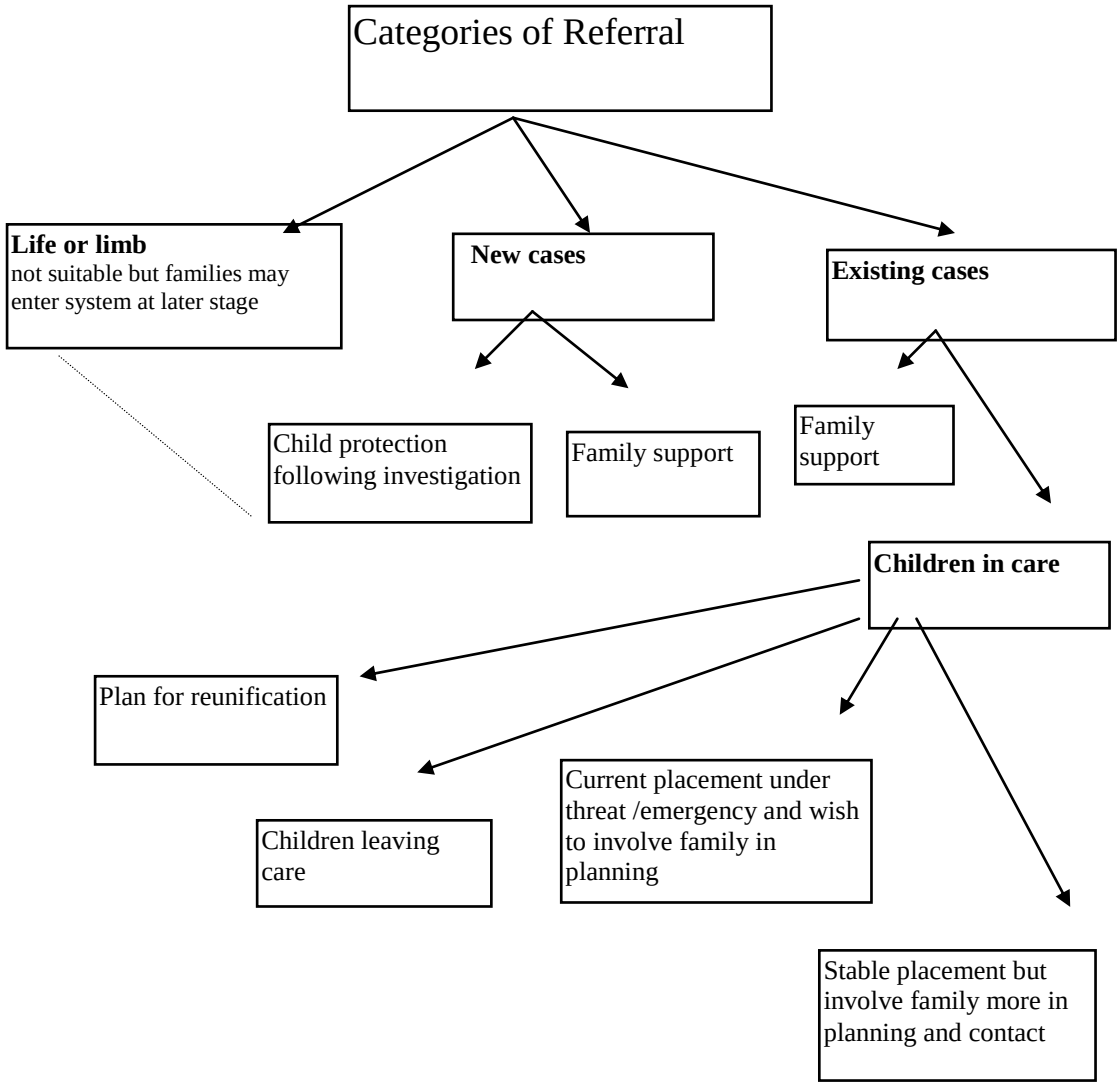
- Family support;
- Child protection, and
- Children in alternative care

Figure 3.1 was developed in training sessions to give an overview of the type of cases that would be considered for an FGC.

Figure 3.1 –

Categories of Referral

(Source : Training Material EHB O'Brien 1999)



3.4.2 Decision-Making by the Referral Committee

A Referral Committee, which included the Project Manager and co-ordinator, Sr Jo Kennedy, was established to consider each referral received. The Committee gave particular attention to the exact nature of the concern, the specific duties and responsibilities of the Health Board in relation to the concern, and the actions needed to be taken prior to the co-ordinator meeting the family.

With administrative systems in place, and appropriate literature for families and professionals prepared, the FGC Pilot Project Office invited referrals from 1st October 1999. The referral rate during the first three months was slow with only four referrals. However, from the four referrals three Family Group Conferences were held by 17th December 1999. This reflects the experience of other FGC projects (Marsh and Crow, 1998 and Lupton, 1995), suggesting that it take some time before social workers begin to incorporate Family Group Conferences into their repertoire.

3.4.3 Origin of Referrals

Into the second quarter of the project, it was agreed that in special cases, referrals would be accepted from other teams. Four referrals were made from non-Health Board agencies inside the catchment area, and one from another community care team. However, three-quarters of referrals have come from the three Community Care Teams participating in the FGC Project.

3.4.4 Details of Referrals Made

As of the end of June 2000, nineteen referrals had been made to the project office. Table 3.1 gives details of the number of referrals terminated, in process and conference completed.

Table 3.1

Details of Referrals Made

Referral Reference Number	**Agency**	**Stage in the FGC Process**	**Plan Agreed**	**Terminated**
1	ERHB CCA 2	Completed	yes	
2	ERHB CCA 2	Completed	yes	
3	ERHB CCA 5	Completed	yes	
4	ERHB CCA 10	Completed	yes	
5	ERHB CCA 5	Completed	yes	
6	ERHB CCA 10	Completed	yes	
7	ERHB CCA 10			yes
8	ERHB CCA 2			yes
9	ERHB CCA 5	Stage One		
10	ERHB CCA 5	Completed	yes	
11	ERHB CCA 4	Stage One		
12	ERHB CCA 5	Stage One		
13	ERHB CCA 2	Stage One		
14	ERHB CCA 2	Completed	yes	
15	Traveller Families' Care	Stage One		
16	Traveller Families' Care	Stage One		
17	National School	Stage One		
18	Family Resource Centre			Yes
19	ERHB CCA 5	Stage One		

Total Number of Referrals: 19	**Total Number in Process: 9**	**Total Number Completed: 8**	**Total Number of Terminations: 2**

(Adapted from Interim Report 2000)

3.5 Conclusion

In this section, the initiation and development of the pilot project was described. The project structure was presented. The objectives of the three phases of the pilot, the training provided for professional staff and co-ordinators, and referral criteria and outcomes were described. Details relating to the

- Outline of events leading up to the commencement of the pilot project.
- Summary timetable of phase one of pilot project
- An account of key events in the pilot project

are contained in Appendix Three.

SECTION 4 - BASE-LINE INFORMATION ON THE FGCs IN THE PILOT PROJECT

4.1 Introduction

This section provides base-line information in respect of the cases that were referred to the pilot project and accepted as suitable for FGCs. Nineteen referrals were accepted into the pilot project within the time-frame October 1999 to end of June 2000. Three were withdrawn during the preparation stage, eight were completed and eight were ongoing at the time of the evaluation. The findings in this report refer predominantly to the eight completed conferences. Where applicable, general observations relating to the other conferences are included, as due to the formative evaluation methodology used, the researcher remained close to the processes as they were developing.

In this section, the profile of the full nineteen cases referred for conferences will be presented, giving brief characteristics. The data on the eight conferences, which were completed within the evaluation time-scale, is analysed in depth in later sections of the report. Information is presented in Table 4.1, entitled Profile of All Cases Referred for an FGC in the first year of the ERHA Project. There were a total of nineteen referrals.

The nineteen referrals were primarily referred from Community Care Areas 2, 5, and 10. In one case Area 5 shared a case with Area 9. Area 2 referred five cases, Area 5 referred six, one of which was jointly shared with Area 9 and Area 10 made three referrals. Of the nineteen referrals, fifteen came from the Health Boards and four from voluntary agencies. Three of the referrals were terminated as other issues persisted and to continue would have been counter-productive.

For comparative purposes, the Lupton (1995) FGC evaluation comprised of 19 families in which 22 FGCs were held. Of those 19 families, 11 were researched in depth. In Taylor (1999), there were 52 referrals of which 21 did not reach the conference stage.

Figure 4.1 –

Agencies Responsible for Making Referrals

(Source: Interim Report, June 2000)

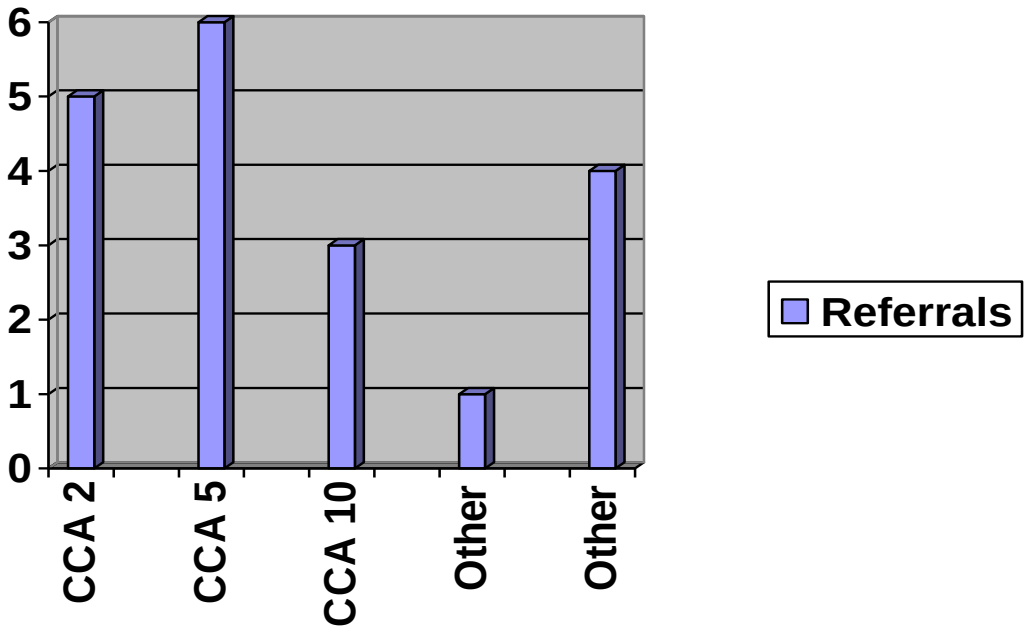

6
5
4
3
2
1
0
CCA 2
CCA 5
CCA 10
Other
Other
Referrals

Table 4.1 –

Profile of all Cases Referred for an FGC in the First Year of the ECAHB Project.

Case No	Area of origin	Age of child	Child attend	Gender	Completed: C Terminated:T In prep: IP	Plan	No. of Family Members	No. of Professionals	Part of Evaluation
1	2	15	Y	F	C	Y	5	5 (1ob)	Y
2	2	13	Y	M	C	Y	5	6	Y
3	5	7&7	Y	M& M	C	Y	5	5 (incl 2FC)	Y
4	10	13	Y	F	C	Y	3	1	Y
5	5	18	Y	F	C	Y	8	4 (+1student sw.)	Y
6	10	8	Y	M	C	Y	2	4	Y
7		17	T	M	T	T		T	T
8	2	13	T	M	T	T		T	T
9	5/9	11		M	IP				N
10	5	5&6	X	M& F	C	Y	2	5	Y
11	4	3-17		F	1P				N
12	5			M& F	1P				N
13	2	12,11,7,2		M,F,M,F	1P				N
14	2	7	X	M	C	Y	6	7	Y
15	5	13-11		F	1P				N
16	10	20		F & F	1P				N
17	5	7-11		F	1P				
18	5	11		M	1P				
19					T				
							36	38	

4.2 Status of Participants

4.2.1 Marital Status of Parents

The marital status of the parents revealed that 50% of children came from "married but separated" parents. There was the same figure (12.5%) for the single parent's category and those in a cohabiting relationship (12.5%). The remaining group was reported under the category of other arrangement (25%). At the time of the FGC, a lone parent headed seven out of the eight families.

4.2.2 Age & Gender Profile of Children

The age profile of the 10 children involved in the project ranged between the ages of 0-7 years (40 %), 8-15 years (50%) and 16 years + (10 %). A gender analysis shows males as representing 60% while females represented 40% of the children included in this study.

4.2.3 History of Contact with the Health Board

The results show that there was a significant history of contact with the Health Board. This involvement was divided into two categories. Firstly, all the children in respect of whom the conference was being called had been involved with the Health Board in the past. Secondly, 75% of other family members had had prior substantial involvement with the Health Board, with the remaining 25% categorised as unknown. The basis for social service involvement with individual families ranged from Child Protection concerns [inclusive of Family Support Service as a secondary service] (63%) to a child being in care on a voluntary basis (37%).

4.3 Connection with the Pilot Project

4.3.1 Reasons for Referral

Referrals were precipitated by a pending or already presented crisis that may have been ongoing or new in the family network. The FGC was viewed by the referring agency as a means of mobilising a wide definition of family and giving this chosen group a facility to pool their resources and offer support in a planned and formal way. Referrals were routed through the Health Board community care area as the first point of contact, but the individual community care areas did not have a veto on referrals made directly to the project office by other agencies. On acceptance, the case was assigned to a co-ordinator, who explained the process and prepared the participants for the FGC.

4.3.2 Referral Rate

The rate of referral of cases to the pilot project was slow, a finding similar to other projects. When this trend was evident, key people in the voluntary sector who had showed an interest in the FGC method were informed that referrals would be accepted from them.

4.4 The Conferences

4.4.1 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 in advance of a personal home-visit. A similar method was utilised for contacting the professionals. Major difficulties arose at this stage as many telephone numbers, especially mobile numbers of family members were out of service for significant periods.

Negotiating Attendance: Negotiating of possible attendees at the FGC was carried out by various combinations of participants, with the aid of the co-ordinator whose remit it was to facilitate this part of the process. It was reported that in 50% of cases the social worker and child worked together with the co-ordinator to negotiate attendance. The mother and co-ordinator were the primary negotiators in a further 25% of cases, and the social worker and co-ordinator in the remaining 25% of cases. In terms of the professionals attending, the mother invited them in 38% of cases, the child in 25% of cases, the mother and child jointly in a further 25% and another person in 12% of cases. Those with statutory responsibility such as Health Board social workers and team leaders were automatically invited and could not be excluded.

Family & Professionals in Attendance: The number of family members who attended the FGCs averaged five, varying from three to seven. In two of the FGC, the numbers were very small (three family members, the child and two professionals) and in the other the birth parents, child and one professional. In 75% of cases, attendance ranged between full to three-quarters of those invited to the conference. In 25% attendance was low, as cited above, representing only a quarter of those invited actually attending. Those who failed to attend were divided into two categories. Firstly, there were those who could not attend due to particular circumstance (88%) and secondly, those who chose not to attend (12%). Professional attendance was high with 95% of those who were invited present at the conference.

In Essex, an average of six family members attended with a range from 3 to 15. 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. Families were quite adamant in many cases that invitations should not extend beyond family into social networks to maintain the privacy of the situation.

Exclusions: The issue of exclusions remained a key issue in the training as reported in Section Three. The co-ordinator was given the power to make a decision as to when somebody should be excluded, but careful attention to the principal of inclusiveness was maintained, while also paying attention to the best interests of the child and other vulnerable family members. A very small number of exclusions occurred based on family's decision to exclude a person with a drug problem. In another instance a family member chose not to attend and, due to his position of power within the network, that also had an impact on the willingness of other family members to attend.

4.4.2 Time Scales involved in the FGCs

Referral: It was found that 80% of the cases referred to the pilot were accepted within two weeks of the referral being made, and the remaining 20% took a further week.

Acceptance to Pilot: The period between acceptance of the referral and the holding of the FGC was three weeks in 75% of cases and four weeks for the remaining 25%. A number of factors accounted for this time lag, and this is something that needs closer attention in Phase Two, as discussed in Section 7.

The time between referral and holding a conference in the Essex study was longer than the time in this project. In the Essex project reported average was five weeks, the shortest 4 days and the longest 114 days.

Preparation: The average length the co-ordinators spent in preparation from referral to the holding of the FGC was 30 hours. The inner and outer times ranged between 25 to 35 hours.

Information Giving: The average length of time for the information giving stage of the actual conference was 45 minutes.

Private Family Time: On the withdrawal of the professionals from the meeting, private family time was found to be on average 60 minutes, ranging from 90 minutes down to fifteen. (Lupton (1995) found that private family time was 2 hours and fifteen minutes at longest, ranging down to 15 minutes).

Presentation of Plan: The presentation of the plan for review and ratification by the professionals took on average 50 minutes.

Duration of FGC: The entire conference generally took an average two and a half hours.

Referral to Completion: The total number of hours the co-ordinator worked in facilitating the conference from referral stage to completion averaged 33 hours. Geographical location, cases involving large numbers of invitees and complex family situations contributed to the variation in time scales. The time commitment involved has major implications for the resource requirements for FGC if it is implemented on a broader level. It can also be expected to impact on the system of payments, as fixed price contracts may not take account of the evident variation.

In the Essex study, the time commitment of the co-ordinators in preparation for and holding of the conference was 29 hours, with variation between 12 and 48 hours. The Lupton study (1995) average was 23 hours, with variation from 8 to 51 hours.

Time Conference was Held: In almost 90% of cases the FGC was held on a weekday with the remainder at the weekend. The preferred time for three of the FGC was the evening which generally accommodated working members of the family network, while the others took place during day time, generally in the afternoons.

The fuller employment in Ireland with larger numbers in the work force invariably means that the trend of evening meetings will continue, especially if wider family membership is to be attracted to the conferences. The may also have some implications for information givers when and if the FGC 's project is expanded.

Venue: In 95% of cases the preferred location for the FGC was a community or parish centre, as it was deemed to be a neutral venue for all participants. It also facilitated the practicalities of a sizeable group meeting. The small number held in the families own home was also a feature of the Essex and Lupton study findings.

4.4.3 Presenting the Plan

Was Plan Accepted: In 87% of cases, the plan as presented was accepted by the health board, with the remaining 12% requiring some minor modification.

Review Date Set: A review was scheduled for two-thirds of the plans, and omitted from one-third of plans.

Monitoring Of Plan: There was explicit reference to the monitoring of plans in 88% of cases and this was seen to be the remit of the designated social worker. In the remaining case, no overt reference was made to the monitoring of the plan.

SECTION 5 - FAMILIES' VIEWS ON THE FGCs

5.1 Introduction to Qualitative Research

In Sections Five and Six, the views of the participants on the pilot project FGCs - the family members (19), the co-ordinators (8) and the information givers (9) - are presented. Section Five reflects the main findings from the family member's questionnaire, drawing on qualitative and quantitative data. There are two aspects to the questionnaire in which the views and feelings of the family are ascertained. Firstly, the four stages of the FGC 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 on the model from a broader perspective.

5.2 Families views on the Four Stages of the Conference

5.2.1 Before the Conference - The Referral and Preparation Stage

A number of key issues, pertinent to the referral stage, are illustrated here. They are as follows:

was the information clear?
did they feel adequately prepared?
was there any conflict regarding attendance?
were the 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 5.1
Summary Table of Family Members' Perspective
on Level of Preparation prior to FGC

	Yes	**In parts**	**No**	**Don't know**
Was information clear	80%	20%		
Were you adequately prepared	74%	5%	21% not adequately	
Any conflict re attendance	16%	32%	52%	
Were helpful people facilitated to attend	62%	26%	10%	
Did you have different views regarding attendance	37%	26%	32%	5%
Were the right Professionals invited	62%		16%	22%

(N = 19)

Clarity of information: The referring worker outlined the concern in writing to the project manager in the referral. This formed the basis as to why the FGC was being held. The 'why' of the conference determined the scope and brief of the FGC for the participants. The co-ordinator was generally the first person in contact with prospective attendees (excepting birth parents, who would have already given permission to proceed with an FGC to the agency). At this juncture the process and reason for their participation being requested was explained. The great majority of families (80%) 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 (20%) expressed some uncertainty.

A key component to the success of this aspect of the preparation was a personal visit by the co-ordinator to those invited to attend. The co-ordinators provided a familiar and recognisable face for the family network at the actual conference, particularly for those with little experience of the Health Board. 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 young person, an attendee, commented that he felt trapped and unprepared when the co-ordinator contacted him by phone to arrange a meeting and would have preferred if initial contact had been made through his social worker or by letter so he would not have been taken off guard.

Adequacy of Preparation: The greater portion (74%) of family members felt they were adequately prepared in all aspects of the FGC in advance of the conference, while a small number (5%) felt some gaps remained for them. Others (21%) considered they were not adequately prepared. This was due in part to people being invited where there was insufficient time for the co-ordinator to prepare them more fully for attendance. Some family members expressed the view that 'it was only by going through the experience that I came to fully understand what it was all about. All the explaining in the world could not do the same.'

Feelings about FGC: Families generally felt hopeful and optimistic regarding what would be achieved by attending the conference as the process was something novel. As one person put it: 'for the first time we are being asked our opinions'. Some took a more sceptical position when they commented: 'what's really going on, why are we suddenly being given the power to decide. Is the health board trying to put the responsibility on us so if it goes wrong they can blame the family and they are off the hook?' A similar sentiment was expressed, viewing FGC as 'more of the same with different window dressing' or 'I only went to keep others happy'. Another woman said that 'at last the truth would come out and we will all be there to hear it and do something about it'.

Conflict re attendance: There was full agreement regarding who should attend in over half (52%) of the families, with no conflict being experienced. Just under a third (32%) experienced minimal conflict while the remaining group (15%) were able to resolve their conflicts through negotiation. The main cause of conflict hinged on exclusions. In one instance two people were deemed unsuitable to attend the FGC, as they were drug abusers. In another situation the father of the children was in and out of prison and a drug abuser and considered unsuitable to attend. There was tension regarding the inter, intra and extra familial attendance. This related to sibling rivalry, strained relationship among extended family and a desire to contain the problem within confines of the family and away from the family's social network. The concerns hinged on privacy rather than on what benefits the excluded persons might bring to the FGC. One man commented: 'I was wheeled in at the last minute, not because I was wanted but because the women decided there should be a male voice'. Another person asked how the process of selecting attendees is negotiated? This may have implications for children choosing who attends and a possible clash of rights of parents, legal guardians and the rights of the child(ren) to have their wishes heard. Other people question the wisdom of children attending all the conference. Whose views take precedence?

Helpful attendees: The majority of family members (63%) felt the appropriate people were contacted and facilitated to attend. Other family members (26%) expressed only minor disagreement, while the remaining group (11%) perceived those in attendance as unhelpful.

Different view regarding attendance: When family members were asked if, on reflection, they had a different view regarding who should have attended just under one third (32%) would have chosen the same

people while a quarter (26%) were mainly in agreement with some minor variation. Some (37%) held a different view regarding attendees while a small group (5%) did not respond. One man would have preferred more of the family to be present saying 'it would be better so that no one is over burdened trying to help and the plan would have a greater chance of working'. This paints the picture of strength being in greater numbers and the more family in attendance the greater the pool of wisdom for solutions and support.

Right Professionals: Slightly less than two-thirds (62%) of the family thought the right professionals were in attendance while the remainder either did not know (21%) or did not agree with those invited (16%). A number of families felt there were too many professionals at the meetings or as one woman put it 'they were surplus to requirements and they did nothing only sit there'. Others would have liked different professionals to attend such as the local doctor, the class teacher or the family support worker. One family member liked the fact that there was a variety of professionals present giving different perspectives on the problem. Another liked the frank and open discussion around the problem by the professionals. One person commented: 'who are the right professionals, to date they all have failed to help?'

Independence of the co-ordinator: Almost half (47%) the respondents were unaware that the co-ordinator was not an employee of the health board, while others were (32%) aware of their independence and yet a further group (21%) did not respond.

Time & Venue: Family members' views on the suitability of the FGC's time and venue are presented in Figure 5.1 below. It can be seen that the majority of family participants were happy with both the time and venue of the FGC. As many people worked, meetings tended towards evening time and the venue was invariably a neutral setting.

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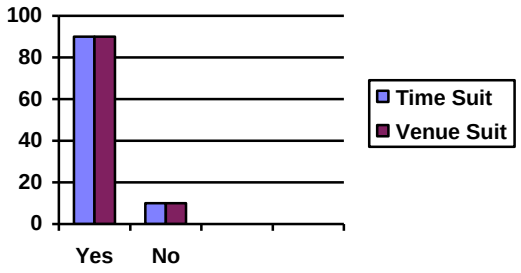
Figure 5.1 –

Time and Venue



5.2.2 The Information Giving Stage

In Table 5.2 the question of adequacy of information, 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 5.2

Summary of Family's Experience

at the Information Giving Stage

	Yes	Some	No	Don't know
Adequate information to make a decision	85%	5%	5%	5%
Chance to speak if you wished	95%		5%	
Answered your questions	58%	21%	21%	
Feel comfortable	63%	21%	16%	

(N = 19)

The majority felt the information giving stage was handled well, with some 85% of family members feeling they got adequate information at this point to enable them make a decision. One person (5%) found some gaps, while an equal number found they did not get adequate information, as did a similar number who did not know.

Comments were passed on the 'big words' used by the social workers and 'we didn't understand what they were saying half the time'. This highlights an occupational hazard for professionals and the use of technical language and jargon that can serve to further alienate people who frequently feel powerless and marginalised.

The multi-disciplinary approach to a problem was commented on by families as something positive that described a difficulty from a number of perspectives. Interestingly, one person expressed surprise at the information being shared as being affirming and positive in many aspects while also being challenging. The inclusion of a strengths perspective to assessment was important.

In many cases families said that there was nothing new in what was being said but it was still useful for the concerns to be heard as a group. Others commented that it was the first time the truth had come out all at once and they now felt they could do something about it. When the processes surrounding the planning were examined it became clear that the great majority of family members would have liked more information, resources and options. Issues of information-giving therefore need to be interpreted cautiously.

The greater number of family members (79%) felt the professionals listened to them very successfully. A further group (11%) felt successfully listened to. Almost everyone (95%) felt they had the opportunity to speak if they wished and over two thirds had whatever questions they had answered. Family members (21%) felt most of their questions were answered while a similar proportion (21%) had outstanding questions remaining. The challenge is to have a context to enable these unasked questions to be asked.

A sizeable number either felt comfortable all the time (63%) or some of the time (21%) throughout the information giving stage and considered the information imparted (85%) was sufficient to enable them to draw up a plan. The co-ordinator played a pivotal role in setting the tone of the conference. They were viewed by family members as someone neutral, with whom a bond had been forged through the home visit. Others would have preferred more information (11%), while a minority (5%) felt that there was no useful information imparted.

5.2.3 Private Family Time

Table 5.3 presents the family members view of the key processes that occurred during private family time. 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 5.3

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

	Yes	Quite a bit	A little bit	No	Don't know
It was made clear what needed to happened when Professionals left	90%	10%			
Extent you felt listened to	74%	5%	5%	15%	
Extent others listened to	58%	16%	26%		
Any difficulties emerge in PFT	11%		42%	47%	
Extent it was easier to talk without Professionals	53%			42%	5%
Extent resources were pointed out	47%	32%		21%	

(N = 19)

In Table 5.3 a number of issues concerning the family members views of private family time are presented. The vast majority (90%) of families had a clear understanding of what needed to happen once the professionals left the meeting , while the remaining (10%) were quite clear. Within the context of this process, just under three-quarters (74%) felt listened to. Of the remaining people, 10% felt quite listened to while 15% felt they were not listened to at all. Over half (58%) considered others were fully listened to. No one felt that were not listened to, but the extent varied between quite an bit (16%) and a little (26%).

While the greater number (47%) experienced no difficulties or abusive behaviour as a result of the professionals not being there, of those that did, most found it manageable (42%) with two out of nineteen people experiencing abusive behaviour. This suggests while the process is being experienced as positive by the family it can be a painful experience for some individuals coming together to discuss a family problem. In one instance the young person walked out, as the pain experienced in discussing the plight of her children simply became too much to handle.

Discussions in the absence of the professionals were easier for the most part (53%) and a sizeable number (42%) experiences no significant difference due to professionals leaving. One young person recounted feeling more vulnerable in the absence of the professionals and would have preferred if they had remained. This person had an extremely strained relationship with her mother who was refusing to allow her return home. The young person frequently felt depressed and many of the comments made were negative in tone. Almost half the family members (47%) felt the available resources were pointed out to them while others (32%) would have liked more information. In one situation the family was in receipt of all available resources on offer from the Health Board, and was still left feeling unsupported.

A number of family members commented that the process might have been easier if someone had to sit in with them. In almost equal measure, family members totally opposed the idea of an outsider and saw that it would work against the family making the decision. Undoubtedly, the experience of family coming together under circumstances where a state agency has an issue in respect of one of their children is likely to evoke a wide mixture of emotions. Combined with this, is the reasserting of old family stories and ways of being, which do not lead to happiness….

Families commented that it was important for children to hear not only from the professionals but also from the family that they are not responsible for the failures of others. However, others commented that great caution was exercised not only in the presence of the children during this time but also in front of adults. Straight talking may have made the situation worse, one person commented. A suggestion was made that the family may need time during this stage when the child is not present to discuss sensitive and difficult issues that may not be in their best interests to hear.

5.2.4. Presenting the Plan

Table 5.4 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 5.4

Summary of Family Members Views of the Process of Presenting the Plan

	Yes	Quite a bit	A little bit	No	Don't know
Do you remember the plan	74%	16%		5%	* 5%
Did it differ from what you thought might be	21%	21%		47%	11%
Was the plan accepted	74%	26%			

Review date	90%			10%	

* Did not receive a copy of the plan. (N = 19)

Table 5.4 reveals a high satisfaction rate on the part of the family. Just under three-quarters remembered the plan in its totality while another group (16%) could recall quite a bit of the plan. Almost half (47%) had very similar ideas regarding the plan reached, prior to attending the conference. In the majority of FGCs (74%) the plan was accepted as presented and the remainder (26%) with only minor modifications. Most also (90%) contained a date for review date.

5.2.5 Reflections on the plan and outcomes

Family members were asked to reflect on the plan, and their views were as follows:

Feeling about the plan now: Reflecting on the plan over half felt either very satisfied (32%) or satisfied (26%) with the plan made. A further group (21%) felt very dissatisfied. Three people out of the nineteen respondents felt either quite unsatisfied, indifferent or failed to respond.

Resolving the difficulty: Over half (53%) of the respondents were very satisfied with the FGC plan in resolving the problem at the time, while a further group (16%) were quite satisfied. Equally, a number (16%) were very unsatisfied and a lesser group (5%) quite unsatisfied. Two out of the people nineteen expressed indifference.

In hindsight: Upon reflection, the majority of people (41%) would still choose the same plan, while a lesser number (32%) would only make minor changes. Three out of the nineteen respondents would have liked a totally different plan while two did not know.

Additional help: In one case the family required additional help outside the plan. However, the majority (58%) did not, while the remainder did not know if the plan required subsequent help.

Family relationships: Approximately half (48%) reported an improvement in family relationships as a direct consequence of the FGC. Many of the others that considered the FGC had no effect (42%) commented that the family already enjoyed good relationships and good communication. No one reported a negative effect while a minority did not know (10%) what effect the FGC had on family relationships.

Use of process in the future if faced with similar difficulties: Families were offered three options if similar family problems emerged in the future. Almost three-quarters would choose the FGC process over the conventional Health Board intervention (21%). Just one person showed a preference for not engaging in wither process but would prefer to sort it out themselves (5%). This person now considered that the extended family was strong enough to resolve their future difficulties.

Families overall impression of the FGC was positive. The majority (74%) found it good in parts. Just over one-third (37%) considered the child's situation to have improved while similar percentages (26%) considered it remained the same as before or had got worse. Two of the nineteen did not know. When asked to account for these outcomes, over half (58%) did not attribute them to the FGC while a lesser group (21%) made a direct connection with the FGC or a tentative connection in parts (19%). Two of the nineteen did not know what the cause was.

SECTION 6 - CO-ORDINATORS' AND INFORMATION-GIVERS' VIEWS

6.1 Co-ordinators

Section Six reflects the main findings from the Co-ordinators and Information-Givers, drawing on qualitative and quantitative data. The findings follow the four movements of the FGC, i.e. referral & preparation stage, information-giving stage, private family time and the presentation of the plan.

6.2 Views of the Four Stages of the Conference

6.2.1 Referral and Preparation Stage

This section illustrates a number of pertinent issues around the referral and preparation stage of the FGC for the co-ordinators. They are as follows:

The ease/difficulty co-ordinators experienced organising the conference;
The additional information sought by family;
The level of preparation of the participants upon initial contact;
The reaction of the participants to the proposed process.

Ease of arranging FGC: Arranging the conferences posed great challenges for the co-ordinators. In over half of the cases the co-ordinators found arranging the FGC as being quite difficult. Some of the difficulties revolved around the clarifying of agency concerns, waiting to make contact with families, waiting to make contact with social workers and dealing with misunderstandings between the family and professionals at the referral stage.

Other information sought: The co-ordinators sought additional information in 5 out of the eight referrals. This request was mainly to the agency to clarify concerns and a bottom line. In response to difficulties that emerged in earlier conferences, a number of changes were made to the referral form which helped both the referrer clarify concerns and assist the co-ordinator in the preparation stage.

Table 6.1
Summary Table of Co-ordinators Perspective on

Level of Preparation upon Initial Contact

	Children	**Parents**	**Relatives**	**Others**
Very well prepared		25%	13%	12%
Well prepared	25%	13%		
Not all prepared	75%	37%	75%	88%
Nothing indicated		25%	12%	

(N=8)

The referring agency holds the responsibility to seek permission to hold a FGC. As part of this negotiation the parents and children, if old enough, have the process explained to them. Information leaflets are also left with the family. It is to be expected that the informal networks of information will them commence in the family and information is exchanged. Therefore, when the co-ordinators contact the designated people in the family it would be usual to have variations in the amount of information they would know. The less they know the more work there is for the co-ordinators. The reverse may also be true and the greater chance there would be for mis-information. In Table 6.1, the co-ordinators perception of the level of preparation experienced upon initial contact with the respective members of the family network is shown. It is an indication of the amount of work the co-ordinator needs to do to prepare a family for an FGC.

Table 6.2
Summary Table of Co-ordinators Perspective on

Level of expectation of Preparation upon Initial Contact

	Children	**Parents**	**Relatives**	**Others**
Did you expect a different level of preparation Y?N	Yes = 75% No = 25%	Yes = 63% No = 12%	Yes = 75% No = 13%	Yes = 75% No = 13%
Nothing indicated		25%	12%	12%

(N=8)

Table 6.2 highlights if a different level of preparation was expected. The low positive responses pertain to the immediate family who had the process partially explained by the designated social worker. This is not to detract from the expectation of preparation by the co-ordinator in almost three-quarters of the cases across the board. However, the low levels of preparation of parents and children prior to the co-ordinator contacting them has further implications for the job of the co-ordinator. It is not clear however who would have prepared other relatives as this is the job of the co-ordinator. Perhaps informal networks could do it better!

Table 6.3
Table of Co-ordinators Perspective on the Initial
Reaction of the Family Network to the Suggestion of an FGC

	Children	**Parents**	**Relatives**	**Other**
Very favourable	1			
Favourable		4	4	5
Neither favourable or unfavourable	7	2	3	2
Unfavourable			1	
Nothing indicated				1

(N=8)

Table 6.3 also needs to be placed in context to give a more accurate interpretation of the findings. There were minimal negative responses to the suggestion of a FGC i.e. one instance with a relative. Many family members preferred to reserve judgement - a 'wait and see' approach which is reflected in the category 'neither favourable or unfavourable'. The positive findings reflect the immediate family who had the process explained to them by the designated social worker and would have given their consent to process advancing.

The group who were neither favourable nor unfavourable were those who only had contact from the co-ordinator before attending the conference. Equally, while all the immediate families had prior Health Board involvement, in many instances it was something new to the extended family. It emerged from discussions with families the Health Board, particularly social workers, are held in deep suspicion. This also contributed to the 'wait and see' verdict.

Table 6.4
Summary Table of Co-ordinators Perception
of the Issues Concerning Attendance at FGC

	Yes	**In part**	**No**	**Not applicable**	**Don't know**
Was there any conflict regarding attendance		37%	63%		
Did co-ordinator have different view regarding attendance	13%	50%	25%	12%	
Did co-ordinator think the right professionals were in attendance	100%				

(N=8)

In Table 6.4 almost two-thirds (63%) of participants experienced no conflict regarding attendance while the remainder (37%) experienced minimal conflict. The co-ordinators were in full agreement with those in attendance in a quarter (25%) of the cases and held partially different view in half (50%) the cases. There was universal acceptance (100%) of the professionals as being the correct people in attendance for the FGC. Co-ordinators experienced frustration in trying to get people who were considered important to the process but were reluctant to get involved for whatever reason to attend. Difficulty was also experienced in making contact with family members who had changed address and mobile phone numbers. Professionals were also difficult to contact due to the community-based nature and volume of their work

6.2.2 Information-Giving Stage

In Table 6.5 summary information is presented in respect of the adequacy of information given to families so they could make a decision, the extent to which the family had an opportunity to speak, the extent to which the family members had their questions answered and the extent to which the conference was child focused.

Table 6.5

Summary of Co-ordinators Experience

at the Information Giving Stage

	Yes	Some	No	Don't know
Was information presented that the family could make a decision	63%	37%		
Was there a chance for the family to speak if you wished	100%			
Was the family able to answer your questions	63%	12%	25%	

(N=8)

In Table 6.5, the co-ordinators generally had a positive view regarding the quality of information presented by the professionals to the family so they could make a decision. It ranged from slightly under two-thirds (63%) being sufficient in all parts to the remainder being sufficient in some parts (37%). The frank and open style of other professionals seemed to be well received however, as alluded too earlier, some caution needs to be exercised to avoid jargon and technical language.

There was an overall perception by the co-ordinators that all family members had the opportunity to speak if they wished. In the majority of situations (63%), there was a feeling that the family were able to answer all the questions put to them by the co-ordinator. 12% of the family were left with some questions outstanding (12%) while in (25%) of the situations; the co-ordinators felt the family was not able to answer questions.

Child Focused: Half the conferences were rated as being child focused and a quarter were perceived as being very child focused and the remaining quarter as being not very child focused. It is important to distinguish between FGC's being child focused when the child is present throughout as opposed to adults going off on a tangent when the child is not present.

Child care decision meetings: In most instances the co-ordinators had no previous involvement with the Health Boards in childcare decision meetings. The FGC process was found to differ in two of the cases where the co-ordinator had had previous Health Board experience in childcare decision meetings. This may be important in the co-ordinators not having pre-existing assumptions but knowledge of the child welfare system is nonetheless important.

6.2.3 Private Family Time

In this section the co-ordinators views of private family time are illustrated. They are as follows:

The extent the professionals left the room to enable the family have time alone;
The extent to which any difficulties arose as a result of the professionals withdrawing;
The extent to which the available resources were pointed out.

Professional's place in private family time: The professionals withdrew from the family in all cases leaving them time on their own to produce a plan. In one case this was as short as fifteen minutes due to the low attendance by family and it was decided that the professionals would return to assist the family to formulate a plan. The principle however was adhered to.

Difficulties during the process: In one FGC out of eight there was no difficulty experienced by the family as a result of the professionals withdrawing. In two FGCs where difficulties arose, the family easily resolved matters. In the remaining five FGCs it was not known if any difficulties were experienced by the family.

Resources available pointed out: In three-quarters of the FGCs, the resources available to the family were pointed out adequately prior to the family being left alone. In one FGC there was a request for more resources to be made available to the family while in the remaining FGCs, it was considered that resources were pointed out insufficiently to the family.

6.2.4 Presenting the Plan

Table 6.6 presents the key findings of the coordinators experience of the process of presenting the plan. It is examined under the following headings:

The degree the plan was different from what they thought may have been reached;
The extent to which the plan was accepted; and
If a date for review was set.

Table 6.6

Summary of Co-ordinators' Views Of the Process of Presenting the Plan

	Yes	Very similar	A little bit similar	No	Don't know
Did the plan differ from what you thought might emerge	1	2	1		4
Was the plan accepted	7			1	
Review date	5			3	

(N=8)

Table 6.6 reveals the co-ordinators in half the FGCs (4) did not have a preconceived plan in mind going into the FGC while in two FGCs the plan that emerged was very similar to their expectations. One FGC was very different and the other was a little bit similar to what they thought may emerge. The plans were accepted as presented in the majority of FGCs (7) according to the coordinators with only one requiring minor modifications. Five out of the eight FGCs contained a specific date for a review.

Successful in resolving the problem: The co-ordinators considered the extent to which the designated plan was helpful in resolving the problem at the time. In one FGC it was deemed to be very successful while in five other FGCs it was considered to be quite successful and in two FGC it was seen as in between.

Liked a different plan: With hindsight the co-ordinators were very happy with 3 FGC plans that emerged while in one FGC there was some reservation regarding certain aspects of the plan. In one case the co-ordinator reported total dissatisfaction with all parts of the plan.

Child's overall situation: There was a high level of uncertainty as to whether the child's overall situation is now better or worse off. This may reflect the fact that co-ordinators do not have ongoing contact following the FGC. The co-ordinators could not address this issue, as their role did not require further involvement beyond the hand-over that took place soon after the conference be completed.

6.3 Information-Givers

The findings presented reflect the views of nine information-givers who were part of the 37 personnel who attended the FGCs. The nine information-givers are comprised of five from the Health Board and four from other agencies. While acknowledging the small number, the data is nonetheless presented in percentages. When appropriate the numbers involved or a combination of both is presented. The information presented follows the four stages of the FGC, i.e. Referral & Preparation stage, Information-giving Stage, Private Family Time and the Presentation of the Plan.

6.3.1 Referral and Preparation Stage

A number of key issues for the information-giver, pertinent to the referral and preparation stage are illustrated here. They are as follows:

The information-givers understanding of the FGC model;
The extent of their previous involvement in FGC's;
The extent of training received;
How well the training equipped them for the process.

The focus then shifts to determine the nature of the agency's involvement, if the information-giver considered the right professional and family members attended the FGC. Lastly, the information-givers are asked for their perception on the level of preparation the family network received.

Table 6.7 A & 6.7 B

Summary of Information-Givers Views On the Referral and Preparation Stage

A	**Very well**	**Quite well**	**Not very well**	**Not at all**	**Not indicated**
How knowledgeable were you of FGC	22%	33%	33%		12%
How well did training equip	22%	33%	12%		55%
B	**Yes**	**No**	**Don't know**		**Not indicated**
Had you any training about FGC	55%	44%			
Had previously attended a FGC	12%	88%			
Right professionals	66%	22%			12%

attended					
Right family members attended	33%	44%	12%		12%

(N=9)

Knowledge of FGCs: The respondents were asked how knowledgeable they were about FGC before attending this one. Two felt very knowledgeable and three quite knowledgeable about the process. A further three did not feel very knowledgeable while the remaining person gave no indication. This is not unexpected, as the pilot was something new and unknown to many prior to attending the FGC. The number who had not previously attended a FGC (8 out of 9) would support this. To place this in context, it was only Health Board social workers that received formal training and many of the information-givers from other agencies did not receive any training. Of the five people who attended training, two indicated training equipped them very well and three quite well while one indicated not very well.

When asked about the appropriate professionals in attendance 6 information-givers considered the right professionals were in attendance while 2 did not. The remaining person did not indicate one way or the other. Out of the two who indicated the right professionals were not in attendance, one would have liked their team-leader to have been present while the other thought there was an over representation of professionals at the particular conference. When considering the same question in relation to family attendance, half the professionals were of the view that the wrong family members were invited while three were of the opinion the right family members were invited. There was one who did not know and the other did not indicate.

This raises an interesting question about the professional's view of the choice the family made themselves and needs to be considered along side the general satisfaction of the professionals with the plan emerging from the FGC.

Table 6.8 illustrates a number of key issues for information-givers regarding their level of expectation of preparation upon initial contact with attendees at the conference.

Table 6.8
Information-Givers Views on

Level of Preparation upon Initial Contact

	Children	**Parents**	**Relatives**	**Others**
Very well prepared	1	1	1	2
Well prepared	4	5	5	3
Not all prepared		1		1
Nothing indicated	4	2	3	4

(N=9)

Table 6.8 reflected a positive picture by those who responded on the level of preparation of the participants. Again caution needs to be exercised when interpreting these results. A distinction needs to be made between the professionals who received formal training and those professionals who did not and the family network who received instruction from the co-ordinator in preparation for attendance at the FGC and those who, for what ever reason, did not.

Table 6.9
Information-Givers Views on

Level of Expectation of Preparation upon Initial Contact

Table 6.9 illustrates the information-givers expectation of preparation upon initial contact with attendees at the conference.

	Children	Parents	Relatives	Others
Did you expect a different level of preparation Y?N	Yes = 0 No = 2	Yes = 1 No = 4	Yes = 1 No = 4	Yes = 1 No = 3
Nothing indicated	7	4	4	5

(N=9)

Table 6.9 shows the information-givers expected level of preparation of participants as positive. This reflects the quality work accomplished during the preparation stage by the co-ordinators.

It is difficult to indicate the level of satisfaction or otherwise with the level of preparation as in one half of the returns nothing was indicated. Less than half the people however were more or less satisfied with the rate of preparation.

6.3.3 Information Giving Stage

This section addresses pertinent issues regarding the information shared at the conference and is presented in Table 6.10. They are as follows:

The extent to which the information produced for the FGC significantly differed from reports produced for case conferences;
The extent to which the information presented was complete and comprehensive;
The extent to which the information presented could be used by the family to make a decision;
The extent the information provided to the family was sufficient to make a decision;
The extent the family understood the information shared;
The extent there was a chance for the family to speak if they wanted to;
The extent that the family was able to answer any questions the information-givers wanted them to;
The extent the conference was child focused;
The extent the FGC differed from other childcare decision meetings the information-giver attended.

Table 6.10

Summary of Information-Givers Experience
At the Information Giving stage

	Yes	In part	No	Don't know	Not indicated
Information produced different for FGC vs Case conference	33%	11%	33%		22%
Information presented complete & comprehensive	55%	22%			22%
Information presented in such a way family could make a decision	44%	33%			22%
Information presented sufficient to make a decision	77%		11%		11%
Family under-stand info.	88%				11%

(N=9)

In Table 6.10 it can be seen that 33% of information-givers considered there was a significant difference in the information produced for the FGC as distinct from a case conference. One indicated there was some variation while a further 33% deemed it to be the same. 22% did not indicate their view.

In over half (55%) the FGCs the information-giver felt the information shared was complete and comprehensive while another group (22%) though it was in part complete and comprehensive and the remaining (22%) did not indicate their views. The omission or concealment of pertinent information from or by families has implications for the plan produced but also how much weight is given to the plan and the subsequent success of the plan.

44% of FGCs respondents, felt the information was presented in such a way that the family could use it to make a decision while 33% felt it was only partly presented in a way that it could be used. 22% respondents did not know while the remaining 22% did not indicate their views. The majority of professionals (8 out of 9) felt the family fully understood the information being shared.

Chance for family to speak: It was felt that all those who wished to speak were given the opportunity and were free to speak.

Able to ask any questions: 44% of information givers were of the view that families were able to ask any question they wanted. This is different from both the co-ordinators view and the family themselves as shown in previous sections.

Child Focused: The greater number (77%) rated the conference as being child focused and the reminder (22%) did not indicate anything.

Resources: The majority of information givers (88%) felt the available resources were pointed out to the family sufficiently prior to private family time. In one FGC is was not indicated what happened.

6.3.4 Private Family Time

This section of the questionnaire seeks to ascertain if the professional withdrew leaving the family alone, if there were only requests for professionals to remain during this time, if an advocate was appointed to safeguard the voice of the child and if rules were negotiated to enhance private family time.

In this section the information-givers views of private family time are illustrated. Table 6.11 addresses the pertinent question as follows:

Did the professionals leave the room during this time?
Was there a request for any professionals to remain?
Was an advocate formally appointed for the child?
To what extent were rules negotiated with family member for this time?

Table 6.11

Summary of Information-Givers Experience
At the Private Family Time stage

	Yes	**No**	**Not indicated**
Did the Prof. leave the room	99%		
Any requests for Prof. to remain		88%	11%
Advocate appointed	11%	33%	44%
Rules negotiated	22%	33%	44%

(N=9)

All the respondents indicated that the professionals left the room however, in one FGC the professionals remained with the family due to the low number (one adult and two children) from the family network in attendance. In general, the principle was observed. In the majority of FGCs (8/9) there was no request for the professionals to remain with the family during private time. It was more the exception (1/9) for an advocate to be formally appointed than not (3/9) while a sizeable number did not indicate (4/9). Where the child remained and was old enough to participate through out, an adult was asked to support of the young person. In one instance where a person was a recovering alcoholic, it may have been helpful if it had been suggested by the information-giver in hindsight that the person's sponsor from the AA meetings could attend as a support and advocate on their behalf.

In the majority of FGCs (5/9) no behavioural issues arose while in other FGCs (2/9) a little conflict was experienced but this was manageable. In one FGC very serious issues surfaced however, it was contained within the family and the professionals did not need to return.

6.3.5 Presenting the Plan

This section looks at the information-givers recollection of the plan, how it differed from what they thought may have been reached, if the plan was accepted and if a date for review was set and if the agency envisaged an ongoing role in the case.

Table 6.12 presents the key findings of the coordinators experience of the process of presenting the plan. It is examined under the following headings:

To what extent the plan that emerged differed from what the information-giver thought was going to emerge?
Was the family plan accepted as presented?
What the view of the information-giver was of the plan?
Was a date for review was set?
Was it envisaged the information-giver's agency would have an ongoing role?

Table 6.12

Summary of Information Givers Views

of the Process of Presenting the Plan

	Yes	Very similar	A little bit similar	No	Don't know
Did the plan differ from what you thought might emerge	1	4	3		1
Was the plan accepted	5	3			1
Review date	5			3	1
Ongoing role for agency	9				

(N=9)

The majority of information-givers (4/9) had very similar plan in mind to that which later emerged from the family and in a lesser number (3/9) the family plan was similar in part to what they expected. In the other two FGCs, one was very different and the other did not indicate.

In most FGCs the plan was accepted as presented or with minor modifications and in one FGC it was not indicated. Dates for reviews were incorporated into a greater number (5/9) and not at all in the remaining three. No information was available on the other case. In all cases the respondents envisaged their agency

as having an ongoing role with the family. There was a generally positive feeling regarding the plan resolving the problem, with the majority considering it very successful (2/9) or quite successful (5/9) with one in between and yet another who didn't know. Equally, in hindsight the majority (5/9) would retain the same plan while a smaller number would make minor changes (3/9) and only one would now choose a completely different plan. The latter was mainly due to pertinent information being concealed from the information givers that would have brought the case in a different direction had it been known at the time.

6.4 Conclusion

The views of the family members, the co-ordinators and the information-givers were presented in Sections 4, 5 and 6. These findings are now discussed and analysed in Section 7.

SECTION 7 – ANALYSIS, RECOMMENDATIONS and CONCLUSION

7.1 Introduction to Section 7

7.1.1 Layout of Section 7

This report provides an overall assessment of Phase One of the Pilot Project, which aims to 'examine the applicability of the Family Group Conference, as a means of improving the management of troubled and troublesome young persons, in the Irish context.' The project goals were identified as being to establish by 31st July 2000, whether the use of Family Group Conferences with selected families can:

- Strengthen families' capacities to provide for and manage their troubled or troublesome young persons.
- Satisfy statutory and /or professional concerns about the young persons involved.
- Result in outcomes unlikely to have been achieved with traditional provision.
- Be cost effective.

The terms of reference of Phase One of the Pilot Project were further developed between May and October 1999. For the purpose of conducting the evaluation for Phase One (May 1999-June 2000) key questions were developed, related to the overall goals of the project. These key questions are addressed in detail in the second part (Sections 7.2 to 7.14) of this Section. In the final concluding part of this section, having considered the detailed issues, the pilot project is reviewed in relation to its high level goals.

7.1.2 Review of Methodology

The aim of the evaluation was to examine the role and contribution of FGCs in child welfare, to review practice as it evolved during the life of the pilot, to capture the changing nature of the practice and to make recommendations which would help in taking the project forward. The methodology (See Section 1.5) was chosen to capture the dynamic nature of the processes and outcomes as they happened. The evaluation aims to reflect the project at different stages over its lifetime, and while the findings are local in nature, the international literature provides a backdrop against which the trends arising in the Irish context can be examined and analysed.

By the end of the first year, a total of 19 referrals were received, from which a total of 10 conferences were completed by the beginning of July 2000. Three of the referrals made to the project were not approved for conferences, and conferences were at the preparation stage for six referrals. This report provides baseline material on all 19 conferences and in-depth analysis on the eight conferences completed by June 2000. It was unfortunate that more of the 19 conferences were

not completed by the end of year one, as this would have provided a larger data set for the analysis. However, attempts have been made to include the broad themes emerging in these later conferences by continuing conversations with the co-ordinators, steering group and the project manager up to the time of writing.

The report draws on the experience and views of the participants, as described in Sections Four, Five and Six. It is based on extensive interviews and questionnaires with key participants, information gathered through the provision of training and consultations to teams, project manager and co-ordinators during the course of the project, and participation in the steering group. The contribution of research assistants, who worked on the evaluation, and who were less involved in the project evolution, provided an important dimension to the analysis as they questioned what may have been taken for granted and sometimes asked the pertinent question that allowed other dimensions to emerge.

7.2 Key Evaluation Questions

The detailed questions outlined in this section were developed in association with the Project Manager and Project Steering Group to elucidate key information on the pilot, and its contribution towards the project development. The questions fall into four main categories:

- the applicability of the model and its fit with the Irish child protection system, (Q1-4)
- participation of families and staff, (Q5-6)
- a consideration of the structures put in place (Q7) and
- costs associated with the practice. (Q8-9)

A summary of the principal findings relevant to the evaluation questions is presented. Key recommendations are made where applicable. These recommendations are incorporated into the practice protocols outlined in Section Eight. The questions considered are as follows:

1 Were the principles of the FGC applied in practice by agency based workers? (Social work managers, team leaders, social workers and co-ordinators.)

2 How does the FGC fits alongside current professional processes of investigation, assessment, case conferencing, and review from the perspective of the key players? (Child care manager, social work manager, team leader, social worker and other key professionals.)

3 Establish if there were examples of innovative and creative Family Group Conference outcomes

4 To identify the modifications needed of the standard Family Group Conference (New Zealand) model in the Irish context.

5 To what extent do family members participate in and have a sense of ownership of the FGC process?

6 To what extent did other 'stakeholders', in child welfare cases participate in the process? (Social workers, legal professionals, court and service providers.)

7 How effective were the FGC Management Committee structures in delivering phase one of the FGC Pilot Project?

8 What were the resource requirements for the successful operation of the Family Group Conference?

9 In particular what were the costs involved in FGC plans as against traditional service provision.

7.3– Question 1

Were the Principles of the FGC applied in practice by agency-based workers involved (social work managers, team leaders, social workers and co-ordinators.)

It is worth restating the main principles underpinning the FGC model as outlined in Section One:

- The child's interests are paramount
- The term "family" is interpreted widely,
- Independence of co-ordinator
- The family always has the opportunity to plan in private,
- The families' plan is agreed by the professionals unless and only unless the plan places the child further at risk.
- Children are best looked after within own family
- Working in partnership is beneficial to children

These principles underpinned the training given in advance of and during the pilot project and the literature developed for family members and professionals. The principles underpinning the FGC are now examined in turn.

7.3.1 The Child's Interests and Perspective

The 'child's interests are paramount' is the most important principle underpinning the FGC and therefore the children's experiences will be first summarised briefly. It was unfortunate that few children could be direct informants of the research. This was connected with ethical issues concerning children in research, research design criteria and the decision not to interview children aged seven years or under. A number of children were unavailable for interview, and another factor was the non-attendance of children at the conference. Two young people, aged under-eighteen, were interviewed. One attended the FGC in his capacity as family member, and the other was the subject of the conference. However with the latter person, there was confusion over the positioning of the concerns, and whether the needs of the pregnant young woman or those of her unborn child were to take precedence. As explained in the methodology section, to compensate for the lack of children's views, other participants' views of the impact on the children was sought.

The majority of the participants felt that conferences were child focused. The biggest area of disagreement was the place of the child at the FGC. There was general agreement in principle that the child should be present. Some participants felt that the child should attend all of the meeting while others felt the adults sometimes needed time to plan and discuss in private as difficult issues under discussion could seriously impact on the child. It was found that when children were present, there was greater attention and sensitivity to how things were said and every attempt was made to make it clear to the children that the situation was not of their making. A difference emerged between the expectation the adults had for the younger child and the older adolescents. Many family members felt the older adolescents had to begin to take some of the responsibility for the direction of their lives and therefore could be more fully involved!

The impact on the child attending the private family time was also examined. It was found that when the child stayed, there was consensus that the advocate system worked. In cases of the young people who stayed, some left when the tension and emotion got too much. This was seen as appropriate way for the young person to exercise control over the process.

Recommendation:

- *Flexibility is needed around the issue of attendance of the children at the FGC. While clear benefits have emerged in favour of attendance, the age of the children, their developmental stage and capacities, the availability of an advocate and the expressed wish of the child should continue to be used to guide practice. This also applies to the place of children in the private family time.*

7.3.2 Wide Definition of Family

In Section Four the range of family members consulted as part of the preparation stage and the family members who subsequently attended were presented. This reflects a wide array of family members, and it also reflects participants from both maternal and paternal sides. (All of the cases (8) analysed in the project were headed by single parents.) In view of the family structure, it is positive that the paternal family was so involved. This can be difficult in practice, as the breakdown of the adult relationship often can leave the child vulnerable to losing contact with one side of its family. This phenomenon is relevant not only to FGC's, but is an issue that is relevant in a lot of child welfare cases. If there is conflict between the maternal and paternal side, which, if either, side should be privileged? In what instances (if any) should two separate FGC be held and if so, how are potentially different plans to be resolved? When there are differences between family and child members in respect of who should attend, how can these differences be reconciled, and whose interests should prevail? These are key questions which will continue to challenge the stake-holders involved in the process.

A major positive aspect of the pilot was that family members were located and contacted, and in most instances they also attended the conferences. Even when family members who were identified as key prior to the conference did not subsequently attend, this provided vital information to the family members who were centrally involved. In one instance, it enabled the young girl to realise that, despite all the promises of a family

placement, the reality was that it would not be forthcoming. In another case, the absolute refusal of any family members to attend highlighted the needs of the child in very stark terms to the agency and the birth parents.

As the number of conferences increased, questions were asked if a sufficient wide definition of 'family' was being taken on? The dominance of family members and relative absence of people from the child's and birth parents social network suggested that there might have been more scope to utilise the social network as opposed to depending on the family network only. When family members' views were sought on this issue, it emerged that inviting people from outside the family caused tensions for some family members. The tensions centred on the wish by some family members to maintain privacy at the cost of allowing themselves to examine the significance of what the non-family members could offer.

Conflict about inviting family members was not a major issue. There was no conflict among over half of the family members regarding attendance. For one third of the families there was some conflict and for the remaining people (15%) there was major conflict over attendance. The tensions for these people were connected with the past history of family relationships.

Recommendations:

- *The issue of practice difficulties surrounding exclusions requires careful attention, and tactful negotiation.*
- *Greater attention needs to be focussed to assessing both the social networks as well as the family network.*

7.3.3 Independence of Co-ordinator

The project was set up to operate with independent co-ordinators. Neutrality was reported as being of central importance to many family members, and the independence is seen as key by all the co-ordinators. The relatively small number of family members, with no previous involvement with the Health Board, were more conscious of the benefits of the independence of the co-ordinator. Family members who had previous experience of the agency varied in their views as to how important the independence was. Some members saw that the co-ordinators brought an objectivity that agency workers could not bring, especially if there was a past history of difficulty, while others saw limited difference.

In order to place the role of independent co-ordinator in context, key findings in relation to their training, skill development, support and challenges, evolution of practice and remuneration are presented.

The positioning of the co-ordinator outside the health board is only one aspect of their contribution to the successful completion of an FGC. Intrinsic to the independence are the skills required. The following is a list of the co-ordinator's skills that were identified at the training of the various participants and were also identified when the participants were asked to reflect on their experience of participating in the FGC. The main skills are those of negotiation, diplomacy, tactfulness, and having an ability to resolve conflict. A knowledge of the statutory organisations, families and inter-agency collaboration was seen as vital. The job is seen as very demanding. For co-ordinators coming from a counselling background, there is a need to avoid slipping into the therapeutic role, and retaining a focus instead on negotiation.

Over the course of the year of the pilot project, the skills and understanding of the FGC process and the complexity involved in family-professionals relationship in the child welfare system grew among the co-ordinators. The fact that this service was provided by a group already immersed in work based on the principles of participation, social justice and community empowerment was a major benefit to the pilot. This facilitated the relative ease of their transition from other more familiar roles to the role of co-ordinator. Over the course of the year, they helped refine the role of co-ordinator in an Irish context. Yet there are issues at the different stages which still need clarification. These issues centre predominantly on the following questions:

- Who takes responsibility for preparing family members and other professionals at the preparation stage?
- To what extent does the co-ordinator need to facilitate more discussion in the information-giving stage?
- Is there a potential role for the co-ordinator in the private family time?

The resolution of these role issues would enhance working relationships between the co-ordinator and social worker and other information-givers.

It was considered that Hesed House provided a good level of administrative back-up and general support to the co-ordinators. The lack of this support was a key issue in a number of UK projects (Marsh and Crow 1998). In general, the service provided by Hesed House for the pilot project was most satisfactory, and this experience provides a template of requirements for any future co-ordinator service providers.

Most co-ordinators felt that the training had equipped them well for their work, but in the absence of previous Irish experience of applying the FGC model to family situations, a lot of decisions had to be made as different situations presented. Many of the questions raised initially in training could not be answered definitively and the co-ordinators were able to negotiate many of these in their practice. The co-ordinators found ready access to the project manger invaluable over the course of the project. This allowed complex issues that emerged to be considered, and solutions found without delay. In general, the ease of access between the co-ordinators, the project manager and the trainer / consultant facilitated the resolution of these complex issues.

This incremental and rolling nature of decision-making was a feature of phase one of the project. As project enters phase two and is expanded, the availability of summary guidelines, as contained in Section Eight, should go some way to providing a more formal process for agreeing and recording decision-making. Communication of key decisions will need to be forwarded to all key participants in a manner that will enhance the cohesiveness of the project.

The key challenges facing the co-ordinators in the pilot were as follows:

- To show the health board staff that they as outsiders can be trusted to deliver a process, which is designed to enhance family decision-making;
- To show that the role of co-ordinator is not in competition with, or is not a privatisation of the role of social worker and information giver;
- to convince health board staff that the independence of the role can free up the social worker to do other vital work;
- To exercise authority in the role, given that the co-ordinator has no statutory basis at present and the professionals and family members may feel that their statutory position outweighs theirs;

- To maintain a position of neutrality and curiosity in the face of often competing discourses, stories and aspirations
- To be persuasive without being coercive of the family
- To let the family know they have power without being disrespectful of the agency and vice versa

The independence of the co-ordinator role is vital in the face of these challenges. There are further challenges connected with each sub-stage of the process. Thus, the positioning of the co-ordinator to ensure independence and the capacity to address the challenges is a key issue that has implications for the future delivery of service.

If the co-ordinators are employees of the Health board, there is a danger that family members will over identify them with the service and they are then seen as part of child care system. There was an overwhelming view among co-ordinators that their positioning outside the agency enhances their non-partisan approach, their authority is independent of both professionals and family members, and it enables them to remain neutral in the process. It was the view of the co-ordinators that 'even with the present structures, the positioning of the co-ordinator is very constrained' and if the co-ordinators were internal employees in the organisation this would be even worse.

Locating the co-ordinators service within the Health Board was suggested to have a number of potential benefits:

- Providing easier service delivery as communication could be enhanced if located in the same organisation;
- Costs can be collapsed into area costs, and therefore no need to pay additional external overhead & service costs;
- If co-ordinators had greater visibility in the system, both formal and informal working relationships would be enhanced, and the FGC would be seen as a more central alternative option.

There is limited evidence to support the claim that proximity alone can enhance multi disciplinary relations or communication. The issue of costs is discussed further in Section 7.10. While costs associated with the use of the FGC are more readily attributable than comparable social work centre costs, the costs involved are not such as to be significant, given the potential benefits. The existence of a dedicated FGC project office was not sufficient to overcome the kinds of work pressures that are seen to exist in area teams (as outlined in section one). Perhaps, apart from issues of principle, the most compelling argument in favour of using independent co-ordinators for FGCs is the extreme pressures which teams are currently operating under. Anything that helps reduce the current burden and enhances practice has to be seen as a positive step.

Recommendations:

- *The independent position of the co-ordinators should be maintained for Phase Two.*

- *The role of the co-ordinator in the project should be in accordance with the Practice Guidance Notes in Section 8*

- *It will be necessary to ensure that an adequate cohort of suitable co-ordinators are available as the project enters phase two, especially if there is to be an expansion of the project into more community care areas and the types of cases will expand from welfare only cases to cases which incorporate a welfare and justice focus.*

- *In seeking organisations to provide co-ordinator services, based on the experience of the pilot project, the following points should be considered for inclusion as criteria:*

  Commitment to the principles of participation, social justice and community empowerment;
  Knowledge of the child care sector, and organisations operating therein;
  Highly trained and skilled staff, experienced of inter-agency, family/ professional, negotiation and conflict resolution, with a thoroughly professional and ethical stance

Capable of providing full support service

- *Co-ordinators support group should be formalised*

- *The system of collaboration and communication between co-ordinators and Project Manager should be maintained*

7.3.5 Private Family Time

The majority of family members were positive about having the private family time, though a very small number of families expressed a desire for professionals to stay. This was associated perhaps with strained family relationships, and while the tensions did not escalate, in some instances the vulnerable felt even more vulnerable as the limited nature of choices open to them became a reality. When family members were asked to what extent they found it easier to talk when they were alone as family, 42% felt it made no difference. It is important not to confuse this finding with the importance families placed on the benefits of having the time to address the issues in private, even though in many instances this was not easy and some families did get stuck.

The issue of professionals staying with the family during private family time must be examined from the perspective of what assistance the family would need from an outsider. When this question was addressed, it became clearer that the difficulties were associated more with having to make a plan with limited information regarding available resources, rather than needing someone to help with conflictual processes. In other words help was required with the task rather than the family dynamics. This has implications for the expectations placed on families, and raises questions as to whether there should be a greater examination of what exactly families are being asked to do. This is considered further in the examination of outcomes in section 7.9.2.

Recommendation:

- *The private family time may be enhanced if the Co-ordinators stay after the information givers leave to help the family make the transition. This needs delicate handling and it is important that the advocates are checked with, in particular to ensure that the vulnerable family members are ok.*

- *Co-ordinators need to consider how information-giving session may be more interactive and less reliant on professionals reading out reports. This will require careful facilitation if it is to avoid getting into a renewed problem definition /assessment session or a therapy encounter.*
- *More information needs to be provided to family members on resources and options available for solutions.*
- *Information givers need to keep personal information to the minimum to avoid undue embarrassment.*
- *Consideration should be given to giving family members a copy of the professionals' reports before the meetings so they can be prepared in advance. Families should have copies of all reports left with them.*

7.3.5 Presenting the Plan

A key principle underpinning the FGC is that the family's plan is agreed by the professionals unless, and only unless, the plan places the child further at risk.

The processes surrounding the presenting of the plan by the family warrants special attention. The finding that the details of many of the plans had to be further negotiated after the private family time is an issue. This finding may be a reflection that the passivity of the professionals during the information giving stage was seen by some family members as connected with the difficulties of coming up with a plan. Some family members felt that the information given was not always as clear as it could be in addressing the long-standing issues that had resulted in the current crisis. As a result the family members during the private family time were restricted in what they could say. Families felt there was a need to make a distinction between outlining options and discussing the advantages and disadvantages of the various options and being non-directive.

The family members did not use the option of either calling back in the co-ordinators or professionals to clarify information that could have then helped them to come up with a plan. Was this because they were not clear on this as an option or did thy feel that it would be a negative reflection of their ability to cope? The limited knowledge of what resources were available may have been another issue. The extent to which the professionals did not adequately point out the resources that were available, or if this reflected the limited resources available anyway needs clarification. Despite the availability of extra resources in the project to facilitate plans, none was asked for, but then there was limited guidance available about the nature of resources availability.

Did this limit the range of solutions the family felt they could come up with, or was there a higher expectation of the family than could have been realised? This undoubtedly is connected with the previous attempts made by family members to resolve the difficulties and the nature of the concerns surrounding the child. If the most important reason for the FGC was to locate an alternative placement as occurred in two of the cases, and the family members felt there were no placement options within their network, then it was easy to understand how family members may feel that there was nothing they could offer. This points to the importance of avoiding too narrow of a focus around potential solutions. It may be easier to enable family members from the outset to acknowledge the likelihood that there may not be a placement resource, and instead the focus may be on opening up other supports and contacts for the child.

Finally the failure to set a contingency system in the event of key aspects of the plan not being followed though was seen as a problem by some family members. Some family members felt isolated after the conference, as there had been no system of information sharing incorporated into the plan.

Likewise the lack of a specific review date or the long duration between review date and FGC emerged as an issue for family members. This was clearly connected with their being unsure as to what was to happen if the plan began to disintegrate. Similarly, there was confusion as to the composition of future reviews and who would organise them, who would be invited and where would they take place and what would the role of the co-ordinator would be. The place of reviews is a central issue that needs clarification and it is important not to confuse the need to have a second conference around the concerns as opposed to having review meetings to examine the progress and the need to make necessary changes. A second FGC would require a co-ordinator. The question is if the worker carrying the responsibility for conducting the work should undertake a review. If the latter course is taken, this has implications for holding a meeting that fits with the principles of a FGC.

Recommendation:

- *The information needs to be clearly presented, and the resources available to support the family made explicit;*
- *There is a need to consider facilitating more discussion of the options as part of the information giving stage;*
- *There is a need to establish and convey to the family a set of criteria against which the proposed plan will be assessed. This should include a clear system for monitoring the plan, and an early warning system in place to alert the key people in the event of this not happening. The failure of the plans may not have immediate impact on the protection of the child, but in medium term it is important to alert the key players before the situation deteriorates further. The on-going communication of developments in relation to the child within the family should also be included, although this has to be balanced with privacy issues. The arrangements for reviewing the plan should be included.*

7.4 - Question 2

How the FGC fits alongside current professional processes of investigation, assessment, case conferencing, and review from the perspective of the key players (Child care manager, social work manager, team leader, social worker and other key professionals.)

7.4.1 Changes in the Operating Environment

Major developments in child care policy and practice are underway in the agency in which this pilot project was carried out. The change from one health board to three health authorities in March 2000 was a significant organisational change, with consequences in terms of staff deployment, arrangements for service delivery, geographical boundaries, organisational and management arrangements. This created a context of uncertainty in the period in which the pilot was conducted.

The second development in the organisation that had significant impact on the fit between FGCs and current professional processes of investigation, assessment, case conferencing, and review were the changes occurring around these procedures themselves. Simultaneous with the FGC Pilot Project, an internal group was examining the protocols needed for case conferences. The question of parental participation was a central aspect of this development. The protocol developed from this process has not as yet been accepted as policy or mainstreamed at the time of writing the report, but it was the view of several child care managers involved that these proposals in general would be incorporated. This protocol had been developed against the general proposals in "children first".

The publication of "Children First, 1999" (Dept. of Health)- the new procedures for child protection – also has a major impact on the place of FGCs in the organisation. The national developments regarding the new guidelines occurred simultaneous with the pilot project and the internal developments highlighted above. Family group conferencing is referenced in these guidelines, but there is limited analysis of the place or the FGC model in the guidelines or of its potential into the future. This is central to any examination of the fit between the FGC model and the current system of investigation, assessment, case conference and review.

The proposals in the new Children Bill, 1999 was another mainstream development happening at the same time as the pilot project. The use of three separate labels for FGCs and the failure to clearly define the different types of conferences is viewed as a major weakness.

In summary, the development of the Children Bill, 1999 the publication and the drawing up of an implementation plan for the "Children First" guidelines, (both Departmental initiatives) and the internal development of new case conference protocols with special reference to parental participation all occurred with limited formal reference to each development. However, the child care managers were central to two of the three developments and were asked to give input into the CEO's response to the Children Bill. This, at least, began the process of making the inter-linkages necessary but more needs to happen at a national level where the majority of the changes were being initiated. It is therefore very difficult to give an accurate portrayal of the fit between FGC model and the child protection protocols, given the high level of both internal and external change that is occurring in the system. What is perhaps more important is the urgent need to take account of the inter-linkages between each of the developments. After all, these developments are part of the same system, and therefore the integrity of the system could potentially be diminished if enough attention is not paid to the overall co-ordination.

7.4.2 Application in Child Protection

On a more limited note the research has shown that the referrals were clearly seen as falling into a child protection category in a number of cases. In these cases the main participants were all generally happy with the process and the outcome. The cases would be considered as being on the lower scale of risks[2], rather than dealing with severe child protection issues. In particular, the sense of participation and sense that the family had been involved was a positive note. However the pain and difficulty for birth parents in these difficult cases must not be minimised .

Another important issue is the apparently haphazard way the referrals were selected in the teams. The cases which were put forward were perhaps similar to a great many other cases in the agency at the time that were not referred. The reasons why referrals get made and the factors that militate against have been already discussed in Section 5.2.1 and this point needs to be seen against that background.

Recommendation:

- *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 across the organisation.*

7.5 Question 3

Establish if there were examples of innovative and creative Family Group Conference outcomes

7.5.1 Innovative and Creative Outcomes?

All information givers and co-ordinators were asked to give examples of innovative and creative Family Group Conference outcomes. No examples were cited of creative or innovative conference plans. Nonetheless, there was, subject to some discussion, a high degree of acceptance of the family plans as proposed. In this context the fact that there were no innovative or challenging plans may be viewed positively, in that too radical or challenging plans at this point may well have been a "change overload". The type of plans proposed may also reflect the cases that were referred to the project and approved for conferences

7.5.2 Satisfactory Outcomes?

Despite the methodological difficulties of measuring outcomes addressed in Section One, the different participants were asked to reflect on the plans as proposed and accepted, and to consider the child's overall situation two months or more after the plan was put in place.

[2] See risk scale in Abbreviations and Definition of terms in Contents outline.

When the family members were asked to reflect now on the plan made at the time, 58% were satisfied at the plan when it was made. The remaining families were either indifferent (5%) and 16% were unhappy. Taking into account the changes that had since taken place, 48% of the family now thought a different plan was needed either in part or in its entirety. This needs to be seen against 39% of the family members stating that the child's situation overall had improved, while 26% of the family members felt that the child's situation had deteriorated. These slightly confused findings needs to be seen against the finding in which family members talked about the importance of having a monitoring system in place to pick up at an early stage if further difficulties are arising or if people are getting overwhelmed with their commitments. This may fit with a scenario where people over commit themselves when emotions are running high, and it may be important to allow a cooling off period before the major decisions are confirmed.

When asked if they would use an FGC in the future with a similar family problem, family members felt the process was worthwhile, and an overwhelming majority felt they would like another FGC. Only one family member felt they would prefer to sort it out themselves.

Recommendation:

- *Further work is required to monitor cases longitudinally and to compare the outcomes of the FGCs that have been held.*

7.6 Question 4

To identify the modifications needed of the standard Family Group Conference (New Zealand) model in the Irish context.

The origins of the FGC model in New Zealand was described in Section One, where the many similarities with trends in child welfare systems internationally were illustrated. The importance of family links, the need to emphasise extended family as a resource, a renewed interest in strengths perspectives, and partnership as an underlying principle are all factors propelling the Irish child welfare system. Alongside these forces for change, there is also a strong context of legalism and managerialism, a narrow definition of child protection, an over emphasis on risk assessment to the exclusion of needs and resources, working simultaneously. It is important that these different value and ideological positions are not viewed in opposition but by reference to the location of the different stakeholders on the continuum in the current child welfare system.

The question of the changes required in the adaptation of the NZ model must also take account that the model in NZ has a statutory basis, whereas this project took place on a pilot basis without a statutory mandate. If the proposals contained in the Children Bill, 1999 are implemented, then conferencing will have a statutory basis similar in part to New Zealand. For the purposes of this evaluation, the questions of modifications will be addressed on the assumption that there will not be a statutory mandate during phase two of the project.

The origins of the FGC in NZ also have a bearing on this question. In NZ the impetus for the change came predominantly from the Maori community who were dissatisfied with what was happening their children in the state child welfare system. The impetus for change converged with a difficult economic situation and a keen interest by many child welfare policy makers and professionals to initiate changes based on a more inclusive

decision-making frame. In Ireland, there is evidence as described in Section One that the impetus for this project was more from the top down. However, it has to be stated that there was wide appreciation of the move expressed by professionals during training. Enthusiasm does not necessarily lead to major change, as reflected in the slow rate of referral to the project and the limited cases that the FGC was seen as applicable for in the teams, as demonstrated by the rate of referrals.

The differences between the Irish and NZ systems are highlighted in Table 7.1 for the different stages of the FGC process.

Table 7.1
Comparison of Irish and New Zealand Contexts

	New Zealand	**Ireland**
	Legal mandate and part of mainstream system	Pilot project
	Co-ordinators independent of the referring professional. Located within social services.	Co-ordinators located within different organisation (similar to many other FGC projects)
Stage One: Referral	Legal mandate and parents can be mandated to attend. Child's right to extended family supersedes parents rights to confidentiality Exclusions stipulated in law. Principle of inclusion considered important	Birth parent's co-operation vital and if no co-operation, no further place for FGC. Exclusions negotiated as part of preparation process Principle of inclusion considered important
Stage Two: Info giving	Information given is legally protected in the conference and cannot be used elsewhere.	No such guarantee

There are no major structural or legal differences between the NZ and Irish system in Stages Three and Four as outlined below:

Stage Three: Private family time	Central part of system	Central part of system
Stage Four: Presenting the plan	If plan not reached, then family court can intervene if this is necessary to safeguard child's protection	If plan not reached, then family court can intervene if this is necessary to safeguard child's protection

The question of modifications therefore needs principally to be seen against the different legal basis. Another important distinction is the tendency of the child welfare system in New Zealand to encourage family members to initiate guardianship. This results in less children entering the state care system but places more responsibilities and burden on family members as the range of allowance open to them are less than those available to foster carers (Worrell 2000). This has relevance in terms of the application of the model and the value system underpinning it rather than a modification needed in the model per se. The

second major difference between New Zealand and Ireland refers to the positioning of the co-ordinators. The arguments for and against locating the co-ordinators as part of the health board structure were presented in Section 7.3.3.

The modifications which may be needed also depend on the stage at which the FGC process will be used, and if the model will play a more central role in the child protection system. If this occurs there may be implications for the length of time between the convening of the conference and the referral. The need to clarify agency concerns should be diminished as the criteria for referral and information requirements become more explicit. The time involved in trying to make contact with the social workers needs attention, as if progress of the process is dependent on key information then a system that works needs to be put in place. The steps involved in contact are covered in Section Eight.

Recommendation

- *The model of FGC as applied in the Pilot Project does not require any significant adjustment to operate satisfactorily in an Irish context. Such modifications as may be required will flow from the context and use proposed for the FGC, and are outlined in the Practice Guidance Notes in Section 8.*

7.7 Question 5

How effective were the FGC Management Committee and project structures in delivering phase one of the FGC Pilot Project?

The structure described in Section 3.2 was set up to deliver Phase One of the project. The project structure comprises four principal components (for overview see Appendix Three)

- The Steering Group who were mandated to oversee the project
- The Project Managers office, which was responsible for running the project
- The three community care teams, who were partaking in the training and running the pilot project, and working directly with the client families
- The external bodies, including the independent co-ordinators, the training/ evaluation consultant and other agencies interested in the project.

Despite the difficult context in which the project operated for its first year, the pilot was successful in that 19 referrals were mobilised from the three community care teams and eight satisfactory FGCs have been held. This is a testament to the project structures working. Much of this success may be attributed to the energy and enthusiasm of people involved at all levels. Despite a short lead-in and implementation period (compared to other pilot projects) the Management Committee was flexible enough to cope with the changing context. Working relationships between most of the participant bodies worked well, which again indicates a successful project structure.

The structure as put in place was firmly on one side of the specialist central/ support office versus generic teams. While this is an on-going debate in pilot projects generally,

the implementation of a major change project, such as introducing FGCs into common practice, requires such a dedicated centrally located support office. The relationship between that office and the community care teams, who are characterised as highly pressured, is the main area of concern. This was seen in the pilot in the slow rate of referrals, and particular the dip in the January to April 2000 period, and also when a number of practice issues emerged. The relationship between the Project Office and the teams is key, if the project is to be expanded.

One aspect of the originally intended project structure which was not put in place was the national committee. This committee was intended to have a role in terms of liaison at both inter-departmental and interagency level, and was intended to be under the aegis of the Department of Health and Children. While the absence of this committee did not impinge on the actual operation of the pilot, it obviously has consequences in terms of giving wider exposure to the concept of family group conferencing and the place of the FGC model in future service delivery. It also contributed somewhat to difficulties for the external members of the management committee, in terms of the mandate of the pilot project and expectations from their own organisation, and their organisations future participation and use of the FGC model.

Recommendation

- *The project structure put in place for Phase One of the Pilot Project was effective in ensuring good relationships generally between the participant groups, and in seeing the required deliverables completed on time. Significant organisational changes have occurred since the project commenced, but it is recommended that a similar structure, expanded and developed to take account of the scale of project chosen, is created to deliver and oversee Phase Two. Consideration should be given to upgrading the position of project manager, given the projected expanded volume of work and scale of the office for later phases. This could also facilitate better liaison between the project office and the social work managers.*

- *There is a need to examine how team accountability regarding the referrals made can be built into the job while avoiding an over rigidity, which could have the effect of diminishing referral rate.*

- *There is a need for greater multi-disciplinary and inter-agency involvement in the project structure, provided the brief is clear in terms of receiving referrals from all sectors.*

7.8 Question 6

To what extent do family members participate in and have a sense of ownership of the FGC process

The overall finding was the family members did participate in meetings organised to address concerns relating to the children in their networks. The family members participated from both maternal and paternal sides with a larger percentage from the maternal side. The family members who participated averaged five per conference (excluding children), and a large majority of those who were invited to attend did so. One

key family member spoke of the difference between the FGC and ordinary contacts with the agency, as his experience was extremely positive in that he felt fully informed and included in all decisions made.

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. 74% of family members felt they were prepared for all parts of the conference. Only one family member (5%) felt they were not prepared at all.

Some family were of the view that 'the leaflets were helpful in describing how it worked', though in a smaller number of cases the family members had not been given the information by the referrers, and its absence was an issue, considering leaflets were available.

The choice over the timing and venue were also factors that enabled family members to feel really involved in the process. The maps giving clear directions to the venues also helped and reduced the tensions normally associated with trying to locate a new building.
There was overwhelming appreciation for the co-ordinators preparatory work, how they imparted the information and their general demeanour. The family members pointed out the importance of being forewarned of the home visit, rather than it 'being sprung on them'. The importance of co-ordinator's hospitality was reiterated as very important in persuading a key person from one of the FGC to attend. This stresses the importance of the co-ordinators having access to a flexible expenses budget to enable them to facilitate participation, and to remove practical and perceived barriers to attendance. Family expenses associated with running the actual FGCs were of the order of a modest £100-150 per conference.

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. The following comment highlights a big difference in perception 'they didn't talk down to you, like' .

95% of the family members felt they were given the chance to clarify and ask any questions they wanted during the information giving stage. A certain caution needs to be exercised around this assertion. 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.

This needs to be seen alongside the extent to which people felt listened to. Three of family members (16%) who attended did not feel listened to, and a similar % finding was evident when the degree to which they felt comfortable in the meeting was examined. 80% of the family felt that the information that they were given was clear. When the family was asked if they were given adequate information to make a decision, only one family member said this was the case. 84% felt they were not given the information needed to address the concerns. This has serious implications and is addressed in the Practice Guidance Notes in Section 8.

63% of the family members felt the right professionals attended, while 27% did not think so or did not know. A small number of family members suggested an over-dominance of professionals at the meeting. The ambivalence surrounding the attendance of professionals was later seen at the presentation of the plan. A number of family members questioned why all the professionals did not come back for this stage. The family members thought they could have made the effort to remain to hear what the family came up with, and to be available to help the family with their decision-making. This latter point undoubtedly is connected with the experience of many of the plans being negotiated in depth during stage three rather than the family negotiating more of the detail themselves and accessing the professionals during the private family time to help them with this task. This is an area that needs further attention in phase two.

Family members raised questions about the type of language used by professionals and the almost universal sense that everyone should understand this language.

Recommendations:

- *Further attention needs to be given to the provision of a standard type of information to the co-ordinator that addresses the concerns of the agency and points to any key information that has a direct bearing on the issue under consideration.*

- *Information packs needs to be given to all family members and attempts made to ensure that family is fully prepared for the conference.*

- *Consideration should be given to the production of a video, as a suitable means of proving information on the FGC.*

- *Co-ordinators and professionals making referrals may need more training and guidance on the extent and nature of the advance preparation to be given to families.*

- *The key issue of who is the family needs further attention and who in the family on behalf of the child can exclude others especially if this may result in the child potentially losing contact with one side of their family?*

7.9 Question 7

To what extent did other 'stakeholders', in child welfare cases participate in the process? (Social workers, legal professionals, court and service providers.)

No legal professional or court provider were involved in any of the FGCs in this evaluation. The limited data returns from the information-givers makes it difficult to address this question. However findings from other meetings with a number of the participants and perspectives from both co-ordinators and family members is used to summarise the findings.

7.9.1 Training Needs of Information Givers

The majority of people on the social work teams, the key managers and a small number of front line people on the multi disciplinary team received the training that was provided for this role. However, less than half of the information givers involved in the FGC received the training. This was largely due to some of the information-givers belonging to agencies that were not targeted for round one of training. Likewise one referral received in the latter part of the project was from an area that did not participate in initial training. This had implications for the co-ordinators role, as the co-ordinator had to spend more time preparing individual participants. It points to the need for universal training for those who are going to be involved in using or participating in the conferences.

The support for the project from community care teams was high at the beginning of the programme. The initial training undoubtedly accounted for some of the support for the project. This was demonstrated by the high motivation shown for training and by the team's abilities to consider in depth both the positives and anxiety provoking issues associated with introducing a pilot project. The fact that conferencing fitted with solution focused & strength-based models of work, and a model that fitted with a social work value base were cited as very positive. Other positives were connected with it allowing staff to work in a more respectful and more child-focused way. The hope was it would

produce outcomes whereby the plans would be more likely to be delivered on, because they would be owned more by the families and the children would derive benefits available in their family network.

The workers were not slow at identifying some of the potential pitfalls of the project. They wondered if some families who had major difficulties may be too damaged and would have little or no resources to offer. They frequently cited anxieties that too much would be expected of families and that the process might be too risky for staff in terms of families not protecting the child adequately. On an organisational issue, the staff wondered if this would simply mean more work for them especially as they were already feeling very overworked, in a context of big changes in organisational structure, and with frequent staff turnover. On a practice level they wondered if they had the ability to sell the ideas to families, and their concerns were also for individual family members who may be left feeling vulnerable as a result of the process.

When asked to explicate the skills needed to work within this process, the teams quickly recognised they already had many of the skills identified. Their communication, negotiation and information imparting skills were seen as essential as were listening, ability to recognise strength and decision making. While there was some small variation in the skill analysis among the teams, many felt the biggest changes would be persuading the families that this would be a different process, the readiness to share power and the need to have role clarity. Overall they felt that they needed to be open to change more than anything. The training given at the beginning of the pilot and throughout the life of Phase One aimed to address these skills and needs identified.

The teams felt that the training met their learning needs and they realised that the next step in the process was for them to get active in the process. As the project commenced, a number of different training sessions were organised with the team leaders and managers and the social workers and managers who had direct experience. The first group were targeted as it was felt that these would be key players in the referral process and supervision would also provide an important context in which potential referrals and issues coming up in the process would be resolved. These sessions were invaluable and provided a context in which issues emerging in the project could be addressed. Unfortunately, the numbers were smaller than anticipated and later attempts to provide training/ consultations for managers were unsuccessful, as more pressing issues in the organisation had to take precedence. Arising from these meetings, there was a proposal that all social workers involved in referring a FGC would make a formal presentation to the team. The project manager made himself available to assist but again due to other work demands, this did not happen. This was to have a major impact on the sense of ownership of the project and could in part account for the lack of referrals.

A second round of training was initially planned during phase one for the team members. This did not happen as a decision was made that it was more important to engage the team leaders and managers. On reflection, if the training had to be provided in conjunction with the workers with direct experience, the teams may have had a greater sense of ownership.

The second issue, which may have impacted, was the turnover in staff. At the end of year one, almost one fifth of the teams had changed, though in part summer locums and new graduates entering the service accounted for this change. This level of turnover has implication for the universal induction and ongoing training referred to above.

Turning to the broader multi disciplinary teams, members of these teams had limited access to the project. The expansion of the project in the agency needs to consider the training needs of all relevant multi-disciplinary team members.

The co-ordinators raised the need to have joint training with the social workers. This was avoided initially as it was felt the co-ordinators needed to have greater certainty of their own role and authority, which would come from direct work experience. It was felt that premature co-training may have increased mistrust between the two groups, which would not have helped the progress of the project. In a small number of cases, the co-ordinators felt the information givers did not fully subscribe to the principles and were too interventionist in the process. Their uncertainty about status and authority, especially in the early stage of the conference compounded the difficulties of knowing how best to intervene.

The professionals, especially from external agencies, found they were not always given the amount of information and therefore they were not sure exactly what their role was. In the majority of cases, the professionals had received the explanatory booklet written especially for professionals but felt this did not equip them satisfactory. There was an increased chance that the professionals within the Health board were better prepared by virtue of been more involved in the process than professional from other agency who would not have received training and would not have access to the informal flow of information surrounding previous FGC's.

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Recommendation:

- The success or otherwise of an initiative such as introducing FGCs is dependent on developing the interest and enthusiasm of the workers involved. The provision of training, which introduces the subject and facilitates workers to contribute to its development, is perhaps the most tangible and direct way of achieving this. Notwithstanding the practical difficulties, it is recommended that training along the lines developed for the pilot project be provided for all social work staff in areas who are going to use the method. Tailored training needs to be extended to other disciplines within the health board and to organisations that interface with the services provided and need to understand the principles and operation of conferences.
- *It is recommended that use for training be made of the first group of persons who have referred cases and worked in the conferences.*

7.9.2 Referrals

The outline of the referral history was outlined in detail in Section Three. The slow rate of referrals initially was a feature common to other pilot projects internationally. Considerable attention was paid in initial team training to help social workers identify cases that may benefit from an FGC, while at the same time the anxieties associated with making actual referrals were explored.
The social workers felt that the following families may not be suitable for a FGC:

- Families with limited or no interest in the process;
- Where there was serious intra familial conflict to date;
- Those that had a limited network;
- Where there was either no acceptance of agency concern and/ or serious intra generation abuse.
- Factors such as timing - if case still under investigation.

The social workers said they would consider families in which the factors listed above would be absent. They thought the FGC process would be particularly applicable for families who:

- Showed an ongoing interest in the children in extended family and where there was evidence of that to date;
- Where the child had a sense of connectedness to the family;
- Where other alternatives have been tried, and
- Families that had mid-range problems as opposed to those with a complex myriad of difficulties.

In discussion at the training stage, the consensus was that many cases on the social workers caseload would have the characteristics identified for families for whom an FGC worked. The actual slow rate of referrals subsequently, and the termination of three referral cases, needs to be seen against the major changes that were ongoing in the organisation. This may also explain the failure of the project to access adequately the team leaders, who were seen as pivotal through their supervisory roles. The lack of formal information sharing as to the process of the cases referred meant that opportunities were lost to engage other referrers. It is important to now consider what needs to be put in place if the rate of referral is to increase and if FGC is to become more of a mainstream service.

Recommendations

- *There is a need to incorporate the option of an FGC explicitly into case discussion at allocation meetings. If a decision is being made not to refer, the reason should be listed. Equally at different stages of case management review, the option of FGC should be raised and a similar exercise of setting out reasons for not using FGC should be noted. (The attitude to FGCs would undoubtedly also change if their use was underpinned by legislation.*

7.10 Question 8

What were the resource requirements for the successful operation of the Family Group Conference.

It appears that FGC's do not appear to draw less on agency support/ resources and cannot therefore be viewed as a generally less costly alternative to traditional meetings. The FGC has to be seen as a vehicle for good practice, with the ultimate goal of ensuring the welfare and protection of children, rather than as a cost saving exercise. Overall, the FGC operates in ways that are consistent with good practice and offers a radically new way of empowering families to make safe decisions for their members with the support of State agencies. It offers new opportunities and possibilities in working with families while challenging conventional practices. If the outcomes desired are simply cost orientated and fail to take account of the broader savings, an opportunity will be lost. Expectations that FGCs will lead to a reduction of the numbers of children entering care, or the FGC may result in a child being placed in a kinship home, thus freeing up scarce foster homes may also give rise to negative consequences. A reduction of numbers entering care and more children cared for within their own family network are positive moves but there are also inherent dangers. If FGC results in a situation where care is care on the cheap, and fails to adequately support the family members (O'Brien 1997) or if alternative care is further stigmatising for children, (O'Brien 1999), then the potential may be jeopardised.

One approach to quantifying the resource requirements for FGCs would be to ascertain the costs associated with each aspect of the pilot project, and to divide this by the number of conferences held and to arrive at an average costing. However, some aspects of the project costs lend themselves to quantification more easily than others. Also, it must be borne in mind that the costs associated with the pilot may vary with a

more widespread use of the method. Some costs in relation to each conference will remain relatively fixed (within a range), while overheads such as project office can be apportioned over more conferences. However, while a focus on the costs is important, it is suggested that it is more relevant to construct key performance indicators and output measures that can be used for comparative purposes. The issue of costs is considered under the following headings:

External

- Expenses associated with conference (spent by co-ordinator)
- Cost of Independent Co-ordinators
- Cost of external consultancy for project training, consultation and evaluation

Internal

- Cost of Project office, including salaries, accommodation, expenses, office requisites
- Cost of Management Committee
- Community Care Team Costs

Each of these is considered in turn.

Expenses for Conferences: The information that is available is the cost of holding each meeting in terms of renting a venue, transport and refreshments costs. A total of £674 was paid out for a total of seven conferences, which averages at £96, ranging from £75 to £150. This cost is comparable to the Northern Ireland and UK experience (Interim Report 2000).

Co-Ordinator Service:

For the purpose of this project, a sum was negotiated with Hesed House for running 18 conferences. This fee included staffing, administration costs, premises, expenses, preparation and convening. A cost for attending Management Committee and training was also included. Hesed House played a key role at the developmental and service provision level in phase one of the project. As it is one of the more readily quantifiable costs, the figure for independent co-ordinator has received considerable attention in the literature, and the issues of costs have emerged as problematic in many of the pilot projects (Lupton 1995). The main issue in the UK surrounds the use of a flat rate per conference payment, which in view of the diverse needs, composition and geographical distribution of many family members, would not appear to be suitable in an Irish context. The question of remuneration and the need to have support and training costs of co-ordinators included emerged as a critical issue at the Third International conference in UK (Winchester 2000). It has to be emphasised that the co-ordinator is required to have a complex array of skills and qualities to facilitate processes of this type. The use of appropriate external bodies to provide this service is cost effective.

External Training/ Consultation and Evaluation. A contract was negotiated with UCD to provide the required services. This is a typical project cost associated with introducing an innovative approach to work in any context.

Health Board to provide figures for internal costs. (Advice on inclusion of this section)

Estimates

Steering Committee	=	£XX,000
PM Office		£YY,000?
Social Workers	=	£,ZZ,000
Administrative Costs	=	£NN,000

External costs are likely to be only a fraction of internal costs

Recommendation:

- *Given the focus on quality services and value for money, appropriate service and financial output measures and performance indicators need to be developed for FGCs. It is suggested that the following be considered*
    - *No of cases referred to Project Office as a % of cases entering their system*
    - *referrals approved for conferences as a % of overall referrals*
    - *no of referrals decided upon within 2 weeks of receipt*
    - *no of conferences held within 2,3,4,5,6,>6 weeks of approval to hold*
- *There is a need to put systems in place to collate base line information required for assessing costs of FGC project.*

7.11 Question 9

In particular what were the costs involved in FGC plans as against traditional service provision.

An evaluation objective was to estimate the costs of Family Group Conference plans against the costs of traditional service provision. The information required for this purpose was requested through the project manager. The base line information on the costs of service provision was not available in a format that was necessary to do a comparative cost analysis. In his interim report to the Department of Health and children he suggested 'In order for a comparative costs analysis to be carried out, a resource audit of family support services in the three Area Health Boards would be required' (Interim Report 2000).

However, some comments can be made on the comparisons between FGC and traditionally arrived at plans. As reported in Section 7.5 nothing that was described as innovative or creative emerged from the FGCs. While regarding that as a positive in terms of enhancing the acceptability of the family's plan, it may also indicate that there was no major resource implication in the plans proposed. Only one of the eight plans agreed has required resources from the project. The families facilitated the other seven FGC plans, with supplementary resources being provided from the local area budget. No breakdown was available on the costs of these plans.

Recommendations

- *There is a need to construct key performance indicators and output measures that can be used for comparative purposes. These could include*
    - *No of plans (%) accepted without amendment*
    - *No of plans (%) accepted after further discussion*
    - *No of plans rejected*

- *There is a need to put systems in place to collate base line information required for assessing costs of traditional service provision.*

7.12 CONCLUSION

This report describes the origins and extent of the Pilot Project on Family Group Conferences. The evaluation has focussed, within the limitations set out in Section One, on the views of participants. The key evaluation questions established in association with the Steering Group and the Project Manager have been addressed, and recommendations for adjustment made where appropriate. The conclusions to be drawn from the evaluation in relation to the aims of the project are clear. These conclusions fit with the international experience also.

From the points noted in relation to evaluation questions 1 and 5, it is clear that the FGC is a most effective means to include and facilitate families in planning for and thereby strengthening their capacities to provide for and manage their troubled and troublesome young persons. The unequivocal experience of this project was that families were willing to be involved, and were capable of coming up with acceptable plans while operating within the principles of the FGC. The respondents reported over-whelmingly that they had felt listened to, and there-by had ownership of what emerged. As noted in the discussion in Section 7.8, the fact that the pilot experience related to family rather than social networks was an interesting outcome.

It is equally clear that, although it is a new way of working, and requires a major attitudinal shift for workers involved, that the experience was that the plans developed by families using the FGCs were deemed acceptable in all cases to the statutory agencies and the persons representing them. The FGC is a vehicle that fits with both current and proposed legislative principles, as well as professional practice and partnership and inclusion. It can be further concluded that the model required very little adaptation for use in an Irish context.

It is less clear however, and it is a limitation with a short-term pilot project, that the plans will work over the years.

In overall conclusion evidence is presented in this report to show that the FGC is

- Desirable in terms of its partnership and inclusiveness ethos,
- Is suitable for use in an Irish context,
- Is effective in terms of getting a widely accepted plan developed, and
- Has potential to improve the management of troubled and troublesome young persons.

While the difficulties associated with bringing the FGC into mainstream practice are acknowledged and highlighted in this report, its fit with the values and principles being increasingly deployed across public services, makes the effort of extending the practice is not just desirable, but essential in this era of partnership and inclusivity.

8.1 Introduction

FGC's have a straightforward structure that is clearly delineated into separate stages. Within this model, the roles of the different participants are relatively clear-cut. Despite the simplicity and relative clarity, the model is a huge shift from traditional ways of working with families, and associated attitudes and values. In Section One, the professionals' readiness to take on this way of working was highlighted. It was shown also that many workers were already working with families in innovative, inclusive and creative ways. The main difference in the FGC approach is the formalising of a wide definition of family members and private family time. The independence of the co-ordinator introduces recognition of the importance of facilitation between what may be two disparate systems.

Within the simplicity, there is a need for flexibility in the process and the structures. If flexibility is retained, there is an increased chance that creative and innovative decisions can be made possible. The need for high standards and a clear value base is essential in the use of FGCs. Guidelines and practice protocols are essential to realising this need. In moving forward to phase two of this project, it is vital to build on the experiences gained through phase one of the project. As part of the process of beginning this project, the application of the model was systematically worked through, and resulted in protocols being developed for the different stages. Much has been learned through experience, and this section aims to address the final evaluation requirement **'To identify operating principles and guidelines for any fuller implementation of the process'.**

The guidance provided in this section is structured according to each stage for the process, and it is divided into specific guidance for the co-ordinators and the information givers where appropriate. The guidance is drawn from work being developed concurrently in the relative care field (MWHB 2000).

8.2 Principles of FGCs

The principles underlying the FGC pilot project were the following:

- The child's interests are paramount;
- Children are best looked after within their own family;
- Families need to be involved in decisions which affect their lives;
- Working in partnership is beneficial to children: partnership includes families, professionals, communities and children themselves;
- The needs of children and adults in families are connected but are not the same;
- Families know their own in a way that professionals never can;
- Vast majority of families will make safe plans for their children.

The key operating principles underpinning the New Zealand model of the family group conference model should underpin the model adapted here in Ireland. These principles are:

- The term family is interpreted widely,
- The family always has the opportunity to plan in private,
- The professionals agree the families' plan unless and only unless the plan places the child further at risk.
- Independent co-ordinator facilitates the involvement of the family /professionals

8.3 Potential Benefits and Constraints of FGCs

The potential benefits and constraints of FGCs may be seen as follows:

Benefits for Families

Partnership
Support families to care for children
Strength focused/ Possibilities
Care as support - Creative supportive practice

Benefits for Social Work

Principles closer to social work values
State services as non-stigmatising
Reasons for care / Experience of care
'Extended family' a resource for children
Less legalistic or bureaucratic protective practice
Public perception of social work profession enhances identity / re-assert skill base

Constraints of FGC Practice

Marginalisation
How can we ensure Family will protect?
Retribution / victim focus
Negativity towards care system
Family: does it exist; patriarchal structure may silence; gender of carers; privacy as abuse.
Minimum State Role
Risk of adequate protection
Challenge to idea of expert knowledge
Support services necessary
Strengths focus may silence and stigmatise

Challenges to current practice?

Changing definitions of child protection
Enhanced social work visibility

Rationing of services in context of scarce resources / Increased expectations in times of economic growth

Greater public interest and media role
Accountability
Increased focus on children's rights
Inquiries: Focus on 'failure'

Practice Guidelines for Different Stages involved in FGC's.

Introduction

The guidelines and practice protocols required for the implementation of FGC's are contained in the following sections. These should be read in conjunction with the key recommendations contained in the executive summary of the ERHA Phase One Pilot Project Evaluation Report. The contribution of the participants who have engaged in the research and training in this pilot project to the development of these practice protocols in a manner that fits with the spirit of the FGC model 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, is also acknowledged. Much of this work has been developed from a study of family/ professional networks, as part of a relative care project.

The FGC is not a simple solution that will resolve the complex 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 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.

Circumstances for Referring a Case for an FGC

- 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 my family to get involved'?)
- Agency willing to name its concerns openly (why are we involved in this family's life?)
- Agency willing to give the family's ideas a chance

Circumstances for not Referring a Case or Refusing a Referral

- If the agency already has made up its mind what it wants done for the child
- If the worker or agency has given up on the family and are only going through the motions
- If the workers and management do not agree with the ideas behind the meetings, or if management of other key professionals involved holds a similar view, (and have top heavy management structure)
- If child needs alternative care but if reason for care is inter-generational abuse and many issues have not yet being 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 there is a failure to see any strengths in the family
- If birth parents are adamant that they do not want to involve their families. However if a child is in the care of the HB, 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 needs to determine if a FGC should be held.

In conclusion, a FGC should not be held in any situation where the safety of the child is prejudiced, placed at risk or compromised.

FGC's: an overview

- Different purposes of meeting 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 extend possible
- The FGC helps the family to 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.

Skills needed by Co-ordinator

- To be respectful
- To facilitate multiple views
- To be able to pull back from social control position/ leave the mandate with the social worker /team leader
- To avoid aligning with the family
- To avoid entering a 'therapeutic' conversation
- To strive for objectivity
- To be in position where participants can say at the end that the co-ordinator was on everyone's side!
- To hold pain of participants while at the same time being able to see and to point out the longer term benefits of the process for the child.
- To listen attentively
- To clarify what is being said
- To pace the process
- To keep the focus on the child
- To keep the focus on the 'now and the future' rather than on the past

Identifying obstacles to applying the FGC in your work place

These may be

- Time involved
- Concerns about own skills
- Fear of intra-familial conflict
- Fear of making difficult situation worse
- Finding this approach not acceptable to agency or supervisor

Stages of the Family Group Conference

The following are the key stages and sub-stages in a Family Group Conference. Each of these is considered in detail in the subsequent sections.

STAGE ONE Referral & Preparation

- *Obtaining permission*
- **Identifying the network**
- *Preparing for the meeting*

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*

Obtaining Permission from Parent/s and Guardians

- *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 rationale for having meeting

- *Obtain permission (keep in mind agency mandate for taking measures/ working co-operatively)*

Don't be surprised if parents are opposed initially 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 own child, how much contact/ involvement would they want
- *Broaden idea of family (many see it initially 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 best met in family
- Emphasise the importance of developing all the resources in 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 they have an ok relationship with parent/s, 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 status of child, care plan for child, ongoing relationship between child and parent and parental ability and willingness to take on board the idea and issues needs to be weighed up.

Making the Referral

- 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 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 that 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.

Preparing for the Conference

- *Referrer and co-ordinator need to be clear as to who is going to do what in preparing family and professionals for FGC.*
- Determine interested parties from parents and child's perspective i.e. Use sociogram/ genogram and ecomap. Some questions that may help to identify key people are as follows:

Who is child called after?
Who would want to be involved if they knew of 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 family?
Anyone economically better off?
What about god parents?

- *Discuss if certain people are to be excluded: if so why? Exclusion should only be as a last resort*
- Use a genogram to construct family tree
- Involve and prepare other professionals
  - It is important that they are told about the principles and value base of the meeting
  - Purpose for professionals is to share concerns - not solutions- though it is ok to share options which the family may want to consider
  - Important that they are reminded of strength 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 issues.
- *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: think of weddings and what can go wrong!!!
- *Obtain views of family members unable to attend if appropriate (these views are then put before the conference)*
- Prepare other professionals about their role and the process (if not prepared they may argue over process and family issues get lost)
- Ascertain what ground rules may be important prior to individual participation, and then at beginning of meeting.
- 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 family is at risk of 'blowing their top' and yet they are important resource, ask them to give someone else permission to 'check them'
- Sensitivity required to issue of literacy levels

Factors that may need attention prior to Conference

- *Make sure that the referral / agency concern is very 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 & child's situation

  Depth of any expressed anger about who is or who is proposing to care for child

  Past unresolved issues that may be relevant to current child care issue

  Current unresolved issues that may be relevant to current child care issue e.g. domestic violence

  Past unresolved issues that is not relevant to current child care issue

  Resistance to the involvement of either of the parents families

Ground rules for Conference and values that should guide the process

- *Need for respect for difference*
- *Accessible information*
- *Information shared in non-judgmental 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 introductions and welcome (family and non family) - Ask people to introduce themselves and their relationship to the child*
- *Purpose of meeting : clarification 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 at preparation stage

- *Commitment of goal to be child-focused*
- *If family have not met for a 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 distributor of 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 available and what is not available including the requirements that agency must work under.*

Information giving

Professionals involved share information re care and protection issues for children (concerns need to be specifically spelt out in clear language in writing)

- *Role clarified*
- Written reports to family members: in clear jargon free language containing bullet points rather than social history.
- 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
- *Facilitators 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 the plan begins to emerge at this stage in too detailed a way, this is the moment for the 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*

Private family time

- *Prior to breaking into private family time*
- **Co-ordinator make observations re clarifying issues, and outlines criteria against which plan will be considered**

- *Check that all family members have adequate information re concerns and resources*
- *Help professionals leave the 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 professional 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 the strengths in the family, I would like to leave you as a family group to see what plan you can work out. I will be in the next room with the workers 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 us a shout when you are finished.'

How to manage unrelated family issues which may take over?

- *Pre-empt the problem by discussing it before the family go into private time*
- *Ask to focus on child and leave 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?*

Presenting Plan and Review decisions

- *Family presents plan*
- *Invite clarifying questions if necessary re concerns and resources*
- The co-ordinator makes sure that everyone is clear about the plan that is being presented.
- *If other professionals still present, is it likely that it is only referring agency that has 'negotiation rights'?*
- *Decisions read back and recorded by co-ordinator to ensure everyone is crystal clear about the plan*
- If agency is not in a position to accept plan either because of legal issues or failure to address safety issue, then 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 need to 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

  It is important to stress that all parts of plan are important and are part of package
  One person may have overall responsibility, and yet is important that all take responsibility for its success.

  Review action plans and next steps (who does what in what time frame)

- *Reconvening meeting discussed*

  Establish in what circumstances

  Initial decisions may not be working and the child may be at risk

  Is it appropriate to widen the family net?

  Reconvening to positively connote and fine tune

  If it fails, what and who are responsible?

- *Fall-back plan and monitoring arrangements included?*

Closing the Meeting

- *Make clear that each participant will get plan in writing within agreed time frame.*
- *End with positive focus on child and the family*
- *Thank the participants*
- *Family may decide to closing a closing ritual if appropriate*

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