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Parkinson, Kate, Pollock, Sarah  and Edwards, Deanna (2018) Family Group Conferences: An Opportunity to Re-Frame Responses to the Abuse of Older Adults? The British Journal of Social Work, 48 (4). pp. 1109-1126. ISSN 0045-3102

DOI: <https://doi.org/10.1093/bjsw/bcy048>

Publisher: Oxford University Press (OUP)

Version: Accepted Version

Downloaded from: <https://e-space.mmu.ac.uk/621326/>

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Family Group Conferences: An Opportunity to Re-Frame Responses to the Abuse of Older People?

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Abstract

Recent legislative and policy changes in adult social care have refocused attention on 15 a strengths-based approach to social work practice. The Care Act 2014 advocates a more inclusive and holistic understanding of individual well-being, which is evident by its expectation of more personalised responses to safeguarding. Family Group Conferences (FGCs) fit well with this policy shift but require further exploration before being integrated into work with adults. A fictitious case study was analysed through 20 an organic group discussion, during which the authors applied their professional expertise to explore the appropriateness of FGCs to provide a response to adult-safeguarding cases. FGCs provide a viable alternative to traditional decision-making approaches in the adult-safeguarding field. The case analysis exposes three main areas that require further consideration to ensure effective implementation. The areas identified are divided into mental capacity, risk and funding. It is important that policy makers and local authorities acknowledge the complexity of transferring an approach originally designed for working with children and families to the context of social work with older adults. More effort should be made to address the practice tensions

Keywords: Family Group Conference, adult safeguarding, older adults, elder abuse, the Care Act

Accepted: April 2018

Introduction

Recent policy and legislative changes in the field of adult social care have ensured that practice is moving towards a strengths-based approach to service delivery. Indeed, the Care Act 2014 advocates for a more holistic approach to ensuring the well-being of adults and has created a framework for a personalised response to safeguarding ([Legislation.gov.uk, 2014](https://www.legislation.gov.uk/ukpga/2014/22/section/1)). This article will explore the use of Family Group Conferences (FGCs) in adult safeguarding, highlighting some of the potential practice tensions that arise from the application of the model in this area. This is of particular relevance to older adults, as recent NHS statistics indicate the subject of 90 per cent of Safeguarding Adult Reviews (SARs) are over the age of seventy-five ([NHS Digital, 2017](https://www.nhs.uk)).

Research into the use of FGCs in the field of adult safeguarding appears to be limited, although there are a number of services that offer FGCs in this area ([Marsh, 2007](#); [Tapper, 2010](#)). This article will take a case-study approach using a fictional case study, drawn from the authors' experience of FGCs and adult safeguarding to demonstrate the application of FGCs in this area. As this is an emerging field of practice and the research evidence is limited, the authors consider that the challenges of offering FGCs in adult social care have not been adequately addressed. Furthermore, it is important to consider that FGCs in the UK were originally introduced to plan for the care or protection of vulnerable children and, whilst FGCs have been implemented in adult services, little attention has been paid to the practice tensions resulting from

applying a model originally intended for children with adults. This paper 25 will address these challenges and offer practitioners the opportunity to consider the issues and better prepare themselves to utilise FGCs successfully.

The current context of adult safeguarding

The legal framework by which adults in England access social work has re- 30 cently been overhauled. The introduction of the Care Act 2014 repealed much existing community-care legislation and replaced this with new duties and powers for professionals. This includes a new assessment framework and national eligibility criteria underpinned by a principle of ‘well-being’ and a focus on person-centred outcomes and anti-oppressive practices. 35 Well-being under the Care Act 2014 is to be individually defined, but also recognises the benefits of including the whole family in holistic, strengths-based interventions to improve outcomes ([Legislation.gov.uk](http://legislation.gov.uk), 2014).

The act contributes to the existing policy focus on providing preventiva- tive support for both service users and carers ([Department of Health](http://www.dh.gov.uk), 40 2000, 2001). It includes duties for ‘local authorities to provide or arrange

for services, facilities or resources, or take other steps’ that would prevent, reduce or delay service user’s or carer’s needs from developing or progressing (Care Act 2014). This means that social workers can now commission support for individuals and their carers before they meet the eligibility criteria, if they can demonstrate that such support will prevent an increase in the individual’s needs.

For the first time in the history of adult social-care law, the Care Act 2014 empowers social workers with the duty to investigate safeguarding concerns. The procedures for safeguarding continue the legislative com-

mitment to well-being, with the guidance clarifying that ‘organisations should always promote the adult’s wellbeing’ (Care Act 2014, section 2). Within the Care Act 2014, safeguarding is promoted under the banner of ‘making safeguarding personal’—an anti-oppressive initiative that ensures that the individual is consulted throughout the process, and is

supported and empowered to make decisions about their own safety as far as possible ([Legislation.gov.uk](https://legislation.gov.uk), 2014). These new duties replace the No Secrets (2000, 2009) government guidance, which provided a code of practice for the protection of adults at risk of harm. Whilst this provided a framework for multi-agency working, it did not establish a duty for so-

cial workers to lead safeguarding investigations, which leads to delays in responding²⁰ to requests for investigation.

Safeguarding adults and the Care Act 2014

The Care Act 2014 establishes what constitutes abuse and neglect, including new categories of abuse: self-neglect, modern slavery and domestic violence, ensuring compliance with the expectations of the 2015 Serious Crime Act. Duties to provide advocacy, create Safeguarding Adults Boards, conduct SARs and co-operate with partners have also been introduced (sections 42–47).

Under section 42 of the act, local authorities have a duty to conduct safeguarding enquiries. Here, the criteria clarify that individuals are eligible for safeguarding support if they have care or support needs, are experiencing or are at risk of experiencing abuse or neglect and, importantly, that it is these care or support needs that prevent the individual from protecting themselves from the abuse or neglect. Local authority

procedures must comply with the six principles of safeguarding—empowerment, prevention, proportionality, protection, partnership and accountability—to provide a personalised and anti-oppressive approach. The Care Act 2014 guidance states that ‘professionals should work with the adult to establish what being safe means to them’ and ensure that

decisions are not routinely made without the agreement of the individual involved [Department of Health and Social Care \(updated 2018\)](#).

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There is opportunity to meet the six safeguarding principles and maintain an individualised, well-being-focused approach by utilising FGCs as a forum for developing safeguarding plans. The Making Safeguarding Personal initiative had already identified the suitability of FGCs in their 2012–13 pilot ([Local Government Association, 2013](#)), with both of the two test sites finding them empowering, person-centred, outcomes-focused and making a positive impact on practice and culture. Since this time, both published research and practice evidence have remained limited, with little scope to explore the potential conflicts arising from implementing FGCs for this purpose. The case study and discussion presented below aim to highlight some of these potential conflicts. In doing so, it is hoped that practitioners will be well equipped to support the implementation of FGCs.

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FGCs

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FGCs originated in New Zealand in the late 1980s and were introduced into the UK in the early 1990s. Currently, they are used by 76 per cent of local authorities ([FRG, unpublished data](#)). A FGC differs from other meetings in social care in the sense that it is a family-led, rather than a professionally led, planning meeting. Families are asked to develop a plan for the care or protection of a child or adult in their family and are supported by an independent co-ordinator to do so. The referrer (usually a social worker) clearly advises the family about the concerns that the plan must address, what resources are available to support the plan and what the ‘bottom line’ is. The ‘bottom line’ refers to specific decisions

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that the local authority will not agree to (e.g. people with whom a child cannot live or have contact). If a family are unable to agree a plan that addresses the concerns, in children’s services, statutory processes ‘take over’ and professionals make decisions about what is in the best interests of children. Potentially, this could lead to children becoming looked after by the local authority.

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The model is based upon the premise that families are the ‘experts’ on their own situations and, whilst they might need statutory intervention, there are strengths and resources in all families that can be capitalised on ([Frost et al., 2015](#); [Edwards and Parkinson \(eds.\) forthcoming](#)).

The definition of ‘family’ is a broad one and may include friends, neighbours and wider members of the community.⁵³⁵

FGCs in child safeguarding are well established and a wide body of evidence and research has started to emerge (Morris and Connolly, 2010). Outcomes from FGCs in this field are positive and have focused on their potential to divert children from the care system. Research suggests that FGCs lead to an increased number of children remaining in the care of their families or kinship network (Kemp, 2007; Connolly and

Smith, 2010; O’Brien and Alohen, 2015). Another significant area highlighted by the research has been the engagement of families and their satisfaction with the FGC process. Evidence suggests that families are more satisfied with FGCs than traditional local authority processes and are more likely to engage with professionals as a result (Holland et al., 2005; Walker, 2005; Brady and Miller, 2009). Indeed, the research

suggests that relationships between families and professionals and amongst professionals themselves improve as a result of the FGC process (Walker, 2005). Critics of FGC research have focused on the small-

scale nature of the research studies and the lack of comparative research (Crampton, 2007; Fox, 2007; Frost et al., 2014). Whilst this may be the case and some argue that more research is needed on the efficacy of FGCs (Crampton, 2007; Fox, 2007; Morris and Connolly, 2010), the messages from the existing research consistently highlight the potential of

FGCs to reduce the need for local authority care and enabling children to remain in the care of their families. The authors assert that this principle could be applied to adults. Indeed, early research from the use of FGCs with adults has demonstrated the capacity of FGCs to divert older adults from local authority care (Marsh, 2007; Tapper, 2010).¹⁵

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The current practice context and evidence base for adult FGCs

FGCs in adult services have now been established in a number of local authorities across the UK and a practice network has recently been established for individuals and organisations who run or are considering

running such a service (Fisher et al., 2018). Services are established in mental health, learning disability, vulnerable adults, dementia and care for older people (Tapper, 2010). Focusing on dementia, Gorska et al. (2016) concluded that, at present, the research evidence for the use of FGCs in adult care is scarce and there is a need for larger-scale evalua-

tions to assess efficacy. Hobbs and Alonzi (2013) add that there are no studies into the cost-effectiveness of such services and a need for the establishment of more pilot projects. Fisher et al. (2018), on the other hand, make the assertion that FGCs have the potential to make cost savings in adult social care. They cite Marsh's (2007) evaluation of adult

FGCs in Kent, which found that each FGC held reduced the spend on adult social care by £7,000. Furthermore, studies by SCIE (2013a,b) on the Greenwich and Central Bedfordshire service found that FGCs diverted people away from costly residential care or complex care packages, ensuring weekly cost savings of between £100 and £1,000.

A number of smaller-scale evaluations have emerged focusing upon practice in the Netherlands and Norway as well as the UK. Metze et al. (2015) have found that practice in the Netherlands has met with

significant resistance from service users in older people's care for a variety of reasons, which have included a reluctance to ask for help and a fear of losing autonomy. Schout et al. (2017), also in the Netherlands, caution that, whilst often successful in reducing coercion in adult psychiatry, the FGC is not always appropriate in adult care, particularly when the severity of mental health conditions means that clients have difficulty with communication and decision making. Gorska et al. (2016), studying a pilot dementia-care FGC service in Scotland, agree that, whilst the FGC was perceived positively by all involved, there are diffi-

culties with using the approach with those with impaired cognitive ability. Unsurprisingly, these include informed consent and the ability to engage in decision making—issues also recognised by Daybreak (2010, 2012). However, de Jong et al. (2014) argue that, in situations where capacity is reduced or impaired, FGCs may remain useful without the cli-

ent present, provided their interests are represented. Hobbs and Alonzi (2013) emphasise the importance of advocacy in such situations and the ability of FGC co-ordinators to recognise and understand issues of capacity and communication.

Where adult FGC services have been evaluated, there is evidence that

they are well received by service users. Johansen (2014) found that the use of a FGC with long-term social assistance recipients in Norway may have been instrumental in strengthening their sense of community and self-worth. Malmberg-Heimonen (2011), also in Norway, found potential benefits in terms of mobilising social networks, increases in life satisfac-

tion and decreases in depression and anxiety. In the UK, several adult FGC pilot services have been evaluated (Marsh, 2007; Daybreak, 2010; Gorska et al., 2016), with promising results in terms of service-user satisfaction. What remains to be seen is a robust longer-term and larger-scale evaluation of such services.

Method

A fictitious case study was developed using a collective case-study method (Berg, 2009). This involves using several case studies to enable an in-depth analysis of a concept or idea (Crowe et al., 2011). The authors adapted this approach by generating one case study to include

all the elements required for analysis. The cases were generated from several real-life scenarios and, although generated in this way, the specific combination of challenges and identifying characteristics present in the scenario ensured that no individual can be identified. All the authors are registered social workers in England, two authors have expertise in

the area of FGCs with children and families, and one author has expertise in adult safeguarding. The method is appropriate to the current

study as it has enabled the consideration of many complex factors simultaneously.

To date, FGC services for adults have tended to replicate the model used with children and families, so the authors use this model as a comparator to facilitate the identification of practice tensions. The case study was treated as a ‘real-life’ case, with the authors following the direction that the case would take in practice if a FGC service was available. When conflict between the FGC process and adult social work legislation and policy arose, this was documented for discussion. The

points were then collated and explored in a discussion forum, which enabled the⁵
organic development of the three main themes.¹⁰

As with all qualitative work, case studies and organic analysis methods can be challenged for lack of objectivity and generalisability (see Robson, 2011 for a more detailed analysis); however, to explore a ‘phenomenon in context’ (Robson, 2011, p. 136) such as FGCs in practice, a flexible¹⁵ approach is required.

Case study

This case study focuses on John, aged seventy-six, and was created by the authors based upon their practice experience. The case study emphasises the practice tensions that could result in applying the FGC model, originally²⁰ developed for use with children and their families, to an adult context.

John’s current involvement with services began via a referral to the contact centre from his son, Graham. Graham lives in Spain but has re-

cently returned to England briefly to visit his father. On arrival at his father’s²⁵ property, he became concerned about several issues and called the adult contact team for advice.

John lives on the eighth floor of a high-rise block of flats on the outskirts of a northern town. He has lived here since selling the family³⁰ property when his wife died six years ago. John struggled with the transition, alongside the passing of his wife and Graham’s move to Spain, and he has been drinking alcohol excessively since this time.

The following information was ascertained from Graham by the social worker taking the referral. Graham has two main concerns. The first is³⁵ his father’s dependence on alcohol, which he believes has contributed to the development of memory problems, along with exacerbating John’s arthritis, making his mobility painful and laboured. The most notable concern relating to memory is John’s inability to account for the substantial profits from the sale of his home.

The second of Graham’s concerns is John’s relationship with his neighbours,⁴⁰ Holly and Jordan, a couple in their early twenties who moved into the only other flat on the eighth floor approximately eighteen months

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ago. Holly and Jordan spend a lot of their time in John’s flat, as neither of them is in work and he has an X Box and Sky TV. Graham believes they are also sleeping there, as the second bedroom of John’s flat appears to be lived in. John and the couple deny this.

Graham’s biggest concern regarding the couple is that, as his father’s mobility has deteriorated, Holly has taken on the role of an informal carer. One of the tasks she completes is the food shopping, when she has also been buying alcohol for John. Since Holly has been purchasing the alcohol, Graham believes his father’s consumption has increased, in terms of both the quantity and the strength of the alcohol he is drinking. As John’s mobility is poor, he has given Holly and Jordan details of his bank accounts along with his bank card and pin number, so that they can access his funds to manage his bills and pay for food.

Over the last six years, John has lost contact with all his friends and rarely has visitors aside from Holly, Jordan and the warden from the flat block, who visits weekly and has a good relationship with John. Graham states that she has similar concerns to his and has informed him that Jordan has a criminal record for assault.

The social worker rings John, who says he is happy to accept any support available, recognising that he would benefit from more help, but is adamant²⁰ that Holly and Jordan be involved in this process.

The FGC in practice

The model of FGCs in children’s social care is well established and it is universally acknowledged that a FGC in children’s services will be a process with four key stages:

1. The Preparation Stage. An independent co-ordinator is allocated, whose role is to support a family in planning their FGC, including whom to invite, the date, time and venue of the FGC, and ensuring that all family members understand their role at the FGC and the purpose. Children and vulnerable adults may be allocated an advocate to support them in representing their views.
2. The Information Giving Stage. This is the first stage of the meeting. The referring social worker presents a brief, jargon-free report outlining the strengths in the family, the issues that need to be addressed, the resources available to support a family with their plan and the ‘bottom line’. For example, where children are at

risk, this could include the people in a family that a child cannot live with or³⁵ have unsupervised contact with.

3. Private Family Time. The family then have time without the professionals being present to develop their family plan. The independent co-ordinator is available to support the family with this process.

4. Agreeing the Plan. If a plan addresses all the identified issues, it is safe and legal, the local authority has the responsibility to agree a plan. If a family do not agree a safe plan, the decision making is taken out of their hands and professionals will make decisions about what is in the best interests of children.

A family's plan can be reviewed at review FGCs to ensure that it is being implemented effectively and to make any necessary changes. ⁵

Results

In considering the steps above, it is evident that the case study raises several issues for adult social workers, highlighting where policy and practice in adult and children's services diverge. The practice tensions were divided into three main categories: mental capacity, risk and funding following an organic discussion between the authors. ¹⁰

Mental capacity

Under the 2005 Mental Capacity Act (MCA), an adult must be presumed to have capacity, with any decision relating to an individual's decision-making ability only able to be made following a decisionspecific assessment, adhering to the five principles of the MCA. The five principles are (i) people must be assumed to have capacity, (ii) must be given all practicable help to demonstrate their capacity and (iii) be free to make unwise decisions. If an individual is deemed not to have capacity relating to a specific decision, decisions must be (iv) made in their best interest and (v) the least restrictive intervention available (Department for Constitutional Affairs, 2013). ¹⁵

In relation to the case study, Graham has identified that John has memory problems that he believes are exacerbated by alcohol consumption. We must, however, presume John has capacity and he has expressed a clear desire for his friends to be involved in his support. If the local authority were to utilise a FGC to develop a safeguarding plan, this would mean that these friends must be invited. This creates a practice dilemma in adult services that would not exist in the same way for children and families' workers. ²⁵

The 1989 Children Act states that social workers must take the wishes and feelings of a child into consideration, but do not have to enact them. Therefore, if a child wished for an individual considered to be high-risk ³⁰

be involved in their FGC, the social worker would have the power to deny this request, as it would not be in their best interests. High-risk individuals could include parents who have abused their children and, in domestic-abuse cases, the perpetrator of the violence. Under the 2005 MCA, 35

if an individual has capacity to decide whom to invite, they are entitled to make their own decisions, leaving the social worker with little option but to invite John's friends ([Legislation.gov.uk](http://legislation.gov.uk), 2005). Their attendance would be problematic, as John would then be open to coercion because he is dependent on their support and friendship. This could then lead to the creation of an unsuitable plan, and failure to adequately address the safeguarding concerns. Alternatively, the social worker could refuse the request, due to the high-risk nature of the concerns. The authors refer to high-risk concerns for those cases which ADASS (Association of Directors of Social Services) would describe as Priority One or Two cases, 10

namely those cases where potential abuse has occurred (in this case, financial abuse from John's friends) and where there is a risk to health (in this case from alcohol consumption, being bought for him by his friends) (ADASS, 2005). This, however, contradicts the very nature of FGCs, which attribute their success to being empowering and service-user-led. 15

The two situations outlined above mean that either the concerns are not addressed or the process becomes disempowering and oppressive. The lack of power to enforce a 'bottom line' in safeguarding adults creates a practice tension not present in working with children and families. Returning to the scenario, John has agreed to a FGC to address the 20

issues his son has raised; this consent is key to the process, as a conference could not go ahead without consent. Given his concerns, Graham may be reluctant to see Holly and Jordan at the meeting. However, it looks unlikely that John would be willing to be involved in a meeting

without them there. Since they are clearly involved in his life, it would seem imperative that they play a role in the FGC. Their involvement may serve to allay some of Graham's fears or may offer the family some opportunity to limit their influence.

Although John has capacity, he does appear to have some memory problems that may impact on his ability to function well in the meeting. Therefore, consideration of advocacy support is essential. Under the Care Act 2014, the social worker would be able to access suitable professional advocacy support to help John to present his views at the meeting if he is deemed to have 'substantial difficulty' in participating without this support. It would not be suitable to suggest a family/friend act as an advocate to support John, since he may well suggest Holly or Jordan. Not only would this be likely to antagonise Graham, but both Holly and Jordan may well have their own agenda to pursue, which would lead to a bias when representing John.

Risk

The Care Act 2014 ensures that individuals are included in safeguarding concerns about themselves from the initial contact to the outcomes of the enquiry and planning processes, unless this would 'increase the risk of harm to them or others'. This means that the adult has a role in identifying what being safe means to them, which areas they would like support with and what level of risk they are prepared to accept in their lives.

In children's FGCs, the professionals develop clear questions for the family to address and create responses to in their plan. In a similar situa-

tion for an adult at risk, the adult would be involved in creating the questions to answer, being required to approve these at each stage. This could result in failing to address more serious issues if the adult was not prepared to include them in the plan. For John, the presenting risks that 10 the FGC would need to address are potential financial abuse, memory problems, alcohol consumption and limited mobility.

This approach can be viewed from two perspectives, primarily as empowering and anti-oppressive, as the service user has full control over what is discussed at the conference, moving away from tokenistic in- 15 volvement to a more inclusive process. The alternate perspective is that the professionals are colluding with the adult by not protecting them from harm or insisting that the abusive behaviour be challenged.

Given that John has difficulties with alcohol, financial concerns and mobility limitations, the co-ordinator may ask him whether he would like in- 20 formation or support with any of these at the meeting. For example, John may well wish to address his drinking and the co-ordinator can ask whether he would like to invite a representative from the community alcohol team who can outline what support might be available. Similarly, he might wish to invite someone who can support him with financial difficulties.

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Children and families' social workers are clear with the conference group about the 'bottom line'; often this can be that the child/ren could be removed into the care system. This understandably provides an incentive for the adult-care providers to engage with the FGC process. In adult FGCs, there is not a comparable incentive, as an adult with capac- 30 ity could refuse the option of residential care and, quite often, the professionals would be keen to avoid this alternative also (DEMOS, 2014).

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A decision could be made by professionals that a FGC is not a suitable way to manage the safeguarding concerns, although this would mean that these services must run alongside more traditional safeguarding planning mechanisms, to ensure the safety of all individuals. For the FGC to be an empowering process, the adult should be involved in the decision about how to manage their protection from harm. This means that, if there was a choice between a FGC and a traditional route, the adult should be involved in making the decision.

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Allocation of funding

Previous evidence advocating the use of FGCs in children's and adult services (LGA, 2013) has attributed their usefulness to their improved outcomes and value for money. Mason et al.'s (2017) evaluation of the Leeds FGC service found that the average cost of an FGC is £2,418 per family. This is significantly less than the cost of residential care, which in many authorities is routinely over £500 per week. These efficiencies are based on the premise that residential care is the default alternative to a FGC. This may be the case in children's services; however, for adults, this assumption fails to acknowledge the element of choice and existence of strict criteria for care-home funding.

The MCA ensures that an adult who has the capacity to make decisions about their future is entitled to make an unwise decision relating to their living arrangements. This means they may choose not to reside in a care home. The Care Act 2014 supports this empowering legal

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provision by ensuring that the adult must agree to each stage of the safeguarding process before actions can be taken. The Care Act 2014 also restates the recent cultural shift away from the use of residential 15 care in its guidance, which advises that this should be a last resort. This is a sentiment echoed in the MCA principle of ‘least restrictive method’, which means that, even if an individual lacked the capacity to agree to a safeguarding plan, residential care would not become a default option.

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The above factors make it unlikely that the efficiency savings FGCs afforded in children’s services would be replicated for adults. It is important to acknowledge here that research indicating the financial benefits of using FGCs in adult services is based on limited evidence from small-scale pilots, with no longitudinal data to evidence these 25 claims.

The financial cost of FGCs is greater than the individual price per conference. In children’s services, funding is allocated as part of existing safeguarding budgets and they are increasingly recommended by the courts (FRG, 2011). This does not protect them from the government- 30 led austerity measures; as they are not part of statutory safeguarding measures, many FGC services have seen a reduction in funding (FRG, 2012). Austerity has reduced available funding for adult social care (Glasby, 2017). Despite the Care Act 2014’s focus on prevention, the budget for providing such support is in many cases spread thinly be- 35 tween existing preventative initiatives. The likelihood of finding additional funding in adult social care for services that are being cut in children’s services appears slim. As the FGC approach would not be

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suitable for every case, local authorities would have to fund these alongside traditional approaches, meaning an increased expenditure. Local authorities would also have to consider the cost of training co-ordinators. FGC facilitators must undergo specialist training to equip them with appropriate skills (Marsh, 2007). If local authorities were to extend these conferences to adult services, they would need either more co-ordinators or an increase in hours for existing co-ordinators.

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Case analysis identified three main practice tensions for John: mental capacity, risk and allocation of funding. The discussion below locates these tensions in the broader context of adult social care.

Discussion

There are a growing number of authorities opting to use FGCs as part of their adult-safeguarding processes and these have been recently advocated by the Principle Social Worker for Adults, Lyn Romeo (Romeo, 2016). The underpinning philosophy fits well with the trend for individualised support, enshrined in the Care Act 2014. If this approach is to be adopted as the default mechanism for safeguarding planning, key issues and practice tensions require further consideration and guidance. Primarily, a consensus needs to be reached about which circumstances and at which stage of the safeguarding process FGCs should be offered. There are occasions when this may not be appropriate, such as when an individual with capacity wishes to invite high-risk individuals or does not acknowledge the key risks. The dilemma here relates to the power local authorities hold; not offering a conference in the circumstances above

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can be seen as disempowering, but to hold a conference that does not address the issues that triggered the concerns could be considered either collusion or tokenistic. Furthermore, in such circumstances, other services would also be required, adding an additional layer of time and resources. In a period of austerity, this is a route that authorities would be unlikely to take.

Local authorities have seen budget cuts since 2008 and, with the election of a Conservative government, resources for adult services have seen a significant reduction ([The Health Foundation, 2017](#)). Against this backdrop, it is fundamental to recognise the cost implications of FGCs. It is an over-simplification to suggest that FGCs are a cheaper alternative to existing processes, or that they will save local authorities money through reducing the need for residential-care placements. To be implemented effectively, FGCs would require substantial initial outlays in terms of recruitment and training. They would also be required to run alongside traditional processes, adding additional costs. As this article demonstrates, adults with capacity to decide on their living arrangements have the right to choose to remain in their own homes. Thus, potential cost savings for adult FGCs cannot be compared to savings seen in children's services.

The introduction of a clear practice framework would help to address these issues. The Family Rights Group have developed a set of practice standards for the implementation of FGCs (2012). These standards are broad and refer to FGCs in general terms and were developed with FGCs with children and families in mind. They do not address the issues particular to safeguarding adults. Clear guidance for local authorities

specifying at what point FGCs would be most appropriate and how to address potential practice issues and dilemmas may persuade local authorities on their benefits and encourage their implementation. The existing, well-established adult FGC services would be a vital source of information and their experiences of delivering FGCs to address adult-safeguarding concerns should inform any practice guidance developed. Financial implications may dissuade local authorities from investing in FGC services so the evaluations from existing services and the early research available about the benefits of FGCs in adult safeguarding could support local authorities in deciding to invest in a service. Ultimately, national support for FGCs and their recommendation as good practice are necessary to create a ‘mandate’ for FGCs and to ensure that they become an embedded part of the adult-safeguarding process.

The Care Act 2014 has introduced national eligibility criteria for care and support and clear legal guidance on safeguarding adults. This is the first time that there has been a coherent, national approach and the authors believe that timely FGC guidance would support the continuation of this approach to working with adults. The lack of national practice guidance for adult FGCs means there is a risk of different services creating their own standards and processes, hence negating the idea of nationally recognised policies and practices.

The authors consider that standards and practice guidance focusing specifically on adult FGCs alongside a policy ‘mandate’ would encour-

age local authorities to establish FGC services that address the specific 25 needs of adult-safeguarding contexts.

Research identifies that older adults can be more likely to favour traditional forms of intervention over new, more personalised support (O'Rourke, 2015) and are less likely to be satisfied when using newer initiatives such as personal budgets. Their reluctance to engage with a 30 new support mechanism may create challenges for the success of FGCs for this age group, although the opportunities for empowering and restorative practice are such that these challenges need overcoming.

Tapper's (2010) evaluation of the Daybreak adult FGC service demonstrates that, when older adults do engage with FGCs, the results are positive, with families feeling 'respected, valued and listened to' (Tapper, 2010, p. 30).

Conclusion

The principles of the Care Act 2014 are clearly aligned with the fundamental values of the FGC model, particularly those of empowerment, 40 strengths-based practice and the importance of family support. However, there is a need for policy makers and practitioners to take a pragmatic approach when considering how FGCs fit within the field of adult safeguarding. The small body of research that exists highlights the potential of FGCs to plan for the safety of adults at risk of harm—an issue disproportionately affecting older adults (NHS Digital, 2017). Evaluations from those services that deliver FGCs in this field emphasise positive 5 outcomes for service users involved. However, this research has not focused on the practice tensions and dilemmas that arise when FGCs are implemented in adult safeguarding, thus stifling discussion about best

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practice and where FGCs can be appropriately situated within adult-safeguarding processes.

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Whilst the authors advocate the use of FGCs to plan for adults at risk of harm, they recognise the potential resource implications for local authorities and that FGCs may not be appropriate in all cases. It is hoped that, despite the limitations of the method (Robson, 2011), this article will prompt a conversation with policy makers and practitioners to consider the possible practice issues, tensions and dilemmas and ensure that FGC services reflect these. This in turn should ensure that services are more robust and in a better position to develop a strong evidence base for the use of FGCs in this area. In the current practice context and economic climate, having a clear evidence base for the efficacy of FGCs is crucial to ensure that the model becomes an established part of the safeguarding process. The authors consider that FGCs should be a fundamental part of the safeguarding process and that a pragmatic approach is now necessary to create a model that recognises the particular practice tensions and dilemmas discussed. This is key to the successful implementation of FGCs and to ensuring that the individual and their families remain at the centre of decision-making processes.

Conflict of interest statement. None declared.

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