

Researching Family Group
Conferences in Adult Services
METHODS REVIEW



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Key words

Family Group Conference; adults; theory; social work; research; strengths-based practice

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ABSTRACT

This methods review considers the background and child-care origins of Family Group Conferences (FGCs) as a context to growing research interests about FGCs' potential as successful interventions in adult social care and social work practice. The theoretical frameworks underpinning the initiative's development and their relevance to social work principles and practice are identified. Methods used to describe and evaluate FGC initiatives for adults in the United Kingdom (UK) are outlined. International research into FGCs' use and effectiveness in adult services is examined and implications for future development and research are discussed.

This review aims to be relevant to practitioners, managers, policymakers, educationalists, researchers and to families themselves all of whom may want to know if FGCs will lead to cost-effective, acceptable and positive outcomes for adults with needs for care and support.

As a methods review commissioned by the National Institute for Health Research (NIHR) School for Social Care Research, this review outlines the methods used to obtain the evidence about FGCs, commenting on the advantages of different methods and their disadvantages. Guides to the running of FGCs are available and, as noted in the review, they are increasingly being included in the family of approaches referred to as strengths-based social work or practice.

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INTRODUCTION

The aim of this review is to explore what methods have been used or might be used to research Family Group Conferences (FGCs) in adult social care and social work in England. As part of the development of strengths-based social work practice in England, there is increasing interest in approaches such as FGCs and the potential to successfully transfer learning about FGCs from children's to adults' services. For researchers investigating interventions in adult social care, the methods used to study FGCs in children's social care may be potentially transferable. This review is not a systematic review or confined to reflect judgements about studies' quality but instead explores the range of approaches taken to study FGCs in the UK and wider contexts and discusses their potential for adult social care research on the subject.

Over the past few years there has been substantial interest in setting up FGCs in children's social care services in England and internationally. Investment in research on FGCs has also expanded and includes the funding of the Family Valued system change programme in Leeds, which received the largest grant from the first Department for Education (DfE) Social Care Innovation Programme that ran from March 2015 until December 2016 (see Mason et al. 2017). A major part of this evaluation was its exploration of the expansion of the Family Group Conferencing (FGC) service in Leeds to a scale not previously seen in the UK, including for families experiencing domestic violence. Mason et al. undertook a Cost Benefit Analysis (CBA) of the Leeds FGC service and compared the costs and savings of FGCs with Business as Usual (BAU) social work involvement without FGCs.

Currently underway is a major evaluation of the Lifelong Links project for young people in care. Lifelong Links is part of Family Rights Group work associated with FGCs. The aim is to:

... identify and engage relatives and other supportive adults connected to a child in care, who are willing to make a life-long commitment to that child. Research shows that the continuity and permanence of these familial relationships will offer the child ongoing emotional and practical support, help provide an explanation of historical events, and reinforce the child's identity and sense of belonging.

Family Rights Group is leading this trial of Lifelong Links within 12 English local authorities and five Scottish authorities. It is being independently evaluated in England by the Rees Centre from the University of Oxford and in Scotland by Celcis from the University of Strathclyde¹.

In another major funding initiative, in 2019 the DfE announced investment of £15 million to fund further development of Family Drug and Alcohol Courts and of FGCs in children's services. The DfE stated that:

Family Group Conferences

This project puts families at the heart of making safe decisions and plans for children that are at immediate risk of being taken into care. Children and young people are involved in the conference along with their wider family network, and often supported by an advocate from outside the family. Together, a plan is agreed by all those involved and families agree to meet again to assess how well the plan is going and make the changes necessary to protect children.

This created much debate and commentary in the social work press about how to evaluate these developments, such as the propositions by the What Works Centre for Children's Social Care (WWCCSC) (See Turner 2019, Janus 2019 and responses in Community Care). As a result, strong feeling about ways to interpret the existing evidence and the ethics of researching the subject further were exposed. An open letter from a group of social work academics also questioned the method and ethics of a proposed evaluation (Turner 2019). Nonetheless, research is going ahead with this FGC evaluation. In 2019 the WWCCSC further funded a randomised control trial (RCT)-based two-year evaluation of one model of FGCs, that has as its focus the early legal or pre-proceedings stage of child safeguarding².

More recently, the WWCCSC published a systematic review on the impact of shared decision-making family meetings on children's out-of-home care, family empowerment and

1. www.frg.org.uk/involving-families/family-group-conferences

2. www.coram.org.uk/news/coram-awarded-role-evaluation-partner-what-works-centre-children%E2%80%99s-social-care

satisfaction (Nurmatov et al. 2020). The authors described this as being the most comprehensive review of evidence so far on the role of shared decision-making meetings on children's out-of-home care, family empowerment and satisfaction, but noted that while a variety of terms are used internationally the most commonly used term in the UK is family group conferences (FGCs). Their review is highly relevant to those considering research on FGCs in adult services (for example, in noting the importance of defining outcomes measures and making comparisons). They argued that while there is still a lack of strong evidence in the children's sector, this should spur researchers to conduct robust studies on ethical grounds:

Not only policy makers and practitioners, but also parents and children deserve stronger evidence about the difference that these meetings can make. Informed consent to taking part in such meetings would be more meaningful if we were able to provide more evidence about the impact that they have (p.41).

FGCS' AIMS AND OBJECTIVES

There are several definitions of FGCs in English children's and family services but one of the most frequently referred to comes from the Family Rights Group (undated):

A family group conference is a process led by family members to plan and make decisions for a child who is at risk. Children and young people are normally involved in their own family group conference, although often with support from an advocate. It is a voluntary process and families cannot be forced to have a family group conference.

Compared to the DfE definition (above) of the FGCs it is investing in currently, the notion of risk is evident in the FRG's definition, but the type of risk is more explicit in the DfE's set of parameters. For researchers this is a key point, in that the thresholds, aims and context of FGCs vary and require clarification. We shall return to this point later, but it is important to be clear in any research about the context, aims, intended outcomes and inclusion criteria of FGCs, particularly when making comparisons with other interventions. Frost et al. (2014) provided a helpful overview of the debates in child and family FGC research, adding their own research ideas and findings about implementation or

FGCs – their origins and potential inclusion of adults

The Maori origins of FGCs are often recalled in many discussions of FGCs for children (for example, De Jong et al. 2011, Connelly and Masson 2014, The Ecologist 2018). The concept of FGCs spread across the Western world (Holland and Rivett 2008, Connolly and McKenzie 1999) having been pioneered and developed in children's safeguarding and then youth justice (see Dijkstra et al. 2016). The initiative's potential to benefit people with care and support needs (as proposed by Marsh 2007) and people for whom there are adult safeguarding concerns (as suggested by Local Government Association 2013) has been canvassed for several years. However, while approximately three-quarters of local authorities in England and Wales claim to offer some form of family conferencing in children and family services (Guthrie 2017), FGC provision for adults is considerably less prevalent.

scaling up of an innovation. In one of the early major studies of child and family FGCs in England, Marsh and Crow (1998) also highlighted implementation as a subject that deserved further thought and data.

In children's services, one model or definition of FGCs is particularly prominent. Rapaport et al. (2019) described this FGC model as a process led by family members that provides a framework to empower families to make decisions about a child deemed to be at risk (risk generally being defined as at risk of removal from its parents to state care). The aim is generally reported to improve family engagement, to enhance long-term impact, and to reduce risks with positive outcomes for children and families. Notions of the initiative's potential to rebalance power between social workers and families to facilitate meaningful dialogue (The Ecologist 2018) and power sharing (Merkel-Holguin 2004) have also been advanced. These overarching dynamics have been argued as equally relevant to other groups, such as people with mental health problems. However, in respect of adult social care, the initial aims of some of the early FGCs were more specifically to increase participants' own

understanding of their respective circumstances and to mobilise their social networks to help them to resolve their problems (Wright 2008, Malmberg-Heimonen 2011).

Child and family FGC initiatives in England and Wales are usually, though not always, commissioned by local authorities and delivered by voluntary or not-for-profit agencies. As noted below, there are fewer adult FGC examples compared to children's; a report produced by the Social Care Institute for Excellence observed that adult social care FGCs have often been more voluntary sector led rather than a statutory development (SCIE 2012). We do not know if that is because adult social care is largely delivered by the independent (mainly private) sector or if there are other reasons. There is no FGC legal entitlement for children and families in England and Wales, although some local authorities, such as Leeds City Council (Mason et al. 2017), may require practitioners to offer the option of a FGC to all relevant families under a policy directive. Likewise, there is no legal entitlement under English adult social care legislation. A recent survey of local authorities by Tew et al. (2020) reported that of the 60 responding, just eight local authorities were promoting (in the sense of both undertaking but also commissioning) organisations to run FGCs as part of their duties of prevention under the Care Act 2014.

In practice, for example in a study of FGCs with families/young people with mild learning disabilities in the Netherlands (Onrust et al. 2015), several studies have observed that FGC coordinators are key to the process and they are

described as coming from non-professional and professional backgrounds, including social work and nursing. In children's services, the coordinator generally facilitates a FGC through (1) responding to a referral, (2) arranging the conference meeting and private family time, (3) planning, and (4) assisting with review stages (see Rapaport et al. 2019). Identifying the members of the family network and providing robust information about the safeguarding concerns and support services available to help a family devise an acceptable and safe plan are described as crucial aspects of the coordinator's role. For researchers this suggests the importance of studying the workforce involved in FGCs as coordinators or in similar roles.

The Family Rights Group (2018), the initiative's champion in the UK, states that a FGC should never be imposed. Importantly, the process may not appeal to all families as found in New Brunswick, Canada, where families subject to child safeguarding have a legal right to access a FGC. However, for reasons unexplored, only 20 per cent opt to take this up (Rapaport and Poirier Baiani 2017). Acknowledging this, Rapaport and Baiani (2017, 2019) raised the potential for valuing people and reciprocity as being at the heart of family and social worker interaction, with mutual empowerment arising from social workers enabling families by providing them with support and information, and the families in turn enabling their social workers to meet the agency's safeguarding objectives. In the next section we explore more directly FGCs in the context of working with adults in need of care and support.

SOCIAL WORK WITH ADULTS AND FGCS: POTENTIAL PRINCIPLES AND THEORIES

A recent publication from the Social Care Institute for Excellence (SCIE) *Strengths-based approach: Practice Framework and Practice Handbook* (Coloma et al. 2019), urged social workers and social care professionals to apply a strengths-based approach when working with adults in need of care and support. This is described as characterised by being holistic, multi-disciplinary and aligned with risk enablement and risk taking, and as promoting the strengths of personal, family and community networks. Although the FGC method is not specifically identified in this handbook, group

conferencing features as a potentially appropriate model of practice for the application of strengths-based practice. However, as Gottlieb and Gottlieb (2017) commented, strengths-based practice is not confined to social care or social work but is also described as fundamental to nursing practice.

Given its focus on the individual and their social context, the FGC initiative is thought to support person-centred 'whole family' approaches (Tew et al. 2014) and is therefore relevant to adult social care. Empowerment, with which the FGC

initiative has long been associated (although variously defined), featured as a potential outcome for family participants (Holland and Rivett 2008, Ogilvie and Williams 2010, Metze et al. 2013). Burns and Früchtel (2014) perceived a strengths perspective within the FGC process across the gamut of participants, agencies and professionals involved. For researchers, the imprecision of terms such as 'strengths-based' approaches suggests that care

is needed when defining terms and developing outcomes so that these are clear to measure and collect. As Evans et al. (2015) suggested, the evaluation of such social care innovations may benefit from careful attention to consideration of a 'proof of concept' approach as set out in the Medical Research Council's (MRC) Guidance on the Evaluation of Complex Innovations (recently updated in Craig et al. 2019).

FGC AND ADULT SAFEGUARDING: LEGAL AND POLICY FRAMEWORKS IN ENGLAND AND WALES

The legal and policy frameworks relevant to FGCs in adult social care have focused in the main on safeguarding adults with care and support needs who are unable to protect themselves from abuse or neglect, to make provision for carer support, and to protect human rights (as set out in England's Care Act

2014). The core elements of these initiatives are illustrated in Table 1 below. It is evident from the studies reported throughout this review that one key difference between adults' and children's FGCs in England is that in adult social care there may not be a sharp focus on immediate risk of harm; although some projects

Table 1: Legal and policy frameworks relevant to Adult FGCs in England mid-2019

Law/policy	Provision
Care Act 2014	Requires local authorities to lead a multi-agency adult safeguarding system, to investigate concerns and to establish Safeguarding Adults Boards. Requires local authorities to assess needs taking into account a person's wellbeing and wishes, ensure the person is involved in the assessment process, and, if necessary, has access to independent advocacy. Care and support statutory guidance 2018 promotes person-centred care and support planning.
Mental Health Act 2007 and Care Programme Approach (CPA)	Requires the Approved Mental Health Professional (AMHP) who is usually a social worker, to consider 'the least restrictive alternative' when carrying out an assessment to decide whether a person is in need of compulsory hospital admission among other tasks. The 'CPA' provides a framework for care delivery to people accepted by secondary mental health services.
Mental Capacity Act 2005	Empowers adults to make decisions wherever possible. Provides a framework to protect adults who lack capacity to address their known preferences and procedures in 'best interest' decision-making. Sets out a mental capacity assessment process to determine whether an adult can understand, consider and recall information to execute a specific decision. Permits the making of advance decisions and appointment of proxy decision makers to inform medical, care and financial decisions in the event of future mental incapacity.
European Convention on Human Rights	Article 5, right to liberty; Article 6, right to a fair hearing and Article 8, right to private and family life.

there are mentions of substantial concerns about wellbeing and safety. The legal context therefore needs to be considered in the context of both practice and research, but this context is variably reported in the studies discussed below.

A safeguarding investigation may lead to a FGC offer in some English local authorities. Fisher et al. (2018) argued that a FGC might also help protect adults from physical abuse, financial abuse and/or neglect. However there is very little research on such activities, as noted, a pilot project (the Bluebird project) in three English local authorities offered FGCs for a brief period to some older people for whom there were concerns about elder abuse and this was evaluated for its funder, Comic Relief. Data were reported in the form of individual case studies; staff estimates of outcomes and cost savings, and statistics about FGC processes (Daybreak 2010).

The Bluebird pilot took place prior to the Care Act 2014 but the potential for FGCs was mentioned within the permissiveness of the Care Act's (2014) first statutory Guidance which noted: 'Personal and family relationships within domiciliary locations may be ... complex and difficult to assess and intervene in' (Department of Health 2015, para 2.15). This may give rise to several practice hypotheses, for example, a FGC, if wanted by the individual in question and supported by committed close family and friends, might provide the basis for a robustly informed, human rights aligned assessment of risks to his or her wellbeing and how wellbeing might be achieved. Alternatively, a timely FGC and bespoke support plan devised by family members who are familiar with their relative's circumstances may prevent a deteriorating situation, avoid hospital admission, and enable the individual to resume his or her family life. However, FGCs are reported to overlap at times with other interventions or approaches such as mediation (Hobbs and Alonzi 2013) or care planning. Given the strains sometimes associated with providing family care, it may also trigger a carer's assessment and advice to carers to facilitate the delivery of a care and support plan/safeguarding plan, but this is hypothetical. Such an approach might link with Making Safeguarding Personal initiatives (Cooper et al. 2016); themselves seen as part of strengths-based practice.

Safe and supportive decision-making generally relies on the person at the heart of the FGC having enough understanding to participate in the process. Hypothetically, Tapper (2016) contended that at the start of an offer to set up a FGC, social workers may need to consider whether an assessment under the Mental Capacity Act 2005 is required to ensure the individual, and perhaps also his or her supporters, has sufficient capacity to make, understand and recall the range of particular decisions necessary to formulate and agree a plan. If the individual concerned lacks capacity to make these decisions, Tapper (2016) suggested that the FGC might be held as a 'best interests' meeting under the Mental Capacity Act 2005 (England and Wales). In such instances, the family would take the lead in making proposals on behalf of the person whilst also considering the views of professionals. The decision-maker (or the FGC co-ordinator perhaps) would be responsible for ensuring that the Mental Capacity Act requirements, such as abiding by the best interests' principle, were fulfilled.

From Northern Ireland, a Department of Health, Social Services and Public Safety (2015) study of FGC and Adult Safeguarding reported on a pilot initiative that aimed to give families and service users greater control in decision-making and to improve professional judgments using FGCs. The findings suggested better outcomes where families are given information and opportunities to make supportive plans. Indeed, the literature as a whole contains several examples of such 'promising' developments in adult FGCs or family group decision making (FGDM) but, overall, there is still little conclusive evidence. A recent systematic review from Hillebregt et al. (2019) considered outcomes for families from controlled studies of both such family-centred interventions. These authors found that studies were low in quantity and quality, meaning that conclusions on FGDM effectiveness must be expressed with caution. They advised that:

Further high-quality intervention studies are required to evaluate the impact of FGDM on adults in need, including their families; as well as evaluation research detecting possible barriers and facilitators influencing FGDM implementation. (ibid p1)

FGC EXAMPLES IN ADULT SERVICES

We return in this section to FGCs developments in adult social care to explore the nature of studies so far and their methods in greater detail.

The option of holding a FGC is mentioned in respect to a small but broad range of services including mental health (Wright 2008, De Jong et al. 2015), children moving to adulthood, planning for prison release (Guthrie 2017 (this latter example is from a presentation not a report)), hypothetically relating to adult safeguarding and older people (Parkinson et al. 2018); with older people (Metze et al. 2018) including dementia care (Gorska et al. 2016), learning disability services (Wright 2008, Onrust et al. 2015), brain injury services, chronic disability and rehabilitation services (Hillebregt et al. 2018) and, in the US, services for the victims of crime (Andersen and Kaveles undated). FGC entitlement exists in New Zealand for youth justice (Doolan 2004) as well as child welfare. Of course, some children's models of FGC may also address the needs of closely involved adults to support safe outcomes. For example, the Leeds initiative mentioned above offered help to perpetrators of domestic violence within a restorative approach with a view to rehabilitating families (Mason et al. 2017).

Fisher et al. (2018) have reported on a FGC Practice Network, started by the London Borough of Camden, that provides a forum for academics, educators and local authorities interested in FGCs in adult social care to come together to promote the initiative and its further development. In their report, the authors listed seven current and one no longer operating adult FGC programmes in the UK. (A FGC pilot in Northern Ireland was separately discovered as a result of our online searches for this present review.) A list of all Adult Social Care FGC initiatives in the UK that we were able to identify (at mid-2020) is provided in Table 2 below. Two local authorities were currently running the service themselves (this was also the case for the terminated Kent pilot). Four programmes were being outsourced to the voluntary sector. The Northern Health and Social Care Trust originally provided FGCs in Northern Ireland (NI) until the voluntary agency *Family Group Conference Northern Ireland* (2018) received charitable status and assumed responsibility for delivering this service.

While the Camden Adult FGC model is only covered briefly in Fisher and colleagues' (2018) report, some details of its funding and use were provided in an internal local authority report (NHS Camden Integrated Commissioning Committee 2017). The Committee report noted that over 40 FGCs had been completed in the previous two years in Camden (including reviews), including 12 'so far' in 2017/18. These FGCs were held for a range of reasons, with the majority addressing care planning or safeguarding concerns. It is reported that they cost in the region of £2,000 per FGC, including coordinator/advocacy/accommodation/refreshment costs (ibid). Of interest to researchers is the comment that capturing data proved hard and the statement of ambition for changes in recording systems to make data collection easier:

This initial study has been made more difficult due to the lack of an effective tracking data on adult FGCs and poor data quality on mosaic*. All FGCs have now been inputted into a tracking tool which captures significant information at the time of referral, making future analysis of the impact of adult FGCs much easier to complete (ibid p.8). (*mosaic is the local authority adult services' IT system)

The Essex FGC service started in 2008 (in North-East Essex) and thus appears to be the longest UK initiative. It is described as unique in the UK context in being nurse led and run by the NHS. It originally focused on mental health patients under the structured care programme approach (CPA), using a recovery model of practice (Leamy et al. 2011). The service itself was quick to report considerable success in reducing isolation and stigma and in improving social inclusion (Wright, 2008). The Trust has stated extending the service to other adult care settings or services, including domestic violence, learning disability and older people, and explicitly seeks to identify carers' needs but details of this are not publicly available (NHS Essex Partnership University NHS Trust undated).

The Kent pilot, previously mentioned, was an early adult FGC example that lasted three years. It covered a range of services for people with learning disability, young adults with physical disabilities and older people, and received a 'high' number of referrals. Its evaluation (Marsh

2007) found positive outcomes from all service user, family and practitioner stakeholders and reported that the service made considerable financial savings. Nonetheless, Fisher et al. (2018) reported that plans to extend FGCs in adult care in Kent had been cut because of organisational restructuring and in 2008 the service closed.

Hampshire's FGC programme in children's services was extended into adult care in 2007 with the Daybreak Bluebird project reported above. The other services mentioned in Table 2 are of more recent origin and some are described as being in their pilot stages. As Table 2 shows, the range of disabilities and client needs is wide and often unspecific. Whilst

Table 2: Identified Adult Care FGC initiatives in the UK (end 2019)

Local authority	Agency	Status	Client/user group
Camden London	London Borough/NHS	Established – funded by the NHS/Local Authority (LA) Better Care Fund	Young people with disabilities moving to adult services; adults with a disability; safeguarding older people
Dumfries & Galloway	Kalm Solutions	Commissioned by LA	Vulnerable adults
Edinburgh	City Council	Pilot	Adult care
North East Essex	Essex NHS Partnership Trust (EPUT)	Established	Mental Health; reported developed to learning disability; domestic violence; adult care
Hampshire (and neighbouring authorities)	Daybreak	Comic Relief funded Bluebird project 2007–10,	Adults with a disability and safeguarding older people. Also recruited advocates
Kent	Local authority (County Council)	Piloted 2005–2008 Ceased.	Learning disability; young and older adults with physical disability
Lincolnshire	No further details	No further details	Safeguarding; people with physical disabilities, dementia; young people moving to adult services
Midlothian	Kalm Solutions www.kalm-scs.co.uk/ family-group-conferencing	Commissioned	Dementia (website in 2020 says they support FGCs in adults and children's services)
Northern Ireland	Family Group Conference Northern Ireland www.nicva.org/organisation/family-group-conference-ni	Pilot continuing	Vulnerable young people at risk; learning disability; physical disability
Swansea	No further details and not included on Family Rights Group listing (July 2020)	Pilot	Dementia

Sources: Fisher et al. (2018). Family Group Conference Northern Ireland, Trustees' report (2017/2018) and website searches July 2020

reducing vulnerability and safeguarding seem to be generally core objectives, support for people living with dementia and helping young people with disabilities in their move from children's to adults' services also feature but with little detail.

Edinburgh Council is reported to have held or considered hypothetically the holding of a FGC for a person with alcohol dependency (Fisher et al. 2018) (see below).

RESEARCH AND EVALUATION

Despite the limitations of UK studies, FGCs in adult services beyond the UK have increased in the last decade with some detailed evaluations. Many of the most recent and more extensive studies hail from the Netherlands where a national evaluation of their FGC service is underway (Schout et al. 2017). We found 16 studies, including an additional research proposal, following online searches for this present review. While most were qualitative studies, one used the randomised control trial (RCT) method based on the approach's ability to investigate causality when evaluating the effects of interventions (Malmberg-Heimonen 2011).

The most common method of enquiry taken by the other studies were

- interviews, including semi-structured interviews (10) and
- focus group interviews (2);
- case studies, including one multiple case design (5);
- questionnaires, including surveys and score cards (4); and
- narrative accounts (1).

Studies were conducted in Norway, the Netherlands as well as the UK. Most were set in mental health and older people's services.

General adult social care and older people

The earliest identified evaluation into FGC outcomes in UK adult care related to the short-lived Kent programme. In this evaluation Marsh (2007) analysed planning and policy documents and case studies of six FGCs held in respect of people with learning difficulties, older people, and young adults with physical disability. He also interviewed stakeholders and the initiative's implementation group. He reported high levels of satisfaction among all stakeholder groups, including carers. He concluded that the service met the government objectives of more choice,

voice and support for people with long-term needs. Professional coordination was found to have improved, resulting in considerable savings as noted above, estimated at £7,000 per FGC.

A Scottish study from Midlothian (Gorska et al. 2016) involved two focus group interviews with a total of six family members (representing three families) and eight professionals and explored the impact of a FGC pilot service for people living with dementia and their families (10 families had been identified following screening for inclusion in the pilot). The initiative was found to have a potentially positive impact on service users, family carers and professionals and the overall culture of care. For family members the FGCs provided a forum to meet to discuss the practical aspects of care, to acknowledge their skills and activate family resources, and to share the 'burden' of care. Professionals acknowledged that the FGC process improved their understanding of the problems under review, supported person-centred and family orientated practice, and shifted power away from themselves to the participant families. There was also a reported change in service users' expectations and realisation that services may not always be able to help. The process was found to encourage natural support networks and to shift attention from the management of dementia to promoting independence and participation. However, while noting that this very small pilot was 'promising' the authors cautioned that:

FGC presents challenges which need to be carefully managed in order to secure maximum benefit to all parties. (ibid p.233).

In particular, the study identified barriers to FGC implementation, especially given the challenges posed by the dementia syndrome. Whilst the authors agreed that the inclusion of the person living with dementia should always be attempted in the FGC process, it was not always possible in practice. Families could also experience problems where the individual living with dementia had limited insight into their

difficulties. In terms of improvements, families would have preferred more information about the roles of health professionals before the FGC meeting and, with the person living with dementia's consent, to be able to make an informed request for professional input as part of the family meeting. The intention behind this last wish was to give the professional a fuller picture of the situation, such as the scenario where an individual who was subsequently visited after the FGC maintained that they did not need any help. The authors concluded from this small pilot that the skill of the coordinator to involve and prepare FGC participants was essential to a successful outcome.

Drawing on the international literature, in the Netherlands Metze et al. (2015) used a case study design to examine FGC effects and researched eight FGC held for older people, selecting two cases for further comparison. They concluded that the concepts of relational autonomy and resilience provided some insight into the FGC process. Compassion and respect for an older person's needs appeared to motivate members of their social networks to help him or her solve problems. The capacity to initiate and maintain social relations and ask for help seemed to bring about change. Other factors such as the nature of the problems in question, the degree of involvement and strength of the social network, and older person's background were also important.

Despite this, social workers (defined as elderly advisors and case managers) were reluctant to refer older adults to the FGC programme leading to Metze and colleagues' (2018) further study to explore the reasons why. They surveyed social workers (36 responded of 106 requested), then undertook three group interviews and five individual semi-structured interviews of FGC-informed social workers. One FGC coordinator was also interviewed. Practitioners seemed positive about the FGCs but were reluctant to refer older people because they were already working with their clients' social networks, feared losing control over the care process, and questioned whether the FGC would have any additional value. They also viewed their clients as reluctant to engage in the process because they feared they could be 'weakened' and pass 'self-mastery' to their families who might be empowered by the FGC. Fear of losing family contact by overburdening their care networks was identified as an

additional barrier to FGC engagement and meant talking to a professional could be preferable to holding a FGC.

As with Parkinson and colleagues (2018) (described below), Metze and colleagues (2018) highlighted the importance of recognising the differences between FGCs in children's services and in adults' services. They contended that in respect of older people's services the issues are usually 'softer and smaller', such as managing finances and providing home care, rather than the threat of a child's removal from home into state care. In such circumstances, holding a FGC may seem excessive. Metze et al. (2018) suggested that older people tend to have better relationships with their social workers than children do with their social workers. Children are expected to become more independent whereas, they argued, older people will become increasingly dependent. They observed less urgency in respect of older people where the goal is to keep the situation stable and sustainable. They also portrayed FGCs in adult care as slow and complicated, possibly because social workers are not experienced in the process. They concluded that practice should possibly place less emphasis on social networks and more on reciprocity and neighbourhood networks.

Overall, Guthrie's (2017) comments about the limited evidence base for FGCs with adults, remain pertinent. As reported above, numbers are often extremely small and longer-term outcomes are not collected. She noted:

There is a shortage of reliable research regarding their impact, particularly in adult services (Malmberg-Heimonen 2011, Wright 2008, Frost et al. 2014), which may in part be due to the challenges of measuring the outcomes of FGCs. Even though the evidence in relation to FGCs, as applied in the context of adult services remains limited, that which is available highlights some positive outcomes (Marsh 2007, Wright 2008, SCIE 2012, Forsyth et al. 2013).

However, it may not be simply the challenge of measuring outcomes but the wide variety of outcomes that are potentially measurable and a lack of 'model fidelity' in terms of whether it is possible to compare FGCs. Such challenges are currently being addressed by the substantial investment in FGC evaluations in the Netherlands (De Jong and Schout 2018).

Mental health

Mental health research forms the largest group of adult FGC studies. The world's largest in-depth research into FGCs for adult clients of mental health (psychiatric) services analysed more than 100 conferences, and 600 semi-structured interviews were conducted with participants and other stakeholders. This major Dutch evaluation took place between 2011 and 2015; it is reported in several papers (de Jong and Schout 2011, 2013, 2015, 2018, de Jong et al. 2014, 2016, Schout et al. 2017, Schout et al. 2017). In terms of methods, as discussed in de Jong et al. (2016), their evaluation mainly used semi-structured interviews to gather data that was then reported under several themes. Data were obtained from 312 respondents out of a total of 473 FGC participants. Out of these 33 cases, the researchers were able to obtain scores from 245 respondents on scales ranging from 0 to 10 about the situation before and after the FGC on three outcome measures covering the quality of: (1) social support, (2) resilience and (3) living conditions.

De Jong et al. (2011) had earlier explored FGCs' potential use in mental health services to expand and restore relationships, improve motivation to seek help and help prevent hospital admissions. They touched upon the professional roles of staff who engaged with FGCs in mental health services in the Netherlands; noting that the terms facilitator and co-ordinator were both used. In this paper they reported findings from interviews with 10 FGC experts in the Netherlands, which included some participants with direct experience. These data were 'member checked' by a larger three-hour meeting of FGC stakeholders.

Building on this work, the team then reported on FGCs in which modest improvements in living and mental health conditions following FGCs were found. Two case studies are reported in de Jong and Schout (2013) as illustrations of where shame and fear of rejection were inhibiting marginalised and isolated individuals' engagement with their families; in these examples holding a FGC helped re-establish contact.

A single case study reported the initially successful outcomes of a FGC that had been organised in a small neighbourhood where an imminent compulsory hospital admission of a man described as having psychotic and unacceptable behaviour was averted (de Jong et

al. 2014). As there had been fears that the FGC would aggravate this man's poor health, the conference was held in his absence with his views being represented by a third party. At a nine-month follow-up the FGC was described as having been highly successful in embedding the man in a supportive social and community networks and diverting him from hospital. However, a year later the plan had catastrophically failed. The individual had deteriorated and been admitted to hospital: the community had been left disillusioned. De Jong, Schout and Abma (2014) were critical of professional failures to provide adequate follow-up. Whilst it is impossible to know whether the FGC would have been more successful if the individual and his social network had been well supported and he had attended 'his' FGC, this case example would seem to suggest the importance of providing appropriate FGC aftercare.

The same research also raised the risk of FGCs being 'too late' to make any difference, if they are used as a 'last resort' (De Jong et al. 2015). The authors suggested that:

Social capital theory points to the necessity of not only renewing informal networks ('strong ties') but of expanding networks through connecting public mental health care clients to paid and volunteer work ('weak ties'). FGC plans can include such action steps. Instituting a 'family manager' to monitor these steps may support the bonding of 'strong ties' and the bridging to 'weak ties' (p.277)

In a further exploration of 'non-successful' FGCs, De Jong et al. (2016) provided insights into factors that may contribute to failure. These include where the FGC is undertaken as a last resort (as noted in the above article), previous interventions have failed, social networks are insufficiently mobilised and the people concerned feel helpless to improve their living conditions. This article is notable in having focused on FGCs that were categorised as successful and non-successful. While 23 of 41 studied FGCs were successful in meeting their goals, the other 18 had apparently failed as the preparations became stuck or because a plan was never reached or fully implemented. The researchers drew on semi-structured interviews with 118 out of a possible total of 215 FGC participants to explore these processes and the impact of the FGCs.

Drawing on a smaller sub-set of 17 cases as part of multiple case studies of FGCs, from this same evaluation, Schout et al. (2017) identified further barriers to FGC usage such as acute danger in coercive situations, severity of mental state, limited time available, professional oversight of the initiative's potential and the individual's social network not being open to supporting a FGC.

Again in a mental health context, another national but smaller study in England using the 'whole family' model (Tew et al. 2017) compared the potential of four approaches: systematic family therapy, behavioural family therapy, the integrated systemic behavioural approach, and FGCs to empower and socially rehabilitate families. These interventions were all classified as 'family-inclusive approaches.' Data were sourced from stakeholder interviews, narrative accounts, and end of study scorecard questions. The FGC was explicitly geared towards supporting reablement outcomes for people using mental health services (including one person who had left in-patient care). In terms of mobilising family relationships in support of reablement, FGCs were found to be more successful in enabling families to provide support than other interventions. Of the seven cases within the FGC theme one was described as having made a small change, two major changes, and four substantial changes. However, FGCs were found to be less successful in dealing with entrenched family problems. The distinctive aspect of the FGC was said to be that it put families in control and 'in the driving seat' (Tew et al. 2017, p.877). However, the researchers warned that in drawing conclusions, it had not been possible to match the demographic characteristics of the study participants and severity of their mental health problems. A further complication, with relevance to the Dutch study above (de Jong et al. 2016), was that each of the seven FGCs held had been complemented by four review meetings that took place between six to twelve months after the original conference as part of the decision-making process.

Unemployment and social assistance

A study funded by the Norwegian Research Council and Norwegian Directorate of Labour and Welfare (Malmberg-Heimonen 2011) used both RCT and qualitative methods to research short- and long-term FGC outcomes. Social workers, trained in the research process, invited

participants to engage in the experiment in which 149 long-term (for over six months continuously) unemployed users of social assistance programmes were randomly assigned to FGC intervention and control groups. Most participants reported a long-term health condition and had been out of work for over three years on average. Baseline and follow-up questionnaires were used to compare outcome measures. Both intervention and control groups received social services as usual, whilst the former also participated in the FGC. The study took place in social services' offices in the cities of Oslo and Bergen from 2007 to 2010. In a paper by Johansen (2012), details of 15 such conferences are reported, with observations of processes in the five that were observed.

Using validated and common measures of social support (e.g. the Oslo three-item scale), life-satisfaction and mental health (GHQ-12, HSCL10), this RCT (Malmberg-Heimonen 2011) found that the FGC intervention group experienced statistically significant increases in life satisfaction and decreases in mental distress, depression and anxiety. Positive trends were also evident in respect of emotional support and accessing social resources. Participants evaluated the FGC process highly and were described as satisfied with the work of the coordinators, questions they had prepared for their respective meetings and the relevance of their action plans. Data were also collected about engagement with the FGC facilitator who worked, on average, 24.3 (Standard Deviation (SD) 8.52) hours with each participant. Most of this time (18.3 hours; SD 7.52) was spent in meeting preparation, 4.2 hours (SD 1.38) for the FGC meeting itself, and a small amount, 1.7 hours (SD 1.25) on completing tasks after the FGC. The study suggested the FGC potential to mobilise and remobilise social networks for long-term recipients of social assistance services; nearly a quarter of whom were immigrants; most were men (single, divorced or widowed), and most of whom had not had much education.

However, the follow-up study that took place a year later (Malmberg-Heimonen and Johansen 2014), found neutral outcomes and that the positive results of the first study had been short-lived. Fifteen of the original study participants were interviewed. Their deterioration and stagnation after the initial positive FGC process were attributed to lack of reciprocity in social relationships and lack of follow-up. The authors concluded that holding

a FGC should only be considered as a preliminary and that follow-on care needed to be an essential part of the process. The role of coordinators in these FGCs was further reported by Natland and Malmberg-Heimonen (2014).

A further example of FGCs being attempted with people receiving social assistance (such as unemployment or disability benefits) to promote their return to work has recently been reported as a feasibility study conducted by Brongers et al. (2019) in the Netherlands.

Alcohol addiction and adult safeguarding: a (fictitious) case study

Parkinson et al. (2018) developed a fictitious case study based on real life scenarios about a man with an alcohol addiction; this was analysed through an 'organic' group discussion. These discussions highlighted that problems arising from fluctuating mental capacity and unwise decisions were not necessarily an indication of mental incapacity. Social work and FGC experts conducted an in-depth analysis of the case discussion to explore the appropriateness of FGCs as a response to adult safeguarding concerns. Where conflict between the FGC

process and adult social legislation and policy seemed to arise, this was used to inform the discussion. The researchers concluded that holding a FGC might be a viable alternative to traditional approaches and identified three main areas for further exploration: mental capacity, risk, and funding.

In the English context (and in Wales) a person must be assumed to have capacity to make decisions, unless it is established otherwise, or is incorrect. Adapting the above fictional Scottish illustration, where there is a different legal context from that of England and Wales, the man might choose for his drinking friends to attend the conference. This was seen to present the FGC team with an immediate dilemma of perhaps being seen to be oppressive when weighing up the risks and appropriateness of his choices, whilst purporting to work within an acclaimed empowering initiative. The researchers speculated that such a FGC in adult services might not be so attractive to local authorities because the financial savings would be less than in children's services where care costs are higher. Significantly, for the attention of policy makers and local authorities, they highlighted the complexity of transferring an approach designed for children to adult services.

DISCUSSION

The studies reviewed into the effectiveness of FGCs in adult services are mostly small-scale and largely short-term, have used a range of study designs, and were located in different jurisdictions whose legal, health and social care systems may have variously impinged on social welfare, care provision and individual wellbeing. The types of adult care scenarios addressed also differed. For these reasons, comparisons between systems and study outcomes should be treated with caution. The two-part Norwegian study uniquely used a RCT method to investigate FGC performance. RCT studies are quantitative, comparative controlled experiments that are typically favoured in clinical trials and are traditionally used to manage large data sets. They are considered to reduce research bias and to provide a rigorous tool to examine cause-effect relationships between an intervention and outcomes.

However, the RCT approach may be 'a poor fit' for complex settings where variables cannot be

well controlled (Sullivan 2011, p.285). In an ongoing FGC multi-centre control trial of 12 Dutch rehabilitation centres providing services for people with spinal injuries and amputations, Hillbregt et al. (2017) have rejected what they described as the otherwise preferred RCT method because they feared non-intervention control groups receiving regular care might be contaminated by FGC-type interventions. De Jong and Schout (2018) also considered that RCTs of FGCs would only be able to provide an abstraction of reality and a partial image of the complex situations faced by families and professionals. Nonetheless, a Norwegian study (Malmberg-Heimonen 2011) found useful outcomes that were broadly reflected elsewhere, for example, participants rated the FGC process positively. This study is important in using standardised measures of emotional and social wellbeing that could be repeated by others. It also provides valuable warning points that, even with the substantial resources of a RCT study, the participant attrition rate was

huge. The likelihood of a similar occurrence may discourage other researchers from using RCT methods in future FGC studies, with consequent implications for research reliability and over-reliance on pilots.

Overall, this overview of research about FGCs for adults shows the value of efforts such as those undertaken by Frost et al. (2014) to regularly collect and discuss learning from FGC research. There is a need to pay attention to the nature and strength of evidence, the measures and duration of outcomes, and methodological developments.

The complexity of transferring an initiative designed originally for children's services to adult care was also evident in many of the study examples. A person- and family-centred focus are common to both. Power shifts that are the hallmark of the FGC are potentially equally relevant in adult and children's initiatives but in different ways. Children are set to gain independence whilst many frail older people with care and support needs are likely to become increasingly reliant on others with advancing health problems; while for people with mental health problems or reliant on social assistance benefits there may be substantial reablement or social activation gains. However, it is important not to stereotype older people; in their close analysis Metzger et al. (2015) reported older people regaining their autonomy and resilience through greater contact with their relationship networks and their capacity to ask for help in the FGC process. This suggests recovery enablement is also another potential FGC outcome. On similar lines, Tew et al. (2016) defined reablement in terms of empowerment and social rehabilitation in mental health that reach beyond reskilling objectives.

The studies help to build a picture of the evidence base of the FGC process in adult services, how it is evolving and provides pointers for development. Most suggest that the aims of the initiative, to help people to increase their understanding of their respective predicaments and harness their social networks, are broadly met. The long-term Dutch evaluation in mental health services (De Jong and Scout 2018) and Norwegian study (Malmberg-Heimon 2011) of FGCs highlighted the importance of ensuring service users' social and community networks are identified and follow-on support is provided. Post-FGC reviews may coincidentally have contributed to the 'reablement' success of the UK mental

health study conducted by Tew et al. (2017). This latter study's findings regarding the FGC's apparent superior success in 'reabling' families but inadequacy where deep seated problems prevailed, suggested initial assessment of a family's relationship dynamics should guide the process of selection. However, the studies when considered overall have also exposed anomalies. For example, in respect of a small pilot study of older people and FGCs, the findings of Gorska et al. (2016) about Scottish social workers' apparent enthusiasm to implement FGCs, was not shared by their Dutch counterparts (Metzger et al. 2018) who considered regular care to be just as, or more suited to the circumstances. Was the 'regular care' perhaps more robustly implemented in the Netherlands, were the Scottish social workers FGC-experienced, or were other factors at play?

The question of whether the person should be present at the conference if lacking mental capacity or likely to become distressed emerged as another conundrum that bears closer examination. Can a person be properly represented by an advocate (De Jong et al. 2014) or on a best interests' basis (Tapper 2016)? Perhaps the outcome of the case study identified by De Jong and Schout (2015) might have been rather different if the man with severe mental health problems had been present at the meeting? Or was this case an appropriate FGC referral? How unwise (Parkinson et al. 2018) and unrealistic decisions (Gorska et al. 2016) should be considered in the context of FGCs is potentially problematic. Whilst the difficulties may or may not be due to incapacity, in all probability the FGC process and agreed plan outcomes are likely to be compromised where these arise. Perhaps the real nettle to grasp here is careful planning. Practitioners and managers may wish to follow the example of the London Borough of Camden (Fisher et al. 2018) in introducing a FGC risk assessment policy to determine participants' motivations and understanding of FGC objectives to guard against any exploitation of the process.

However, the application of the FGC and its effectiveness are complex given the myriad of possible care and support needs among adults stemming from problems of physical disability, sensory impairments, learning disability and brain injury, frailty and so on. Whilst findings from the awaited multi-centre study (Hillebregt et al. 2018) may shed new light, the FGC's effectiveness has yet to be tested in these areas

where independence may be additionally and differently compromised. Differences in funding scenarios require further exploration given the ambiguities regarding possible cost-effectiveness claims. Whilst care services may indeed be more expensive in children's services than in respect of older people, this may not hold in mental health services, or other care intensive adult services. Furthermore, what happens where an adult is self-funding? Does financial empowerment influence the process and compliance with services that might be on offer? Do formal FGCs occur if the local authority has no financial incentive to offer one, or is family conferencing in such circumstances an entirely private matter? Connolly and Masson (2014) warned that the FGC may be viewed as an intrusion on privacy, given the amount of information sharing involved. Conversely, Tapper (2010) asserted that the 'no blame' and restorative culture of the FGC encouraged participants to engage in the process. This suggests that during the FGC meeting information will be consensually disclosed. Given the importance of information exchange in the assessment and management of risk, how participants consider confidentiality within the FGC process and how they are prepared for likely exposure warrants further examination.

Crucially, the practice of cultural competence in FGCs as identified by Barn and Das (2016) in respect of the delivery of FGCs in children's services was largely missing in many of the above reports and discussions of FGCs in adult

social care. A recent meta-synthesis by Nygård and Saus (2018) has suggested that care is needed in transferring the FGC model to other indigenous contexts that might have salient messages for FGCs within adult social care. Forsyth et al. (2013) (in Midlothian) have reflected on cultural dimensions of FGCs but have not drawn on data and as noted above, the immigration status of several participants in FGCs in Malmberg-Heimonen's (2011) study was mentioned. The potential challenges posed by racial and cultural diversity when working with black, Asian and minority ethnic families or migrants are relevant to adult social care. They highlight the importance of cultural knowledge when working with families and social networks and possible consideration of ethnic matching of FGC coordinator and family in contributing to positive outcomes. Overall, we can only conclude that ethnicity data gathering (and other data relevant to the Equalities Act 2010) is essential for future service planning, delivery and evaluations.

As with any research overview, this review has its limitations; we accessed English language material only, have included a range of material not just peer-reviewed articles, and we have concentrated on self-described FGCs, not the wider span of family meetings as included by Hillebregt et al. (2019), whose systematic review focussed on family group decision making. We have concentrated on research methods not implications for policy, practice or skills development.

CONCLUSION

The development of FGC interventions in adult social care is gathering interest if not momentum. A small group of large studies in mainland Europe is evaluating the initiative's progress and these raise the potential for further lines of enquiry in the UK. Policy and practice forums such as that in Camden (see Fisher et al. 2018) may be well placed to advance ideas for further research and service development. Social workers have been engaged in many of the above studies as participants and as colleagues in the research process. Far less is known about the role of other practitioners, such as nurses in England, or the role of other social care staff. The initiative as it stands continues to be described as offering promising opportunities for practice-based research and other developments and

creative practice in social work, and this would appear relevant to the wider social care sector. To move from 'promising' to 'proven' requires consideration and clarification of the concept being evaluated, its practice or service setting, and decisions about assessing and measuring processes, costs, comparisons, and outcomes.

This overview has discussed the many research methods that have been adopted in studies of adult FGCs. Largely absent is much detail of cost-effectiveness which, in adult social care, is often seen as important in making investment in services. Further, few studies have collected data about the medium- to long-term outcomes for the people concerned to consider if promising outcomes are sustained and individuals' wellbeing enhanced.

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