Family Group Conference: a Scoping Study of Self-Referral Processes


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FAMILY GROUP CONFERENCE: A SCOPING STUDY OF SELF-REFERRAL PROCESSES

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March 2019
Introduction

As a family-led decision making model, Family Group Conferences (FGC) have become embedded in many areas of social care provision in the UK, but particularly in the fields of child protection and planning for children at risk of entering state care. This model of participatory decision-making aligns with UK legislative principles of partnership working and supporting the care of children within their families. A key feature of FGC is acknowledgement of the wishes, expertise and strengths of the family. While a social worker will attend the FGC and approve the plan, the meeting is facilitated by an independent co-ordinator, the family have private discussion time, and the family decide the plan in consultation with social workers, rather than social workers deciding on a plan in consultation with families (Edwards, 2018) Therefore in both purpose and process, Family Group Conferences have the potential to promote the right to respect for private and family life (Article 8 of the Human Rights Act 1998). However, while the FGC is intended to be family-led, at present it is rare for it to be family-initiated. Most FGC referrals are made by social care professionals and few services accept referrals directly from families.

Empowerment principles, promoting more equal power relations and a shift away from paternalism, underpin the FGC approach. However, it is possible that this might be more fully realised if parents, young people or other family members had the choice to initiate the process. The authors were commissioned by Family Group Conference NI to undertake an audit of FGC referral processes with the aim of identifying best practice for operating a self-referral model. The elements of this project were:

1. Audit of referral information published on the internet by FCG providers in the UK.
2. Online survey sent to 80 FGC providers in the UK, and responded to by 29 providers.
3. Consultation with statutory sector FGC providers in Northern Ireland to inform interview topics and analysis.
4. Telephone interviews with 15 FGC providers who operate a self-referral process, now or previously or have/would consider implementing self-referral.

Section 1: Aims and Methods

The aims of this project were to:

- Identify best practice in self-referral models for accessing Family Group Conferencing (FGC) also known as family group decision making or family group meetings;
- Identify barriers and enablers to implementing such a model;
- Identify potential UK partners to help develop a self-referral project with Family Group Conference NI.
- Produce a report with identified next steps that may be used by FGC NI as the basis for funding applications to establish a self-referral model of family group conferencing in Northern Ireland and other UK regions.
The study was commissioned by Family Group Conference NI and undertaken by Dr Mandi MacDonald, Lecturer in Social Work, and Dr Davy Hayes, Senior Lecturer in Social Work. Ethical approval for the study was granted by the School Ethics Committee in the School of Social Sciences, Education and Social Work, Queens University Belfast.

Three of the FGC projects currently operating in Northern Ireland are operated by statutory sector providers i.e. Health and Social Care Trusts. Due to the integrated nature of health and social care in Northern Ireland, a three-stage process of approval would be required in order to include staff from an HSC Trust in this scoping study: approval from the executive directors of social work; approval from the National Health Service ethics committee (Office of Research Ethics Committees, Northern Ireland); and governance approval from each HSC Trust involved. This is a lengthy process and there was not scope within the timeframe of this project to obtain these approvals. Staff from the three statutory projects in NI were not, therefore, invited to participate in either the online survey or the telephone interviews. However, we did consult with managers in these services by phone and email to help us identify appropriate topics and questions for the telephone interviews and to inform the thematic analysis of the data.

Internet audit of Family Group Conference webpages

We conducted internet searches for Family Group Conference, Family Group Decision Making, Family Meeting services across the UK. The aim of this internet search of publicly available information was to:

- identify providers of FGC services across the UK and obtain contact details
- identify existing referral processes
- map the range of referral models in place for accessing FGC services across the UK
- identify models of good practice for advertising the option of self-referral.

We searched information publicly available via the internet and identified 95 family group conference, family group meeting or family group decision making service providers across the UK. Some of these operated several projects in different locations under one umbrella organisation. From this exercise we charted: service name; provider organisation; designated contact person or service manager; contact email. If email addresses were not provided on webpages, we phoned the service provider and ask for an email address. This allowed us to send invitations to participate in the online survey.

We identified six services whose websites clearly indicated that families could contact directly to request a conference or obtain further information. Their details are summarised in Table 1. Following the online survey, in which 11 respondents indicated that they do accept self-referrals, we reviewed the websites of all these providers. However, bar the 6 already identified in Table 1, we were unable to find any information about self-referral on the webpages for the remaining 5 services.
Table 1: FCG Self-Referral Information Available via Internet Search

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Website</th>
<th>Referral information for families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torbay Social Services</td>
<td><a href="http://www.torbay.gov.uk/children-and-families/services-and-support/fgc/">http://www.torbay.gov.uk/children-and-families/services-and-support/fgc/</a></td>
<td>Families can request a FGC themselves by contacting us or they can be referred by their social worker or anyone involved with them.</td>
</tr>
<tr>
<td>Your Family Matters</td>
<td><a href="http://yourfamilymatters.org.uk/">http://yourfamilymatters.org.uk/</a></td>
<td>You can ask your social workers, solicitor or any other organisations that you are working with or you can contact us directly.</td>
</tr>
<tr>
<td>Preferred Futures</td>
<td><a href="http://preferredfuturesfs.co.uk/">http://preferredfuturesfs.co.uk/</a></td>
<td>Dedicated section on website for families with extensive information</td>
</tr>
<tr>
<td>Flintshire Family Group Meetings</td>
<td>n/a</td>
<td>Telephone number and leaflet for families</td>
</tr>
<tr>
<td>Joint Decisions</td>
<td><a href="http://www.jointdecisions.co.uk/">http://www.jointdecisions.co.uk/</a></td>
<td>Telephone call to manager</td>
</tr>
<tr>
<td>Family Group Decision Making Edinburgh</td>
<td><a href="http://www.edinburgh.gov.uk/info/20100/support_for_families/217/family_meetings">http://www.edinburgh.gov.uk/info/20100/support_for_families/217/family_meetings</a></td>
<td>Please contact us to discuss how a family meeting could help you. Telephone number and email given.</td>
</tr>
</tbody>
</table>

Online survey of Family Group Conference providers

We established an online survey hosted by Survey Monkey and invited participation from all those FGC providers identified through the internet search for whom we could obtain valid email addresses (80 individuals). The aims of this activity were to:

  o Identify how providers categorise their referral process.
  o Determine the extent of self-referral provision.
  o Ask those who operate self-referral about their experiences of this model
  o Ask those who do not operate self-referral about their perceptions and views.
  o Invite service providers to participate in a telephone interview and obtain contact telephone numbers.

The survey was distributed to 80 recipients, via an invitation email containing a link to the questionnaire, on 30th November 2018. Invitation emails gave detailed information making it clear who was conducting the study, how we were funded, the aims of the project, how data would be handled, how we planned to analyse the data, how we planned to use and publish the findings. As noted above, because of complexities of securing NHS ethical approval, we were unable to send survey invitations to providers from the HSC Trusts in Northern Ireland.

Participants indicated consent prior to starting the survey.

The survey was brief to minimise the time and effort required to complete it, and participants could choose how much or little information they wish to provide in response to open-ended questions.
The survey remained open for an 11-week period until 15th February 2019 and reminder emails were forwarded in December 2018 and January 2019. Responses to the questionnaire were received from 29 services (response rate = 36.3%) with 24 of these being complete responses and 5 being partial responses.

Telephone Interviews

Respondents from more than half (n=17) of the FGC services who responded to the survey indicated that they were willing to be contacted by telephone for a short follow-up interview as follows:

- 10 services that currently accept ‘self-referrals’. These comprise 4 statutory sector organisations (2 based in England, 1 in Scotland, and 1 in Wales), 5 voluntary/community sector organisations (1 in England, 2 in Scotland, 1 in Wales, and 1 in Northern Ireland), and 1 private sector organisation operating in England.
- 1 service that accepted self-referrals in the past but no longer does so. This is a voluntary/community sector organisation based in England.
- 2 services that have previously considered accepting self-referrals but decided against this. Both of these are statutory sector organisations providing services in England.
- 2 services that state they are open to considering self-referrals. These services are both based in England with 1 being a statutory sector organisation and the other a voluntary/community sector organisation.
- 2 services which do not currently accept self-referrals, have not in the past, have not considered it and state that they are not open to considering it. Both of these are statutory sector organisations in England.

We were unable to make contact with, or arrange a suitable time with three of these and in the end interviewed 15 individuals (one of these was a joint interview with two individuals).

Prior to each interview participants were reminded of the aims of the project and how their data would be handled and used. They were asked whether they consented to:

- taking part in the interview
- having the interview recorded on a digital voice recorder
- speaking directly with Family Group Conference NI
- having their contact details passed on to Family Group Conference NI
- giving Family Group Conference NI a summary of their data

We followed the same schedule of interview questions, followed by the same set of prompts if needed, for semi-structured interview with each participant. These questions were developed from analysis of the survey responses and through telephone consultation with FCG project managers in the HSC Trusts in Northern Ireland.

1. Do you think self-referral is a good idea? If so, why?
   a. How does it fit with early intervention?
b. How might it fit with the services you provide/work with?

2. Could you please tell us your views and experiences about the benefits of a self-referral model?
   a. Empowerment?
   b. Family engagement?

3. Could you please tell us your views and experiences about the challenges of a self-referral model?
   a. Motivation?
   b. Family dynamics?
   c. Resourcing?
   d. Referral process?

4. Operating a self-referral model: What works well? What works not so well? How do families know about the service and how to access it?

5. What advice would you give to Family Group Conference NI as they try to establish a self-referral model?
   a. Funding?
   b. Advertising?
   c. Referral process?

Interviews were audio recorded and transcribed. The transcripts were input to Maxqda data analysis software to facilitate a thematic content analysis of the discussions. These themes, with selected illustrative quotations, are summarised in the next section. The number of participants who raised each broad theme is given in brackets.

Section 2: Summary of Survey Responses

Characteristics of FGC Services

As outlined in Table 2, the majority of responses were received from FGC services provided by statutory sector organisations (n=19) and from services operating in England (n=21). Voluntary/community sector organisations accounted for 8 responses (3 from England, 2 from Scotland, 1 from Wales, and 2 from Northern Ireland) and 2 responses were received from private sector organisations, both located in England.

<table>
<thead>
<tr>
<th>Sector</th>
<th>England</th>
<th>Scotland</th>
<th>Wales</th>
<th>N. Ireland</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory</td>
<td>16</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>19</td>
</tr>
<tr>
<td>Voluntary/Community</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Private</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>21</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 2: FGC Services by Sector and Country
The service user groups that FGC services reported they catered for are outlined in Figure 1. Of the 29 respondents, 25 services offered FGCs within children’s services (17 statutory sector organisations, 6 voluntary/community sector organisations, and both of the private sector organisations). FGCs were provided in adult services by only 3 of the services (1 statutory sector organisation and 2 voluntary/community sector organisations) with 2 of these stating that they also provided FGCs in children’s services and 1 catering exclusively for adults. This question was not answered by 1 of the FGC services.

The approximate number of referrals that respondents reported their service had received in the past 12 months is summarised in Table 3. As illustrated, voluntary/community sector organisations and private sector organisations generally reported receiving a lower number of referrals with statutory organisations being more likely to report receiving 150 referrals or more. The exception to this was 1 voluntary/community sector organisation that reported receiving the largest number of referrals in the past 12 months (n=900). This organisation, it should be noted, offers FGC services across a range of sites in England. In relation to the approximate number of referrals FGC services reported that they had received in the past 12 months, the range was 1-900 with a mean of 208.11 and a median of 130.

![Figure 1: Service User Groups Catered for by FGC Services](image)

*Other service user groups mentioned by respondents included school attendance issues (1), domestic violence (1), edge of care (1), and early help/intervention (4)
Table 3: Approximate Number of Referrals Received by Sector

Data missing for 1 statutory sector organisation

As displayed in Figure 2, respondents reported that they accepted referrals from a range of individuals. Referrals were most frequently reported to be from professionals, predominantly social workers \( (n=27) \) although some services indicated that they also accepted referrals from service users and/or family members. Referrals from parents were stated to be accepted by 9 services, from a child or young person by 7 services, from a family member by 6 services, and from an adult service user by 7 services. The most common response in relation to who were the most frequent referrers was social workers \( (n=25) \) although a number of other individuals and agencies were also mentioned, each in 1 instance (social care, early intervention, education, family support, ‘professionals’, courts, family support hubs, ‘families’, and parents).

![Figure 2: Who FGC Services Accept Referrals From](chart.png)

*Other accepted referrers respondents mentioned included early help workers (4), team around the family workers (1), family support workers (1), family support hubs (1), courts (1), and ‘other’ professionals (1)
Self-Referral to FGC Services

Figure 3 presents the survey findings in relation to self-referral (i.e. whether or not an individual service user/family member can refer themselves/their family directly to the service without having to go through a professional). As indicated, over one-third of respondents stated that they currently accepted ‘self-referrals’ and these comprised of 5 statutory sector organisations (2 in England, 2 in Scotland, and 1 in Wales), 5 voluntary/community sector organisations (1 in England, 2 in Scotland, 1 in Wales, and 1 in Northern Ireland), and 1 private sector organisation based in England.

The approximate number of ‘self-referrals’ that respondents reported their service had received in the past 12 months ranged from 0-65 with a mean of 9.3 and a median of 2. This question was not answered by 1 of the FGC services. All but one of these services reported receiving 10 or fewer ‘self-referrals’ in the past 12 months with 3 reporting that they had received none, 1 reporting that they had received 1 ‘self-referral’, 2 stating they had received 2, 1 having received 5, 1 having received 8, and 1 stating they had received 10. Exceptionally, 1 statutory sector organisation reported that they had received 65 ‘self-referrals’ representing 28.3% of all the referrals they had received in the past 12 months.

Figure 3: Survey Responses in Relation to ‘Self-Referral’
Respondents who stated that they currently accepted ‘self-referrals’ indicated that there were a number of benefits associated with this. These benefits were all framed in relation to the service user/family in terms of their motivation, engagement and ownership of the issues and the plan to address them and reducing the need for statutory intervention:

“Family are more engaged.”
(Statutory sector organisation – England).

“High level of motivation, greater ownership of the process and plan.”
(Voluntary/Community sector organisation – Scotland).

“The family want the service. Gives more self-confidence and ownership.”
(Statutory sector organisation – Wales).

“More direct, reduces need for family court involvement, empowers family.”
(Voluntary/Community sector organisation – England).

A number of challenges were also referred to by respondents. Voluntary/Community and Private sector organisations stated that funding was an issue as they had to absorb the costs of providing ‘self-referred’ FGCs if they were not contracted specifically to provide these and if families were unable to pay for the service:

“Funding for the work – are the referrals within the criteria we are funded to work with...Service’s capacity to carry out an FGDM if not funded to do so...Can families afford to self-fund the FGDM process and what pressure would this place on the family. Can [service] find the resources to fund this work.”
(Voluntary/Community sector organisation – Scotland).

“Costs (when funding unavailable).”
(Voluntary/Community sector organisation – England).

“My answer...assumes that the ‘self-referrer is able to self-fund. Although this service [‘self-referral’] is offered, funding is an issue. The major issue is that of funding.”
(Private sector organisation – England).

Other challenges identified by respondents related to the lack of professional involvement in ‘self-referral’ FGCs, including consequent difficulties in relation to clarity of purpose in convening the FGC and in supporting service users/families to implement the plan:

“Sometimes lack direction.”
(Statutory sector organisation – Wales).

“Not having a ‘referrer’, therefore no information giver.”
(Voluntary/Community sector organisation – Wales).

“Lack of clarity around support systems.”
(Statutory sector organisation – Scotland).

“Identifying a professional to oversee the plan.”
(Statutory sector organisation – England).

“Finding people/agencies to support the family to implement the plan.”
(Voluntary/Community sector organisation – Scotland).
Additional challenges identified included raising awareness in the local community of the FGC service, ensuring that the service was working for all family members and not just those who have made the referral, and a feeling that sometimes ‘self-referrals’ happened too late when the service user/family was at crisis point:

“...cases often referred too late (last resort).”
(Voluntary/Community Sector organisation – Scotland).

In terms of the factors that enabled the ‘self-referral’ process to work effectively in their service, respondents noted the primary importance of being responsive, flexible, adaptable and creative in their approach to the work and have a ‘family-centred’ culture:

“We are adaptable to the family’s needs.”
(Statutory sector organisation – England).

“Flexibility and creativity of the service.”
(Voluntary/Community sector organisation – Scotland).

“To be able to allocate in a timely manner. No waiting list and no drift.”
(Statutory sector organisation – England).

“Having a family-centred culture in the organisation.”
(Voluntary/Community sector organisation – Scotland).

“Our flexibility. Our direct relationship with the referrer. Simple online referral process.”
(Voluntary/Community sector organisation – England).

Other enabling factors identified included good awareness amongst the local community about the availability of the service (achieved through word of mouth and use of social media), the fact that the family was not under any external pressure from professional agencies, and having a mix of funding that allowed the service to have some discretion in terms of who they offered FGCs to.

As outlined in Figure 3, in addition to the 11 services who stated that they currently accepted ‘self-referrals’, 1 service (a voluntary/community sector organisation based in England) indicated that they had previously accepted self-referrals in the past. The benefit of ‘self-referrals’ identified by this service was that the need for an FGC meeting was often highlighted at an earlier stage. The issue that led to this service no longer accepting ‘self-referrals’ was again the issue of funding:

“Lack of funding to allow these referrals. We do not have surplus funding to pay for these.”
(Voluntary/Community sector organisation – England).

An additional 5 services, as outlined in Figure 3, stated that they had previously considered accepting ‘self-referrals’ but had, ultimately, decided against this. These services were all based in England and comprised 4 statutory sector organisations and 1 private sector organisation. Their impetus for considering accepting ‘self-referrals’ related to the perceived benefits in terms of service user/family motivation, engagement and empowerment:
“Concurs with family-led decision making.”
(Private sector organisation – England).

“People will clearly want the service.”
(Statutory sector organisation – England).

“Early engagement – family empowerment.”
(Statutory sector organisation – England).

The challenges that these services envisaged in providing FGCs on a ‘self-referral’ basis, however, led to them deciding not to proceed in this direction. These challenges reflect those identified by services currently accepting ‘self-referrals’ and related to issues of funding and the perceived difficulties that may arise through a lack of professional involvement in the process:

“Funding approval and ‘sign up’ of social worker in the process.”
(Private sector organisation – England).

“No completed assessment to identify the child’s needs clearly. Without clarity of need this can be heavily influenced by one side of the family over the other.”
(Statutory sector organisation – England).

“Resources – service demands.”
(Statutory sector organisation – England).

“...the families may need the support of a worker to help them stay focused on the needs of the child and also to provide ‘funding’ to enable family members to attend the FGC.”
(Statutory sector organisation – England).

As displayed in Figure 3, of the remaining 12 FGC services who completed the survey, 4 stated that they were open to considering ‘self-referrals’ (2 statutory sector organisations and 1 voluntary/community sector organisation in England, and 1 voluntary/community sector organisation in Northern Ireland) and 5, all statutory sector organisations working in England, stated that they were not open to considering this. The remaining 3 services did not respond to this question. All of the services who did respond were asked to give their views in relation to ‘self-referrals’.

The potential benefits of ‘self-referral’ FGCs were, again, stated in terms of service user/family motivation, engagement and empowerment:

“Empowering families to make the choice for themselves.”
(Voluntary/Community sector organisation – England).

“Families acknowledging they need to come together. They would be more likely to invest in the plan. It would be truly voluntary.”
(Statutory sector organisation – England).

“The family are motivated and have a desire to resolve their own issues.”
(Statutory sector organisation – England).

“Motivation and commitment should be high if referral coming from family themselves. I also think it would be very empowering for families to choose the service they want.”
(Statutory sector organisation – England).
“...family commitment to the plan would possibly be greater.”
(Statutory sector organisation – England).

“Would take away the stigma of having social work involvement.”
(Statutory sector organisation – England).

“Self-referral would give an indication of the family’s level of motivation to change. FGC may be better attended / plans may have more likelihood of being formulated and implemented.”
(Statutory sector organisation – England).

The perceived challenges again reflected some of those outlined by services already accepting ‘self-referrals’. These challenges reflected concerns about funding and resources, the possible impact on the process of a lack of professional involvement on the process, a potential lack of clarity regarding the purpose/agenda for the FGC, the motivation and/or ability of service users and families to engage, and how service users/ families could be made aware of the availability of the service:

“The agenda setting - if it is set by family themselves then it may not be in the interest of the children? it may marginalise some family members further? There would be no monitoring of the plan, therefore difficult to monitor success. The coordinator is more likely to get more involved in a ‘case management’ role and taking away the independence role. Resourcing these referrals when services at capacity to other referrals.”
(Statutory sector organisation – England).

“Families knowing about the service; financing the service, whose budget?”
(Statutory sector organisation – England).

“The agenda may not be clear, and there would need to be a ‘lead’ family member who will monitor and support the plan.”
(Statutory sector organisation – England).

“Recognition agreement about the difficulties being faced? Referrals may not be done when needed. Literacy levels of families may prevent access...”
(Statutory sector organisation – England).

“For families where there isn’t the capacity or motivation to progress with FGC involvement...it can be a challenge for families to think beyond their present situation and be future focused and see the need for support at this time, keeping in mind it is a voluntary process.”
(Voluntary/Community sector organisation – Northern Ireland).

Finally, in relation to the factors that respondents thought would be needed in order to make ‘self-referrals’ work effectively, they mentioned the need for clear criteria for referrals and simple referral processes, awareness raising for service users/families, and issues in relation to funding and the capacity of services to deal with these referrals:

“Less restrictions on how funding is used.”
(Voluntary/Community sector organisation – England).

“Funding to resource the referrals. In-depth consideration to the guidance around these FGCs and how they differ to other referrals.”
(Statutory sector organisation – England).
“Major promotion to make families aware of the option and the benefits it could offer them.”
(Statutory sector organisation – England).

“...the number of referrals coming through...Capacity to take up the referrals.”
(Statutory sector organisation – England).

“Clear communication about what is being offered and a simple system to support as many families as possible to make the referral...”
(Statutory sector organisation – England).

“More media attention, more information being made available through other professional services, families seeing it as a positive step to support their situations rather than an intervention that is negative.”
(Voluntary/Community sector organisation – Northern Ireland).

Section 3: Summary of Interview Themes

Consultation with statutory sector providers in NI identified some key issues, in addition to the themes that emerged from the survey responses, that were included in telephone interview questions and prompts. In particular, issues identified to explore with telephone interviewees included: whether families who are not at a point of crisis will be motivated to seek FGC; whether the action of the referring family member might be resented leaving them isolated in the process; whether the service can be advertised widely and clearly enough to attract appropriate referrals; articulating how self-referral fits with the underpinning theory and ethos of FGC; whether funders are prepared to invest in families before difficulties escalate to e.g. child protection.

The Benefits of Self-Referral

All interviewees stated that they believed that offering self-referral could be a good idea and all identified some actual or potential benefits to this. All interviewees believed this to be a more empowering way of working and most (8) said that self-referral aligns with the ethos of Family Group Conferencing. Most believed self-referral to be an effective way of providing early preventative help to families (10), who in turn more motivated to engage in the process and effect change (8). Two people articulated how, in their experience, there is a demand for this type of working that is not necessarily recognised by statutory funding bodies but which is felt by families and helping professionals:

‘There is clearly a need out there and any way of getting that need identified and met I am all in favour of.’

‘We get workers in schools, or a Health Visitor might call, you know, that know about our service and they’ll say, ‘Oh there’s a family that could really benefit from your service, could you send them information’, but that worker can’t even refer let alone the family themselves.’

Empowering practice

All interviewees spoke of ways in which a self-referral model was in their view or direct experience a more empowering way of offering the Family Group Conference service.
‘There’s nothing more empowering that a family saying, ‘We’ve recognised there’s an issue here, we want to do something about it and this is what we want to do.’’

The ways in which this might be more empowering fell into five main themes: choice, power, respecting family autonomy, responsiveness and hope.

**Choice**

Interviewees noted that although all participation in FGC is voluntary many families can feel somewhat coerced into engaging with the process and ‘the voluntariness of it is sometimes compromised when families are in Social Care’. Families can feel that they have little choice because of the perceived or explicit expectations of their social worker, or because they believe that there will be negative consequences if they do not agree to a conference. Interviewees highlighted that when families refer themselves for a conference they are making a deliberate choice. Offering this choice is both more ethical and more effective in the sense that it demonstrates motivation on the part of the family.

‘It’s a family making their choice with the idea, it was their choice. They’re not doing it to tick a box or please a worker that they might like, they’re doing it because they think it’s the right thing for them.’

‘Families are motivated and they’re making a genuine choice, they’re not being coaxed into it.’

‘I think because they are asking to do it they are more engaged the family are more engaged with you.’

**Power**

When a family refers themselves they retain control of decision-making and a different power dynamic is evident when the focus of the FGC service is on the self-referring family rather than on a professional as the referrer.

‘It’s about the power and where it lies, the family are saying, ‘We would like to use your service’ and they are the main starting point for the piece of work.’

‘They’re taking control from the get go.’

**Respecting Family Autonomy**

The family-led ethos of self-referral promotes the autonomy, independence and self-determination of the family. It also recognises families as experts on their own lives. This is not just ethical in terms of immediate practice, but also might equip families with skills that will be of benefit to them when they face future difficulties. Some noted that the ethos of promoting sustainable, family-led change is now permeating statutory child welfare services.

‘They (the family) are acknowledging the problem rather than being told these are the problems you have.’

‘It tends to give them a bit of sense of autonomy and kind of empower them to reach resolution as independently.’

‘If the family can get set in the way of doing it and helped along in the beginning, then it’s something hopefully they take along for life.’
‘For positive outcomes to be sustainable they need to come from within the family.’

Responsiveness
The option of self-referral means that the service can respond to help-seeking by families and provide the support they feel they need when they need it. This responsivity may prevent family difficulties escalating to the stage that referral to social services or other intensive services is required.

‘It’s about being responsive to what families need and want and acknowledging that they are actually coming forward and saying can I have help.’

Hope
Self-referral was seen as a more hopeful way of working that emphasised families’ own resourcefulness and strengths and promoted their sense of confidence in their own ability to address their difficulties.

‘It sounds like a positive offer that you are making them rather than that kind of failed thing well you better come up with something or we are going to move in.’

‘A belief in the process of a family group meeting that actually by coming together they make be able to affect some sort of change or difference... a great deal of more confidence coming together.’

Early help
Families being able to self-refer at their point of felt need, rather than at the point where they are already involved with social services, may prevent them from needing assistance from higher tier services. As a mechanism of offering early help, self-referral may prevent family difficulties escalating to the stage of statutory intervention. This may be cost effective as it may reduce the need for families to use more expensive services. It is also more beneficial to families. Extensive involvement with social services can be disempowering for families and they can begin to lose confidence in their own abilities. To have the opportunity to refer themselves to the service at an earlier stage of difficulties may be more effective because problems are less entrenched and families are more hopeful.

‘At earlier stages, before families have been around that system for too long, their confidence in their own ability to make a plan and carry it out, were higher. They still had a lot more hope and were less despondent.’

‘Families were incredibly motivated and were approaching us before things had become too difficult and too ingrained, and before families had given up hope. So in that sense it was really positive.’

‘Potentially mean them not becoming involved with a local authority in the future.’

‘It definitely needs to be something they can access early on rather than the issues escalating for them.’
As a model of early intervention, self-referral to family group conferencing may be particularly appealing and helpful for families who have already had social work assistance, who have experienced the benefits of FGC and who do not to return to their previous level of difficulty. For such families, the option to self-refer may prevent a repeated re-referrals to social services and possibly repeated episodes of child safeguarding or children coming into care.

‘A lot of families will come back in that, they’ve maybe had a family group meeting before that Social Workers referred in for them, and maybe they don’t have a Social Worker involved anymore but they think that a family group meeting would be useful to alleviate if things are kind of slipping back, and to avoid having to come back into, you know, the other services.’

‘If you can get a self-referral in a family with the first child they have, and they go onto have three or four children, that could take three or four children away from a lifetime of being involved with Social Care.’

Motivation for engagement and change
When families self-refer it is because they have come to their own realisation that they need help to change. They are more likely to identify problems that need to be addressed, and to take ownership of the process of resolving their difficulties. Although one interviewee felt that once any family ‘has bought into’ the process, regardless of referral source, they will be highly motivated to engage in the process. Others felt that self-referral leads to families being more motivated to engage in the FGC process and to make best use of the service.

‘It’s actually something that they are seeking to do so the motivation is already there.’

‘The families were very on-board and very much wanted to participate.’

‘I think they are more likely to change because they have realised themselves that there is an issue rather than someone else saying it, they have already identified themselves that things aren’t quite right and they need something to change but they don’t know how to do it, so I think that kind of the penny dropped.’

The ethos of Family Group Conferencing
Offering families the option to self-refer aligns with the family-led ethos of FGC and its strengths-focused orientation that seeks to support families as they mobilise their own coping strategies and resources. This is perceived to be a more ethical, less stigmatising and also a more effective way of working. Some noted that when local authorities are commissioning the service, the focus can be on whether or not a meeting was held as the primary outcome indicator. Self-referral however places more emphasis on the process of working with families which is also more in keeping with the ethos of the approach.

‘A vision that we have about the family and the wider family being able to come up with solutions with the professional network supporting them to do so rather than the other way round.’

‘It’s ethical, but also at times it’s better engagement.’

‘It goes back to the very ethos of the model, which isn’t the meeting, it’s the process that’s
important.’

‘I think the whole thing about family group conferences is the family taking ownership of their future.’

The Challenges of Self-Referral

While all interviewees identified clear benefits to self-referral, many also anticipated or had encountered a range of challenges associated with families accessing the family group conference service directly. These challenges fell into six main categories: the absence of a referring professional (10); less clarity about the process and referral criteria (8); unpredictable demand (4); additional work (6); lower motivation (5); and difficult family dynamics (3).

Absence of referring professional

When a professional is making a referral to FGC the expectation is that they will understand the aims of the service and how the process works and will therefore be making an appropriate referral that fits with service criteria and will explain this to the family they refer. If there is no other professional helping with this, the full onus falls to the co-ordinator to ensure that the family understands what is being offered, and to ascertain whether this is indeed the right service to meet their needs. There is a greater likelihood of inappropriate referrals or of families misunderstanding the purpose and process of FGC. The referring professional can bring particular benefits to the FGC process that would be missed in a self-referral service: they can ensure that families have an accurate understanding of the service; they can help identify target issues and provide direction; help to implement the plan and support families in sustaining change; hold statutory responsibility for responding to risk and safeguarding concerns. Furthermore, for the co-ordinator to help families draft workable plans based on realistic expectations they need to know what services are and aren’t available to them – this is much more difficult to ascertain if the relevant professionals are not part of the process.

‘You need to have quite a strong co-ordinator I think, because if it’s a self-referral, you’ve not got that professional that tends to give it a bit of direction.’

‘A concern that you would end up holding responsibility for situations just because you are the one who got in touch with them… that is a potential worry isn’t it, I think it would leave us a bit vulnerable to that situation.’

‘A thing that is quite difficult is when a safe-guarding concern comes up, cause when it’s in Social Services all you do is you mention it to the Social Worker, ‘Oh actually I was a bit concerned about this and I wanted to pass this onto to you’. But when it’s self-referral you don’t have a Social Worker to tell that to and go back to. Of course the clear cut things, that’s clear cut, that’s easy. But it’s those kind of grey ones.’

‘Sometimes things can escalate very quickly to safeguarding issues and people need to understand that.’

Working without a partner professional can also be isolating, and one person identified the need to consider the safety co-ordinators when working with an unknown family.

‘Some issues that need to be considered one is safety - the referrals I get from the local authority they have already been involved with the family they know the background the
situation and so on. If I were to receive a referral direct from the family that would be an
unknown to me so certainly that would have to be a consideration how that was
approached.’

One interviewee disagreed that the absence of a referring professional was problematic and indeed
perceived this to be a direct benefit of self-referral as it can free up time to spend directly with the
family.

‘You might have that time extra because you wouldn’t be dealing with the professionals as
well, because obviously we deal with both families and the professionals to find out what the
issues are, but you would have a little bit more time to maybe to give to the family because
you wouldn’t be dealing with all those people.’

Lack of clarity
More than half of the interviewees said that the aims and processes of family group conferencing
are relatively complex and therefore difficult to communicate clearly and succinctly in community
advertising. This increases the likelihood of inappropriate self-referrals that do not fit with service
criteria or where families would benefit from a different service. Families may also have unrealistic
expectations of what the service can offer and this would need careful negotiation. One interviewee
also highlighted that, compared to referrals from social workers where there is often a measurable
aim, for example a child not having to enter care, the outcomes for self-referral are less clear cut and
harder to quantify.

‘Trying to make sure that the expectations of families are correct. I suppose you want a base-
line of public understanding of what the process would actually be.’

‘My concern is that it will be interpreted as a mediation service, and that we don’t know
that the referrals are going to be right for our services.’

‘Self-referral usually come to us when they’re not in the Social Services system, so it’s usually
less quantifiable, they’re getting on a bit better or people have had a nice chat, they’ve had a
good experience. Not that a big decision has been made to care for this child, or to keep
child at home with Mum or whatever, so it’s more difficult to measure the outcomes... We
know that in Social Services we’re preventing that child from coming into care, they’re the
quantifiable. You can’t quantify that a family are talking to each other a bit nicer.’

Three interviewees specifically disagreed that lack of clarity was a challenge in self-referral. Families,
as experts on their own lives, can have clear ideas of what issues they want to address and, for those
who don’t, early meetings with the co-ordinator can help set a clear agenda.

‘I think it could be clearer coming from the family to be honest.’

‘If you’ve got a good co-ordinator there that is able to kind of support the families to create
maybe, an agenda that is what they want to discuss and what they want to do within the
meeting, it can alleviate those difficulties really, of it being cloudy.’

Extra work
In a self-referral service, some of the work usually undertaken by a referring professional will have to
be completed by the co-ordinator, for example identifying target issues, preparing families,
signposting other supports, monitoring plans.
‘The time we have spent on those (self-referral) FGCs have been more preparation time than the ones that are higher up like in child protection.’

‘It might need some family support involved, that might not be our role but because we are the ones that have worked with the family they are calling on us. I think it’s a lot more kind of family support issue kind of role when you are actually working with a family because in some of ours it’s like we have opened a can of worms kind of thing but then we have identified some extra support, you know we have signposted them.’

Four interviewees, however, said that while the work may differ with self-referral, the overall time and commitment required can be very similar to traditional processes.

‘It’s the same in each case we budget for around twenty hours. So in terms of hours it’s probably roughly the same, but that twenty hours is spread over a longer period of time.’

Motivation

Five interviewees queried whether families self-referring at an earlier stage of problems would be as motivated to engage in the process as families referred by a social worker where the rewards for achieving change, and the consequences of remaining static were both higher. They also perceived that when a social worker makes a referral they share the same objective for change and can help motivate families to work towards that target. Part of the role of a self-referral service would therefore be to help families see that seeking help early can prevent difficulties from escalating.

‘If a family are highly motivated enough to not need a referrer why would they need us.’

‘Symptoms have to be really bad before people want to admit that they need help. To be able to do a self-referral, you have to be very aware of that.’

‘The stakes aren’t as high, so they might be less likely to engage, but if we can get in there and have the conversation and sell it, then they’re likely to engage.’

Unpredictable demand

A small number of interviewees queried how the demand for a self-referral service could be estimated and how this unpredictable demand could be factored into funding and staffing arrangements. They were concerned that if the service were advertised widely and many families self-referred they may not be able to meet this demand in a timely way, thereby contradicting the very aims of the model which would be to provide a response at the point of need.

‘How would you estimate the numbers of referrals you would get? And how would you ensure that you’d costed that, so that you could meet the expectations of people?’

‘If there are loads of people come through with a self-referral then we would be in a mess then because we wouldn’t be able to deal with them.’

Family dynamics

A minority of interviewees perceived a potential for self-referral to lead to some difficult family dynamics and tensions arising from resentment or feeling pressurised. However, as the following quotation illustrates, they also acknowledged that these difficulties are not insurmountable and that
there could likewise benefits in that self-referral might promote motivation and cohesion among family members.

‘It can cause tension, you know, when the family has made a self-referral, you know, they’ve not got that professional that they can blame. So sometimes families may be feeling, when you’re going out to visit them, and saying it’s a family member that’s made the referral, that we’re doing everything we can already, so why do we need one of these? They might question the other persons’ motivation depending on their relationship. But then again some can see it as a positive that they’re taking control of the situation and wanting to come up with a way of dealing with it before it gets any worse.’

The Obstacles to Implementing a Self-Referral Model

Most interviewees cited a variety of reasons why they were unable to offer a self-referral option, or why, to date, self-referrals represented only a small proportion of their work. The prevailing obstacle to offering self-referral was the lack of appropriate funding or resources (10) or the constraints of the restrictive funding model (7) and inflexible service structure (6) within which their service sat. A minority (5) also noted that the prevailing culture and attitude among commissioners was not conducive to the more flexible and early intervention approach of self-referral.

Funding and resources

Most (10) interviewees indicated that if they were able to access additional or less restrictive funding they would be very willing to enable families to self-refer to their service, or to expand the number of self-referrals they were able to offer. None were able to identity where such funding might be sourced. Their teams were already operating to capacity and would need funding for additional staff in anticipation of the extra volume of work if another referral stream were to be opened up. Furthermore, some were operating a waiting list for the service but felt that it would be particularly inappropriate to ask a family who self-referred to delay the FGC process in the absence of a supportive professional.

‘If I could find a source of funding which would let me to offer family group conferences without any cost to the family themselves I would I’d be more than happy to do that, but to date that kind of funding has been elusive.’

‘The big question would be how would you fund those referrals. If we had the funding, separately from the funding we get now, then we just widely offer the service, but we don’t have the funding to do that. We’ve got loads of ideas for our service but ultimately if we don’t have the money to provide it we can’t.’

One interviewee, however, suggested that funding should not be a significant obstacle to establishing a small pilot project.

‘If you set up a pilot I don’t think it will massively impact on capacity or resources or anything like that or be a problem at all. I think small numbers would be ok to start.’

Restrictive funding model

Seven interviewees said that strict contracts with funders meant that they were unable to offer self-referral. Some funders were restrictive in the sense that they could purchase services only for those families to whom they have a statutory obligation. Others said that the funder’s requirements for
measurable outcomes e.g. conversion rates from referral to actual conference meeting, meant that benefits which were less measurable, although equally tangible to the family, could not be captured and therefore could not be called upon to justify expenditure in the service. One person suggested that a direct funding stream not restricted by Local Authority priorities would allow for a more flexible approach.

‘The local authority that is spot purchasing they will only purchase for families that they are already involved with presumably as their funding model cos they have got an obligation to them.’

‘I need to make a justification as to what it was I was asking them to fund really so if an FGC costs between 800 and 1000 pounds to deliver they will want to know what outcome it will provide for them against their statutory responsibilities.’

‘It would be nice to have direct funding from government, rather than going through the Local Authority, so that we could just have an open door policy and not have a limit to our funding.’

Service structures
Interviewees whose funding came from statutory sources noted that in order for a family to receive any service they have to fall within particular categories of need or risk and in those who do almost always have contact with a professional who would make a referral on their behalf. This service structure does not allow for families to self-identify into categories of need or allow those who use only universal support to access higher tier services. FGC providers that sit within statutory structures, aligned to Local Authority teams, noted that the level of bureaucracy and governance required within that setting might not suit families who want to self-refer. For example, families may not be happy to have their details logged on social services’ recording systems, especially if they’ve not had a social work service previously.

‘We can only take referrals that come through the Social Care or Early Help, which is kind of a pre-Social Care, stream. So anyone not in that stream, the families using just you know, universal services like school or something, they can’t, even a school worker can’t refer directly to us. They have to get into this kind of pre or fully Social Care stream. So that’s the issue really for us, we can’t take ourselves outside of that stream... There’s a whole group of families who can’t access our service, that probably would benefit from it.’

‘We would have to develop a different recording system probably because we currently work on a local authority recording system and families might not be happy to put their data on this, so that’s a whole area that would have to be considered and I don’t know how the authority would feel about that because they want everything to be streamlined.’

Attitude
Some noted that even when the explicit policy position aspired to all families getting ‘the help they need when they need it’ the lack of resources undermined this aim, with authorities having to prioritise families with the most acute, or higher tier, need. This approach they considered to be short sighted and missing the opportunity of early intervention. A further attitudinal obstacle was a misinterpretation, conscious or otherwise, of the ethos and purpose of FGC, for example a reluctance to support family autonomy and self-determination if this proved more expensive or ran contrary to professional opinion. Some noted how in the Netherlands, the ethos of family group conferencing is culturally embedded and felt that a ‘cultural shift’ to a similarly wide-spread understanding and wholesale acceptance of the model a worthy ambition for the UK. It was noted
that despite FGC services operating in the UK for some time there is still a lack of awareness among professionals, and so even more so the general public, that the service exists and the benefits it can offer.

‘Local Authorities have really, really scarce resources. So they’re not going to spend those resources in areas that they don’t think the greatest need is.’

‘The short sightedness of the authorities commissioning these services.’

‘If they’re not actually buying into the idea that families should make their own decisions from a right’s perspective, then when a family makes a decision which might cost the Local Authority money, they wouldn’t support that decision. They have to believe in families in order for it to work. Otherwise they would just ignore families’ decisions when it doesn’t suit them.’

Guidance for Implementing Self-Referral

All interviewees were asked if they had any guidance for FGCNI as they considered establishing a self-referral mechanism for their service. They had a range of tips which fell mainly into the categories of: service set up and funding (9); the target market i.e. potential service user groups (10); and advertising and access (10). Most said that they would like to see FGCNI, or others, establish a pilot self-referral project with robust evaluation so that the learning re this way of working could be shared widely.

Service set-up

Interviewees had a range of suggestions for addressing the challenges and drawbacks they had identified (above).

- Consider taking a co-production approach to setting up the service in collaboration with families and community groups to ensure that the project will be targeted to the needs of potential service users and has acceptability and credibility within their communities:
  - ‘Have some of the people in the community, the people that are likely to need it, try and get some of them on board in moulding it, in putting it together. They’re the people that will give it credibility and if you have those people on board, saying ‘ok, we’ve helped build this idea’, then I think you’re more likely to get people self-referring, because it’s theirs, it’s not something that somebody high up has deemed to give a bit of money.’

- Consider using a team of trained volunteer co-ordinators to cut down on resource costs. The model used in the Netherlands is one example of where this works well. The drawback to this would be ensuring quality and consistency of practice.

- Consider running regular community-based drop-in sessions, ‘a surgery type approach’, to cope with unpredictable demand. The disadvantage of this approach is that it ‘might take away some of the personalised nature of FGC’ but the advantage would be that the service would become embedded in communities and families would know how and when they could access it.
• Consider using digital technology and telecommunications to reduce costs, e.g. using Facetime calls for people living at a distance to reduce travel costs.

• Secure sufficient funding to allow cases to be co-worked to address the challenges of working without a referring professional:
  o ‘If possible have people to co-work the self-referral. If your funding would allow it, you would have somebody who works as the independent co-ordinator and then somebody who was supporting. Because it is very isolating when you do self-referral, you’ve just got the family, you’ve nobody to report back to.’

• Recognise that the process of self-referral is different and that some families who do not actually proceed to a family meeting will gain benefits from the discussion and preparation process. Therefore, have funding linked to the number of referrals rather than the number of actual conferences convened.
  o ‘Get rid of all of the other pre-conceptions that you have about timescales and outcomes; so think about the process rather than the, you know, how many meetings did you have and how many people came to those meetings’.

• Take a flexible approach to identifying outcomes. Ask families for their own evaluation of the process and outcome using measures that are relevant to them and their priorities.
  Questions to ask families might include:
  o Do participants feel that their emotional well-being has improved?
  o Do families feel that they are more resilient?
  o Do they feel that family life and relationships have stabilised or improved?
  o Have the family been able to talk to one another and expressed what they wanted?
  o Are the family feeling better about themselves?
  o Are the family communicating better?
  o On a scale of one to ten how were things before? On a scale of one to ten how are things now?

• Preferably find a funder who is flexible in terms of the types of referrals accepted, who will, for example, fund for referrals in relation to families involved with statutory services referred by their social worker, and for referrals from families themselves. This may be easier to achieve in adult services where FGC is considered more innovative.

• Stay true to the FGC model and be prepared for the long-haul:
  o ‘This is something you would be looking to achieve over at least five years, it would take to get things going and get the results. It’s also something you’d want to try and get five years of funding.’

• Consider funding an evaluation by a research organisation to help establish the value of the project and lay a foundation for sustainable funding:
  o ‘If you get good results... Local Authorities will start to sit up.’
The Target Market

Interviewees had a range of suggestions for who they thought would most benefit from a self-referral project.

- Consider encouraging self-referrals from families involved with social services who would normally be referred by their social worker in order to establish more choice and control in the process:
  - ‘Even at the beginning of Child Protection process, if you can offer it to the family in a way that they can still self-refer, might still be helpful.’

- A group that was considered particularly likely to self-refer and benefit from such a project were families who had previously had a social worker, had experienced the child protection process or had a child admitted to care, and who were beginning to struggle again. Such families are likely to know about FGC and how the process works, to value the help that FGC can provide, and be highly motivated to prevent family difficulties escalating.
  - ‘People who had social work involvement previously and don’t want it again. You may have been through a child’s system previously and you know as an individual, as a parent, that you are struggling and you don’t want to go back there, and you say ‘how can I access that service that support’ or ‘how can I help bring my network back together around me’.’

- Another particularly relevant group of potential self-referrers are parents involved in disputes over parental contact or residence of children, especially those families involved in protracted private law applications through the courts. One interviewee suggested a private funding model where families in this situation might pay for the service themselves as this might, in the long run, save money spent on legal fees.

- The range of issues that FGC might help resolve for families included:
  - Elderly care, particularly planning help at home or a move to residential care
  - Care for children with disabilities
  - Families whose children have difficulty with school, or getting children to attend school
  - Resolving neighbourhood disputes.

- Think about the current geographical spread of FGC services and target areas where current service provision is scarce. For example, one interviewee identified the Midlands region of England as being particularly under-served in terms of FGC.

Advertising and Access

A small number of interviewees talked about the particularly strong model of self-referral FGC in the Netherlands which is embedded across the country and aligns with cultural understandings of community and family support:

‘You need to make sure the whole country knew what family group decision making was. The Netherlands because they very much, their whole model is self-referral. They advertise on
public television, so they have TV adverts and very much community based and it’s every family’s right. So they have that very strong model. What they say is, family decision making is part of their democratic culture. So it’s actually part of their country, it’s not an add-on, to a Social Work department. So you can see how it would work in that culture, but we haven’t got that culture.’

One interviewee cautioned against advertising too widely in case demand for the service outstripped the resources and staffing available to respond:

‘If you published something in all the different towns, the different villages or communities, the benefits of the model and what it can help, how it can help, then I think you could potentially be overrun with applications or referrals.’

However, most thought that a wholesale cultural shift in the UK towards FGC as a family-led, community based early intervention, or an influx of self-referrals, were very unlikely. They had some pragmatic suggestions for making sure that families know about the FGC service and could access it readily when needed.

• Make self-referral easy for families and provide some assistance with the process:
  o ‘Making it very, very easy for them to self-refer, almost kind of baby stepping them along the process, but if you just threw it out there and expected them to do it you are not going to get the response.’

• Most said that professionals in universal services were best placed to identify those families who might best make use of FGC, give them information about the service and even help them make the referral, though not necessarily do this on their behalf:
  o ‘You can have Head Teachers, GPs all sorts of people, who are still advertising the service, and who might say to a family, ‘You know what there’s a service I think that could meet your needs, and let me give you a hand to get in touch with them’.’

• Likewise it was suggested that advertising should be targeted to those delivering universal services and that effort should be directed at training teachers, doctors, midwives, health visitors and others who support families to both understand the benefits of the service and how to direct families to access the service.
  o ‘Go into schools or whatever, places where you could kind of really sell that service as something that’s meaningful, empowering and helpful.’
  o ‘There would be schools, Drs, Health Visitors. People like that would be interacting with the family at a very early stage and may be thinking well things aren’t right. Potentially a route in for self-referral would be for people like that to be trained to make families aware that they could refer.’

• Additionally, alerting social services intake teams to the service may prevent some families needing social work assessment:
‘It works really well for at the front door of Children’s Services, if people are phoning up to make referrals and it doesn’t quite meet the threshold, they make them aware of family group meeting and they can make a self-referral.’

Advertising and awareness raising could take the form of:

- Posters and leaflets in areas that families frequent e.g. GP surgeries, schools, early years centres, nurseries
- An animated video such as that used in Camden
- Direct people to the Family Rights Group website
- Presentations to practitioners, schools etc.
- Networking widely among family support agencies

‘Getting out into the community as well, if we’ve got say children from family centres and they have baby groups or things like that, or parents, parent/teachers, go out and just kind of advertise and get yourself known and explain what you’re doing basically.’

Section 4: Conclusions and Suggestions

This scoping exercise shows that, among Family Group Conference providers across the UK there is a keen interest in self-referral as a process whereby families can access this service directly. Everyone we spoke to, and most of the survey respondents, believed that offering families the option to make a referral directly to a Family Group Conference service had the potential to be very beneficial and effective. However, numbers of providers offering a self-referral option are low, and among those who do allow referrals this way, most were still receiving the majority of their referrals from a social worker or other professional. The main obstacles that seemed to be inhibiting greater use of self-referral were restrictive funding models and a lack of practitioner wisdom or practice frameworks to follow.

The key benefits identified for self-referral were:

- The fit with the value base and ethos of family group conferencing in terms of promoting choice, empowerment and family autonomy.
- The ability to respond to families at their point of felt need.
- The fit with UK policy priorities for offering early intervention and preventative supports.
- Increased motivation and confidence for families leading to effective outcomes.

The main obstacles preventing greater use and/or uptake of self-referral were:

- Lack of necessary funding and resources.
- Restrictive funding mechanisms allowing providers only to offer services to those families using higher tier services e.g. child protection.
- Undervaluing of early help for families.
Lack of a practice model to follow and/or guidance from services currently operating this way of working.

The most challenging potential difficulties when offering self-referral were:

- The absence of a referring professional to provide clarity in the referral process and ongoing support to the family.
- The unpredictable demand for the service and unknown level of unmet need among families.
- Extra work involved in advertising the service, managing inappropriate referrals, and preparing families.

Taking an overview of the survey responses, the telephone interview themes and our consultation with NI statutory providers, we would suggest the following should be key considerations for any FCG services seeking to develop a self-referral process:

- Developing the self-referral model
  - We suggest that families should be closely engaged in helping to co-produce the service model, advertising literature, referral mechanisms etc. to ensure that they are appropriate to the needs and objectives of the end users.

- Funding
  - Financing for the services should be sought from funders who have a commitment to early help, family empowerment and partnership working.
  - Funders should be able to take a flexible approach to outcomes and accountability, for example seeing the value in harder to measure benefits for families such as improved communication and greater sense of hope.
  - Given that it is a novel and innovative way for FGC to operate in the UK, it is likely to take some time to establish a self-referral project. Funders should be able to commit to longer term investment that will deliver benefits directly to the families involved, but also to wider society by way of attitudinal and culture change in how and to whom services are offered.

- Identifying the potential target market
  - The service should engage closely with community family support providers and with families to ascertain the likely demand for the service and the level of current unmet need.

- Advertising
  - Non-targeted advertising e.g. via the internet, is unlikely to be effective given that most families are unlikely to know what terms to search for. Advertising should be channelled through partner organisations that are already working with families or places where families already tend to go to for support. Awareness raising efforts should be directed toward professionals and organisations who offer universal services or community based family supports.

- Engagement with other services
  - Working in the absence of a referring professional is a key difference between self-referral and the way most services operate.
The FGC project should engage closely with other helping professionals and community based support organisations both to help advertise and direct families to the service, and to help mobilise the services families might need to effectively implement their plan.

- Staffing levels should be sufficient to allow for co-working by two co-ordinators if needed.
- Staffing will also need to allow for additional time in the preparatory stages to help the family decide whether FGC is right for them and to get ready for the meeting.

- **Capacity Building**
  - It is clear that there is an appetite among FGC providers for offering self-referral, but a lack of information and guidance on how to go about it. A pilot project should, therefore, involve evaluation as a key element, and seek to disseminate the wisdom and learning widely to other FGC providers.