Research, Policy and Planning (2016/17) **32**(3), 169-182

Role theory and family values – a conceptual framework for family and social work reciprocation

Joan Rapaport[1] and Geraldine Poirier Baiani[2]

[1] Visiting Research Fellow, Social Care Workforce Research Unit, King's College London
[2] Former Assistant Deputy Minister in New Brunswick, Canada

---

Abstract
Normalization and Social Role Valorization have been extensively associated with the closures of long-stay hospitals for people with mental health problems and with learning disabilities. The related theory of Reciprocal Role Valorization emerged from within a study of the nearest relative, a patient safeguard under the Mental Health Act 1983 in England and Wales. It illustrated the potential for reciprocation provided by the nearest relative powers and related Approved Social Worker duties, to achieve mutually agreed objectives for patient welfare. The theory is conceivably transferable to other case scenarios.
The Family Group Conference helps families to find solutions to their respective problems and promotes family and social work collaboration. This framework of interaction suggests Reciprocal Role Valorization may be implicitly at work at the heart of the conference process. The theory's relevance to the Family Group Conference, in particular the model developed by the Canadian Province of New Brunswick, is here examined. The importance of specialist post-qualifying professional development and professional maturity to enable social workers to unlock family potential is also argued in the context of increasing interest in strengths based social work.

Keywords: Reciprocal Role Valorization, nearest relative, Family Group Conference, social worker, strengths based approaches

Terms used
In this article the term 'service user' is preferred to that of patient and used to describe an individual who receives mental health services. The term 'patient' is used to describe a person who is detained or liable to be detained under the Mental Health Act 1983 in England and Wales. The term 'carer' refers to unpaid family or friends providing a person with care and support; in some jurisdictions the term 'caregiver' is used. The role of the nearest relative and that of the now former Approved Social Worker are those defined under the Mental Health Act 1983.

Introduction

This article has two main parts. The first focuses on the theoretical and sociopolitical context surrounding the legal category of the nearest relative in England under the Mental Health Act 1983. It provides a brief overview of a study of the role's functioning and the theoretical development of Reciprocal Role Valorization. The second concentrates on the Family Group Conference, its innovative developments in the New Brunswick, Canada and how the theory arising out of the nearest relative study relates to the province's initiative.

The role of the nearest relative under the Mental Health Act 1983

The role of the nearest relative is officially recognized as a patient safeguard to prevent unnecessary hospitalization (Department of Health, 1999). The rightful designate is identified under Section 26 of the Mental Health Act 1983 from a hierarchy of relatives (see **Box 1a**) and rules relating to divorce, separation and partnerships, half-blood relationships and residence. The patient's highest existing relative who has reached the age of majority and eldest at each level, is usually the nearest relative. The nearest relative has four main powers to influence a close relative's hospital detention (see **Box 1b**).

Box 1a. Definition of 'relative'. **Box 1b** Powers to influence hospital detention.

a) Hierarchy of relatives	b) Overview of main powers
Husband or Wife Son or Daughter Father or Mother Brother or Sister Grandparent Grandchild Uncle or Aunt Nephew or Niece	• To ask social services to assess the patient with a view to hospital admission (Section 13(4)) • To make the application to detain the patient in hospital, if supported by two medical recommendations (Section 11(1)) • To object to the patient's hospital detention for treatment (Section 11(4)) • To seek to discharge the patient from detention (Section 23)

The powers are discretionary and subject to certain controls. The nearest relative has undergone changes during its lifetime.

Political and social contexts

The nearest relative was introduced under the Mental Health Act 1959 with powers to detain a close relative in hospital, to object to his/her detention for treatment and to seek his/her discharge from detention. It was conceived during the reform of mental health and mental deficiency laws (the language of the time) during the mid to late 1950s when stories of unlawful detention had surfaced. The Royal Commission (Percy Report, 1958), convened to advise on law reform, regarded the lay perspectives of social workers and caring relatives as valuable counterweights to medical decision-making when hospital admission was under consideration (Rapaport & Manthorpe, 2009). The Act introduced the new social work role of Mental Welfare Officer (MWO) with powers of detention in the event of the nearest relative being unable to act (Percy Report, 1958). However, as the potential for unsuitable relatives to manipulate hospitalization had also emerged, the nearest relative power to detain was controversial. Had the MWOs been professionally qualified, one option would have been to identify the MWO as the sole legal applicant for compulsory admissions. Critically, the Mental Health Act 1959 did not mandate social work training for MWOs.

The Mental Health Act 1983 prioritized a relative who 'cared for' the patient over the others identified in the hierarchy as the rightful designate (Section 26(4)). It also provided an additional power to request a psychiatric assessment of the patient (Section 13(4)). However, it was changes within the social work profession and the introduction of the Approved Social Worker (ASW), the MWO's replacement, that ultimately had the most impact on the nearest relative functions. In this reform, the ASW was legally required to be professionally qualified, to have had two years' post-qualifying experience and to have received additional training tailored to meet the demands of the role. Although the nearest relative's contentious power of detention remained, the ASW was newly authorized to make a thorough assessment of the patient's circumstances and identified as the preferred applicant for this function. ASW duties to respond to a nearest relative's request for an assessment confirmed this position. Inherited and new duties to inform and consult nearest relatives and to work with families and mental health colleagues were incorporated (LAC 86(15)). However, it was professional training that would ultimately influence how the ASW duties would be performed.

Whereas the Mental Health Act 1959 was introduced just after the asylum population had peaked, the 1983 Act came into being when the long-stay hospitals were starting to close and 'care in the community' policies were underway. Normalization and Social Role Valorization principles underpinned the movement to shift the locus of care from the institutions to the community, with inevitable consequences for patients and families.

Theoretical perspectives

Introduced by Nirje (1969a), Normalization is more usually associated with Wolfensberger who developed the concept and its later version of Social Role Valorization (SRV) (Wolfensberger, 1972; 1983; 2000). Normalization is briefly summarized as helping people to obtain living conditions as close as possible to those of others living in society (Nirje, 1969a). SRV is defined as the culturally valued means to establish social roles for people at risk of being devalued (Wolfensberger, 2000). Normalization and SRV theories challenged notions, prevalent in the 1960s and 1970s, of deviance deriving from individual pathology. They asserted instead that characteristics and behaviours are largely determined by society's stigmatizing reactions to people once they have been labelled as deviant (Brown & Smith, 1992). As such, disadvantaged people should be helped to lead lives valued by themselves and the society in which they live.

As 'care in the community' policies started to unfold, calls for greater patient empowerment, patient autonomy and citizen rights grew (Brandon, 1991; Lindow, 1994; Gates *et al*., 2000). Lay advocacy, conceptually linked to SRV theory, started to expand alongside a rapid emergence of service user action groups (Atkinson, 1999). SRV became increasingly important to the development of appropriate services (McCourt Perring, 1993). Professionals were asked to strive to prevent disabled people from being cast into negative roles and to help them to establish culturally valued social identities (Wolfensberger, 1983; 2000).

However, whilst the theories provided a conceptual framework for many positive developments, they were also considered to have limitations. Ramon (1991) perceived the ambiguity arising from the imposition of white middle-class values contained within the Normalization approach, yet its focus on a non-competitive lifestyle that differs markedly from the competitive ethos of middle class culture. No account was taken of the discomfort that disabled people might feel when joining mainstream society (Lawson, 1991). In addition, challenges posed by the devastating effects of disadvantage on a person's morale and capacity for personal interaction were asserted. Yet Ramon (1991, p.10) observed that for SRV to be meaningful people have to be able to reciprocate to 'improve their level of functioning and self-image'.

SRV theories were also criticized for neglecting the role of carers who, if family members, also risked being classed as occupying a 'deviant' role (Brown & Smith, 1992). This suggested that carers, like service users or patients, might also require extra SRV support. In such cases, the powers might be potentially burdensome and possibly also open to misuse. Critically, weaknesses in the law to remove unsuitable relatives were known (MHAC, 1991). Whether the introduction of the 'cared for' criterion under the 1983 Act was an attempt to strengthen able and committed carers in line with SRV principles is not known. However, the Parliamentary Committee that debated the nearest relative changes clearly considered 'a stable warm relationship with a human being' to be an important means of patient support (HC, 1981-1982; C423).

Nearest relative study

A small-scale exploratory study by Rapaport (2002) examined how the nearest relative powers were being exercised and with what effect. The study found that the actions of an ASW-supported nearest relative could reflect back on and strengthen the ASW role. It introduced the theory of Reciprocal Role Valorization (RRV) to frame the concept of interactive support

between, in this instance, the nearest relative and ASW roles as an advance over the one-way dynamic of SRV.

The study used semi-structured focus group interviews to generate data. Five carer, four service user and four ASW 'stakeholder' groups participated. Groups were selected to address inner-city, rural and urban/rural and ethnic minority (Afro-Caribbean) perspectives. The interviews were conducted between 1997 and 1999, in the wake of a spate of high profile 'psychiatric homicides' and heightened sensitivity about public safety (Reith, 1998; Taylor & Gunn, 1999). Grounded Theory (Glaser & Strauss, 1967), conceptually linked to SRV theory and the case study (Yin, 1994), provided the framework for the research design, data collection, data analysis, and comparing outcomes (summarized in Rapaport, 2012). Strauss & Corbin (1990, p.180) acknowledged the need for concepts derived from literature and experience to give studies using Grounded Theory analysis a 'beginning focus'. Their approach was essential given the topic's sociopolitical context and the researchers' ASW experience. Interviews were recorded and analysed using the inductive and deductive processes of Grounded Theory. A coding hierarchy was developed and the integrating core category identified. The case study facilitated comparisons between the three stakeholder groups. A brief overview of key findings supporting the theoretical emergence of Reciprocal Role Valorization is provided below.

First, the safeguarding potential of the nearest relative role when in the right hands, was appreciated. There were several examples where ASW duties to involve the nearest relative had enhanced the latter's safeguarding potential and resulted in successful hospital diversions and in one case, even discharge. Second, there were instances where the ASW had worked with the nearest relative and medical colleagues to secure continued hospital treatment. In one such case, a carer's assessment under the Carers (Recognition and Services) Act 1995 had highlighted a patient's risk behaviours and prevented a premature hospital discharge. In another, where a nearest relative objected to her daughter who had suffered from a near fatal reaction to anti-psychotic medication being detained for treatment, the ASW procured for the mother a special psychiatric consultation. There were no legal grounds to remove the nearest relative who, in the circumstances, was acting entirely reasonably to safeguard her daughter's interests. The psychiatrist knew that without the nearest relative's consent the treatment section could not proceed and agreed to advise the mother about the treatment plan. The mother felt reassured by the consultation and lifted her objection. In essence, the combined dynamic of nearest relative powers and ASW duties persuaded the psychiatrist to make the crucial concession. Such examples illustrated how ASWs had applied their knowledge of mental health and wider law and expertise in working with mental health colleagues, patients and families.

The study findings suggested that the combination of a well-qualified ASW and a nearest relative, able and enabled to reciprocate, could effectively counterbalance medical decision-making. The intrinsic dynamic of reciprocation appeared within the framework for interaction provided by the nearest relative powers and corresponding ASW duties, and strengthened the potential of both roles to achieve mutually desired objectives. The positive examples of nearest relative and ASW reciprocation exercised for the patient's welfare suggest the influence of SRV and its integral principle of reciprocity in respect of the development of both roles under the Mental Health Act 1983. The study advanced the term Reciprocal Role Valorization (RRV) to explain the potential, not facilitated by SRV, of the two roles working together:

> *RRV was found to occur where the nearest relative and ASW supported each other to achieve mutually respected and identified goals to help the patient, that were also recognized by the professionals and significant others involved.* (Rapaport, 2002)

RRV offers a conceptual framework to support collaborative working between families and professionals to ensure that decisions to remove recipients of care services from their homes and communities are only taken after a thorough assessment of all the circumstances and the family's strengths.

RRV potential

RRV is conceivably transferable to other scenarios underpinned by legal, policy and practice initiatives that aim to promote therapeutic and meaningful interaction between people who use services and their supporters and professionals. The Family Group Conference (FGC) is a likely contender, given its emphasis on family and professional collaboration. The New Brunswick FGC has been identified by Mike Doolan, an internationally renowned child welfare expert (Hughes, 2015) as:

> *'A shining light in child protection' and 'one of the few places in the world… using Family Group Conferences in a comprehensive programme'. (In Innes, 2014)*

This endorsement determined the choice of the New Brunswick model to examine the potential relevance of RRV to the FGC initiative.

Family Group Conferences

This section provides a general introduction to the Family Group Conference (FGC) and a brief overview of its implementation in England and Wales. It builds on an article describing FGC developments in the Canadian Province of New Brunswick and a portfolio of six typical case scenarios offering insight into the experiences of some families and how they find solutions to their problems through a robust FGC process (Poirier Baiani & Rapaport, 2015a; 2015b). The dynamics of family and social work interaction demonstrated in the case studies are examined. New Brunswick's innovation is identified as a practice example of Social Role Valorization and Reciprocal Role Valorization.

Family Group Conferences – a brief summary

Families whose children are subject to or at risk of state intervention may be no less affected by social exclusion and stigmatization than people receiving mental health services. The Family Group Conference (FGC) is a recognized means of enabling families to come together to find solutions to their problems, the hope being that they will find satisfactory alternatives to their children being taken into care. The model's origins lie in the Maori culture of New Zealand. It is now offered in over 17 countries and is considered by some to be the gold standard in child protection when 'correctly' implemented as it improves outcomes for the child at reduced public expense (Hughes, 2015, p.46). Holland & Rivett (2008, p.22) observed that 'promotional literature tends to emphasize the empowerment value base of the intervention, the expertise of the family and the practical outcomes that may emerge'. Relevant to FGC potential, Harry *et al*., (1999) suggested Normalization/SRV theory and reciprocity were useful guiding principles to improve family collaboration with professionals, with the objective of adapting mainstream assistance to suit individual cultural backgrounds.

The Family Rights Group (FRG), a leading charity in England and Wales that champions the FGC and other family initiatives to keep children safe in their communities, identifies the key preparation, conference process, planning and review stages of the FGC (FRG, 2012; see **Box 2**).

Box 2. Family Group Conference process.

Family Group Conference: Key Stages
• **The point of referral and allocation of a family group coordinator.** • **The preparation: identification of the family, extended family and friends who play an important part in the life of the child or children in question. The coordinator meets the family network to explain the child welfare concerns and the FGC process.** • **The actual conference: the coordinator ensures all those in attendance understand the purpose of the conference and the process.** • **Private family time: officials and coordinator withdraw to allow those in attendance to consider possible solutions to the identified concerns and devise a plan.** • **Presentation of the plan to the authority: plan is agreed and implemented.** • **Review of the plan: at a later stage.**

Sourced from Family Rights Group www.frg.org.uk 2012, accessed 16/2/16.

Overview of developments in England and Wales

The FGC was introduced into the United Kingdom by the FRG in the early 1990s and has since been supported by the Family Justice Review (FRG, 2011). Considered as a useful early intervention strategy, statutory guidance states that local authorities should have arrangements in place to offer the initiative (DfE, 2010). Mercer *et al*. (2015) found that 75 percent of local authorities in England claimed to have a full FGC policy. However, in respect of accessibility and critical point of entry to the service, their study also cautioned:

> *What is of use to family and friends' carers is information about the referral criteria and process. Very few policies provided this information.* (Mercer *et al*., 2015, p.41)

The FRG advocated that the FGC should be a legal entitlement to ensure all potentially eligible families are offered the service and not dependent on different local commissioning arrangements. Although traditionally associated with children's safeguarding, the model has been used in other sectors including mental health, where it is suggested as a means to promote social inclusion (Wright, 2008). However, in England, under the Department for Education's (DfE) Innovation Programme (DfE, 2014; 2016a; 2016b) a variety of new schemes, in addition to the FGC, are being developed in respect of family welfare with the aim of reducing the numbers of children coming into state care and improving outcomes. The importance of agency vision or theoretical stance, opportunities for critical reflection (DfE, 2014), and

enhanced knowledge and skills, tailored to meet the requirements of the particular schemes (DfE, 2016b) are generally considered vital for the delivery of good children and family services and beneficial outcomes.

The New Brunswick FGC programme

New Brunswick, situated on the east coast of Canada, is one of three provinces collectively known as 'The Maritimes'. Its population is about 755,000. Many are descended from early British and French settlers. The First Nations population is over 10,000.

Political and social context

The Department of Social Development (DoSD) in New Brunswick is responsible for child and adult care and protection and is the largest employer of the province's social workers. First Nations peoples are given delegated authority under the Family Services Act to deliver their own child welfare programmes. These are monitored by the DoSD. First Nations sectors strive to appoint social workers from Aboriginal communities. In 2006, following mounting concern about an apparent increase in untoward incidents, significantly amongst families considered to be low risk (Gagnon, 2015), a decision was taken to redesign the children's welfare service. As in the UK, it is individual cases such as that of 'Baby P' that often trigger high profile concern (Jones, 2014). In New Brunswick the case of Juli-Anna, killed by her mother and mother's boyfriend in 2002, attracted adverse media attention (Hughes, 2015). Conventional child welfare services of early developmental checks, safeguarding alerts and social work visits were deemed to have had limited benefit. The necessity for service redesign was strongly influenced by the philosophy of Dr. W.E. Deming who through scientific inquiry discovered 'The 85–15 Rule'. This states:

> *Everybody works within a system governed by conditions over which the individual has no control… The 85-15 Rule holds that eighty-five percent of what goes wrong is with the system and only fifteen percent with the individual person or thing.* (Walton, 1991, p.20)

Deming's philosophy underpinned the decision to change the prevailing system, to seek expert advice about alternative child welfare services and to introduce the accredited FGC.

FGC preparation

The FGC implementation involved three years intensive preparation. Juli-Anna's death attracted huge interest from staff, government and the public to ensure that a similar tragedy did not recur. The Ombudsman, the Independent Officer of the Legislative Assembly responsible for investigating complaints from the public about New Brunswick government services who had originally criticized the DoSD, worked closely with those involved in the preparations. Political will was considered to have been vital to the successful introduction of the scheme. The DoSD, through its communications' staff, provided articles on FGC developments. It also engaged with partner agencies and community groups to ensure allied services and the public were informed about the planned changes. New legislation was drafted to authorize the service. Core programme standards were developed to ensure a quality service. Researchers and social work teaching staff at the University of Moncton were appointed to evaluate the initiative. A service user 'FGC Feedback' form was devised as part of the evaluation. An information leaflet explaining the FGC process and the people involved was also produced (Government of New Brunswick, undated).

FGC training in New Brunswick was developed with input from frontline practitioners and the extensive research of senior staff into training initiatives in other parts of the world. This led to the introduction of the Competency Based Child Welfare Training Scheme, developed by the DoSD (Poirier Baiani & Rapaport, 2015a), of which solution focused, conflict resolution training and family therapy are core modules. A training committee was established. This devised and

continues to devise training programmes taking into account feedback from social workers and evolving developments in FGC practice. The core standards also stipulated that only social workers with five years' post-qualifying experience could apply to work within the FGC service.

FGC implementation

The FGC was introduced in 2009 under the 'New Directions' programme (Innes, 2014) as an evidence based model aiming to improve services to families, to ensure the safety and wellbeing of children and to maintain their right to lifelong kinship and cultural connections. The Family Services Act 2008 gave families a legal right to be offered the service. Thus the onus is on social workers to promote the FGC as a viable option.

However, at the outset, managers reported that even experienced social workers could not believe that the families known to them would be able to work within the FGC requirements:

> *… this is never going to work… families are never going to plan… let alone use flip charts to do so.* (Poirier Baiani & Rapaport, 2015b, p.6)

Some were to experience a dramatic conversion and later become emotional when describing the 'healing' process that can take place within families as a result of the FGC (Poirier Baiani & Rapaport, 2015b). Those involved in delivering FGCs have noted that families have been able to disclose sensitive issues and to participate in the decisions and solutions regarding the welfare of their children. In addition, children are considered to be safer (Poirier Baiani & Rapaport, 2015a). Crucially, the therapeutic nature of New Brunswick's training programme appears to alleviate the oppressive effects that child protection discourse can have on participating families (Ney *et al*., 2013), whilst maintaining a safeguarding focus. The intensive nature of the programme also supports Holland & Rivett's contention (2008) that FGC benefits may be enhanced by the incorporation of family therapy.

Whilst only around a fifth of eligible families opt to use the FGC service, this relatively small proportion seemed to have had a dramatic effect on the numbers of children coming into state care. At the end of the first year there had been a reduction of almost 20 percent in the numbers of children taken into care: seven years later the proportion had fallen by a further five percent (Poirier Baiani & Rapaport, 2015b). Financial savings have enabled the DoSD to employ more social workers, reduce the size of caseloads and provide more intensive family support. As a result of this upward spiral, the average size of FGC social workers' caseloads is now just seven families each (Poirier Baiani & Rapaport, 2015a).

Feedback from participating families had also been very positive. Children and families who have participated in the FGC report a satisfaction rating 'of more than 90% on all feedback indicators (Gagnon, 2015, p.4). More recently the FGC has been introduced to help children in care retrieve their kinship links with their families and is about to be implemented in Adult Services. Other government departments such as Justice and Public Safety may adopt the FGC to involve families in decision-making. Whilst the innovation is acknowledged to be labour intensive in terms of frontline work, it is viewed as leading to better, quicker decision-making and as helping those using the service to feel respected.

Case studies: findings and RRV

Six case studies reported in Poirier Baiani & Rapaport (2015b) identify RRV theory. One is analysed here. The cases were chosen at random as typical family scenarios by frontline social workers together with their supervisor. Changes to certain demographics and other characteristics were made by the team manager to protect client confidentiality. The social workers were not identified anywhere in the portfolio, as additional client protection. In all of the six cases the children were destined for possible long-term care or adoption because of safeguarding concerns, but as a result of the FGC were able to thrive with their parents or extended family.

The selected case study typically highlights the dynamics of family and social work interaction present in each of the other case examples. It differed in one respect in that the children in question (twins) had been in state care for some time rather than with their parents. Whilst the parents were apparently loving and visited regularly, they did not appear to understand that their children needed a permanent home. The preparatory work revealed that whereas the children's mother had little family support, the father had a very large extended family some of whom had the financial means and competence to provide childcare. An offer from the father's family was originally thought to be the most likely outcome of the conference.

The family had a long private meeting. Contrary to all the department's expectations, the family decided 'very authoritatively' that if the parents did not address their problems, the children should be placed for adoption. On the other hand, this course might be avoided if the parents agreed to accept responsibility for attending their rehabilitation programme to address their addiction and domestic violence problems. If the parents cooperated and the children were returned to their care, the family would provide relief childcare and even housing.

'In other words, the family was holding these parents accountable and were clear with their own expectations as to what needed to happen in order to meet the Department's bottom line' (Poirier Baiani & Rapaport, 2015a, p.9).

In the event, the parents agreed to cooperate with the plan and worked with their drug addiction counsellors. They eventually resumed caring for their children. Throughout the life of the case, the social worker continued to monitor, review and work with the family, in line with DoSD protocols. The original FGC plan was adjusted as required. Four years later, the children were still with their parents and the Department's case file remained closed.

This case illustrates the potential of the FGC to achieve results where traditional approaches have failed. Participants were enabled by the boundaries of the FGC process, social work expertise and 'rules of respectful discussion', developed by the family to suit their cultural preferences, to explore options and to find a solution acceptable both to themselves and the Department. The narrative shows the FGC at work and its potential to empower a family 'to work reciprocally with Social Workers to achieve mutually agreed objectives' (Poirier Baiani & Rapaport, 2015b, p.22). In accordance with SRV and RRV principles, social work support enabled the family to understand the issues at stake and strengthened its position to find acceptable solutions to identified problems. The family's achievement reflected back on and reaffirmed the potential of the social work role to help families to make their own informed decisions. Here the dynamic of social worker and family interaction is shown to strengthen both roles and to exert meaningful pressure to provide the catalyst to bring about change. The selected case study also illustrates how families are able to fit within and complement professional support systems, give flexible care, and exert meaningful influence where the lifestyle choices of parents, whose children are the focus of concern, need to change. It additionally shows how social workers can complement informal care arrangements with therapeutic interventions made more accessible to parents by the reflected benefits of the family's input. In line with the nearest relative findings, the selected case study highlights the two-way dynamic of RRV. However, here the jointly agreed objective was to help the parents to regain responsibility for their children's care.

Implications for research, policy and planning

The New Brunswick innovation builds on the FGC framework that promotes family and social work collaboration. Its apparent use of RRV potential to strengthen joint decision-making endorses the relevance of the nearest relative research and the development of role theory. The impact of the intrinsic dynamic of family and social work reciprocation at the heart of the New Brunswick process, suggests that a robustly implemented FGC may also benefit adult and other welfare services. In terms of more particular aspects, the careful preparation of administrative and professional infrastructures would appear to have made an important

contribution to New Brunswick's success and is therefore noteworthy. The DoSDs work with the press to publicise service developments is also commendable. Furthermore, Deming's philosophy suggests that willingness to investigate the possibility of system failures is of paramount importance when something goes wrong.

Although officially acclaimed as an important patient safeguard, the role of the nearest relative has never been monitored and evidence of its effectiveness is small. Its positive potential has been eclipsed by problems highlighted in case law (Rapaport, 2002). Fortunately, New Brunswick's FGC does have in-built monitoring arrangements and these have shown positive results. Yet the nearest relative and FGC are equally important safeguards against preventable statutory intervention. Both share the same RRV potential to energize family and professional cooperation to decide best possible outcomes. Although the New Brunswick service continues to prove its worth in reducing the numbers of children in care from only a quarter of referrals, low service take up is also revealed. This is perhaps understandable given the sensitive nature of family problems. However, the innovation still lacks research evidence. Crucially, the reasons so many families decide against the FGC service in spite of its encouraging outcomes are not known. The attitudinal and other factors that influence families to opt for or against the FGC would therefore seem to be priority areas worth investigating. New Brunswick's success suggests that the FGC programme should be maintained and further developed, lest it share the fate of the nearest relative.

Summary and conclusions

The power dynamics of the nearest relative role and FGC bear many similarities. Although families do not have specific powers, the FGC, on a par with the nearest relative, gives them discretionary rights to be involved in the decision-making process on matters that may have long lasting consequences on their lives. Both the nearest relative and FGC may be supported by experienced social workers who have been boosted by post-qualifying professional development. The FGC framework and evidence from New Brunswick illustrate how families and professionals may be able to work together and enhance each other's potential to achieve mutually agreed objectives. RRV is arguably more alive in New Brunswick's 'comprehensive' FGC than it is in the role of the nearest relative. However, whereas the former has thrived on political will, the latter has endured political neglect.

Conceptual frameworks are more than the sum of their parts. They give shape and meaning to actions and can help to ensure services are on track with identified objectives. Although retrospectively applied, Reciprocal Role Valorization is offered as a framework to ensure families are being served in the best possible way, that the right to family life is respected, and that state care, in respect of children and adults, occurs as a last resort. There is increasing evidence that good alternatives to family care are scarce (Rahilly & Hendry, 2014); that family ties may be weakened and even lost forever when children are removed from home; the emotional distress of separation possibly having lasting effects on both parents and children and in respect of the latter, may contribute to problems in later life. Likewise, compulsory assessment and treatment may have disruptive consequences on an individual's life. In addition, following hospital discharge, re-establishing social networks and community links may be challenging. RRV, allied to the growing interest in strengths based social work, is potentially of enhanced importance in the wake of high profile reactions to individual tragedies that traditionally trigger defensive practices. Where kinship ties can be kept intact, family care may be able to avoid the potential 'class' and cultural discomforts raised in earlier Social Role Valorization critiques and reduce the risks of poor outcomes, stigma and social exclusion for both children and for adults.

Acknowledgements

Thanks are due to Professor Jill Manthorpe and Jess Harris at the Social Care Workforce Research Unit at King's College London and to Marc Gagnon, Director of the Department of Social Development, New Brunswick, Canada, and the Family Group Conference team for their help in the preparation of this article.

References

Atkinson, D. (1999) *Advocacy: A Review. Joseph Rowntree Foundation*, Brighton: Pavilion.

Brandon, D. (1991) *Innovation Without Change? Consumer Power in Psychiatric Services*, Basingstoke: MacMillan Press.

Brown, H. & Smith, H. (1992) 'Assertion, not assimilation: a feminist perspective on the normalization principle', in (Editors) Brown, H. & Smith, H., *Normalization: A Reader for the Nineties*, London: Routledge, pp. 149-171.

Carers (Recognition and Services) Act 1995, Elizabeth II, Chapter 12, HMSO.

Department for Education (2010) *Family and Friends Care: Statutory Guidance for Local Authorities*, London: Department for Education.

Department for Education (2014) *Rethinking Children's Social Work. Department for Education Children's Social Care Innovation Programme*, London: Department for Education.

Department for Education (2016a) *Children's Social Care Innovation Programme*, London: Department for Education.

Department for Education (2016b) *Children's Social Care Reform. A Vision for Change*, London: Department for Education.

Department of Health (1999) *The Expert Committee Report Review of the Mental Health Act 1983*, London: Department of Health.

Family Services Act 2008, Government of New Brunswick.

Family Rights Group (2011) *Family Justice Review. Final Report. London and Cardiff*, Ministry of Justice: the Department for Education and Welsh Government.

Family Rights Group (2012) *The Family Group Conference Process*, London: Family Rights Group, accessed 16/2/16 at: www.frg.org.uk.

Gagnon, M. (2015) 'Foreword', in (Editors) Poirier Baiani, G. & Rapaport, J., *Family Group Conferences in the Canadian Province of New Brunswick. Six Case Studies*, London: Social Care Workforce Research Unit, King's College London, pp. 3-4.

Gates, B., Wray, J. & Krinjen-Kempf, E. (2000) *The 18-25 Project: Evaluation of a Citizen Advocacy Project for Young People in Lincolnshire, Hull*, The East Yorkshire Learning Disabilities Institute: University of Hull.

Glaser, B. & Strauss, A. (1967) *The Discovery of Grounded Theory*, Chicago: Aldine Publishing Co.

Government of New Brunswick (undated) *Family Group Conferences. Family Centred Planning for Children's Safety and Wellbeing*, accessed 25/11/16 at: www.gnb.ca/socialdevelopment.

Harry, B., Rueda, R. & Kalyanpur, M. (1999) 'Cultural reciprocity in sociocultural perspective: adapting the normalisation principle for family collaboration', *Exceptional Children*, **66**(1), pp. 123-136.

HC (1981-1982) *House of Commons Parliamentary Debates. Official Report*, Standing Committees: Volume X1.

Holland, S. & Rivett, M. (2008) ''Everyone started shouting'. Making connections between the process of Family Group Conferences and Family Therapy Practice', *British Journal of Social Work*, **38**, pp. 21-38.

Hughes, J. (2015) *Early Intervention. How Canada's Social Programs Can Work Better, Save Lives, and Often Save Money*, Toronto: James Lorimer and Company Ltd, Publishers.

Innes, W. (2014) *New Directions: Presentation on Child Welfare Reforms*, Fredericton: Canada, Government of New Brunswick.

Jones, R. (2014) *The Story of Baby P: Setting the Record Straight*, Policy Press: University of Bristol.

LAC 86(15) Mental Health Act 1983 – Approved Social Workers, London: Department of Health and Social Security.

Lawson, M. (1991) 'A Recipient's View', in (Editors) Brown, H. & Smith, H., *Normalization: A Reader for the Nineties*, London: Routledge, pp. 62-82.

Lindow, V. (1994) *Self-help Alternatives to Mental Health Services*, London: MIND.

McCourt Perring, C. (1993) *The Experience of Psychiatric Hospital Closure: An Anthropological Study*, Avebury: Taylor and Francis.

Mental Health Act 1959, 7 & 8: Elizabeth II, Chapter 72, HMSO.

Mental Health Act 1983, Elizabeth II, Chapter 20, HMSO.

Mental Health Act Commission (1991) *Mental Health Act Commission 4th Biennial Report 1981-1991*, HMSO.

Mercer, A., Lindley, B. & Hopkins, A. (Ed. Ashley, C.) (2015) *Could Do Better… Must Do Better. A Study of Family and Friends Care Local Authority Policies*, Family Rights Group.

Ney, T., Stoltz, J. & Maloney, M. (2013) 'Voice, power and discourse: experiences of participants of family group conferences in the context of child protection', *Journal of Social Work*, **13**(2), pp. 184-202.

Nirje, B. (1969a) 'The Normalization Principle and its Human Management Implications', in Kugel, R. & Wolfensberger, W., *Changing Patterns in Residential Services for the Mentally Retarded*, Washington: President's Committee on Mental Retardation, pp. 255-287.

Nirje, B. (1969b) 'The Normalization Principle and its Human Management Implications', in Kugel, R. & Wolfensberger, W., (Editors), *Changing Patterns in Residential Services for the Mentally Retarded: Chapter 7*, Washington D.C: President's Committee on Mental Retardation, pp. 179-195.

Percy Report (1958) *The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, London: HMSO.

Poirier Baiani, G. & Rapaport, J. (2015a) 'A Canadian encounter', *Social Work History Network Bulletin*, **2**(1), pp. 8-14.

Poirier Baiani, G. & Rapaport, J. (2015b) *Family Group Conference in the Canadian Province of New Brunswick. Six Case Studies*, London: Social Care Workforce Research Unit: King's College London.

Rahilly, T. & Hendry, E. (2014) *Promoting the Wellbeing of Children in Care. Messages from Research*, London: National Society for the Prevention of Cruelty to Children.

Ramon, S. (1991) 'Principles and Conceptual Knowledge', in (Editor) Ramon, S., *Beyond Community Care, Normalization and Integration Work*, Basingstoke: MacMillan Press, pp. 6-33.

Rapaport, J. (2002) *A Relative Affair: The Nearest Relative under the Mental Health Act 1983. PhD Thesis*, Cambridge: Anglia Polytechnic (now Ruskin) University.

Rapaport, J. (2012) *Reflections on 'A Relative Affair'. The Nearest Relative under the Mental Health Act 1983*, London: Social Care Workforce Research Unit, King's College London, accessed 21/6/16 at: www.ac.uk/sspp/policy-institute/scwru/pubs/2012/reports.aspx.

Rapaport, J. & Manthorpe, J. (2009) 'Fifty years on. The legacy of the Percy Report', *Journal of Social Work*, **9**(3), pp. 251-267.

Reith, M. (1998) *Community Care Tragedies: A Practice Guide to Mental Health Inquiries*, Birmingham: Venture Press.

Strauss, A. & Corbin, J. (1990) *Basics for Qualitative Research. Grounded Theory Procedures and Techniques*, Newbury Park: Sage.

Taylor, P. & Gunn, J. (1999) 'Homicides by people with mental illness; myth and reality', *British Journal of Psychiatry*, **174**, pp. 9-14.

Walton, M. (1991) *Deming Management at Work*, New York: Perigree Books.

Wolfensberger, W. (1972) *The Principle of Normalization in Human Services*, Toronto: National Institute on Mental Retardation.

Wolfensberger, W. (1983) 'Social Role Valorization: a proposed new term for the principle of Normalization', *Mental Retardation*, **21**(6), pp. 234-239.

Wolfensberger, W. (2000) 'A brief overview of Social Role Valorization', *Mental Retardation*, **38**(2), pp. 105-123.

Wright, T. (2008) 'Using family group conference in mental health', *Nursing Times*, **104**(4), pp. 33-34.

Yin, R. (1994) *Case Study Research, Design and Methods*, Thousand Oaks: Sage.

Notes on Contributors

Joan Rapaport qualified as a Child Care Officer in the UK in 1967. Her social work career spans child care, mental health and project development. After completing her PhD in 2002, Joan worked at the Institute of Psychiatry and the Social Care Workforce Research Unit at King's College London, where she later became a Research Fellow. Her main research topics include carer issues, advocacy and mental health. Joan was a lay member of the Mental Health Review Tribunal from 2002-2014. Throughout her career she has been an active member of the British Association of Social Workers. Joan is currently a Visiting Research Fellow at the Social Care Workforce Research Unit.

Geraldine Poirier Baiani was appointed as Assistant Deputy Minister in the province of New Brunswick, Canada in 2007. At the time of her appointment she was the *Regional Director of the Department of Family and Community Services* in Southeast New Brunswick and had 29 years of frontline and senior leadership experience in social services and child welfare. She graduated from the Universite de Moncton and is a member of the New Brunswick Association of Social Workers. She has been involved with many boards and community organisations including Board and Campaign Chairs for the United Way of Southeastern New Brunswick. She retired from government in 2013.

Correspondence

E: Jwm.rapaport@gmail.com

T: 07941 774 855