

VU Research Portal

Family Group Conferencing in Public Mental Health Care

de Jong, G.

2014

document version

Publisher's PDF, also known as Version of record

[Link to publication in VU Research Portal](#)

citation for published version (APA)

de Jong, G. (2014). *Family Group Conferencing in Public Mental Health Care: A responsive Evaluation*.

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

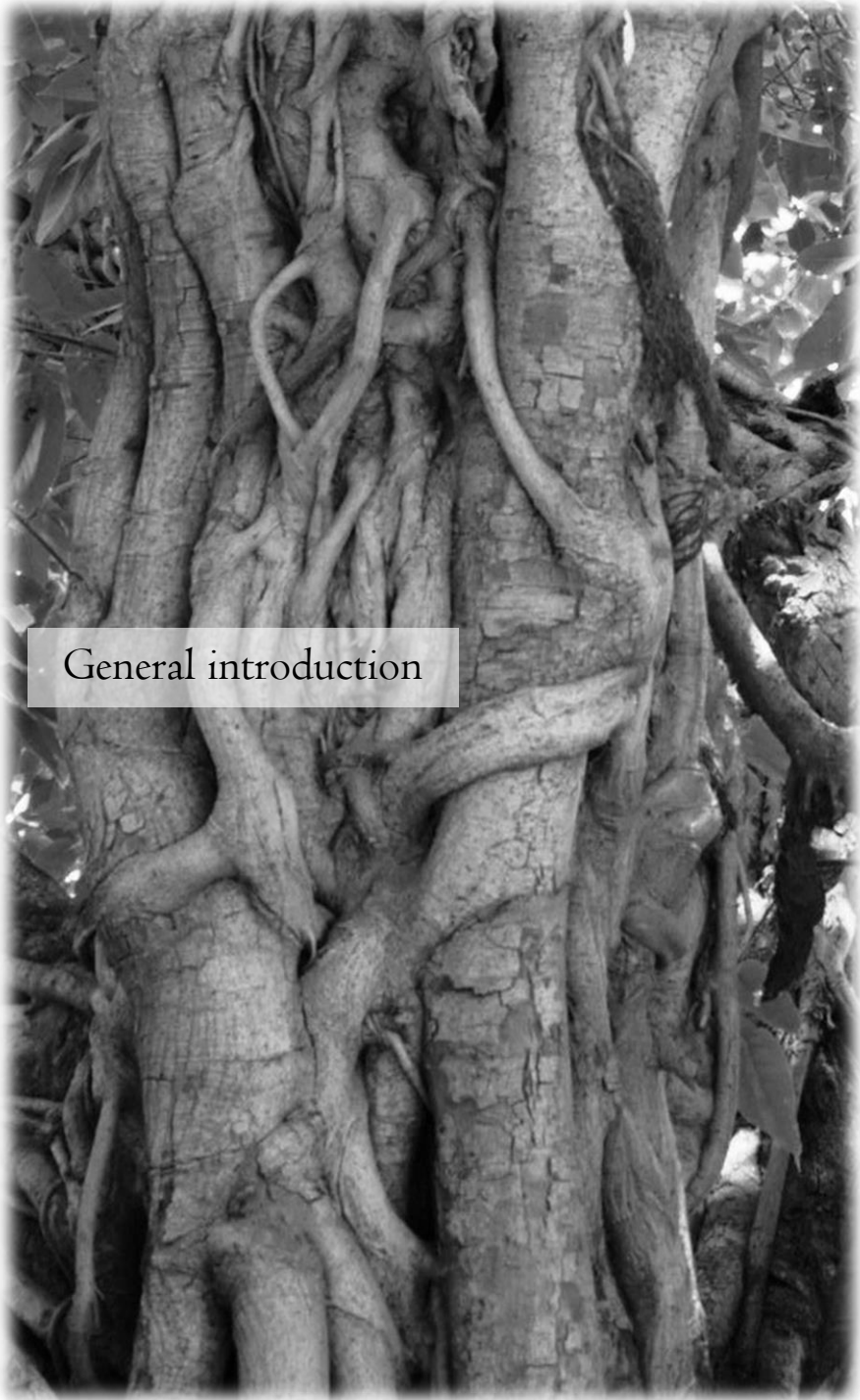
- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

E-mail address:

vuresearchportal.ub@vu.nl



General introduction

Chapter One

General introduction

When we started with our research project ‘Family Group Conferencing in public mental health care’ in 2009, there were no signs that five years later this decision-making model would be looked upon as a good practice in the new Youth Care Law (‘Jeugdwet’) that has been passed on 18 February 2014 in the Senate of the Netherlands (Eerste Kamer der Staten Generaal, 2014). A specific amendment within this law is that families have the right to develop a plan along with their social network before youth care professionals intervene.¹ It is not surprising that the last two years Family Group Conferencing (FGC) has been subject to heated debates in the Netherlands, receiving a lot of attention in national newspapers (see among others Besselink, 2012, 2013; Jorritsma, 2013). The well-read weblog Sociale Vraagstukken even dedicated a complete dossier on the effectiveness of FGC containing contributions from several scholars.²

The discussion started when Stams and Van der Helm (interviewed by Van Dam, 2013) heavily criticised a study by Schuurman and Mulder (2011) on the outcomes of 100 family group conferences for multiproblem families in Amsterdam that indicated a significant reduction in the demand for professional help after the conferences. Their criticism was that this study was meaningless as it lacked a control group. Further on, they raised questions by the state of the art of research projects that have been carried out so far examining the impact of FGC, mainly qualitative evaluation studies (Stams & Van der Helm, 2013). The Dutch Youth Institute (‘Nederlands Jeugdinstituut’, NJi) even went a step further, by stating that the research methods deployed so far are unreliable and lack rigour, resulting in invalid findings and doubtful conclusions (Nji, 2013). This debate, however, cannot be understood isolated from political reforms in the Netherlands. As the national government is confronted with the global economic crisis, its income is declining and consequently budget cuts on health care and social welfare are reinforced. Inspired by Blond’s (2010) ideas on civic engagement, there is an aim to transform the welfare state into a so-called participation state wherein citizens are

¹ Similar amendments were adopted in New Zealand in 1989, ‘The Young Persons and Their Families Act’ (see Levine, 2000), and in the United Kingdom in 2008, ‘The Public Law Outline’ (see Evans, 2011). Like the Dutch amendment, both legal regulations are meant to reduce the role of the state and to empower families to deal with issues in the family.

² <http://www.socialevraagstukken.nl/site/dossiers/werkt-eigen-kracht/>

stimulated to solve problems first on their own and with the help of their social network before calling in professional help (Troonrede, 2013). The new Youth Care Law is a good example hereof.

Often FGC is misunderstood by policy makers, managers and professionals who do not recognise its pursuit to give back citizens the right to make plans on their own before the state intervenes. Rather, FGC is seen as a way to cut budgets as by mobilising informal support it is believed that the demand for professional help will subsequently decrease. What is overlooked, however, is that FGC was already introduced in the Netherlands thirteen years ago as a means to strengthen families in their decision-making and social capacities. In other words, proponents of FGC criticise the normative superiority of the state and paternalistic intervening professionals. Further on, they promote capacity building. These proponents do not necessarily embrace efficiency and financial argumentations to reform the welfare state (e.g. RMO, 2013, p. 19).

The rise of FGC in the Netherlands can be seen as the forerunner of various initiatives that entail changes in the relationship between the government and citizens. Not only in the Netherlands, but also in several other countries in the Western World a reconsideration is taken place of what can be expected from the welfare state and how resources from the civil society can be mobilised (Blond, 2010; De Boer & Van der Lans, 2011; Kampen *et al.*, 2013; Lupton & Nixon, 1999; Pennell, 2006; Tonkens, 2008; WRR, 2006, 2012). In the Netherlands, this is reflected in the introduction of the Social Support Act ('Wet maatschappelijke ondersteuning') and Social Welfare New Style ('Welzijn Nieuwe Stijl') and the emergence of social interventions such as 'wraparound care', 'community support' and 'safety network' ('Vangnetwerk'). In our research project we aimed to answer the question whether the client group of the public mental health care (PMHC) can benefit from the protective features of social networks that are activated by FGC.

Public mental health care

On January 1, 2007, the Social Support Act (SSA) came into force. The purpose of this act is 'social participation'. The SSA must ensure that every citizen can participate in society, independently or helped by family, friends and acquaintances. Mutual commitment between people is an important pillar of the SSA. Various fields of care are included under the umbrella of the SSA, as well as the PMHC (De Klerk *et al.*, 2010). All activities in the field of mental health care that are not performed and guided by a voluntary and individual demand for help are covered by the PMHC. In PMHC there is

no demand for care in the traditional sense. The diffuse requirements for help are usually not felt and expressed by clients themselves. The client group of PMHC is an exceptional group that typically does not benefit from the mutual commitment which is so important to the SSA. These people often have a limited social network from whom little help can be expected.

Clients in PMHC often have to contend with multiple problems. Various social institutions use a variety of indications for this group: problem tenants, people who avoid the care they actually need, trouble makers within neighbourhoods, addicted homeless, homeless youth, and people who are deteriorating and languishing in silence (those ‘who waste away behind the geraniums’). Often clients are vulnerable and lack capabilities and resilience to hold their own ground in society. Generally they lack the help of a social network. They normally do not use the existing facilities. Sometimes they recognise their need for help, but do not know where to demand for it (Gezondheidsraad, 2011; Schout *et al.*, 2010, 2011; Van Hemert & Wolf, 2011).

The four largest cities in the Netherlands – Amsterdam, Rotterdam, Utrecht and The Hague – and providers of mental health and addiction care define the PMHC client group according five criteria (G4, 2006):

-
1. presence of a psychiatric disorder (including addiction), or severe psychosocial problems;
 2. the presence of multiple problems in several areas at the same time;
 3. leading to an insufficient provision in their living conditions (housing, income, social contacts, self-care, and so forth);
 4. lack of ability to solve problems themselves;
 5. absence of a proper demand for help.
-

The backgrounds and forms of PMHC issues relate to several factors such as unfinished education, disabilities, unemployment, addiction, psychiatric disorders, learning disabilities, trauma, living in deprived areas, somatic disorders and poor social skills (Schout, 2007). But also demographic factors play a role: the shrinking of social networks associated with aging and an increasing number of single households. This list is not exhaustive. For such a diffuse client group as the one of the PMHC, it is not an easy task to formulate an exhaustive list of determinants and mechanisms. What is clear is that in many cases the problems of this client group interact and reinforce each other. Addictions often generate psychopathologies, and vice versa. Addictions are frequently intertwined with domestic violence, financial difficulties and legal problems. PMHC clients therefore are often referred to as ‘problem-tangle clients’ (‘probleemkluwen-

klanten’). This term emphasises that health problems cause other problems, resulting in an inextricable tangle caused by problems that reinforce and recall each other (Lohuis *et al.*, 2008).

The challenge for the PMHC is to provide help to those who apparently do not want to be helped. The PMHC is not a traditional agency with an office and paid staff. In PMHC mental health professionals from different disciplines work together in so-called safety nets to help disadvantaged people who would otherwise not receive help (Schout *et al.*, 2011; Schout, 2012). In most cases, clients do not actively seek help, but are reported by others (such as relatives and neighbours) to a special hotline (‘Meldpunt Zorg en Overlast’, Hotline Care and Nuisance) that is provided by the municipality. The hotline may refer the worry or complaint to the PMHC team, and the notified person is consequently designated as a PMHC client.

To summarise, the PMHC can be seen as a network that operates at the municipality level wherein different agencies and social professionals work together, such as community mental health nurses, social workers, police officers and housing association officials. This collaboration is based on agreements that might or might not be covered by municipality laws. There is no central party here who takes the lead. Each stakeholder has its own interests, performs various tasks and has different objectives. Together, these stakeholders should provide assistance to people who do not actively demand for help (Schout, 2012).

Why studying FGC in PMHC?

Internationally there is little experience with FGC for adult clients. To our best knowledge there are only two studies which have evaluated the outcomes of FGC for adult clients with similar problems to those of the PMHC population. First is a Norwegian study that examined the impact of FGC on the wellbeing of longer-term social assistance recipients (Malmberg-Heimonen, 2011; Malmberg-Heimonen & Johansen, 2013). Second is a pilot on FGC for adults who suffer from schizophrenia, bipolar disorder or personality disorder in a community mental health practice in the county of Essex (UK) (Mirsky, 2003; Wright, 2008). Both studies revealed that FGC helped in restoring contacts with family members and friends, mobilising their support and overcoming social isolation. These studies point to the potential benefits of FGC for adult clients in PMHC.

There are three arguments to study FGC in PMHC. First, we question whether PMHC clients who normally can only rely on limited help from an often faded and broken social network, could still benefit from the informal resources who are nevertheless mobilised with the help of FGC. Studying the process and outcomes of

FGC in this field of practice could indicate the potency of this social intervention as a means to revitalise social networks. Second, a general assumption of FGC is that its participants are intrinsically motivated. Precisely PMHC clients often lack motivation for help and avoid the care they actually need. Could FGC help overcoming this lack of motivation and stimulate clients to accept support from their network and professionals? Third, achieving real progress with this client population is difficult. It is therefore interesting to examine whether FGC could help in breaking through vicious circles of deterioration and languishing.

Family Group Conferencing

A family group conference³ is a meeting wherein a client (referred to as ‘main actor’ in the vocabulary of FGC)⁴ and its network are stimulated to find solutions to a problem and develop a joint plan on their own. Since 2001, FGC has been organised in youth care in the Netherlands (Van Beek & Muntendam, 2011).

According to Doolan (2003), the FGC model is an approach which seeks to bring the informal system of the family and social network together with the formal system of the government and care agencies, so that both systems can have hold on each other’s information and consequently the best decision regarding a client can be made.⁵ This involves mobilising the resilience and capabilities of clients and their social network. Different parties participate in a family group conference. Not only the client and his or her family are present, even friends, neighbours and colleagues can participate, together referred to as ‘the extended family’. Through democratic decision-making a plan is developed whereon each participant of the conference need to agree. It is the aim in

³ In this thesis we strictly use the abbreviation ‘FGC’ for referring to the decision-making model ‘Family Group Conferencing’ (uppercase). When we refer to a single conference, we use the term ‘family group conference’ (lowercase) or just a ‘conference’.

⁴ In the literature study we carried out we came across different terms, such as care demander, child, client, family and citizen. In this study we mainly use the term ‘client’ and sometimes ‘main actor’. With ‘client system’, we refer to either a couple, family or a wider family who can all be considered as PMHC clients. Sometimes we also use the term ‘neighbourhood’, as in PMHC problems occasionally happen between several residents living closely together.

⁵ In recent years FGC is increasingly brought under the ‘umbrella’ of Family Group Decision Making (FGDM). Several other decision-making models are also indicated as a form of FGDM, such as Family Team Meetings, Family Circles, Family Finding and Safety Circles. All these approaches have in common that they aim to engage the wider family and community, and that a central role is coined for them in the decision-making process (see Morris, 2012; Shlonsky *et al.*, 2009).

FGC that all participants are able to share their ideas for possible solutions, but are also given voice to express their dissatisfaction and grievances (Holland & Rivett, 2008). If necessary, so called ‘spokespersons’ or ‘advocates’ could help vulnerable voices to be heard, such as the ones of children (Dalrymple 2002; Holland & O’Neill 2006; Pennell & Burford 1994). The plan describes the roles and responsibilities of the different actors.

In FGC, the traditional method where professionals are in control is abandoned: it is the client and the social network who set the agenda and content of the plan. FGC is a cultural sensitive approach that corresponds to the lifestyle and history of families and communities (Jackson & Morris, 1999; O’Shaughnessy *et al.*, 2010; Waites *et al.*, 2004). Unlike traditional approaches that are often “family-centered”, a family group conference is “family driven” (Merkel-Holguin, 2004, p. 164). In other words, this approach *does not focus on* the family, but *achieves results through* the family. In a sense, FGC aims to mobilise the human resources who are present within the civil society.

A core element of FGC is the independence of the coordinator who organises the conference: a citizen who preferably has no background in social work or other care fields, who positions himself as organiser, listener, reliever and encourager (Natland & Malmberg-Heimonen, 2013). Another important pillar is the private family time during the conference: free from oversight of professionals, the client and his or her family are stimulated to come up with a plan on their own (Doolan, 2003). The entire process of a family group conference consists of four phases (see figure 1).

Clients in PMHC and their close relatives generally do not know about the existence of FGC. It are mainly care providers who attend their clients to the possible benefits FGC can yield for them. Without the intercession of professionals, client systems would usually not be aware of this opportunity. In PMHC, the reference is usually done by a professional. Though, clients or family members can also directly contact the regional manager of the FGC organisation (‘Eigen Kracht Centrale’).⁶ The regional manager will search funding (mainly from SSA municipality budgets) and will appoint a FGC coordinator when a budget is available. Together with the client, the coordinator explores the informal resources from the social network who can be approached for participating within the conference. Although the coordinator thinks along with the client, the choice of who to invite for the conference lies primarily with the client. The conference usually takes place four to six weeks after the referral. Also professionals can participate, but only during the informative stage, where they can outline the problem situation and share possible solutions. Crucial to the conference is the private time where

⁶ www.eigen-kracht.nl

the family is motivated to develop their own plan. In the last stage of the conference the plan is formalised by the coordinator. Usually a well-respected person from the client’s network is appointed to take responsibility for the implementation of the plan.

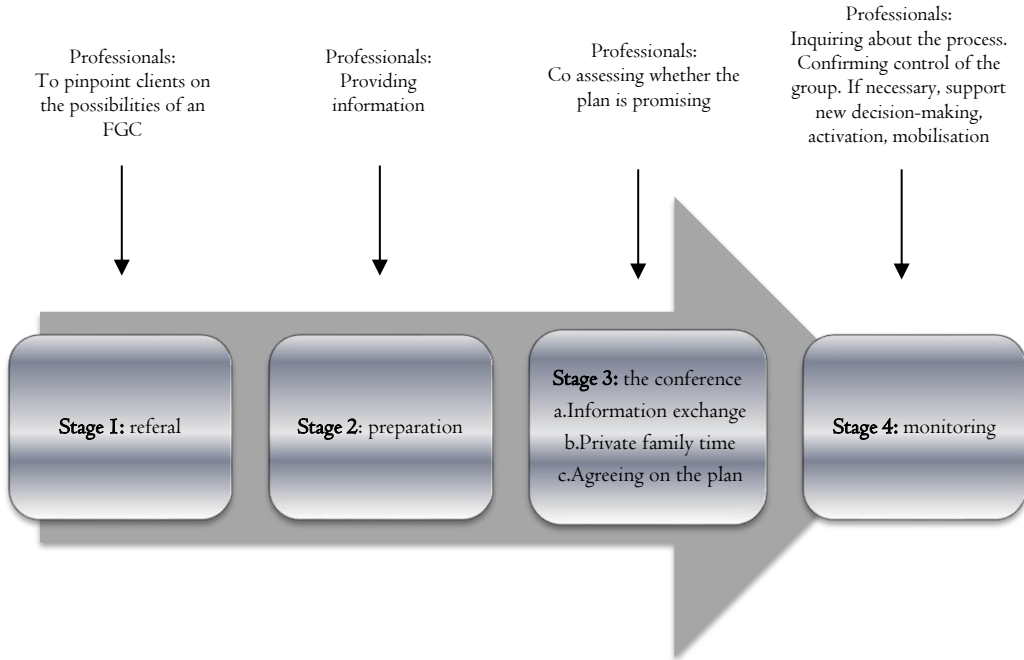


Figure I. Stages of Family Group Conferencing and the role of professionals

The role of professionals is not ceased to apply. Professionals refer clients to FGC, they are present during parts of the conference, they provide information and support, but also open up resources from other agencies. Their task perception nevertheless changes into what Gerritsen (2013) describes as “egoless care”: professionals who enjoy making themselves redundant and who give the social network the feeling that they solve the problems themselves.

Essential in the Dutch FGC approach is that people not only have capabilities of their own, but that they also live together and develop capabilities. Hilhorst (2009) calls this ‘community capability’ (‘samenredzaamheid’). He argues for new forms of solidarity. In his view, for too long we have outsourced commonality and solidarity to the state. Confidence in the state, however, is compromised because its bureaucratic logic has difficulties in connecting with the lifeworld of citizens. According to Hilhorst, FGC is a new form to shape direct solidarity.

Theoretical background

Two theoretical perspectives underpin our research project. First, we have used sociological theories to gain an understanding on the necessity of being socially embedded and on the emergence of and need for FGC in Western welfare states as a means for ensuring social embedding. Second, the positive psychology paradigm gave us clues on the central concepts of empowerment, resilience and capabilities that underlie the FGC approach.

Before we started with our research project we did not have a clear view on our theoretical underpinnings that we aimed to investigate. We had ideas on the benefits for PMHC clients of being socially embedded in communities characterised by mutual solidarity, and understood that central to the FGC approach was strengthening the capabilities of clients and their network, not on emphasising their incapacities. However, we developed our theoretical framework along new insights that arose during our research. We tried to find ideas from the literature to get a better understanding of our empirical findings. Insights from the social capital theory appeared to be paramount. It became clear to us that combining these insights would be the key to understand the process and outcomes of FGC in PMHC.

Social embedding in communities of fate

The emergence of FGC can be partly explained by combining traditional and current insights from sociology. FGC can be seen as a new form of civic engagement. In Western welfare states civic engagement is mainly related to the relationship between what sociologists call ‘crowding in’ and ‘crowding out’. Crowding out refers to the situation where active citizenship is hindered by professionals. Crowding in means that the state and the civil society complement each other – the state creates conditions for citizens to take responsibility themselves. Durkheim (1951/1897, 1997/1893) already described in the nineteenth century that the state competes with the civil society and thereby frustrates organic solidarity. Organic solidarity is replaced by mechanical solidarity. This process is characterised by a social contract wherein taxes form the basis for activities that are carried out by the state. Freed from traditional ties and obligations, individualism thrived.

Various traditional sociologists, such as Durkheim (1951/1897, 1997/1893), Nisbett (1953) and Tönnies (2004/1887), suggest that individualism paved the way for alienation. As a result, the feeling of belonging to a particular culture or society decreased, as well as the loyalty and solidarity within the own group. According to these sociologists, state interventions break down traditional, informal bonds and therefore

erode people's social embedding in 'communities of fate'. Stinchcombe (1965) described a community of fate as an organisation in which the success of individual participants is closely linked with the success of the larger collective. Hirst (1994) sees them as 'existential communities': "one is born in them and raised in them" (p. 52). Boundaries, identity and belonging are crucial features of communities, but communities of fate do not necessarily share identity; rather a situation, a process, a fate (Brydon and Coleman [Eds.], 2008). The concept of social embedding emphasises the emotional relational aspects between members of these communities – in their time of need they will help each other. Social embedding is about feeling belonged and having reciprocal relationships of mutual trust.

That social embeddedness in a family or community is important, was already emphasised by Gehlen (1988/1949) in the 1940s. In recent years empirical evidence has indicated that a lack of social embeddedness, and therefore the lack of informal support, lays the foundation for vulnerability (see for example Poortinga, 2006). To survive, an individual needs the support from family and friends. Could the emergence of FGC be seen as a response to the crumbling social institutions and a lack of sense of belonging to a group or community?

More recently, Furedi (2004) argued that the liberated individual is actually uncertain and does not have the ability to deal with setbacks, rejection and the stress that comes along with it. Societies wherein market forces are dominant, fuel this vulnerability; they do not address the strengths and capabilities of their citizens, but instead emphasise their incapacities. It are precisely these incapacities that, when addressed, provide care organisations legal grounds to declare money from the state and insurance companies, resulting in an ongoing growth of health care budgets. Furedi described the emergence of the 'therapy culture', a society wherein experts and professionals are seen as the only legitimate entity to solve problems. In a therapy culture, families are regarded as pathological, not able to overcome problems themselves. Could FGC help in overcoming a lack of resilience? Could FGC strengthen the social embedding of citizens?

In order to explain how FGC mobilises informal resources, we call in another sociological theory, namely that of social capital. Since the 1980s, there is interest in trust as fuel for social capital (Bourdieu, 1986; Coleman, 1988; Nooteboom, 2002; Portes, 1998; Putnam, 1995, 2000; Steyaert, 2012). McPherson *et al.* (2006) suggest that the social capital among the population in the United States has declined in recent decades (especially links with the family, neighbourhood and wider community), resulting in an increase of socially isolated people. A process that can also be observed in the Netherlands as such, where approximately one million people sense feelings of loneliness (Hortulanus *et al.*, 2003). Time, intensity, intimacy, and – above all –

reciprocity⁷ and recognition are the engine of strong bonds within networks. Reciprocity is subject to obligations⁸ between people – networks wherein members are bounded by mutual obligations usually have a strong social capital (Coleman, 1988). These networks are also characterised by “bounded solidarity” (Portes, 1998, p. 8) as through identification with the group, people are willing to help others in their time of need. When reciprocity is not set in motion, trust will come under pressure and people lose interest in helping each other. People who have little reciprocity to offer, usually have a limited social capital where they can rely on (Bourdieu, 1986; Komter, 2003).

Restoring and improving relationships within networks and subsequently being socially embedded are important goals of FGC. However, these goals are apparently difficult to realise in PMHC as a large part of its client population has few informal resources from where to draw on (Van Hemert & Wolf, 2011). Sometimes contacts within networks of clients are so damaged that one can wonder whether the PMHC client group would benefit from a one-sided focus on restoring contact. A single family group conference would likely create insufficient conditions for this.

Another purpose of FGC is ‘widening the circle’ with concerned bystanders such as neighbours, volunteers and social entrepreneurs (Pennell & Burford, 1994; Pennell, 2004; Pennell & Andersson, 2005). Would it be recommendable, instead of refuelling broken and damaged contacts that are difficult to restore, to expand the network of PMHC clients with potential new resources? Granovetter (1973) revealed that ‘weak ties’ – people with whom we do not have a strong bond and from whom we therefore could not expect emotional support, but who on the other hand can help us bridging to other networks – are a source for innovation. People who have loose ties with various networks have access to resources that are not within reach in closed networks. Even when PMHC clients are embedded in a network consisting of strong ties – people whom we consider as close friends and relatives from whom we can expect emotional support – FGC will create little progress when other members themselves have limited human capital (knowledge, skills, contacts with other networks) as well (e.g. Bourdieu, 1986, p. 53; Portes, 1998, p. 13-14). Connections to other networks are needed to increase opportunities for clients.

⁷ Reciprocity is understood as the norm of social reciprocity (Chandola, Siegrist & Marmot, 2007). This assumes that when person A provides a service to person B, the expectation arises that person B in the near future will provide a service of a similar value to person A. Coleman (1988) calls these mutual expectations ‘credit slips’.

⁸ Obligations are not only formal ‘credit slips’, such as in a work relationship, but also the perceived responsibilities within families where children, for instance, feel morally obliged to take care of their parents when they get old and infirm.

Empowerment – strengths, capabilities and resilience

The FGC approach aims to strengthen the capabilities of families and their resilience, or in other words, to empower them (Metze *et al.*, 2013). FGC has a strong link with the positive psychology paradigm which emphasises the strengths and capabilities that clients have, not their limitations and disabilities (e.g. Seligman & Csikszentmihalyi, 2000; Sheldon & King, 2001). Positive psychology is an umbrella term that includes all studies that are focused on positive emotions and character traits (Seligman *et al.*, 2005). Instead of focusing on healing weaknesses and inadequacies, the aim of positive psychology is to cherish and reinforce human strengths and virtues which act as buffers against mental illness, such as courage, perseverance, hope, honesty, and reflective capacity. Important to mention here is that in positive psychology explicit attention is paid to the benefits of being socially embedded, as it is assumed that this reduces risks and prevents from mental illnesses (Seligman & Csikszentmihalyi, 2000).

A particular form wherein the ideas from the positive psychology are fleshed out is the solution-focused therapy, that was developed within psychotherapeutic practices in the 1980s when evidence came to the surface that in the traditional, problem-focused approaches the used therapies actually maintain problems and do not solve them. Solution-focused therapists argue that reflecting on the nature of problems does not necessarily lead to improvement. In the solution-focused therapy, the client has a leading role. The aim of this approach is – in contrast to the traditional psychotherapeutic practices – the increase of healthy behaviour, not the decrease of the problem or unhealthy behaviour (Bannink, 2006).

We explicitly highlight the concept of empowerment as it is often mentioned as a main goal of both solution-focused therapy (Bannink, 2006) and FGC (Lupton & Nixon, 1999). Metze *et al.* (2013) distinguish a particular form, namely relational empowerment, as appropriate to understand FGC. According to these scholars, relational empowerment

[...] can be seen as the central concept and most important process of the FGC. To explain the process of relational empowerment in the FGC-context, two important concepts are resilience and relational autonomy. The most important factors contributing to resilience are (1) self-reflection, (2) reciprocity, and (3) social support. The concept of resilience focuses on the individual reflection on ones thoughts and actions, but also acknowledges the influence of receiving social support and experiencing the power of giving (reciprocity) on the self-reflection process. The most important factors contributing to relational autonomy are (1) self-respect, (2) received respect, and (3) compassionate interference. [p. 11]

Empowerment goes beyond self-determination and independence. It also revolves around informal support, supplemented or balanced with professional support, and the resilience of a social system. Empowerment is achieved when an individual or a group of individuals support another individual or group, so that eventually this individual or group experience more control on their life. Empowerment can thus be accomplished by one person, but also by several persons together. When members of a group support each other than this could be indicated as community capability. Thus, the definition of Metzger *et al.* (2013) of relational empowerment and the idea of community capability complement each other.

FGC as a means to social embedding and empowerment

How can we understand the link between FGC and sociological theories on social embedding, and the concepts of empowerment within the positive psychology paradigm? Sociological theories on individualisation and alienation give us clues on why in the Western World there is the need for belonging to a bonded group of individuals who on the bases of reciprocity and obligations take care of each other. FGC has the potency to solve conflicts and restore contacts within families and communities, subsequently reinforcing bonds and therefore could ensure the social embedding of people who have been living in social isolation and who have been languishing for a long time.

One potential means to break with the negative tendencies of the by Furedi (2004) described therapy culture, such as medicalisation and psychologisation, is the positive psychology paradigm. FGC intersects with the solution-focused therapy, as FGC coordinators encourage clients and their network to take the lead building on and developing their social and relational capacities (Natland & Malmberg-Heimonen, 2013). They empower clients and their network to develop a plan in which particular attention is paid to their capabilities and the improvement of self-reliance, resilience, and increase of social support. Like in positive psychology, in a family group conference virtues and strengths such as wisdom, courage, humanity, justice, and compassion are cherished and reinforced (e.g. Seligman *et al.*, 2005).

The language of FGC is strongly focused on capabilities and opportunities, but a valid question is whether defects and disorders are not overlooked. In our research project we therefore also had an eye for the problems of clients who were included in the study.

The research project: FGC in PMHC

In 2009, commissioned by the municipality of Groningen in the north of the Netherlands, we examined whether the informal resources⁹ of PMHC clients can be utilised.¹⁰ The aim hereof was to promote social rehabilitation, fostering socio-cultural integration and the reduction of social vulnerability. The municipality and the administrative bodies of the province of Groningen wanted to know whether the FGC approach could be deployed for the PMHC client group. (Inter)nationally, little is known about its possibilities in mental health care, let alone a field even more specific such as the PMHC. This raised the question whether or not it would be possible to support people who usually do not have vital social networks with FGC, and to strengthen them to support each other. We completed an exploratory study to answer this research question (see De Jong & Schout, 2011). Experts we interviewed in this study indicated the potential of FGC in averting coercion such as youth protection measures, housing evictions and involuntarily admission to a psychiatric ward. Further on they argued that FGC can promote the involvement of the natural network of a client and subsequently can help breaking through negative spirals of social isolation and deterioration. In chapter four we will elaborate in detail on this exploratory study.

On the basis of the promising results of this study and the possible benefits FGC might have for the PMHC client group, we received grants to start a pilot and evaluation study. Consequently, from January 2011 until September 2013, 41 case studies of FGC were carried out with an equivalent number of clients and families in the 23 PMHC networks of the province of Groningen.¹¹

⁹ Resources such as family members, friends, neighbours and co-workers, but also the potential resources of the wider community. In Chapter Three we will underpin this with the concept of social capital in relation to FGC.

¹⁰ Utilising intended as: searching, developing, repairing, removing, or making use of the above described resources.

¹¹ Besides these 41 cases, we also have analysed during those years 7 so-called Safety-Net Conferences ('Vangnet-conferenties') that had been organised by LIMOR, a Dutch organisation providing shelter to the homeless (see www.limor.nl). These conferences have similarities with FGC as they also aim to mobilise support from the social network by organising family meetings. The main goal of these conferences is to provide shelter for the client within its social network. Also a case have been analysed wherein a community mental health nurse along the FGC philosophy organised a family group conference himself. However, we did not include this case and the Safety-Net Conferences in our study, as it is an aim within the Dutch FGC organisation that conferences are organised by independent citizens. Finally, we also did do follow-up interviews with respondents of fifteen cases to examine the long term outcomes of the conferences, and carried out a comparative study between several social network strategies wherein we placed these approaches on a continuum in between 'family driven' and 'professional driven'.

The objectives of our project were as follows:

1. Promoting social rehabilitation, fostering socio-cultural integration and reducing social vulnerability of the PMHC client group.
 2. Halting languishing and deterioration of clients.
 3. Improving the quality of life in communities and neighbourhoods.
 4. Appealing the civil society in general, and more specifically, the use of resources that are present within society.
-

Overall aim and research question

The aim of our study was twofold. On the one hand, we aimed to describe on the individual case level how the family group conference in the given PMHC setting proceeded and its outcomes in terms of improving of the living conditions of clients, client systems and neighbourhoods, increasing of the social support on which they can rely, strengthening their capabilities and alleviating the caseload of professionals. On the other hand, we aimed to describe on the meta level in what kind of situations and under which circumstances in PMHC FGC can be deployed, so we could come to an understanding of how FGC in PMHC proceeds and how (a lack of) successful outcomes could be explained.

The exemplary value – the lessons that can be extracted from this study (e.g. Abma & Stake, 2014) – lies mainly in the description and understanding of the course (and specific twists and turns hereof) of the 41 family group conferences in a field where worldwide limited experience is with FGC. On the basis of these insights, in the last chapter of this thesis we describe its added value when FGC will be permanently deployed for the client group of the PMHC and if there are specific concerns in relation to optimising this decision-making model.

A Rortyan view on evaluating FGC in PMHC

In line with the American philosopher Richard Rorty (1991), a central goal of our study was to *understand* – or as the Germans say *Verstehen* – the process and outcomes of FGC in PMHC. Even with our quantitative study we did not aim to *prove* the effectiveness of FGC in PMHC. Rather the quantitative findings helped us to gain a better understanding of how the conferences in this field of practice proceeded.

Unprejudiced understanding is not possible. It is precisely because of certain prejudices that we are able to interpret the world surrounding us. According to Rorty,

someone can only achieve partial truth; a comprehensive overview of the whole truth is simply not within reach. An interpretation is successful when all the parts of the interpreted themselves fit together. A successful interpretation is also time-proof, as when time passes by there is no doubt on its veracity. On the other hand, prejudices are subject to change, so that after a while observations done in the past will be interpreted differently. Important here is that the researcher has the capacity to critically reflect on his own prejudices and does dare to put them at stake.

Rorty, being an antirepresentationalist, views knowledge not as getting a reality right, “but rather as a matter of acquiring habits of action for coping with reality” (as cited in Leigland, 1999, p. 485). What does count in Rorty’s view is how language and vocabularies represents reality. The one vocabulary in its own right is not necessarily a better representation of the truth than the other. Language is always influenced by the environment wherein we live, our history and cultural values. It corresponds with what we want to aim in the physical world.

As Rorty states, it is not possible to reconstruct the reality doing independent scientific tests, such achieving evidence for FGC by deploying randomised controlled trials. Contrarily, what is important is that scientists are connected with the reality, or actually the reality surrounding and within them. But providing ‘hard facts’ is a messy task: “the hardness of fact in all these cases is simply the hardness of the previous agreements within the community about the consequences of a certain event” (Rorty as cited in Leigland, 1999, p. 486). And (Rorty as cited in Leigland, 1999, p. 487):

[f]rom a Wittgensteinian or Davidsonian or Deweyan angle, there is no such thing as “the best explanation” of anything; there is just the explanation which best suits the purpose of some given explainer. Explanation is, as Davidson says, always under a description, and alternative descriptions of the same causal process are useful for different purposes. There is no description which is somehow “closer” to the causal transactions being explained than the others.

Rorty’s pragmatism therefore seems to contradict with positivism, and even attacks its knowledge claims (Leigland, 1999, p. 488):

What this means is mainly that pragmatism would oppose any of the varieties of positivism insofar as the latter would assume that there are facts to be gotten from scientific investigation that would serve as the foundation of knowledge or truth. As we have seen, pragmatism has assumed the task of attacking such foundations of any kind from any source, and tying all terms, facts, and foundations back into human language, culture, and history.

In conclusion, according to Rorty science is not a window on reality or truth, but just one of the many – although important – achievements of the human race.

Operationalising central concepts

In our study, the concepts of social embedding and empowerment are paramount. More specifically we were interested in social support, resilience, quality of living conditions and alleviating the caseload of professionals. We operationalise these concepts as follows.

The definition of social support is derived from the literature on social capital. As already described, social capital can be understood as the aggregate of actual or potential resources which are linked to a durable network of mutual relationships (Bourdieu, 1986). It is both defined by the quality and quantity of support within this network (Putnam, 2000). While quantity indicates the number of resources from who support is received, quality means how social support is perceived, in the sense if family and friends are available in times of need (Coventry *et al.*, 2004; Panayiotou & Karekla, 2013). Social capital can therefore act as a resource for help (Coleman, 1988). Resilience is the sense wherein people feel they have gained a better control over their lives in order to adapt to challenging circumstances (Metze *et al.*, 2013). The quality of living conditions is the individual's subjective experience of wellbeing (Lim *et al.*, 2014) as indicated by the access to knowledge (self-knowledge, consciousness raising, skills development, or competence), quality of health (e.g., autonomy, self-confidence, self-efficacy or self-esteem) and sense of freedom (positive and negative) (Tengland, 2008). In relation to neighbourhoods, quality of life could be understood as residents' satisfaction on living in their residential area, summarised as 'neighbourhood cosiness', quality of social contacts with other residents, residential stability and housing conditions (Drukker & Van Os, 2003). Professional care consists of all support provided by people who get paid for delivering help. Blond (2010) describes that when resources from the civil society will be strengthened, there will be less demand for professional care and thus the caseload of professionals will be alleviated.

Research questions

The central question of this study is divided in two parts. First, there is the question that relates to how the family group conference proceeded and what were its outcomes on the individual case level:

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?

We propose that an improvement in the living conditions and social support were indications for being socially embedded, while strengthened capabilities and a less demand for professional help aimed to an increase of the empowerment of clients and client systems.

The second question concerns the meta-analysis of remarkable findings from the 41 case studies:

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 is divided into several sub-questions:

-
1. In what kind of situations and under which circumstances can Family Group Conferencing be deployed?
 2. What patterns underlie (the absence of) a successful completion of Family Group Conferencing in public mental health care?
 3. What is the role of Family Group Conferencing in mobilising social support and increasing the capabilities of clients and client systems with limited social resources?
 4. When is Family Group Conferencing successful in terms of ensuring social embeddedness in communities of fate?
-

The study

The 41 family group conferences had been evaluated within a responsive evaluation design wherein the perceptions of various stakeholders were addressed (Abma, 1996, 2005; Abma & Widdershoven, 2006, 2011). We carried out both qualitative and quantitative methods. Of each of the conferences a description had been made of the initial situation (outline of the problem, the actors involved, the context) and the course of the conference itself (the preparation stage, the three phases during the conference, whether the conference yielded a plan that consequently got implemented, concluding

with the results that had been achieved). This has resulted in 41 individual case study reports.

Every case had been studied by two students and a research supervisor (author of this thesis) of the Hanze University of Applied Sciences, Groningen. More than 120 students of both the Hanze University of Applied Sciences and the University of Groningen had been involved in this research project, most of them being students of Social Work and Nursing who participated in this study project as part of their bachelor research. Of them, 82 helped us in analysing the course and outcomes of the conferences. Thus research reports had been written on 41 family group conferences in PMHC. Accordingly, meta-analyses were carried out on remarkable findings that emerged in several cases.

At the start of our project, 36 care providers of Lentis (the general mental health agency in Groningen) and VNN (the largest agency for addiction care in the three northern provinces of the Netherlands) working in one of the PMHC networks in Groningen, were offered a training on their role within FGC and were provided clues on which of their cases could be suitable for a conference. This knowledge was later extended to all PMHC coordinators in the province of Groningen and during three regional meetings with key actors from PMHC in the three northern provinces of the Netherlands, such as police officers, community mental health nurses and social workers. Besides, three meetings were organised with FGC coordinators to share experiences but also to discuss bottlenecks.

The purpose of the evaluation study was to support the implementation process of FGC wherein we investigated whether a social intervention which has extensively been studied in one field (youth care) could also be successfully deployed in another field (PMHC). In other words, the evaluation was used to examine the feasibility of FGC in PMHC. In close consultation with professionals, FGC coordinators and, last but not least, the participants of the conferences, we aimed to ascertain what changes were necessary in the implementation process so FGC could yield successful outcomes for the PMHC client group. We did not only focus on success factors as we also examined the nature of the situations where FGC did not prove to be useful.

Research design – case study and responsive evaluation

Each family group conference had been examined through a case study, in which both the course and the outcomes of the conference were described. The qualitative case study in a social constructivist paradigm is increasingly seen as a fully-fledged research method in health (see Abma & Stake, 2014; Anaf *et al.*, 2007; Anderson *et al.*, 2005) and nursing sciences (Anthony & Jack, 2009; Gangness & Yurkovich, 2006; Luck *et al.*,

2006; Zucker, 2001). As Anthony and Jack (2009, p. 1177) state: “this methodology is a comprehensive research strategy that can be used to describe, explore, understand or evaluate phenomena or professional interest appropriateness for many nursing contexts.” Actually, according to Flyvbjerg (2006), social sciences cannot deliver context-independent knowledge, and, thus, “has in the final instance nothing else to offer than concrete, context-dependent knowledge. And the case study is especially well suited to produce this knowledge” (p. 223).

We considered each case as a unique and complex situation. We were therefore interested in the context and circumstances wherein the conference was held, and what patterns could explain a successful course and outcomes (Stake, 1995). We have chosen specifically for the case study approach of Stake (1995), as in this approach – compared to Yin’s (2009) broader application of case study research – there is specific attention to applying holistic, ethnographic and phenomenological qualitative research methods that fit better with the aim of our study, namely developing an understanding of the patterns underlying (the absence of) a successful course and outcomes of FGC in PMHC.

There is a clear link to be drawn between the pragmatic approach of Rorty (1991) on what is considered the truth and Stake’s (1995) case study approach. Both Rorty and Stake consider the truth being a relative phenomenon; it depends on the individual perspective. However, according to Stake, intersubjectivity does exist in the reality. He proposes that a shared reality is shaped through social interactions. Meaning and perceptions are always contextual. These thoughts come close to Rorty’s view that language and vocabularies represents the social reality, and these are based on the environment wherein actors are living and working at a giving time.

A particular research methodology that aims to understand various phenomena and practices is responsive evaluation. In each case study we made use of insights from the responsive evaluation methodology as it helped us in creating a conversation space for PMHC clients and their networks. These clients often have a history of expropriation and therefore their perceptions are barely taken into account by professionals and researchers.

Responsive evaluation was introduced by Robert Stake in the 1970s as a means to gain a better understanding of processes instead of outcomes whereon goal-oriented evaluation studies usually focussed (Abma & Stake, 2001). Responsive evaluation pays explicit attention to the context of the phenomena and practices that are investigated. It actually proposes that every research subject has its own specific perspective that is context and morally bounded. Important to responsive evaluation is bringing stakeholder groups together, and especially to give voice to the “silenced voices [...] because they are often hard to find, for example, because they want to remain

anonymous or because they fear sanctions” (Abma, 2005, p. 280). Through dialogue, storytelling and narratives the various viewpoints are shared and a learning process is set in motion so stakeholders can learn more about themselves and others. Ultimately, this process leads to mutual understanding and even a sense of feeling empowered to change the own position for the better.

Usually, the responsive evaluation cycle consists of four steps (Abma & Widdershoven, 2006). First the social conditions for the research project are created, such as selecting the relevant stakeholder groups and defining the role of the researchers in the process. In the second phase interviews with all stakeholder groups are deployed to gather all possible perspectives. Following, the research participants are asked to reflect on intermediate findings and subsequently findings could be altered along their insights. This is what Guba and Lincoln (1989) indicate as ‘member checks’. The researcher ensures an open atmosphere during the whole process of data gathering so that participants feel at ease to share their opinions. The third step is bringing the various perspectives within a stakeholder group together. The researcher will not only have specific interest in homogeneous perspectives between members from one stakeholder group, but also focuses on the similarities and differences between the various stakeholder groups. This fourth and last step is crucial in the responsive evaluation design as it could bring the perspectives from heterogeneous groups together. It could therefore help in breaking through asymmetric power relations and transform the social position of otherwise marginalised groups. Underlying responsive evaluation are participation, empowerment and equalising power inequalities.

Role of the research supervisor and student researchers

In a responsive evaluation the researcher is not an outsider who from the ‘ivory tower’ observes what is happening in the real world. Contrarily, the researcher is embedded in the practice that is being investigated. In close consultation with the actors of this practice the reality is shaped. The researcher is his own instrument to stimulate collaboration and reach mutual understanding between the various stakeholder groups by asking positive questions “that focus on the life-giving and life-sustaining aspects of people and communities” (Baur, 2012, p. 25). Further on, the researcher is responsive to the power inequalities, especially when vulnerable and marginalised groups are involved.

As already said, 82 students were involved as case study researchers within our project. They were all guided by the author of this thesis, who is also referred to as ‘research supervisor’. The research supervisor provided close oversight of the students’ work prior to the start of the research up to collecting and analysing the data, and finally writing the case study report (their bachelor thesis). As the students were in their final

year they were trained in conversation skills which they already had applied in various social work and nursing settings in previous years. These skills were useful in establishing contact with and gaining the trust of an otherwise difficult to reach group (Schout *et al.*, 2010). The role of the student researchers could be characterised as the ‘concerned outsider’, as they combined empathy and critical reflection with a non-judgmental attitude. The research supervisor explicitly trained the students in being responsive to power inequalities and giving voice to vulnerable and marginalised clients.

Population, recruitment and selection

The client group of PMHC is difficult to distinguish as PMHC serves as a safety net wherein anyone who is underserved will be helped. In this study, between February 2011 and February 2013 (1) all referrals to the PMHC networks or to the hotlines for inconvenience in the province of Groningen and (2) all individuals, families or communities (streets, houses around courtyards, neighbourhoods) who are underserved (this can involve difficult-to-reach groups such as care avoiders, the homeless or multiproblem families who do not receive indicated care), were enrolled in this study. In the months prior to the study, all PMHC coordinators received a letter containing the description of the client group. Through these letters, all professionals participating in PMHC were notified to refer cases to this project.

Because the client group of PMHC is diffuse and sometimes takes the form of a ‘situation’ (such as liveability problems in a courtyard without an individual client to be appointed), and there are ‘moments’ that arise where FGC can be suitable, we instructed potential referrers in which situations and during which moments FGC could be deployed. These included the following (based on Schuurman, 2008):

-
- When the social network should be extended or its cooperation improved.
 - When clients are not motivated for treatment and FGC can offer an alternative.
 - When threatened housing evictions, child protection measures and involuntary admissions need to be averted.
 - In troubled living conditions wherein the capabilities of the extended network should be mobilised.
 - When liveability problems, nuisance and conflicts in neighbourhoods should be solved.
-

Each of the 23 PMHC networks in the province of Groningen was asked to refer cases to our project. Consequently, a relatively high number of seemingly hopeless cases were

included in this study. When clients were motivated for FGC, their case managers referred them to the FGC regional manager who in addition appointed a FGC coordinator to plan a first exploratory meeting with the client.

Every week we had close consultation with the FGC regional manager about the newest referrals. First we examined whether the referrals could be indicated as PMHC client or situation, and if so, we aimed to get a first idea on their background and problem situation. As the client population in PMHC is diverse, we needed to ensure that a various group of clients and client systems would be included in the research sample. For example, the first six months of our study, many male clients aged between 40 and 60 years with alcohol problems and who had been languishing in socially isolated circumstances were referred to FGC. Finally, we deemed it necessary to halt all new referrals where similar problems were on the foreground, so there would still be space left to organise conferences for client groups with different problems, such as those who had dominantly psychiatric problems. However, it appeared to be difficult to motivate clients with psychiatric problems for FGC as a possible conference evoked too much fear and aggravated their psychotic problems. Finally, in our research sample both individual clients, couples and clients systems were included. Further on, in eleven cases the problem situation revolved around neighbourhood conflicts. In these cases it were not individual clients who were involved, the cases rather revolved around several actors who were in conflict with each other. In almost all of the 41 cases psychosocial problems were paramount, usually interwoven with psychiatric and addiction problems. An overview of the cases can be found in Appendix I.

Research participants

We aimed to enhance mutual understanding between the different stakeholders by bringing them in contact with each other (see Abma, 1996, 2005). Everyone who participated in the conference and/or could reflect on the situation was approached for an interview. Four groups of respondents can be distinguished: 1) main actors (individual clients, couples, families, community members); 2) participants from the social network (family members, friends, neighbours, concerned bystanders); 3) professionals (everyone with a professional background who had interference with the case, such as community mental health nurses and social workers, but also policy workers of municipalities, counsellors of social housing corporations and police officers) and; 4) FGC coordinators. We paid explicit attention to give voice to the “silenced voices” (Abma, 2005, p. 280). This is of particular importance in PMHC as clients and their network often had been ‘expropriated’ from taking decisions themselves as they

were confronted with housing evictions, compulsory admissions, or other forms of coercion.

We tried to involve everyone who participated in the conference, or who could reflect on the problem situation prior to the conference and the actual situation. A total of 312 respondents were interviewed from a possible range of 473 conference participants. When many participants took part in a conference (more than fifteen), then respondents were selectively approached (purposive sampling, see Silverman, 2013). Ensuring diversity of perceptions was important. We therefore provided a sufficient spread of respondents from the four respondents groups as outlined before. Reaching saturation was not feasible in every case, especially when the number of the participants was limited or when only few wanted to cooperate within the case study.

Data collection

In each case study we systematically evaluated the process and outcomes of the conference. We both carried out qualitative and quantitative data collection and analysis methods (mixed methods, e.g. Creswell, 2009).

Students analysed one conference in couples. For them, doing a case study was not only a learning process in becoming an ‘investigating professional’, during the research they also learned about the concepts of ‘Social Welfare New Style’ and social network strategies that are increasingly important in the different fields of social work and community mental health nursing. Students conducted the interviews at sites designated by respondents (at their home, at work, or in a neutral environment) and at moments convenient to them (both during daytime and in the evening, during weekdays and in weekends). The semi-structured interviews were recorded and later on transcribed verbatim. We worked with a topic list whereon a distinction was made between process (course of the complete FGC cycle) and outcome topics (see Appendix II). We also maintained a memo list on specific twists and turns during the data collection and analysis.

Describing the process of FGC

In the interviews, students asked respondents to reflect retrospectively on the course of the conference. Qualitative indicators were the perceptions of clients, members from their social network, professionals and FGC coordinators on the whole process of the family group conference and all the twists and turns that occurred. In describing the course of the conferences, three topics were central: 1) a description of the referral; 2) the preparation stage; 3) the process of the conference itself, and; 4) the implementation of the plan. The exploration of the conference included multiple subtopics such as a

description of the problem situation, expectations prior to the conference, the decision-making process during the conference and the role of the FGC coordinator. Further on, we tried to capture if the social network elevated the work of professionals and if the conference reinforced the cooperation between clients, their network and professionals.

Examining the outcomes of FGC

As quantitative indicators we used the extent wherein languishing and deterioration had been reduced, the degree whereon participants experienced control over their own lives (increase in their capabilities and resilience, or in other words, the degree wherein they felt to be empowered), the degree wherein insecurity (domestic violence, conflicts in neighbourhoods) had been halted, the degree wherein the risk of coercion had been reduced (evictions, compulsory admissions, youth protection measurements), and the degree wherein social isolation had been reduced. We measured these outcomes using scale questions ranging from 0 to 10 in which the respondents were asked to give a score regarding an outcome measure on the situation prior to the conference and a score on the situation after the conference. 0 stands for the worst possible outcome, 10 for the most ideal position. With these scale questions progress or stagnation with respect to (realising) the outcomes could be determined. This method builds upon the solution-focused therapy, which itself stems from the positive psychology paradigm. Applying scale questions is a relatively simple and accessible way for coaches, therapists and researchers to get insights into the problems and possible solutions of people (see for some applications: Bannink, 2005, p. 13; Fisher, 2006, p. 83-86). Respondents were also asked to give arguments for an increase or decrease. When, for example, a low score was given with regard to the quality of social support prior to the conference and a high score to the actual situation, then respondents were asked to substantiate these scores and reflect on if this could be attributed specifically to the conference or to random factors. Thus we obtained individual scores of 245 respondents in 33 cases.

Group member checks

In each case study we carried out group member checks wherein we presented interim findings from the interviews to respondents (see Guba & Lincoln, 1989), both for validation but also as a means to gain new insights on how the course and outcomes of the conference could be understood. These meetings were organised at a time when the majority of respondents could be present, with the strict condition that at least the main actors (clients) were given the opportunity to reflect on interim finding. A total of 144 participants took part in the 41 member checks. A limitation of these meetings was that not every respondent we had interviewed was able to participate, or even resisted

towards participation. Respondents who could not, or would not be able to take part were subsequently asked to reflect on interim findings by telephone or through e-mail. The member checks were chaired by the research supervisor, aiming to prevent that individual respondents would act dominantly so others would not be able sharing their opinion.

Overview of the data collection

The total number of semi-structured interviews in the 41 case studies was 312 (an average of 7.6 respondent per case) out of a possible number of 473 FGC participants. On average, interviews lasted 60 to 90 minutes, ranging between 15 minutes and 4 hours. Sometimes respondents were interviewed a second time when new insights emerged during a later stage of the case study. Each group member check lasted 90 minutes, on average 3.5 participants took part in it.

This whole project required a careful data management. Would we have chosen not to involve students, then we would not have been able to provide such a deep and thorough picture of the conferences.

Data analysis

We analysed the qualitative and quantitative data in two distinctive steps. First, we described of each family group conference its process separately and reported on them in individual case study reports. The quantitative data on the outcome measures as gained in each case study, gave insights into if the living conditions had improved and resilience and social support had increased after the conference. Second, we carried out qualitative meta-analyses to reveal remarkable patterns that could be observed in several cases and applied inferential analyses on the quantitative data to examine the outcomes of all 41 studied conferences.

Analysing the process of the conferences and examining their outcomes

The qualitative data analysis took place in a cyclical process of the constant comparison method (Boeije, 2002). Transcribed interviews were analysed by the students using ATLAS.ti. Codes were assigned to meaningful sentences or fragments (open coding). These codes were combined and grouped into categories, either core labels (data reduction through axial coding). Eventually, these labels were linked together (selective coding), so it was possible to describe the course of the conference and all the twists and turns that happened. Findings from this first part of data analysis were derived in a continuous dialogue between the students and the research supervisor.

Interim findings from the interviews were validated during group member checks where all individual respondents were invited to take part in. In addition to the student researchers and the research supervisor, also the regional manager of the FGC organisation in the province of Groningen was present during most of the 4I meetings, mainly because she wanted to learn from these meetings and consequently would be better able to instruct FGC coordinators how to organise conferences for the PMHC client group. Besides validating interim findings, it was also possible to share new insights and subsequently gain a better understanding of the course and outcomes of each conference.

In line with Flyvbjerg (2006, p. 223), we considered validating interim findings as a crucial part of our research project as

[c]oncrete experiences can [only] be achieved via continued proximity to the studied reality and via feedback from those under study. Great distance to the object of study and lack of feedback easily lead to a stultified learning process, which in research can lead to ritual academic blind alleys, where the effect and usefulness of research becomes unclear and untested.

In each case study report quantitative data (on whether client's living conditions did improve, if their resilience and capabilities were strengthened, if the quality and quantity of social support did increase, and if the caseload of professionals was alleviated) were visualised in bar charts. Each respondent in a case was asked to provide scores. We were therefore able to obtain scores from different positions. Making individual and average scores visible in bar charts was a clear way to indicate progression, stagnation or deterioration in a certain outcome measure. We also asked respondents to reflect on given scores. Consequently we were able to formulate arguments why, for example, the living conditions of a client did improve or not.

Of each case study a report had been written wherein the complete course of the conference and all its twists and turns were described, as well as the outcomes of the conference and the insights that arose during the member check. Purpose of each case study was to conclude if the family group conference in the given situation had a positive effect or not and what the specific patterns were that helped in understanding its success or failure.¹²

¹² Not all of the 4I cases proceeded to the actual conference. In nine cases, the conference got stalled in its preparation stage. We have still included these cases in this study, as we considered the preparatory stage towards the conference as an important part of the FGC model. FGC coordinators invested a lot of time and energy in motivating clients and their network for a conference. Further on, many interesting twists and turns happened in these cases. Actually, not all of these nine cases could be considered as a failure, as for

Indicating remarkable patterns

In addition to the individual case studies, we carried out meta-analyses on remarkable patterns that could be observed in several cases. During the meta-analyses we made use of insights from the multiple case study approach (see Stake, 2006; Yin, 2009), which is also known as the collective case study approach (Baxton & Jack, 2008; Stake, 1995). Within this approach, several analyses are made of the same phenomenon, wherein there is an aim to construct answers on propositions (in Stake's terminology 'issues', as cited in Baxton & Jack, 2008, p. 552) which can be found in several cases simultaneously. Are there patterns within findings that can be found in several cases? What are the similarities and differences between the cases in relation to these constructs and answers to propositions? We, however, tried to prevent ourselves from being too heavily influenced by fixed propositions as in a responsive evaluation it is a main goal to remain open to new propositions that emerge during the research process (e.g. Abma & Stake, 2001, p. 9).

As Baxton and Jack (2008) emphasise, it is not a strict rule within the multiple case study approach that contexts in several cases should be completely similar to formulate conclusions that count for several cases at the same time. In that sense it was possible for us to draw similarities between analysed family group conferences of which the main actors had different backgrounds and problems.

Already after ten analysed cases, it proved to be possible to carry out a meta-analysis. It became clear to us that in each of these cases the concept of shame played an important role in the success of a conference. We reflected hereon by highlighting two cases. This resulted in an article published in the *British Journal of Social Work* (De Jong & Schout, 2013) that is included in this thesis as Chapter Six. Up to the moment the case study report of the final conference was written, we continuously carried out meta-analyses on remarkable patterns that could be observed in several case studies. Emerging patterns and themes were discussed with both promoters of this PhD thesis, further tightened and finally resulted in four articles that have been submitted to various journals and that are included as chapters (chapter six-nine) in this thesis.

To understand the course of FGC in PMHC we constructed two taxonomies. The first is on how conferences with a successful course and outcomes can be understood. The second indicates which patterns underlie the apparent failure of conferences. The

example in one case (case 3, Case overview table in Appendix I) we have seen that during the preparation stage a solution came to the surface, or in another case (case 19, Case overview table in Appendix I) on a conflict between neighbours it was decided to cancel the organisation of the conference while afterwards there were no longer police reports made on the conflict (as which was the case prior to the referral to the conference).

taxonomies can be found in Appendix III. We analysed the remarkable patterns along guidelines from the multiple case approach (Stake, 2006) and the critical realist grounded theory approach. The latter (Oliver, 2012, p. 372)

[...] marries the positivist's search for evidence of a reality external to human consciousness with the insistence that all meaning to be made of that reality is socially constructed. It accepts that the social constructions themselves can constitute what we know as the reality of our social worlds.

In this approach, critical realism as constructed by Bhaskar is combined with insights from the grounded theory approach of Glaser and Strauss (see Oliver, 2012). Critical realism makes it possible to do simultaneously justice to the individual perceptions of reality of those respondents being interviewed, as to a shared reality of how the world works according to several respondents (intersubjectivity).¹³ By applying grounded theory it is possible to disentangle their perceptions so shared realities in various stories are brought to the surface. Deeper layers of meaning can thus be found, imaging why FGC in a specific PMHC case did work or not.

Analysing the outcomes of FGC

At the level of the individual case, the quantitative data particularly supported the qualitative data, these data are therefore descriptive. When, however, the given scores in all cases are weighted, it is possible to apply inferential analyses. It was not possible to obtain meaningful quantitative data in all 41 cases, still in 33 cases a total number of 245 respondents reflected on the outcomes of the conferences.

Usually FGC and related decision-making models that are organised in diverse fields result in four general benefits (see the following effect studies: Berzin *et al.*, 2008; Crea *et al.*, 2009; Jeong *et al.*, 2012; Landsman *et al.*, 2014; Malmberg-Heimonen, 2011; Malmberg-Heimonen & Johansen, 2013; Pennell *et al.*, 2010; Sheets *et al.*, 2009; Wang *et al.*, 2012; Weigensberg *et al.* 2009). By examining if these benefits also occurred in

¹³ As Stake (1995, p. 12) states, "the interpretations of the researcher are likely to be emphasised more than the interpretations of those people studied, but the qualitative case researcher tries to preserve the multiple realities, the different and even contradictory views of what is happening." According to Baxter and Jack (2008), Stake's case study approach is therefore based on social constructivism. In here, the truth is considered to be relative, depending on the individual perspective. Though, intersubjectivity does exist here. In other words, a shared reality is shaped through social interactions. Meaning and perceptions are always contextual. In the eyes of Stake, assigning meaning is therefore based on where you are at a certain moment, with whom you live and work together, and on your living conditions (see Abma & Stake, 2001).

the cases we have analysed, it became possible to indicate if conferences were successful or not. Accordingly we formulated and studied four questions:

-
1. Has the quantity and quality of social support for the main actor(s) been increased?
 2. Has the main actor(s)'s resilience been increased?
 3. Did the conference have an influence on an improvement of the living conditions of PMHC clients, client systems and neighbourhoods wherein PMHC clients are living?
 4. Has the demand for professional care been decreased?
-

In chapter five we will further elaborate on this particular quantitative analysis and its outcomes.

Measures for quality and rigour

Instead of validity and reliability, it is common in qualitative research to use the terms credibility and trustworthiness (Guba & Lincoln 1989). Credibility relates to whether the results of the research reflect the experiences of the participants in a believable way. Trustworthiness needs to be understood as: how far do the respondents' answers actually reflect their own experiences, and how can we prevent that the researcher's own assumptions come into play when he or she interprets the answers (Silverman, 2013)?

As we have already indicated, involving stakeholders from different backgrounds who share their opinion on the research topic is an indication of quality and rigour in case study research. Ensuring a diverse array of perspectives is therefore a sign of how credible the research findings are and how much trust we can put in them (have we really managed to provide a reliable picture on how the family group conferences in the given PMHC setting proceeded?).

Another tool that is frequently used to ensure quality findings are member checks wherein stakeholders reflect on intermediate findings from interviews and subsequently refine them (Guba & Lincoln, 1989). The member checks we organised took the form of a focus group interview. We not only intended to invite respondents we did interview for these meetings, but also other stakeholders who could reflect on the problem situation prior to the conference and the actual conference. In line with the responsive evaluation approach, we aimed to use the member checks also as evaluation loops in order to alternate the process of data gathering and analysis where necessary.

By involving enough 'cases within the case' (e.g. respondents reflecting on one conference), our purpose was to reach a certain level of saturation, in the sense that no

new insights would arise on the course of the conference and its outcomes should we continue interviewing (Guest *et al.*, 2006; Small, 2009).

To ensure reliable findings (findings that are trustworthy and the result of a low-inference description) we made field notes that were tracked in a logbook. Further on, the conferences were analysed along an inter-coder agreement (Silverman, 2013) which means that the two students who were carrying out the case study as a couple analysed the data together and agreed on the code name that would be given to a certain interview section and the clustering of several codes under the umbrella of one theme. Eventually, the outcome codes and themes were discussed with the research supervisor.

Finally, in line with Flyvbjerg (2006), it was not our aim to make the case studies as “all things to all people.” Our goal was “to allow the study to be different things to different people.” We tried “to achieve this by describing the case[s] with so many facets – like life itself – that different readers may be attracted, or repelled, by different things in the case” (p. 238).

Stakeholders and social relevance

In a responsive evaluation stakeholders are often simultaneously respondents of the study as well as those who have interest in its outcomes (Abma, 2005). Both PMHC clients, their social network, professionals and FGC coordinators were asked in this study how the family group conference wherein they participated proceeded and what were its outcomes. In addition to the individual interviews, they were also invited to participate in group member checks to discuss interim findings.

The following stakeholders had interest in the outcomes of this research project:

-
- Main actors of the family group conference. The conference revolved primarily around them. It was an important aim to improve the living conditions of individual clients, families and neighbourhoods wherein clients reside. The main actors can be characterised as PMHC clients simultaneously. They had an interest in a successful course and outcomes of the conference as it directly influenced their life.
 - Social network of the main actors. This stakeholder group was formed by relatives, friends, neighbours and concerned bystanders. These people did participate in the conference, and if not, though having a clear view on the situation prior and after the conference, they were still asked to reflect on the

outcomes of the conference. This stakeholder group had an interest in a successful conference as it affected the wellbeing of their loved ones.

- Involved professionals. We characterise a professional as everyone who from a professional point of view had been involved in the case. This refers mainly to community mental health nurses and social workers, but also to housing association officials, police officers and municipality workers. They had an interest in a successful conference as it made the communication patterns within the network of their clients clear and promoted their collaboration with clients and their network. In several analysed cases it was visible that due to the conference the caseload of professionals was alleviated.
- The Dutch FGC organisation ('Eigen Kracht Centrale'). The regional manager in the province of Groningen received referrals to a conference and subsequently appointed a FGC coordinator who was about to organise the conference. The interest of this organisation was mainly because the regional manager and coordinators wanted to learn from the research findings so consequently the FGC model for the client group of the PMHC could be optimised.
- The municipality (city of) Groningen and the province of Groningen. These two parties were the financiers of the 4I family group conferences. In the context of the socialisation of care and social participation of vulnerable people – both objectives of the SSA – this stakeholder group wanted to know if FGC can be permanently deployed for the PMHC client group.
- Hanze University of Applied Sciences in the city of Groningen. Mainly within the study of Social Work, increasingly attention needs to be paid to the promotion of clients' self-reliance and the application of social network strategies. This research project provided insights to the Hanze University on how these targets could be achieved.
- Students of Social Work, Nursing and Applied Psychology of the Hanze University, who did do their bachelor research within our project. Besides graduating on analysing one family group conference through a case study, students learned about social network strategies and how to apply these.
- The funding resources of our research project: the Dutch Ministry of National Health, Welfare and Sport ('Ministerie van Volksgezondheid Welzijn en Sport'), Netherlands Foundation of Mental Health ('Fonds Psychische Gezondheid'), and Fonds NutsOhra. They had an interest in this project as their actual goal is to fund projects with an aim on improving the self-reliance and social support of

clients suffering from mental health and addiction problems and the cooperation between the civil and professional society.

The social relevance of deploying FGC in PMHC is roughly two-fold. On the one hand to pursue the objectives of the SSA, such as promoting the social participation and self-reliance of vulnerable people at the municipality level. On the other hand, to ascertain whether FGC can help stopping the increase of budgets for health care and social welfare. Scholars such as Blond (2010) argue that when citizens first will solve their problems themselves before relying on professional help, their demand for care would decrease. In other words, we also examined whether FGC can contribute to the substitution of care that is otherwise provided by professionals (e.g. Jagtenberg *et al.*, 2011; Schuurman & Mulder, 2011).

Our project is relevant as worldwide up to this date no scientific study has been carried out specifically on FGC in PMHC. Though, as we have described earlier, there are similarities to be drawn with a Norwegian study wherein the effects of FGC for longer-term social assistance recipients – a client group that often has similar problems as the one of the PMHC – were examined (Malmberg-Heimonen, 2011; Malmberg-Heimonen & Johansen, 2013) and a pilot on FGC for adults who suffer from schizophrenia, bipolar disorder, or personality disorder in a community mental health care practice in the county of Essex (UK) (Mirsky, 2003; Wright, 2008). Insights from our study can help filling this knowledge gap.

Ethical aspects

Public mental health care is a network organisation operating in an ethical laden context. The contributing organisations, like mental health care, addiction care, social work and the municipality, have their own ethical committees. For this study, executives of these organisations formed an advisory board to assess the legal and ethical implications that come along with it and approved the procedures.

In order to ensure informed consent, we paid attention to the following implications. The client and intended participants of the family group conference were prior to it asked to participate in the study. Our aim was to let FGC coordinators at the end of the first orienting conversation ask clients to sign a form whereon they agreed with participation in the conference and subsequently being interviewed on its course and outcomes. This, however, evoked so much fear and suspicion among clients, eventually leading to mistrust in coordinators and reluctance towards continuing with the

preparation towards the conference. We discussed this with the advisory board of our project. We decided that when clients would orally agree with the conference and evaluation study, then coordinators could continue with preparing the conference. If they agreed, they were after the conference contacted on when they could be interviewed.

The experiences and expertise of clients and their network were stressed during this study, as they were not only interviewed but also asked to reflect on interim findings. Respondents were asked for permission if information could be shared in scientific articles and publications in Dutch and international journals on social work and nursing professions.

The following safeguards for privacy, anonymity and repeatability of information were taken (e.g. Silverman, 2013). All names of persons, streets, places and institutions have been replaced by a unique code in reports and articles. In this way, only the researchers can determine to which persons, streets and towns codes refer. Respondents were not informed about the content of other interviews. Each case study report had been made available to the respondents, but has not been distributed to other parties. All data files are archived and will be kept private until 2018 and then subsequently be deleted and erased. Finally, all (student) researchers did sign a confidentiality agreement that meets the ethical standards of client-related research.

Outline of the thesis

This thesis is divided into two parts. In the first part (Chapter Two-Four) we roughly sketch the background of the evaluation study. In Chapter Two we contest the merits of PMHC and examine the mission and structure of PMHC as a service. We conclude this chapter by stating that before relying on a safety net such as PMHC, professionals should be alert on the possible resources of the social network before deploying assertive outreach, by for example referring their clients to a family group conference. Chapter Three is an exploration on the rise of and the need for FGC along insides from classical and actual sociological theories. In Chapter Four we foreground the possible benefits and limitations of FGC for the PMHC client group.

The second part (Chapter Five-Nine) of this thesis consists of the findings from the evaluation study that had been carried out following the exploratory study. We start in Chapter Five with the quantitative analysis of the family group conferences we had studied. Using t-tests and multilevel analyses we measured if after the conferences the client's living conditions improved, if their resilience and capabilities were strengthened,

if the quality and quantity of social support increased, and if the caseload of professionals was alleviated.

Chapter Six, Seven and Eight are reports of individual case studies based on qualitative analyses. In Chapter Six we present reports on two case studies in which shame and fear of rejection are designated as main causes for clients to avoid contact with their social network, resulting in isolated and marginalised living circumstances. The following chapter is a report on how coercion in a community mental health setting can be prevented by FGC. We describe a case on an imminent involuntary admission to a psychiatric ward of a man with schizophrenia who resides in a courtyard and who commits increasingly liveability problems. In Chapter Eight we provide more evidence for the possible benefits of this type of FGC for groups by evaluating so called community conferences that had been organised in neighbourhoods characterised by resident conflicts.

On the bases of the three former chapters somehow the impression could rise that FGC only yields benefits for the PMHC client group. However, not all of the analysed conferences resulted in positive outcomes. In eighteen cases respondents indicated that the conference they participated in had failed. In Chapter Nine we therefore critically reflect on why these conferences had failed and if there were still remarkable side effects to be indicated.

This thesis ends with Chapter Ten. Here we bring all the findings from the different studies together and reflect on them with the help of insights from the literature. Special attention will be paid to the strengths and limitations of our study project. Following we provide suggestions for further research and implications for practice. We finally conclude this thesis with a general conclusion.

Note to the reader

Each of the chapters of this thesis has been individually published in scientific journals or is under consideration for publication. These chapters can be read independently. Accordingly, there is overlap between the several chapters, as in most chapters we describe (either extensively or briefly) the concept of Family Group Conferencing, the field of public mental health care, and the possible benefits and limitations of FGC in PMHC. In this thesis the words 'paper' or 'article' actually refer to 'chapter'.

References

- Abma, T.A. (1996). *Responsief evalueren. Discoursen, controversen en allianties in het postmoderne* [*Responsive evaluating. Discourses, controversies and alliances within postmodernity*]. Delft: Eburon.
- Abma, T.A. & Stake, R.E. (2001). Stake's responsive evaluation: Core ideas and evolution. *New Directions for Evaluation, volume 2001* (92), 7-21.
- Abma, T.A. (2005). Responsive evaluation: Its meaning and special contribution to health promotion. *Evaluation and Program Planning, 28* (3), 279-289.
- Abma, T.A. & Widdershoven, G.A.M. (2006). *Responsieve methodologie: Interactief onderzoek in de praktijk* [*Responsive methodology. Interactive research in practice*]. Den Haag: Uitgeverij LEMMA.
- Abma, T.A. & Widdershoven, G.A.M. (2011). Evaluation as a relationally responsive practice. In: N. Denzin & Y.S. Lincoln (Eds.). *The SAGE Handbook of Qualitative Research* (pp. 669-680). Los Angeles: SAGE Publications.
- Abma, T., Stake, R. (2014). Science of the particular. *Qualitative Health Research*, in press (to be published July 2014).
- Anaf, S., Drummond, C. & Sheppard, L.A. (2007). Combining case study research and systems theory as a heuristic model. *Qualitative Health Research, 17* (10), 1309-1315.
- Anderson, R.A., Crabtree, B.F., Steele, D.J. & McDaniel, R.R. (2005). Case study research: The view from complexity science. *Qualitative Health Research, 15* (5), 669-685.
- Anthony, S. & Jack, S. (2009). Qualitative case study methodology in nursing research: An integrative review. *Journal of Advanced Nursing, 65* (6), 1171-1181.
- Bannink, F. (2005). De kracht van oplossingsgerichte therapie: Een vorm van gedragstherapie [The power of solution-focused therapy: A form of behaviourist therapy]. *Gedragstherapie, 38* (1), 5-16.
- Bannink, F.P. (2006). De geboorte van oplossingsgerichte cognitieve gedragstherapie [The birth of solution-focused therapy]. *Gedragstherapie, 39* (3), 171-183.
- Bannink, F.P. (2007). Solution-Focused Brief Therapy. *Journal of Contemporary Psychotherapy, 37* (2), 87-94.
- Baur, V. (2012). *Participation & partnership. Developing the influence of older people in residential care homes*. Amsterdam: VU University Amsterdam.
- Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13* (4), 544-559.

- Berzin, S.C. (2006). Using sibling data to understand the impact of Family Group Decision Making on child welfare outcomes. *Children and Youth Services Review*, 28(12), 1449-1458.
- Berzin, S.C., Thomas, K.L. & Cohen, E. (2007). Assessing model fidelity in two Family Group Decision-Making programs: Is this child welfare intervention being implemented as intended? *Journal of Social Service*, 34(2), 55-71.
- Berzin, S.C., Cohen, E., Thomas, K. & Dawson, W. (2008). Does Family Group Decision Making affect child welfare outcomes? Findings from a randomized control study. *Child Welfare*, 87(4), 35-54.
- Besselink, N. (2012). De hulpverlener moet op z'n handen zitten [The care provider should sit on his hands]. *Trouw*, 3 October 2012, De Verdieping, pp. 4.
- Besselink, N. (2013). Jeugdzorg door de buurvrouw [Youth care by the neighbour]. *Trouw*, 3 April 2013, De Verdieping, pp. 8-9.
- Blond, P. (2010). *Red Tory. How the Left and Right have broken Britain and how we can fix it*. London: Faber and Faber.
- Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality & Quantity*, 36(4), 391-409.
- Bourdieu, P. (1986). The forms of capital. In: J.G. Richardson (Ed.). *Handbook of Theory and Research for the Sociology of Education* (pp. 241-258). New York: Greenwood Press.
- Brydon, D. & Coleman, W.D. (Eds.) (2008). *Renegotiating community: Interdisciplinary perspectives, global contexts*. Vancouver, BC: University of British Columbia Press.
- Chandola, T., Marmot, M. & Siegrist, J. (2007). Failed reciprocity in close social relationships and health: Findings from the Whitehall II study. *Journal of Psychosomatic Research*, 63(4), 403-411.
- Coleman, J.S. (1988). Social capital in the creation of human capital. *American Journal of Sociology*, 94, Supplement S95-S120.
- Coventry, W.L., Gillespie, N.A., Heath, A.C. & Martin, N.G. (2004). Perceived social support in a large community sample: Age and sex differences. *Social Psychiatry & Psychiatric Epidemiology*, 39(8), 625-636.
- Creswell, J.W. (2009). *Research design. Qualitative, quantitative, and mixed method approaches [Third edition]*. Thousand Oaks: SAGE Publications.
- Dalrymple, J. (2002). Family group conferences and youth advocacy: The participation of children and young people in family decision making. *European Journal of Social Work*, 5(3), 287-299.

- De Boer, N. & Van der Lans, J. (2011). *Burgerkracht. De toekomst van het sociaal werk in Nederland* [Citizens' Power. The future of social work in the Netherlands]. Den Haag: RMO.
- De Jong, G. & Schout, G. (2011). Family group conferences in public mental health care: An exploration of opportunities. *International Journal of Mental Health Nursing*, 20 (1), 63-74.
- De Jong, G. & Schout, G. (2013). Breaking through marginalisation in public mental health care with Family Group Conferencing: Shame as risk and protective factor. *British Journal of Social Work*, 43 (7), 1439-1454.
- De Klerk, M., Gilsing, R. & Timmermans, J. (2010). *Op weg met de Wmo. Evaluatie van de Wet maatschappelijke ondersteuning 2007-2009* [On the road with the SSA. Evaluation of the Social Support Act 2007-2009]. Den Haag: Sociaal en Cultureel Planbureau.
- Doolan, M. (2003). Family Group Conferences. Waarom het zo moeilijk is deze samenwerkingsmethode in te voeren... [Family Group Conferences. Why it is so difficult to implement this corporation model...]. In: R. van Pagée (Red.). *Eigen Kracht. Family Group Conference in Nederland. Van model naar invoering* [Family Group Conferencing in the Netherlands. From model to implementation] (pp. 93-103). Amsterdam: SWP.
- Drukker, M. & Van Os, J. (2003). Mediators of neighbourhood socioeconomic deprivation and quality of life. *Social Psychiatry and Psychiatric Epidemiology*, 38 (12), 698-706.
- Durkheim, E. (1951). *Suicide. A study in sociology*. New York: The Free Press [First official English translation of Durkheim's original study *Le Suicide* from 1897].
- Durkheim, E. (1997). *The division of labor in society*. New York: The Free Press [First published in 1893].
- Eerste Kamer der Staten Generaal (2014). Eerste Kamer stemt in met nieuwe Jeugdwet [The Senate of the Netherlands agrees on the new Youth Care Law]. Retrieved at 19 February 2014 from http://www.eerstekamer.nl/nieuws/20140218/eerste_kamer_stemt_in_met_nieuwe
- Evans, C.A. (2011). The Public Law Outline and Family Group Conferences in childcare practice. *Child Care in Practice*, 17(1), 3-15.
- Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, 12(2), 219-245.
- Furedi, F. (2004). *Therapy Culture. Cultivating vulnerability in an uncertain age*. London: Routledge.

- G4: Voogt, A., Van Hemert, A., Mulder, N., Dietvorst, J., Mulder, W., Havenaar, J., Lipsch, C. & Slegers, J. (Red.) (2006). *Niemand over de schutting* [No one to be left behind]. De gemeenten Amsterdam, Rotterdam, Utrecht, Den Haag en de aanbieders GGZ en verslavingszorg.
- Gangness J.E. & Yurkovich, E. (2006). Revisiting case study as a nursing research design. *Nurse Researcher*, 13(4), 7-18.
- Gehlen, A. (1988). *Man in an age of technology*. New York: Columbia University Press [First published in 1949].
- Gerritsen, E. (2013). *De wonderen zijn de wereld nog niet uit* [Wonders will never cease]. Retrieved at 19 September 2013 from <http://www.binnenlandsbestuur.nl/sociaal/opinie/columns/de-wonderen-zijn-de-wereld-nog-niet-uit.8974453.lynkx>
- Gezondheidsraad (2011). *Broodnodig. De ontwikkeling van kennis voor de openbare geestelijke gezondheidszorg* [Badly needed. The development of knowledge on public mental health care]. Den Haag: Gezondheidsraad, Health Council of the Netherlands.
- Granovetter, M.S. (1973). The strength of weak ties. *American Journal of Sociology*, 78(6), 1360-1380.
- Granovetter, M.S. (1974). *Getting a job. A study of contacts and careers*. Cambridge: Harvard University Press.
- Granovetter, M.S. (1983). The strength of weak ties: A network theory revisited. *Sociological Theory*, 1, 201-233.
- Guba, E.G. & Lincoln, Y.S. (1989). *Fourth generation evaluation*. Newbury Park, CA: SAGE Publications.
- Guest, G., Bunce, A. & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82.
- Hayes, D. & Houston, S. (2007). 'Lifeworld', 'system' and Family Group Conferences: Habermas's contribution to discourse in child protection. *British Journal of Social Work*, 37(6), 987-1006.
- Hilhorst, P. (2009). Samenredzaamheid [Community capability]. *De Volkskrant*, 6 oktober 2009.
- Hirst, P. (1994). *Associative democracy. New forms of economic and social governance*. Cambridge: Polity Press.
- Holland, S. & O'Neill, S. (2006). 'We had to be there to make sure it was what we wanted': Enabling children's participation in family decision-making through the family group conference. *Childhood*, 13(1), 91-111.

- 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(1), 21-38.
- Hortulanus, R.P., Machielse, A. & Meeuwesen, L. (2003). *Sociaal isolement. Een studie over sociale contacten en sociaal isolement in Nederland [Social isolation. A study on social contacts and social isolation in the Netherlands]*. Den Haag: Elsevier Overheid.
- Jagtenberg, R., Hulst, B. & Roo, A. (2011). *Maatschappelijke opbrengsten van Eigen Kracht-conferenties. Onderzoek in het kader van geïndiceerde jeugdzorg trajecten met een toespitsing op multi-probleem gezinnen [Social benefits of Family Group Conferencing. A study within the frame of youth care trajectories with an emphasis on multiproblem families]*. Delft: Technische Universiteit Delft, Innovatie en Publieke Sector Efficiëntie Studies.
- Jackson, S. & Morris, K. (1999). Family Group Conferences: User empowerment or family self-reliance? – a development from Lupton. *British Journal of Social Work*, 29(4), 621-630.
- Jeong, S., McGarrell, E.F. & Kroovand Hipple, N. (2012). Long-term impact of family group conferences on re-offending: The Indianapolis restorative justice experiment. *Journal of Experimental Criminology*, 8(4), 369-385.
- Jorritsma, E. (2013). Los het zelf maar op [Solve it yourself]. *NRC*, 9 February 2013, Z&Z.
- Kampen, T., Verhoeven, I. & Verplanke, L. (red.) (2013). *De affectieve burger. Hoe de overheid verleidt en verplicht tot zorgzaamheid [The affective citizen. How the government tempts and obliges to caring]*. Amsterdam: Van Gennep.
- Komter, A. (2003). *Solidariteit en de gift. Sociale banden en sociale uitsluiting [Solidarity and the Gift. Social ties and social exclusion]*. Amsterdam: Amsterdam University Press.
- Landsman, M.J., Boel-Studt, S. & Malone, K. (2014). Results from a family finding experiment. *Children and Youth Services Review*, 36(1), 62-69.
- Levine, M. (2000). The Family Group Conference in the New Zealand Children, Young Persons, and Their Families Act of 1989 (CYP&F): Review and evaluation. *Behavioral Sciences and the Law*, 18(4), 517-556.
- Leigland, S. (1999). Pragmatism, science, and society: A review of Richard Rorty's 'Objectivity, relativism, and truth: Philosophical papers, volume I. *Journal of the Experimental Analysis of Behaviour*, 71(3), 483-500.

- Lim, M.H., Gleeson, J.F., Jackson, H.J. & Fernandez, K.C. (2014). Social relationships and quality of life moderate distress associated with delusional ideation. *Social Psychiatry and Psychiatric Epidemiology*, 49(1), 97-107.
- Lohuis, G., Schilperoort, R. & Schout, G. (2008). *Van bemoei- naar groeizorg. Methodieken voor de OGGz [From assertive outreach to progressive care. Methods for public mental health care]*. Groningen/Houten: Wolters-Noordhoff.
- Luck, L., Jackson, D. & Usher, K. (2006). Case study: A bridge across the paradigms. *Nursing Inquiry*, 13(2), 103-109.
- Lupton, C. & Nixon, P. (1999). *Empowering practice? A critical appraisal of the Family Group Conference Approach*. Bristol: The Policy Press.
- Malmberg-Heimonen, I. (2011). The effects of Family Group Conferences on social support and mental health for longer-term social assistance recipients in Norway. *British Journal of Social Work*, 41(5), 949-967.
- Malmberg-Heimonen, I. & Johansen, S. (2013). Understanding the longer-term effects of family group conferences. *European Journal of Social Work*, advance access 1 August 2013, doi: 10.1080/13691457.2013.818528.
- McPherson, M., Smith-Lovin, L., & Brashears, M. E. (2006). Social isolation in America: Changes in core discussion networks over two decades. *American Sociological Review*, 71(3), 353-375.
- Merkel-Holguin, L. (2004) Sharing power with the people: Family Group Conferencing as a democratic experiment. *Journal of Sociology and Social Welfare*, 31(1), 155-173.
- Metze, R.N., Abma, T.A. & Kwekkeboom, R.H. (2013). Family Group Conferencing: A theoretical underpinning. *Health Care Analysis*, advance access 31 July 2013, doi: 10.1007/s10728-013-0263-2
- Mirsky, L. (2003). Family group conferencing worldwide: Part two in a series. April 3, 2003. Restorative Practices eForum. Retrieved at 29 September 2009 from http://www.iirp.org/iirpWebsites/web/uploads/article_pdfs/fgcseries02.pdf
- Morris, K. (2012). Thinking family? The complexities for family engagement in care and protection. *British Journal of Social Work*, 42(5), 906-920.
- Natland, S. & Malmberg-Heimonen, I. (2013). A study of coordinator positionings in family group conferences. *Nordic Social Work Research*, advance access 9 August 2013, doi: 10.1080/2156857X.2013.826142.
- Nederlands Jeugdinstituut (Nji) (2013). *Advies over verplicht netwerkberaad in kader van OTS [Advice on mandatory network conferencing within the frame of guardianship]*. Utrecht: Nederlands Jeugdinstituut.

- Nisbet, R. (1953). *The quest for community. A study in the ethics of order and freedom*. New York: Oxford University Press.
- Nooteboom, B. (2002). *Trust. Forms, foundations, functions, failures and figures*. Cheltenham: Edward Elgar Publishing Limited.
- O'Shaughnessy, R., Collins., C., & Fatimilehin, I. (2010). Building bridges in Liverpool: Exploring the use of family group conferences for black and minority ethnic children and their families. *British Journal of Social Work*, *40*(7), 2034-2049.
- Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work*, *42*(2), 371-387.
- Panayiotou, G. & Karekla, M. (2013). Perceived social support helps, but does not buffer the negative impact of anxiety disorders on quality of life and perceived stress. *Social Psychiatry & Psychiatric Epidemiology*, *48*(2), 283-294.
- Pennell, J. & Burford, G. (1994). Widening the circle: The family group decision making project. *Journal of Child and Youth Care*, *9b*(1), 1-12.
- Pennell, J. (2004). Family Group Conferencing in child welfare: Responsive and regulatory interfaces. *Journal of Sociology and Social Welfare*, *31*(1), 117-135.
- Pennell, J. & Anderson, G. (2005). *Widening the circle: The practice and evaluation of family group conferencing with children, young persons, and their families*. Washington, DC: NASW Press.
- Pennell, J. (2006). Restorative practices and child welfare: Toward an inclusive civil society. *Journal of Social Issues*, *62*(2), 259-279.
- Pennell, J., Edwards, M. & Burford, G. (2010). Expedited family group engagement and child permanency. *Children and Youth Services Review*, *32*(7), 1012-1019.
- Poortinga, W. (2006). Social relations or social capital? Individual and community health effects of bonding social capital. *Social Science & Medicine*, *63*(1), 255-270.
- Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology*, *24*, 1-24.
- Putnam, R. (1995). Bowling alone: America's declining social capital. *Journal of democracy*, *6*(1), 65-78.
- Putnam, R.D. (2000). *Bowling alone. The collapse and revival of American community*. New York: Simon and Schuster.
- Raad voor Maatschappelijke Ontwikkeling (RMO) (2013). *Terugreden is vooruitzien. Maatschappelijke veerkracht in het publieke domein [Retreating is anticipating. Societal resilience within the public domain]*. Den Haag: RMO.
- Rorty, R. (1991). *Objectivity, relativism and truth. Philosophical papers*. Cambridge: Cambridge University Press.

- Schout, G. (2007). *Zorgvermijding en zorgverlamming. Een onderzoek naar competentieontwikkeling in de OGGz* [Care avoidance and care paralysis. A study of competence development in public mental health care]. Amsterdam: SWP.
- Schout, G., De Jong, G. & Zeelen, J. (2010). Establishing contact and gaining trust: An exploratory study of care avoidance. *Journal of Advanced Nursing*, 66(2), 324-333.
- Schout, G., De Jong, G. & Zeelen, J. (2011). Beyond care avoidance and care paralysis: Theorizing public mental health care. *Sociology*, 45(4), 665-681.
- Schout, G. (2012). *Wat elke professional over de oggz moet weten* [What every professional should know about public mental health care]. Houten: Bohn Stafleu Van Loghum.
- Schuurman, M. (2008). *Momenten voor Eigen Kracht* [Moments for Family Group Conferencing]. Voorhout: Bureau WESP.
- Schuurman, M. & Mulder, C. (2011). *Eigen Kracht-conferenties bij gezinnen in de regio Amsterdam. Wat levert het op?* [Family Group Conferencing for families in the region of Amsterdam. What does it yield?]. Nieuwegein: Kalliope Consult.
- Seligman, M.E.P. & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55(1), 5-14.
- Seligman, M.E.P., Steen, T.A., Park, N. & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist*, 60(5), 410-421.
- Sheets, J., Wittenstrom, K., Fong, R., James, J., Tecci, M., Baumann, D.J. & Rodriguez, C. (2009). Evidence-based practice in Family Group Decision-Making for Anglo, African American and Hispanic families. *Children and Youth Services Review*, 31(11), 1187-1191.
- Sheldon, K.M. & King, L. (2001). Why positive psychology is necessary. *American Psychologist*, 56(3), 216-217.
- Sherman, M.D., Faruque, H.D. & Foley, D.D. (2005). Family participation in the treatment of persons with serious mental illness. *Psychiatric Services*, 56(12), 1624-1625.
- Shlonsky, A., Schumaker, K., Cook, C., Crampton, D., Saini, M., Backe-Hansen, B. & Kowalski, K. (2009). Family Group Decision Making for children at risk of abuse and neglect (Protocol). *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD007984. doi: 10.1002/14651858.CD007984.
- Silverman, D. (2013). *Doing qualitative research* [Fourth edition]. London: SAGE publications.
- Small, M.L. (2009). "How many cases do I need?": On science and the logic of case selection in field-based research. *Ethnography*, 10(1), 5-38.

- Stake, R.E. (1995). *The art of case study research*. London: SAGE Publications.
- Stake, R.E. (2006). *Multiple case study analysis*. New York, NY: Guilford.
- Stams, G.J. & Van der Helm, P. (2013). Eigen Kracht-conferentie is onvoldoende onderzocht om verder uitgerold te worden [Family Group Conferencing is understudied so it should not be further implemented]. *Sociale Vraagstukken*. Retrieved at 19 January 2014 from <http://www.socialevraagstukken.nl/site/2013/03/23/eigen-kracht-conferentie-is-onvoldoende-onderzocht-om-verder-uitgerold-te-woorden/>
- Steyaert, J. (2012). Sociale wetenschappers over sociale netwerken [Social scientists on social networks]. In: J. Steyaert & R. Kwekkeboom (Red.). *De zorgkracht van sociale netwerken [The care power of social networks]* (pp. 25-35). Utrecht: MOVISIE.
- Steyaert, J. & Kwekkeboom, R. (Red.). *De zorgkracht van sociale netwerken [The care power of social networks]*. Utrecht: MOVISIE.
- Stinchcombe, A.L. (1965). Social structure and organizations. In: J.G. March (Eds). *Handbook of organization* (142-193). Chicago, IL: Rand McNally & Company.
- Tengland, P.A. (2008). Empowerment: A conceptual discussion. *Health Care Analysis*, 16(2), 77-96.
- Tönnies, F. (2004). *Community and society*. New Brunswick: Transaction Publishers [first published in 1887].
- Tonkens, E. (2008). *De bal bij de burger [It is the citizen's turn]*. Amsterdam: Vossiuspers.
- Troonrede (2013). Koning Willem-Alexander heeft in de Ridderzaal de troonrede uitgesproken [King Willem-Alexander has spoken the King's Speech in the Knights Hall]. Rijksoverheid, The Hague. Retrieved at 29 October 2013 from <http://www.rijksoverheid.nl/documentenpublicaties/toespraken/2013/09/17/troonrede-2013.html>
- Van Dam, J. (2013). 'Effectiviteit Eigen-kracht conferenties moet nog worden aangetoond' ['Efficacy of Family Group Conferencing still needs to be proven']. *Sozio*. Retrieved at 19 January 2014 from <http://www.sozio.nl/effectiviteit-eigen-kracht-conferenties-moet-nog-worden-aangetoond/1024855>
- Van Hemert, H.M. & Wolf, J.R.L.M. (2011). Wat is OGGz? [What is public mental health care?]. *Epidemiologisch Bulletin*, 46(2/3) 14-22.
- Van Regenmortel, T. (2009). Empowerment als uitdagend kader voor sociale inclusie en moderne zorg [Empowerment as challenging frame for social inclusion and modern care]. *Journal of Social Intervention*, 18(4), 22-42.

- Visker, R. (2009). Michel Foucault: Surveiller et punir. Naissance de la prison (1975). In: R. Gabriëls (Red.), *De Twintigste Eeuw in veertien filosofische boeken [The Twentieth Century in fourteen philosophical books]* (pp. 215-231). Amsterdam: Boom.
- Visser, C. (2006). *Doen wat werkt. Oplossingsgericht werken, coachen en managen [Doing what works. Solution-focused therapy, coaching and managing]*. Culemborg: Van Duuren Management.
- Waites, C., Macgowan, M.J., Pennel, J., Carlton-LaNey, I. & Weil, M. (2004). Increasing the cultural responsiveness of Family Group Conferencing. *Social Work, 49*(2), 291-300.
- Wang, E.W., Lambert, M.C., Johnson, L.E., Boudreau, B., Breidenbach, R. & Baumann, D. (2012). Expediting permanent placement from foster care systems: The role of Family Group Decision-Making. *Children and Youth Services Review, 34*(4), 845-850.
- Weigensberg, E., Barth, R.P. & Guo, S. (2008). Family Group Decision Making: A propensity score analysis to evaluate child and family services at baseline and after 36-months. *Children and Youth Services Review, 31*(3), 383-390.
- Wetenschappelijke Raad voor het Regeringsbeleid (WRR) (2006). *De verzorgingsstaat herwogen. Over verzorgen, verzekeren, verheffen en verbinden [The welfare state being reconsidered. On taking care of, guaranteeing, uplifting and connecting]*. Amsterdam: Amsterdam University Press.
- Wetenschappelijke Raad voor het Regeringsbeleid (WRR) (2012). *Vertrouwen in burgers [Trust in citizens]*. Amsterdam: Amsterdam University Press.
- Wright, T. (2008). Using family group conference in mental health. *Nursing Times*. Retrieved at 25 September 2009 from <http://www.nursingtimes.net/nursing-practice-clinical-research/using-family-group-conference-in-mental-health/564092.article>
- Yin, R.K. (2009). *Case study research. Design and methods [Fourth Edition]*. Thousand Oaks: SAGE Publications.
- Zucker, D.M. (2001). Using case study methodology in nursing research. *The Qualitative Report, 6*(2), retrieved at 6 November 2013 from <http://www.nova.edu/ssss/QR/QR6-2/zucker.html>