Family Group Conferencing in Public Mental Health Care

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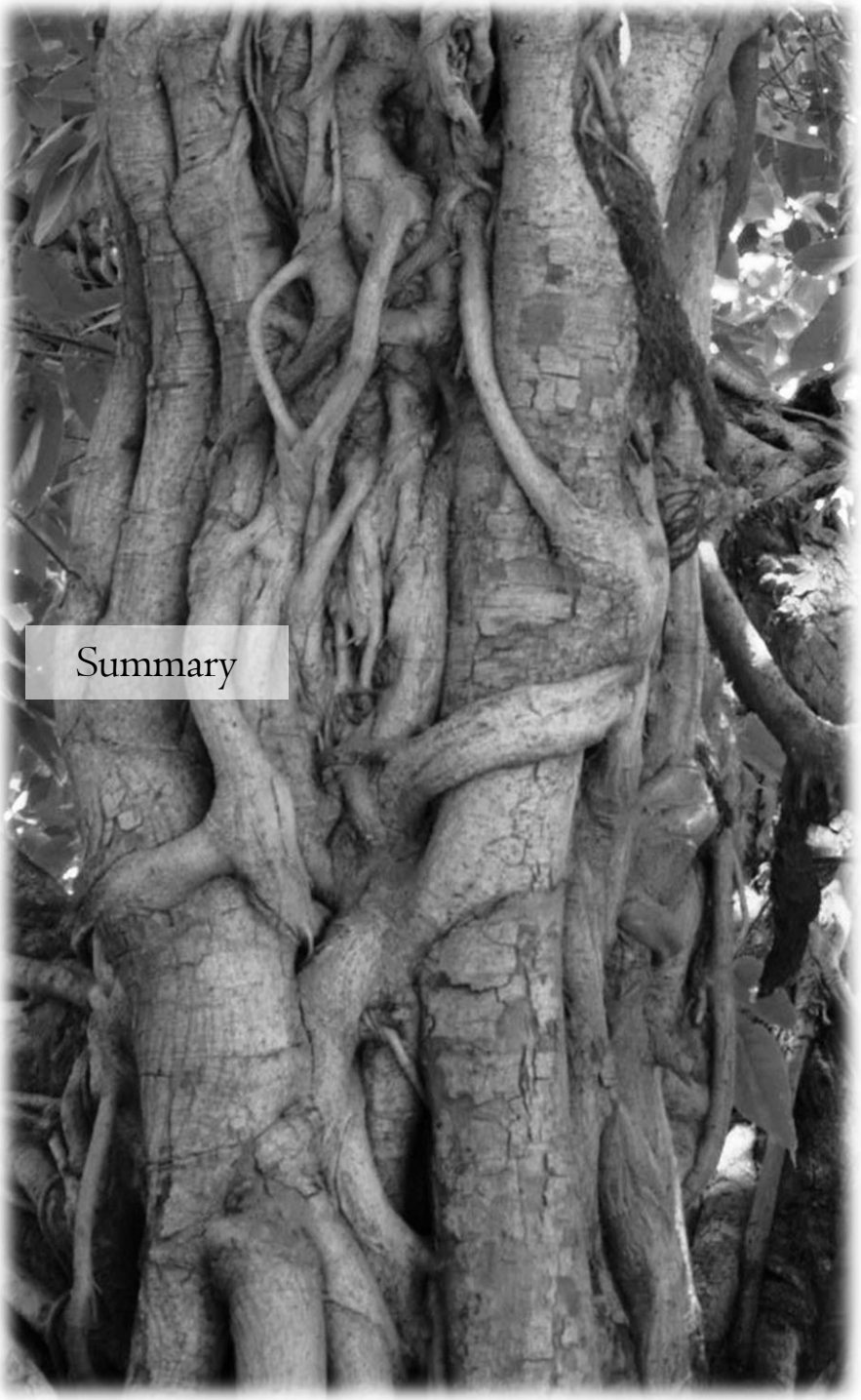

Summary

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In several Western countries the commitment of the community and what can be expected from the welfare state is being reconsidered. In the Netherlands this trend finds its reflection in the transition from the welfare state to the so-called participatory society. Various initiatives to make citizens responsible for their own health and wellbeing and that of their neighbourhood are encouraged by the state. Without being exhaustive, this involves the introduction of the Social Support Act (in Dutch known as 'Wet maatschappelijke ondersteuning', Wmo) and Welfare New Style ('Welzijn Nieuwe Stijl', WNS), the interest in community capability, and the revaluation of social network strategies such as 'wraparound care', 'protective coats, 'community support', 'signs of safety', and 'safety network'. The aim of this thesis is to seek an answer to the question whether the client group of Public Mental Health Care (PMHC) can benefit from the protective effects of social networks that are activated by Family Group Conferencing (FGC).

There is plenty of experience with FGC in youth care, both in the Netherlands as well as in other countries. To date, however, there has been little research done on the process and outcomes of FGC for adult clients in general and PMHC clients in particular. Between 2011 and 2013, 41 family group conferences in the PMHC networks of the province of Groningen were examined how they proceeded and what they yielded. PMHC is a field wherein people are offered help who avoid the care they actually need, or who do not know where to ask for help. A large part of this group lives in degenerated and degraded conditions and/or is involved in liveability problems in neighbourhoods. These are people who apparently have a limited network; relationships are broken or faded. It is therefore questionable whether the realisation of the goals as indicated in the Wmo – promoting social integration and participation, mobilising informal support and achieving social cohesion – is possible with the PMHC client group.

Chapter 1

In the introduction chapter specific attention is paid to the current transitions in health care and social welfare in the Netherlands. There is a growing emphasis on stimulating the self-reliance and resilience of clients, but also their embedding in a social network. It is assumed that embedding in a social network reduces clients' vulnerability and strengthens the capabilities within their network.

In the theoretical background several reasons are outlined which help to understand the increasing popularity of FGC and adjacent forms of social network strategies. Classical sociological theories of alienation and individualisation indicate that humans are social beings who are not able to live disconnected from each other. Disruption of social networks leads to vulnerability. FGC can be seen as response to the drawbacks of individualisation. FGC has the potency to break through social isolation and strengthen communities. FGC is also a response to the disadvantages of the 'therapy culture', such as medicalisation and psychologisation. There are similarities to be drawn between FGC and the paradigm of positive psychology, and a specific form hereof, namely the solution-focused therapy. Both FGC and solution-focused therapy have a focus on strengthening the mutual capabilities people have, not on the treatment of disorders and impairments of individuals.

The transitions in health care and social welfare demand a different approach on how to help and support troubled citizens and the professional attitude that should come along with it. There is a need to gain knowledge on how these transitions are taking place. Can people who have an apparently small and damaged network still take advantages of the informal resources that may be mobilised by FGC? In 2009, an exploratory study pointed to the potential opportunities of FGC for the client group of PMHC. Subsequently the municipalities in the province of Groningen decided to assign a grant to organise and evaluate 41 family group conferences in 23 PMHC networks for a period of two years. In 2011, a responsive evaluation was set up to evaluate the process and outcomes of these conferences. The conferences were per case analysed by final year students of Social Work and Nursing of the Hanze University of Applied Sciences in Groningen. The main question of these individual case studies was as follows:

How did the family group conference in the given public mental health care setting proceed according to the participants, and what were its outcomes in terms of improving the living conditions of clients, client systems and neighbourhoods, intensifying their social support, strengthening their capabilities, and alleviating the caseload of professionals?

To answer this question, in each case (i.e. a conference for a client, client system or neighbourhood with liveability problems) both qualitative and quantitative methods were combined. Interviews were done with four groups of stakeholders: 1) the main person(s) of the conference (clients, client systems, several actors who were directly involved in liveability problems; 2) members of the social network (family, friends,

concerned bystanders such as neighbours); 3) professionals (psychiatric nurses, social workers, police officers, housing association officials), and; 4) FGC coordinators.

The different intrinsic case studies yielded insights on how to understand the process and the outcomes of FGC in PMHC. The second main question of the study was therefore:

How can the process of Family Group Conferencing in public mental health care be understood, and which explanations can be given for the perceived outcomes or lack thereof?

This question was the starting point of this thesis and led to the empirical chapters, which are included in Part II.

The study was in essence a responsive evaluation. In a responsive evaluation diverse stakeholder groups are asked to share their perspectives on the research object with the aim to achieve mutual understanding between the groups. In this research methodology explicit attention is given to the 'silenced voices'. This is especially important to the client group of PMHC as these clients often have a history of expropriation and state interference. In a responsive evaluation they can bring in their perspectives and views.

The 41 family group conferences were analysed with the help of insights from the intrinsic case study approach to gain an understanding of how the conferences proceeded and what they yielded in terms of an increased social support, strengthened individual and community capabilities, improved living conditions, and alleviated caseload of professionals. Within the 41 case studies, 312 semi-structured interviews (7.6 interviews per case) were carried out along a topic list that was divided in process and outcome topics. Interviews lasted on average between 60 and 90 minutes, were recorded and subsequently transcribed verbatim. Qualitative data were analysed along the structured method of inductive analysis according to the ground theory approach using ATLAS.ti, so an understanding was gained of how the conferences proceeded and what were specific twists and turns during this process. Interim findings from each case were presented to respondents in a group member check that sought to determine whether participants could agree with the analysis and interpretations of the researchers. Forty-one group member checks were organised with a total number of 144 participants (3.5 participants per case). The meta-analyses that followed the individual case studies – known as the multiple case study approach – revealed patterns that can be observed in several cases. Quantitative data from 245 respondents in 33 cases (on average 7.4 respondents per case) were processed in a dataset for descriptive and inferential (both t-tests and multilevel analyses) statistics.

Part I

Part I of the thesis consists of three chapters that outline the context of the research project as well as the theoretical background of the empirical study. Chapter Two and three are published as articles of which the author of this thesis is the second author. It was decided to include both articles to weave a red thread through the entire thesis; including both articles helped to clarify the structure and mission of the PMHC, as well as the reasons behind the growing popularity and need of FGC in an individualised society.

Chapter 2

This thesis is partly the result of a research programme that was set up at the Institute of Andragogy of the University of Groningen in the 1980s. The Care Coordination ('Zorgcoördinatie') Project played an important role in the formation of a safety net for people who were avoiding the care they actually needed or who did not know where to ask for help. In the 1990s this safety net, which was functioning on the municipality level, became nationally known as Public Mental Health Care (PMHC). Following the Care Coordination Project, a study was initiated that lasted for eight years and focused on revealing the competences and personal qualities of professionals to establish contact with and gain trust of PMHC clients. This research project was embedded in the Research Group PMHC ('Lectoraat OGGz') of the Hanze University of Applied Sciences and co-financed by the municipality of Groningen. This chapter is the culmination of this last research project which initiated the study into the process and outcomes of FGC in PMHC. The chapter is a critique of the field in which the PMHC operates. In a neoliberal context health agencies are stimulated to expand their markets. These agencies benefit from growing target groups. This makes it understandable why PMHC keeps on increasing in size. The project FGC in PMHC that was started in 2009, was an attempt of the municipality of Groningen and the Research Group PMHC to avoid that PMHC would degenerate into a 'stopgap' for failing systems.

In a market-oriented health care system, the contribution of self-care and community-care are easily overlooked. This leads to excessive forms of professional commitment and commensurate an increase in health care expenses; expenses that need to be reduced by production limits and the tightening of indications for care. This also creates thresholds to the accessibility of care. The inaccessibility of care forms the background for a safety net such as PMHC. In the absence of generalist and accessible services for people with multiple and complex problems, the need for a safety net arises. The existence of PMHC is associated with the co-modification and emergence of a

market-oriented care in which the patient is seen and behaves as a consumer. In such a context primary health care declines.

This chapter, which is based on a literature study and reflections on practice experiences, calls for a reorientation of self-care, family care, and the values that are associated with primary health care. It concludes with a description of PMHC that reflects the dynamics between primary health care, specialist mental health care, and the resources the civil society has to offer.

Chapter 3

Chapter Three focuses on the theoretical background of the study; it is based on insights from classical and contemporary sociology. The theoretical findings in this chapter are mirrored in a short case report of one of the 41 conferences. The case is about a family with two adult sons who created a lot of trouble and therefore negatively affected the lives of their mother and stepfather.

Individualisation leads to alienation. Alienation increases loneliness and the feeling of not belonging, as well as the crumbling of loyalty and solidarity within the own group. According to several sociologists, state interference breaks down traditional relationships. Empirical research on the functioning of social networks, reveals that social embeddedness reduces vulnerability. To survive an individual needs support from family and friends. This chapter wonders whether the rise of FGC in Western welfare states can be seen as a reaction on the crumbling social institutions.

Another question in this chapter is how the process of FGC can be explained. The sociological theory of social capital offers clues. Time, intensity, intimacy, and – especially – reciprocity and recognition are the engines behind strong ties in networks. Reciprocity is subject to obligations between people – social networks with mutual obligations are characterised by a strong social capital. These networks have a robust 'bounded solidarity'; via identification with the group, people are willing to help other group members in time of need. When reciprocity is lacking, trust comes under pressure and people lose interest to help each other. People who have little reciprocity to offer usually have a limited social capital where they can draw on.

Improving relationships in networks is an important goal of FGC. However, this is apparently difficult to achieve in PMHC where a large part of the client group has little informal resources. Frequently contacts within the networks of clients are so damaged or have faded that it can be questioned whether or not PMHC clients will benefit from a one-sided emphasis on restoring contact. Just a single conference will likely create insufficient conditions for this. Another important aim of FGC is to extend the group with extra resources ('widening the circle'). Is there a need in PMHC to look for cross-

connections to other networks when strong ties within the client's network are limited? A strong body of research indicates that people with a lot of weak ties have access to knowledge and resources that their own social network cannot offer. Even when PMHC clients are embedded in networks with strong ties, FGC will achieve little progress if these networks themselves have a limited capital (knowledge and skills). Connections to other networks, such as paid work and volunteer jobs, are needed and could open up new opportunities for PMHC clients.

Chapter 4

The previous two chapters provided insights on the potential benefits of FGC for the client group of PMHC. Before the pilots with FGC in the PMHC networks of the province of Groningen started, an exploratory study was conducted with the central question: *What are the opportunities and limitations of FGC in PMHC?* A literature review on the history of FGC and its implementation in different (care) fields, and semi-structured interviews with experts in the field of PMHC and FGC brought diverse perceptions to the surface about the possible benefits of FGC for clients in PMHC. These findings were then presented to a larger group of experts during a panel meeting. Eventually six reasons were formulated to launch pilots with FGC in PMHC:

1. In PMHC, care providers often need to deal with clients who are not motivated. Even without the presence of the client, FGC could yield support or provide a plan.
2. FGC might constitute an extension of the repertoire of treatment options between voluntary help and coercive treatment.
3. Clients in PMHC often have a limited network. FGC promotes the involvement of the natural network around a client. It expands and restores relationships and generates support.
4. FGC could succeed both in a crisis and in other non-critical situations. Sometimes pressure is required before clients accept help from their network (such as in the case of an imminent eviction), while in other situations, it is required that clients are stabilised before a family group conference can be organised (such as in the case of a psychotic episode).
5. Clients who have negative perceptions about care agencies and their representatives might be inclined to accept a family group conference because these agencies act in another (modest) role.
6. Finally, the social network could elevate the general tasks the care provider normally needs to fulfil.

Part II

In Part II, five chapters highlight different facets of the empirical data of this study. Chapter Five concerns the results of the quantitative analysis that sheds light on the outcomes of the conference, while the four subsequent chapters report on the results from the meta-analyses that were carried out on the qualitative findings from 41 case studies.

Chapter 5

This chapter gives an account of the outcomes of the analysed conferences. It was possible to derive meaningful quantitative data from 33 cases. These data are the individual scores of respondents from the four stakeholder groups. On scales ranging from 0-10, they reflected on four outcome variables, namely: 1) improving the living conditions of clients, client systems, and neighbourhoods that are characterised by conflicts in which clients are involved; 2) improving the quality of social support and an increase in the number of informal resources; 3) increase of the self-reliance of clients, client systems, and neighbourhoods where clients reside, and 4); alleviating the caseload of professionals. Each respondent was asked to assign retrospectively a score to the situation with regard to the outcome variable prior to the conference and a score to the situation after the conference. Several respondents per case were asked to reflect on the outcomes of the conference to form a congruent picture on the outcomes of the conferences. Our approach benefitted from extensive experience in the solution-focused therapy with this type of scale questions and reflections on given scores (respondents were asked to provide arguments for an increase or decrease in the outcome scores) to understand the effectiveness of therapies and interventions.

Of the first three outcome variables, it was possible to make statements about the entire group of 33 cases. Both t-tests and multilevel analyses revealed that the self-reliance (from 4.09 to 6.32, on a scale of 0-10), the living situation (from 3.73 to 6.64, on a scale of 0-10) and the quality of social support (from 5.04 to 6.73, on a scale of 0-10) improved significantly after the conferences. In addition, the number of informal resources where clients could rely on (from 3.59 to 6.67, number of persons) also increased, while the number of professionals involved had remained almost unchanged (from 2.26 to 2.07, number of professionals involved).

Chapter 6

After just a few case studies, the prominent role of shame struck us, and fuelled a more systematic exploration of this pattern. Shame can turn in two different directions: driven

by shame, an individual is inclined to (1) attack other people or him- or herself, or (2) withdraw from or avoid shameful situations. In almost every case study this pattern influenced to a greater or lesser degree the process and outcomes of the conference.

In this chapter, two case studies are highlighted that attempt to explain why shame leads to social isolation, but also serves as an incentive to prevent a relapse into old destructive patterns after a conference. The first case is about a man in his mid-sixties, who for a while had been deteriorating and languishing. He drank excessively, neglected himself and finally found himself back in social isolation. The second case considers a couple in their mid-forties whose house was seriously smeared. Especially the woman got increasingly socially isolated. In both cases shamed played a central role in the process towards and after the conference, because the living conditions evoked so much shameful feelings that consequently the social network was kept aloof. Eventually, even doors were not any longer opened and the curtains remained closed.

It appeared in both cases that FGC offered a platform for clients whereon they felt at ease to share their shameful feelings with the social network. Both cases show that shame was the reason why the clients found themselves back in social isolation, but that it also helped after the conference to prevent relapsing in old patterns; apparently clients did not want to feel so embarrassed again and therefore did not relapse in destructive behaviour that once again would evoke shame.

Chapter 7

Prevention of coercion in Dutch mental health care, is desperately needed, because we have the highest number of involuntary admission worldwide after Japan and Belgium. The question addressed in this chapter is whether FGC can help to prevent various forms of coercion in PMHC, especially imminent housing evictions and involuntary admissions to psychiatric wards.

This chapter specifically highlights a case wherein the threat of compulsory psychiatric admission of a man with schizophrenia was evident. It concerned a situation in a small neighbourhood with seven residents. These residents increasingly had difficulties with the deteriorating psychotic behaviour of the client. A Judicial Authorisation ('Rechterlijke Machtiging') for compulsory psychiatric admission was requested by the ACT (assertive community treatment) team that had the man in their caseload. This, however, caused resentment among the residents, because they only wanted advice from the ACT team on how to deal with the man. A family group conference was requested in which the man himself, finally, did not participate. Due to his cognitive disabilities he was not able to oversee the situation. After his approval he was represented by his sister. During the conference it was decided that another case

manager should be added. After the conference, the new case manager and a PMHC professional paid explicit attention to the needs of the neighbourhood and helped them to get along with the man. The sister also had a consulting role. Finally, the ACT team decided to withdraw the Judicial Authorisation. As the residents were strengthened and started to act as a unified entity, they knew better how to correct unacceptable behaviour of the client without risking escalation.

The case shows that it is not necessarily required that a client him- or herself participates in the conference. If a possible conference evokes so much fear or aggravates psychotic problems, it can be jointly decided with the person it concerns that the parties directly involved in the conflict turn into the main actors of the conference and let them establish a sustainable plan that potentially can prevent coercion. However, this implies a different attitude among professionals, namely from one that solely focuses on promoting the well-being of the client to the active involvement of the social context of clients; people who are needed to prevent clients from downward spirals. In this approach, results are not achieved *in* the community, but rather *through* the community.

Chapter 8

A specific form of FGC is conferencing for groups. This type of FGC is internationally known as Community Conferencing (CC) and is mainly organised in neighbourhoods and residential areas with liveability problems. In these situations usually several parties contribute to inconveniences and conflicts. The group conferences themselves are different from those for individuals and families, because there is not a private family time and professionals can think along with the group in developing the plan.

Of the 41 analysed conferences, 11 were group conferences. Chapter Eight puts emphasis on three of these conferences; cases that are exemplary for the other eight. In all three cases, liveability problems between multiple parties could be revealed. Two cases were centred around small neighbourhoods, while the third case covered a whole residential area. The process and outcomes were different for each case. The three selected cases differ with regard to the perceived outcomes. In the first conference participants indicated the conference as successful, the reactions on the outcome of the second case were various, while in the third case every actor agreed that the conference had failed. Our study focussed on the underlying patterns to gain a better understanding of the process and outcomes of this specific type of FGC.

A meta-analysis resulted in three patterns: 1) the importance of a neutral party who formulates clear frames for the plan of the conference, but who does not influence the content of the plan itself, as well as the importance of adding individual conferences to the group conference for the parties that directly contribute to the liveability problems;

2) the creation of conditions in which every actor feels at ease to share his or her opinion, which will also prevent certain actors from dominating the conference while others are not able to share their perceptions, and wherein there is the opportunity to express emotions so that the turning point of collective vulnerability can be reached – the moment where emotions have reached such a high level that people realise the impact of their behaviour on others and consequently will change their unacceptable behaviour; 3) the requirement that the troublemakers participate in the conference, and the involvement of concerned bystanders from the community who can act as 'shock absorbers', but who can also come up with creative solutions.

Chapter 9

Of the 41 cases, 18 were by several respondents identified as failed conferences. Precisely analysing the patterns that clarify a failed implementation of FGC, helps to answer the question whether this decision-making model is an appropriate means to strengthen the social networks of PMHC clients and to find solutions for liveability problems.

This chapter reports on striking patterns in these 18 'apparently' failed conferences. 'Apparently' is put between brackets, because it is the question whether these conferences have indeed failed. A grounded theory analysis revealed four patterns that shed light on the processes underlying the failure of conferences: 1) social resources who can or want to participate in the conference, but with whom the contact with clients is so diluted or damaged that there first is a need to invest in restoring contact; 2) shame and pride can make the client reluctant towards inviting those who could potentially have an important contribution; 3) a lack of initiative during and after the conference to formulate and effectively implement a plan, and participants who are diametrically opposed to each other and who are not willing to reach a compromise, and; 4) seeking refuge in professional care when the social network after the conference falls down.

When conferences do not (seem to) succeed, then it is still important that professionals and FGC coordinators are sensitive to remarkable side effects of the conference and point out these to the participants. Professionals, for example, can gain a better view on the size of the social network and the possible support it has to offer after the conference. Clients can have a more valid idea of whom they can rely on, while the conference may inform the social network who sincerely offered their support that the client is indifferent and does not do anything with their help so they do not have to feel guilty when the client once again neglects him- or herself. Finally, a conference gives people with a history of expropriation and state interference a voice; even when the

conference fails, they at least have had the chance to formulate their own plan before the state once again intervened.

Chapter 10

In this final chapter, the main findings of the study are discussed. The reflections on these are related to findings from the literature. Methodological challenges and limitations of the study are discussed. Based on insights from two philosophers, Richard Rorty and Hans-Georg Gadamer, the validity of the study is considered. Then suggestions for future research and implications for practice are shared and finally an answer is given to the question which patterns help to understand the process and outcomes of FGC in PMHC.

The assumption is that FGC can only be beneficial when enough social resources are mobilised. It is often assumed that this is difficult with people living in socially isolated circumstances and therefore a conference is already doomed to fail. One of the main findings of this study, however, is that social isolation is not a contraindication, but rather an important reason to organise FGC; several case studies have shown that FGC was a first step to recovery of contacts, and that informal support could be sustainably mobilised once contacts were restored.

Another key finding is that a 'kitchen-table-conversation' often cannot create the progress that is needed in PMHC. During such a meeting between the client and professional, the perspectives of a larger group of concerned bystanders are missing; not only their creative ideas for possible solutions, but also their ability to upset' the client, as the expression of certain words is precisely needed to let clients realise their unacceptable behaviour and create an urge to change it – words that professionals never would (or even legally could) use, but that are necessary to break with negative spirals of neglect, decay and conflict. It appears from this that clients would change for their loved ones, but the willingness to do so for professionals was nil ('for your mother you will change, not for professionals').

Some cases indicate that FGC can help preventing housing evictions and involuntary admissions in psychiatry, both forms of coercion that are regularly deployed in PMHC. FGC can create conditions for people who found themselves on the margins of society to be socially embedded once again. Precisely when clients are socially embedded their vulnerability will be reduced and thereby also the risk of future coercive measures.

The preparation of FGC is a process that is not always done along a script, especially when conferences are organised in the complex reality of PMHC. During this process many twists and turns can happen that require a certain sensitivity and tact of FGC coordinators. Professionals are essential to help this process succeed. They are not only

needed for the referral, but they can also help coordinators to deal with their clients and gain their trust as well as that of the social network. However, working from the FGC philosophy requires another professional attitude, namely one in which professionals are adept at making themselves superfluous and create conditions in which the self-reliance of clients and community capability within the social network are reinforced. Sometimes it is not feasible for professionals making themselves superfluous, so they need to find a balance between taking care, supporting self-care, and activating clients and their social network.

Ultimately, it can be concluded that slightly more than half of the analysed conferences (n=23, 56.1%) can be considered successful as a plan was established and goals were achieved according to participants. The resilience of PMHC client(system)s was reinforced after the conference. However, the increase in their capabilities and self-reliance was not spectacular. Their living situation improved, albeit limitedly. As both the quality and quantity of the social support increased, we can state that the conferences had a positive effect on increasing help from informal resources. The caseload of professionals did decrease a bit, but in most cases professionals remained involved. This however is not a negative sign as learning to connect with and have trust in professionals is actually a main goal of PMHC. It is remarkable that in the group conferences with a successful outcome, we have observed a decrease in demand for care; professionals in these cases indicated that after the conferences they were significantly less involved with the situation than before.

Given the characteristics of the study population, these results are modest but promising. That the outcomes were not more significant can be explained. The clients referred to our study often had a unilateral network (barely weak ties) and few social resources from who support could be expected. FGC helped in restoring contacts, but widening the circle was a bridge too far. Many clients did not want to hang out the dirty laundry and preferably chose a route to professional care where same degrees of shame are usually not evoked.