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de Jong, G.

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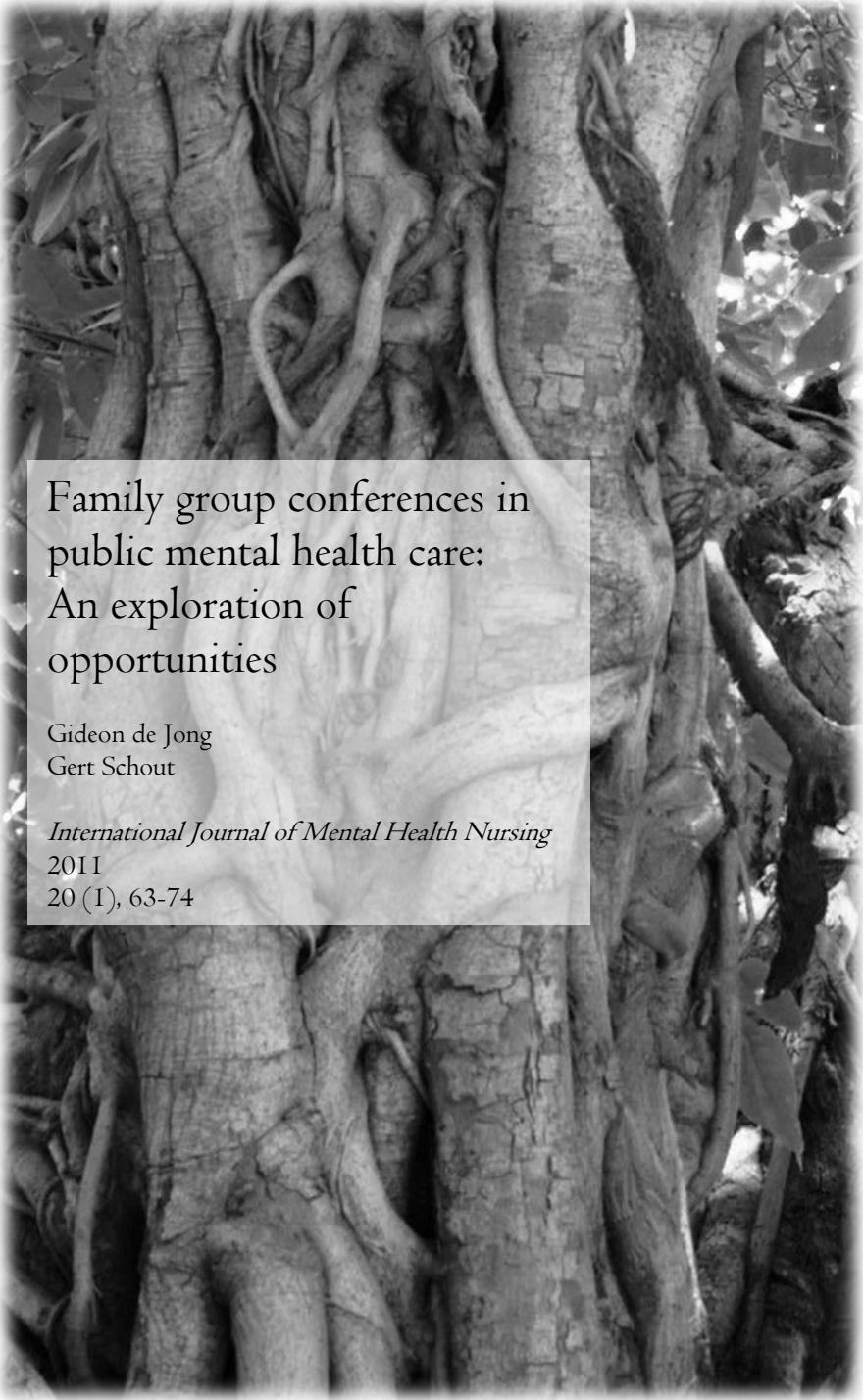
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Family group conferences in
public mental health care:
An exploration of
opportunities

Gideon de Jong
Gert Schout

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Chapter Four

Family group conferences in public mental health care: An exploration of opportunities

Abstract

Family group conferences are usually organized in youth care settings, especially in cases of (sexual) abuse of children and domestic violence. Studies on the application of family group conferences in mental health practices are scarce, let alone in a setting even more specific, such as public mental health care. The present study reports on an exploratory study on the applicability of family group conferencing in public mental health care. Findings suggest that there are six reasons to start family group conference pilots in public mental health care. First, care providers who work in public mental health care often need to deal with clients who are not motivated in seeking help. Family group conferences could yield support or provide a plan, even without the presence of the client. Second, conferences might complement the repertoire of treatment options between voluntary help and coercive treatment. Third, clients in public mental health care often have a limited network. Conferences promote involvement, as they expand and restore relationships, and generate support. Fourth, conferences could succeed both in a crisis and in other non-critical situations. Sometimes pressure is needed for clients to accept help from their network (such as in the case of an imminent eviction), while in other situations, it is required that clients are stabilized before a conference can be organized (such as in the case of a psychotic episode). Fifth, clients who have negative experiences with care agencies and their representatives might be inclined to accept a conference because these agencies act in another (modest) role. Finally, the social network could elevate the work of professionals.

Key words

Care avoidance, community mental health care, family group conference, family involvement, public mental health care.

Introduction

Reducing social exclusion, while mobilizing the capacity of civil societies, is a challenge worldwide (Burford, 2005). On 1 January 2007, the Social Support Act (in Dutch: Wmo, 'Wet maatschappelijke ondersteuning') was passed in the Netherlands. The goal of the Social Support Act is 'participation'. The Act aims to ensure that people remain independent as long as possible, and that they can fully participate in society, whether or not they are helped by friends, family, or acquaintances. Fundamental in the Social Support Act is mutual engagement between people. One of the domains in the Social Support Act is public mental health care, which deals with all activities in mental health that are not guided by a voluntary, individual demand for aid. The core of public mental health care is to provide help, even with a lack of active cooperation from the person (or persons). Clients often lack the support of a vital social network, and the target group is clients who do not benefit from the mutual commitment described in the Social Support Act. Public mental health-care clients (Schout *et al.*, 2010):

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1. Are not sufficiently able to provide their own living conditions, including shelter, food, income, social contacts, and personal care.
 2. Have several problems simultaneously, including a lack of personal care, social isolation, unhygienic living circumstances, lack of a permanent stable home environment, debts, and mental and addiction problems.
 3. Do not (from the perspective of the care system) receive the care they need in order to remain independent in society.
 4. Do not ask for help, although family, neighbours, and others often offer help, so there is unwanted interference or assistance.
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Commissioned by the municipality of Groningen in the north of the Netherlands, we examined possibilities to strengthen the resources of clients who are helped in public mental health care. We raised the following question: how can these resources be discovered, developed, or restored? Our aim is to promote social rehabilitation and cultural integration and to reduce social vulnerability. Therefore, the central question of our study is: can family group conferencing be applied in public mental health care? Internationally, there is little knowledge on the use of family group conferences in mental health-care practices, let alone in a field as specific as public mental health care. Therefore, we ask: is it at all possible to help people who normally do not have vital social networks by using this approach, or rather, help them to help themselves and perhaps each other? This present study deals with these questions.

Background

As Burford and Hudson (2000a) state, the core idea of a family group conference is a meeting of all family members, state officials, and other people involved with the family to establish a plan for the care and protection of individual family members. The meeting is organized by a coordinator who creates conditions so that members can work together to find solutions during a private session where professionals are not present.

In a family group conference, all who are involved with the family, and who can contribute, are invited. This means that not only the client, his/her family, and care providers are present, but also friends, neighbours, and school teachers can participate. Through a democratic process, the family establishes a plan. At the end of the conference, every participant needs to agree with this plan. The plan provides a description of the roles and responsibilities of all the different actors involved in resolving the problem. In the family group conference approach, the traditional method of decision making, where a professional is in charge, is abandoned. Here, it is the family who determines the agenda. Families are often better able to find workable solutions than care providers (Lupton, 1998). Family group conferences enable them to cope with problems in a manner that is more consistent with their own culture, lifestyle, and history (Jackson & Morris, 1999). Unlike 'traditional' approaches that are often "family centred", a family group conference is "family driven" (Merkel-Holguin, 2004, p. 164). That is, the approach is not aimed at the family, but achieves results through the contributions of the family. Therefore, a family group conference uses resources that exist within society; the natural resources of the family and others are mobilized and used.

The family group conference approach is not an isolated method. It was developed in New Zealand in response to situations involving Maori children (Levine, 2000; Macgowan & Pennell, 2002). These children were often placed outside of their homes, while no attention was paid to alternatives for avoiding these out-placements. Therefore, the Department of Social Welfare developed a culturally-sensitive approach, and in 1989, The Young Persons and Their Families Act was passed. The purpose of this Act was to reduce the role of the state in youth care and to emphasize the responsibility of the family and those who are directly involved in the care of the child. Family group conferences became central to this Act (Levine, 2000). In some cases in New Zealand, a conference is mandatory, and the client (or family) must be present. Families can either choose to accept a family group conference or they will be confronted with a judicial proceeding (in most cases, an out-placement of a child). As Adams and Chandler (2004) argue, these proceedings can have a deterrence effect on families because they sense a loss

of control. Family group conferences, however, emphasize the resources and capabilities of the family, making it an attractive approach.

Family group conferencing is an approach that tries to combine the formal system of government and care agencies with the informal system of the family and their social network, so that both systems have access to each other's information, and the best decision can be made (Dalrymple, 2002). Here, "decision making is the responsibility of the family, while the state provides appropriate services and facilitates the decision-making process" (Dalrymple, 2002, p. 288). The conference itself must ensure the safety of the child, while strengthening the resources of the family (Adams & Chandler, 2004; Brown, 2003; Crampton, 2004; Macgowan & Pennell, 2002). From a broader perspective, a conference helps the family to develop a sense of social responsibility (Macgowan & Pennell, 2002), and promotes active citizenship (Dalrymple, 2002).

Conference process

The care provider determines which families are eligible for a conference (Crampton, 2007), and informs the family of the possibility of organizing a conference (see stage I, figure 1, Chapter One). Once an agreement between the client, his/her family, and the care provider is reached, an independent coordinator is asked to organize a conference (Crampton, 2007; Hayes & Houston, 2007; Macgowan & Pennell, 2002). People are invited to the conference through the "snowball process" (Macgowan & Pennell, 2002, p. 74).

That is when people are invited to the conference, they are asked to invite others who can contribute. This process widens the circle (Pennell & Burford, 1994). Of importance is that people from outside the family will be given a voice, because "members who are not directly involved in the problem can strengthen the message of community expectations" (Pranis, 2000, p. 46). By involving others, such as neighbours, lecturers, and other community members, "conferences encourage sharing responsibility for the well-being of the children and family" (Pranis, 2000, p. 46). It is not unusual for the client and his or her family to exclude 'significant others' (i.e. uncles, aunts, neighbours, or friends) from contributing to the conference. Clients can feel uncomfortable inviting them to a conference because they become aware of the client's problems (Levine, 2000; Macgowan & Pennell, 2002). Therefore, a coordinator ensures that the right people are invited, while finding a balance between supporting the agenda and respecting the wishes of their clients.

The invitees are asked to provide essential information to be shared in the family group conference. Extra attention is paid to sensitive information, especially in cases of sexual abuse. Therefore, it is essential that the coordinator has "an in-depth knowledge

about family dynamics and the impact of intimidatory dynamics on processes of participation” (Connoly, 2006b, p. 350). Connoly (2006b) further argues “that creating a climate of honesty and being up front with families increase the potential for the family to also deal honestly with the issues” (p. 355).

The conference can be organized on weekdays, evenings, and weekends, preferably on neutral ground where everybody feels at ease, such as in churches or community centres (Levine, 2000; Macgowan & Pennell, 2002). During the conference, the coordinator creates the conditions for the family to create a plan, including a safe environment where every participant feels comfortable.

Preferably, the coordinator is not a(n) (ex-) care professional who is experienced in the culture and tradition of the care system, but a person who can think and act independently. He/she is a person who does not try to resolve problems by mobilizing professionals (Holland & Rivett, 2008; Lupton, 1998; Macgowan & Pennell 2002; Sundell et al. 2001). In addition, the coordinator acts as “a role model and enabler for responsible citizenship. In carrying out this role, the coordinator demonstrates and fosters democratic decision making in reaching collectively-defined goals” (Macgowan & Pennell, 2002, p. 71). Coordinators view “families as partners who are capable of responsible decision-making” (Macgowan & Pennell, 2002, p. 72).

In the first phase of a conference (see stage 3a, figure I, Chapter One), essential information is shared with all actors, followed by a discussion. The second phase (see stage 3b) begins when the coordinator and the care provider(s) withdraw(s) from the group, and the family has the opportunity to discuss and decide on a plan in a private session. Normally during this session, a family member takes over the role of moderator (Holland & Rivett, 2008; Macgowan & Pennell, 2002). This private session is essential, as it is free from supervision by professionals, and the family has a chance to develop a plan of their own (Vesneski 2008). This is considered the “heart” of the family group conference approach (Mirsky, 2003a, p. 3). If necessary, steps are taken to deter others from dominating the meeting (Berzin *et al.*, 2007; Connoly, 2006a,b; Gallagher & Jasper, 2003; Holland *et al.*, 2005; Lupton, 1998; Macgowan & Pennell, 2002). In such cases, there is also the possibility to assign advocates, especially in cases where children are involved (Dalrymple, 2002; Holland & O’Neill, 2006; Pennell & Burford, 1994). Finally (see stage 3c), the coordinator rejoins the group so that the family can agree on a definite plan. In cases of judicial proceedings, the care provider is asked to check the plan for issues, such as safety and applicability (Macgowan & Pennell, 2002). After this, the plan is distributed to each actor so that everyone knows their roles (see stage 4, figure I, Chapter One) (Levine, 2000). A family member or care provider can be designated as the person(s) who will be responsible for a mid-term review of the plan,

because “without extended follow-up and sufficient contact, family members may be no more likely to follow plan elements than they would in traditional case planning” (Berzin *et al.*, 2008, p. 50) (see table I for care providers’ tasks). If the plan fails, no one should be blamed. The family must create a new plan that is functional (Macgowan & Pennell, 2002; Sundell *et al.*, 2001).

Table I. Care provider’s tasks before, during and after a FGC

Care provider’s tasks before, during and after a FGC
1. Care provider’s tasks before, during and after a FGC
2. Setting the agenda and providing instructions to the family as to what needs to be discussed during the private phase
3. Helping formulate a feasible and safe plan
4. Monitoring the plan after the conference

Source: Holland *et al.*, 2005

Family group conferencing in public mental health care

The family group conference approach is implemented in the youth care systems of different countries and is subject to various forms of evaluation, although randomized, control studies or evidence-based practices are scarce (see Berzin *et al.*, 2007, 2008; Berzin, 2006; Burford & Hudson, 2000b; Crampton, 2007; Sheets *et al.*, 2009; Sundell & Vinnerljung, 2004; Weigensberg *et al.*, 2009). The impact of family group conferences is mostly favourably evaluated. In 90% of conferences, agreement is reached on the proposed decisions, where in many cases, creative decisions are made by the family without interference from care providers (Lupton, 1998). Actors are satisfied with the process, such as better cooperation with care providers and better accessibility to care services, as well as with the achieved results, such as reducing risk (Berzin *et al.*, 2007; Connolly, 2006b; Holland & O’Neill, 2006; Levine, 2000; Lupton, 1998; Mutter *et al.*, 2008; Pennell, 2004; Sheets *et al.*, 2009; Weigensberg *et al.*, 2009) or prevention of recidivism of juvenile crime (Baffour, 2006). Sometimes deterioration of a problematic situation within the family or an out-placement can be averted with the help of a family group conference (O’Shaughnessy *et al.*, 2010). Care providers who have experienced a conference are generally positive about the approach (Levine, 2000; Sundell *et al.*, 2001).

Implementation remains mostly confined to youth care and related systems (Hayes & Houston, 2007). In the last decade, there have been more family group conferences in other fields, such as in education (Hayden, 2009), with minority groups (Chand & Thoburn, 2005; O’Shaughnessy *et al.*, 2010), or in situations preventing recidivism of

juvenile crime (Baffour, 2006). Although in several countries there is a call for a stronger emphasis on family involvement in mental health (i.e. Ewertzon *et al.*, 2008; Jubb & Shanley, 2002; Lakeman, 2008; Sherman *et al.*, 2005), studies on the application of family group conferences in mental health practices are scarce. Studies in a more specific field, such as public mental health care, are very scarce.

Mirsky (2003b, p. 3-5) and Wright (2008) reflected on the application of family group conferences in a community mental health-care practice in the county of Essex (UK), based on a programme for adults who suffer from schizophrenia, bipolar disorder, or personality disorder. According to the developers, this programme places emphasis on increasing support from networks and combating isolation, discrimination, and stigma (Mirsky, 2003b). In this practice, 'family' is understood in a broad sense, that is, anyone who is involved with the client. There are agreements with and between actors, family members, neighbours, friends, and care providers on their roles when the client's situation worsens (Wright, 2008). A family group conference in youth care is organized in a crisis situation. This is one key difference to the practice in Essex. In this practice, a conference will not be organized in a crisis situation, for example, when a client displays psychotic symptoms or acts suspiciously towards his/her family (Mirsky, 2003b). In Essex, a family group conference is understood as an additional approach and complements existing methods. A psychiatric nurse practices the role of a conference coordinator. Wright (2008) does not speak about a coordinator, but a facilitator. The facilitator informs the client of the possibilities of organizing a conference. The question is whether the coincidence of the role of care provider with the role of facilitator/coordinator justifies the philosophy of the family group conference approach. The practice in Essex can also be understood as a practice where effort is made in developing social network strategies.

According to Flynn (in Mirsky, 2003b), family group conferences are especially valuable to clients who suffer from personality disorders, and therefore, often live in chaotic circumstances. A conference provides them with structure they cannot otherwise develop themselves. It creates thresholds for chaotic behaviour. Family group conferences also encourage clients to use the services that care agencies offer. Often clients feel ashamed to utilize the services of these agencies. The conferences ensure that these barricades will be broken (Mirsky, 2003b). Finally, conferences break social isolation by increasing the amount and quality of social relationships.

In Dutch mental health care, there is little experience with family group conferences. The few examples that exist provide little insight into the use of conferences in public mental health care. However, in Amsterdam, conferences are introduced in situations of imminent evictions (Hogeschool van Amsterdam [HvA], 2008). People in Amsterdam

who are at risk of eviction show an overlap with clients in public mental health care. This group also has difficulties in finding its way to care agencies, and often also has accumulated problems. Both coordinators and care providers designate family group conferences as a suitable approach for clients dealing with imminent evictions. Isolated clients need social capital to master their problems. In the event of a crisis, such as an imminent eviction, the support of family, friends, and neighbours is crucial (HvA, 2008).

In situations of imminent evictions, a crisis is often needed to make clients realize the importance of a family group conference. Often when the crisis is resolved, clients lose the motivation and cooperation to achieve the goals of the plan. Therefore, finding the right moment to organize a conference is essential. It needs to be a moment where there is enough pressure for motivation and enough time to examine the problems (HvA, 2008). Care providers must make sure that they do not resolve a crisis too early, such that there is no longer a need for a family group conference.

Method

Aim

The aim of this study is to explore the applicability of family group conferencing in public mental health care.

Design

The present study is based on a descriptive, exploratory study, conducted between September 2009 and January 2010 in the Netherlands.

Data collection

The study consists of three parts.

Literature research

We started with a literature search on the applicability of family group conferences in (public) mental health. We used search strings with the words 'public mental health care', 'community mental health care', 'family involvement', and 'family group conference' in PubMed and PiCarta, the most common databases in the Netherlands.

The literature research yielded new questions for empirical research, namely:

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- To what extent should one adhere to the established procedure of family group conferences when they are organized in public mental health care?
 - What will the role of a conference coordinator be in public mental health care, and what are the essential criteria of a coordinator?
 - To what extent is it possible to organize conferences for clients who have a limited network?
-

Interviews

We interviewed 10 experts with a background in public mental health care or family group conferences. Four of them worked as care providers in public mental health care, while one was a lecturer in public mental health care at a social work department of a local university. The experts within the field of family group conferencing consisted of three coordinators and two staff members from the national Dutch family group conference organization (known as 'Eigen Kracht Centrale', see www.eigenkracht.nl).

One researcher interviewed was from the field of social work and recently finished a study on the applicability of family group conferences in situations of imminent evictions. This sample is an attempt to capture all possible varieties of opinions, perspectives, and specialties on the applicability of family group conferences in public mental health care. The open interviews were structured by a topic list containing the main themes we found in the literature research (topics were 'applicability', 'context and client situations', 'goals', 'limitations', 'role and competency of the coordinator'). In total, 10 interviews took place with an average length of 1.5 hours. Interviews were audiorecorded and transcribed.

Even after the interviews, there were unanswered questions, such as whether:

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- The presence of a coordinator and care provider during the private session is recommended.
 - The coordinator should have expertise in psychiatric mental health.
 - A crisis is a(n) (contra-)indication.
 - A family group conference can be held without clients being present.
-

Member check

We organized a member check with 27 experts, including policy officials, administrators, teachers, professionals, and experts from the domains of youth care, public mental health

care, and family group conferencing. We facilitated a discussion on the ideas and issues that were converted during the first two parts of our research. The purpose of the meeting was to gather ideas, find solutions for five bottlenecks, validate interpretations, and share findings. This method is very similar to the member check developed by Guba and Lincoln (1989). The member check lasted for 3 hours, was audiotaped, and transcribed.

The initial idea was to organize a member check, that included clients, to validate interpretations, discuss differences, and to share findings. However, it was difficult to organize appointments. Another reason why we did not invite clients was the potential anxiety and pressure that could be triggered by a member check.

Ethical considerations

The study was approved by the relevant university research ethics committee. All ethical considerations were addressed, including informed consent. During the study, care providers and coordinators interviewed were treated as experts on the study topic and were asked to provide feedback after transcription of the audio documents. Findings of the member checks were discussed with the ethics committee.

Data analysis

The data collection of the empirical research continued until no new ideas, capabilities, applications, concerns, and constraints about the use of family group conferences in public mental health care emerged. That is, in all lines of inquiry, saturation occurred (Guest *et al.*, 2006; Morse, 1995). The transcribed interviews and member checks were analysed with the software programme ATLAS.ti (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany), resulting in trends, patterns, and deviations of patterns about the applicability of family group conferences in public mental health care. Finally, findings from all forms of inquiry were compared, and deviations were analysed, resulting in the formulation of conclusions and recommendations. An important question from this study was whether there was sufficient evidence to start thoughtful and safe family group conference pilots in public mental health care.

Findings

Interview findings

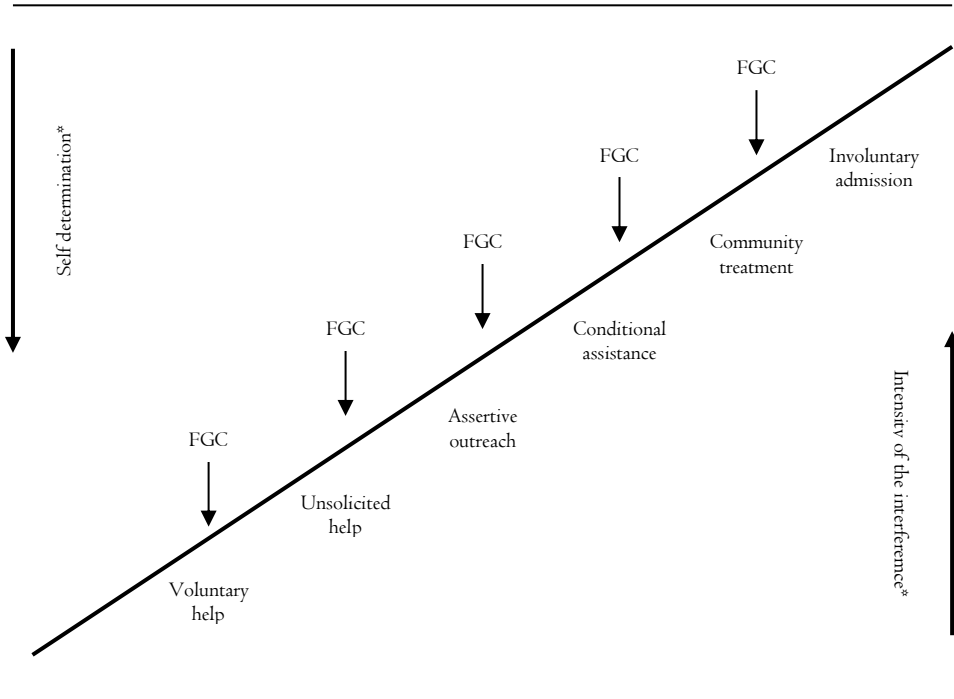
All participants agreed that there are good reasons to start family group conference pilots in public mental health care, but opinions differ on its suitability. There were two

distinct camps: (i) representatives of the family group conference approach; and (ii) professionals from public mental health care. The former believe that conferences can be applied in all situations where social problems occur, including in public mental health care. They have two arguments for this position: (i) positive outcomes of conferences with families with several problems legitimizes the use of family group conferences in public mental health care, because target groups and context show overlap with the public mental health care; and (ii) public mental health-care clients, like other citizens, are entitled to self-determination, which is promoted by a conference.

Professionals from public mental health care also have positive expectations about family group conferences in public mental health care, but show more reservations. First, they are sceptical of the possibilities of mobilizing the network. Many clients have too limited a network. Relationships are often damaged, resulting in a limited number of people who can be mobilized for a conference. In addition, the professionals are sometimes concerned about a client's behaviour, so they wonder whether a coordinator is able to deal with such behaviour, especially when he or she does not have a background as a (public mental health-care) care provider.

Several interviewees, both representatives of the family group conference approach and professionals from public mental health care, underlined the possibilities of a conference to avoid future coercive proceedings, and therefore, care providers should seize the possibilities of a conference more quickly. One care provider stated that there are good reasons to assign a prominent place for family group conferences in the so-called 'care continuum' (Lohuis *et al.*, 2008). He advocated the application of conferences as a means of preventing coercion. Conferences can be applied between different stages of voluntary help, unsolicited help, assertive outreach, conditional assistance, community treatment orders, and involuntary admission (see figure 4). That is, conferences have the potential to prevent coercion.

Not all public mental health-care clients will welcome family group conferences. Some might see a conference as a new means of a care system they would normally try to avoid. In such situations, according to a regional manager of family group conferences, it must be possible for a family to request a conference, even when the client himself/herself will not be present. The central question then is how they can deal with the living circumstances or the deviant behaviour of their relative.



* When interference increases (from voluntary help to involuntary admission), self-determination decreases. FCG, family group conference.

Figure 4. Family group conference as a preventative tool of coercion

Member-check findings

The ideas, potencies, and constraints in the interview data were transformed into propositions and presented to participants of the member check (see table 2).

Organizing a family group conference only with the client's consent

Participants who agreed with this statement did so for several reasons. The most important of these reasons was that the client would not take responsibility for the conference when he or she does not recognize its value, so there would be little effort during the conference and implementation stage of the plan. Based on such a scenario, the plan would not be expected to last. It is the care provider's responsibility to reduce the client's resistance and motivate them to take part in a conference.

A slight majority of participants disagreed with the statement. They argued that a large part of the public mental health-care population is demoralized for asking for

assistance, including a family group conference. In such cases, a conference can be requested by a relative or a care provider, without the presence of the client during the conference. Families need support and advice, especially families of clients who reject care. One respondent indicated that prior to a conference, clients might have doubts, but eventually choose to attend the conference because it concerns them, and that over time, they appreciate the value of the conference.

Table 2. Member-check result propositions

Propositions	No participants
<i>Organizing a family group conference with the consent of the client</i>	
Agree:	10
Disagree:	15
No opinion:	2
<i>Clients in public mental health care have too limited a network for family group conferences</i>	
Agree:	1
Disagree:	23
No opinion:	3
<i>Family group conferences only succeeds in crisis</i>	
Agree:	3
Disagree:	19
No opinion:	5
<i>Coordinators should have a background as care providers</i>	
Agree:	6
Disagree:	16
No opinion:	5
<i>Coordinator and/or care provider need to be present during the private session of the conference</i>	
Agree:	11
Disagree:	13
No opinion:	3

The propositions and responses to them are as follows.

Clients in public mental health care have a limited network

A majority of participants disagreed with this proposition and believed that there is always a network to be found in a client's life that can contribute to a family group conference. The respondents' arguments were: (i) it is always worth organizing a conference to restore contact with family members; (ii) a limited network is a particularly good reason for organizing a conference, as many problems in public mental health care are caused by a limited network and isolated living circumstances; and (iii)

there is always a network that can be used, but it is often tired or paralyzed. Therefore, a conference can revitalise or heal relationships.

Three participants questioned whether contacts who had been previously cut-off would be willing to participate in a conference.

Family group conferences only succeed in crisis situations

Participants who agreed with this proposition argued that the motivation of a client to change is stronger during a crisis: 'With their backs against the wall, they will more likely agree with a family group conference.' In other words, a crisis is an opportunity for change.

Yet a majority of participants disagreed with the proposition. They indicated that clients must always express a clear request for a family group conference in order to improve their living circumstances. They suggested that in a crisis situation, the client is not sufficiently able to formulate this request. One respondent suggested that a conference, both during or after a crisis, is a valuable tool: 'Often professional help is needed to address the crisis, but to make a plan for what needs to be done when the crisis is solved and how to prevent the next crisis happening, a family group conference can be a good approach.' Finally, according to another respondent: 'If you only introduce the possibility of a conference during crisis situations, you risk everything being disintegrated as soon as the crisis has come to an end, and everyone will (revert to) their old patterns again.'

Participants who did not take a clear position in the debate concerning this proposition had different arguments. First, one needs to understand the nature of the crisis. Sometimes pressure is needed to enable clients accept help. However, during a crisis caused by psychosis or drug misuse, organizing a family group conference is usually of limited value. In the first case, a crisis can generate motivation for a conference, for instance, an imminent eviction. In the latter case, it can even be counterproductive.

Coordinators should have a background as care providers

Participants who agreed with this proposition argued that coordinators need to deal with complex issues when organizing family group conferences in public mental health care. The assumption of these participants was that a coordinator with a background as a (public mental health-care) care provider is better equipped with professional knowledge, and therefore, better able to deal with complex issues in public mental health care.

A cornerstone in the philosophy of family group conferences is the independence of a coordinator. The 'Eigen Kracht Centrale' in the Netherlands recruits coordinators who

have no background as care providers. A majority of participants agreed with this principle, and therefore, disagreed with the proposition. It is best to let an independent coordinator do the job, especially when organizing family group conferences in public mental health care. This is particularly crucial in relation to clients who avoid the care professionals they need. According to one respondent, these people act so suspiciously to representatives of care agencies, that if they knew that the coordinator himself/herself had a professional background as a care provider, they would reject a family group conference.

A respondent, who did not take a firm position in this particular debate, said: 'Care providers who work in public mental health care have a more independent position than care providers who work in youth care usually have. In youth care, conditional assistance is customary. Care providers are not independent; they monitor, report, and have power to take action. Therefore, there is no objection to a care provider to act as a family group conference coordinator in public mental health care.' Another respondent underlined the value of a care provider who had already developed a good relationship with the client. In such cases, the care provider would be the most suitable person to organize a family group conference.

Coordinator and/or care provider need to be present during the private session of the conference

Another essential issue in the family group conference approach is the necessary absence of the coordinator and the care provider(s) during the private session of a conference. Some respondents stated that, for reasons of safety and progress of the decision-making process, it could be helpful when a coordinator or care provider is present during this stage. Without their presence, they felt that it would be difficult to resolve the problem.

However, other respondents strongly argued that in no case is one allowed to deviate from the normal family group conference approach, and therefore, no coordinator or care provider should be present during the private session. One stated: 'Public mental health-care clients are not different from clients in youth care. There is no reason to deviate. Public mental health-care clients are citizens who want to stay in control of their lives.' Another respondent complemented this argument: 'The examples all do affect the core of the approach: the empowerment of citizens in favour of professionals. It is not necessary to deviate from the approach. I can imagine that clients themselves have the power to say whether they want such an exemption (for example, the coordinator being present during the private session); only in this scenario is it possible to deviate from the approach.'

Several respondents wondered whether it would still be legitimate to call a conference a family group conference when there will be too much of a deviation from the normal family group conference approach.

Discussion

In this section, we successively address three questions: (i) what does this study add to the body of knowledge? (ii) what are the implications for practice? and (iii) what are the limitations of the study?

Clients who are helped in public mental health care are socially vulnerable. Unemployment, socioeconomic deprivation, alcohol and drug abuse, and criminal involvement are often compounded by the fragmentation of local communities, leaving clients few resources from which to draw on. O'Shaughnessy *et al.* (2010) pointed out that family group conferences are difficult to implement under these circumstances. The findings of our study suggest that these circumstances underline the necessity of family group conferences. Poor resources are the reason why relationships need to be mobilized and recovered. In public mental health care, this implies efforts to explore and restore the power of actual and previous contacts, but who takes the initiative for these actions: the coordinator or the care provider? Is restoring relationships the responsibility of the coordinator? In the research literature, we did not find information on this matter. Also our empirical data provided no answers. Further research is required here.

Clients in public mental health care are known to avoid the care professionals believe they need (Schout *et al.* 2010). We can assume that avoiding care also means rejecting a conference. Jubb and Shanley (2002) argued that families of patients with mental illness can be confused about how to deal with clients' living circumstances or behaviour. Our empirical data suggest that in cases of care avoidance, a conference could be requested by a family member so that the family is better equipped in dealing with their relative (see table 3).

Clients who avoid the care they need can have negative experiences with care agencies and their representatives. They can act suspiciously to a coordinator who has a background as a care provider. In line with Crampton (2007), Hayes and Houston (2007), and Macgowan and Pennell (2002), we therefore emphasize the need for an independent coordinator in organizing conferences in public mental health care. We expect an independent coordinator would be better accepted by the client. Future research needs to determine whether the coordinator should at least be equipped with knowledge of public mental health care and its target groups.

Table 3. Reasons for organizing family group conferences

Reasons for organizing family group conferences	
<i>From the literature:</i>	
1.	Averting or postponing judicial proceedings in youth care and welfare (Adams & Chandler, 2004; Brown, 2003; Connolly, 2006a, 2006b; Crampton, 2004; Gallagher & Jasper, 2003; Holland & O'Neill, 2006; Levine, 2000; Lupton, 1998; McElrea, 1998; Pennell, 2004)
2.	Preventing domestic violence: (Pennell & Burford, 2000; Crampton, 2004; Weigensberg et al., 2009)
3.	Inhibiting youth truancy (Hayden, 2009)
4.	Resolving problems in forensic youth care (Mutter et al., 2008)
5.	Preventing recidivism of juvenile crime (Baffour, 2006)
6.	Preventing evictions (HvA, 2008)
7.	Resolving problems within families from minority groups (Chand & Thoburn, 2005; O'Shaughnessy et al., 2010; Sheets et al., 2009; Waites et al., 2004)
8.	Combatting stigmatization and social isolation in community mental health care (Mirsky, 2003b; Wright, 2008)
<i>From the interviews and panel discussion:</i>	
9.	Preventing coercion in public mental health care

In youth care, a conference is normally organized during a crisis, such as the (sexual) abuse of children and domestic violence (Adams & Chandler, 2004; Brown, 2003; Connolly, 2006a,b; Crampton, 2004; Gallagher & Jasper, 2003; Holland & O'Neill, 2006; Levine, 2000; Lupton, 1998; McElrea, 1998; Pennell, 2004), whereas in community mental health-care practice in Essex, a conference is only organized when clients are stabilized (see Mirsky, 2003b; Wright, 2008). As crisis situations often occur in public mental health care, our empirical data suggest that care providers have to make estimations and determine if it is worthwhile organizing a conference. Sometimes a crisis causes motivation for a conference, while in other cases, a crisis is a contraindication. The outcomes of this study address the power of family group conferences in public mental health care in preventing coercion. The next stage towards involuntary admission can be preceded by a conference (see figure 4). With the help of conference evictions, child protection proceedings, or requests for an involuntary admission, can be averted or postponed.

The findings of this paper are based on an exploratory study. The systematization of opinions of professionals are contrasted with the findings of literature research. Various measures were taken to ensure valid and reliable outcomes: (i) in all three lines of inquiry, saturation was reached, and data collection continued until no new information could be retrieved; and (ii) trivial and ambiguous issues were converted into research questions for

the empirical part of the study and finally submitted to a panel for discussion. Because of the small scale of the present study, the research findings need to be taken with caution. It is not justifiable to argue that conferences are presently valuable in public mental health care, therefore, pilot studies need to be carried out.

Nevertheless, our findings provide a basis for future research into the application of family group conferencing in public mental health care. To what extent are conferences an extension of the repertoire in public mental health care is a subject for further research. Also, research is needed to determine whether socially-vulnerable clients with little social capital benefit from the restorative power of family group conferencing.

Conclusion

Whether or not family group conferencing, as an approach, is valuable in public mental health care cannot be determined by this study. However, the findings of this study indicate that there are good reasons to start piloting family group conferences in public mental health care. These reasons are:

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1. In public mental health care, care providers often need to deal with clients who are not motivated. Even without the presence of the client, family group conferences could yield support or provide a plan.
 2. A family group conference might constitute an extension of the repertoire of treatment options between voluntary help and coercive treatment.
 3. Clients in public mental health care often have a limited network. A family group conference promotes the involvement of the natural network around a client. It expands and restores relationships and generates support.
 4. Family group conferences could succeed both in a crisis and in other non-critical situations. Sometimes pressure is required before clients accept help from their network (such as in the case of an imminent eviction), while in other situations, it is required that clients are stabilized before a family group conference can be organized (such as in the case of a psychotic episode).
 5. Clients who have negative perceptions about care agencies and their representatives might be inclined to accept a family group conference because these agencies act in another (modest) role.
 6. Finally, the social network could elevate the general tasks the care provider normally needs to fulfil.
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Our empirical research shows differences in perceptions between the representatives of the family group conference approach and public mental health-care professionals. These differences are mainly related to: (i) how to adhere to the standard family group conference procedure; (ii) whether the coordinator should have a background as a care provider; and (iii) whether a family group conference could only be organized with agreement of the client.

Family group conferences are used in avoiding judicial proceedings in relation to child protection, domestic violence, and evictions. The value of conferences in public mental health care could be in line with the following practices (see table 3): the tapping and mobilizing of resources; to combat stigma, discrimination, and social isolation; and to prevent coercion. Future research needs to verify if this is tenable.

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