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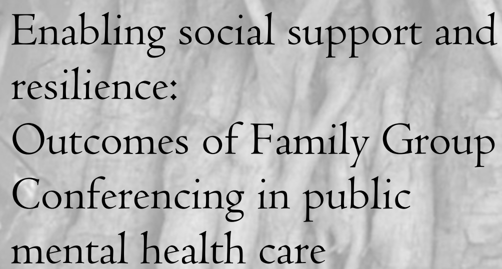

Enabling social support and resilience: Outcomes of Family Group Conferencing in public mental health care

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Chapter Five

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Abstract

Family Group Conferencing (FGC) is a decision making model where clients with their social network formulate their own plan. There is little experience with FGC in mental health care. We studied the outcomes of 41 conferences in a public mental health setting in the north of the Netherlands. We interviewed 312 respondents out of a total of 473 conference participants. In 33 cases, it was possible to obtain scores from 245 respondents on scales ranging from 0-10 about the situation prior and after the conference on three outcome measures: the quality of: 1) social support, 2) resilience and 3) living conditions. In the 33 cases, t-tests and multilevel analyses indicate on all of the three outcomes measures significant positive changes after the conferences. On average, the scores on the quality of social support (5,04 to 6,73), resilience (4,09 to 6,32) and the living conditions (3,73 to 6,64) had been increased since the conferences were organised. The results are modest but remarkable. That the outcomes of FGC are not more substantial can be explained. The clients referred to a conference in this particular study, mostly had a limited network and few recourses from whom little support could be expected.

Keywords
Community mental health, Family Group Conferencing, public mental health, quality of life, resilience, social support

Introduction

Public mental health care (PMHC) in the Netherlands is a safety net where clients are helped who avoid the care they actually need or who do not find their way to care providers and welfare services (Schout *et al.*, 2010, 2011). Clients are usually difficult to engage in psychiatric treatment (Mulder *et al.*, 2014). Problems are severe and

interwoven, including psychiatric disorders, addictions and social problems (debts, a neglected household and a lack of self-care). Professionals, such as social workers and community mental health nurses, not only provide unsolicited assistance to underserved clients, but also intervene in neighbourhoods with liveability problems.

Like in many other European countries, the political debate in the Netherlands on public health and social welfare is influenced by Philip Blond's (2010) ideas on civic engagement. Recently, it was emphasised that there is a need to transform the welfare state in a so called 'participation society' (Troonrede, 2013). This policy transition is mostly driven by economic motives. It is believed that budgets of health care and social welfare need to be cut if the Netherlands wants to maintain its wealth. Help from the informal network will probably lessen the demand for professional care. As PMHC is part of the social welfare system, it is also confronted with these political decisions. New care concepts like Family Group Conferencing (FGC) aim to mobilise informal resources and stimulate clients to accept support from their social network.

FGC is a decision making model that consists of a meeting wherein clients and their network are empowered to come up with a plan on their own. For two years, we have evaluated the process and outcomes of 41 family group conferences in a PMHC setting in the north of the Netherlands. One of our assumptions was that FGC could be a valuable means to restore broken and faded contacts of clients and solve conflicts within neighbourhoods in which clients are involved (De Jong & Schout, 2011). In this article we report on the outcomes of these conferences, in terms of an improvement of living conditions, an increase of clients' resilience and their social support. Given the positive impact of social support on the wellbeing of psychiatric clients (see Becker *et al.*, 1998; Lim *et al.*, 2014; Panayiotou & Karekla, 2013; Strine *et al.*, 2008; Sündermann *et al.*, 2014; Thoits, 2011), FGC has potency to complement the repertoire of social workers and nurses working in community mental health practices.

Background

A family group conference is a meeting wherein the client and his or her network are empowered to come up with a solution to a problematic situation and develop a joint plan. The origin of FGC lies in New Zealand. It was developed to allow social work practices to work with Maori cultural values, acknowledging the importance of collective responsibility for one's wider family rather than a more nuclear western perspective (Lupton & Nixon, 1999). Since 2001, FGC is successfully deployed in the Dutch youth care sector (De Jong & Schout, 2011). Essential in the philosophy that underlies FGC, is that people not only have capabilities themselves, but share these with others to

develop empowerment within their communities. FGC is a means to shape this new form of solidarity by emphasising and strengthening the resources from the civil society.

The entire process of FGC consists of four phases. 1) The referral is usually done by a professional. However, an official referral is not necessary, as clients or their family members are also stimulated to contact the organisation that coordinates FGC themselves (see www.eigen-kracht.nl). 2) An independent FGC coordinator will prepare the conference. Together with the client, the coordinator determines the members of the social network that will be approached for participation in the conference. The client makes the final decision who to invite for the conference. 3) The conference usually takes place one or two months after the referral. Professionals can also participate in the conference, but only during the first part, wherein the problematic situation is being outlined and suggestions for possible solutions are shared. The private session is essential, as it is free from supervision by professionals, and the client and his or her network has a chance to develop a plan of their own. 4) The plan whereon everyone agrees at the end of the conference, will afterwards be formalised by the coordinator and send to all actors. Usually the client, someone from the social network or a professional will be determined to ensure its implementation.

The role of professionals in the process of FGC is not ceased to apply. Whether FGC is set in motion strongly depends on professionals: they refer clients to FGC, are present during parts of the conference, provide information and support, but also open up resources from other agencies.

Worldwide, FGC has been studied from different angles, such as its impact in youth care (Pennell *et al.*, 2010; Wang *et al.*, 2012) and juvenile delinquency (Jeong *et al.*, 2014). There is little experience with FGC in adult care settings and in PMHC in particular. To our best knowledge, scientific publications on the impact of FGC in mental health care are rare. An exception is a randomised controlled trial on the effects of FGC for people who receive long-term social assistance in Norway that highlighted significant positive short-term effects of FGC for clients receiving social assistance: up to four months after the conference clients experienced a greater degree of social support and more pleasure in life (Malmberg-Heimonen, 2011). However, over the long run, these positive effects faded away because the social network experienced little reciprocity, got disillusioned and gave up on the client (Malmberg-Heimonen & Johansen, 2013). The characteristics of the target group in this Norwegian study are adjacent to that of the PMHC. In both fields clients often have multiple problems and a limited network (cf. Schout *et al.*, 2010, 2011). Many PMHC clients live in marginalised and neglected conditions and/or are involved in liveability problems. Due to social disabilities, relationships with their family and friends have often been broken or faded. One of the

outcomes of an exploratory study that preceded the current study, is that social isolation is not a contraindication, but a reason to organise a conference. FGC can restore damaged and faded contacts between clients and their social network (De Jong & Schout, 2010, 2013).

The study

From January 2011 to September 2013, 41 family group conferences in the PMHC setting of the province of Groningen (the Netherlands) were analysed by a naturalistic case study approach focusing on the process (Abma, 2005), aimed to give voice to clients and their networks by emphasising their expertise (Abma & Stake, 2014). This resulted in 41 case study reports (Schout & De Jong, 2013). To complement the process findings, in each case study a quantitative evaluation was performed to gain a better understanding of the outcomes of the conferences.

Aim and research questions

The aim of the overall study was to describe and understand the process and outcomes of FGC in PMHC. The quantitative evaluation, of which the results are highlighted in this article, aimed to describe whether FGC had an effect on an increase of social support of clients, an increase in their resilience, an improvement of their living conditions, and whether the caseload of professionals got alleviated.

Usually family group conferences that are organised in diverse fields result in four general benefits (Berzin *et al.*, 2008; Jeong *et al.*, 2012; Malmberg-Heimonen, 2011; Malmberg-Heimonen & Johansen, 2013; McCrea & Fusco 2010; Pennell *et al.* 2010; Sheets *et al.*, 2009; Wang *et al.* 2012; Weigensberg *et al.*, 2008). By examining if these benefits also occurred in 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 (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 the 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?

The definition of social support is derived from the literature on social capital. Social capital is 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 whom support is received, quality means how social support is perceived, in the sense if family and friends are available in times of need (Coventry, Gillespie *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 life 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, competence), quality of health (e.g., autonomy, self-confidence, self efficacy, 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.

Research design

This study was based on descriptive quantitative data from 41 case studies on the outcomes of FGC in the PMHC of the province of Groningen, the Netherlands.

Participants

Between February 2011 and February 2013 all referrals to the PMHC networks in the province of Groningen were included in this study. This applied to all individuals, families and communities (streets, courtyards or neighbourhoods) who are underserved (this involved hard to reach groups such as care avoiders, homeless people or multi-problem families not receiving indicated care).

The client group of PMHC is diffuse. Sometimes it consists of not just one client but rather a situation – such as liveability problems in neighbourhoods where no individual client can be designated. At the start of our project, the potential referrers to a conference (community mental health nurses and social workers) had been pointed out the situations wherein a conference can be desirable:

- When the social network should be widened or its cooperation improved.
- If clients are not motivated for treatment.
- In the case of imminent home evictions, child protection measures or in the case of compulsory admission to a psychiatric ward.
- In apparently hopeless situations, where the capabilities of a group have to be mobilised.
- In neighbourhoods with liveability problems.

Clients in PMHC and their relatives usually are not aware of the existence of FGC. It are mainly social workers and community mental health nurses who attend clients on the possible benefits of FGC. The PMHC networks in Groningen were asked to refer cases to our study. As a result many apparently hopeless cases were referred. In addition to the 41 cases wherein the process of FGC had been started up, there were 30 other cases that never progressed beyond an exploratory conversation between the client and FGC coordinator. In these cases we observed that clients who initially agreed to a conference, were afterwards difficult to reach for both FGC coordinators and professionals, especially in cases of drug addiction. Sometimes a conference evoked so much fear or aggravation of psychotic problems that it was not possible to proceed with it.

Our aim was to interview everyone who attended the conference or could reflect on its outcomes. We interviewed 312 respondents out of a total of 473 conference participants. 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 that had interference with the case, such as social workers and community mental health nurses, but also policy workers of municipalities, counsellors of social housing corporations and police men) and, 4) FGC coordinators.

Data collection

Data were collected during a single interview with respondents that was carried out within one to six months after the conferences. Respondents were asked to reflect on if an increase or decrease in the four outcomes measures was perceived. The first three research questions were measured using scale questions with a range from 0 to 10. Respondents gave a score to a measure prior to the conference and a score after the conference. 0 stood for the worst possible position in relation to the measure concerned, 10 for the most ideal position. Using these scales made it possible to determine progress,

stagnation or deterioration with regard to (realising) the outcomes of the conferences. There is a lot of experience with this method in solution-focused therapy stems from the Positive Psychology paradigm which emphasises the capabilities of clients instead of pointing to their disabilities (Bannink, 2007). Besides measuring the quality of social support, we indicated the quantity (measure 3) by asking all actors involved in one case to give the exact numbers of social resources that were involved prior and after the conference. The same we applied for the number of professionals prior and after a conference (measure 4) – a decrease in this number would indicate a reduce in the demand for professional care.

In 33 of the 41 cases we were able to obtain individual scores from 245 respondents. In the other eight cases it was not possible to achieve meaningful quantitative data as conferences became stuck during their preparation (clients whose motivation for a conference decreased or conflicts within the social network that broke out resulting in that it did not follow through) or participants could not sufficiently reflect on the outcomes of the conference.

Ethical considerations

The study proposal was positively reviewed by an ethical committee consisting of representatives from both the main mental health care organisation and addiction care of the province of Groningen. Clients and intended participants of the conferences were asked to participate in the study. However, taking part in a conference implied participation in the study. As signing informed consent evoked too much fear amongst clients or aggravated psychotic problems, we decided after ten cases that when clients orally agreed with participating, we would continue deploying and studying the conference.

The experience and expertise of the participants were stressed during the study as they were asked to comment on mid-term reports. All names of respondents, streets, places and organisations were replaced by a unique code. All data are recorded and will be stored until 2015. On each conference a case study report had been written that is only available for the participants of the conference and the researchers and that will be stored for 5 years. All involved researchers did sign a confidentiality agreement.

Data analysis

At the level of the individual case, the purpose of the quantitative data was to support the qualitative data on the process of FGC in order to gain a better understanding of how the conference proceeded and what it yielded. The data are therefore descriptive.

When, however, the scores given in all of the 33 case studies were weighted, it became possible to apply inferential statistics.

The four questions measuring the outcomes were examined with SPSS Statistics for Windows, Version 20.0. We used paired t-tests in order to weight the differences between the average scores given for the situation before and after the conference. Results from the paired t-tests were, however, negatively impacted because they were based on scores from respondents who were not independent from each other, so the data were clustered. Respondents all belonged to a particular case and thus had similar information as the other respondents involved. Hence, in addition to the paired t-tests, multilevel analyses (specifically 'nested modelling' as the obtained scores per case were dependent on each other) were carried out to provide more rigour results. A multilevel analysis calculates a reconsideration between the mean scores prior to and after the conference (Field, 2009). It is more robust than a paired t-test as it takes into account that the number of respondents is not independent from each other (as required in normal regression analysis). In the analyses it was therefore assumed that the scores on the dependent variable could be different from each other.

Validity and reliability

Prior to the interviews we concluded that we would not construct indicators for the outcome topics, as we wanted to maintain an open conversation with the respondents wherein they would reflect on why they indicated an increase or decrease in given scores. We were open to new clues that arose during the interview sessions and asked respondents we had interviewed earlier to reflect on findings that had emerged during latter interviews (iterative reflection). We aimed to let respondents formulate indicators for an increase or decrease themselves.

The scales on which scores were obtained have not been tested whether they yield valid and reliable outcomes, such as the Health of the Nations Outcome Scale (HoNOS) which is increasingly used in mental health settings to obtain an overall view on mental health problems of clients and their social functioning (Wing *et al.*, 1998). We have tried to capture this by not just taking the given scores for granted and, in accordance with insights from the solution-focused approach (see Bannink, 2007), we asked respondents to formulate arguments why they indicated an increase or decrease after the conference. The strength of our study is that the number of respondents who reflected in the 33 cases on the outcome measures was large, namely 245. This means that on average in each case 7.24 respondents reflected on the outcomes of the conference. This study therefore had a strong ecological validity, that is to say that the

quantitative methods were aligned and connected with the field of research so that real-world phenomena could be articulated (e.g. Schmuckler, 2001).

Results

In this section we first provide an overview of the descriptive statistics, based on all 41 cases. Then the results of the inferential tests concerning the four questions (based on the 33 cases where quantitative scores were obtained) will be discussed.

Descriptive statistics

A total of 473 participants were involved in the 41 conferences (on average 11,54 participants per case, ranging from 4 to 36) (see table 4). Most respondents who took part in the study belonged to the social network of the main actor(s) (119 of a total number of 312 respondents in 41 cases; 38,1%). Furthermore, 74 main actors (23,7%), 77 professionals (24,7%) and 42 FGC coordinators (13,5%) participated as respondent. The majority of the cases were located in rural areas of the province of Groningen (26 of the 41 cases; 63,4%), the other cases were located in the city Groningen. Of these cases, 16 conferences were organised for individual clients (16 out of 41; 39,0%), 5 for couples (12,2%), 9 for families (22,0%) and 11 for neighbourhoods (26,8%). Psychosocial (multi)problems are most common among the involved cases (20 out of 41 cases; 48,8%). These situations consisted of several interwoven problems such as debt, neglect of the household, lack of self-care, often in combination with psychiatric and addiction problems. The number of cases consisting of psychiatric disorders (3 of the 41 cases; 7,3%) and addiction problems (8 out of 41 cases; 19,5%) were limited. These numbers were low because we only categorised those cases to these two groups where in fact psychiatric disorders or addiction problems were on the foreground. In the other cases, there were issues concerning the liveability of neighbourhoods wherein PMHC clients were living (10 of 41 cases, 24,4%). In most cases, the conferences yielded a plan (26 out of 41 cases; 63,4%). In 20 cases the main actor(s) received professional help prior to the conference, in 21 cases there was no professional help involved. Slightly more than half of the conferences can be considered successful, as goals formulated in the plan had been achieved in the months after the conferences (23 of 41 cases, 56,1%).

Table 4. Frequency table respondents (N=312) and cases (N=41)

Variable	N	Percentage
Respondent group		
Main actor	74	23,7%
Social network	119	38,1%
Professional	77	24,7%
FGC coordinator	42	13,5%
Total number of participants in 41 conferences	*473*	
Area* **		
Urban	15	36,6%
Rural	26	63,4%
Case type		
Individual client	16	39,0%
Couple	5	12,2%
Family	9	22,0%
Neighbourhood	11	26,8%
Main problems		
Psychosocial (multi)problems*	20	48,8%
Psychiatric disorders**	3	7,3%
Addiction**	8	19,5%
Liveability problems	10	24,4%
Plan		
Conference with plan	26	63,4%
Conference without plan	6	14,6%
In preparation successful and therefore no conference	3	7,3%
Got stuck during preparation towards conference	6	14,6%
Professional help prior to conference****		
Yes	20	48,8%
No	21	51,2%
Succeeded*****		
Yes	23	56,1%
No	18	43,9%

* Several psychosocial problems (debts, neglect of household and lack of self-care) that are interwoven and frequently combined with psychiatric disorders and addictions

** In these case the psychiatric disorders and addictions are on the foreground (although there are still psychosocial problems to be indicated)

*** Only the city Groningen we considered as ‘urban’ area, all the other municipalities we considered as ‘rural’ areas

**** We determined strictly if prior to the conference there was frequent professional help over the long run

***** This percentage we have based on the qualitative analysis (see Schout & De Jong, 2013). When we will indicate if a conference was successful by results from the quantitative analysis, this percentage would be even higher

Table 5. Description of the used variables

Variable	Means (standard deviations)/ percentages	Minimum	Maximum	N=245 (67 missing values: 312-245=67)
Age	41,99 (14,25)	14	85	119
Respondent group	Main actor: 22% Social network: 46,1% Professional: 20% FGC coordinator: 11,8%			245
Gender	Male: 55,3% Female: 44,5%			218
Quality living conditions prior to conference *(scale 0-10: extremely bad – excellent living circumstances)*	3,73 (1,82)	0	8	179
Quality living conditions after conference *(scale 0-10)*	6,67 (1,80)	1	10	189
Quality social support prior to conference *(scale 0-10: damaged and diluted contacts – totally satisfied with both quantity and quality social support)*	5,04 (2,07)	0	10	171
Quality social support after conference *(scale 0-10)*	6,61 (1,94)	1	10	171
Quality of resilience prior to conference *(scale 0-10: weak/dependent on others – resilient/autonomous/grip on situation)*	4,09 (1,78)	0	8	176
Quality of resilience after conference *(scale 0-10)*	6,36 (1,90)	1	10	183
Number of resources from social network before conference	3,59 (2,55)	0	10	116
Number of resources from social network after conference	6,67 (5,79)	1	19	116
Number of involved professionals before conference	2,26 (1,70)	0	8	206
Number of involved professionals after conference	2,07 (1,38)	0	5	208

The outcomes of the 33 cases wherein quantitative data were obtained are as follow (see table 5). A small majority of the respondents were male (55,3%). Their average age was 42 (with the caveat that we only obtained the age of 119 respondents). On average, the scores on the quality of social support (5,04 to 6,73), resilience (4,09 to 6,32) and the living conditions (3,73 to 6,64) had been increased since the conferences were organised.

Following the descriptive analyses, statistical tests had been performed to verify whether the increases in the 33 cases were significant. Before getting more into detail, the scores given by the four respondent groups will be presented because these yield interesting differences between the groups.

Differences between respondent groups

Table 6 indicates that of the four respondent groups for each of three outcomes measures the FGC coordinators assigned the highest scores to the situation after the conference, followed by the main actors. Professionals related somewhat less positive, while the social network assigned in every measure the lowest scores.

Table 6. Differences between the four respondent groups

Measure and respondent group	Mean scores prior to conference	Mean scores after conference	Differences
1. Social support			
Main actor(s)	5,05*	7,01	+1,96
Social network	5,02	6,29	+1,27
Professionals	5,06	6,86	+1,80
FGC coordinator	5,04	7,47	+2,43
2. Resilience			
Main actor(s)	4,44	6,49	+2,05
Social network	3,80	5,92	+2,12
Professionals	4,04	6,26	+2,22
FGC coordinator	4,31	6,60	+2,29
3. Living conditions			
Main actor(s)	3,48	7,20	+3,72
Social network	3,48	6,09	+2,61
Professionals	3,93	6,84	+2,91
FGC coordinator	4,00	7,60	+3,60

* Scores 0-10, a higher scores indicates a positive result in relation to the measure

Nevertheless, all respondent groups were optimistic about the increase of social support and resilience after the conference, as they also saw an improvement in living conditions. Both paired t-tests and multilevel analyses indicated that these increases were significant (see table 7).

Table 7. Results from the t-tests and multilevel analysis

Variable	**T-test**			**Multilevel**		
	Average increase	*St. error*	*T*	*Average increase*	*St.error*	*T*
Difference social support	1,69	,16	10,24*	1,71	,19	9,15*
Difference resilience	2,23	,16	13,40*	2,13	,30	7,18*
Difference living conditions	2,91	,18	16,45*	2,80	,31	9,12*

* Significant at p<0,01

Outcome measures

Prior to the conference, the mean score on the quality of social support given by the respondents was 5,04, after the conference 6,73. This means that quality of social support had increased with 1,69 points. This difference is significant (paired t-test, p<0,01). The multilevel analysis also indicated a significant increase in the quality of social support of 1,71 points. The perceived quality of social support had thus, in comparison with the situation prior to the conferences, been improved. Regarding the descriptive statistics, the number of persons that gave social support to the main actor(s) had also significantly increased after the conference, with an average of 3,08 persons (from 3,50 to 6,67) (see table 5). Based on these data it appears that FGC ensured that both the quantity and quality of social support increased in the 33 analysed cases. Qualitative findings of the study indicate that in most cases this concerned a restoration of broken and faded contacts (see Schout & De Jong, 2013). Just in a few cases, the conferences helped in establishing contacts with new persons who subsequently could come up with creative solutions to be incorporated in the plan.

The resilience of the main actor(s) had increased on average with 2,23 points (4,09 to 6,32). This difference is significant (paired t-test, p<0,01). The multilevel analysis also indicated that the resilience had significantly been increased, namely with 2,13 points. In conclusion, PMHC clients and neighbourhoods with liveability problems prior to the conferences in 33 cases experienced an increase in resilience.

The living conditions of the main actor(s) improved after conferences, with a significant increase of 2,91 points (paired t-test, p <0,01) (from 3,73 to 6,64). The

multilevel analysis also indicated an improvement of the living conditions (increase of 2,80 points). In other words, the conferences were accompanied with an perceived improvement in the living conditions of individual clients, client systems and neighbourhoods wherein PMHC clients are living.

The descriptive statistics indicated a small decrease in the number of professionals that were still involved after the conference (from 2,26 to 2,07 professionals) (see table 5). The paired t-test revealed that the decrease of 0,18 was significant ($p<0,05$). However, this difference is so minimal that it cannot be concluded that the number of professionals actually had decreased after the conference.

Discussion

The findings from this study supplement Malmberg-Heimonen's study (2011), namely that FGC has the potential to increase social support and wellbeing of adult clients with multiple and interwoven problems. Several studies have indicated that clients suffering from psychiatric diseases benefit from strengthening social support (Almedom, 2005; Becker *et al.*, 1998; Evert *et al.*, 2003; Giordano & Lindström, 2011; Lim *et al.*, 2014; Mohnen *et al.*, 2011; Panayiotou & Karekla, 2013; Rothon *et al.*, 2012; Strine *et al.*, 2008; Thoits, 2011). People who are socially embedded are less vulnerable (Poortinga, 2006). Our study indicates that FGC can help in restoring broken and faded contacts as both the quantity and quality of social support after the analysed conferences had increased. Although our study lacks causal relationships, on the bases of evidence from other studies, it is plausible that an increase in social support after the conferences positively affected resilience of clients and improved their quality of life (e.g. Becker *et al.*, 1998; Lim *et al.*, 2014; Panayiotou & Karekla, 2013; Strine *et al.*, 2008; Sündermann *et al.*, 2014) as well as in neighbourhoods that formerly were characterised by a lack of social contact and residential instability (Drukker & Van Os, 2003).

The FGC process is in a specific way depending on the referral of social workers and nurses. These professionals are by far the largest profession in community mental health teams. If they are not aware of the possibilities FGC might offer, there will be no conference. Social workers and nurses working in different psychiatric settings should take into account the benefits of a strong social network for clients in their caseloads, and subsequently consider social network strategies such as FGC.

Strengths and limitations

Discretion is needed, because in nearly half of the cases that were referred to a conference (30 of 71) no FGC was performed. FGC is a relatively new phenomenon in PMHC. Without any experience it was difficult for social workers and community mental health nurses to figure out which cases would be applicable for a conference. Many clients were reluctant towards discussing their problems with family and friends and therefore rather chose the pathway to professional assistance where similar degrees of shame are not evoked.

This study did not take into account long-term effects, and it is unknown whether the positive outcomes will last. We need to reckon the results demonstrated in the follow up study of Malmberg-Heimonen and Johansen (2013) with a comparable target group where positive effects faded away as the social network experienced little reciprocity, got disillusioned and gave up on the client. Our findings, however, are encouraging, especially because there was little progress to be expected in the cases concerned.

Gathering data retrospectively on outcome measures led in a few case studies to recollection bias, because respondents had difficulties with giving a score to the situation prior to the conference as it got organised a long time ago (six or more months). Another limitation of this method is that this could have increased the risk of scoring for positive changes. We have tried to capture this by not just taking the given scores for granted and, in accordance with insights from the solution-focused approach (see Bannink, 2007), we asked respondents to formulate arguments why they indicated an increase or decrease after the conference.

Not every participant of the conferences wanted to cooperate; the absence of their insights has affected the validity of the findings negatively. Further on, the results are self-reported, and perhaps biased. It is, however, striking that the FGC coordinators assigned the greatest increase to improvement in living conditions, resilience and social support. Clients were slightly less positive, while professionals and respondents from the social network were the least positive. It is conceivable that coordinators and clients were more positive, because coordinators indirectly assessed themselves when they assigned scores, while clients might wanted to give a better and more accepted account that did not reflect their real state. It is plausible that the social network and professionals gave a more truthful image of the outcomes of the conferences, because of their distance towards organising the conference and the client's living situation. They both represented a large majority of the total number of respondents who assigned scores (respectively 113 and 49, together 66,1% of in total 245 respondents in 33 cases), and therefore had the biggest impact on the mean scores.

The results of the 33 conferences cannot be generalised to the entire PMHC population, more and varied cases that reflect the diversity within the population would be desirable. Nevertheless, with 245 respondents who reflected on the outcomes of 33 conferences, we can conclude that the living conditions, resilience and social support of PMHC client(systems)s and neighbourhoods which are characterised by conflicts wherein PMHC clients are involved, had been improved.

This study aimed to describe the outcomes of FGC in PMHC clients in the Netherlands. A descriptive and not an experimental design was used. Whether the positive outcomes can be attributed to FGC or other factors like the Hawthorne effect remains unsure. Further research is required whether outcomes of the conferences can be improved by care providers reinforcing and mobilising the social network when clients fall back or quit.

Conclusion

In the analysed cases, the resilience of clients, client systems and neighbourhoods as perceived by several respondent groups increased after the conferences, however not with spectacular amounts. The perceived living conditions of the main actors also improved, the same applies for the quality and quantity of social support. The number of involved professionals almost remained unchanged. The continued involvement of professionals in PMHC, however, is not a negative sign as learning to have trust in professionals and maintaining this trust is actually a goal of PMHC. Given the characteristics of the population being studied, the results are modest but remarkable. That the outcomes of FGC are not more substantial can be explained. The group of clients referred to FGC in this particular study, were mostly clients with a limited network and few recourses from whom little support could be expected. FGC helped in restoring social contacts, but extending the network with new resources proved to be difficult to realise with this target group.

As the positive outcomes of the analysed conferences are not guaranteed over the long-run (e.g. Malmberg-Heimonen & Johansen, 2013), we recommend that when FGC is continuously deployed in PMHC and other mental health practices wherein clients who have a history of troubled relationships are helped, it is an important task for social workers and nurses after the conferences to stimulate clients' sense of reciprocity so restored but still fragile contacts with their network will maintain. With this in mind, it is conceivable that FGC can complement the repertoire of community and public mental health services especially for people with complex and on-going mental health problems.

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