

Family Group Conferencing in psychiatry: forming a new practice

On sharing power and understanding relational complexity
of family and network support



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Colophon

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Family Group Conferencing in psychiatry: forming a new practice

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Chapter 1

General introduction

General introduction

In the Netherlands there is a growing emphasis on the reduction of coercive treatment¹ in mental health care (Landeweer, 2013; Voskes, 2015; Abma, Voskes & Widdershoven, 2017); at the same time, however, coercion in mental health care increases considerably (Van der Post et al. 2009a, 2009b; Van der Post et al. 2012; Broer, Koetsier & Mulder, 2015). Coercive treatments in psychiatry are a profound experience for individuals infringing their fundamental human rights and bioethical principles like respect for autonomy and freedom. They entail a loss of ownership over the situation and so deprive people of the right to control their own lives (O'Brien & Golding, 2003; De Stefano & Ducci, 2008; Landeweer et al., 2009; De Jong & Schout, 2010; Katsakou et al., 2010). Moreover, when compulsory admitted people are not able to participate in society; it denies citizenship and leads to isolation (Maylea, 2016).

Societal context and health care policy

The call to reduce coercion in psychiatry takes place in a complex field and time juncture. In this section we will sketch the societal and policy context complicating the intended innovation in psychiatry.

The past decades an emphasis has been placed on ambulanzation and deinstitutionalization in mental health care. Care and support must be offered in society, instead of in psychiatric hospitals, and people with psychiatric vulnerabilities should be enabled as much as possible to live, work and have meaningful social relationships in society. A process in which, like Kroon (2018, p. 42) sketches, some progress has been made but where there has been an unstable course in which there is a going back and forth between specialization and normalization, between safety issues and trusting on self-reliance, and finally between care programs for specific target groups and the organization of integrated care in networks.

1 In this thesis, coercion or coercive treatment refer to a broader range of measures that mental health professionals may execute to limit clients' autonomy and freedom of choice with the attention to serve their own good and public safety (O'Brien & Golding, 2003). A distinction between formal coercion and informal coercion can be made; where the first is a measure exercised on behalf of the state (with compulsory admission as the most radical form) and the latter are practices not regulated by law (Rugkása, et al., 2016). So, coercion refers to compulsory care in both psychiatric hospitals and the community and also to the non-statutory pressures exerted upon clients to accept treatment, for example: leverage, inducement, threat, persuasion and compulsion (Khazaal, Manghi, Delahaye, Machado, Penzenstadler, & Molodynski, 2014; Molodynski, Rugkása, & Burns, 2010; Szmukler & Appelbaum, 2008).

Due to austerity measures however, the amount of beds in mental health care organizations have been reduced, while ambulatory care has become less accessible for people who experience severe mental health problems; at the same time treatment for people who experience milder problems, has increased (Delespaul et al., 2016, p. 112). Fragmentation and overspecialisation in (mental) health care organizations constitutes conflicting interests. Governments, markets, organizations and citizens are confronted with each other when it comes to shaping (informal) care. Cooperation between these different actors has become difficult as competition is fuelled by the logic of market requirements². The marketization of mental health care and the consumerism, overtreatment, overconsumption and cherry picking as well as the affordability of care form the background of the irradiation of integrated care for people with severe and ongoing mental health problems.

In addition, in the debate on ‘mentally confused persons’, social problems related to nuisance and safety are reduced to mental disorders, while the capacity of mental health care and local police stations has been reduced (NVvP, 2016; Polderman, 2016). Citizens have high expectations of the police, mental health care and government to protect them against ‘mentally confused persons’; risks should be avoided as much as possible (NVvP, 2016). It is often mentioned that society is less tolerant when it comes to ‘deviant behavior’ and that, for example, concerned local neighbors make quicker reports of ‘deviant behavior’ because they feel unsafe (NVvP, 2016; Polderman, 2016). The debate shows how on the one hand government and society call for risk avoidance and ‘protection against confused persons’ while on the other hand there is less room for people that are viewed as strange. Karlijn Roex (Oosterom, 2019) mentions that ‘normal still cannot live with abnormal and a debate driven by fear has arisen’. While on the other hand a call for informal care and an appeal on citizens to care for themselves and loved ones has become increasingly important (Newman & Tonkens, 2011). Encouraging citizen’s self-reliance and participation, or generally speaking addressing the civil society, are policy aims that have become more important in recent years and are stipulated in the ‘participation society’ - in Dutch known as “participatiesamenleving”- stated in the Netherlands by King Willem-Alexander in 2013’s Kings speech (in Dutch known as the *troonrede*) (Newman & Tonkens, 2011; Verschoor, 2015).

One might question whether citizens are ready to include fellow citizens that are perceived as strange or disturbing in their midst and if these people on the other hand want to accept help from their neighbours in a context wherein policy makers want people to take care for themselves and each other. But there is more.

2 See for example van Staveren, 2017; van der Aa & Kok, 2019

The marketization of care brings along different challenges connected to cherry picking and a fragmented mental health care landscape. Tensions between - on the one side 'a safe society' and on the other side an inclusive society, make it difficult to initiate sustainable changes in psychiatry. In the meantime, the number of coercive measures in psychiatry continues to rise despite different initiatives to turn the tide (see for example Voskes, 2011, www.hic-psy.nl). The Ministry of Health, Welfare and Sport expects the new law 'Mental Health Care Act on Compulsory Treatment' (Wet verplichte geestelijke gezondheidszorg, Wvggz) to lead to a reduction in the number of coercive measures in psychiatry. We will now discuss these new legal arrangements.

New legal arrangements

In the Netherlands coercive measures took place under the act Special Admissions in Psychiatric Hospitals (Wet Bijzondere opnemingen in psychiatrische ziekenhuizen, BOPZ). The government has decided to replace this law from January 1, 2020, with the Mental Health Care Act on Compulsory Treatment (Wet verplichte geestelijke gezondheidszorg, Wvggz). This law has been extensively discussed and criticized in national newspapers. In this law a guiding principle is that coercion needs to be avoided when possible and the legal position of people imposed to coercive measures is improved (Tweede Kamer der Staten-Generaal, 2017). Those threatened by coercive measures get the option to avert such measures by making a plan with their social network. The procedures to request coercive treatments are radically changed and the possibilities for coercive treatment are expanded making it possible to impose coercive measures outside the walls of mental health institutions (see Dwang in de zorg, 2018). It is questionable whether compulsory treatment at home can be seen as an improvement; the last 'safe place' – at home - is therefore no longer safe³. There is more criticism on this law; it is considered more of a 'safety law' than a law which seeks personalized treatment and improvement of legal position of clients, as the law is more focused on safety and public order issues (Prinsen, 2017). The logic of the Wvggz is one of control; of a government that wants to intervene behind the front door and control the behavior of citizens - it shows vertical (hierarchical) power. Looking at guidelines for drawing up a own plan, we see that it is mainly a reflection of practical matters (see for example 'Handreiking Eigen Plan' op www.dwangindezorg.nl), but we also see the reflex to make the plan controllable and manageable. Pathways to investing in horizontal relationships between people are insufficiently explored

3 See <https://wijzijnmind.nl/ervaringsverhaal/wet-verplichte-ggz-wvggz-mogelijk-fatale-gevolgen/1473>

by this law. Drawing up a plan of one own to avert coercion does not seem to meet the complexity of what is going on in a psychiatric crisis.

Social networks and support

The recovery process of people experiencing mental health issues is deeply connected to their social context (Mezinna et al., 2006; Topor et al., 2006). Experiencing social support and belonging to a group have therapeutic value (Thoits, 2011; Uchino et al., 2012). Social support also has a positive contribution towards stress coping, self-control, and a sense of optimism and hope (Thoits, 2011; Uchino et al., 2012). Additionally, social support plays a role when it comes to enhancing or preserving the mental health of people. The social network has protective features; with support from others the worsening of problematic situations can be prevented (Pahl & Spencer, 2004, 2010; Umberson & Montez, 2010; Lim et al., 2013; Sündermann et al., 2013; Thoits, 2011). So, the value of social networks and their support can hardly be overestimated, but this does not mean that social networks are systematically involved in the treatment of people with psychiatric vulnerability (Priebe, Burns and Craig, 2013), or that families are willing and capable to be involved in the care for their beloved but ill family member. Priebe, Burns and Craig (2013) mention that psychiatry is characterized by a neurobiological paradigm where the focus has shifted towards the individual. Few services actively work on increasing social cohesion and social capital within the communities their clients are part of, in order to improve their clients' mental health.

In the next paragraph we will start by presenting Family Group Conferencing (FGC; in the Netherlands known as 'Eigen Kracht-conferenties) as a decision model to strengthen the social network and support for people with psychiatric vulnerabilities in the social historical context. We will continue by introducing our guiding research questions, we will describe our research design and the chosen methodology. After that we will describe the theoretical, epistemological underpinnings of our responsive evaluation approach and how this approach is connected to the values of FGC. Finally, we will give an outline of the thesis.

1.1 Strengthening Social Networks and Support via Family Group Conferencing

A short background

The deployment of FGC has been studied especially in youth care. Skaale Havnen & Christiansen (2014) describe different studies indicating that FGCs can prevent the outplacement of children. De Jong (2014) also shows the potential of FGC in public mental

health care to strengthen and mobilize social support from clients' social network. Other studies show that FGCs can have a positive role in increasing the relational autonomy of older people; this is bounded to a set of factors like diversity of the network and openness to share problems within the network (Metze, 2016). Different reviews show positive experiences with FGC in youth care or (mental) health care (Frost, Abram & Burgess, 2012; Skaale Havnen & Christiansen 2014). There is, however, a lack of studies on long-term experiences with FGC (Frost, Abram & Burgess, 2012; Skaale Havnen & Christiansen 2014). At last, Skaale Havnen & Christiansen (2014) mention that research on FGCs in psychiatry is scarce. The potential of FGCs to increase ownership; to prevent coercion; to strengthen and widen circles of support; to address the increasing appeal on citizens to care for themselves, their families and friends; and the scarcity of research on FGCs in psychiatry, all contribute to the relevance and value of studying the process and outcomes of FGCs organized in the case of coercive treatment in adult psychiatry.

Internationally there is a growing interest in family-oriented approaches in different care settings such as youth care, care for people with intellectual and developmental disabilities (see Boelsma, Caubo-Damen, Schippers, Dane & Abma, 2017) and mental health care. This coincides with increasing attention to empowerment, participation and the role of civil society (as we introduced earlier). FGC is one of these family-oriented approaches in which interest has grown over the last decade and is subject of research in different settings (as named above). FGC has its origin in New Zealand's Maori tradition, it was developed as a decision-making model that recognizes the importance of collective responsibility for families and near community (Doolan, 2012). In a conference the formal world of government and organizations comes together with the informal world of families and friends (Lupton, 1998, Doolan, 2012). The FGC approach is characterized by the mobilization and utilization of social support present in social networks. Sharing stories and perspectives on the problematic situation can lead to more understanding of each other, can reinforce relationships and can generate ideas. Some studies show FGCs can bring families closer together and strengthen positive family ties (Frost, Abram & Burgess, 2012). Furthermore, plans to deal with problematic situations are more effective when developed with regards to the culture of the family and social network (Berzin et al., 2007; Chand & Thoburn, 2005; Nixon, 2003; O'Shaughnessy et al., 2010). Berzin et al. (2007, p. 57) identify three main points that are important in the FGC philosophy:

- 1) Recognizing family and individuals as key players when it comes to professional support related to care institutions.
- 2) The pursuit of an in-depth involvement of family and striving for the best possible cooperation between family, communities and institutions.
- 3) Realizing of empowerment of family and individuals through the formulation and execution of their own plans.

In conclusion, FGCs use and mobilize the natural commitment of families, friends and others involved.

Stages of Family Group Conferencing

In FGCs, clients or individuals dealing with a problematic situation are referred to as main actors (we will use both terms; clients and main actors). They are the ones to set the agenda, together with the FGC coordinator and point out the people that can be approached for participation in the conference. The coordinator facilitates the conference and supports the involved group of people when preparing the conference. The function of the coordinator is characterized by an independent position; he or she is not on the pay roll of a welfare or healthcare organization (compare Nixon, 2003). The coordinator does not interfere with the content of the problematic situation and does not have particular interest into the outcome of the developed action plan. He or she widens the circle of support by paying a visit to all potential participants of the conference and tries to remove barriers for their participation.

The FGC process has four different stages, see figure one for the role of professionals herein. All stages are conducted by 'de Eigen Kracht Centrale (organization responsible for the conduct of FGCs in the Netherlands). In the first stage, a referral to the FGC has to take place, this is done by a professional, family member or the main actor. Professionals have a modest but crucial role in guiding the main actor and family or friends to the possibility of organizing an FGC (Crampton 2007). After the referral, a coordinator is asked to support the preparation of the actual conference (second phase) and facilitate the conference in the other phases. The coordinator plans the conference together with the main actor and others that are involved. In the third stage, the actual conference takes place, usually one or two months after the referral. Everyone who was invited comes together to develop an action plan. The actual conference has three different stages. In the first stage, essential information is shared between all participants. The role of mental health professionals is to provide information that could be useful for developing the action plan, for example information about protective mechanisms when it comes to psychosis. After this sharing of information, the coordinator

and professional(s) leave, and the main actor and social network sit together to develop a plan. The private time of the main actor and social network gives them the opportunity to develop ownership and autonomy over the situation (Vesneski, 2008). In the last stage of the conference, the plan is shared with the coordinator and professional(s), the implementation of the plan is more successful when all actors (clients, family and professionals) approve the plan at the end of the conference (Connoly, 2006). Most of the times, at the end of the conference, someone is appointed to monitor the implementation of the action plan and any adjustments, this is the fourth stage (Skaale Havnen & Christiansen, 2014). In this study on the application of FGC in coercive psychiatry these stages and the role of professionals therein are characterized as follows (Schout et al, 2016):

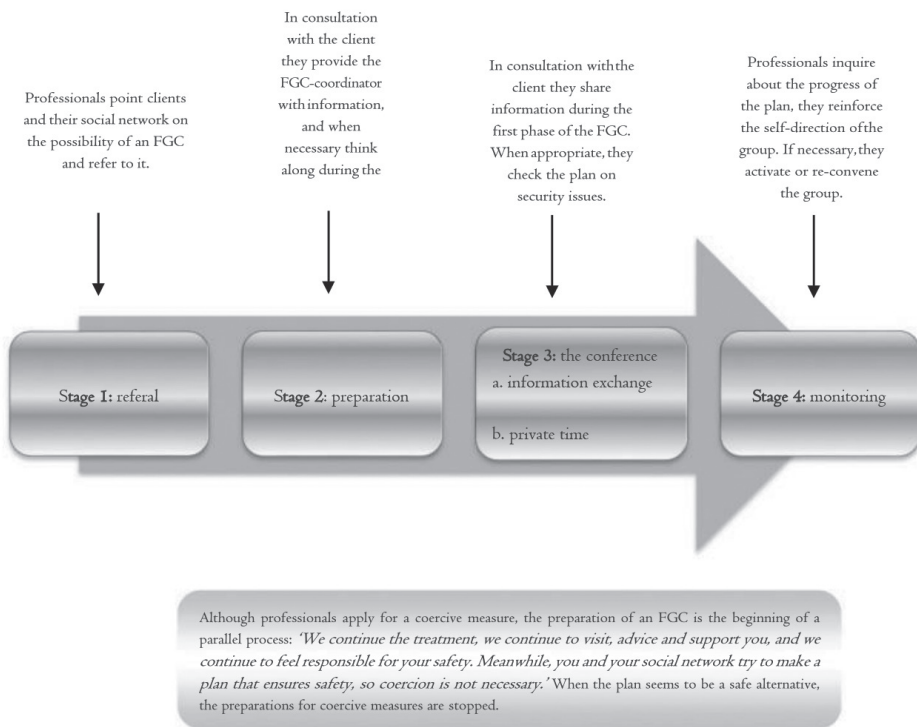


Figure 1. Stages of an FGC and the role of professionals in coercive psychiatry.

FGCs internationally and in the Netherlands

FGCs are organized throughout the world, the decision-making model 'evolved between borders and continents' (Skaale Havnen & Christiansen, 2014, p. 17). FGC has developed over time and on local level there have been adaptations regarding the original model that

emerged in New Zealand. The model in Europe has the basis of the ‘original’ FGC method, but in North America Family Group Decision Making (FGDM) variants evolved into one method called Family Unity Meeting (FUM), this can be considered an alternative for FGC (Skaale Havnen & Christiansen, 2014). In the United States the most different practices of FGDM are present (Nixon et al., 2005). Skaale Havnen and Christiansen (2014) and Frost, Abram and Burgess (2014) describe challenges in implementing FGC worldwide. Different countries have different ways of implementing this practice. Skaale Havnen and Christiansen (2014) mention for example that in Sweden municipalities are responsible in deciding whether or not to practice FGC in their area and in Denmark municipalities can decide they want training in FGC but there is no oversight and follow up on coordinators. Studies in the UK and US show that even if there are projects evaluating FGCs this does not mean that the deployment of the decision making model is common and implementation is often sporadic (Brown, 2003, 2007; Merkel-Holguín, 2003; Weigensberg, Barth, & Guo, 2009). In some countries FGCs are included in laws regarding serious child welfare decisions/cases and the juvenile courts, these countries are: Ireland, Canada, some states in Australia and the US and of course New Zealand (Barnsdale & Walker, 2007). In their knowledge review on FGC, Skaale Havnen & Christiansen (2014) distinguish three types of FGC mandates according to the role played by local authorities (see p. 19):

1. Good practice mandate; the use of FGC depends on each practitioner or on a local leader who takes initiative to use the method.
2. Procedural mandate; services/institutions set specific standards or expectations for where and when FGC should be used with families.
3. Legal mandate; professionals and users have the right and obligation to use FGC in certain kinds of cases.

As mentioned above there are few countries that have included FGCs in their law, Skaale Havnen and Christiansen (2014) join Merkel-Holguín (2003) in concluding that guidelines or regulations from governments are a precondition for implementing the decision making model. They also argue that a debate about the values of FGC is just as important as ‘simply’ including FGCs in the law. In New Zealand, for example, the discussion of legally mandating FGCs had to do more with human rights than what actually worked in implementing FGCs (Skaale Havnen and Christiansen, 2014; Merkel-Holguín (2003).

In the Netherlands, a new ‘youth law’ was developed wherein the right to make a ‘family group plan’ was included; the law does not prescribe how to draw up a family group plan

(Vereniging van Nederlandse Gemeenten, 2016). FGCs are mentioned as an option to make a family group plan (Vereniging van Nederlandse Gemeenten, 2016). The good practice mandate seems to be the best suited description for the application of FGCs in the Netherlands; the use of FGC depends on practitioners for example in mental health care or youth care.

We study FGC in the tradition of practice theory (see Nicolini, 2012). Practice theories ‘do more than just describe what people do; they are interested in meaning making and identity forming’ (Nicolini, 2012, p. 7). FGC makes an effort to form new communities of practice in psychiatry. Nicolini mentions that ‘communities of practices imply participation in a system in which participants share understanding concerning what they are doing and what that means in their lives and for their communities; practices performs community’ (Nicolini, 2012, p. 87-88). Viewing FGC as a practice opens up perspectives to understand what’s going on and experienced as meaningful and complex in the eyes of those involved and integrate action in practice.

1.2 Research aim and design

The aim of the thesis is to contribute to the formation of a new practice based on power sharing among clients, family and professionals through Family Group Conferencing in the context of coercive psychiatry. This exploration is focused on FGC as a way to restore ownership, widen and strengthen circles of support. FGC is a decision making model that facilitates families and networks to deal with a problematic situation in a way that is consistent with their own culture and lifestyle (Jackson & Morris, 1999). In this section we will discuss our overall research aim and design. The methodological framework is also explained.

Research question

The general question that underlies this thesis is formulated as follows:

How to further the emergence of power sharing through Family Group Conferencing in coercive psychiatry and what lessons can be learned for actors in psychiatry?

To find answers to this central research question we use two guiding sub questions:

How do actors perceive the impact of Family Group Conferencing in coercive psychiatry, and how do they form a new practice around Family Group Conferencing in the light of traditional power relations and relational complexity?

How to further the emergence of family and social support in psychiatry and what is the importance of such support for clients' ownership and belongingness as well as partnership relations with professionals?

Methodological framework

This thesis is part of a larger research project about the impact and process of FGCs in coercive psychiatry in the Netherlands. A responsive evaluation, with quantitative and qualitative elements was deployed (Abma, 2005), and carried out parallel to the deployment of FGC. In responsive evaluation, evaluation is aimed at mutual understanding among stakeholders about the meaning of their practice, as a vehicle for practice improvement– opposed to a more traditional approach of evaluation in which the emphasis lays on assessing the effectiveness of interventions (Abma, 2005). The approach is grounded in social constructionism, in this perspective people give meaning to their social world and social reality is constructed by multiple perspectives (Woelders, 2020; Schwandt, 2002; Gergen, Mc Namee & Barrett, 2001; Guba & Lincoln, 1989; Stake, 2004). In order to understand social reality the focus needs to be on understanding different experiences, meanings and thoughts of stakeholders, instead of gaining objective knowledge about ‘reality’ (Woelders, 2020). This requires an approach where in experiences and thoughts are made explicit, as is the case in hermeneutic or interpretative approaches – including responsive evaluation. These approaches acknowledge, and are sensitive to, complex and ambiguous contexts and postulate people as actors who give meaning to their own life events in relation to each other (Woelders, 2020, Schwandt, 2002; Abma, Leyerzapf & Landeweer, 2016).

Responsive evaluation has been developed over time, it was first introduced by Stake (2004) to broaden the scope of evaluation with more attention for process, implementation and relationships between stakeholders. Guba and Lincoln (1989) shifted the focus to a common consensus and acceptance amongst stakeholders from a responsive constructionist angle, they promoted a more participatory and transformative process where stakeholders are co-owners of the evaluation process (Woelders, 2020). Abma tailored this approach to health care programs and research, added a narrative approach and social-critical perspective (Woelders, 2020). Narratives, as stories that have multiple meanings and in which people can express themselves, are helpful when it comes to interpreting meaning and dialogue in evaluation contexts (Abma & Widdershoven, 2005). In the context of health care practices, where there are hierarchical relations between different stakeholders, responsive evaluation, from a social-critical stance, aims to include voices of marginalized groups where evaluators have a role in establishing conditions for dialogue and collaborative practice improvements (Baur, Van Elteren, Nierse &

Abma, 2010). Woelders (2020) mentions the moral horizon of responsive evaluation: it strives for the transformation of practices in order to create social change.

The nature of the study was interpretative and aimed at changing practice in psychiatry; through exploring the possibilities of FGC in this context. Responsive evaluation suited well in this context, because it aims to derive insight from the insiders perspective; is responsive to the issues, values, experiences and interests of all the different stakeholders and their context (see Abma, 2005). The chosen research methodology of responsive evaluation reflects the underlying values of FGC, both aim to increase personal and mutual understanding through dialogue and to include marginalized voices. They are based on democratic principles in which people are entitled to make their own plan and give meaning to a situation.

Different stakeholders were involved in formulating the research question and method; such as the Dutch FGC organization (Eigen Kracht Centrale), professionals and policymakers from various mental health care institutions, representatives from different client and family movements and academics from several universities and policy makers. The design emerged gradually out of conversations with these stakeholders and their issues. As pointed out, various stakeholders' perspectives were gathered to gain an in-depth understanding of the meaning of FGC. The context of coercive psychiatry brings along a mixed group of stakeholders, including clients, brothers, sisters, parents, friends, colleagues, neighbors and all sorts of professionals like psychiatrists and (community) mental health nurses. All these actors have different ideas, interests and insights and it was tried to incorporate these different perspectives.

A case study strategy was used as part of the responsive evaluation approach because this strategy is appropriate to gain an in-depth and contextualized understanding of a demarked entity (the case) (Abma & Stake, 2014). In this instance, the client central in an FGC was considered the case. Each case was studied from multiple stakeholder perspectives. With the help of the case study we wanted to gain insight in the particularities of the cases (Abma & Stake, 2014). We included multiple perspectives 'from the ontological notion that reality is constructed, and that experiences gain different meanings in the context of different biographies, disciplinary frameworks, and positions' (Abma & Stake, 2014, p. 1152). We aimed at comprehending the different cases in line with the tradition of 'Verstehen' (understanding; meaning that 'it is not so much the factual world that interests us, but the interactively constructed meaning endowed to the world' (Abma & Stake, 2014, p. 1152). So in the end, by understanding the particularities of a case, a case report could be made that reflects the meaning and context of the case. We enriched the data with theory, and kept in mind that theory 'functions like a spotlight; it shines with one and the same force on a

demarcated entity; and the rest remains dark' (Abma & Stake, 2014, p. 1158). Theory was not imposed a priori, but gradually plugged in on the basis of findings (Jackson & Mazzei, 2013), for enrichment of data and deepening of insights. In other words, an iterative process took place back-and-forth between the data and analysis, whereby the analysis steered the further data gathering until saturation was reached.

Research team & role as responsive evaluator

The team within the research project consisted of four researchers and a project leader (senior researcher). Three researchers were involved from the beginning of the project and were responsible for data collection in a region assigned to them. The fourth researcher, with experience in the subject, particularly played a role in the final phase of the research project, in the analysis of the data and reporting on it. The researchers met under the leadership of the project leader to discuss the inclusion of clients in the project, discuss plans about data collection and analysis. During these meetings, experiences were exchanged and the researchers reflected on their experiences and the data they collected. The researchers, together with the region manager (of the relevant region) of the 'Eigen Kracht centrale', brought together clients with impending or actual coercive measures and coordinators who facilitated the FGC. Intensive consultations were also held with the regional managers about the inclusion of clients and cases and the process leading up to a conference. The FGC coordinators were mainly contact persons for the researchers with regards to specific cases / conferences when it came to further data collection. Together with FGC coordinators it was also examined what they encountered in the FGC process in coercive psychiatry. After all, there was no or little experience with FGCs in adult psychiatry. In addition, the coordinators were also respondents. The researchers were not part of the actual FGC, but retrospectively monitored how conferences were introduced, and how clients were included and discussed the meaning and value of the FGC afterward with interviews and member checks. Clients were seen as competent actors who by their participation in interviews and member checks thought along about the lessons that could be learned from their FGC for all actors.

Students also played a role in the research project; students from different bachelor and master programs were involved. Under the supervision of the researchers, they carried out a partial research within the project, often in the context of their bachelor's or master's thesis. After the supervisors and students had decided to engage in the process, students were asked to present their research questions and objectives. Students were encouraged to independently come up with a research proposal that would fit into the framework of the research project. The next step was to train the students in approaching the participants of the FGC and doing

the interviews and data analysis (more information about the collaboration with students can be found in chapter 9).

The choice for responsive evaluation requires a certain attitude from the evaluator or researcher. The evaluator strives to actively involve all stakeholders and encourages mutual learning, as this are important aspects of responsive evaluation (Woelders, 2020). An evaluator should be transparent about challenges that occur during the evaluation process and justify choices he makes in the evaluation design, so that mutual expectations and needs are clear to all parties (Woelders, 2020). During the research, I (Ellen Meijer, the researcher) kept a logbook in which experiences and reflections with regard to the research and my own role were written down. In these reflections, I pay attention to my role as a facilitator and social commentator that is embedded in the practice of FGC in psychiatry. I collected (in collaboration with students) data in one of the regions; many of the memos are about what I experienced in this region. The other researchers also kept (personal) logs about their experiences in the other regions. Experiences and reflections were shared during joint consultations and new memos were added to the logbook, together the memos form a comprehensive logbook about the experiences in practice.

Population and recruitment

The FGCs were organized from 2013 until 2015 in three regions in the Netherlands: Groningen, Noord-Holland Noord and Eindhoven. In the three regions we planned to include 20 FGCs per region, in collaboration with three mental health institutions, the involved researchers and 'de Eigen Kracht Centrale'. The FGCs were facilitated and organized by 'de Eigen Kracht Centrale', the organization responsible for the conduct of FGCs in the Netherlands. During a two-year trial period clients were given the opportunity to organize an FGC, when the threat of coercion was eminent. The researchers organized briefings, in collaboration with 'de Eigen Kracht centrale' and designated ambassadors at the institutions to inform mental health professionals about the possibilities of an FGC and to inform them about the research project. The selection criteria for the study were also discussed in these briefings; clients were included when there was an imminent or actual coercive treatment at hand or a history of recurrent coercive treatments⁴. Furthermore all clients needed to have a municipal bond to one of the three regions. When clients were informed about the possibility of an FGC, they were given time to think about whether or not organize one.

4 With the exception of elderly people who, as a result of dementia, were considered a danger to themselves or others. They were excluded because the dynamics, stakeholders and perspectives differ from clients in adult psychiatry.

Sometimes making this decision took a few weeks to months, depending on the situation of the client. If someone was in severe crisis and very confused, they were asked at a later stage if they wanted to organize an FGC and participate in the research project. Participants were informed that organizing an FGC also meant participating in the research project. Also included as respondents, were the attendees of the FGCs: members from the social network such as family members, neighbors, friends and colleagues, professionals (primarily community mental health nurses and psychiatrists) and FGC coordinators.

In order to meet the requirements set to inclusion, research and funding of the FGCs a division in three phases was made. Phase one consisted of cases where the information exchange between 'de Eigen Kracht centrale' and client did not lead to the start of an FGC; the reasons for this were examined by the researchers. In the second phase the information exchange led to an application for an FGC at 'de Eigen Kracht centrale', and the process of preparing the FGC started. If it did not come to an actual FGC, the preparation of the FGC was ended and the background, reasons and the lessons learned were part of the study ('de Eigen Kracht centrale' was responsible for financing the preparation of the FGC). In the third phase the application at 'de Eigen Kracht centrale' led to an actual conference and plan; impact and meaning were studied. We continued to approach clients until we included 20 cases in each region; consisting of phase 2 or phase 3 cases. This led to a total of 60 cases (19 in phase 2 and 41 in phase 3).

Data collection

Respondents reflected on process and impact of the FGC retrospectively through interviews and member checks (see sections below). We tried to interview all participants of a conference, if however the amount of participants was high we purposively choose participants that could give new information (See Silverman, 2013). Per case it was important to create variety in the group of respondents; family, friends, neighbors, colleagues, women/men, professionals and coordinators. Eventually we interviewed 289 respondents, while there were 466 participants in a total of 41 conferences. The researchers in the three regions worked together with students from different universities or applied universities (University of Amsterdam, VU University, Hanze university of applied sciences, Amsterdam university of applied sciences and Inholland university of applied sciences) to collect and analyze the data; in most cases a student couple was appointed one conference to analyze and write a case report on. See chapter 9 for our reflections on our collaboration with students and the role of students as co-researchers.

Interviews

The clients and other participants of the FGC were informed by the FGC coordinator about the research project. The researchers contacted the participants of the FGC one to six weeks after the conference took place to arrange an interview. The semi-structured interviews took place at mutually agreed locations and times, for example in respondents' homes or in a neutral environment. The interview lasted approximately one hour. An interview guide, setting out topics and scale questions (see appendix I) was used during the interview. Respondents reflected retrospectively on open and closed questions. An example of an open question was 'To what extent was social support from others mobilized'? The closed questions were scale questions about, for example, the quality of social support before and after the conference – the respondents reflected here on an increase or decrease in the outcome measures of the study. The impact and outcome measures were as follows: 'belongingness', 'ownership' and 'coercion'. The scale questions ranged from 0 to 10, where 10 presented the most ideal position and 0 the worst. The scores were given for the situation before the conference and after the conference. Respondents were asked to underline the scores they gave with arguments and examples; in solution focused therapy these kind of questions are often used (See Bannink, 2007). The scale questions made it possible to examine the impact of the conference; by defining whether there was progression, regression or stagnation when it comes to the situation before and after the conference. As mentioned, a total of 289 respondents were interviewed. This means that on average per conference six respondents were interviewed. Respondents were contacted again for a brief interview about the long-term impact of the FGC after seven up to 18 months. Of the 41 FGCs that were included, 27 cases were suitable to approach respondents for follow-up interviews. In these cases, the FGC had already taken place some time ago and collected information about would be an addition to the information already collected. Not everyone was willing to talk to the researchers again, in only 18 cases the researchers were able to conduct follow-up interviews.

Participant observations

Besides interviews, participant observations were conducted to unravel the impact of (organizing) FGCs and their meaning for participants. The researchers witnessed and participated in different cases wherein relational dynamics between different stakeholders became evident. They gained insight in the shift of responsibilities between professionals and civil society, and they were sensitive to their own role as actor in the complex processes with regards to (organizing) FGCs in coercive psychiatry and forming a new practice. The researchers described their impressions, observations and interpretations with empirical

and theoretical memo's in a logbook and discussed their findings within the research group (Emerson, Fretz & Shaw, 2011).

Member check

Based on the interviews of each FGC a report with preliminary conclusions of the process, impact and meaning of the FGC was presented and discussed in a (group) member check with the participants of the FGC (see Lincoln & Guba, 1985). This was done to validate the findings of each case (internal validity/credibility), but also to facilitate a group discussion that could gain new insights about the process and outcomes of the FGC. Lincoln & Guba (1985) mention that member checks play an important role in verifying that the presented findings reflect the actual meaning intended by participants and that it is a crucial tactic for assessing trustworthiness (see quality procedures). Through soliciting the perspectives of participants in a member check researchers can identify and challenge their own personal bias, explore alternative meanings and explanations and also gain a more holistic understanding of the subject (Lincoln & Guba, 1985). Kornbluh (2015) underlines that member checks are especially suitable for those who view the research process as participatory, with an emphasis on collaboration with participants and mutual learning or for action research in which findings are utilized to inform social action. Engaging in dialogue and providing feedback on findings increases the ownership, of participants, over the data to utilize for social change (Kornbluh, 2015, p. 398). In our research, the member check advanced discussion about the plan made in the FGC; did it meet the needs of those involved? The interviews, observations and member checks contributed to a narrative of the case.

The member checks were organized at a time (and a location) where the main actor of the FGC could be present, together with the majority of the other respondents (from that FGC). In total 121 respondents participated in the member checks. This means that not every respondent we interviewed, was able or willing to participate in the member check. In these cases we sent the report for feedback by email and subsequently discussed the report in telephone conversations when possible.

Data analysis

In this responsive evaluation data collection and analysis were iteratively interwoven; the course of the study could change depending on new insights (See Abma, 1996; Abma & Stake 2014). The observations, interviews and (if possible) the member checks were all recorded, transcribed and analyzed with the software program Atlas.ti. The analysis consisted a qualitative and quantitative part, that are described below.

Qualitative analysis

The qualitative analysis was performed in two different ways; by analyzing single cases and by depicting patterns and deviations in all cases, clustering interview transcripts as well as participant observations of the cases and member checks. The single cases were analyzed (sometimes by students) with insights from the Grounded Theory (see Glaser & Strauss, 1967; Strauss & Corbin, 1994). This means that the researchers took several steps, the first step was open coding which means that the interviews and memos from participants observations and member checks were read and key passages were marked and given a specific code. In the second step, when the coding is completed, a check took place on overlap between codes; and codes were merged if necessary. In the last step codes were clustered into categories that identified different themes; these themes thus emerged from the data. The coding process was characterized by a constant comparative analysis, meaning that the researcher moved back and forward between the emerging categories to identify patterns and deviations. Eventually this resulted in a case report about the meaning and impact of the conference, where insights from interviews, participant observations and member checks were used to illustrate the case and contributed to making 'thick descriptions' (Abma & Stake, 2014).

Besides analyzing the single cases, we were also studying the patterns and deviations that came forward in all cases and wanted to identify more general themes. As mentioned we wanted to gain insight in the particularities of the single cases, and identify more general themes with insights from the multiple case study approach. The multi case study approach starts with recognizing what concept or themes binds the cases together (See Stake, 2006). The approach describes how analyzing different cases makes it possible to see how a phenomenon occurs in different environments or contexts and its aim is to find patterns, related to the binding concepts, that occur in several cases at the same time. The interviews, observations and member checks were also of importance when making thick descriptions.

Quantitative analysis

The scores that were obtained by means of the scale questions (in the interview) gave an impression of the FGC at the level of an individual case. At this individual case level, the quantitative data is mainly used to support the qualitative data and is therefore descriptive of nature. When the given scores obtained in all cases were weighed, it became possible to perform inferential statistics. To analyze the impact of the FGCs, on the earlier described outcome measures, different analyzing methods were used; first paired sampled t-tests and later multilevel analysis (in SPSS version 22). A more detailed description of this analysis is given in chapter two, where the outcomes are also discussed.

Quality procedures

Guba and Lincoln (1989) developed criteria for evaluating qualitative research, and use terms as authenticity, credibility, dependability, confirmability and transferability to assess the trustworthiness of a study. We will discuss these different criteria in this section. When it comes to authenticity Lincoln & Guba (1985) describe five dimensions: fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity. The different dimensions focus on diverse aspects of (possible) change in participants, system- or power structures associated with the evaluation process (Shannon & Hambacher, 2014). Fairness includes an assessment of all different stakeholder perspectives and whether these perspectives are represented in the study in a fair manner (Shannon & Hambacher, 2014). Authenticity is shown when these different perspectives are exposed by the researcher and when they provide depth of understanding. Several techniques were applied to ensure the authenticity and credibility of the study; triangulation took place in different ways. Findings obtained during interviews were discussed and compared by the researchers; this also meant that findings from the three different regions were compared. The findings of the different participants in the FGC were compared; do the different participants share their view on the meaning of the FGC? The scores on the scale questions (quantitative findings) were compared with the qualitative findings from interviews and participants observations, to find out if they were congruent and consistent. Lastly the empirical findings were related and contrasted to theoretical findings to understand the process of (organizing) FGCs.

Dependability can be seen as an equivalent of reliability and confirmability refers to plausibility of data (are conclusions based on the data?). In this study we assured that the data and interpretations are ‘rooted in contexts and persons apart from the (one) evaluator and are not simply figments of the evaluator’s imagination’ - the findings were not dominated by the assumptions of one researcher (Guba & Lincoln, 1989, p.243). Furthermore reflexivity of the researchers was emphasized within the study, keeping a logbook with empirical and theoretical memos contributed to this – just as the joint process of analysis and interpretation of the data. The member checks that were organized contributed to a discussion with participants about the process and outcomes of the FGC and sometimes led to new insights. The transferability-the extent to which results can be transferred to another context or situation- of the study findings was increased by presenting the (interim)results of all cases to a group of representatives of clients, professionals and academics and by providing thick descriptions which facilitates people to make ‘transferability judgments’ and assess if the study is applicable to their own situation.

On ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity we will reflect in the discussion. The first two are assessed by determining the degree in which participants have become more aware of the complexity of the social environment and the extent to which they experience awareness and respect for the perspectives of others (Shannon & Hambacher, 2014; Lincoln & Guba, 1985). Catalytic and tactical authenticity are harder to assess. Catalytic authenticity is assessed by exploring whether the research process encouraged action on the part of stakeholders and tactical authenticity is assessed by exploring whether a redistribution of power among stakeholders occurred (Shannon & Hambacher, 2014).

Ethical considerations

The research proposal was presented to the scientific research committee of the VU University Medical Center and the three mental health organisations that contributed to the study: Lentis, GGZ NHN and GGzE. The study was approved under the condition of informed consent, taking into account safeguards concerning privacy, anonymity and confidentiality. Personal information was replaced in transcripts, reports and articles by a unique code. Only the interviewers could trace personal information, links were later destroyed. The interviewees were not informed about the content of other interviews other than the aggregated preliminary results. Participants were informed that this study might be used for research purposes beyond this project and that findings from the case studies would be used for scientific papers. The (student) researchers have signed a confidentiality agreement.

Through our responsive design, we paid attention to learning and changing practices together with stakeholders and also saw and emphasized the value of learning together during the research process (See Banks, Brito, Cook, Gradinger, Springett, von Unger & Wright, 2013). Mutual respect was of great importance in working together and we committed ourselves to including all voices in our research project, in which different or opposing perspectives were also heard. In the discussion we will further reflect on the challenges we encountered.

1.4 Outline

This thesis is divided in several chapters representing studies that are published as articles in various journals. In the structure of this thesis we reveal an increasing complexity of our study. We start with part one in which we discuss the perceived impact and value of FGCs in coercive psychiatry. The focus in the second chapter lays on the quantitative outcomes and

we give a first impression of the potential of FGCs. In the third chapter we present a reflection on the added value of FGC in mental health care, in relation to other forms of support.

In the second part of this dissertation we discuss forming a new practice around FGC in psychiatry. In chapter four we first describe the barriers we encountered in forming FGC practice and sketch the demanding and strenuous context of FGC in coercive psychiatry. In the fifth chapter we then explore the potential of FGC practice as catalyst for recovery and ownership in mental health care by zooming in on two different cases. Subsequently in chapter six we aim to understand the process of FGC in the context of coercive psychiatry, discover challenges in the forming of a partnership between clients, their social network and professionals, and describe that despite the potential of FGCs the forming of a partnership is complex.

In the third part of this thesis the relational complexity of family and network support in psychiatry is described. The seventh chapter reflects on the role of informal care in a neoliberal context and explores how persons shape their involvement and commitment when a family member experiences psychiatric crisis, by discussing a case from the research project. We illustrate that there are all kinds of hesitations and ambivalences amongst family and friends to support a relative in need, and that reconciling different values is not easy. There is however also hope for expanding social networks into a wider network of care. Then in chapter eight we address the complexity of organizing FGCs by plugging in Bourdieu's (1990) insights on symbolic capital in three cases and highlight the struggle for legitimation, appreciation and symbolic power in the different 'fields' of family, friends and near communities. In chapter nine we discuss what we learned from involving students as co-researchers in our research project and how our experiences can be used to shape communities of practice. Finally in the last chapter, we reflect on the main findings of this thesis and on the methodological framework. Future directions and suggestions for further research will be explored.

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Part I



Perceived impact and value of Family Group Conferencing

Intermezzo 1 ‘Letting go of a positivist perspective’

While working on this dissertation, there have been multiple learning opportunities for all actors, including lessons I have learned as a researcher. In the discussion of this thesis, these lessons are explored and provided with future perspectives. While working on this thesis it became clear to me how (and why) I should become visible as a researcher and that I didn't have to erase my own perspective on the world. This thesis was written from a specific lens; that makes it important to provide a view through this lens; my background and learning moments will emerge in three different intermezzo's.

The first part of my thesis focuses mainly on the impact and added value of organizing FGCs in psychiatry. One of these articles is devoted to the impact of FGC in psychiatry. Although the intention of this article is to help understand the benefits FGC may have in coercive psychiatry, it has become a bit of an ‘odd’ article. It is characterized by typical ‘utility thinking’; where numbers are of importance when evaluating. It almost gives the impression that organizing FGCs was a straightforward process while for many people this is not corresponding with their reality. It rather was a complex process; as the structure of this thesis suggests. It is not my intention to fall into an emic versus etic debate here; both perspectives can actually reinforce each other and provide a holistic view of research topics. The structure of this thesis also shows my own development as a researcher. I would like to dwell briefly on this.

When I was seventeen I chose to study Applied Psychology, hoping to learn more about human behavior and motives. Later on I became more interested in ‘the bigger picture’; in complex social issues and the individual interacting with the collective (and vice versa). So, I followed a master in Sociology. While completing this master I was introduced to FGC when I was looking for an internship where I could also write my master thesis. My study required me to adopt a positivist approach, whereby the person ‘behind’ the researcher had to become invisible. I had to objectify and try to avoid “bias” as much as possible. In my dissertation, and the reflections (and these intermezzos), the opposite was asked of me. I had to become visible as a person and my own experiences and background were significant, as befits a responsive researcher. The structure of my thesis clearly illustrates the journey I made as a researcher. It starts with value and impact and later on there is more space for discussing meaning, ambiguities, differences and tensions - in which the experiences of myself are crucial.



Chapter 2

Regaining ownership and restoring belongingness: impact of Family Group Conferences in coercive psychiatry

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Abstract

Aim. This study examined the impact of Family Group Conferences on coercive treatment in adult psychiatry.

Background. Coercive treatment in psychiatry infringes the fundamental rights of clients, including the right to control their lives. A promising intervention is the Family Group Conference (FGC), which has the potential to prevent crises through the integration of the expertise of informal and professional networks.

Method. From 2013 - 2015, 41 FGCs were studied in three regions in the Netherlands. The impact of every conference was examined with scales (ranging from 0-10) during interviews with attendees (clients, family members, friends, mental health professionals and FGC coordinators) who reflected on three outcome measures: belongingness, ownership and coercion.

Results. After the FGC, respondents indicated a slight reduction in their experience of coercive treatment. They also mentioned an increase of ownership and belongingness.

Conclusion. FGC seems a promising intervention to reduce coercion in psychiatry. It helps to regain ownership and restores belongingness. If mental health professionals take a more active role in the pursuit of an FGC and reinforce the plans with their expertise, they can strengthen the impact even further.

Introduction

In the Netherlands and other European countries, the number of coercive treatments in psychiatry has increased over the last two decades (van der Post *et al.* 2009, van der Post *et al.* 2012). The number of compulsory admissions in the Netherlands increased from 3101 in 1979 to 8376 in 2009. The number of court ordered admissions more than doubled in between 1999 and 2009, from 4353 to 10,284 (Nationale Atlas Volksgezondheid 2011, Mulder *et al.* 2006, van der Post *et al.* 2008). In this paper coercive treatment refers to compulsory admissions in crisis situations and court ordered admissions in both psychiatric hospitals and the community. Even though the number of coercive treatments increased, it still can be seen as a highly controversial issue (Seo *et al.* 2013). There is consensus among scholars that these treatments need to be limited because they entail a loss of ownership or control over the situation and are a profound experience for individuals infringing their fundamental rights (De Jong & Schout 2010, De Stefano & Ducci 2008, Katsakou *et al.* 2010, Landeweer *et al.* 2009, O'Brien & Golding 2003, Roskes 2009). People should have the right to control their own lives and make decisions for themselves (O'Brien & Golding 2003).

Psychiatrists and nurses working in psychiatric hospitals and in community treatment in the Netherlands, often are the gatekeepers of coercive treatment (Schout *et al.* 2016). As outlined above coercive treatment undermines the option of making choices for oneself and promotes a sense of helplessness at times (Laugharne *et al.* 2011). This seems to be in contradiction with the therapeutic relationship and promoting of autonomy that Norman (2009) describes as the basis of nursing in mental health care. Mental health nurses intervene in a field where they experience tension between, on the one hand, doing justice to the autonomy and ownership of clients and, on the other hand, wanting to ensure the health and safety of them. Voskes (2016) explains that autonomy is not directly related to freedom of choice but by enabling clients to restore control over their lives through working together with them. This requires a proactive and committed role of mental health professionals.

Besides the loss of ownership a compulsory admission entails, it also means that individuals are deprived of their sense of belongingness and the possibility to connect with (important) others is restrained. As described by Baumeister and Leary (1995) 'the need to belong can be seen as a fundamental human motivation' (p. 521). The essence of belongingness is defined as the need to connect and relate to family, friends or communities in a long term way (Baumeister & Leary 1995, Gere & MacDonald 2010). Social support has therapeutic value and can have a positive contribution to stress coping, self-control and a

sense of optimism and hope (Pahl & Spencer 2004, Umberson & Montez 2010, van der Post *et al.* 2009, Uchino *et al.* 2012, Thoits 2011).

In the view of Baumeister and Leary (1995) humans are driven towards ‘establishing and sustaining belongingness’ (p. 499). More recently Hill (2009) underlined that belongingness or connectedness can be a protective factor when it comes to suicidal ideation. Endo *et al.* (2014) also found a relationship between suicidal ideation and perceived social support; they reported that people who had suicidal ideation experienced less support from their family. Moreover, the recovery process, in case of psychiatric problems, cannot take place without the inclusion of clients’ social context (Mezinna *et al.* 2006, Topor 2001, Topor *et al.* 2006). A promising intervention to restore ownership and promote a sense of belongingness is the Family Group Conference (FGC). This is a decision-making model that facilitates families to solve problems in a way that is consistent with their own culture and lifestyle (Jackson & Morris 1999).

Background

FGC has its origin in the Maori tradition in New Zealand and is nowadays used in various countries across the globe (Skaale Havnen & Christiansen 2014). FGC was developed in New Zealand as a decision-making model that acknowledges the importance of collective responsibility for the family or tribe, instead of the institutionalised perspective of the individual nuclear-family (Lupton 1998). Belongingness and connectedness are important values in the Maori tradition and FGC aims to encourage these values (Connolly 2006, Love 2009, Nikora *et al.* 2012). The potential of FGC lies in the establishment of informal social networks which create mechanisms for effective problem-solving. This, in turn, facilitates persons to regain autonomy and control over their situation. Furthermore, the expertise of informal social networks is combined with professional expertise from, for example, psychiatrists, community mental health nurses or social workers (Skaale Havnen & Christiansen 2014).

The process of a FGC consists of four different phases. During a FGC the main actor and his (or her) family, friends, neighbours, community members and mental health professionals can develop a plan on how to deal with the situation. A FGC coordinator facilitates the meeting and supports the group when preparing the conference. This person is a citizen that besides their normal job, is involved in the above-mentioned task several times a year. The function of the coordinator is characterised by an independent position which means that the coordinator is not on the payroll of a welfare or health care organisation. The coordinator does not interfere with

the content of the situation and does not have any interest in the outcome of the developed plan. During the conference, everyone is working towards a plan that is established and supported by all attendees and where the burden of care and support is distributed over several shoulders. Professionals have a crucial role in guiding the main actor and family or friends to the possibility of organising a FGC (Crampton 2007). The role of mental health professionals is to provide information that could be useful for the plan, for example, information about protective factors in relation to preventing a psychosis. The willingness to make the implementation of the plan successful is greater when all actors (client, family and professionals) approve the final plan at the end of the conference (Connolly 2006).

The application of FGCs has been studied in different fields, especially in youth care. Several studies indicate that it can prevent the outplacement of children by increasing the odds of reunification with family and placement with relatives (see for an overview Skaale Havnen & Christiansen 2014). Research in public mental health care also shows the potential of FGC to strengthen social support and resilience and to mobilise help from clients' social network (De Jong 2014). Furthermore, this study shows that FGCs have potential in preventing coercive treatment in psychiatry. Research amongst older adults shows that FGC can have a positive role in increasing the relational autonomy of the elderly. This is however bounded to a set of factors, for example, if older adults are open to share problems with their social network or if they have a diverse social network (Metze 2016).

As mentioned by Skaale Havnen and Christiansen (2014), different studies on FGC do confirm or complement each other but sometimes also contradict. Where most studies describe positive outcomes, sometimes more varied or neutral outcomes have been reported (Skaale Havnen & Christiansen 2014). Skaale Havnen and Christiansen (2014) mentioned that follow-up studies are important in determining the long-term impact of FGCs. Furthermore, they describe that research on FGCs in mental health care is scarce. In the study presented in this article, the impact of FGCs that were organised in the case of coercive treatment in adult psychiatry is examined.

The study

Aim

The aim of the study was to examine the impact of FGCs, that were organised in the case of coercive treatment in adult psychiatry, on the outcome measures 'belongingness', 'ownership' and 'coercion'.

Design and process of FGCs

A responsive evaluation, including qualitative and quantitative methods, was deployed to study the process leading up to the FGC and the proceedings of the conference itself, including barriers and pitfalls experienced by respondents. The impact of the FGCs for 60 individual clients who were at risk of coercive treatment and their social network was also studied. Different stakeholders were involved in formulating the research question and method, such as the Dutch FGC organisation (Eigen Kracht Centrale), representatives from various mental health care providers and academics from several universities. Furthermore, it was important to include a variety of situations based on the selection criteria and to describe the outcomes of FGCs organised in the case of coercive treatment from different stakeholder perspectives. Therefore, we chose a responsive design, incorporating all relevant perspectives (Abma *et al.* 2016, Abma *et al.* 2009, Stake 2004). Besides evaluating the impact of FGCs for clients and their social networks we wanted to gain insight in the added value of FGCs in the context of coercive psychiatry since there is little experience with the application of FGCs in this field. Respondents reflected on process and impact retrospectively. This article reports mainly on the quantitative findings. Qualitative findings are shared to gain a better understanding of the impact of the quantitative outcome measures.

The FGCs were organised from 2013 until 2015 in three regions in the Netherlands (Groningen, Noord-Holland-Noord, Eindhoven). The FGCs were facilitated and organised by 'de Eigen Kracht Centrale', the organisation responsible for the conduct of FGCs in the Netherlands. In all regions it was intended to include 20 FGCs in collaboration with three mental health institutions in the aforementioned regions, 'de Eigen Kracht Centrale' and the involved researchers. Finally, in 41 cases a FGC was organised that resulted in a plan.

The process of the studied FGCs consisted of four different phases, all conducted by 'de Eigen Kracht Centrale' (in the Netherlands). In the first phase a referral to a FGC was made. This was done by a professional, the family, or the person in a problematic situation. The person in the problematic situation is described in this study as the 'main actor'. Usually it was a professional who informed the client of the possibilities for organising a FGC. A coordinator from 'de Eigen Kracht Centrale', was matched to the situation and supported the preparation of the actual conference (second phase). Before the FGC was organised it was important that an agreement between the main actor, family, friends and professionals was reached on the options to develop a plan through a conference. The coordinator planned the conference together with the main actor and visited all those concerned and asked them to give information that could be helpful in organising the conference. The planning of the

FGC was determined on the basis of the wishes of the main actor and their social network. The conference took place in evenings or weekends, most preferably on neutral ground.

In the third phase the actual conference took place, usually one or two months after the referral. Everyone who was invited came together to develop a plan. The actual conference consisted of three different stages. In the first stage, essential information was shared between all those involved. The second stage began when the coordinator and professionals withdrew from the conference. Then it was up to the main actor and social network to develop a plan. This private time gave the main actor and social network a chance to develop autonomy and ownership (e.g. Vesneski 2008). In the final stage, the plan was shared with the coordinator and professionals. In most cases, at the end of the conference, a person was appointed to monitor the implementation of the plan and the need for adjustment of the plan (fourth phase) (Skaale Havnen & Christiansen 2014).

In all four phases of the FGCs the involved researchers had contact with the FGC coordinators or region managers of 'de Eigen Kracht Centrale' about the cases that were included in the study and discussed their progress or difficulties. The researchers were not part of the actual FGC, but retrospectively monitored how conferences were introduced, how clients were included and assessed the impact afterwards with interviews and focus groups.

Respondents

In a period of two years, at three mental health institutions in the aforementioned regions, the option of a FGC was considered by mental health professionals and clients when deciding about coercive treatment. Briefings were organised to inform mental health professionals about the possibilities of a FGC. The selection criteria for the study were also discussed with mental health professionals. Clients were included when there was an imminent or actual coercive treatment at hand or a history of recurrent coercive treatments was present. All clients needed to have a municipal bond to one of the three regions. When clients were informed by mental health professionals about the possibility of a FGC they were given the choice whether or not to organise one, sometimes the making of this decision took a few weeks to months (depending on the situation of the client). Also included as respondents, were the attendees of the FGCs: members from the social network such as family members, neighbours, friends and colleagues, professionals (primarily community mental health nurses and psychiatrists) and FGC coordinators.

Data collection

Interviews. Clients and the other participants of the FGC were informed about the research by the FGC coordinator. Researchers contacted the respondents one to six weeks after the conference to arrange an interview. Not every attendee of the conference was interviewed because some did not want to participate or did not have time. Clients, their social network, mental health professionals and FGC coordinators were interviewed individually. These interviews were carried out by the involved researchers (or in collaboration with nursing and health sciences students or social work students). The interviews took place at mutually agreed locations, for example in respondents' homes or in a neutral environment. The interviews consisted of open and closed questions and lasted approximately one hour. The interviews were conducted with the help of a topic-list that, besides topics to evaluate the FGC process, also entailed scale questions where the respondents reflected on an increase or decrease in the impact measures of this study. An example of an open question was 'To what extent was social support from others mobilised'? The closed questions were scale questions about the quality of social support before and after the conference. During the interviews the respondents reflected retrospectively on the process and impact of the FGC. A total of 289 interviews were conducted, these were mostly interviews with single respondents. On average, per conference six respondents were interviewed. To ensure a varied perspective on the conference, at least one person from each group (clients, social network, professionals, FGC coordinators) was interviewed. After approximately seven up to 18 months respondents were re-contacted for a brief interview about the long-term impact of the FGC.

Outcome measures. The impact of FGCs had been measured using the following outcome measures: 'belongingness', 'ownership' and 'coercion'. These outcome measures were evaluated by respondents on scale questions that ranged from 0 to 10. 0 represented the worst possible situation and 10 reflected the most ideal position. Respondents were asked to give a score for the situation before the conference and a score for after the conference. Respondents were asked to underpin these scores with arguments and examples. This means that all outcome measures were based on the experience or perception of the respondents. There is a lot of experience with this type of scale questions in solution-focused therapy to evaluate the effectiveness of psychological treatment (Bannink 2007). With the scale questions it was possible to examine the impact of the conferences, by determining whether there was progression, regression or stagnation in the situation before and after the conference.

The outcome measures were:

- Belongingness* Being connected or related to family and friends (Baumeister & Leary 1995, Gere & MacDonald 2010). This was measured with a scale question about the perceived social support before and after the conference.
- Ownership* The feeling of having control over the situation (based on O'Brien & Golding 2003). This was measured with a scale question about perceived control over the situation before and after the conference.
- Coercion* Referring to all forms of pressures exerted on clients to accept treatment, such as persuasion, leverage, inducement, threat and compulsion (Khazaal et al. 2014). Measured as perceived coercive treatment, ranging from voluntary professional support (10) to an involuntary admission (0).

Ethical considerations

The research proposal was presented to the scientific research committee of the VU University Medical Center and the three mental health organisations that contributed to the study: Lentis, GGZ NHN and GGzE. The study was approved under the condition of informed consent, taking into account safeguards concerning privacy, anonymity and confidentiality. Personal information was replaced in transcripts, reports and articles by a unique code. Only the interviewers could trace personal information. The interviewees were not informed about the content of other interviews other than the aggregated preliminary results. Participants were informed that this study might be used for research purposes beyond this project and that findings from the case studies would be used for scientific papers. The researchers have signed a confidentiality agreement. Based on earlier decisions regarding FGC evaluations in public mental health care (PMHC), the interviews and meetings with focus groups were considered as an evaluation of a social intervention seeking the expansion of ownership and voice. Experiences from previous research in PMHC showed that the research is not burdensome. Focus groups can be confrontational but are usually perceived as energizing, moreover the goal was to restore ownership, to prevent coercion and to shorten compulsory admissions.

The experience and expertise of the participants was called on in the investigation, they were asked to comment on written reports and give their opinions in focus groups.

Data analysis

The scores which were obtained by means of the scales specify the level of the individual case and give an interpretation of the perceived impact of the studied FGC. At the individual case level, the descriptive quantitative data support the qualitative data. If the given scores

in all cases are weighed, it is possible to perform inferential statistics. To analyse the impact of FGCs on the outcome measures, different analysing methods were used (in SPSS version 22). A P value of <0.05 was considered as the level of significance. First, paired t-tests were deployed to weigh the difference between the average scores given for the situation before and after the conference. This was done with the outcome measures belongingness, ownership and coercion. When taking belongingness as example, the perceived social support before and after the conference were included in the 'paired sampled t-tests' to establish if there was a significant difference.

Results from the paired t-tests, however, did not consider that scores from respondents were not independent from each other, as the data were clustered. Respondents all belonged to a particular case and thus had similar information as the other respondents. Hence, in addition to the paired t-tests, multilevel analyses were carried out to provide more rigorous results. In the multilevel analysis, the outcome measures were analysed again. This was done, per outcome measure, by extracting the scores prior to the conference from the scores after the conference, to gain a 'weighted mean difference'. The weighted mean difference was included as a dependent variable in the multilevel analysis. The variable 'case number' was included as 'subject' to take into account the clustered data.

The purpose of the paired t-tests and multilevel analysis was not to reveal causal relationships between the FGC and the outcome measures, they were only conducted to make insightful if respondents experienced stagnation or progress with regards to the FGCs.

Validity, reliability and rigour

The scales on which scores were obtained have not been tested as to whether they yield valid and reliable outcomes, such as the Health of the Nations Outcome Scale which is increasingly used 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 the study is that the different perspectives of the respondents were revealed, which gave a rich and multiple understanding of the impact of the FGCs. No remarkable differences were observed between the perceived outcomes of the four respondent groups.

Findings

The descriptive and inferential statistics give an impression of the outcomes of the conferences that were analysed. In this section four tables are included. First, the characteristics of the respondents are presented. Subsequently, the results of the conferences, as experienced by the respondents on the basis of the outcome measures of ‘belongingness’, ‘ownership’ and ‘coercion,’ are discussed.

Characteristics of the cases and respondents

Table 1 indicates that the average age of the respondents was 48 years and there were more women included than men. In the 41 cases, a total of 34 clients were interviewed, 139 respondents were members of clients’ social network, 58 were mental health professionals and 29 FGC coordinators.

Clients were often diagnosed with a psychotic disorder, or with a combination of addiction and psychiatric problems. Only in one case there was a combination of a personality disorder feasible with mood disorder. Table 1 only provides a summary of the principal diagnosis. In various cases, besides the aforementioned diagnosis, there were also other identified problems. We have chosen to highlight the psychiatric diagnosis in this study and did not conduct a further analysis of additional problems.

Table 1. *Characteristics of the respondents (N = 260) and cases (N = 41).*

Variable	Number of respondents/conferences or average (percentage)
Age*	47.3
Gender*	Male: 122 (48.8%) Female: 128 (51.2%)
Respondent group	Client: 34** (13.1%) Social network: 139 (53.5%) Professionals: 58 (22.3%) FGC coordinator: 29 (11.2%)
Region	Region one: 12 FGCs (30%) Region two: 15 FGCs (37.5%) Region three: 14 FGCs (35%)

Table 1. (continued)

Variable	Number of respondents/conferences or average (percentage)
Type of coercive measure**	Involuntarily admitted with COA***: 4 (12.9%) main actor (m.a.) Involuntarily admitted with CA**: 3 (9.7%) m.a. Impending COA: 11 (35.5%) m.a. Formerly admitted with COA: 9 (29%) m.a. Formerly admitted with CA: 2 (6.5%)m.a. Impending COA: 2 (6.5%) m.a.
Psychiatric diagnosis****	Bipolar disorder: 4 (13.3%) m.a. Combination of personality disorder with mood disorder: 1 (3.3%)m.a. Depression, anxiety and panic, suicidal tendencies: 3 (10%) m.a. Addiction with psychiatric disorder: 6 (20%) m.a. Psychotic disorder: 16 (53.4%)m.a.

* Of some respondents their age and gender is unknown, so there are missing values

** 41 FGCs were organised around clients in problematic situations, 34 of those clients participated in the interviews.

*** This concerns the situation during the referral to the conference, where there is an imminent compulsory admission (CA) or court ordered admission (COA), or the client was involuntarily admitted at that particular moment or recently in the past

**** Background information from some clients is missing

Differences between the respondent groups in perceived outcome measures

Table 2 presents, for each respondent group, how they perceived the outcomes by providing the mean scores on the three outcome measures on the situation before and after the conferences. It indicates that for the outcome measure ‘sense of belongingness’, all respondent groups experienced progress after the conference. Mental health professionals and coordinators, recognised a major difference between the situation prior and after the conference, the scores given by the social network are higher than those of the mental health professionals. The same applies to ‘ownership or control over the situation’ of the clients: mental health professionals and coordinators indicated the biggest difference between the situation before and after the conference. The analysis considering the outcome measures is based on 40 FGCs where 253 respondents scores have been obtained. In one case, it was not possible to obtain quantitative data because the respondents were not able to reflect on the scales. When it comes to the experienced coercion, the clients experienced the strongest reduction in coercion (+1.85), hereinafter followed by the coordinator (+1.07). The clients (6.98) and the social network (6.35) experienced the lowest degree of coercion after the conference.

Table 2. Differences between the four respondent groups on perceived study outcomes (belongingness, ownership and coercion).

Outcome measure and respondent group	N (number of respondents)	Average score prior to conference	Average score after conference	Difference
Belongingness (social support):		5.43	7.01	+1.58
Client	33	5.30	6.61	+1.30
Social network	135	5.75	7.13	+1.39
Professionals	56	4.75	6.66	+1.91
FGC coordinator*	29	5.14	7.26	+2.12
<i>(scale 0-10: damaged and diluted contacts – totally satisfied with both quantity and quality of social support)</i>				
Ownership (control over the situation):		3.74	5.78	+2.04
Client	33	4.56	6.40	+1.85
Social network	135	3.85	5.52	+1.66
Professionals	56	3.36	5.53	+2.17
FGC coordinator*	29	3.36	6.12	+2.76
<i>(scale 0-10: weak/dependent on others – resilient/auto-nomous/ grip on situation)</i>				
Coercion:		5.22	5.92	+0.70
Client	33	5.13	6.98	+1.85
Social network	135	6.08	6.35	+0.27
Professionals	56	4.96	5.14	+0.18
FGC coordinator*	29	3.75	4.82	+1.07
<i>(scale 0-10: involuntarily admitted – voluntary assistance)</i>				

* Some FGC coordinators had difficulty reflecting on the outcome measures as they had limited information on the situation after the conferences

Inferential statistics

In this analysis, the difference in scores on the outcome measures ‘belongingness’, ‘ownership’ and ‘coercion’ were weighted. Scores on the situation before and after the conferences were analysed. Table 3 presents the results of the paired t-test and multilevel analysis.

Table 3. Results from the paired t-tests and multilevel analysis (nested modelling).

Variable	T-test			Multilevel		
	Average in-/decrease	St. error	T	Average in-/decrease	St.error	T
Difference belongingness	1.58	.14	11.43 *	1.49	.26	5.72***
Difference ownership	1.94	.15	-13.33 **	1.94	.24	8.10****
Difference coercion	0.55	.33	1.65	1.00	.64	1.56

*p 0.000; **p 0.001; ***p 0.000; ****p 0.000

On the outcome measure ‘belongingness’, the average score for the situation prior to the conference was 5.43 and for the situation after the conference 7.01. This is an increase of 1.58 and this is a significant difference (p 0.000). The multilevel analysis indicates that there is a difference in given scores of 1.49. This outcome is also significant (p 0.000) and thus demonstrates that the respondents were of the opinion that the ‘sense of belongingness’ had increased after the conferences.

Second, it was assumed that ‘ownership’ or having a sense of control over the situation would be strengthened after the conference as they could rely on more social support after the conferences. On this outcome measure, the average score of the situation prior to the conference was 3.74, while afterwards the obtained average score was 5.58. This indicates that respondents experienced an increase in the ownership over the situation after the conferences. On the basis of the paired t-test, the increase of 1.94 is significant (p 0.001). A similar result was found in the multilevel analysis: 1.94 (p 0.000).

Lastly, we examined the perceived coercion. Respondents reported a small decrease in coercion after the conferences. However, both the paired t-test as the multilevel analysis indicate that this decrease is not significant and therefore it cannot be concluded with statistical certainty that the respondents perceived a reduction of coercion.

Reduction of coercive treatments in the long run

Respondents were approached between seven and 18 months after the conference to participate in follow-up interviews, with questions to foster reflection on the reduction of coercion. Of the 41 included conferences, in 27 cases it was possible to carry out follow-up

interviews (the other 14 conferences were organised shortly before the end of our research project and were therefore not suitable for follow-up interviews). Not everyone was willing to enter once again into dialogue with the researchers, however, we were able to review 18 cases to determine whether coercive treatments were imposed or not. In 13 cases, no coercive measures were imposed and there was usually voluntary support from mental health professionals involved after the conferences. These interviews mapped how respondents experienced a decrease in coercive treatment in the long run after the conferences occurred. The cases vary in the extent to which successes were achieved with regard to recovery and regaining ownership over the situation, as well as in strengthening and expanding relational contacts. The follow-up interviews show that some effects, related to the FGC, last longer than others.

Discussion

Our study shows that FGCs offer a promising perspective to restore belongingness. In most cases, ownership over the problematic situation was regained: respondents experienced more control over their situation after the conference had taken place. This corresponds with the underlying concept of empowerment in FGC; facilitating people in making their own plan, instead of experiencing coercive treatment. It also corresponds to the specific way FGCs are designed, the main actor plays an active role in organising the conference; together with family and friends a plan is made. They all contribute to the plan. Furthermore, they decide who will monitor the plan. What also may have contributed to the increase in ownership is whether or not the main actor experienced coercive treatment after the conference.

Belongingness was also restored, respondents perceived more social support after the conference. Fragile relationships were strengthened and circles of support were widened; aspects that are crucial to clients who deal with the profound experience of coercive treatment (O'Brien & Golding 2003, Landeweer *et al.* 2009, Katsakou *et al.* 2010). Organising a FGC corresponds to the needs of people to connect and relate to family and friends. The main actor decides, with guidance of the coordinator, who to invite for the conference. The coordinator supports the main actor in finding persons that are willing to participate in the conference. They let the main actor critically reflect on the composition of the participants, for example by asking 'what kind of support do you need from your social network?' Coming together and sharing stories and perspectives on the problematic situation can lead to a comprehensive understanding and reinforce relationships.

A small decrease in coercion was also reported after the conference, especially clients reported on a decrease of coercion, but this was not a statistically significant outcome. The reduction of coercion does correspond to the earlier mentioned study on the application of FGCs in public mental health care (De Jong 2014), and also complements findings on the application of FGCs in youth care, where outplacements of children are prevented by FGCs (Skaale Havnen & Christiansen 2014). Furthermore this is in line with the study of Voskes (2016), who describes that contact, communication and a pro-active role of mental health professionals emerge as important care ethical and preventive factors in coercive treatment.

Follow-up interviews a year after the FGC showed that the effects of the FGCs in some cases persisted over time, but the positive effects also diminished. Attendees of the FGC did not describe the conference as a futile experience, even in situations where those involved had expected or hoped for more. The findings of this study are even more promising considering the qualitative research data, showing that most FGCs proceeded with minimal support from mental health professionals (Schout et al. 2016). As mentioned earlier, professionals, like psychiatrists, community mental health nurses or social workers, do play a modest but nonetheless crucial role in all phases of FGC and reinforce the plans with their expertise (Connolly 2006, Crampton 2007). If mental health professionals would commit to this role, it is conceivable that the impact of FGC will increase further.

Limitations

It was not our purpose to prove a causal relationship between the use of FGC and the potential effects it might achieve. On the other hand, our study helps to understand the benefits FGC may have in coercive psychiatry.

The generalisability of our study is strongly related to the circumstances that occurred at this juncture in the Netherlands. Would there be a new legislative framework and structural possibilities for financing FGC, the attitude of mental health professionals, families and clients regarding the application of FGC would probably change and would produce different findings. In line with Metze (2016), it seems conceivable that future conferences would generate sustainable effects when the context wherein they are organised does encourage a family-driven attitude among mental health professionals.

As already mentioned, the data were collected in retro-perspective, this could have led to recollection bias. Sometimes respondents had trouble in remembering the situation before

the FGC and giving a reliable score. Therefore, we asked respondents to give arguments when they indicated an increase or decrease after the conference. Another issue that should be mentioned is that the researchers were not participating in the FGCs. They were, however, closely involved in their organisation. For example, the researchers took part in discussions with FGC coordinators about the organising of the conferences. By evaluating the FGCs from multiple perspectives, we have tried to develop a comprehensive image of the process and impact of the different FGCs.

There were several researchers working together in this study. To ensure reliability of study findings, they frequently reflected on collected data and worked closely together during the data analysis (peer debriefing). A standardised topic list was used and interviews were recorded and written verbatim; interviews and analysis were critically scrutinised. Furthermore, triangulation of different methods (interviews, focus groups, memos) was used to increase reliability.

The different plans of each conference were tailored to a specific group of people, or a case. However, the preparation and organisation of the conference was identical, i.e. the original FGC model was followed. Meaning that coordinators all received the same training in how to organise and facilitate FGCs. In addition, the FGCs were all organised on neutral ground. The results of this study are used to improve the application of FGCs.

Conclusion

FGC is a promising intervention to regain ownership, restore belongingness and reduce coercion in psychiatry. Results of this study complement findings in public mental health care and youth care. FGCs hold the potential to expand the repertoire of nurses to support human functioning in crisis situations with help from social networks. The partnership between social networks, communities and mental health professionals can be strengthened with FGCs. Furthermore, if professionals like (community) mental health nurses, would take a more active role in the facilitation of FGCs and reinforce the plans with their expertise, they can strengthen the impact of FGCs even further. Research into the role of the different professionals in the process of FGCs warrants further investigation. The increase or decrease of coercive treatment is probably influenced by a complex set of factors; further exploration therefore is needed to reveal the success factors for reducing coercive treatment with FGCs.

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Chapter 3

Family Group Conferencing – Its added value in mental health care

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Abstract

Worldwide, there is a growing emphasis on reducing coercion and involving social networks in the care of mental health clients. Nurses should encourage their clients to regain control over their lives, preferably with less coercion and with help from their social network. During four years, a Dutch evaluation study was deployed to determine the applicability of mobilising help from social networks of people with psychiatric problems. Specifically the potential of Family Group Conferencing was examined. In this discursive paper the question is addressed what Family Group Conferencing adds to the existing methods that aim to reduce coercion in mental health care and promote inclusion.

Introduction

There is a growing emphasis on reducing coercion and involving social networks in the care of clients with ongoing mental health conditions in the Netherlands. Addressing the civil society in general and encouraging clients' self-efficacy in particular, are important policy aims. Nurses are expected to encourage their clients to regain control over their lives, preferably with less coercion and with help from their social network. Further on, they are directed to take a modest position in the decision-making process. Both in inpatient and outpatient psychiatric care these aims need to be implemented.

The current legislation on compulsory admissions in Dutch psychiatric clinics ('Wet Bijzondere opnemingen in psychiatrische ziekenhuizen', Bopz) will be replaced by the Mental Health Care Act on Compulsory Treatment ('Wet verplichte geestelijke gezondheidszorg', Wvvgz). This new act stipulates that people who are confronted with coercive measures should be given the opportunity to avert these measures by establishing a plan together with their social network. Mobilising help from the social network is a key component of the Wvvgz as the act aims to provide care under the legislation of a community treatment order at clients' home as a lesser profound intervention than a compulsory admission to a psychiatric clinic. This is in line with the principle of least coercive care as articulated by O'Brien and Golding (2003).

There is confusion about the definition of coercion in mental health care (O'Brien & Golding, 2003). It is commonly interchanged with compulsion (Rugkåsa *et al.*, 2016). In line with O'Brien and Golding (2003) we consider coercion as the broad range of measures that mental health professionals may execute to limit clients' autonomy with the intention to serve their own good. This does not only involve profound measures such as admissions to a psychiatric ward and seclusion, but also more subtle forms of coercion where professionals manipulate and persuade clients' wishes. Rugkåsa *et al.* (2016) make a distinction between measures that are exercised on behalf of the state (formal coercion) and practices not regulated by law that are imposed on clients (informal coercion). Compulsion we see as a manifestation of coercion where interventions are deployed under judicial legislation and that are directly against clients' will (e.g. Rugkåsa *et al.*, 2016), with the compulsory admission as its most radical form (De Jong *et al.*, 2016).

The essence of involving the social network

Besides reducing coercion, another aim of the Wvvgz is mobilising social support. The role of the social network in psychiatry is connected to a wider debate than just the involvement

of family in the care of clients. Individuals with severe mental health problems were usually regarded as victims and were mostly seen in terms of their disabilities and symptoms (Andreassen, 1984; Frith & Johnstone, 2003; Topor, Borg, Di Girolamo, & Davidson, 2011). This meant that mental health professionals did not have to deal with the experiences, expertise or viewpoints of clients (Topor *et al.* 2011). Topor *et al.* (2011) describe that in this context it seems important to emphasise the individual aspects of recovery, they also mention however, that “this line of reasoning could prevent us from seeing that the road to recovery is also a social process” (p. 90). In other words, family, friends and other concerned bystanders cannot be overlooked. To overcome an one-sidedness approach on the wellbeing of the individual client, we have been investigating the applicability of mobilising help from social networks in the care of people with psychiatric problems. We studied in between 2011 and 2015 the decision-making model Family Group Conferencing (FGC) where a lot of experience with has been gained in the prevention of coercion in youth care. Our project has resulted in two research reports on the process and outcomes of FGC: in the first project we investigated 41 conferences that were organised for clients in a public mental health setting, in the second project we evaluated an equal number of conferences that were deployed for clients who were confronted with a compulsory measure (compulsory admission to a psychiatric clinic or a community treatment order). In various journals we have published on our research: both on the outcomes (Author’s Own) as on the process of implementation and application (Author’s Own). The findings from our study underline the potential of FGC as a strategy to reduce coercion in mental health care, and the crucial role that nurses can have in appointing their clients to the possibilities that FGC might offer and in helping them in the implementation of the plan (Author’s Own).

In this discursive paper we address the question what FGC adds to the existing strategies to reduce coercive care and promote inclusion. This paper can be viewed as a search for meaning, as a way of understanding the findings from two research projects into the process and impact of more than 80 family group conferences that were organised in the turbulent circumstances of crisis psychiatry and public mental health care in the Netherlands. The conclusions of this paper draw upon an interplay between the empirical findings, a theory driven literature search on approaches that aim to reduce coercion and innumerable discussions we had in our research group. Let us first explain more into detail the origin of FGC and its underlying principles.

Family Group Conferencing

Family Group Conferencing is a decision-making model that was developed in New Zealand in the 1980s. At the foundations of FGC lay principles and values of the Maori (the indigenous people of this country). An important pillar of this model is the involvement of a large and varied group of stakeholders – (extended) family members, friends, neighbours and other community members – to solve problems where individuals or families are struggling with. This idea is summarised under the name ‘group-efficacy’ and is shaped in social welfare and health care practices by giving clients and their social network the opportunity to establish a plan on their own. To ensure a successful outcome it is important to ‘widen the circle’ (Pennell & Anderson, 2005): it is assumed that using the capabilities of a diverse group of participants increases the likelihood of positive results. Professionals are not overlooked; they are invited to bring in their expertise. The conference is prepared by an independent coordinator, a trained fellow citizen who does not have an interest in the outcome of the conference.

The meeting itself consists of three distinctive parts. During the first stage, information on the problematic situation is shared, including professional expertise. At the start of the second stage, the FGC coordinator and professionals leave the meeting. This stage is called the ‘private family time’; it is the heart of the conference as it is during this stage that the client and social network are fully encouraged to establish their own plan. The coordinator joins the meeting once again when the group has agreed on a draft plan and subsequently explores the feasibility of this plan. In cases of coercive measures or where they are considered, professionals are asked to review the plan on safety issues.

Underlying principles

FGC aims to encourage a process of cooperation between clients and their social network, enriched by the expertise of professionals. Self-efficacy of clients and group efficacy are central. FGC establishes links between two different worlds: connecting the lifeworld of citizens with the system world of professionals (Burns & Früchtel, 2014). The idea behind this is that when both worlds are brought together, new perspectives on how to solve problems arise which ultimately contribute to a better quality of life. The regular way of decision-making with professionals in the lead (professional driven) is abandoned; it is the family that determines the agenda and draws up a plan. In contrast to traditional approaches that are family-centered, FGC is family-driven (Merkel-Holguin, 2004). Outcomes are not achieved *with* the social network but *through* the social network.

In FGC clients are referred to as main actors. They set the agenda and appoint the people they want the coordinator to approach for participation in the conference. The role of the independent coordinator is important as they think along with the main actors and help them to formulate the central question for the conference. The coordinator also tries to widen the circle of concerned bystanders by visiting all potential participants and removing barriers for their participation. Sometimes the coordinator needs to ask a question like What do you need in order to participate? The social network is encouraged to actively participate in the decision-making process. The goal is that each participant finally agrees with the action plan. In situations of an impending compulsory measure, it is important that professionals provide clear frames for the plan; they indicate the minimal conditions that the plan should meet. The role of the coordinator comes to its end when the conference is concluded and the client and their network implement the plan. Professionals provide information. In this they are possibly backed-up by professionals.

Digging up the added value

The question *What does FGC adds to existing methods to reduce coercion and overcome a psychiatric crisis?* was the starting point of reflection, discussion and theoretical search. However, at the beginning, our research project was highly iterative and tightly linked to the data (Eisenhardt, 2002). Our initial findings were shallow and did not shed sufficient light on the added value of FGC in emergency psychiatry. The theoretical search led to the insights of the Dutch political scientist Gerritsen (2011).

Gerritsen (2011) distinguishes between a functionalist paradigm that assumes direct social engineering and a social-interpretative paradigm that assumes an indirect type of social engineering by encouraging group learning and self-organisation. The decision-making model of FGC is linked to the tradition of this last paradigm. Gerritsen (2011) demonstrates that stimulating learning processes and convening stakeholders around a social problem addresses the complexity of contemporary issues. The problems of our study population are complex as well. Even apart from psychiatric symptoms, most clients in our study also had other problems, such as addiction, social isolation, a lack of meaningful activities and daily schedule, debts and housing problems – problems which altogether have a complex character. Our assumption was that the capabilities of a large support group, enriched with the expertise of professionals who are sensitive to the needs of the group, respond well to the complexity of these problems. Involving others can generate new ideas and solutions that professionals

alone might never have considered. In other words, the gathering of different social actors helps to prevent blind spots and provide wider solutions.

On the basis of Gerritsen’s insights we constructed a matrix which indicates several interventions that are used to avert coercion in psychiatry and the added value that FGC may have as a relatively new and unexplored approach. We contrasted in the matrix the horizontal axe with a vertical axe, representing the tension between family and professional driven interventions.

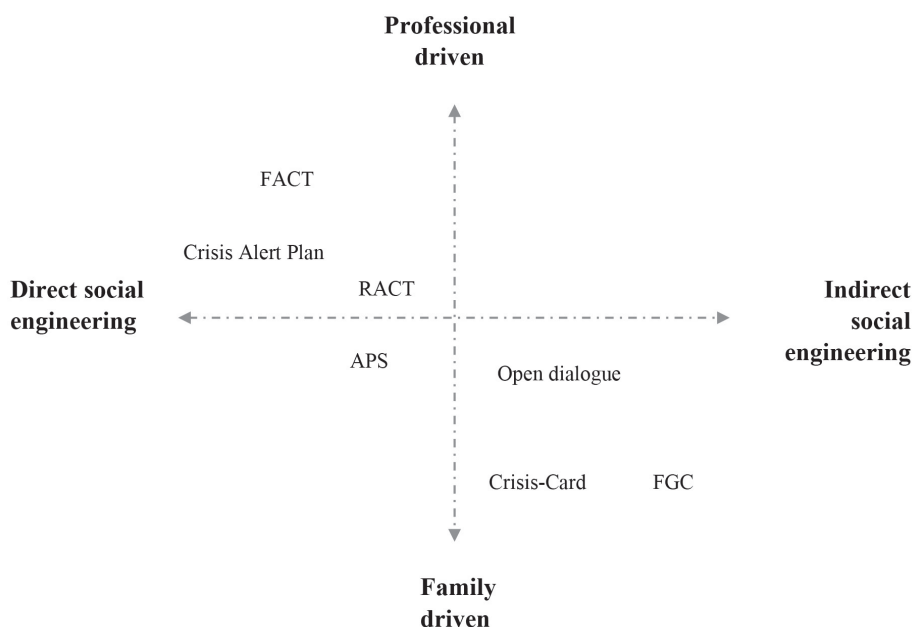


Figure 1. Decision-making models and social network strategies in between professional driven and family driven, in between direct and indirect social engineering

Existing methods to reduce coercion in psychiatry as represented by Klaassen (2014), Landeweer (2013) and Voskes (2015) are placed in the quadrants of the matrix. Below we attempt to describe the relationships and distinctions between these methods.

Other decision-making and social network methods

In Dutch mental health care, during the past decade several initiatives were taken to reduce the number of coercive measures (primarily compulsory admissions and seclusion, see Noorthoorn *et al.*, 2016). Ample attention was paid to the strengthening of social networks

around clients to prevent an involuntary admission – interventions that address the complexity of clients' problems and embrace their broader social context. FGC fits well in this tradition. Several initiatives were taken (Klaassen 2014), such as the Triad Card, the development and implementation of family policy, and the involvement of family when clients are admitted. The project Informal and Formal Coercion in Mental Health Care ('Project Dwang en Drang') has produced a large number of initiatives aiming for the reduction and prevention of coercion in clinical settings, such as the re-modelling or elimination of nursing stations, the development of comfort rooms and family rooms, the construction of Intensive Care Units, the First-5-Minutes Method, (reflections on) de-escalation approaches and the deployment of client experts/peer supporters during admission (Landeweer, 2013; Voskes, 2015).

Crisis-card and crisis-plan

Strategies for reducing coercion in community mental health settings include the so-called 'crisis-card' and 'crisis plan' to prevent crises. The crisis-card is a small expandable card in the format of a bank card, in which the card holder has indicated what to do if he or she relapses in a psychiatric crisis. The idea of a crisis-card, as an advocacy tool for use in mental health crises, originates from the voluntary sector in the United Kingdom (Sutherby & Szmukler, 1998). An important goal of the crisis-card is to ensure that clients have ownership over the treatment of their possible future crises (Henderson, Swanson, Szmukler, Thornicroft, & Zinkler, 2008; Sutherby & Szmukler, 1998.). Research into the effects of the crisis-card is scarce, but points to positive experiences of clients who are using it. There is, however, a lack of knowledge on the use of the crisis-card and its effect on the prevention of involuntary admissions (Sutherby, Szmukler, Halpern, Alexander, Thornicroft, Johnson, & Wright, 1999; Van der Ham, Voskes, Van Kempen, Broerse, & Widdershoven, 2013). The client determines, with support of an independent counsellor, what should be indicated on the crisis card and also helps preparing for the more extensive crisis-plan (Voskes 2013). The crisis-plan incorporates all relevant agreements the client has made with his or her environment in the event of a psychiatric crisis. The crisis-card is developed specifically for people with severe mental health problems that are susceptible to a psychiatric crisis. A distinctive part of the crisis plan is the 'crisis alert plan'. This plan is deployed to prevent relapse of clients before there is a downturn, and to start up adequate help. The plan is drawn up together with relevant mental health professionals and the client and arranges the signals issuing when the client does not feel well, is at risk of deterioration, or already has deteriorated (Voskes, Theunissen, & Widdershoven, 2011). The main difference between the crisis-card and the crisis alert plan is that the first is initiated by the client and the community of which he or

she is part of; it is an advocacy tool, whereas the crisis alert plan is designed in consultation with professionals.

'Guardian angels' and 'open dialogue'

Additional methods include the Admission Preventing Strategies (APSs) ('Opname Voorkomende Strategieën') of Jenner (1984) and the 'open dialogue' approach from Finland. Thirty years ago, the Dutch psychiatrist Jenner worked closely together with those directly involved in the care of psychiatric clients (he called them 'guardian angels' or 'bodyguards') to ensure the safety of the client and to get through an acute psychiatric crisis without being involuntarily admitted. In Jenner's strategies, family members and significant others were seen as auxiliary forces, as resources in overcoming a crisis. The APSs as described by Jenner (1984) are based on the capacity for positive change inherent to crisis situations. This ability to see a crisis situation as an opportunity to learn and change in a positive way has its origin in the 'crisis theory' that got developed by Caplan (as cited in Poal 1990). According to Caplan, a crisis mostly refers to a person's reaction to a threatening situation, and cannot be defined as the threatening situation. The experienced difficulty and importance of the crisis situation plus the resources to deal with it, play an important role in the reaction of a person to the crisis. Crises can be seen as periods of transition where there are opportunities for growth or deterioration for individuals, as well as for the community they belong to (Poal 1990). The near community as a whole has a chance to gain resilience when dealing with crisis situations, through learning from the situation and from each other.

The Finnish 'open dialogue' approach is a similar, practical strategy of emergency care that, if necessary, gets deployed straight away. Undergoing uncertainty together, the search of a life purpose, and the encouragement of dialogue within the social network, are at the core of this approach (Seikkula & Trimble, 2005; Seikkula, Alakare, Aaltonen, Haarakangas, Keränen, & Lehtinen, 2006; Seikkula, 2008).

Resource Group Community Treatment

Professional care for people with a severe mental illness is strongly influenced by the Assertive Community Treatment (ACT) approach that got developed in the United States during the 1970s and 1980s. ACT is a form of intensive outpatient care that has a focus on recovery and the prevention of psychiatric crises. In the Netherlands, an adaption on the ACT-model was established ten years ago which is known under the name Flexible ACT, abbreviated as FACT. This model is characterised by switching flexibly between intensive team coaching and less intensive individual counselling, and a daily adaptation to the specific needs of

clients (Nugter, Engelsbel, Bähler, Keet, & Van Veldhuizen, 2015; Van Veldhuizen, 2007). A second, relatively new form of ACT, is the Resource Group ACT (RACT), which is an approach to enrich FACT. In the RACT model, the social network is heavily involved in the care of psychiatric clients. The concerns of clients are central in this model and they have an important voice in the decision-making process (Nordén, Ivarsson, Malm, & Norlander, 2011). Wellbeing, functioning and symptom reduction are at the heart of the RACT model (Nordén, Malm, & Norlander, 2012). Within the RACT-model, the social network is intensively educated and trained to form a resource group together with professionals (Nordén Eriksson, Kjellgren, & Norlander, 2012). It, however, remains professional driven, but there is an intensive cooperation with the social network. It is conceivable that the RACT model offers space for clients and their social network to jointly make a plan that is aligned with their needs and expertise of professionals. In FGC where professionals are subservient to the plan that clients and their network establish, let alone that there is an independent coordinator involved and a private family time incorporated. Unlike the RACT model, where clients can nominate who they want to include in the resource group, the FGC coordinator aims at widening the circle and will therefore sometimes explore and try to take away clients' hesitation to include family and friends. Often relationships got damaged and recovery is needed. Enlarging the resource group is combined with reconciliation and the recovery of contacts. Herein lays the distinction between FGC from RACT.

The added value of FGC and its timing

What FGC adds to the range of existing interventions to reduce coercion and promote inclusion, is a decision-making model and social network strategy that is aligned with the tradition of indirect social engineering, which can be placed at the very end of the continuum between 'professional driven' and 'family driven'.

The added value of FGC is connected to and also limited by its timing. We observed in our study that conferences sometimes were organised too early or too late. When does FGC yield the most potential for a positive outcome? With two case examples we will illustrate the difficulties in the timing of FGC.

The first case is about a woman diagnosed with a bipolar disorder. She contacted on her own initiative the organisation responsible for organising FGC, but was compulsory admitted to a psychiatric hospital a few days later. She lost contact with reality, and together with the family the decision was made to postpone the (preparation) of the conference. This situation lasted for about half a year. In the meantime the coordinator remained in

touch with the woman and her family, and eventually the preparation could start off and a successful conference was organised. In this case we saw the importance of a right timing; the coordinator adapted to the new situation and decided to start organising the conference when the woman got mentally stabilised.

In another case the preparation of the conference took more than a year and a half. The main actor was a man diagnosed with schizophrenia and addiction problems. He held off the preparation of the conference and was ambivalent about it. His mother, who was ashamed for having enabled his drug use in the past, also held off the conference. But as the man did not want to be involuntarily admitted, he finally agreed with the organising of a conference. The outcome was not successful; while during the conference it was agreed that the man should take more initiatives, he remained passive. In this case the postponing of the actual conference was not helpful; it only gave affirmation to the man that important life decisions can be put off until a later time.

Our findings indicate that in situations where a coercive measure (this mainly considered an impending compulsory admission to a psychiatric clinic) was considered, or when such a measure was already deployed, clients and/or their families were not able to get grip on the situation and change it for the better. The confusion, disinhibition, or addiction took such a prominent place in the preparations towards the conference, that it was sometimes too much. Interviews revealed that clients and their network regularly found it stressful to continue working on a plan once the coordinator and professionals left prior to the private time. Sometimes they wanted (one of) them to be present or nearby.

In other cases, we had the impression that a single conference was not enough to make the plan operational. In the case of a young man, who experienced manic and depressive episodes and who used excessively alcohol and drugs, the organising of a second conference would have been a valid idea. The conference that was organised resulted in a plan, but the young man had difficulties to implement the plan. He experienced that he was stuck between a rock and a hard place as his personal life world did not match well with the system world of professional assistance. He had a troubled contact with former care providers and for that reason he was avoiding the care he actually could benefit from. Professionals were therefore not invited for the conference as the man did not have professional support at that time. As after the conference his mental health slightly deteriorated, a community mental health team became involved. A second conference could have been deployed together with the professionals to figure out how the plan that got established in the first conference could be implemented and how professional help could supplement this plan.

The cases we have studied raise questions. Is the formula of FGC well-aligned with its function to prevent coercion in mental health care? Should the formula be adjusted, for example by being less strict in applying the model when clients or their network want the coordinator or a professional to be present during the private time? These questions we discussed with the different stakeholders of this project. FGC has a small chance of sustainable outcomes when it is used as a unique, one-time action, and then also organised at the most stressful moment, namely when there is the threat of a compulsory measure. As a single isolated action, FGC does not make sense and will not generate progress. In our research we saw the deployment of FGC during these stressful moments, when other options were already exhausted. This raised the question of whether all mental health clients should be informed about the possibility of FGC, prior to a compulsory measure. Alternatively, should we accept that differences between mental health care providers occur, with some choosing to offer FGC as part of standard care, and others choosing not to do so? Further research is required to answer these questions.

Conclusion

Our research indicates that there are grounds for a wider application of FGC in mental health, even outside the framework of coercive care. These reasons are primarily that a person should have the right to make a plan on their own before or when the state intervenes with compulsory measures; secondly, that addressing the capabilities of a diverse group of people meets well with the complexity of the problems that the client target group is struggling with; thirdly, that some clients only would change for their relatives, but not for professionals, and that FGC offers the opportunity therefore; fourthly, that FGC provides the chance to realise partnerships between clients, their relatives, and professionals. And finally, that the last three reasons together form a crowbar that can be used to pry ingrained positions and thereby reduce coercion in mental health care.

In our study we observed that clients and/or their social network were not always able to participate in a conference, let alone to bring in enough self-direction so that during the private time a plan could be established. Some clients were too disturbed due to the negative consequences of a mood or psychotic disorder or were in a phase of mania that was so severe that the organisation of a conference was not feasible. Though, in the eyes of interviewed stakeholders, even the (preparations of) these 'failed' conferences brought benefits. What we can learn from these cases is that professionals sometimes must act in the tradition of direct social engineering and treat first psychiatric conditions, so that in a later stage they can act

in the tradition of indirect social engineering by bringing in their expertise and thus making space for clients and their social network to establish their own plan; in these cases, family driven strategies should first reserve space for professional driven interventions.

The findings of our study can help nurses and other mental health professionals to avoid the pitfalls of direct social engineering. FGC is a way to strengthen civil rights by making a plan before authorities intervene with compulsory measures, or lifting these measures when the plan ensures safety. It opens up possibilities for clients who avoid mental health care institutions fearing their power to take over. It offers family, friends and neighbours a platform to express their concerns, bring in ideas, show commitment and get involved. FGC is relevant for nurses as it expands the strategies to reduce coercion while mobilising the resources of the near community. The ultimate goal of this paper is to increase the awareness among mental health professionals of these possibilities.

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Part II



Sharing power:

on forming a new practice
around Family Group
Conferencing

Intermezzo 2 'Significance of family and friends'

In this second part of my dissertation, I will dig into the significance of organizing FGCs for those involved. The chapters show that despite the value of FGC when it comes to its contribution to recovery and ownership, there were different barriers in the process of (organizing) FGC. The partnership between client, family and professionals was full of challenges and learning potential. Despite the difficult start and progress of the project, we did not lose heart. But why did I have such an interest in the progress of the project? Why did I not give up but kept looking (along with others) for possibilities to discuss the value of FGC and organizing conferences? To answer this question we have to return to the village where I grew up.

I was born and raised in Nieuwe Pekela, a village in the East of the province of Groningen. The attitude of many 'Pekelders' and myself is characterized by working hard, 'no whining' and 'no talking' with a good dose of 'Groninger' modesty and a down-to-earth mentality. My family situation (still) can be described as 'a warm and safe nest'. I have known many of my friends since childhood and puberty. We met at our homes, played together on the streets, cycled to the same high school, or (when we were older) stood side by side in the pub and celebrated student life when we went to college or university. We know each other, take care of each other, laugh with each other, cry with each other. I still am part of a warm community of family, friends and colleagues. In my life so far it came naturally that we were there for each other and helped each other out when needed. My 'warm nest' has made me committed to people who do not experience this; who cannot trust on others to be there in times of need whether for emotional or practical support, especially in those situations where it is urgently necessary to share problems, worries or sadness. My concern for these people meant that, when I became acquainted with the subject of the research project 'FGC in coercive psychiatry', I immediately saw it as a path that could bring me closer to my deeper motives. It also meant that I could not just let go of the subject, that I needed to turn over every stone and wanted to hear from all kinds of different people how they experienced developing a plan in (very) unstable situations together with family, friends and professionals.



Chapter 4

The use of Family Group Conferences in mental health: Barriers for implementation

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Abstract

Summary: The number of compulsory admissions in Dutch psychiatry has increased in the past 25 years. The reduction of coercion with Family Group Conferences in youth care has been successful. How, when and under what conditions can Family Group Conferences reduce coercion in adult psychiatry, is subject of an extensive inquiry. This paper, however, focusses on the reverse question, namely, in what circumstances can Family Group Conferences *not* be deployed? An answer to this question provides insights regarding situations in which Family Group Conferences may (not) be useful. Barriers in 17 cases were examined using multiple case studies.

Findings: The following barriers emerged: (1) the acute danger in coercion situations, the limited time available, the fear of liability and the culture of control and risk aversion in mental health care; (2) the severity of the mental state of clients leading to difficulties in decision-making and communication; (3) considering an Family Group Conference and involving familial networks as an added value in crisis situation is not part of the thinking and acting of professionals in mental health care; (4) clients and their network (who) are not open to an Family Group Conference.

Applications: Awareness of the barriers for Family Group Conferences can help to keep an open mind for its capacity to strengthen the partnership between clients, familial networks and professionals. The application of Family Group Conferences can help to effectuate professional and ethical values of social workers in their quest for the least coercive car

Introduction

In the Netherlands, the number of compulsory admissions, community treatment orders and court-ordered admissions for mental health treatment has increased dramatically over the last 25 years (Broer, Koetsier, & Mulder, 2015; Mulder et al., 2006; Van der Post, 2012; Van der Post, Peen, & Dekker, 2013). Besides changes in the social climate, this increase is also related to changes in psychiatric epidemiology and methods (Van der Post, 2012). One of the changes is a decrease in the duration of compulsory admissions in combination with an increase of re-admissions, as seen in all European countries in the last 20 years (Mulder et al., 2006; Salize & Dressing, 2004; Van der Post, 2012). A recent study into the application of Family Group Conferences (FGCs) in public mental health care in the Netherlands showed possibilities for the prevention of coercion.

A compulsory admission is a profound experience for clients which infringes their fundamental rights (De Jong & Schout, 2010; De Stefano & Ducci, 2008; Katsakou et al., 2010; O'Brien & Golding, 2003; Roskes, 2009). It is therefore desirable to limit the number of compulsory admissions, especially when there are alternatives at hand or when these can be developed (Mulder et al., 2006). It should be kept in mind that coercion in psychiatry is a contested and broad concept. It refers to compulsory care in both hospitals and the community but also to the non-statutory pressures exerted upon clients to accept treatment, such as persuasion, leverage, inducement, threat and compulsion (Khazaal et al., 2014; Molodynski, Rugkasa, & Burns, 2010; Szmukler & Appelbaum, 2008). Even 'voluntary' clients often feel coerced to accept mental health treatment (Burns et al., 2011). Coercion in this paper refers to all these forms of coercion, from inducement to compulsory admissions.

Forced residential and foster care are successfully reduced in youth care using FGCs (Pennell, Edwards, & Burford, 2010; Wang et al., 2012). FGCs can also prevent the risk of recidivism in juvenile crime (Bergseth & Bouffard, 2007; De Beus & Rodriguez, 2007; Jeong, McGarrell, & Kroovand Hipple, 2012). This study builds on that research by applying FGCs to adult mental health care. It also builds on studies in overcoming psychiatric crises in the community with the support of social networks (Jenner, 1984, 2013; Owens et al., 2011; Seikkula et al., 2006; Wallcraft, Steffen, & Amering, 2011). The strategies developed by Jenner to cope with a psychiatric crisis without a compulsory admission, using 'guardian angels' and the intensive coaching of those closely involved, can be seen as a Dutch exponent of this line of research.

FGCs

An FGC is a formal meeting which involves the extended family in making a plan for a social problem. During the conference, solutions are sought and a joint plan is composed on how to deal with the situation. Although the original FGC model as developed in the 1980s in New Zealand has been moderated several times, the key characteristics are to (1) widen the circle (involving the extended family), (2) connect the expertise of professionals with the resources of the family network, (3) appoint an independent coordinator who prepares the meeting including the use (4) of ‘private family time’ for decision-making (Merkel-Holguin, 2004). The initial FGC model underlines a shift of power to lay people. The position of the FGC coordinator in countries such as Norway and the Netherlands reflects this. Here, the coordinator is a fellow citizen, someone without a professional background who has no particular interest in the outcome (Natland & Malmberg-Heimonen, 2014).

In the first stage of the conference, but also in the preparation of the FGC itself, professionals provide information, though it is the network itself that makes the plan. Through a democratic decision-making process tailored to lay people, a plan is made on which every participant needs to agree. The plan describes the tasks and responsibilities of the different actors. The traditional way of decision-making where professionals are in the lead is abandoned. It is the family that determines the agenda and draws up a plan. In contrast to traditional approaches that are family-centered, an FGC is family-driven (Merkel-Holguin, 2004). So, outcomes are not achieved *with* the social network but *through* the social network.

The particular relevance of our study springs from recent legal transformations in the Netherlands. The current legislation on compulsory admissions in psychiatric hospitals (‘Wet Bijzondere opnemingen in psychiatrische ziekenhuizen’) will be replaced by the Compulsory Mental Health Care Act (‘Wet verplichte geestelijke gezondheidszorg’). The aim of this new law is to enable psychiatric clients and their social network to come up with their own plan to avert compulsory treatment. FGCs in youth care may have proven to be successful but in what kind of situations an FGC can be applied to prevent coercion in adult psychiatry is still unclear. Commissioned by the Dutch Ministry of Health, Welfare and Sport (‘Ministerie van Volksgezondheid, Welzijn en Sport’), we commenced an investigation into the application of FGCs in order to prevent coercive measures in psychiatry in three mental health care institutions in the Netherlands.

In coercive psychiatry, it is usually the social network who request for help in a crisis situation. The concept of ‘family’ refers in these cases to a wider context: also friends, colleagues and neighbours who are worried or have to endure nuisance but still want to

help, can participate in a conference. For this reason, we describe these social networks as ‘post familial solidarity networks’. A key element of the philosophy of FGCs is that families themselves can request for an FGC. However, clients and their networks in psychiatry are not familiar with such a conference and the possibilities it might bring. That is why professionals are crucial in pointing clients and families on the possibilities of an FGC; without informing and referring to an FGC, the process leading up to an FGC is never started (see Figure 1).

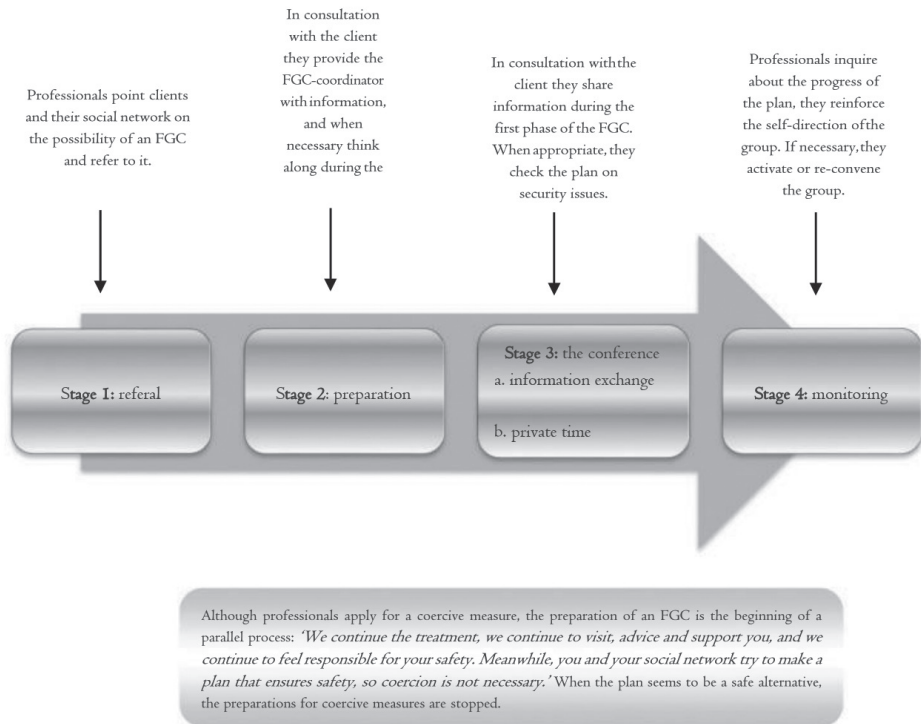


Figure 1. Stages of an FGC and the role of professionals in coercive psychiatry.

Obtaining cooperation from professionals in psychiatry appeared to be difficult. From the start of our study, the introduction of FGCs in the three mental health care institutions involved did not proceed smoothly. Few professionals informed their clients about FGCs and few made referrals to this new social intervention. Professionals gave all sorts of reasons why it was not appropriate for a particular client. The aim of this article is to explore barriers for using FGCs in the quest for the least coercive care in psychiatry. The investigation was focused on situations, both clinical and ambulatory, where clients were confronted with an imminent or actual compulsory admission or a court-ordered treatment and where no consid-

eration was given to refer him or her to an FGC. We specifically interviewed psychiatrists and nurses working in emergency care and community treatment, as in the Netherlands those professionals are often the gatekeepers of compulsory treatment, and who do or do not refer to an FGC. The following three research questions guided the study: (1) which barriers are present when an FGC is not deployed in these situations? (2) What are reasons, motives and considerations of professionals for not referring to an FGC? (3) What is typical for the situations where an FGC was not carried out? This current investigation is part of a comprehensive study into the application of FGCs in situations where coercion is used or considered. The aim of the wider study is to explore whether FGCs hold potential for clients to regain control, reunite them with their social resources and reduce coercion. Not only are social workers the second largest professional group after nurses in mental health care in many countries, their historical stance and ethical orientation on self-determination and dedication to human rights (Wu, Tang, Lin, & Chang, 2013) seem much needed in view of the findings of this study.

Methodology

The research can be characterised as a qualitative descriptive and exploratory study using multiple case studies. Interviews were used to collect data and a focus group was organised to validate the findings. This method is supplemented with insights we have derived from organising these case studies and with theoretical reflections on the findings.

Data collection

In the months prior to our study, psychiatrists, community mental health nurses and social workers in emergency services with specific tasks and responsibilities for acute care were made aware of FGCs and their features. More than 60 professionals in three institutions, all working in clinical and ambulant settings were briefed by the researchers on how to refer clients to FGCs. To obtain reliable and valid outcomes, a deliberate sample was chosen with a wide variety of professionals and cases. Semi-structured interviews were conducted with four psychiatrists and two community mental health nurses. These six professionals worked in assertive community treatment teams (long-term care for crisis prone clients) or emergency care (short-term clinical care for clients in crisis) of the three institutions. All of them attended the information sessions. The 17 chosen cases met the criteria as discussed above (imminent or actual compulsory admission or a court order for compulsory treatment). The 17 cases these interviewees presented included 8 women and 9 men, aged 20 to 66 years, who had varying

psy- chiatric problems like mood disorders, psychosis, suicidality, personality disorders, addictions or combinations thereof. The social networks of these clients ranged from small and hardly involved to concerned and involved. In a number of cases this was not (yet) sorted out. The reasons for coercion were the protection of others or the health and safety of clients themselves (suicide or neglect).

In every case, we retrospectively reflected on the decision not to opt for an FGC and stimulated the interviewee to reflect on his or her decision. We searched for reasons, motives, considerations and circumstances *not* to opt for an FGC (bar- riers). From the three main questions, a topic list was derived guiding further questioning. As the study progressed, new topics emerged and were added to the topic list. When all interviews with the professionals were finally carried out, we interviewed an experienced client who herself had a history of coercion and com- pulsory admissions, an interviewee who later also joined the focus group. The interviews lasted between 45 and 100 minutes were audio-recorded and subsequently transcribed verbatim.

Data analysis

Data reduction and the identification of themes were carried out using an induct- ive, iterative approach (Patton, 2002). We started with a global reading of the interview transcripts and subsequently a provisional identification of themes. We used ATLAS.ti to assign codes to meaningful fragments (open coding), to combine and group codes into themes (data reduction – axial coding) and eventu- ally cluster data and link themes (selective coding). Triangulation was applied by: comparing findings from different actors; comparing findings from different cases; comparing findings from interviews and focus groups, and; contrasting empirical findings with theoretical findings.

Validity and reliability

The interview transcriptions were submitted to the various interviewees for valid- ation. Interviews continued until no new labels and themes came to the surface; 17 cases were needed to reach data saturation. Finally, the major findings from the interviews were presented to a heterogeneous focus group. Participants of the focus group were an FGC coordinator, a mother of a client (family perspective), an user of psychiatric services (client perspective), a psychiatrist, and a commu- nity mental health nurse (perspective of mental health care), a professor of ethics and philosophy and a researcher of coercion in psychiatry (scientific perspec- tive), as well as two researchers who facilitated the meeting. The aim of

this meeting was to validate, criticise, correct, amend and expand findings (Liamputtong, 2011). The focus group lasted 90 minutes was audio-recorded and subsequently analysed.

Findings

We found four barriers (themes). Ten particular patterns (codes) outline their course. The findings of interviews and focus group are presented under these 10 patterns in Table 1. The four psychiatrists are indicated in this article as respectively P1 to P4, the community mental health nurses as CMHN1 and CMHN2 and the experience expert as E1. Quotes illustrating the findings are added and numbered corresponding with Table 1.

In 9 of the 17 cases, the professionals did not deliberately choose for or consider an FGC. Two quotes illustrate this mind-set:

In crisis situations 'I fall back on my routine'. (CMHN2; code 3.2)

It is not yet in my system. (P2, P4; code 3.1, 3.2)

Time pressure

Three of the four psychiatrists interviewed worked within an emergency department. In the course of a judicial measure, it is their task to assess the disorder and the degree of danger that comes along with it. The psychiatrist who does not work at the emergency department is doing these assessments in addition to his work in long-term care. Sometimes they assess clients at police stations. All situations are characterised by mental disorders, risk, time pressure and pressures for treatment. The assessments can lead to a compulsory admission within 24 hours ('Inbewaringsstelling' [IBS]) or within two weeks depending on the legal measure.¹ Within these time frames, psychiatrists must decide whether or not an FGC is feasible. In 8 of the 17 cases (cases 1, 5, 8, 12, 15, 14, 16, 17), time pressure was a barrier for deploying an FGC. All interviewees, also apart from the cases, indicate that deploying an FGC is hindered by the time pressure and the assumed danger. The interviewed client sees the constraints of time pressure as inherent to psychiatry.

Table 1. Barriers (themes) & patterns (codes)

Time pressure	The severity of the mental state of clients	Professionals cannot picture it	Clients and/or networks were not open to it
<p><i>Pressure to intervene</i> In crisis situations there is little time to organise an FGC. A decision within hours/days is required. Pressure from the social Environment aggravated by danger and risks Cases: 1, 5, 12, 14, 15, 16, 17</p>	<p><i>Decisions and arrangements</i> Unable to make decisions and arrangements based on reliable information. Cases: 5, 8, 9, 13, 15</p>	<p><i>Effect on problem situation unclear</i> It is hard to adopt a new method and not knowing the state of the art and possible effects. Cases: 9, 16, 17</p>	<p><i>Clients were not open to it.</i> Shame. Clients do not want to air the dirty laundry in front of others. Cases: 6, 7, 11</p>
<p><i>Timing</i> Clients are at a boiling point (timing). Cases: 8, 14, 17</p>	<p><i>Communication</i> Unable to perform coherent conversation (blockade for discussing an FGC) Cases: 6, 7, 8, 15</p>	<p><i>Mind shift</i> FGC is not yet in routine. No sufficient knowledge and experience. Cases: 4, 6, 8, 12</p>	<p><i>Networks were not open to it.</i> The network does not see an FGC as a solution. Cases: 2, 14, 16, 17</p>
<p><i>From reactive to proactive</i> Cases: 14, 17</p>			<p><i>Ambivalence.</i> Hesitation to interference/to get involved Cases 6, 7, 11, 14</p>
Total number of cases: 1, 5, 8, 12, 15, 14, 16, 17	Total number of cases: 5, 6, 7, 8, 9, 13, 15	Total number of cases: 4, 6, 8, 9, 12, 16, 17	Total number of cases: 2, 6, 7, 11, 14, 16, 17

The call to intervene

Besides time pressure and the degree of danger, there is often the demand from the familial network or bystanders to intervene. In cases 5, 14, 15, 16 and 17, the presence of acute danger is explicitly mentioned as a barrier for an FGC. In these cases, there was not enough time to organise an FGC because of the imminent danger. In such circumstances, the community expects psychiatrists to intervene.

Imagine, there is somebody at the police station. You see the person at 2 am and you talk for one hour. You agree to consult his general practitioner for example, or his family, and then you actually make a decision. [...] It depends on what is going on with someone: Is the person psychotic? Completely psychotic? Did bad things happen? Is there any support or



professional care left? Did that man for instance beat someone, or is he seriously suicidal? In such circumstances, then you just have to intervene. Then there is no time to organise an FGC. (P3)

In cases 1 and 12 there was no acute danger, but nonetheless the social environment feared for it and forced the psychiatrists to intervene. In one case, a decision had to be taken within 10 days. The time to motivate the client for an FGC and start the preparation of a conference was too short.

The focus group pointed out that an FGC in an acute crisis is feasible if there is a committed network receiving professional support. It is not always required for the client to be present. If a conference is too burdensome for the client, the network can also make a plan without him or her to get through a crisis. Even if the client is admitted against his or her will, the network can still make a plan to shorten the compulsory admission or prevent future coercion. Also an intersection is conceivable between a crisis plan with a small group and a formal FGC in which the full social network is present when the client has been stabilised.

Timing

The second barrier is choosing the right time to organise an FGC with respect to the mood of the client. Often, when the crisis reaches a 'boiling point', clients are angry and emotional. When such a 'boiling point' is reached, it is difficult to propose an FGC (cases 8, 14, 17).

I also think that we are often called in when the social system is exhausted and other care providers fall into a crisis as well. Everyone reached their boiling point. And that makes the situation difficult. Perhaps much earlier, in a previous phase, when there is still room for manoeuvre, it [proposing an FGC] has more chance of success. (P4; code 1.1, 1.2)

If coercive treatment is likely to be deployed, you are already too late. When the bucket is already overflowing, it is difficult to organise an FGC. (E1; code 1.2)

From reactive to proactive

Three of the interviewed psychiatrists and both community mental health nurses indicate that organising an FGC in situations of coercion in acute crises is seen as less feasible under time pressure. Each interviewee indicates that an FGC is more likely to succeed when deployed in an earlier stage. In the context of impending coercive measures it will not work;

however, all interviewees consider looking ahead with the social network and making plans on how to act when a new crisis occurs as a promising strategy.

We should be able to make progress with an FGC during the relative calm period of a court order [6 months, mostly without immediate danger]. (P3; code 1.3)

In almost all 17 cases, except case 14, contact with professionals had been made prior to the moment the emergency service was called in. So before the crisis occurred, clients were known by the agencies. In the course of this study, interviewees were asked why they did not suggest the opportunity of an FGC in an earlier phase when the client was still stable. The last three interviewees (P4, CMHN2, E1) replied that unfamiliarity with FGC and the nature of the work to respond to an immediate crisis explains the hesitation to propose an FGC during a calm phase. Several participants of the focus group stated that an FGC can produce a plan for preventing relapse or to reduce the depth or duration of a crisis considering its ability to ensure social embedding.

Clients in a severe mental state

The second barrier is related to the intensity of the disorder. This involves two aspects: one is the ability of clients to make decisions and commitments, and the other is their poor capacity to conduct a coherent conversation. In total, there were seven cases (5, 6, 7, 8, 9, 13, 15) in which the absence of these characteristics formed a barrier for starting an FGC. In cases 5, 8, 9, 13 and 15, it was estimated that clients were not able to make reliable decisions or commitments in view of their mental state. The clients in these cases did not adhere to agreements and exhibited threatening, dangerous and unpredictable behaviour, although they had psychotic symptoms and a limited cognition. Two respondents (P1 and P4), however, do not consider this as a barrier for an FGC. Clients do not constantly need to be able to assess and decide, as long as they can decide whether an FGC should be organised or not. Only then it makes sense to start an FGC.

That someone is psychotic does not mean that he cannot participate in an FGC. [...] But he has to be able to make a decision and the FGC should have a function. Someone should be able to extract strength out of it. (P1; code 2.1)

According to P2 and P3, the insights of clients into their disorder are important factors influencing whether an FGC can be organised or not. A poor understanding of the problem

can hinder decision-making. In cases 6 and 7, this lack of insight was a barrier for the deployment of a conference.

In the focus group, the positive role of medication was discussed. Medication can ensure that the client unwinds and regains control over the situation and that the social network gains confidence in a positive outcome. Medication is often required in these situations, but is not a prerequisite for an FGC.

Communication

Another feature in the individual characteristics of a client which forms a barrier is inadequate communication (cases 6, 7, 8, 15).

When there is no adequate conversation; the client speaks incoherently, is associative, there is hostility in contact; and there are endless stories and inability to actually keep appointments; then there is no point in proposing an FGC. (P4; code 2.1, 2.2)

When clients are not able to conduct a coherent conversation, barriers emerge in the process. As a result of difficult communication, doubts arise whether the idea of an FGC dawns on the client. Does he or she understand what is intended with it?

Here it is difficult to follow her and entering the conversation. [...] That is introduced by: 'Hey, I want to discuss something with you.' We are investigating the possibilities of an FGC. And Mrs. D. got stuck there. 'How do you mean my own strength? I'm already in my own strength?' [see endnote 2] That's how she talks. Then she picks out a word from your sentence and tries to grasp it. And if she does not understand it, she becomes restless. [...] It is walking on eggshells; how can I bring it up [an FGC]? (P2; code 2.1, 2.2)

The second barrier is the mind-set of the interviewees. Unlike the FGC-coordinators, the interviewees cannot imagine the healthy influence relatives and friends could have, especially in the private-time of the FGC. The context of illness and professionalism seems to recall dependency and subsequently rises doubts that clients can adequately join in the process of an FGC.

It is also a difficult man, pompously, hard to interrupt when telling his story. That makes me thinking of that this will play a role in the FGC as well. How would that work during

the process of the conference? He and all those people at one table...? I cannot exactly picture what good can come out of that. (P2; code 3.1)

Professionals cannot picture it for themselves

All respondents, except one, have no professional experiences with FGCs. Only one of them has in his private life experienced something that was similar to an FGC. The professionals all have referred some clients to an FGC, also in acute situations, but still do not have examples of a successful FGC.

Effect on problem situation is unclear

Of the 17 discussed cases, there are three cases in which the professionals cannot picture the possible positive effect of an FGC on the problem situation (cases 9, 16, 17). In case 9, a client who had been in treatment in mental health care for a long time appeared to be stuck in a pattern of escalation and de-escalation (a cycle leading from one coercive measure to the other). The practitioners could not imagine the beneficial influence of an FGC in such a repetitive process. In cases 16 and 17, there were doubts if the serious threats to the immediate environment of the client could be elevated with an FGC.

Mind-set: It is not yet a routine

All interviewees indicate that using FGCs implies a new way of thinking. For that shift in mind-set (from professional-driven to family-driven), factual knowledge is required on the merits of FGCs and how the process towards such a conference might look like. According to the interviewees, this knowledge is not yet sufficiently present. Without this knowledge, considering the possibility, or let alone deciding for an FGC, does not come naturally. This applies for all of interviewees. Moreover they have the impression that this applies for other professionals in the field as well. In cases 4, 6, 8 and 12, this mind-set played an explicit role in not deploying an FGC. For example, in case 4, it is presumed that there was a limited network but the potential assets of the social network were not properly inventoried, nor did the professional consider the possibility of an FGC to expand or revitalise the social network.

You're used to working with what comes along, but involving the social network in the treatment is actually a few steps further ahead. It will cost you more time. (P1; code 3.2)

One interviewed psychiatrist indicates that the standard routine for many professionals is to stay close to what they consider safe and what they are familiar with. Choosing an

alternative can be seen as neglect in the eyes of colleagues. Trying something new is difficult since psychiatrists do not want to withstand professional norms. In her view, psychiatrists cannot imagine how an FGC might work in conflictive family relationships and are not aware that an FGC can be applied to restore relationships or to widen the circle with other acquaintances. Two interviewees indicate that it is difficult to inform clients due to lack of knowledge from their side.

We can be convinced that this [FGC] is an alternative, but you still have to convey the client who knows nothing about it at all. And it also means sharing this insecurity with other people, people you sometimes don't know. (CMHNI; code 3.1, 3.2)

The focus group underlined that the shift of power an FGC brings forms a barrier in deploying an FGC. That clients and their network determine what is going to happen, is difficult for professionals. For families, the reverse is true: they probably get more power, but they shy away from the responsibility it brings. This forms a barrier as well.

Client and network are not open to an FGC

In some cases, the client and/or the social network indicate that there is no need for an FGC. In seven cases (2, 6, 7, 11, 14, 15, 17), this formed an obstacle to the deployment of an FGC. Not only did the client and/or network not want an FGC, there were other barriers such as communication problems and severity of the disorder. Although case 11 is listed in Table 1, it does not fit in any theme since a complex of factors played a role, like limited knowledge of the composition of the familial network and since clients were avoiding contact with professionals.

Within the theme 'client and or environment is not open to an FGC', there are two perspectives: the one of the client and the one of the social network.

Client is not open to an FGC

When clients in the discussed cases were not open to an FGC, an intervention of an authority or the network seemed to play a decisive role. In cases 6, 7, 11 and 15, this proved to be true. In cases 6 and 7, it was clear that the intervention of an agency was the reason that they did not want to deploy an FGC. In cases 11 and 15 this was less clear, while in case 11 the client wanted to keep the mental health services and his social network aloof. This was the reason for the interviewee to believe that the client would reject an FGC.

That man would not have allowed anyone to organise an FGC that would be about him. [...] He didn't even want to talk to anyone. (P3 reflecting on case 11; code 4.1)

The social network is not open to an FGC

Besides the client, the social network must be willing to participate in an FGC and contribute to the plan. If not, this forms a barrier. In cases 2, 14, 16 and 17, the familial network saw no point organising an FGC. In these four cases, there was an acute threat: in cases 2 and 14, there was the threat of suicide and in cases 16 and 17 the directly involved were threatened by the client. The social environment of these clients saw no benefit in an FGC, but rather in a compulsory admission.

There was family involved, but they had problems of their own. However, they insisted only on an admission. Although there was a large network, there was no consensus between its members. Putting the intermediate step before the compulsory admission didn't succeed. (P1; code 4.2)

The members of the focus group note that it is hard to organise an FGC if clients and their network do not support the idea of an FGC. Also, when there is practically no social network, this forms a barrier. However, participants of the focus group view the latter precisely as a reason to organise an FGC and restore broken contacts.

Barriers from a client's perspective

In the previous sections, we have described barriers that deter professionals from proposing an FGC in the context of involuntary admissions. The experienced client, however, added two barriers: (1) the tension between the client and its network and (2) the tension between the client and mental health professionals.

E1 points at a common misunderstanding between social networks and clients in mental health care situations where coercion and restraint are on the forefront. The network on one side might believe that there is a problem and decides to take action in an effort to help. Yet the client might see this as an infringement and as unnecessary interference and keeps distance from the network. In such conditions, it is likely that clients will perceive an FGC as an extension of this interference. Heartfelt concern might be experienced as meddling. The familial network, on the other hand, doubts whether there are grounds for interventions.

It is often the case that people who care about you want something to happen and thus enter your domain. Then you feel threatened, although they actually do it out of love. [..] The biggest fear of a client is: I have to attend a meeting where my own network decides what is good for me. (E1; code 4.1)

E1 also mentions that clients can feel vulnerable when they share feelings with their immediate environment. The fear to share problems with clients and the ambivalence of the network that is prompted by the perceived interference together form a barrier.

The second barrier is formed by mistrust in mental health services. This is usually related to previous negative experiences. E1 underlines that the power relationship between client and psychiatrist, where the client takes a passive role and the psychiatrist is perceived as the expert who also has the position to impose coercion, causes a mixture of passivity and mistrust. This mixture forms a barrier for an FGC.

You're a client, you're in a passive position, another one knows what is best for you. [..] They [clients] have no idea that they themselves can direct their own lives. 'I've never been heard as a client, so why should my opinion count this time?' It is that suspicion. (E1; code 4.1)

The focus group participants emphasised that there is a principal moral argument as well. Besides the benefits an FGC might have to offer, every client facing coercion should have the right to make their own plan and avert danger before professionals intervene. Such a plan should be legally enforced. In that case, judges can demand whether this form of subsidiarity has been given a chance. Networks and clients are now extradited to the coincidental preferences and insights from professionals.

Discussion

Findings in a wider context

The most striking barrier in this study was that an FGC was hardly considered as a possible intervention despite the briefing sessions. A statement like *'It is not yet in our system'* refers to this barrier and can be understood in the context of the studies of Voskes, Theunissen, and Widdershoven (2012) and Ney, Stoltz, and Maloney (2013).

Voskes et al. (2012) conclude that complex transitions like the reduction of coercive interventions can only be successful if they are accompanied by system transitions. Complex systems are maintained by a distinct culture. In this culture, cognition is structured by broadly shared values and norms, nourished by fixed and shared processes that control action. Methods and other social structures perpetuate this culture. According to these scholars, changes of complex systems occur at three levels: processes (do), structure (organisation) and culture (thinking). Only if changes occur at all three levels, there is a widespread and rooted transformation. Ney et al. (2013) describe the tensions that arise when two opposite discourses interact: the democratic, participatory discourse of FGCs with the legal and bureaucratic discourse of conventional youth care. These discourses are competing with each other and become armed in a neoliberal context in which liability and avoiding risks reinforce and recall each other. Although the study by Ney et al. (2013) is situated in youth care, their analysis applies for the implementation of FGCs in mental health care for adults as well. In terms of Habermas (1981, 1989), the rationality of the system world collides with the personal features of the life world. The capacity of FGCs to bridge the life world of clients and their families with the system world of agencies and services is the topic in a series of publications (Burns & Fruchtel, 2014; Garrett, 2009, 2010; Hayes & Houston, 2007). Our study indicates that FGCs in the coercive practice of psychiatry not only have a hard time bridging this gap, it seems an impurity itself: it does not match with the discourse (the way actors structure their thinking and doing) of professionals. Experts and laymen seem to have difficulties understanding each other (Pellizzoni, 2001), let alone work together in severe crisis situations where action is required. FGCs are an addition to this repertoire; enabling laymen to come up with a plan of their own and professionals to move from shared decision-making to supported decision-making (Pathare & Shields, 2012).

Support for FGCs without evidence seems difficult in a field of medical reasoning. Much more value is assigned to the lack of evidence than to the fundamental right to make a plan on your own to avert danger. Against this background, it is understandable that a project to prevent coercion with the help of familial networks is not easily accepted.

Strengths and limitations

Although it was a small scale study, saturation occurred in the data collection and, moreover, the study is repeatable. We are confident that other researchers in similar contexts, following a similar design would find the same insights and would assign similar labels and most likely the same themes. Nevertheless, the generalisability is limited to practices where the 'me-and-my-client-culture' is dominant. It is conceivable that in rural areas where communities are

used to resolve issues mutually, these findings would be less prominent or absent. Also the findings do not generate a clear-cut way out of the barriers that dominate in practice. Further research is required on how to overcome the barriers we have found. However, the findings can be the starting point of a dialogue on this topic.

Conclusion

Time pressure and the severity of psychiatric disorders are inherent to the nature of psychiatry. This barrier cannot be removed. It is, however, possible to organise an FGC when the confusion of the psychosis has declined and stability has returned. Another possibility is to work in stages: first to meet with a small group of ‘guardian angels’ to make a plan for the immediate crisis, and later on to organise an FGC with the wider social network to set up a prevention plan for future crises. A prerequisite is that clients and their network are informed about the possibilities to avert danger with a joined plan. Though, support from professionals and the network in all barriers is crucial. If the familial network notices that the psychiatric services are accessible when it comes down to it, and vice versa if professionals find out that the network can play a role in support and early detection of relapse and if actors additionally notice that an FGC can bring this about, then support for it will presumably follow naturally. Professionals can search, highlight and articulate such a practice.

Nurses and social workers form the largest professional groups in Dutch mental health care. This article shows that the culture of ‘me-and-my-client’ rooted in a medical approach that views clients as a bearer of disease, is still dominant in mental health care. In the light of their professional and ethical orientation, social workers are probably more equipped to strengthen the partnership between clients, familial networks and mental health services. The awareness of the possibilities and barriers for using FGCs can help psychiatric social workers to articulate this orientation and support the quest for the least coercive care.

Ethics

The research proposal was sent to the ethical committee of VU University Medical Centre. The study itself was not subjected to the Dutch Law on medical research involving humans (‘Wet medische-wetenschappelijk onderzoek met mensen’) and did not get a reference number because it did not involve patients. Approval was given on the condition that the following safeguards for privacy, anonymity and traceability of information were taken. All names of people, streets, places and organisations were replaced in reports and articles by a unique code. In this way, only the interviewers can relate information to persons, streets, towns

and settings. The researchers have all signed a confidentiality agreement. Participants were informed that the findings from the study would be used for scientific papers.

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Note

1. The interviewees refer to the emergency compulsory admissions (IBS) ordered by mayors and admissions pursuant to court orders (Rechterlijke Machtiging [RM]). In the latter there is more time to deploy an FGC. According to the Psychiatric Hospitals Compulsory Admission Act an IBS admission must be preceded by an examination of the patient by an independent psychiatrist to assess the severity of the psychiatric illness and the danger the patient poses to himself/herself or others. On the basis of this physician's report, the mayor issues an emergency admission order within 24 hours. Within five working days, the court must decide whether or not to authorise the continuation of the admission for a period that can extend to a total of three weeks from the date of the initial admission. A court order can extend this period to six months.

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Chapter 5

Family Group Conferencing as a catalyst for recovery and ownership in mental health

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Abstract

Recovery is not only a journey of personal change, but also of social re-engagement. Recovery underlines the essence of social environments that are supportive to the recovery of people with ongoing mental health issues. The process of recovery also affects other actors and likewise these actors exert their influence on the recovery of their family member or friend. Since 2009, we have been studying whether the decision-making model Family Group Conferencing (FGC) helps mental health clients to increase their self-reliance. The essence of FGC is that citizens who experience problems have the opportunity to develop a plan together with their social network. Clients in mental health have to deal with different forms of disempowerment, especially when they are threatened with compulsory measures. It is an aim to help them regaining ownership over their problems as well as over the potential solutions. From 2011 to 2013, we evaluated 41 family group conferences that were organised for clients in a public mental health care setting in the north of the Netherlands. Each conference was analysed within a qualitative case study framework. This article highlights two case portraits. It gives insight into how ownership was restored and what this meant regarding clients' recovery process. FGC seems a promising tool to shift the attention from disorders and inabilities to capacities and the rediscovery of social resources.

Introduction

Since the start of the new millennium, the concept of recovery has gained a central place in the psychiatric rehabilitation movement. Recovery is, according to Bonney and Stickey (2008), a contested concept. Increasingly, scholars across the Western world are advocating for the role of social factors in the recovery of mental health issues (Tew et al., 2011), although it is still mainly seen as a personal journey (e.g. Leamy et al., 2011). Slade (2011, p. 1), who elaborates on Anthony's (1993) original description, defines personal recovery in mental health as

a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Contrarily, as Topor et al. (2011) propose, recovery is not an individual process, but takes place in a social context. In line with Schön et al. (2009), Tew et al. (2011) and Topor et al. (2011) we underline that the description of recovery as a personal process falls short. The process of recovery also affects other actors, and likewise these actors exert their influence on the recovery of their family member or friend. Besides a personal journey, recovery is therefore also a social process.

Since 2009, we have been studying how to increase the self-reliance of people with ongoing mental health issues along with the help from their social network. Clients in mental health have to deal with different forms of disempowerment, especially when they are threatened with compulsory measures such as a community treatment order or involuntary admission (Author's Own). It is an aim to help them regaining ownership over their problems as well as the potential solutions. We have specifically studied the potential of Family Group Conferencing (FGC) which is a decision-making model where a lot of experiences with has been gained in youth care and where families are stimulated to make their own plan before professionals intervene.

From 2011 to 2013, we evaluated 41 family group conferences that were organised for clients in public mental health care (PMHC), and from 2013 to 2015, we examined the process and impact of an equal number of conferences in cases of a (impending) compulsory measure in adult psychiatry. This article focusses on two case portraits from the PMHC study. Firstly, it gives insight in how ownership was restored and secondly, what this meant regarding the recovery process.

Background

Recovery, ownership and the essence of involving family and friends

Working from the perspective of clients is viewed as a key element of good practice. This means that the needs and wishes of clients are taken seriously and that professionals support clients in fulfilling these needs (Barker & Buchanan-Barker, 2011). The importance of demand-driven and client-oriented care delivery has been underlined for two decades. More recently, another component was added, namely, the strengthening of clients' self-reliance and whether or not by means of their social network. Striving for self-advocacy, in other terms self-reliance or ownership, is an important tool in the recovery process (Mezinna et al., 2006). It is a way to increase access to other opportunities and can help in redefining the sense of self beyond that of a person with psychiatric problems. It is not hard to imagine that an increase in self-reliance leads to a sense of regaining ownership over one's own life.

Relationships with others are crucial in the recovery process and can represent continuity between diverse facets of a person's life (Mezinna et al., 2006; Schön et al., 2009; Topor, 2001; Topor et al., 2006). Family or friends participate in a person's life and sometimes provide material support or symbolise stability and wholeness (Topor, 2001). Family and friends of people with mental health problems can have all sorts of different functions. They can provide the possibility to ventilate thoughts and feelings, can help in testing if experiences are delusionary and hallucinatory or real (in cases of psychosis), and they also have a role in confirmation and integration of thoughts on whether these are coherent and logical (Topor, 2001; Topor et al., 2006). Furthermore, family and friends can motivate people with a psychiatric diagnosis in their recovery process through providing support (Schön et al., 2009). Especially for people with ongoing mental issues who are frequently socially isolated and stigmatised, it is important to have someone around who has something to offer and share in terms of company and emotional support (Topor, 2001; Mezinna et al. 2006). In summary, the social context of which a person is part should not be overlooked in the recovery process.

Stimulating self-reliance and regaining ownership are key aims of FGC. But instead of having primarily a focus on the individual, the focus is also on a family- and community-oriented approach because the underlying principle is that the client is always part of social structures. Moreover, without family and friends sustainable results are hard to achieve. In fact, in FGC results are achieved not *with* but *through* the social network. FGC does not only help in restoring ownership over one's own problems but also in gaining ownership over the

potential solutions. The outcome of FGC is a plan that is better aligned with the complex world of which clients are part.

Family Group Conferencing a means of social network involvement

The past two decades voices has been raised throughout the Western world that advocate for the inclusion of family and friends in the treatment of people with ongoing psychiatric problems. Specific interventions were developed which aim for the engagement of a person's social and family network, such as the Open Dialogue approach (Seikkula & Trimble, 2005), the crisis card and crisis plan (Sutherby & Szmukler, 1998), and Resource Group Assertive Community Treatment (Nordén et al., 2012). Family Group Conferencing fits well in this tradition.

FGC is a decision-making model that is based on the traditions and cultural practices of the Maori, the indigenous people of New Zealand. Much has been written about its origins and global implementation and for an international orientation we refer to Skaale Havnen and Christiansen (2014).

The essence of FGC is that citizens, also referred to as main actors, who experience problems, have the opportunity to develop a plan together with their social network. The plan describes how to cope with the problem and defines the roles of the different involved actors (Burford & Hudson, 2000). The social network is invited by an independent coordinator who plans a meeting at a convenient time and location for those involved. Not only family and friends are invited for the conference, but also concerned bystanders, such as neighbours and volunteers, are asked to join. The coordinator only facilitates the process. The coordinator contacts every potential participant and would optionally visit them at their home when the situation demands this. The coordinator is an independent fellow citizen who does not necessarily have a background in professional care. He or she is a communicator and mediator who is competent in making contact and gaining trust (Natland & Malmberg-Heimonen, 2014). The coordinator should be capable of gathering people with whom contact with the client has been faded, but with whom recovery is recommended. Especially the participation of these people can create momentum toward significant change.

When taking the above into account, it is not surprising that the preparation for a conference usually takes one to two months. The conference itself lasts approximately one to five hours and is divided into three parts (Hayes & Houston, 2007). In the first part information is shared that is needed to gain a better understanding of the problem situation. Also professionals are asked to share their perspective on the situation. These professionals are not only mental health professionals, but also sometimes police officers, housing counsellors and municipality workers are invited to join the conference. Crucial to the FGC is that

during the second stage the professionals and the coordinator withdraw from the conference. This so-called “private time” provides the main actors and their network the opportunity to come up with a plan that is fully drawn up by themselves. This part usually lasts the longest. It happens regularly that conflicts have to be resolved first before the network is able to establish a plan. Creating conditions so that emotions can be expressed is important during this private time. The sharing of dissatisfactions paves the road to recovery. When tension between the different actors arises then usually a proficient person tries to calm down the situation (Holland & O’Neill 2006). The coordinator may be asked to mediate when the network considers this as necessary. The private moment comes to an end when concrete actions are formulated on how to cope with the problem situation. The coordinator will then return to help the network drawing up a concrete plan. In situations that are characterised as unsafe, such as in a situation of an impending compulsory measure, professionals are asked to review the plan on efficacy (Macgowan & Pennell, 2002). After the conference the coordinator will work out the plan and send it to each participant of the conference. The role of the coordinator is then completed and it is the duty of the client and the social network to implement the plan and evaluate it over time.

The philosophical principles that underlie FGC are implicitly included in the above given description of its process. These can be summarised as: 1) widening the circle (Pennell & Anderson, 2005) – the idea behind is that the inclusion of people with a varied background generates creative ideas for potential solutions; 2) the private family time which is considered the ‘heart’ of the conference (Mirsky, 2003), as it is during this time that professionals withdraw from the meeting and the family therefore is given the chance to develop a plan on their own; 3) the independency of the FGC coordinator who is free from ties with state agencies and therefore has no interest in the outcome of the conference (Crampton, 2007); 4) establishing connections between the lifeworld of citizens with the system world of professionals so that both can optimally benefit from each other’s information (Burns & Früchtel, 2014).

There is a lot of experience gained with FGC in youth care. In this field, (multi-problem) families have proven to be able to draw up a plan and thereby, for example, avoid the threat of an outplacement of a child (see for an overview Skaale Havnen & Christiansen, 2014). The positive experiences with FGC in this field inspired us in 2009 to start pilots with this decision-making model in a completely new field, namely the public mental health care (Author’s Own).

Method

From 2011 to 2013, we evaluated 41 family group conferences in a PMHC setting in the north of the Netherlands. For each conference a case study was written on its process and outcomes. Specifically responsive evaluation methods were used to reconstruct the conference from different perspectives (Abma & Stake, 2014). In this article we focus on the process of two conferences where regaining ownership and social embeddedness were important outcomes. These two case studies show the potential of FGC as a means to regain ownership and self-reliance, and ultimately supports the process of recovery. We have highlighted specifically these two cases because they were exemplary for other cases we have evaluated where the main persons were socially isolated and got stuck in their recovery from psychiatric and addiction problems.

Context of the study

In the Netherlands, public mental health care (PMHC) is a field where people who avoid care or do not find their way to professional support (Author's Own), are helped. A PMHC network functions on the municipality level and is usually led by a psychiatrist. Most members of this network consists of community mental health nurses and social workers who assertively outreach to citizens who appear to be struggling with psychosocial and mental health problems and who are frequently homeless or socially isolated. Professionals in this field should be able to establish rapport with these people who often have lost confidence in regular mental health services. Empathy and perseverance are important features that professionals must possess to gain the trust of this client group.

In 2009, commissioned by the municipality of Groningen in the north of the Netherland, we examined whether the informal resources (family members, friends, neighbours and co-workers, but also the potential resources of the wider community) of PMHC clients can be utilised. 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 Author's Own). Experts we interviewed had the assumption that specifically for this underserved group FGC could

be the starting point of gaining ownership and recovery in a social context. The criticism that FGC would not work because of the social isolation where most clients find themselves in, was countered by turning this into an important reason for FGC, mostly because FGC can help in restoring contacts and formulate a sustainable plan where family, friends and concerned bystanders can play an important role.

In 2011 we received grants to study the process and outcomes of 40 conferences in the 23 PMHN networks of the province of Groningen. At the start of our project, we instructed potential referrers (community mental health nurses and social workers) in which cases a conference would be desirable (Author's Own): 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.

Finally, there were 41 cases included when we concluded our study in 2013. A total of 473 participants were involved in these cases. Apart from the clients (74 in total), the most significant respondent group in our study was the social network; 119 of a total number of 312 respondents. Furthermore, 77 professionals and 42 FGC coordinators participated as respondent. The majority of the cases were located in rural areas of the province of Groningen (26 of the 41 cases), the other cases were located in the city Groningen (with 200,000 inhabitants this is the biggest city in the three northern provinces of the Netherlands). Psychosocial (multi)problems were most common among the involved cases (20 out of 41 cases). 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 where psychiatric or addiction problems were paramount were low because we only categorised cases to these two groups where in fact psychiatric disorders or addiction problems were on the foreground. In most cases, the conferences yielded a plan (26 out of 41 cases). 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) (Author's Own). In most cases, clients could only rely on a limited number of resources and described their living situation as socially isolated. We saw that the social

isolation in these cases was only countered when enough family members and old friends with who contact had been faded were willing once again to be part of clients' lives. To ensure that these restored but fragile contacts would not once again fall apart, a certain degree of reciprocity appeared warranted.

Participants and data collection

In the two case studies that we highlight in this paper, all participants of the conference were asked to retrospectively reflect on its process and outcomes. Semi-structured interviews, using a topic list, took place in a period of one to three months after the conference. Everyone who participated in the conference or could reflect on it was approached for an interview. This means that in addition to the client, members from the social network, involved professionals and the FGC coordinator were interviewed. In the first case 8 interviews were conducted. In the second case equal number of interviews were also conducted. Interviews took place at a convenient time and location for the participants and lasted in between 30 and 120 minutes.

Data analysis

The aim of the case studies was to provide insight into the process and the outcomes of the conferences. This article solely focuses on the reconstruction of the process. The recorded interviews were first transcribed. Any ambiguities in the transcripts were presented to participants for reflection. The next step consisted of deducting codes and themes from the interview transcripts, along insights from the grounded theory approach. This was done on the basis of the following three steps. (1) Through open coding all the key passages from the interviews were selected and given a specific code name. (2) When all the interviews were coded, there was a check to see if there was any overlap between codes. As a consequence several codes were merged together. (3) The codes were finally clustered into themes. This action made it possible to outline the problem situation prior to the conference, as well as the reference to the conference. Additionally, it made it possible to outline what happened during the preparation towards the conference, how the conference itself proceeded (three phases: information sharing, private time, agreeing on the plan), and whether the plan got implemented and evaluated. The role of the FGC coordinator was also a theme.

Quality indicators

All interviews were conducted by two researchers in order to prevent blind-spots. The researchers were open to new insights that came to the surface during the interviews. This iterative process led to new topics, where in subsequent interviews participant were asked

to reflect on. The analysis was also done by two researchers. They had to find consensus in naming codes and clustering them into an overarching theme. Inter-coder agreement is a quality indicator in this type of research. Another instrument that was used to ensure the reliability and validity of the study was the organisation of group member checks (Guba & Lincoln, 1989). Results from the interviews with participants were presented in a focus group where they were questioned whether the researchers had interpreted the situation correctly.

Ethical considerations

The study met the European Union's guidelines for client-oriented research. Firstly, the expertise of the participants was emphasised. By only looking at the conference from all possible perspectives, we were able to reconstruct the conference in a way that matched the reality. The case study reports are anonymous and not traceable to place and person. Audio recordings and transcripts are stored until 2018 and subsequently erased.

At the start of this study, an advisory committee was formed consisting of representatives of the client's movement in the Netherlands, the local mental health care, addiction care organisations, and the 'Eigen Kracht Centrale' (the overarching organisation in the Netherlands who facilitates FGC). This committee approved the research proposal, as well as adaptations in the research process.

Findings

In this section we highlight the two cases. In the first case, we outline the story of a man in his late twenties who is deprived of social contacts and who uses cannabis excessively. The second case is about a middle-aged man with a long history in psychiatry and addiction problems.

Case 1

The young man that we describe in this first case has been known by the local addiction care organisation for several years because of his excessive cannabis use. His parents got divorced when he was young and his mother was left, then on, with the care of her four children. The man left home at a young age and became homeless after having lived in several shelters. His cannabis use increased and made it difficult to function independently. An admission, lasting six months, in an addiction care clinic followed. After this admission the man moved to a rehabilitation facility, where he lived with other ex-addicts. At that time he was working at an internet café, but due to a conflict with his boss, he decided to quit the job. Then he applied for financial aid for young people (in Dutch known as 'Wajong-uitkering'). In the meantime

his financial debts began to increase. This was the moment that his mother started managing his finances. The contact with other family members was broken and this meant that much of the care for the man landed on the mother's shoulders.

The current situation is that the man has no work and does not follow education. Because of his difficulties with the authority the man is not able to keep a job. The idleness of the days brings along boredom. He has no daily structure and therefore has relapsed into excessive cannabis use. The few friends he has are caught up in the same small world of idleness and cannabis use. The man has difficulties in managing his finances and therefore participates in a debt management plan. The following quote from the eldest sister sums up his situation:

Literally having the feeling of being stuck in life. He doesn't take care of himself in terms of food, he has money issues. And I think because that this is hard for him, he tries to survive by using cannabis, so it is all a little less overwhelming for him. [oldest sister]

Because he appears to be completely stuck in life and is at risk of eviction, as he has not paid the rent for several months, a family group conference is requested. It is his mother who takes the initiative. She wants to break with the downward spiral. She also wants the burden she is experiencing from caring for her son, to be distributed over several shoulders, especially since her son avoids contact with care providers. She is therefore deprived from professional support. His brother and two sisters already broke contact years ago:

I noticed that I removed myself from the situation even further; I don't know what to do anymore, I had the feeling that I am only making it worse. It does not result in anything good. [oldest sister]

From the beginning the man welcomed the organisation of a family group conference, especially since he himself would get a leading role and the participation of mental health professionals was not required. The FGC coordinator was able to win the trust of the man. His empathetic approach was appreciated by all those involved. It was decided to organise the conference in a meeting room of a local public facility, because this location was more formal than a meeting at one of the participants' home. In addition, nobody had to feel responsible for the role of host/hostess and everyone was able to have full attention to the content of the conference. However, the expectations regarding the possible outcomes of the conference were not high. His sisters and brother were sceptical:

I obviously had a lot of hope, but I also knew the reality so I did not expect too much. But Paul [fictitious name of the man] wanted it himself, so I thought at least that should be fine. [youngest sister]

All of the man's siblings decided to participate. This concerned his older sister, his second sister and older brother with their partners (all in their early thirties). Also their mother and a friend of hers (woman in her late fifties) were present. With his father he had a troubled relationship and therefore he did not want to invite him. The few friends he had he also did not want to invite as they got stuck themselves in heavy cannabis use. Most participants did expect that the conference would produce a joint plan on how to manage the finances properly and how to break through the social isolation. A plan to which everyone could contribute.

The preparation of the conference took four weeks. At the day of the conference, the man was picked up in a car by the coordinator. During the car ride toward the meeting the coordinator indicated that he wanted to discuss the cannabis use of the man with his family because it was possible that they would ask questions about this. Although the man did see the relevance in discussing this topic, he did not want it to be part of the plan. During the conference it was his brother who brought up his cannabis use. The man acted defensively and stated that this was not the main problem and explained that using cannabis was a coping strategy. It made him feel relaxed and ensured peace of mind. Eventually his family started to understand his situation and could be at peace with the way their son and brother described his motivation to use cannabis and that stopping with using it should therefore not be included in the plan – after all it was his plan.

The private family time continued in a relaxing manner and was described by participants as “involved”, “loving” and “open”. An important issue was that the man wanted more contact with his brother and sisters. His brother responded by indicating that the man himself also had to take more initiative. His mother's friend took a mediating role during the private time. This was because she was the only outsider and therefore was not completely familiar and involved with the problem situation. She ensured that everyone could say what was on their mind. Her role was appreciated by everyone:

The private family time did not escalate as at a particular moment one of the participants, actually the only external person who is not a family member, ensured that the conversation went in another direction so we could continue working toward a plan. [youngest sister].

Everyone had a positive feeling about the process of the conference. The man himself appreciated that he could indicate what he needed, instead of being imposed by professionals what to do. One goal of the conference was that the burden of care that the mother experienced would be distributed over several other shoulders. The oldest sister indicated that she would help her brother with finding suitable education. His brother and youngest sister, and their partners, would take more initiative to meet up with him and also give him money for the train so he can visit them. Furthermore it was agreed that the man would help his brother with the renovation of their house. The progress after the FGC was mentioned by the man as follows:

I am perceiving myself in a more positive way after the FGC, especially after hearing how other people perceive me. [client]

However, the implementation of the plan stumbled across some difficulties. There was confusion about each other's role and the distribution of tasks. This was partly because there was not a moment planned for the evaluation of the plan. Despite these issues, the family ties were strengthened and the man got the feeling that he was not any longer left on his own. Also, an improvement was seen in the structuring and planning of his daily life. He says the following about this:

I did enough to get through the day and that was about it. Now I do more. The things I have set in motion, started all on my own initiative. Before the conference I was motivated but easily lost motivation as well. Now it is easier to remain motivated. [client]

After the conference, the man experienced a greater understanding among his family for his living situation. They now recognise that his cannabis use is as a form of coping.

The group member check that followed the interviews brought a new perspective. Because his family was not any longer as critical about using cannabis, the man started to look from a different perspective at his drug use. During the group member check he even mentioned that he wanted to stop using completely. Besides the peace of mind, he also became aware of the disadvantages of the cannabis use for his health. He now wants to experience what life without cannabis use is like. Though he does not have a clear cut plan for this yet:

An alternative for using cannabis could be yoga or another sport, but first I have to stop using it and then I will see what to do. [client]

Case 2

The client in this second case is a single man in his fifties. Twenty years ago he was addicted to alcohol and drugs and eventually became homeless. He also suffered from psychosis which led him to social isolation. Since a few years he has a home and lives with his two dogs, which mean everything to him. The man describes himself as someone with a slightly obese posture. He weighs 153 kilograms. Walking long distances is difficult for him and he uses a rollator. He wants to lose weight and is on the waiting list for a gastric bypass surgery. This surgery means that he will be away from home for at least four days and he is deeply concerned about the welfare of his dogs. He has lost two dogs in the past and this caused him a lot of pain. He does not want something like that happening again. The planned surgery brings along a lot of tension. What makes it extra burdensome is the lack of a social network on which to fall back. Contacts with friends and relatives have weakened over the years. There is, however, still contact with a brother, an old school friend and a younger man who is currently renting a room in his apartment. Occasionally there is some contact with neighbours, though he is reluctant to ask them for help. A family group conference is requested by his case manager from the mental health care in order to draw up a plan for the period during and after the surgery and to widen the social network:

He is reluctant to ask people who he knows vaguely for help. He really needed a helping hand. [mental health professional]

The FGC coordinator saw the necessity of the participation of his neighbours and was able to persuade the man to invite them to the conference. This was tough for the man because he was fearsome that the coordinator would talk about him behind his back:

I am always like “What the hell, I’ll do it myself!” And then all of a sudden you have to ask people for help. That is not my nature. [client]

The coordinator, then, decided to have an open conversation with the neighbours and continuously engage the man in the preparation towards the conference. In this way the man would not lose his motivation. Two neighbours were, immediately, willing to participate in the conference. Besides the neighbours, also his brother and the long term friend decide to participate as well as the young man who is currently renting a room in the apartment of the man. On the other hand, due to time inconveniences both his addiction care as mental health care case managers were not able to participate in the conference.

Due to his walking difficulties, the conference took place at the man's home. The atmosphere was relaxed and the tension that the man initially experienced, rapidly decreased. During the private time the care for his dogs was discussed:

It was actually just about his dogs. They were his main concern, as well as the housekeeping. If he could not manage that alone, if we could help him with that. And he would get a gastric bypass surgery. That was also mentioned, he was anxious about that and if we could stimulate him so that he would undergo the surgery. [neighbour]

The neighbours said that they were willing to help him out when needed. This meant that in the conference they quickly moved to discussing practical issues as exchanging phone numbers and who to call in case of an emergency. When everyone had agreed on this the coordinator was asked to join the group again. The main points were further concretised and the coordinator would incorporate them into an action plan.

Afterwards, the conference especially ensured a calm state of mind for the client. The man knows that if he undergoes the surgery he has a social network that will support him and will take care of his dogs:

It is now organised in a good way. He is calmer and he knows that everything will work out because we know what to do. [brother]

But perhaps the most important outcome is that the social network has been expanded. The contact with the neighbours has been established and the relationship with his brother and the friend has greatly improved. The contact with the neighbours is appreciated by both sides:

More commitment, supporting each other, sometimes you visit each other. [...] I also never had such nice neighbours before. [client]

At first he thought he had to solve everything on his own, but that was not the case. This is because he came from a neighbourhood where he did not live pleasantly. He did not have any relationship with his neighbours there and had to deal with everything on his own. And now it's a different situation, I will do anything for him, he is a special person to me. [neighbour]

The involved mental health professional has the impression that the demand for her support has decreased after the conference. She visits him less frequently nowadays and he appears less lonely. She notes that the man seems happier, and that the neighbours help him out wherever they can. She indicates that he has other people who he can rely on. She now visits him only once every three weeks instead of every week.

Three years after the conference, the gastric bypass still did not take place. The social embedding provided enough emotional support to prevent the man from relapsing into binge-eating. A neighbour started to encourage the man to join him to go to a fitness centre and his body weight has therefore gradually decreased.

Discussion

Recovery is about “rebuilding a worthwhile life, irrespective of whether or not one may continue to have particular distress experiences” (Tew et al., 2011, p. 443). On the basis of their systematic review, Tew et al. (2011) state that recovery is not only a journey of personal change, but also of social re-engagement, which underlines the essence of social environments that are supportive to the recovery of people with ongoing mental health issues. They identify three central themes to recovery: empowerment, identity, and connectedness. Looking at the cases highlighted in this paper, as well as the other family group conferences we have studied, FGC holds potential as a catalyst for the recovery of people with ongoing mental health issues. Especially as it empowers them to come up with a plan together with their social network, it encourages their self- and group-efficacy. It emphasises their strengths and capabilities rather than their disorders, weaknesses and incapacities. It reconnects ties with family and friends, and ultimately ensures social embedding.

The two cases have ‘exemplary value’ for other cases where FGC can be considered (e.g. Abma & Stake, 2014). What both cases show is that FGC holds potential as a catalyst for recovery within a social context and the retrieval of ownership. For many years, both men experienced a decrease in social contacts. What remained, were the few contacts with relatives who did not want to abandon them. When the social network decreases, social isolation is usually not far away, and what we see with the client group of the PMHC is that professionals tend to fill the gaps (Author’s Own). Recovery, on the other hand, is about taking back power and control, and therefore about active participation (Bonney & Stickey, 2008). This pattern was especially true for the man as described in the second case. The man had two case managers, one from addiction care and the other from mental health care. Both of them had frequent contact with the man. However, after the conference the mental health case

manager mentioned that she was less involved in supporting the man because his neighbours got increasingly involved. Three years later this was still the case and she only had sporadic contact with the man. Besides the new contacts, the relationship with his brother and a friend also improved.

Restored and intensified contacts with family was also a striking outcome in the first case. Before the conference the brother and two sisters of the young men had already broken contact a long time ago. Only his mother remained involved, even though the burden of care was pressing heavily on her shoulders. After the conference the brother and sisters offered practical support and the opportunity to do something pleasant and relaxing together. This shift towards greater equality and the essence of reciprocity are indicated as key components of recovery in a social context (Tew et al., 2011; Topor et al., 2006). The brother and sisters also expected something in return, for example that he should help with the renovation of his brother's house and looking after the dog of his youngest sister. This could have given the man the feeling that he matters as a person and implicitly this could have had an impact on his decision to change his excessive use of cannabis. The man was no longer only the owner of his problems, but became also the owner of potential solutions. On the other hand, these positive results are vulnerable to confounding. To ensure that clients do not relapse in old patterns so that their network once again will give up on them, besides family, friends and neighbours, also the involvement of volunteers and peer-supporters who can help in the recovery journey of both clients and their network can be considered (Author's Own).

Methodological reflection

Abma and Stake (2014) argue that the strength of the qualitative case study lies in the lessons that can be learned from it. A frequently articulated criticism is the lack of transferability of findings in a case study research (see for a reflection and counter argument on this Flyvbjerg, 2006). 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 were therefore aware of that the context of the cases we studied should not be overlooked, otherwise it would have been difficult to distil lessons from the case studies and make clear why the family group conference in a corresponding context may (not) have the chance to succeed. The cases we have highlighted are highly bounded to their context. Describing the process of the conferences from a single perspective was not sufficient. That is why in both cases we interviewed the client, members from the social network, professionals

and the FGC coordinator. The shared perceptions provide a compact insight into the process and outcomes of the conferences. We also worked with several researchers who differed in background and experience. When deemed necessary, junior researchers were trained in conducting interviews or they collaborated with an experienced researcher during the data gathering and analysis. For the purpose of reliability the researchers met with each other frequently so they could reflect on the collected data and their analysis (peer debriefing). Furthermore, a topic list was used and interviews were recorded and subsequently transcribed. Finally, we used different data collection methods (interviews, focus groups, participant observations) to increase the reliability and validity.

Conclusion

FGC provides fertile ground for ownership and recovery. This is a key finding from both the study we carried out in PMHC as well as the study into the use of FGC in compulsory treatment in psychiatry. In the featured case studies, both men had an abrasive relationship with mental health care and its representatives. This was mainly because of the disempowerment they experienced during their journey in mental health. It is still common that people with psychiatric problems are defined exclusively in terms of deficiencies, disabilities and diseases, and therefore not being capable to form and maintain normal social relationships (Schön et al, 2009; Topor et al., 2011). When these people are seen as sick patients with all their shortcomings, then professional expertise is quickly favoured above laymen's knowledge. FGC seems a promising tool to shift the attention from disorders and inabilities to capacities and the rediscovery of social resources. The two cases we have highlighted reveal two important conditions for its success. First, a significant number of PMHC clients do not want to change for professionals, but they for their family and friends they do want to change. Second, FGC provides a platform for restoring relationships. A platform whereon the client dares to discuss shameful feelings and the social network has the chance to express their concerns. Consequently this platform helps breaking through the embarrassment to ask for and provide help.

The role of professionals in FGC should not be overlooked. In our study we saw that most clients were referred to FGC by their case managers. The majority of these case manager were nurses and social workers. These professionals traditionally fulfil a supporting role and try to complement the shortcomings of their clients. The strength of their actions lies in the therapeutic relationship they develop with clients. The realisation that a one-sided focus on promoting individual well-being is not sufficient, slowly begins to settle ground

among professionals working in mental health. FGC does do justice to the recovery in a social context, and therefore should be considered by professionals from the start of a therapeutic contact as an appropriate tool to generate sustainable results for this client group.

On the other hand, the shortcomings of people with mental problems should also not be swiped under the carpet. As already indicated by Topor in 2001 during his ground-breaking work into the recovery of mental health clients in a social context, there is a recurrent theme running through these practice stories of recovery. That people in their everyday lives are not reducible to their problems, but at the same time these problems must not be denied. That people have both weaknesses and strengths, sometimes existing within the same spheres of life and occurring simultaneously. That in relationships with other people they are given scope to manage and living with these contradictions is of central importance for recovery practices.

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Chapter 6

Family Group Conferencing in coercive psychiatry: on forming partnership between the client, social networks and professionals

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Abstract

Family Group Conferencing is a new decision model to assign caring responsibilities among various actors in society, including the client, social networks and professionals. The process of Family Group Conferencing in coercive psychiatry is delicate, nevertheless it paves the way for courageous conversation, it facilitates ownership over the problematic situation and the formation of a partnership. Different actors co-construct an open and new actuality by taking initiative during and after the Family Group Conference; by confronting each other; by sharing information about the situation and so forming a partnership. Family Group Conferencing requires a change in thinking and doing of mental health professionals that is close to nursing; instead of focusing on the treatment of individual clients they support primary groups to deal with the situation at hand.

Introduction

Research from Wittenberg, Kwekkeboom, Staaks, Verhoeff & De Boer (2017) showed that roles of informal caregivers, like family and friends, are not always taken into account and discussed in the care for people with psychiatric problems, and that the division of different caring responsibilities is sometimes unclear. They argue that an explicit discussion on the assignment of caring responsibilities is necessary to realize good collaboration; professionals should build a relationship with informal caregivers wherein they explicitly discuss divisions of care with informal caregivers. Family Group Conferencing (FGC) offers a new decision model to discuss caring responsibilities for clients.

FGC facilitates persons and their social networks to deal with problems in a way that is consistent with their own culture and lifestyle (Jackson & Morris, 1999). It is a family-oriented approach that has its origin in New Zealand's Maori tradition; recognizing the importance of collective responsibility for families and near community (Doolan, 2012). Studies showed that FGC can bring families and social networks closer together, strengthen family and network ties and widen the circle of support for those dealing with a problematic situation (Frost, Abram, & Burgess, 2012; Skaale Havnen & Christiansen, 2014). Sharing stories and different perspectives on a problematic situation (which was the reason for organizing a FGC in the first place) can lead to more understanding and generate ideas to deal with the situation.

In a FGC an individual dealing with a problematic situation (or in the case of this study a client) is referred to as a main actor (we will use both main actor and client). Main actors set the agenda for the conference and decide who is invited (for example family, friends, neighbors, professionals). The FGC coordinator has a facilitating role in this process and supports the main actor in the preparation of the conference. In our context (The Netherlands) the function of the coordinator is characterized by an independent position, meaning that he or she is not on the pay roll of a welfare or healthcare organization. Coordinators do not meddle with the content of the situation, they widen the circle of support by visiting (potential) participants of the conference and have no interest with regard to the outcomes of the FGC (Skaale Havnen & Christiansen, 2014).

The process of a FGC has four different stages. In the first stage a referral to the FGC has to take place, this can be done by the main actor, a family member or professional. A coordinator is then matched to the situation and asked to support the preparation of the conference and facilitates the conference in the other stages (second stage). In the third stage the conference takes place. This is usually one or two months after the referral. The

conference itself has three different phases; in the first phase information is shared between the participants. Professionals can share information that could be used for drawing up the action plan that is made in the next phase. In the second phase the coordinator and professional(s) leave and the main actor and other participants (social network) discuss the information and develop a plan to deal with the problematic situation of the main actor. In this plan activities to deal with the problematic situation and the roles of the different participants are described. At the end of the conference the coordinator and professionals come back and the plan is finalized; one of the participants is appointed to monitor the plan. Monitoring and adjusting the plan is known as the fourth stage of FGC (Skaale Havnen & Christiansen, 2014). For more information on FGC and underlying principles we refer to our other article in this journal (Schout, Meijer & De Jong, 2017).

We discussed the added value of FGC in (public) mental health care in this journal and underlined that FGC provides a possibility to realize partnerships between clients, their social networks and professionals (Schout, Meijer & De Jong, 2017). Based on a quantitative study we demonstrated that FGC is a promising way to inhibit isolation, restore ownership and strengthening or widening the circle of social support in the context of coercive psychiatry (see De Jong, 2014; De Jong & Schout, 2011; Meijer, Schout, De Jong & Abma, 2017). The purpose of this article is to understand the process of FGC in the context of coercive psychiatry in order to further discover its opportunities and limitations in forming a partnership between clients, their social networks and mental health professionals.

The study

Design

This article is based on data drawn from a study into the process (qualitative) and impact (quantitative) of (the preparation of) FGCs organized for clients who were at risk of coercive treatment in psychiatry, in the Netherlands. In this article we will focus on the process of the FGC based on qualitative data. The impact of FGC in coercive psychiatry (quantitative data) is reported on in Meijer, Schout, De Jong & Abma, 2017. The study took place between 2013 and 2015. FGCs were organized in three regions in the Netherlands in collaboration with three mental health institutions (Groningen, Noord-Holland Noord, Eindhoven). The 41 FGCs were facilitated and organized by ‘de Eigen Kracht Centrale’; a national foundation that is responsible for organizing FGCs in the Netherlands. The coordinators are affiliated with ‘de Eigen Kracht Centrale’, but are not employed by this organization.

A responsive evaluation within a case study framework was deployed to study the process leading up to the FGC and the process and the proceedings and the impact of the conference itself. Responsive evaluation is an approach to evaluation aimed at deriving more insight from the insiders perspective; responsive to issues, values, experiences and interests of different stakeholders and their context (see Stake, 2004; Abma, 2005). This design was used to address the deliberative and exploratory nature of the study, where experiences of participants on the process and impact of the FGC are central (See Abma et al., 2016; Abma, et al., 2009; Stake, 2004).

Every client and the FGC conference for this specific client was a case in this study and seen as unique. Although the study consisted out of 41 cases this allowed us to gain insight in the particularities of the cases (Abma & Stake, 2014). We aimed at comprehending the different cases in line with the tradition of 'Verstehen' (understanding from a first person perspective); meaning that 'it is not so much the factual world that interests us, but the interactively constructed meaning endowed to the world (Abma & Stake, 2014, p. 1152). We made a case report of each case that reflects the meaning and context of that case, in order to understand the particularities of the case. In this study, the data was enriched with theory. The data collection and analysis followed an iterative process; as theory was not imposed a priori but gradually plugged in on the basis of findings, for enrichment of data and deepening of insights. The researchers were not part of the actual FGC, but retrospectively monitored how conferences were introduced, how clients were included and assessed the meaning and value of the FGC afterwards with interviews and focus groups.

Participants

At three mental health institutions in the aforementioned regions, the option of a FGC was a consideration presented to clients by mental health professionals. Clients were included in the study when there was an imminent or actual coercive treatment at hand or a history of recurrent coercive treatments was present. All clients needed to have a municipal bond to one of the three regions. The participants in this study were the attendees of the FGCs: clients, family members, neighbors, friends, colleagues, professionals (primarily community mental health nurses and psychiatrists) and FGC coordinators.

From data to thick descriptions in a case report

Attendees to the conferences were individually interviewed on the process and impact of the FGC one to six months after the conferences took place. A total of 289 interviews,

about 41 FGCs were conducted by the research group. The interviews consisted of open and closed questions and lasted approximately 1 hour. These were conducted with a topic list on the situation prior to the conference, the conference itself and the situation after the conference. The interviews were recorded, transcribed and summarized in a case report with preliminary conclusions of the process and impact of the FGC. This was discussed in a member check with the participants of the FGC (Lincoln & Guba, 1985). In addition, participant observations were conducted to understand the process of organizing FGCs, including communication among attendees and their interactions, and led to fieldnotes. The fieldnotes and interpretations from interviews and member checks were described by the researchers, with theoretical and empirical memos, and discussed within the research group (Emerson et al., 2011). This resulted in so-called ‘thick descriptions’ (Abma & Stake, 2014).

With insights from the multiple case study approach generic themes that bind the cases together were identified (Abma & Stake, 2014). We discussed the data from the different regions, searched for themes and patterns that we encountered multiple times and that seemed underlying the cases.

Validity, reliability and rigour

Perspectives from different actors were included to obtain a rich and multiple understanding of the process of FGCs in coercive psychiatry. Interviews per case continued until no new information and no new insights on the process or impact of the conference popped up; this is an indication of methodological quality and refers to saturation of information (Guba & Lincoln, 1989; Guest et al., 2006; Small, 2009). Finally, triangulation took place in different ways, by comparing findings between the different methods (interviews, member checks and participant observations); by comparing findings between different cases and regions; by comparing findings between researchers; and by comparing findings between different participants within one case.

Ethical considerations

The research proposal was presented to the scientific research committee of the VU University Medical Center and the three mental health organizations that contributed to the study: Lentis, GGZ NHN and GGzE. The study was approved under the condition of informed consent, taking into account safeguards concerning privacy, anonymity and confidentiality.

Findings

The outcomes of FGC in coercive psychiatry will be discussed through different themes and stories that show what was going on in the 41 cases. The themes will be discussed in two parts: (1) outcomes of FGC in coercive psychiatry and (2) conditions in forming a partnership.

Part I: outcomes of FGC in coercive psychiatry

Ownership over the situation and taking initiative after the FGC

Several clients mentioned that the FGC contributed to their feelings of ownership (the feeling of having control) over the situation. For example, appointments and agreements with family and friends, gave more structure to the life of clients, served as an extra motivation or ensured that a client could get used to the daily rhythm of ‘normal life’ after being admitted to a psychiatric hospital. Clients indicated that agreements made with loved ones are serious; more serious than those made with professionals:

Since it – the agreements- is written on paper, and I said “yes” to it, I cannot fool myself anymore and try to get away with it by not complying to them. That does not make it easier for me, however it does make it more serious. [Client]

In a number of FGCs, explicit attention was paid to the ‘crisis alert plan’ to prevent crisis situations; this was often brought up by the clients and involved professionals. This ensured that social networks had an overview of the signals that indicate that a crisis situation was emerging. The agreements in the FGC plan also provided more grip for the immediate family, they experienced more control over the situation because the burden of care was divided over several shoulders:

...Now I know my sister or mother is visiting him and I don’t have to worry; I have more peace of mind. Before I had a dormant feeling because I knew that he was home alone and unhappy and that affected me of course. So this give me more peace of mind. [Family member]

There were also several cases where those involved did not experience more control over the situation after the conference, because nothing really changed; this was, for example, the case in situations where the client did not show any initiative or ownership with regards to the plan that was made. Family members or friends were sometimes really clear about their expectations:

But we've always said, we're not going to motivate and encourage him, he has to do it himself...the agreement was that he would take initiative, if he doesn't do that.. he has to deal with the consequences. [Uncle]

These fragments show that gaining ownership over the situation could be complicated and challenging at the moment that different actors did not take initiative in the situation; the conference then had little impact.

Belongingness and widening the circle of support

In the process before the conference, it sometimes happened that clients were hesitant in involving family members. They wanted to protect them and did not want to burden them unnecessarily:

I thought: I already have so much professional support, what can this contribute? I also did not want to do an appeal on my social network them [e.g.- the social network]. I knew for sure that I wanted to have my girlfriend and my sister there, but yeah.. then they were also burdened with my situation. [Client]

The cases show that by discussing the problem and asking support from those involved during the preparation of the FGC, already changed the relationships. There was more understanding for the client's situation amongst family and friends, and sometimes they came to the realization that the situation was more critical than they thought; the problems related to their mental health, finances or housing were more severe. This led to a stronger involvement, support and willingness to take action. In several cases it was also mentioned that the circle of those involved had increased after the FGC:

That is what a conference is for, I think, to support [name client] and to literally say: "Here we are, we are there for you". And if you need support, just ask it. So we literally told him that we support him and that we are there for him. Others in the family have also opened up to him now. First they did not want anything to do with him and now they are committed to supporting him too. So it – the conference – has done a lot of good. [Family member]

However, there were also family networks where it was difficult to divide tasks and make plans, especially when the family experienced a lot of burden. These networks had often lost their energy, did not know how to deal with the psychological vulnerability of their relative and did not want to be involved anymore:

Family members have tried a lot in this situation, but at a certain point they could not reach him anymore and invested so much in it – in the situation- that they said we are going to let go now. Because they could not handle it anymore. [professional]

In some cases the FGC alone was not enough to widen the circle of support and to mobilize more people. The fragments below show that in cases of severe and ongoing mental health problems the role of continuous and durable professional support is crucial in forming a partnership with families and friends; they need to know if a professional is there to back them up, especially in crisis situations, before they express commitment to support the client (again). We will discuss the role of professionals further on in this section and in the discussion.

And for us, that our care – for the client - was taken care of, because my father did not sleep at a given moment. He did not go to work anymore or he went to work occasionally. He could not handle it anymore, so much worries [...] So yes, at a given moment you will suffer from it yourself, or there are people who suffer so badly that they will experience consequences in their own lives themselves. [Family member]

The last four member checks make it clear that family members dare to participate in a conference if mental health professionals are a continuous factor, are available to the family and are clear about their role and responsibilities. As soon as they experience doubts about the accessibility or availability of the mental health professionals the family members are reluctant to actively participate in the conference and take responsibility in the plan that is made. (Empirical Memo, no. 40).

Part II: conditions in forming a partnership

Disclosing shameful feelings and embracing vulnerability

The experience of shameful feelings was a barrier when inviting people for the FGC. Clients and close relatives did not always dare or wish to widen the circle of support and involve too many people:

I constantly had the feeling of; I really have to cross the threshold

and go to someone again, give them an explanation about the situation I'm in. And invite them to the FGC...[client]

The psychiatric problems of the clients were often accompanied by shame and (self) stigma:

The constant comparing with other people and then uh yes, saying: 'I'm lying in the gutter and what have I done with my life' and stuff like that. And also, well that does not have anything to do with his depression maybe. What I noticed when we meet with our eating club is that he found it very scary, very exciting to come into a social group. [friend]

Asking others for support required openness from clients and their relatives, people sometimes had to overcome embarrassment and were challenged to confront their vulnerability. If participants experienced troubles related to the foregoing this could have as a consequence that the situation was not discussed openly. Ultimately this could lead to a situation wherein the plan did not meet the needs of the client or to what the social network needed or could offer. On the other hand, it also occurred that a FGC was a reason to break with taboos and prejudices in social networks and contributed to strengthening the relationships.

Avoiding confrontations

We saw that the loved ones sometimes avoided the confrontation because of what occurred in the past. They focused on the future, avoided confrontation and did not make an effort to discuss concrete agreements; with the result that plans were not concrete enough regarding to boundaries and expectations.

In some cases where participants made plans in the conferences, these plans were later labeled as “romantic” or insufficiently capable of preventing new crisis situations. The plans did not provide a clearly defined path; there was little regard for the various relationships and underlying expectations and insufficient attention was paid to the concreteness of the plan. Some social networks did not seem to have the capacity to come to a plan that could meet the needs of those involved in the crisis situation, in the conference they avoided discussions about difficult situations:

We did not discuss – in the conference- his psychiatric problems, which he experiences regularly. [family member]

There were some social networks that wanted to keep peace and did not took the effort to confront the client, because they were afraid of losing contact, leading to social isolation of the client. In many situations those involved were ready to take responsibility and did not avoid ‘the place of difficulty’ as they participated in the conference, the following memo illustrates this:

During the member check it becomes clear that the client (who's situation was a motive for organizing the conference) is satisfied with his quiet and peaceful life. In the conference this was not discussed, attention was given to the point of view of the family, they think he should make more of his life. The family did however not participate in the member check and avoided the 'place of difficulty'. Perhaps because the family was absent, the client stood up for his own opinion about his life. [Empirical Memo, no. 44]

The above example illustrates what we often encountered in our study; in the conference participants were involved and made plans with each other. But in hindsight it became clear that actors did not always confronted each other and did not discuss different expectations.

Change of attitude needed amongst mental health professionals

The logic of a FGC with an independent coordinator, a conference that takes place outside the mental health care organization and where professionals contribute to a plan that the family group makes, is distant from mental health practice. Professionals had to discover how to deal with situations that occurred during the FGC and which roles and responsibilities they had.

There were families and friends who were suspicious of the mental health care organizations that the professionals represented, through experiences with these organizations. They felt abandoned but wanted to be heard. The following fragment illustrates the foregoing and shows that the family eventually seemed to need recognition from professionals:

We also felt left alone by all the professionals, they only had attention for her, while she was actually the problem. There has never been a conversation with us, no one ever talked to us. So at one point we were done with them. I have called all general practitioners, all kinds of mental health professionals and some of them did not even want to talk to me, only to her [the client]. That was the end of it. [family member]

It was indicated by family, friends and neighbors that they were happy to meet the professionals and to exchange information during the conference. Professionals could respond to this for example, by providing information about the problem (in consultation with the client). In the few situations in which the latter occurred, we often saw positive outcomes; the client continued to work on his plans for the future, together with family, friends and professionals:

.....because you just know each other, in terms of face to face contact, because you have a lot to do with each other, the line is short, so that makes it easier to stay in contact and

reach out to each other. And maybe that is the advantage of the FGC in this case, that the thresholds are gone when it comes to contact – with the social network.

[Professional]

It is important to note that this support by professionals led to shared control and not to more coercion. In some cases, we also saw that professionals felt it was important to ensure that the situation prior to the FGC was as optimal or comfortable as possible for the client. But also afterwards; ensure that the process after the conference is as positive or hopeful as possible:

The plan described what the professionals from our organization had to do. The part of the network was completely missing. So I sent the plan back and they- client and social network- will soon come together to adjust it. This is the second time I have sent the plan back to them. I want to read what the social network can do at the moment that the client faces a crisis situation. For example visiting him, people going on trips with him, some housekeeping and administration maybe. In the plan this is not described. They have to discuss this further. The family keeps me well informed about this process. [Professional]

We also saw that professionals had different attitudes towards the FGC and its process; sometimes they found it hard not to interfere in the situation or the FGC rose awareness of the importance of involving family in the treatment of clients. Supporting clients and their relatives, however, was experienced as difficult; and was sometimes distant from professional work-routines. The following fragments exemplifies this:

He ([the involved professional]) also said to me at the end of the conference, you have to think about this and about that - with regards to situation of the client and family. I said; I do not have to think about anything, just let the family do the thinking. He could hardly let that go, but that is his role. He is good at his job and is someone who stimulates ownership over the situation. Still, I saw that he found it difficult to let this go. [Coordinator]

The facilitating role of the coordinator

The coordinator had a facilitating role in the process of forming a partnership. This role was valued positively when they were able to give guidance to the conference, as a prelude to a plan that offered support. Coordination with the client and the network, but also with professionals (with regards to coercive measures), was of importance and was sometimes missed. A clear structure and procedure of an FGC gave the participants grip on the process:

So I had a very clear assignment, which I also prepared with Mrs. So for me it offered a lot of clarity in that sense; that I could prepare myself very focused and knew what I could or could not do [in the FGC]. [Professional]

There were however, also situations wherein the coordinators saw that the discussed plan was not very concrete and sometimes struggled with their role, as illustrated in this fragment:

Nothing was mentioned- in the plan- about helping with things or doing something together; it was all about what the client should do. I tried to facilitate them in this, actually I do not allow myself to interfere with the content, but I did that a bit. It was good that they all came together in the conference and talked – that was good and valuable in itself, but more could have been done. [coordinator]

Discussion

Melief (2011) points out that there are many nursing theories, perspectives and views on the essence of the nursing domain. Her work and that of Kim (2012) underline this variety, but central views are that nurses support self-care and empower clients to care for themselves, and to manage their symptoms and their life transitions by utilizing available resources and creating new resources. Nurses focus on affecting the ability for coping, self-care, human becoming and adaptation; not only for individuals but also for communities. These central concepts separate nursing's orientation from that of disease (Kim, 2010, p.4-5). Supporting and facilitating of informal structures, such as families and communities who are engaged in caregiving, helping individuals, families and communities to cope with the stress of illness and life events is central to many nursing theories (see Melief, 2011, p87-108). Helping to cope reflects a modest rhetoric; a rhetoric which fits the way of thinking in the field of FGC. Mobilizing resources from family and communities is central in both lines of thought.

The process of FGC is however complex and builds on the contribution of different actors; the client, the involved social network, professionals and the FGC coordinator. A FGC can contribute to feelings of ownership over the situation (the client is in) and to a stronger involvement and support amongst social network members. Many factors determine the success or failure of an FGC, but the commitment of these actors is essential. Schout & de Jong (2018) mention, however, that professionals, such as nurses tend to underestimate client capabilities of the client and social network and overestimate professionals capacities. They argue that this is the result of bureaucratization, legalization and risk aversion. These market

driven incentives together with an emphasis on privacy legislation and ‘medicalization’ are an obstacle in mobilizing informal support in psychiatry. FGC requires a change of attitude for mental health professionals; it means more than involving family in the situation of the client. Instead of focusing on the individual clients, professionals support the primary group to deal with the situation at hand; with their expertise they contribute to the plans of clients and their social network taking over as little as possible; validating their commitment and control over the situation. Schout & de Jong (2018) describe this professional stance as ‘egoless’ care; where professionals mobilize social resources, and have confidence in the ability in the group to deal with challenging situations.

Jansen et al. (2015) developed a partnership framework as a practical tool to facilitate dialogue between different stakeholders, consisting of four components: values, relations, actions and conditional factors. They based their framework on Hook (2006); who identified eight partnership facets between clients and professionals: relationship, power sharing, shared decision-making, patient autonomy, shared knowledge, participation, communication and professional competence. These elements are relevant in the forming of a partnership between the different actors in FGC. They show the importance of disclosing shameful feelings, embracing vulnerability, confronting each other and discussing different expectations between the involved actors. Furthermore the framework stresses, just as this study, that professional competence is important when it comes to shared decision making.

Additionally participants of a FGC need to be challenged by mental health professionals and the FGC coordinator to discuss difficult situations and confront each other about their expectations and roles. The concept of ‘courageous conversations’ fits well here. This concept is often used in work on race and gender or social justice and encourages to take risks in conversations, speak the truth and experience discomfort instead of avoiding it (Singleton & Linton, 2006; Singleton & Hays, 2008; Arao & Clemens, 2013). Arao & Clemens (2013) complement this with the suggestion of cultivating “brave spaces” instead of “safe spaces”; where courage is needed in the dialogue with others. If you have to embrace your vulnerability, courage is required and this is rewarded with a deeper understanding of the situation and mutual trust. Courageous conversations can pave the way to forming a partnership; as mutual trust is being built this way and underlying expectations are discussed. An FGC can facilitate a dialogue on values, relations, actions and conditional factors in forming a partnership. Further research into the facilitation of courageous conversations in a FGC seems necessary.

Limitations

Our intention was to continue with conducting interviews per case or conference until there were no new information and no new patterns. This is an indication of methodological quality, refers to saturation of information (Guba & Lincoln, 1989; Guest et al., 2006; Small, 2009). In one single case it was only possible to reconstruct the process of the FGC from the perspectives of the FGC coordinator and involved professionals. As the research project progressed, different patterns emerged between the conferences; at one point reviewing new cases would have probably provided little new insights. The researchers did not participate in the actual FGCs, they were however closely involved in the organization and discussed with FGC coordinators the organizing of conferences – developing a comprehensive image from multiple perspectives was therefore important.

By looking back on the data from a more nomothetic perspective different themes emerged that run through the cases. New themes were uncovered, like the input of theory on courageous conversations, which provided a new and deeper insight that can be used to reduce coercion and strengthen partnership in psychiatry.

Conclusion and implications

The process of FGC in the context of coercive treatment in psychiatry is complex, as it builds on the input and commitment of different actors. Together these actors enact an open and new actuality enabled by the platform of a FGC. This study shows that FGC has the potential to provide a learning platform for partnership between professionals, clients and families affirming ownership and empowerment of the latter. It is of importance in forming this partnership that vulnerability is embraced and that courageous conversations are started. Furthermore FGC requires a change of attitude for mental health professionals; instead of focusing on the treatment of individual clients, they need to support the primary group to deal with the situation at hand and contribute to the plans of clients and their networks, with their expertise. Mental health professionals need to understand hesitations and fears while encouraging actors to take part in ‘brave spaces’ instead of avoiding them. By studying this process further; with explicit attention for the pitfalls and possibilities in starting courageous conversations and creating a partnership, the application and potential of FGCs in psychiatry is explored.

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On forming partnership between the client, social networks and professionals

Part III



Relational complexity in family and network support

Intermezzo 3 'the peat'

Someone from Pekela - a Pekelder - is also called a "roegbainder". This can be traced back to the peat colonial history of Pekela and refers to someone who spends all day working up to the knees in the peat, getting dirty.

The fact that I, without doubt, was part of a close community does not mean that I did not see and understand (relational) complexities, tensions and struggles that co-existing in (whatever context) irrevocably brings along. In this research into the relational complexity of family and network support in psychiatry, I have also been able to draw from my own experiences. Although often not as impetuous as in the stories of the people that my thesis revolves around, my experiences illustrate the complexity of our relationships with family and friends.

Where I first wanted to systematically dig the peat at a brisk pace to get answers to the research questions asked, I discovered, also by reflecting on my own experiences, that our relationships with family and friends can better be described as soggy peat. I had to muddle through as a researcher and as a partner, mother, (grand) daughter, sister, friend or colleague. Whether or not to provide emotional or practical support is not by definition a matter of (un)will; all kinds of ambivalences play a role. I also experience my own moral ambivalences, and am familiar with internal conflicts and cold feet. There are times when I dare not ask or give support.

My own experiences color how I look at the world, I am aware of this and see how my personal history forms me and how this background influences me and my surroundings. The reality of the research project was unruly, I was up to my knees in the swampy peat and was a 'roegbainder' in the academic field. In order to understand the meaning and complexity of relationships, it was necessary to stand still, ask questions, become 'dirty' and include my own frame of reference.



Chapter 7

Am I my brother's keeper? Moral dimensions of informal caregiving in a neoliberal society

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Abstract

Within the current Dutch policy context the role of informal care is revalued. Formal care activities are reduced and family and friends are expected to fill this gap. Yet, there is little research on the moral ambivalences that informal care for loved ones who have severe and ongoing mental health problems entails, especially against the backdrop of neoliberal policies. Giving priority to one's own life project or caring for a loved one with severe problems is not reconciled easily. Using a case study we illustrate the moral ambivalences that persons may experience when they try to shape their involvement and commitment when a relative is in need. The case comes from a research project which explores whether it is possible to reduce coercive measures in psychiatry by organizing a Family Group Conference. The purpose of the article is to explore what theoretical concepts such as 'communities of fate', 'communities of choice' and 'personal communities' add in understanding how persons shape their involvement and commitment when a family member experiences recurrent psychiatric crises.

Introduction

In the past few decades there has been a debate about the role of the welfare state and the use of informal care or family care is revalued (Lupton, 1998). The role citizens themselves have in society is subject to change. They are summoned to be more independent from the welfare state and need to feel the responsibility to care for themselves and loved ones (Newman & Tonkens, 2011). In Great Britain this development is known as 'big society'; where the reformation of society and the transformation of the state to facilitate relationships between citizens are key elements (Blond, 2010). In the Netherlands similar voices are heard, emphasizing the participation of citizens. Rather than depending on the government and having a 'wait and see attitude' they have to help others in need (Trappenburg, 2015). Trappenburg (2015) describes how this requires different attitudes and actions from citizens and advocates for a change from passive to active solidarity. Furthermore, she explains, the moral call 'help someone in need', isn't heard by everybody. This means that the burden of caring for someone in need is not always distributed in a fair way.

We recognize the difficulties in this transition where informal care becomes of more importance and want to add that persons may experience certain tensions between the willingness to care for a family member or neighbor and the time constraints that are inherent to living in a modern society; where being productive through labor is seen as important and where not everyone has the possibility to reduce their working hours (Howard, 2007; Tonkens, 2011; van Houwelingen, Boele & Dekker, 2014). How do persons shape their involvement with and commitment to others if there are conflicting expectations and moral dilemmas that accompany them? How do they want to relate to family, friends or peers? How is that reflected in forms of sacrifice and self-interest, of solidarity and calculation, of generosity and obligatory giving, of intimacy and aloofness?

These different feelings are well illustrated in the Italian/French film "Mia Madre" by Nanni Moretti where we see the struggles of a son and daughter in taking care of their ill mother (Moretti, Procacci, & Pè're, 2015). The daughter, who pursues a career in film making experiences severe problems in dealing with her personal problems and professional career. Whereas the son takes leave from his job to care for his mother. Both struggle in this process and have different reasons for their actions. Giving priority to one's own ambitions or to caring for loved ones seems to be surrounded by ambivalence. Different moral values may come into conflict with each other. Persons can also experience feelings of responsibility to support a loved one, based on love and generosity or on a sense of obligation towards others, or because one cannot bear the suffering of another.

The social and therapeutic value of social networks and social support can hardly be overestimated. The mental health of people can be enhanced and preserved when social support is present (Pahl & Spencer, 2004; Umberson & Montez, 2010; van der Post, Mulder, & Bernardt, 2009). Persons with a mental illness also benefit from a committed network because with their help worsening of the situation can be prevented; the network has protective features (Lim, Gleeson, Jackson, & Fernandez, 2013; Sündermann, Onwumere, Kane, Morgan, & Kuipers, 2013; Thoits, 2011). Social support has a positive influence on coping with stress, self-control, a sense of optimism and hope (Thoits, 2011; Uchino, Bowen, Carlisle & Birmingham, 2012). Having a social network that offers support or care, in short has a profitable effect on the mental health of people. But how self-evident is giving support or care to a family-member or friend with a mental illness? On the one hand solidarity, generosity and intimacy seem to be important values but simultaneously pursuing a career, earning money, and living your own life is seen as meaningful. Nowadays persons in Western societies have to deal with these moral ambivalences, because there are conflicting visions on what is considered good (a good life, good action, being a good family member).

How persons shape their involvement and commitment in the life of relatives in need has been studied extensively from a care ethics perspective by Lindemann. According to Lindemann (2014) families can be seen as networks where love and trust are important (generally speaking). The affection in the family leads to a certain kind of vulnerability and induces responsibilities to care for and commit to each other (Lindemann, 2014). However, Lindemann (2014) also mentions that affection in the family can be combined with aspects like selfishness, indifference or carelessness. The moral ambivalences persons may experience when experiencing these different feelings when they care for someone, remain mostly unclear. The purpose of this article is to illustrate moral ambivalences in a neoliberal context, using both theory and the reality of a case, and to explore what theoretical concepts such as ‘communities of fate’, ‘communities of choice’ or ‘personal communities’ may add in understanding how people shape their involvement and commitment when a family member or friend experiences recurrent psychiatric crises.

We have carried out this study in the field of mental health care, a field where persons with severe and ongoing psychiatric problems and their families and friends often have complex relationships, where uncertainty and ambivalences to be involved in informal care occur (Schout, De Jong, Meijer & Abma, n.d.). These moral ambivalences also crop up in other areas of medical decision making. The length of the stay in hospitals and nursing homes is often related to the support of family members (Zimmerman, Cohen, Reed, Gwyther, Washington,

Cagle et al., 2013). In all situations where compensation of self-care deficits is required, these dilemma's arise.

The question we want to answer in this article is: How do persons shape their involvement with and commitment to a family member who has severe and ongoing mental health problems and how are they dealing with the moral ambivalences they experience in this situation? And what is the contribution of theoretical concepts from the field of sociology including 'communities of choice', 'communities of fate' and 'personal communities' in understanding these ambivalences? First we will discuss a case example that illustrates the moral ambivalences that family members and friends may encounter. Then we will point out theoretical concepts and will begin to explore what these concepts add in understanding how persons shape their involvement and commitment when a family member experiences recurrent psychiatric crises.

Case Example

A case that illustrates the moral ambivalences family members may encounter comes from the research project 'Family Group Conferencing in psychiatry'.⁵ In this project we investigated whether it is possible to reduce coercive measures in psychiatry by organizing a Family Group Conference (FGC). The psychiatric patients in this research project were at risk of being involuntary admitted in a psychiatric hospital, or sometimes still are admitted, due to risky or dangerous behavior in relation to their own safety or that of others. Research on the application of FGCs in Public Mental Health care shows that FGCs hold potential in preventing coercive measures in psychiatry (De Jong, Schout, Pennell, & Abma, 2014). This corresponds with the findings on the application of FGCs in youth care, where forced residential and foster care are prevented using FGCs (Pennell, Edwards & Burford, 2010; Wang, Lambert, Johnson, Boudreau, Breidenbach & Baumann, 2012). FGCs also reduce the risk of recidivism in juvenile crime (Bergseth & Bouffard, 2007; De Beus & Rodriguez, 2007; Jeong, McGarrell & Kroovand Hipple, 2012) and are applied in elderly care as a means to reinforce relational autonomy and resilience (Metze, Abma & Kwekkeboom, 2013).

FGCs originated in New Zealand and can be regarded as a decision-making model where the formal world of the government and organizations, comes together with the informal world of individuals, families and friends (Doolan, 2012). The conference is a meeting

5 The research proposal was approved by the Medical Ethic Review Committee of VU University Medical Centre. The Medical Research Involving Human Subjects Act (WMO) does not apply to the above mentioned study. An official approval of this study by the committee was not required (28th of March 2013).

organized by the patient and FGC-coordinator, where plans are made along with family, friends and sometimes professionals to deal with the (problem) situation. An FGC gives the patient and social network the opportunity to deal with a (problematic) situation in a way that matches their own culture and lifestyle [De Jong, Schout, Pennell, & Abma, 2014; Jackson & Morris, 1999; Metze, Abma & Kwekkeboom, 2013).

The potential of FGCs in avoiding coercive treatments in psychiatry lies in the widening of the circle of support, restoring of relationships and the involvement of a knitted community that is available 24/7 (De Jong & Schout, 2010; De Jong, Schout, & Abma, 2014). Plans can be made wherein social networks have a signaling function and can prevent escalation of an situation into a coercive treatment in collaboration with a client. The idea is that bringing these groups together offers possibilities for new solutions that improve the situation (Berzin, Thomas, & Cohen, 2007). Furthermore FGCs appeal on the ownership and autonomy of the persons involved. This is contradictory to coercive measurements which most clients experience as a loss of ownership and infringing their fundamental rights (De Stefano & Ducci, 2008; Katsakou, Bowers, Amos, Morriss, Rose, Wykes, & Priebe, 2010; Landeweer, Abma, Santegoeds, & Widdershoven, 2009).

In the research project 60 cases, where patients volunteered to participate in (the preparation of) an FGC, have been evaluated. The patients were included in three different mental health care organizations in the Netherlands. The methodology can be described as a responsive evaluation (see Abma, 1996). The purpose of the evaluation is to describe experiences during the process of the FGC, the character of the project is exploratory. Process and outcomes of the FGCs have been studied by interviewing the participants afterwards.

The case we selected has elements that are recognizable for persons in similar situations, holds learning potential and will be used to illustrate moral ambivalences persons experience in caring for a loved one. This is in line with Abma and Stake (2014) who describe that case studies are especially fit to pinpoint the particularities and complexity of situations. Furthermore they specify that ‘if we are able to capture the essence and uniqueness of the case in all its particularity, it will reveal something that is universal’ (Abma & Stake, 2014, p. 1159). By discussing the case, identifying patterns and combining it with theory we hope to achieve a better understanding of the complexity that comes along with caring for a relative in need in a meritocratic and neoliberal political context. We discuss a case in which a professional referred a mother of two daughters in their twenties, for an FGC. The mother has had a long history in psychiatry, characterized by strong mood swings caused by a bipolar disorder and behavior making it sometimes difficult for family and professionals to approach her.

Mother, her daughters and other family members have a history of incidents where the safety of all was at stake. The social network of the mother had shrunk to only a few family members. When the risk of being involuntarily admitted to a psychiatric hospital was high and an FGC was being considered at the same time, she was staying in different places and avoided necessary forms of care. The professionals who were involved wanted to prevent an involuntary admission and suggested the possibility of an FGC. Mother didn't want to participate in an FGC, her family, however, did and with them the dialogue for organizing an FGC continued. In the preparation of the FGC it became clear that the whole situation was a heavy burden for the family. The daughters have been through a lot with their mother and experienced psychological and emotional problems in their own lives. Despite everything the eldest daughter felt a strong responsibility towards caring for her mother. According to an aunt (sister of the mother) it was better if she would take less responsibility due to the experienced burden. This aunt (50) had also been through a lot with her sister and would rather walk away from the sorrow and misery. She had been insulted and harassed by her sister, yet she also indicated: 'Of course, this is not what my sister wants herself'.

One of the sisters approached the aunt with the question whether she wanted to participate in the FGC. Actually she wanted to reject the request given the past. She had lost the faith in a positive outcome and doubted that the FGC would succeed. According to the aunt other attempts had failed too often. It required a lot from the aunt to participate in the FGC, also because she did not live in the same region and she had her own job and family. Furthermore it cost energy and time. It is imaginable that the aunt would experience feelings of doubt and guilt if she decided not to attend the conference. The daughters of her sister had already been through so much with their mother that they couldn't do without her support. Despite the possible doubts and feelings of guilt that the aunt might experience, she had the choice not to interfere with the situation. This applied to everyone involved in the situation; all could choose to end the relationships and continue with their own lives.

The mother in this case might avoid contact with her family because of everything she put them through; the daughters probably realized that if they decided to walk away from their mother she had little reason to control her mood swings and seek for professional help. The aunt, in turn, would probably realize that her involvement in the situation could make a difference. The moral ambivalences in this case are far from unique. In cases of severe and ongoing mental health problems we see besides commitment all sorts of reservations, doubts, aloofness and hesitation.

Neoliberal Identity

The willingness to practice a certain degree of commitment in the life of important others in need and the moral ambivalences experienced in this process are set against the backdrop of a neo-liberal discourse in which humans understand themselves as largely selfish individuals, making choices autonomously. Sandel (2012) addresses the problem of the illusory promises of liberalism, that liberal subjects have autonomy and control over their lives. In such a context it seems like success is directly related to the persons own efforts, they have control over their own destiny and determine what happens in their lives. Harvey (2005) describes the rise of neoliberalism in recent decades, and mentions that individuals are personally responsible for their own success and failure. Markets and market oriented thinking expanded and market values reached into aspects of life that are traditionally driven by more nonmarket norms (Sandel, 2012). Success means that people can live up to the demands of society and when they fail they owe this to themselves. It isn't hard to imagine that others may pose a threat in the quest of the individual to lead a successful life; this may create competition between individuals in society. Competition between individuals and also between organizations is an important virtue in neoliberalism (Harvey, 2005). Competition is believed to be the route to excellence and quality.

This fits the notion of negative liberty discussed by Berlin (1958). Negative liberty means that other persons should not interfere with your choices or hinder you from attaining a goal. Berlin (1958) however mentions that persons are interdependent and that no one can ever act in such a way that he will never hinder the lives of others. He also states that some will need help, support or education before they can understand the concept of freedom and make use of it and asks the question 'what is freedom to those who cannot make use of it? Without adequate conditions for the use of freedom, what is the value of freedom (1958, p. 124)?' Moreover, persons can be hindered by themselves to attain their goals and their freedom, they can experience internal barriers to achieve freedom. The help or support of others is necessary to achieve freedom and autonomy.

Fukuyama (2011) discusses the 'Hobbesian fallacy', the idea that humans are primary individualistic beings and that they only enter society on the base of a rational calculation that social cooperation is the best option for them to achieve their own life goals and projects. Building on primate studies of chimpanzees he illustrates how our ape-like ancestors behaved in a social way and that chimpanzees and humans, have similar forms of social behavior. This makes it reasonable to assume that humans have always behaved in a social way and never were isolated individuals (Fukuyama, 2011). Nevertheless self-interest plays a role in

relations, indeed it is important to recognize and accept the tension between selfishness, self-interest and social and altruistic behavior. If this succeeds the inconsistencies that people experience can be embraced and confined. As mentioned before, in current Western society the competitive side of people is stimulated. It remains hidden that we stand on the shoulders of our predecessors and cannot perform without the support of others. The myth of autonomy as self-determination continues. In this dominant meritocratic ideal success and failure are seen as the responsibility of individuals themselves (Kampen, Elshout & Tonkens, 2013). Success is linked to personal excellence and failure to personal shortcoming (Kampen, Elshout & Tonkens, 2013). Against this background, it appears to be acceptable when people 'choose for themselves'; to a greater or lesser extent, everyone wants to be successful. In this market orientated thinking altruism, solidarity or generosity are resources that come under pressure when used. They are seen as scarce resources that need to be used carefully. Market tradition neglects the option, however, that our capacity to act altruistic or generously is increased with practice (Sandel, 2012). Sandel sees altruism and generosity as 'muscles that develop and grow stronger with exercise' (2012, p. 130).

The foregoing is also relevant in understanding the moral ambivalences of the aunt; she is free to make the choice not to join her family and others could see this as an understandable choice. If she decides to join in the situation this means that she has to invest time, energy, attention and commitment and this is also required for her own family and job. Ultimately the aunt decides to engage in the situation, and is present at the conference. She says, 'Maybe it's a good thing to come together—with my nieces and the involved professional.' She wants to be there for the daughters of her sister and she wants to make life more enjoyable for them. The decision of the aunt raises the question how it is possible that, in contexts where neoliberal values dominate, persons still show involvement in each other's life and seem to care about relatives in need.

The Moral Neoliberal?

In her book *The Moral Neoliberal* Muehlebach (2012) discusses that despite the neoliberal context we live in, persons do actually behave morally and feel responsible for others. Although the established neoliberal order creates rational, utilitarian and instrumental acting persons, these persons do have an affective identity characterized by compassion and empathy. According to Muehlebach the market and the moral life have always coexisted. Besides the abundance of material wealth (in the west), there is also an abundance of so-called 'virtues'; people are fanatically seeking success and wealth but also have a moral sense which makes

them sympathize with others and care for them. Following Muehlebach compassion for others and ‘the coldness of wealth and success’ are not opposed to each other (2012, p. 20).

Muehlebach’s (2012) study of Italian volunteers in Milan, gives an image of a moral style of contemporary neoliberalism. She shows that volunteering is especially important in a relational way and is based on the affection of persons for each other. The government is withdrawing itself from the moral responsibility to care for citizens and shifts this responsibility to citizens themselves. The idea of ‘citizenship lived with the heart’ (Muehlebach, 2012, p. 11) arises and this becomes the moral soil on which a community of solidarity can be reformed. The emergence of volunteering in Italy originates from a discourse in which a new kind of ethical commitment is seen between different groups in society. This commitment is based on a moral obligation rather than based on social rights and is not controlled or facilitated by the state (Muehlebach, 2012). In addition there is a need for meaning, commitment and love for persons in vulnerable situations. A volunteer in the study of Muehlebach describes this as “helping others while helping oneself” (2012, p. 161). Reciprocity between generations is not central, but a spirit of free gifting is (Muehlebach, 2012).

Melucci (1996) also points out that people can act in a selfless and altruistic way, and this can be seen as altruistic action. Altruistic behavior can be seen as a symbolic challenge, it is at odds with the rationality of calculating behavior and the efficiency of technology; because it is based on the commitment of people, their generosity and the desire for communication without a hidden program (Melucci, 1996). To give and offer without expecting a favor in return is an essential point rather than thinking in costs and benefits (Abma & Baur, 2012). Altruistic action is established on a voluntary basis and has no direct (financial related) gain or benefit for those who act this way. People do get something in return, the opportunity to have an active and meaningful role in the life of important others and experience feelings of connection and belonging to a group. Major resources for altruistic action are gratitude and the ability to provide support or assistance (Abma & Baur, 2012).

The work of Muehlebach and Melucci makes it conceivable that expressions of solidarity and commitment do not need to be scarce and that there are resources outside the nuclear family. As Sandel mentions, altruism, solidarity and generosity have to be ‘exercised more strenuously to renew our public life’ (2012, p. 130). FGCs can play a role here, by utilizing the available resources and facilitating forms of solidarity.

Communities

Even in neoliberal and meritocratic contexts supporting others or feeling compassionate for them is seen as an important value. It is however not hard to imagine that interfering in the life of someone with severe and ongoing mental health problems while dealing with the obligations of one's own life, is challenging. A number of theoretical concepts are meaningful in understanding the shaping of involvement and commitment, and the moral ambivalences that persons experience doing so. First we will discuss these concepts and later on we will illustrate with the for mentioned case how useful these concepts actually are.

The first theoretical concept to be discussed is that of 'communities of fate'. Stinchcombe (1965) points out that 'communities of fate' can be seen as communities where the success and well-being of the individual is linked to that of the larger whole. More explicit, according to Hirst (1994), they can be seen as existential communities in which a person is born and then grows up in. 'Communities of fate' involve the sharing of a situation, process or particular fate. Despite the sharing of a fate, process or situation it is still possible for people to withdraw themselves from the care for others; to what extent can we speak of a shared fate persons have to submit to?

Hirst (1994) mentions a shift from 'communities of fate' to 'communities of choice', which corresponds to the development of a neoliberal identity. The collective identities of people are increasingly influenced by their individual life projects. People build their lives according to their own preferences and want to be part of self-chosen, often temporary, communities (Lorentzen, & Hustinx, 2007). This means that the family as traditional community is losing relevance. People want to be part of networks wherein others have the same preferences or interests or where they can meet contacts who would yield a career advantage. 'Communities of choice' emphasize the choice for a community, whereas 'communities of fate' imply a shared fate or destiny. Persons do not choose each other, they are connected through the situation, fate or process they share. Relations in chosen communities can be for example, friends, acquaintances or fellow members of an association or party. Whereas 'communities of fate' can be seen as family, sharing a fate and a blood tie. The distinction between 'choice' and 'fate' is however arbitrary; the family we have is given to us, but we can choose to keep distance. Likewise we can also choose to be involved with family, despite the shared fate. When living in a small town friends can be seen as part of a 'community of fate' because there are few options to choose your social contacts.

Pahl and Spencer (2004) question the shift from 'communities of fate' to 'communities of choice'. To demonstrate this shift demographic studies are used, which show an increasing

number of divorces, greater social mobility, an increase in the number of highly educated people (especially women), an increase in the number of women in the labor market and the growth of non-heterosexual households (2004). This implies an increase in the importance of 'communities of choice'. There are however other statistics showing that family ties are still relevant and there are few signs that friends are completely replacing family (Pahl & Pevalin, 2005; Park & Roberts, 2002). It is more plausible to assume that traditional communities gradually disappear and new forms occur simultaneously (Pahl & Spencer, 2004; Stolle & Hooghe, 2005). The vertical and more mandatory relationships that accompany traditional communities gradually merge with horizontal, chosen and more free forms of communities, where mandatory relationships play a smaller role (Kunneman, 2013). Involvement with society and the communities where citizens are part of seem to have a different shape. Relationships with family or friends are not always clearly distinguishable. Persons have more flexibility and freedom organizing their personal relationships (Allan, 2008; Pahl & Pevalin, 2005). For example in choosing how they want to live together and how they want to raise their children. Even though the fore mentioned freedom is limited by social and economic location a less standardized normative image of relations and a tendency for diversity is developing (Allan, 2008).

Taking account of the composition of relationships with family and friends Pahl and Spencer (2004, 2010) developed the concept of 'personal communities'. With this they mean that persons have different relationships that vary in the degree of commitment and the extent to which they are given or chosen. The chosen relationships that Pahl and Spencer describe correspond to the previously described 'communities of choice'. The given relationships resemble the 'communities of fate'. Using the concept of 'personal communities' Pahl and Spencer (2004, 2010) study the social world of persons at the micro level and want to gain insight into the different relationships and communities where they are part of. Pahl and Spencer (2004) recognize that different stakeholders, such as family and friends can play similar and contrasting roles. They also notice that a sharp distinction between given and chosen relationships is difficult to make and mention 'a range of given and chosen relationships representing different forms and styles of suffusion' (2004, p. 203).

Despite the neoliberal culture we live in people are willing to behave in altruistic or solidary ways. Within a FGC choices are made intersubjective, where values like altruism or generosity are negotiated upon with others in a community. Using the concept of personal communities brings insights who might be involved in a problematic situation. The concept makes social contacts outside 'the given' ones more distinguishable; a reservoir of social recourses opens up.

This opens up opportunities to use FGCs as a means to alleviate the burden of the 'community of fate' and to expand the 'given' relationships with 'chosen' relationships.

Returning to the Case

That the aunt in this case decides to interfere in the situation and doesn't abandon her nieces because of what they've been through together can be described as a form of shared fate. In line with Pahl and Spencer (2004, 2010) the relationships in the case can be seen as given, they are based on the sharing of a situation. Sharing the difficult process as a mother, sister, daughter or aunt creates a bond that no one leaves behind easily. The involvement of the aunt seems to be primarily based on wanting to 'ease the burden experienced by the daughters of her sister' because they have been through a hard time. She apparently expects nothing in return.

Considering Muehlebach (2012) and also Melucci (1996) this can be seen as altruistic, because reciprocity seems less important and the aunt can play a meaningful role in the lives of her nieces. The expectation of reciprocity applies to a lesser extent because the mother and her daughters don't have much to offer in return because of the struggles they experience in their own lives. During the process of the conference the family decides to start a procedure for a compulsory admission for their mother/sister because they can't endure the situation any longer. In the following weeks however she stays at a psychiatric ward voluntary. The outcome of the conference revealed for the daughters and sister that they can actually support each other and also has created a better cooperation with the involved professional. Yet the situation remains fragile, durable support was not created. There is only a small group of persons involved, who seem to experience that they are bound together by a particular fate. The case illustrates how challenging it can be to shape informal care and offer durable support. Where the involvement first seems to be based on a shared fate later on the choice for professional help, with the appeal on an involuntary admission, is made. This illustrates that while on the one hand the relationships are experienced as given, they also have an aspect that is experienced as a choice; by reaching out to professional help. Just as mentioned by Pahl and Spencer (2004, 2010) a sharp or dichotomous distinction between given and chosen relationships seems difficult to make.

Looking back on the preparation of the conference there could have been more focus on the restoring of relationships and widening the circle of those involved. The small family network doesn't feel capable to resolve the problems and keep supporting their mother or sister, considering that little reciprocity is to be expected. Specific for the mother in this

situation it would probably be necessary to restore relationships because her social network has shrunk to only a few family members.

Building on the insights of Muehlebach (2012), it would be fruitful to expand this small and fragile network with persons who are not connected by a shared fate. What would emerge when the small family group was expanded with neighbors, acquaintances or maybe volunteers or peers? An FGC could play an active role in restoring and/or strengthening the existing network, widening the circle and building a bridge between professionals and the social network. By widening the circle opportunities to include new points of view, considering the problematic situation, arise. In other words the 'given' relationships could be strengthened and ultimately widened with 'chosen' relationships.

Conclusion and Discussion

In current Western societies persons experience moral ambivalences how to balance their own life style choices with caring for family members or friends who are in need. In a society with numerous options, there can be various ways to be involved in the life of others. How this is experienced or realized may differ. The concepts of 'communities of fate' and 'communities of choice' are used to explore how persons shape their involvement and commitment in the life of loved ones, and the moral ambivalence it brings about. The boundaries between the two communities are not dichotomous. To what extent do persons actually have a choice in relationships with friends or neighbors? Location (economic) and social, personal and material resources are of importance in experiencing the possibility of having choices and making them. Furthermore, there is also the possibility to evade obligations. Crucial is however the way in which persons experience their relationships, do they see them as given or chosen? Does the sharing of a particular fate play a role or are the relationships based on a thought-out choice?

The value of both concepts lies in identifying that persons can experience given and chosen relationships and that friends and family can play the same role. There's more to it than just a connection through blood ties. The concept of 'personal communities' is useful in understanding the different relationships that persons have and in understanding their motives to be involved. We can however challenge the use of the word 'personal'. It implies that relationships are centered around one person, and that this one person can decide who is part of that particular community. It is more plausible to assume that everyone in the community must contribute to maintain the relationship or community, fuelling reciprocity in the process. Lindemann (2014) mentioned that carelessness or selfishness can also occur in

families. Using a case we identified moral ambivalences persons may experience, and showed that making choices, about caring for a relative, is complex and full of tensions.

The three women in the case for example may indeed choose not to commit to the situation, but they decided otherwise because they experience a shared fate and have motives not to abandon or hurt their mother or nieces. The aunt shows how complex it can be to deal with different moral expectations, on the one hand she has the choice not to interfere with the situation and pursue self-interest but on the other hand she has feelings of generosity and a certain feeling of obligation towards her nieces to support them. The latter appears to be of more importance for the aunt than pursuing her self-interest and invest time in her own life only. Through discussing the case we identified feelings of self-interest, solidarity and calculation, generosity and obligatory giving, intimacy and aloofness. They seem to form a complex whole and exemplify the feelings and ambivalences that persons can encounter when caring for a relative in need.

The concept of personal communities makes insightful who are involved in a problematic situation, as described in the case. When a reservoir of social resources becomes visible, opportunities to widen the circle and strengthen relationships, with the help of a FGC, arise. Further research into the use of concepts like 'personal communities' and describing the different social networks involved and the motives and ambivalences they experience is necessary to comprehend what occurs in informal care against a meritocratic and neoliberal background.

Awareness for the moral ambivalences of persons who have both solidary aspirations and the desire to pursue their own life goals, provides opportunities for family, friends and professionals to consider how they want to shape their involvement and commitment. A positive tension between given and chosen relationships reveals itself. Both are of value, on the one hand we have our given relations with whom we share a fate but the choice to engage in meaningful relationships with others is also present. Despite the neoliberal and meritocratic culture people are relational beings and they need each other to form and give expression to relational autonomy. Muehlebach (2012) argues that relations with others are not always based on reciprocity but can also be based on an a form of 'charitas' this means caring out of love or charity.

The social network in the example of the case, is small and worn out. The protective features of the network could be expanded through restoring relationships and widening the circle with volunteers or peers. Doing so this relational autonomy can be formed again. Moreover it may lead to a more balanced distribution of care and support and gives a hopeful perspective for those involved. The majority of psychiatric patients however experience social isolation or have difficulties to fuel the process of reciprocity, especially in those situations

it seems necessary to widen the circle and alleviate the burden for the few persons that are involved and to strengthen those relationships. FGCs can be useful when persons need support or facilitation in restoring relationships or widening the circle by facilitating this process. Sandel (2012) argues altruism needs to be evoked and practised, this requires changes in long term care structures and policies in the mental health arena. This also invokes a change from professionals in mental health care, policy makers and communities themselves. Further research into conditions for informal care and the role of communities and professionals herein is needed.

Am I my brother's keeper? Individualisation and detraditionalization are transforming the way people respond to this call. The work of Muehlebach and the case example show, however, that there is hope for expanding social networks into a wider network of care, despite the time pressure of today's life projects in a neoliberal context and holds a promise to widen the circle for those in need of support.

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Chapter 8

Family Group Conferences in coercive psychiatry: understanding relational dynamics by plugging in Bourdieu

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Abstract

Alternatives for coercive treatment in psychiatry, based on partnership between clients, social networks and social workers, need to be given full attention. Despite its potential to inhibit isolation, self-exclusion and reduce coercion, organising Family Group Conferences (FGC) in this field is complex. The process of a FGC may evoke shame and unbelief in the willingness of people to help out. Furthermore a lack of reciprocity in relationships can contribute to the stagnation of the FGC process. The goal of this article is to understand relational dynamics between clients, relatives and friends in the carrying out of a FGC, by applying theoretical concepts on symbolic capital, recognition, reciprocity and gift giving derived from Bourdieu. Using the analytical strategy of 'thinking with theory', we selected three FGCs suitable for illuminating both challenges and opportunities viewing each FGC as a social field. Bourdieu's theoretical concepts help to understand and overcome difficulties in organising a FGC so participants can discuss, decide and negotiate relational dynamics in the field. Working with FGCs requires for social workers a shift in doing and thinking; facilitating the primary group to discuss expectations, diffusion of tasks, commitments and plans.

Introduction

Coercive treatment in psychiatry is still widely used in the Netherlands and other European countries (De Stefano & Ducci, 2008; van der Post *et al.*, 2009). In this article coercive treatment refers to involuntary admissions in crisis situations and court ordered admissions in both psychiatric hospitals and the community. Coercive treatment leaves people disempowered and denies their citizenship; as they are not able to participate in society (Maylea, 2016); it leads to isolation, while the recovery process from psychiatric issues is profoundly connected to the social context someone belongs to (Mezinna *et al.*, 2006; Topor *et al.*, 2006).

Maylea (2016) mentions that if social workers continue to accept a role for coercive treatment they accept a practice reality in which people are denied citizenship. Social workers can position themselves as supporters of decision making, and need to develop alternatives to coercive treatment, considering the genuine commitment of social work to the recovery model in mental health care (Maylea, 2016). Strier (2013) argues that professional institutions symbolize exclusion and paternalism, and that traditional unbalanced power relations, between professionals and clients, should be left behind and a social work approach based on an egalitarian partnership needs to be embraced.

In view of the above, it seems valuable to explore the potential of Family Group Conferences (FGCs) to reduce coercive treatment in psychiatry. FGC is a decision-making model wherein the client, family and other social contacts meet in order to solve problems and inhibit isolation and self-exclusion, facilitate a return to communities and reduce coercion (De Jong, 2014; Meijer, Schout, De Jong & Abma, 2017). The process of a FGC consists of four different stages. Both professionals and coordinators have specific roles during the different stages of the FGC proces. Professionals like social workers, play an important role in referring clients to the option of a FGC in providing information during the conference for developing the action plan (in consultation with the client) and in encouraging the group to overcome difficulties. Studies show that professionals do not always inform their clients about the possibility of FGC and do not always refer them; they see barriers when it comes to their clients and their networks organising a FGC (Skaale Havnen & Christiansen, 2014; Schout, van Dijk, Meijer, Landeweer, & De Jong, 2016).

FGCs are organised throughout the world, and in different care settings such as youth care, elderly care, the social sector, within the justice system and mental health care (Skaale Havnen & Christiansen, 2014). The potential of FGC lies in the establishment and strengthening of communities for effective problem-solving, this facilitates persons to regain autonomy

and control over their situation (De Jong & Schout 2010; De Jong, Schout & Abma, 2014; Skaale Havnen & Christiansen, 2014; Meijer, Schout, De Jong & Abma, 2017). Trustful partnerships between the different actors (network, professionals and clients) contribute to the reduction of coercion. FGC has developed over time, and in different countries there have been adaptations regarding the original model that emerged in New Zealand. In the USA FGC has developed in several variants of Restorative Justice for example (Skaale Havnen & Christiansen, 2014). The application of FGCs has been studied intensively in youth care, where different studies mention that FGCs can prevent the outplacement of children (see for an overview Skaale Havnen & Christiansen, 2014) and in public mental health care, where the potential of FGCs to strengthen and widening the circle of support came forward (De Jong, 2014).

In an earlier study on outcomes and impact of FGCs in coercive psychiatry, we showed how FGCs regained clients' sense of ownership over their situation, how they experienced more social support, and also how a slight reduction in coercion was mentioned (De Jong, Schout, Meijer, Mulder & Abma, 2015; Meijer, Schout, De Jong & Abma, 2017). The findings indicated that the particular FGC partnership between different actors (network, professionals and client), contributes to such reduction of coercion (for more discussion about what FGC adds to the range of existing interventions in coercive psychiatry, such as Flexible and Resource Group Assertive Community Treatment; open dialogue; crisis-card and crisis-plan, see Schout, Meijer & de Jong, 2017). However, despite its' productive power, our research also indicated how participating in a FGC process may be complex and participating in the process is accompanied by different tensions. Our research demonstrated how it can evoke feelings of shame, wanting to keep family and friends away, or unbelief in other people's willingness to help out. These tensions can be interpreted as connected to the relational dynamics between clients, relatives and friends that are unavoidable in the FGC context. This adds a complexity to the FGC process that is important to understand in order to succeed with carrying out FGCs. In this article we aim to address this complexity by discussing the FGC process in terms of relational dynamics, reciprocity and gift-giving.

In a study of FGC within a social work context, Malmberg-Heimonen and Johansen (2014) show the importance of reciprocity in social support exchange: "(...) one would expect that the FGC model, from a longer-term perspective, meets the terms of reciprocity in the social support exchange' (p.568). However their research demonstrated that a lack of reciprocity in social relationships in FGCs contribute to the stagnation of an initially positive FGC process (Malmberg-Heimonen & Johansen, 2014). Research should focus on the difficulties of reciprocal exchange between the different actors in the FGC process

(Malmberg-Heimonen & Johansen, 2014). Kjørstad (2016) wrote a literature-based critique in this journal on reciprocity as a generative mechanism, in the context of social work and the implementation of a policy of workfare in Norway. She mentions how the norm of reciprocity is connected to processes of exclusion and marginalization and is critical about this norm in the context of the asymmetric relationship between social workers (in public services) and their clients. Kjørstad (2016) critically examines the principle of reciprocity (described by Mauss, 1925 and Gouldner, 1960); it is an underlying mechanism in relationships that produces dependencies and expectations. We want to elaborate on this delicate process of reciprocity and gift giving by using theoretical concepts from Bourdieu (2000) especially how he posits reciprocity and gift giving in the context of social action and the struggle for recognition. These insights contribute to the understanding of the relational dynamics actors experience in the fields they are part of and the processes of legitimation and appreciation in their relationships that comes with it. In this article we want to address the complexity of organising FGCs by reflecting on the relational dynamics, between clients, their relatives and friends when it comes to reciprocity and gift-giving.

The work of Bourdieu

Bourdieu locates social action within a field. This field is a framework in which agents (people) and their social positions are located and a site where the symbolic struggle for legitimation takes place (Bourdieu, 1990). The position of someone in a field depends on the habitus and social, cultural, economic, and eventually the symbolic capital of a person, in combination with the rules of the field. The habitus encloses the way someone perceives, thinks or acts and is formed by past experiences. The expectations and opportunities in the field correspond with that of the habitus and share the same past; they shape each other. The symbolic struggle for legitimation in the field is postulated as ‘a game’ where individuals pursue different interests and where they have different expectations and opportunities depending on their (social) position (Bourdieu, 1990). Important in this struggle, is a certain sense of ‘feeling for the game’ (Bourdieu, 1990, p.66); knowing what to do in certain situations that occur in the field. In the case of severe and ongoing psychiatric problems this ‘feeling for the game’ is hard, a mismatch between ‘player’ and field arises. Psychiatric clients, who often experience stigma, could have internalized feelings of fear, shame or guilt in such a deep way, that every attempt to escape from the position they are in is deemed to fail. Uncertainty and fear to be excluded and judged can be of profound impact in someone’s life (Bourdieu, 1990, 2000).

Bourdieu (1990) emphasizes that individuals do not only pursue their own interests but also invest in relationships with others. He mentions that individuals are driven by the search

for recognition and legitimation from others; people are constantly searching for approval and appreciation, resulting in a symbolic struggle for recognition and legitimization of their existence (Bourdieu, 2000). Symbolic power is gained by ‘communication, through symbolic exchange’ (2000, p. 199). The power is exercised by words, symbols and predispositions that are confirmed and rooted by communication (Bourdieu, 2000). Bourdieu (2000, p.241) mentions that ‘there is no worse dispossession, no worse privation perhaps, than that of the losers in the symbolic struggle for recognition, for access to a socially recognized social being, in a word, to humanity’. The struggle for recognition is a competition for power and gains its existence from others and their perception and appreciation – a power over a desire for power (2000, p. 241). The symbolic power relations are not intentional acts of consciousness; they are power relations that are made up and continued through knowledge and recognition. If one wants to symbolically dominate; the dominated have to share the same schemes of perception and appreciation with the dominators. Knowledge and recognition have to be rooted in practical dispositions of acceptance and submission (2000, p.198). Bourdieu does not define recognition; he describes the symbolic value of recognition and regulating the use of symbolic attributes for example when speaking of ‘mutual recognition’ when discussing the concept of marriage.

Relationships with others are shaped via gift giving. Bourdieu uses the work of Levi-Strauss and Mauss to elaborate on ‘the double truth of the gift’. Gift giving is surrounded by a certain degree of uncertainty because the receiver of the gift could always refuse to settle the debt or does not have the resources to settle it. Despite the selflessness that gift giving entails, it is a form of symbolic capital (reputation or status that people have) according to Bourdieu. The symbolic capital consists of respect or guilt towards the giver and is based on reciprocity. When a gift is not repaid, then this can be experienced as treason: how can you not return the favor after all we’ve done for you (Bourdieu, 2000). Giving is uncertain, people never know if the favor is returned and it is a provocation; if the receiver cannot return the favor they may be embarrassed and lose appreciation or recognition from others (Bourdieu, 1990). Furthermore, being expected somewhere and counting in other people’s lives and along coming obligations or commitments ensure not only that existence is significant but gives, in words of Bourdieu, ‘a continuous justification for existence’ (2000, p. 240).

Belonging to a stigmatized or deprived group means that the symbolic struggle for recognition is hard, along with the competition for symbolic power. Stigmatized persons have diminished strategic positions which affects their vision of the future, it becomes blunted or even disappear (Bourdieu, 2000). The feeling of hope increases when people experience more power because the present and accompanying possibilities in the future are influenced easier

(Bourdieu, 2000). In this article we will ‘plug in’ the following concepts from Bourdieu to address the complexity of FGC in coercive psychiatry and reflect on the relational dynamics between clients, their relatives and friends: ‘the player and the field’, struggle for legitimation and recognition and reciprocity and gift-giving in relationships.

Methods

The three cases on which this article is based are drawn from a study into the process and impact of (the preparation of) FGCs for 60 clients who were at risk of coercive treatment in psychiatry, in The Netherlands. Between 2013 and 2015 at three mental health institutions in three regions in the Netherlands, a FGC was considered by mental health professionals and clients. Clients were included in the study when there was an imminent or actual coercive treatment at hand or when there was a history of recurrent coercive treatments, furthermore a municipal bond to one of the regions was necessary. We will briefly describe the framework and methodology of this larger study, to make insightful how the data were collected, then we will discuss the selection of the three cases and how we analysed them.

In the larger study a responsive evaluation (Stake, 2004) was used to evaluate process and impact of the FGC’s (See Abma, Leyerzapf & Landeweer, 2016; Abma, Nierse & Widdershoven, 2009). Participants of the FGC, such as, clients, their social network, mental health professionals and FGC coordinators were interviewed about the process of the FGC individually. The interviews were conducted with a topic list that contained topics about the situation prior to the conference, after the conference and the process and evaluation of the conference. A total of 289 interviews, about 41 different FGCs, were conducted, recorded and transcribed. On average, per conference six respondents were interviewed. Not all participants of the FGCs were interviewed; some did not want to participate in an interview or did not have time.

We created opportunities for feedback on our findings through ‘member checks’ (Lincoln and Guba 1985), for example by sharing summaries of interviews with respondents. This is in line with Doyle (2007, p. 890) who states that the process of member checking is ‘highly supportive of developing a participatory framework and (...) encouraged negotiation of meaning between the participant and the researcher’. Likewise we used the member check as an opportunity to ‘share “analytic power” with respondents’. A report, containing preliminary conclusions about the conference, was presented to the participants of the FGC at the member check (if this was not possible the report was sent for feedback by email). Furthermore participant observations were conducted in meetings at mental health

institutions with professionals, clients or family and the FGC coordinators; in interviews with different participants; and in member checks. Impressions, observations and interpretations were described with theoretical and empirical memos, and discussed within the research group (Emerson, Fretz & Shaw, 2011). When referring to the empirical memos in the section of findings we use the abbreviation 'EM' with a number.

For this article we selected three cases that show the diversity and complexity of the FGC process. The purposefully selected cases identify main themes in the different stories that had been told by the participants of the different FGCs, and offer 'learning potential' (Abma & Stake, 2014). The selected cases reflect the encountered difficulties in the context of FGC in psychiatry; the themes that emerge from the three cases shed light on the lessons that can be learned from this study. The selected cases are diverse in the outcomes of the FGC and the relational dynamics that were present, they show the variety of situations we encountered in this study. The table below shows an overview of the selected case and collection of data.

Table one: overview of cases and collection of data.

Case	Conference	Interviews	Membercheck	Participant observations
Case 1 'Henk'	10 participants: client, family, friends, professional, FGC coordinator	7 interviews: client, family, friends, professional, FGC coordinator	9 participants: client, family, friends, professional and researchers	Membercheck, EM* no. 26 and 45.
Case 2 'Frans'	9 participants: client, family, friends, professional, FGC coordinator	9 interviews; client, family, friends, professional, FGC coordinator	6 participants: client, friends, professional, FGC coordinator and researchers	Membercheck, EM* no. 43 and 46.
Case 3 'Ingrid'	17 participants: client, family, friends, acquaintances from church, 2 professionals, FGC coordinator	12 interviews: client, family, friends, acquaintances from church, professionals, FGC coordinator	10 participants: client, family, friends, professional, FGC coordinator and researchers	Interview/ interview transcript EM* no 44.

* EM refers to Empirical Memo

Data analysis

For the interpretation of the three cases we used the work of Bourdieu, as discussed above, using a strategy described by Jacksons and Mazzei as ‘thinking with theory’ a concept they picked up from Deleuze and Guattari (1987; 2013, p. 261-262). In this strategy data interpretation and analysis do not take place through coding, where data is reduced to themes (Jackson & Mazzei, 2013, p.261). Data and theory are plugged into one another and the process of ‘thinking with theory’ shows how knowledge is opened up and generated rather than simplified; interpretation of data is necessary and the context is important (Jackson & Mazzei, 2013). In this process data are approached with analytical questions informed by key concepts, from theorists, that are ‘plugged’ into the data and back and forth into the theory (Jacksons & Mazzei, 2013).

The analytical questions we defined are based on the earlier discussed theoretical concepts of Bourdieu:

1. To what extent a mismatch between player and field arises in the three different cases?
2. To what extent does the struggle for recognition and legitimation become visible in the three different cases?
3. How can we describe the social fabrics of the main actors in the cases and to what extent are relationships formed and described in the form of gift-giving?

The three cases were studied by analysing the interview transcripts from the different participants of the FGCs, and by analysing the empirical memos belonging to the cases (conducted by the first author). When analysing these transcripts and memos, the analytical questions played a leading role. We choose concepts and questions that would help extend our thinking and plugged them into the interview transcripts; pushing data and theory to exhaustion and focused on generative and constitutive aspects of texts (in line with Jacksons & Mazzei, 2013, p. 265). The first and second author discussed the foregoing extensively and the third author critically reflected on the findings. Furthermore we were sensitive to how the respondents already gave meaning to their story by what they chose (not) to reveal. Thinking with theory does not provide a ‘full answer’, as only a small range of theoretical concepts is included in the process; it gives insight in a different way (Jackson & Mazzei, 2013).

Ethical considerations

The research proposal was presented to the scientific research committee of the VU University Medical Centre, and the three mental health care organisations that contributed to the study:

Lentis, GGz Noord-Holland-Noord and GGzE (GGz is the Dutch abbreviation for mental health care). The study was approved under the condition of informed consent, taking into account safeguards concerning privacy, anonymity and confidentiality. A unique code replaced personal information in transcripts, reports and articles. In this way only the interviewers could trace personal information. The researchers have signed a confidentiality agreement.

Findings

The three different cases will be introduced and then the analytical questions will be discussed thematically. For the purpose of readability, anonymity and confidentiality we use fictitious names in the cases, and refer to the empirical memos with the abbreviation 'EM'.

Case one – 'me against the world'

This case is about a middle-aged man, named Henk, who experiences personality problems and mood swings. He has a traumatic past that influences his behaviour and is known with a history of multiple house evictions. These house evictions often follow after aggressive, unpredictable and suicidal behaviour. Henk has a small social network consisting of family and a few friends. He has trust issues and his relationships can be characterised as troublesome. In this case the FGC was organised, by a mental health professional involved in his case for several years, because of financial problems, the problematic history of the man, a recent house eviction and the constant threat of coercive treatment in psychiatry. The FGC made it possible for his family to review how they want to relate to Henk, and how to limit his passiveness and unpredictable behaviour. They agreed, with Henk, that he should show more initiative.

Case two - 'choosing my own path'

The second case is about a young man, in his thirties. Who, as a child, was in an accident that caused brain damage with the consequence that he processes information slower. The life of the man, named Frans, has been characterised by schizophrenia and psychotic vulnerability. Frans has had several psychoses and admissions to psychiatric hospitals. In the past he had some addictions problems, now he occasionally smokes weed. His social network consists of family and friends. A lot of his friends have a similar background as Frans himself. Frans now works on a 'care farm' and is living on his own again. The FGC was organised because of the coercive treatment impending on Frans and gave him support for his view on the way he wants to live his life.

Case three – joining the herd again

The main actor in this case is a woman, Ingrid, she is in her early thirties. Her social network consists of family, friends, and acquaintances from church. She experiences psychotic vulnerability and has been diagnosed with a bipolar disorder and is slightly mentally disabled. She finds it difficult to regulate stress and experiences pressure fast. When everything is going ok in her personal life and at work (sheltered workplace), she gets the feeling that she can stop her medication and does not recognize the aforementioned difficulties. Eventually she loses touch with reality and gets in a psychotic state. In this state she withdraws herself from social situations, because troublesome experiences from the past are re lived by her. The FGC was organised to prevent coercive treatment in psychiatry. In the preparation phase of the conference it became clear that the different actors in the social network of Ingrid did not know each other. After the FGC the social fabrics were restored and strengthened.

The player and the field

In the symbolic struggle for legitimation in the field, a sense of feeling for the game is crucial. If a player in the field lacks this “feeling for the game”; a mismatch arises. Henk and the field wherein he acts do not seem to match. He makes sure, on forehand, that any imposed expectations from his social network are diminished, so that he does not have to live up to them. Before he gets involved in binding relationships he already starts a fight and is in search of conflicts to gain control over the situation. This becomes evident in the member check:

In the member check Henk makes sure he is not actually participating in discussing problems and solutions for his own situation. He nervously laughs it all away and makes cynic remarks. At some point he leaves the room angry and does not come back. It seems like he does not know what to do with serious interest in his story or situation. (EM, no. 26)

Furthermore his sister mentions:

Henk wants to do things in his own particular way, when he gets the feeling that this is threatened he becomes very angry. (Henk’s sister)

The mental health professional, involved in Henk’s life, describes how Henk feels; that he is alone in this world and that the world is stupid and people are best described dumb. If people try to help out Henk he pushes them away. He does not take himself serious and at the same time experiences a public stigma, which becomes clear in this statement from Henk:

I am portrayed like an idiot in this city, the people here are crazy. (Henk)

For the family and involved professionals the FGC opens up the opportunity to discuss, with Henk, how they want to relate to him and how they want to react on the self-exclusion that he initiates with his behaviour towards them.

Frans is characterized by his social network as an intelligent person, who could take more initiative to utilize his qualities. Especially his family thinks that he can and should make more of his life. A friend confirms this point of view the family takes, and mentions that Frans himself is satisfied with his life. He needs a quiet, peaceful life where he can be safe in the comfort of his own home. Frans mentions that he occasionally uses cannabis even though it is better to stop this, given his psychotic vulnerability. In the field of his family a mismatch occasionally occurs, as Frans is not behaving as he is supposed to, according to the rules and values of the family. He lacks ‘feeling for the game’ in this particular field, and while he is living his own life, he has to tolerate criticism from his family in return.

Ingrid is doing the best she can to participate in society, her job is really important for her. It helps her with feeling like she belongs in the different fields she participates, where most people have jobs. Her work-ethic leads to Ingrid pushing her boundaries regarding stress; she does not easily say no to her boss at work. Eventually this goes ‘wrong’ resulting in a psychosis. When this happens, Ingrid withdraws herself from her social life and becomes isolated, she cannot, in the words of Bourdieu, ‘play the game’ in different fields anymore. Ingrid’s open and helpful attitude however, contributes to other people involving her in the field again; they want to do something for her. Her sister mentions the following:

She might be mentally disabled and experience psychotic episodes but it -the FGC- is about her and she has to make choices. We cannot make choices for her. The only thing we have done as a group is trying to give her insight into her own behavior. We just contributed in that way and on that basis she can make a decision about what she wants and what she does not want. (Ingrid’s sister)

In the member check the involvement also comes forward:

It is striking to see, at the member check, how the family of Ingrid and Ingrid herself, have an urge to be involved in each other’s lives and keep everybody together (EM no. 45).

To sum up this sub-section, when we consider the case of Henk it becomes clear that the FGC was helpful for the family in discussing how to deal with the situation in a suitable way. When considering the case of Frans we see he is confronted, again, with the conflicting expectations

of his family. He, however, chooses his ‘own path’ and differentiates, he wants to lead an undemanding life. Lastly Ingrid, for her the FGC revealed that she is able to ‘join the herd’ again, a plan was made and it became evidently clear that everybody wants to be involved.

Struggle for recognition and legitimation

Considering people are driven by a symbolic struggle for recognition and legitimation from others; they are searching for approval and appreciation (Bourdieu, 1990, 2000). In this search Henk struggles with the different relationships he has. He seeks the proximity of this family with Christmas, but also seems to be afraid for the closeness of his family and the along coming reciprocity and expectations. This comes forward in the member check:

Henk’s sister describes how he shows up at Christmas at the house of her and her spouse, of course he is invited. But he stays longer than intended by his sister, after almost two weeks he is forced to leave –because they cannot deal with his negative energy any longer- and they have to drive him to his own place (EM, no. 45).

He cannot deal with the fact that people care about him and responds by attracting and repelling them. Henk has repeatedly broken the contact with friends, once there is no contact anymore, he sends desperate messages in which he indicates that he might hurt himself. His sister mentions that:

Now he saw that people care about him – in the FGC. But he finds it damn hard to deal with it properly. The first thing he did at the conference was saying how idiotic the conference was and that we did not have the potential to listen to what he wants. (Henk’s sister)

The fragment illustrates Henk’s difficulties in dealing with the reality that people care for him, undermining the image that he has of the world and foremost himself. Henk wants to be legitimated and recognized by others, but at the same time experiences great difficulties with the accompanying relationships. Henk has become a “loser” in the symbolic struggle for recognition; he does not see himself as a socially recognized social being.

In the case of Frans we see that his friends appreciate and acknowledge him for who he is. They recognize him by conforming he is living his life in the best possible way. Frans sees his friends regularly and they eat together, make music together or go for a walk. His family, however, has another opinion about some parts of Frans his life. Especially Frans’ mother

finds it hard how Frans lives his life; she acts more like a professional care giver which results in Frans leaning backwards. The following fragment illustrates the foregoing:

During the member check it becomes clear that Frans is satisfied with the way he is fulfilling his life. Some of the people involved, amongst them is the coordinator of the FGC, find it hard to understand that Frans is satisfied; as they think Frans has more potential. Frans gives the impression that he finds it annoying that everyone has come together again, just for him, while everything is ok in his life according to his own opinion and seems somewhat blunted for the different opinions about his life. (EM, no. 43).

The coordinator later reflects on his attitude and concludes that:

We can all be happy in our own way. (The FGC coordinator)

It seems as the struggle for recognition, that Bourdieu speaks of, has somewhat left Frans his life, at least when it comes to his relationship with his family. He is satisfied and of importance is that his friends, whom have a similar life style, do not bother him and seem to appreciate him, that is enough. Paraphrasing Bourdieu: Frans is not a “loser” of the symbolic struggle in the field he shares with his friends.

The family and friends of Ingrid are really committed with appreciating Ingrid for who she is. They acknowledge Ingrid for who she is and try to balance between ‘normal’ contact and a more controlling function with regards to Ingrid’s psychotic vulnerability. Ingrid’s brother says:

It is hard, sometimes, to determine whether Ingrid really does not want to see me because she does not feel like it, or because she is in a bad place. (Ingrid’s brother)

The family does not want to give Ingrid the feeling that she is thought of as a ‘crazy person’ by being suspicious about every move she makes. Although the family has a certain sensitivity regarding appreciating and recognizing Ingrid for who she is, Ingrid experiences feelings of shame when asking them for support. The next fragment makes this visible:

Remarkable is that most family of Ingrid indicates that the reason why she finds it difficult to ask for help, is that it evokes feelings of shame. In the interview with Ingrid herself, however, she does not connect this to shame. She mentions how she asks her family for support, but does not talk about experiencing shame. The subject of shame is not discussed

with the interviewer. Maybe talking about it out loud would make it even more real or maybe Ingrid is afraid she will be portrayed as weak (EM, no. 44).

The struggle for recognition becomes visible in Ingrid's life in different ways; despite the attitude of the family Ingrid does not ask for support as this could be a potential threat for recognition by others. This is probably related to the family history, relationships are described as good but at the same time they bring along a traumatic past. In the past, during Ingrid's psychotic episodes her family could be overprotective, leaving Ingrid feeling belittled and not taken seriously. She tried to fight against this overprotective mechanism from her family by proving that she was capable to live a normal working life. Which led to pushing her boundaries and eventually triggered her psychotic vulnerability. It becomes evident that Ingrid needs boundaries and limits to make sure that she does not lose contact with reality, and that family and friends make sure that Ingrid still feels appreciated by them. After the FGC Ingrid has taken matters into her own hand. She is working a little less and arranged professional support that fits her own vision on life in a better way. Furthermore she describes, in the member check, that she wants to organise more meetings like the FGC in the future because situations can change. Ingrid is not afraid to look at the future, as Bourdieu mentions counting in other people's lives and being of importance provides a justification of existence that brings along trust in the present and future. Ingrid certainly has the feeling that she is of importance in the life of her family and friends and is appreciated by them. This gives her the confidence to face the future.

To sum up this subsection, when considering the case of Henk, we see the situation he is in generates hopelessness. On the one hand he avoids attachments but on the other hand seeks contacts on his terms; dosing the closeness of it. Henk does not seem to know how to live up to the expectations in his social fields and experiences little symbolic power. In the process leading up to the FGC more attention could have been given to his fears and difficulties regarding his position in the social fields he takes part in. In Frans' situation the FGC revealed that his friends support him in his view on life where he chooses his own path, he gains support from them. Knowing that recognition or appreciation by his family is hard to get, he keeps his distance, pursuing to live the life he is capable of. This could have impact on the way Frans views his future, as he still has little symbolic power in the field of his family. In Ingrid's case during the FGC it becomes apparent that asking for support does not mean that she is not appreciated by the people surrounding her and that the appreciation from important others leads to confidence in her own future.

Social fabrics & gift giving

Bourdieu mentions the importance of gift giving in the shaping of relationships with others; gift giving can be seen as a form of symbolic capital as it based on reciprocity (Bourdieu, 2000). In the end if a receiver of a gift cannot return the favor they may lose appreciation or recognition from others. The social network of Henk mostly consists out of relationships with family and a few friends. His social network is larger than expected by the mental health professional involved in his case for several years. These friends are sometimes supported by Henk, he loans them money which is never returned. His friends do not show him appreciation and Henk seems to avoid the situation wherein the favor could be returned, after all he knows what to expect from his friends after a few times. He wants to be ahead of feeling disappointed and ashamed, and hangs out with unreliable friends. After all they have been through Henk's family still supports him, they arrange new furniture and help him moving between houses. Henk, however, does not seem to appreciate this or cannot handle that these people seem to care about him, just a few weeks after all the help with moving he is evicted out of his house. The favor is not returned, for the family it would have been enough if Henk would have just lived there for a couple of years without too much trouble. In the conference his sister makes clear:

We are here for you. You should not abuse our help, but we are here and want to help out. (Henk's sister)

Frans has a social network containing family and friends. According to his sister:

I do not know whether the network of Frans represents an average network, because his friends do not live a very ordinary life. (Frans' sister)

Frans sees his friends on a regular basis, they eat together and make music or go walking. Sometimes he could take a little bit more initiative according to his friends. The involved mental health professional thinks that a change in the dynamics between Frans his mother and Frans himself could be promising, because he can be very claiming towards his mother. At the member check the following observation has been made:

Frans seems to coincide in his fate of a quiet peaceful live, in the time we live in that could be considered as quite brave. Especially since his family is not willing to agree on his vision

and have different expectations, which is striking considering they still have a role in his life (EM, no. 46).

Frans does not want to answer to the expectations his family has of him; if his family arranges something he does not play along and returns the favor. His reputation and thus symbolic capital is under tension in the field of his family. Frans loans his justification for existence from his relationships with his friends; where he is expected and has some commitments.

The network of Ingrid is quite large and consists of family and friends from church. The goodwill of family and friends towards Ingrid is vast, partially because she lives up to expectations of reciprocity. The family of Ingrid is willingly in supporting Ingrid and they do not expect anything in return, as long as the friends of Ingrid back them up. However, as mentioned before, Ingrid is a person who is eager to support someone else. She helps out in the church, for example and took a family member in her house that needed support. This was however not the best idea as a friend explains:

At the time I thought it could be a good experience, Ingrid helping a family member out. But now I know it is not a very good idea, because it is very stressful and then it goes wrong again. (friend of Ingrid)

For the persons involved in Ingrid's life it seems that the willingness and eagerness of Ingrid to do something in return is enough, the favour does not actually have to be returned, a gesture is enough as a friend exemplifies:

She gives me a hug now, to say thank you. In my opinion that is a nice gesture. (friend of Ingrid)

Ingrid had a chance at the FGC to notice that the shame she feels when asking for support is not necessary and that she does not risk the appreciation and recognition from her family.

To sum this sub-section up, in Ingrid's case the FGC accelerated the process of ownership over her own life, she makes the decisions now and is conforming herself to a 'new lifestyle' where she is able to canalise her struggle for recognition in a way that is appropriate for the situation she is in. In the case of Henk there are possibilities to further exploit the potential of the FGC.

In both cases of Frans and Henk, there are possibilities to further exploit the potential of FGCs. In the case of Frans the coordinator found a match with the family on basis of norms and values that ‘one should make something of his life’. Frans’s voice was hardly heard at first, the coordinator learnt to look for the ‘right question’ and to ask for clarification. More attention to underlying expectations in the social network and the relationships between different network members seems important here, especially when it comes to reciprocity in the relationships and in the end appreciation and recognition from others.

Concluding Henk’s case, despite his social network that still wants to play a (more modest) role in his life he remains in the discourse of ‘me against the world’. This struggle cannot be settled in one conference. Would it ever come to a follow-up conference, more attention should be given to the difficulties of returning gifts and living up to expectations as well as everybody’s role in it.

Reflections on the cases

By plugging in the work of Bourdieu the value as well as the complexity of the FGC process in various situations becomes understandable. Our theoretical goals, and the lessons we seek to draw from our study, extend well beyond the three cases. It underlines the potential of Bourdieu’s theory on symbolic power to analyse strength and weaknesses of social fabrics in society and communities, but also the capacity of FGC to rejoin the field for those who withdrew from it.

Malmberg-Heimonen and Johansen (2014) indicated that research into the role of reciprocity in the process of FGC is important. This article using Bourdieu’s theory is an attempt to do so. His theory makes it understandable why the struggle for symbolic capital in the different fields people are part of, comes with all sorts of difficulties that are related to reciprocity and gift-giving and are connected with legitimation, recognition and a mismatch between field and player. As Bourdieu mentions gift-giving and reciprocity are uncertain processes that are related to appreciation or recognition from others (Bourdieu, 1990).

Organizing an FGC in coercive psychiatry is complex, as illustrated in the cases there are many underlying expectations and mechanisms that play a role in the relational dynamics between the different involved people in the conference. The cases of Henk and Frans show that they cannot join the fields of family and/or friends; we see the symbolic struggle for recognition. Henk wants to be recognized by his relatives and friends, but cannot deal with the fact that people care about him. He seems to be afraid for the closeness of his relatives and along coming expectations and issues related to reciprocity. Frans is not recognized by his family, especially his mother acts like his professional caregiver. In this field Frans does not have much symbolic

power. In the field of his friends however Frans is expected to eat and make music together; here he does not appear to be a “loser” of the symbolic struggle Bourdieu speaks of. To further enhance the potential of the FGC in the cases of Henk and Frans, the participants of the FGC could discuss underlying expectations between participants, the different relationships between network members, and the different roles in the field. In the case of Ingrid her family has a certain sensitivity regarding recognition; they don’t want Ingrid to have the feeling that she is thought of as a ‘crazy person’. Ingrid does experience shame when receiving support from her family – she really wants to return the favor.

Conclusions and implications

By looking at the cases by plugging in Bourdieu’s, the importance of discussing relational dynamics, expectations and struggles when it comes to recognition and power are foregrounded. This was made possible by using the guidelines of Jackson & Mazzei (2013); by using their ideas we payed attention to social context, insiders’ perspectives and hermeneutic interpretation instead of reducing data to codes and loose fragments. It became possible to identify underlying processes in the three cases, that were not evidently present at first, and give meaning to how clients relate and respond to others in the process of a FGC. Through ‘thinking with theory’ the conformism of Ingrid to ‘join the herd again’ becomes understandable, the same goes for the destructive behaviour of Henk where ‘me against the world’ has a central place; we see the (troublesome)-search for recognition and appreciation. Or in the case of Frans, we see the avoidance of that struggle in the field of his family, having a low-profile attitude as he strives to “live on the lee side”.

The insights of this paper can deepen the understanding of social workers regarding the tacit motives of clients to avoid the expectations of the field and to encourage them to rethink their withdrawal from the field and discuss, decide and negotiate on relational dynamics in the field. In an FGC, professionals and coordinators have a facilitating in role in this process. This requires a shift of mind from professionals; they contribute to the plans of clients and their social networks and help them to gain symbolic capital. When experiencing coercive treatment in psychiatry, such as a compulsory admission, a total loss of symbolic power occurs. As Bourdieu (2000) mentions symbolic power, associated with recognition and appreciation, opens up predispositions regarding future possibilities and is important in the way people vision their future. As a decision model FGC has the potential to create opportunities where people can decide and negotiate on their positions in the field, discuss relational dynamics, restore social fabrics and symbolic power in relations. This could

eventually contribute to an increasing feeling of hope; as people experience more power to influence their possibilities in the future.

FGCs complement the repertoire of strategies to prevent and reduce coercion. FGCs have potential to avoid symbolic violence and strengthen the quest for more symmetric and non-coercive practices. Plugging in Bourdieu like we did in this paper might open up possibilities for social workers to see what is going on in their cases engage in partnership relations of another kind, and perhaps offer clients and their social network a way to return the field or re-evaluate opinions and commitments. Natland & Malmberg-Heimonen (2013) studied the position of FGC coordinators in the FGC process and the interaction with different actors. In further research on FGC in (coercive) psychiatry more attention should be given to the relational dynamics in the FGC process and the different roles and positions all actors have; coordinators, professional, families, friends and clients. A follow-up study using participatory action research is required to experiment with these findings and to learn more of its applicability. This research design might create possibilities for a joint learning process together with different participants and stakeholders, in which a new habitus can be developed and where there is an eye for tensions, different expectations and power in relationships (see, Groot et al., 2018 and Abma et al., 2019).

Strengths and limitations

Using a theory-driven analysis and interpretation of the data, as in this article, it is inevitable to leave findings out. In other articles on this project we have presented an overall picture of the outcomes (Meijer, Schout, De Jong & Abma, 2017), in this article however we left everything out regarding quantitative outcomes and implementation problems in order to focus on understanding the difficulties of restoring relationships in coercive psychiatry using FGC. The weakness of this approach would probably be its external validity and its reliability. Knowledge claims based in this article are therefore modest; when the insights of this article are used and recognized as genuine and inspirational for coordinators and professionals in the field, these claims can become more confident.

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Chapter 9

Involving undergraduate nursing students in participatory health research: implications from the Netherlands

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Abstract

Purpose: Internationally, there is little reported experience with involving undergraduate nursing students as co-researchers. This paper demonstrates and discusses the inclusion of final year undergraduate nursing students as co-researchers in collaborative and participatory health studies.

Data sources: A demonstration of how undergraduate nursing students in the Netherlands got involved in a large-scale study on the process and outcomes of Family Group Conferencing in mental health and how their contribution was optimally utilised. Literature published in the past twenty years that reported on participatory health research initiatives, and more in particular the role of undergraduate nursing students as co-researchers herein, was purposively searched for to provide an extra layer of understanding.

Implications for nursing: The benefits for students participating in a large-scale, participatory health research are twofold: firstly, students could conduct a research thesis tailored to their studies, and secondly, as demonstrated in the illustrated research project, they gain insights and ideas for transferable skills to meet changing demands in the nursing profession such as activating self-care and social resilience, utilising social resources and supporting near communities.

Conclusion: The inclusion of students as co-researchers, among various other stakeholders, in participatory health studies provides them learning opportunities that can diminish the theory-practice divide; it encourages students to implement nursing skills they acquired during their studies and learn from experienced supervisors through demonstration and the transference of tacit knowledge.

Introduction

In the last decade research professorships ('lectoraten') have been created at schools of nursing, part of universities of applied sciences, in the Netherlands with the aim to include students as co-researchers in large-scale studies. One means to an end for these universities is their role in practitioner-based and participatory health research. This has led in recent years to multiple initiatives, such as the development of new research modules for final year baccalaureate students (Van der Donk & Van Lanen, 2015) and workplace learning opportunities in clinical placements where students participate in care innovation projects established between care organisations and nursing faculties (Snoeren, Volbeda, Niesen, & Abma, 2016). From 2011 to 2015, we gained experience as a research professorship related to a Dutch school of nursing with engaging final year undergraduate nursing students as co-researchers in a large-scale study on the process and outcomes of Family Group Conferencing in Mental Health Care.

For decades, knowledge transfer in health care was largely passive and linear "where research funding (inputs) enabled design of research protocols and interventions (activities) leading to papers (outputs) and new or improved services (outcomes) producing better health and reduced mortality (longer term impact)" (Abma, Cook, Råmgård, Kleba, Harris, & Wallerstein, 2017, p. 3). Academics knew 'what was best' and did not take the practical knowledge of professionals and the lived experiences of clients into account. Since the new millennium, voices are raised for the inclusion of a varied group of stakeholders in health research, among them health professionals but also clients (Abma *et al.*, 2017). Practitioner-based and participatory health research is of importance here, as it takes place within the context of a professional practice, is conducted in corporation with health professionals and clients, and aims for the improvement of this practice (Abma *et al.*, 2017; Van der Donk & Van Lanen, 2015). In here, there is a continuous systematic interaction with the environment to answer questions that emerge during the distinctive phases of the research cycle. Participation of various stakeholders is an important value in this type of research. Nursing students, however, are not always considered as stakeholders or co-researchers in participatory health research, while their inclusion could diminish the theory-practice gap as knowledge and practice are systematically integrated into research, education and services. But also because the research agenda is not dominated entirely by academics and the perspectives of a varied group of stakeholders are taking into account (Abma *et al.*, 2017). Students as participatory (co-)researchers are, in the words of Abma *et al.* (2017), ideally positioned to support "reflection and dialog to enable critical awareness of hierarchies and

of power relations that otherwise are taken for granted” (p. 14). This is especially important when doing research with marginalised and vulnerable client groups, such as those who are confronted with coercive measures in psychiatry and other forms of disempowerment and paternalism (Authors’ Own). Participating in such a study will guide students how to act as advocates for clients and their families once they are graduated.

In our participatory research project, we included and worked together with final year undergraduate nursing students as co-researchers and trained them how to empower clients and their network to share their perceptions on a social intervention, Family Group Conferencing (FGC), where up to the implementation of the project just little knowledge was gained in mental health. FGC, in its very essence, aims for the democratisation of decision-making in care and social welfare practices. It was therefore self-evident that a collaborative and participatory research design would be the best fit to evaluating FGC when this would be organised for a group of clients with a history of disempowerment and marginalisation. The aim of our project was to shape a research practice with various stakeholders and evaluate in what kind of situations and under which circumstances in mental health FGC could be deployed. In this discursive paper we address the question how to collaborate with undergraduate nursing students in a large scale, participatory health research and illustrate their added value as co-researchers. This might inspire nurse educators across the world to develop creative assignments to foster social resilience and mutual learning.

Improving the research capacity of undergraduate nursing students

Since the new millennium, several nursing faculties have introduced research modules in their undergraduate courses. In the Netherlands, as in other countries in the European Union (Gallart, Bardallo, de Juan, Rodríguez, & Fuster, 2015), the bachelor thesis is the mandatory conclusion of studying an undergraduate degree at a school of nursing. The process of developing a proposal, gathering and analysing data, and finally writing a thesis, lasts a period of 20 weeks during which students work full time (40 hours a week without being enrolled in other courses) on their research subject. Various scholars (Bailey, Zanchetta, Velasco, Pon, & Hassan, 2015; Borglin & Fagerström 2012) argue that undergraduate nursing students are traditionally not equipped with the right tools to develop these skills in their taught program. Undergraduate students often perceive research as difficult and complicated (Ax & Kincade, 2001; Christie, Hamill, & Power, 2012; Niven, Roy, Schaefer, Gasquoine, & Ward, 2013; Spatz, 2008), and therefore develop negative attitudes towards it (Halcomb & Peters, 2009)

or lack to see its relevance and cannot connect it to the practice of nursing (Sheriff & Caney, 2006). Schools of nursing, therefore, are increasingly emphasising the ability of research and academic writing in their undergraduate curriculum (Borglin, 2012; Halcomb & Peters, 2009; Johansen & Harding, 2013; Latham & Ahern, 2013). In most European countries, this capability must be reflected in students' final bachelor thesis which is the apotheosis of their 4 years' undergraduate degree. Lundgren and Robertsson (2013) argue that writing a bachelor thesis generates transferable knowledge and skills useable in nursing practice. Successfully completing a research project with a well-written thesis is the ultimate demonstration that students are able to think critically about and deploy the best possible research methodology to address problems in their field of practice, evaluate theoretical assumptions, construct arguments and support these with insights from the academic literature, and present their thoughts logically (e.g. Bailey *et al.*, 2015). Recent evidence from Turkey also suggests that writing a thesis has a positive effect on how nursing students perceive research and how it evokes awareness of the essence of evidence-based practice (Toraman, Hamaratçılar, Tülü, & Erkin, 2017).

As Halcomb and Peters (2009) on the basis of their thorough literature review conclude, there is a lack of rigorous evaluation of effective strategies for engaging undergraduate nursing students in research. The examples that are available report on the positive experiences that students gain by contributing to research initiated by faculty nursing staff, such as learning that research can be exciting and relevant, being involved in every phase of the research project, gaining a greater knowledge of a particular nursing intervention, and the improvement of patient care (see Greenawald, 2010; Jamerson, Fish, & Frandsen, 2011; Jansen, Jadack, Ayoola, Doornbos, Dunn, Moch, Moore, & Wegner, 2015; Niven *et al.*, 2013; Ravert, Boyer, Harmon, & Scoffield, 2004; Sheriff & Chaney, 2006; Snoeren *et al.*, 2016; Taber, Taber, Galante, & Sigsby 2011; Thompson, McNeill, Sherwood, & Starck, 2001). In recent years voices have been raised that call for more creative and interactive strategies to make science relevant to the practice of nursing, such as the embedding of research throughout curricula apart from the separate research classes (Christie, Hamill, & Power, 2012) and the inclusion of students as research assistants (Burkhart & Hall 2015). Jansen *et al.* (2015) report on recent initiatives in US-based schools of nursing where undergraduate students work as co-researchers in faculty research rather than carrying out small-scale bachelor thesis research. There is just few experiences with this outside the United States.

Data sources

This demonstration and discussion paper is based on experiences we have gained with including final year undergraduate nursing students in a large-scale study conducted by a research professorship related to a school of nursing in the Netherlands. Central to this paper is describing how undergraduate nursing students can get involved in participatory health research and how their contribution could be optimally utilised. Literature published in the past twenty years that report on participatory health research initiatives, and more in particular the role of undergraduate nursing students as co-researchers herein, was purposively searched for to provide an extra layer of understanding.

Description of the research project

Research on Family Group Conferencing in mental health care

Family Group Conferencing is an approach which aims to bring the informal system of clients and their social network together with the formal system of the government and care agencies (Pennell & Anderson, 2005). Consequently, both systems have hold on each other's information and can make the best decision on how to solve a problematic situation. Different actors 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'. The 'heart' of the conference is the private time where the client together with the social network develop a plan on their own which in cases of threatening measures is reviewed by professionals on practicability and achievability. It is the aim in 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). The plan describes the roles and responsibilities of the different actors.

From 2011 to 2015, we examined the practice of FGC in mental health care, first through a research professorship related to the School of Nursing of the Hanze University of Applied Sciences in Groningen, and since 2013 from the Department of Medical Humanities of the VU University Medical Centre in Amsterdam. The research project consisted of two parts. From 2011 to 2013, 41 family group conferences were studied in a public mental health setting in the north of the Netherlands, while from 2013 until 2015 we examined 41 conferences in three regions (Groningen, Noord-Holland-Noord, Eindhoven and its surroundings) as a means to avert coercive measures in psychiatry. Altogether, 82 case studies were carried out to evaluate the process of FGC and their outcomes in terms of strengthening clients'

capabilities, mobilising social support, improving their living conditions, and reducing the risk of coercive measures. We interviewed around 600 participants (clients, their family, friends, neighbours and colleagues, health and social professionals and FGC coordinators) who had experienced FGC. The research project therefore is the world's most in-depth study on FGC for adult care recipients.

In the case studies, we collaborated with multiple stakeholders. We invited people from various backgrounds to assist in the formulating of research questions and methods. These stakeholders were linked to client and family movements, professionals from mental health care institutions and academics. A continuous collaboration with clients, their families and mental health providers was initiated. Besides, the Dutch organisation responsible for conducting FGC (De Eigen Kracht Centrale), was included as a stakeholder. All these stakeholders had their own interests in the implementation of the research project. The involved students needed to act in this dynamic field and were responsible, together with their research supervisors, for the evaluation of a single case study.

The collaboration between students and supervisors

Around 165 final year undergraduate and 10 postgraduate students participated, in this study as research team members; they came from various bachelors and masters programs. Many (around 70) were students finishing their bachelor degree in nursing. In a bachelor research study it is an objective that students independently work on a specific subject, supervised by nursing lecturers who encourage critical and reflexive thinking (e.g. Gallart *et al.*, 2015; Lundgren & Robertsson, 2013). An important pillar these days at Dutch nursing schools is to stimulate an inquiring attitude in their students. Nursing schools therefore questioned whether this objective was within reach when students would participate in a predetermined group project. That students would participate in such a large-scale study was new for nursing schools and therefore a little uncomfortable for them. Would students be given the freedom to shape their final research project at their own discretion, as long as the requirements of their school programmes were followed? Was the research protocol as it was prescribed from the research group not too much of a straitjacket? Without the students we would have never been able to carry out such a thorough study; simultaneously we offered them the opportunity to take part in a large-scale study where their critical and reflexive thinking about a relevant nursing issue was developed, however we had to ensure that their involvement allowed them to uphold the rules governing their thesis study. On the other hand, there were also goals beyond academic writing skills at stake in this project. These goals refer to the broader aim of this project to establish together with students a practice of clients, families,

near communities, professionals and municipal services, which tried to minimise coercion and restore relationships.

The students were supervised by four experienced researchers (supervisors) who were employed at the aforementioned research professorship of the Hanze University of Applied Sciences and from 2013 at the Department of Medical Humanities of the VU University Medical Centre. Two of them worked part-time as mental health nurses, while the other two had gained significant knowledge on coercion and family involvement in psychiatry through former studies they participated in.

The recruitment and training of students

Prior to the start of their bachelor research, students were recruited to work on the study through the digital communication channels of their university schools. An appealing title about doing research into the practice of FGC in public mental health care and coercive psychiatry, and an accompanying text proved to attract interest among students. Students were then invited for an interview guided by one of the supervisors to ascertain their level of interest and research capabilities. The supervisor would also be the assessor of their graduation and as such would evaluate the student's thesis together with a second assessor. These second assessors were lecturers employed in the involved schools of nursing who had experience in supervising undergraduate students throughout their bachelor theses. They were responsible for a second review of the students' proposal and thesis. Because the supervisors were trained in the undergraduate curriculum of the nursing schools and took part in peer-review sessions with the second assessors, they were able to simultaneously supervise the students in the merit of the research project as well as addressing the requirements of their school programs.

After the supervisors and students had decided to engage in the process, students were asked to present their research questions and objectives. Students were encouraged to independently come up with a research proposal that would fit into the framework of the research project. Once students had gone through this process, they received the standardised research protocol with the request to use it to document their plan. The final proposal was the best of both worlds: students' own opinions and ideas, and the requirements of the research group and their university schools received equal priority.

The next step was to train the students in approaching the participants of the FGC and doing the interviews. Niven *et al.* (2013) describe that undergraduate nursing students usually perceive research as difficult. They therefore propose a "one step at a time" approach when training in all stages of the research process (p. 67). Although the schools of the students involved in our research project offered courses on qualitative research, the training that we

provided was specifically aimed at preparing them for doing a qualitative case study (Stake, 1995) using responsive evaluation methods (Abma, 2005). Besides general research skills (gathering and analysing data), nursing competencies such as empathy, perseverance, and dealing with disruptive and unpredictable behaviour (see Author's Own), ethical awareness (the assurance of preserving anonymity and confidentiality) and a sense of self-confidence and self-protection (e.g. Blenkinsop, 2003; Lundgren & Robertsson, 2013) were central to this training. During the interviews students needed to be able to bring attention to the topics mentioned in the protocol, but simultaneously to be open to new insights that could come to the surface. Awareness was built on the iterative process of interviewing (e.g. Merriam, 2009).

The last training session consisted of a two-hour session on data analysis using the software programme ATLAS.ti (Friese, 2014). This programme is a useful tool in structuring interview data where the answer on a particular question in every interview can be given at a different time, and helped in finding a 'red thread' running through the diverse stories that the students gathered from their respondents. This 'red thread' enabled the process of the conference to be described, including all the specific twists and turns within it.

The research cycle

This study followed a Rortyan, pragmatic theory of truth (Authors own; Rorty, 1991). Students in this project were trained to gather information on what works for the participants of the FGC, to derive from each conference a narrative on the problematic situation prior to the conference and the plan that got established to address it.

Students were especially trained in reflecting on new insights that would emerge during the interviews (iterative reflection); this helped in understanding why the conference had succeeded or failed. The supervisors 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), and therefore encouraged academic writing and critical thinking. As mentioned before, a second assessor was included to prevent bias in the marking of theses. As the students were in their final year, they were trained in conversation skills which they already had applied in various nursing settings. These skills helped in establishing contact with and gaining the trust of an otherwise difficult to reach group (Author's Own). The role of the student researchers could be characterised as the 'concerned outsider', who combined empathy and critical reflection with a non-judgmental attitude.

Students conducted the semi-structured 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). They also

maintained a memo list on specific twists and turns during the data collection and analysis. In the interviews, students asked respondents to reflect retrospectively on the process of the conference. Qualitative topics of the interviews were the perceptions of clients, members from their social network, professionals and FGC coordinators on the whole process of the family group conference (referral, preparation, the conference itself, implementation of the conference plan). Several subtopics were included 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, students tried to capture if the social network alleviated the work of professionals and if the conference reinforced the cooperation between clients, their network and professionals.

The semi-structured interviews were recorded, transcribed verbatim and analysed with the help of ATLAS.ti. Interim findings from this analysis were shared with respondents in group member checks (see Guba & Lincoln, 1989), first to validate these findings, and second to provide new insights about the process and outcomes of the conference. These meetings were organised at a time when the majority of respondents could be present, with the proviso that in any case the client would have the opportunity to reflect on the findings. The group was asked to exchange views on the actual developed plan and the plan that should have been developed to better address the problem. This method yielded experiential knowledge, both for the family group, the professionals, the FGC coordinator, and the student researchers. This method also ensured that student investigators stayed close to the data so that they could validate findings and check interpretations. Biases and variations are in this Rortyan approach input for discussion leading to a narrative that works for the group.

A report of each case study was written wherein the process of the conference and seminal moments were described, as well as the outcomes of the conference and the insights that arose during the member check. For most students, this formed their bachelor thesis. The purpose of each case study was to explore 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.

Discussion

Working together with different stakeholders was fruitful and challenging. As around 80 student pairs had helped us carrying out the 82 case studies, it was possible to reach every participant for an interview. We were therefore able to conduct around 600 semi-structured interviews with an average length of 60 to 90 minutes and organise a group member check

in every case study. Without the commitment of these students, we would not have been able to carry out this study at such a large scale. Below we will share the major lessons learned from our research project that could have exemplary value for other nursing schools who aim for the implementation of participatory health research with a prominent role for students herein. We conclude this section with the broad implications a participatory health study such as described in this paper has for the practice of nursing.

Undergraduate nursing students who encourage self-activation and social resilience

Participatory health studies, such as this research project, are shaped bottom-up and give voice to needs, insights and results of multiple stakeholders (Abma *et al.*, 2017). The reflection on this type of collaboration yields added value for all stakeholders. In the process of the family group conferences citizens were confronted with questions like “How do I want to relate to my relative, neighbour or friend?”, “What are my responsibilities?” or “How can we divide tasks?” and learned to address them. The knowledge institutes (universities and schools of nursing) facilitated this process; staff and students learned to promote self-activation and social resilience. In the illustrated research project students demonstrated a critical view on power relations, on the conduct of family group conferences and the role of the various participants (clients and their family, mental health professionals and FCG-coordinators) herein. They provided a fresh perspective to their supervisors and the other stakeholders. Furthermore, students played a role in generating knowledge from individual cases, so other practices could learn from it.

A close working bond between students and supervisors

When implementing participatory health research, a ‘click’ between students and supervisors is important, as both parties would engage in an intensive process together (e.g. Burkhart & Hall, 2015; Lundgren & Halvarsson, 2009; Taber *et al.*, 2011). The benefits of students mentored by experienced researchers is emphasised by various nursing scholars: working closely together with a mentor allows students to gain first-hand knowledge and nursing research skills (Burkhart & Hall, 2015; Jamerson *et al.*, 2011; Lev, Kolassa, & Bakken, 2010; Ravert *et al.*, 2004) and encourages their self-efficacy on how to deploy these (Lev *et al.*, 2010). Besides being experienced researchers, another advantage in the described project was that two of the four supervisors were trained themselves as mental health nurses, while the other two supervisors had extensive experience in issues related to family involvement in (coercive) psychiatry. Therefore they were also able to help students how to make contact and gain trust

of a client group who can frequently act suspicious towards representatives of the professional society (Authors' Own). In sum, the role of experienced supervisors in participatory health research can be described as demonstrators who diminish the theory-practice divide through implicit learning and the transference of tacit knowledge (e.g. Polanyi, 1966).

Students working in pairs complement each other

The undergraduate students worked together in pairs, which meant they were able to reflect on each other's work and counteract individual biases. A possible downside to this approach was that a student with a stronger personality may have influenced a more passive student. However, we mainly saw that students had different qualities and competences, and that they actually encouraged each other to make use of their particular strengths and therefore complemented each other. For example, we saw with several student pairs that one of them had a strong sense of how to make contact and gain the trust of suspicious respondents so that the interviews could go ahead, while the other student had the capacity to think critically so that the insights from the interviews could result in a comprehensive thesis. Working with a large group of students also prevented dominance of the preferences and perceptions of one researcher or the nasty drawing of conclusions – students came up with fresh perceptions that we as supervisors alone never would have thought of. On the other hand, this holds the risk of inconsistent data collection (Thompson, McNeill, Sherwood, & Starck, 2001). The limitations of our study were mainly located in the interview skills of the students and their experiences with and capabilities of analysing qualitative data. This was addressed by the supervisors who managed the whole research cycle of the project. During their case study, each student pair had been guided intensively through the whole research process.

Implications for Nursing

The benefits for students participating in this large-scale research project were twofold: firstly, students could conduct a research thesis tailored to their studies, and secondly, they gained insights and ideas for transferable skills to meet changing demands in the nursing profession (e.g. Blenkinsop, 2003; Burkhart & Hall, 2015; Jamerson *et al.*, 2011; Jansen *et al.*, 2015; Niven *et al.*, 2013; Ravert *et al.*, 2004; Sheriff & Chaney, 2006) such as strengthening clients' capabilities, activating self-care and mobilising social support. Students also demonstrated with the successful completion of the case study and the bachelor thesis they wrote on its findings, that they were capable of writing academically and of incorporating practice based evidence (Hellerstein, 2008) and therefore that they could bridge the 'theory-practice' divide (Borglin, 2011).

A large-scale, participatory health research, such as the one illustrated in this paper, distributes its benefits among all stakeholders. First of all, clients and their network are recognised and acknowledged as equal partners. Second, students can meet real clients, with real problems. They can also apply innovative research methods and get involved in knowledge development. Universities of applied sciences, and schools of nursing in particular, are given tools to close the gap between theory and practice and to meet the complexity of social problems with the contribution of diverse actors in the research process. And finally, for all actors together, large-scale, participatory health research can effectuate the partnership between universities, schools, practice institutions and citizens.

If schools of nursing want to contribute to solving social issues, the dialogue between different forms of knowledge, different disciplines and stakeholder groups is of great importance. Forming communities of practice wherein students, teachers, researchers, nursing practice and citizens all have a role, could be a way to start this dialogue (e.g. Andrew, Tolson, & Ferguson, 2008).

Conclusion

This paper seeks to inspire schools of nursing to engage their students as co-researchers in large-scale health studies conducted by research professorships. Our research project FGC in Mental Health Care revealed that students' participation in participatory health research works well on several fronts. First of all, the inclusion of students as co-researchers, among various other stakeholders, provides them learning opportunities that can diminish the theory-practice gap; it encourages them to implement nursing skills they acquired during their studies and learn from experienced supervisors through demonstration and the transference of tacit knowledge. Second, students provide creative perspectives where a small group of researchers alone would never think of themselves. Besides, pitfalls would be prevented when more co-researchers get involved who can think critically. Students are given the chance to make a valuable contribution to socially relevant research which is a means to become engaged in a subject. Simultaneously their critical and reflexive thinking about such research is developed and it enables them to see what research could add to their practice so they could serve as advocates for marginalised client groups and their social networks. Additionally, this process prevents the conduct of small-scale bachelor theses that after completion would gather dust on the shelves. The final goal for students is not only that they write a thesis that is actually read, but that they take part in a joint learning process on real problems recognised by various stakeholders in mental health.

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Chapter 10

General discussion and conclusion

10.1 A context full of paradoxes and ambivalences

This thesis on Family Group Conferences in psychiatry addresses belongingness, ownership, and moral ambivalences regarding involvement and commitment of family carers and social networks. It demonstrates the moral and relational complexity of being committed to a primary group and getting your life back on track as well as the complexity related to collaborations between informal and professional care.

This theses started in the context wherein governments in different western European countries would wish their citizens to become 'their brothers keepers' and care for themselves and loved ones (Blond, 2010, Newman & Tonkens, 2011, WRR, 2017). Intentions for this call upon citizens can be called, at least, ambivalent. They are inspired by a mix of budget cuts and nostalgic desire for communities and community life (see Abma, 2017; Achterberg & Peper, 2019). Furthermore, to impose participation is, however, paradoxical; perpetuating unequal power relations. According to Abma (2017) when participation is 'given' to the other, it may as well be taken away again later for whatever reasons, thus leaving control and power in hands of external to the people it concerns. The term is not used for citizens who fall within the norm, but for those who are "different", because of vulnerabilities in terms of illness or old age. The new normativity of participation comes with the expectation of adherence to modes of autonomy and self-reliance, and a pressure to look after oneself, and has gradually become a standard that excludes people who are not able to participate due to their vulnerabilities or do not do so in an appropriate manner (Abma, 2017).

Moreover, various scholars, commentators and journalists, point out a challenge in current society related to social cohesion. In Western societies nowadays there is relatively much individual freedom, partly derived from technology as this enlarges choices and people act assumingly. Citizens experience more choices and accompanying temptations because there are more products and services to choose from (Wetenschappelijke Raad voor Regeringsbeleid (WRR), 2017). Slob (2017) mentions in a column the road movie 'American Honey' - about a teenage girl who joins a traveling magazine sales crew, to escape the life she has, and ends up in a whirlwind of partying and law bending. The movie shows a directionless and purposeless dreamland where the teenagers live in a world without connections. What does this imply for the willingness of family and social networks to correct and take care for their relatives and friends?

The above seems full of paradoxes, and shows a discrepancy between government policy encouraging the 'participation society' on the one hand and the zeitgeist of individual freedom and fractured social cohesion on the other hand.

There are more concerns regarding the ideal of the 'participation society'. Hilhorst & Van der Lans (2015) call the soil for this society 'arid and dry'. They call the rhetoric's on the 'participation society' 'poor', the ideals remain a verbal announcement and politicians or policy makers are silent about the changes in social infrastructure that should accompany this tremendous transition (Hilhorst & Van der Lans, 2015). Another critical point comes from Hurenkamp & Tonkens (2011), they describe that independence from communities like family and friends is seen as positive nowadays and professionals are called in when support or care is needed. Tonkens and Duyvendak (2013) question if citizens even want that certain support is given by their social network and also have concerns about the deployment of informal caregivers and volunteers; are they prepared for the workload that is coming their way? Bredewold (2014, 2016) underlines that citizens sometimes choose professional support above care from family-members being ashamed to ask friends or family support and rather 'suffer' in silence. She also mentions positive sides to giving care; but in government policy more attention needs to be given to the different kinds of relationships citizens have (Bredewold, 2014; 2016).

The WRR (WRR: scientific council for government policy) published a report wherein the ideal of self-reliance (in Dutch zelfredzaamheid), which is part of the 'participation society' is questioned. In this ideal self-reliant citizens must be able to plan, act, persevere and also withstand temptations. The WRR (2017) mentions that a large part of the Dutch citizens are not able to act according to the ideal of self-reliance asked by the Dutch government. This is not because of a lack of intelligence but about the appeal that is done on all other mental skills such as the ability to act when needed or to follow good intentions. Abma (2016^{ab}) argues that it is important that we do not lose sight of the social activist movements like the disability movement that originally strived for participation, self-determination and autonomy. Participation now has a neoliberal meaning that of self-reliance, and the interpretation has become merely individualistic. Here may lay a risk of the FGC model, that it sets a new standard that excludes those unable to meet it, especially in a neoliberal context, since the emphasis is on strengthening one's own position and autonomy. Acknowledging suffering and dealing with shame openly is a road to more acceptance of help and support – the condition in which family and network support emerges. FGC can facilitate a dialogue about mutual needs and expectations. A social change needs to be established to achieve a society that has compassion with suffering and vulnerabilities, and the experience of otherness (Bos, 2016). Where there is room for participation and social inclusion fostered by a welcoming social environment (Kal, 2016) and the sharing of power and control, and where people can make their own choices regarding participation, including the choice

not to participate (Abma, 2016^{ab}; 2017; van de Bovenkamp & Bont, 2016). This calls for a different interpretation of participation in which critical reflection on norms and values that hinder participation is of importance as well as cultural change in the acceptability of the universalizing qualities (versus a marker of insufficiency) of vulnerability and imperfection (Abma, 2016^{ab}).

10.2.Unease around Family Group Conferencing

The discourse around the concepts of participation and ‘Eigen Kracht’ influenced the deployment of FGC in the Netherlands, and became a source of unease, especially among those who introduced the idea in our country. A complicating factor was the Dutch translation of FGC: ‘Eigen Kracht-Conferenties’. When freely translated to English it would say self-reliance conferences, suggesting a neoliberal ideal of self-management. As such it was understood and embraced by policymakers, but later also received critique as it was denying the vulnerability and struggles of people with psychiatric disabilities and underestimating the relational complexities in families and social networks and the acceptance of and collaboration with professionals. Hilhorst & van der Lans (2014) describe how ‘Eigen Kracht’ was indeed introduced as a personality trait and was informally seen as a civil liability. Citizens had to arrange support in their own network, or help from volunteers, before they could demand professional support (Van der Lans & Hilhorst, 2014). This order (first arrange support in your own network) disregarded that support of a social network is not always something that can be easily managed and arranged. Family and network relationships are often complex – as we showed in this thesis. Moreover, families also need support and forming a partnership with professionals is a learning process of those involved.

The appeal that citizens have to do on their social networks became a new normativity and an obligation rather than an alternative way of dealing with a problematic situation and restricts the options citizens have when it comes to arranging (professional) support (Van der Lans & Hilhorst, 2014). The call for ‘Eigen Kracht’ thus risked becoming an exclusion mechanism for those who did not fit into or were not able to meet the new norms of self-reliance (Van der Lans & Hilhorst, 2014). Like Abma’s comments (2016) with regards to the concept of participation, the meaning of ‘Eigen Kracht’ was reduced to and became merely neoliberal and individualistic. This was counterproductive because not everyone is able to meet the implicit norm of participation, leading to feelings of shame, social isolation,

exclusion and marginalization⁶. This is at odds with the underlying values and philosophy of FGC, an alternative decision making model with an emancipatory character, mainly used to promote the cooperation of life- and system world and to avert government intervention like out-of-home-placements of a child or compulsory admissions in a psychiatric hospital (Van der Lans & Hilhorst, 2014). So, despite the resonance of concepts as ‘Eigen Kracht’ or ‘participation’ in Dutch society, FGC still remains a relatively new and contested model of decision making which is based on democratization, group learning and self-organization (see Gerritsen, 2011, Schout et al., 2017). The model focuses strongly on strengthening the position and rights of clients and the strength of their network. As well as reducing the paternalistic involvement of professionals. As this thesis shows, reality is complex; and a new kind of realism is needed. By this we do not mean that we should go back to the ‘old’ situation in which professionals often determined the needs of their clients (Kroon, 2018). Nor do we think we can expect ‘everything’ from new structures. The suffering of people with psychiatric vulnerabilities cannot simply be answered or fixed. The same applies to the organization of support and care from family or wider network and to the collaboration with professionals. This thesis has made its way through these swampy conditions⁷ from start to finish, it shows the dilemmas that all actors experience and shows the complexity of being committed to a social network and regain ownership over decisions concerning health care. In the discussion we will elaborate further on ambivalences experienced by social networks and clients in the context of FGC, and the risks as well as the potential of FGC practice as catalyst for recovery and social belonging.

The following research question was central in this study:

How to further the emergence of power sharing through Family Group Conferencing in coercive psychiatry and what lessons can be learned for actors in psychiatry?

To find answers to this central research question we use two guiding sub questions:

How do actors perceive the impact of Family Group Conferencing in coercive psychiatry, and how do they form a new practice around Family Group Conferencing in the light of traditional power relations and relational complexity?

6 Abma (2017), lecture for Movisie at Utrecht, titled ‘Beyond the ideology of isolation, towards an ecological thinking’ (In Dutch: Voorbij de ideologie van isolement, naar een ecologisch denken).

7 Swampy conditions: refers to the swampy lowlands see later on in this chapter.

How to further the emergence of family and social support in psychiatry and what is the importance of such support for clients' ownership and belongingness as well as partnership relations with professionals?

In the next part we will summarize and discuss the main findings and lessons learned for the different actors. In the following section methodological issues will be elaborated on, ideas for further research and practical implications will be mentioned. Finally a general conclusion is given.

10.2 Main findings and reflections

Below we will first discuss that FGC brings along another perspective in the current context of mental health care in the Netherlands and relate FGC to other strategies where advocacy and/or involving the family and social network in care have a central place. Then we will elaborate on how FGC has a contribution in the recovery processes of people experiencing mental health problems by restoring ownership and belongingness, and consider how FGC can be a vehicle for forming a partnership between different actors in psychiatry. We focus on moral and relational complexity, participating in courageous conversations and the contribution needed from all actors in forming a new practice.

10.2.1 FGC practice: a catalyst for recovery

In chapter two we provided a quantitative overview of the perceived impact of FGCs in coercive psychiatry and throughout the chapters 5, 6, 7 and 8 we discussed different cases characterized by a diverse range of psychiatric problems and a (long) history in mental health care settings, sometimes combined with addiction problems, housing issues, or deprivation of social contacts. These variation of cases shows the diversity and complexity of FGCs in situations in this research project. The quantitative overview showed that in most situations, where an FGC was organized, ownership over the problematic situation was regained. Respondents experienced more control over the situation they were in, after the conference took place. A small, but not significant, decrease in coercion was also reported after the conferences. Furthermore belongingness was restored; the respondents experienced more social support after the FGC. The cases show that it is possible to gather people from a social network to participate in an FGC; the networks vary in size from small (case in chapter 7) to larger (case of Ingrid and Frans in chapter 8).

In chapter 5 we described the potential of FGC as a catalyst for recovery for people who experience ongoing mental health issues. FGC is consistent with the ideas behind the recovery oriented approach, since empowerment, strengthening and widening the circle of support are core values. In the two cases in this chapter FGC contributed to restored and intensified contacts with family, friends or neighbours, an increase of practical support, exchange of expectations and favours between family members, and a decrease of professional support. However, the cases also show that FGC is not a straightforward model. Expectations of each other were for example low in advance because of what happened in the past or the implementation of a plan was complicated due to confusion about tasks and roles. Through sharing stories, understanding each other does become easier (see chapter 5, 6, 7 and 8). The social networks were sometimes expanded, by restoring relationships with ‘old’ friends or ‘lost’ family members (chapter 5). These modest results are promising as the research population consisted of people who had a history of coercive treatment and where it was thought that coercion was the only solution to the problematic situation they were in. We often saw that FGC was deployed when other options were already exhausted. Working on relationships was not easy and required from all actors a degree of openness about their needs, experiences and opinions. They needed to overcome shame and give each other a new chance to engage in dialogues and thus create mutual understanding. This was a process of muddling through where mistakes were made and new beginnings were not uncommon.

If we take into account chapter 6 it also becomes clear that there were multiple situations where people were not able to get a grip on the situation; they were overwhelmed by the crisis-situations they were in. Sometimes they found it stressful to work on plans or they needed multiple conferences to work together in making a plan operational. These cases also hold learning potential as they show how the potential of the FGCs can be explored further; by perhaps making changes to the model or expanding the education of FGC-coordinators with the insights from Bourdieu (see reflections below). The positive outcomes of the FGC processes are fragile. Actors are challenged to keep struggling in swampy conditions; where they have to find a way to deal with each other and the situation in a suitable way and continue to engage in a dialogue in order to keep positive changes and further improve their mutual understanding.

Reflections

In their review article, Skaale Havnen & Christiansen (2014) describe that FGCs are seen as useful, sometimes are associated with more cohesion between family members, stimulate creativity, generate a desire to help, activate recourses, re-establish unity between family

members and provide the hope that help and support are present in someone's network. The increase in ownership and belongingness found in our study corresponds with the underlying concepts of FGC, where empowerment, strengthening and widening the circles of support are emphasized (Frost, Abram & Burgess, 2012; Skaale Havnen & Christiansen, 2014).

Recovery and empowerment are connected to each other, they both are personal processes in which people get to know their own possibilities and vulnerabilities and gain the courage to embrace the future again. In doing so, they learn to rely on their own equity and resilience. The recovery process is linked to empowerment and emancipation (Slade & Longden, 2015; Boevink 2017); it is about taking back power and control (Bonney & Stickley, 2008). Tew (2012) refers to different forms of recovery capital: economic capital, social capital, relationship capital and identity capital. All are of importance in the recovery process. He describes persons who experience mental health problems as persons who have the potential to move forward, build on existing strengths and resources, with support from interventions and services that help to address gaps in their ability to mobilize forms of recovery capital (2012, p.13). His analysis shows that it is of importance to intervene in relation to clients social context, in order to promote longer-term efficacy and sustainable social capability. Relationship capital involves having significant others that can simply be there, through different periods of ups and downs: 'people who may be touched and moved by our experiences without being overwhelmed by them (Tew, 2012, p. 8)'. Especially of importance are relationships that offer recognition and acceptance with some degree of reciprocity: recognition of one's uniqueness, value and potential, and acceptance of the reality and severity of one's mental distress' (Tew, 2012, p. 8).

Family, friends or neighbours, volunteers and peer-supporters have a role in the recovery journey of individuals and their social network; as a dominant focus of (peer) support is supporting people in identifying their own dreams and aspirations and advocating them (Stratford, et al., 2017). The process of recovery and empowerment can be burdensome and tough. Kunneman (2009, p. 157) describes how clients in mental health care suffer from 'social wounds', being at the bottom of the social ladder and suffering from the accumulation of underprivileged backgrounds, lower levels of education and the awareness of being thought of as a 'second-class citizen', accompanied by a reduced cultural capital. Cultural capital refers to knowledge, cognitive skills and education of a person with which a certain degree of social mobility can be realized (Bourdieu, 1990). Empathy, personal attention and space for co-creation become scarce when someone's position on the 'social ladder' is low and has little contribution to the dynamics of postindustrial society or is perceived as a nuisance to those dynamics (Kunneman, 2009, p.157). The chance to be confronted with professionals,

that need to follow protocols and guidelines within their institutional framework, increases for these people (Kunneman, 2009, p.157). So eventually, when ‘in a bad place’ the circle of informal support decreases and that of professional support increases. While counting in others people’s lives and being of importance for them, provides a justification of existence that results in more trust in the present and in the future (Bourdieu, 1990).

Bourdieu’s theory is a helpful tool in understanding the strength and fragility of social fabrics. It lights up different mutual expectations, roles and positions in the social fields, the way in which participants want to relate to each other and express appreciation or recognition. It also sheds light on the role on how the struggle for recognition is a competition for symbolic power and gains its existence from others and their appreciation (1990, p. 241). Professionals and FGC coordinators have a role in facilitating this process of discussing, deciding and negotiating on relational dynamics in the field. The competition for symbolic power is not something that is easily ‘solved’ or instrumentalized; it especially requires a different attitude, in which empathy is important. But above all, it requires tolerance for imperfection and the uncontrollable, for the fact that sometimes nothing can be ‘done’ other than to endure the situation. FGC can facilitate the way back to the field and accompanying relationships, and offers a platform, where people share personal stories, work on understanding each other and where there is room for co-creation. It offers an opportunity to avoid the reproduction of dependency cultures; as clients are facilitated to re-join the field and shape their relational autonomy fuelling the recovery process (see chapter, 3,5,6).

10.2.2 Forming a new practice: ambivalences and relational complexity in family and network support

Throughout the different chapters it became clear that forming a new practice based on power sharing via FGC is complex and builds on the contribution of all those involved. Multiple contingencies are of influence when it comes to drawing up a plan to deal with the situation at hand; commitment of the different actors is essential. We saw how actors involved in the FGC experienced different ambivalences and relational challenges when participating in the FGC. Per subheading we will now discuss these ambivalences and challenges.

Clients & their social network

Clients experienced different ambivalences when it came to participating in a conference; they found it hard to involve their social network because of shameful feelings about things that had happened or because of experienced stigma (chapter 6 and 8). They questioned if people want to be involved in their life and are willing to give support. Furthermore they wondered

if family and friends appreciate them for who they are (unconditionally) and are hesitant in 'exposing' themselves at the conference; it takes courage to be vulnerable and not fit into societal norms on autonomy and self-sufficiency (chapter 6 and 8). This is even harder having experienced coercive treatment in psychiatry, where a total loss of symbolic power occurs. Clients cannot participate in the fields they belong and lose recognition from important others. The aforementioned issues are of existential nature and show that the well-being of clients is not just a matter of a new model or a more 'open' and inclusive environment, but is related to their personal struggles, (in)abilities and desires.

Chapter 6 of this thesis showed that family and friends also have issues when it comes to living up to expectations, experience stigma, sometimes struggle with taking initiative and have a hard time confronting each other in the FGC. Furthermore the case example in chapter 7 shows how persons in social networks can experience moral and relational ambivalences with regards to supporting a friend or family member in need; doubts and hesitations to do so are common as they need to figure out how to balance their own life (and choices) with supporting someone. In crisis psychiatry family and friends expressed a need to know if a professional is there to back them up before they express their commitment to support the client. As became clear in chapter 6 it is not always possible for them to make an appeal to professional support. Because professionals are not visible for them, they are hesitant in being committed to an uncertain situation or they may ask for professional support, but do not gain a response.

Coordinators & professionals

In the process of forming a partnership the coordinator had a facilitating role; in chapter 6 it came forward that this role was mostly valued when coordinators gave guidance throughout the FGC process and a prelude to a plan. Both the coordinator and involved professionals struggled with their role and responsibilities in the FGC; they were not always sure about their responsibilities; who should ask questions about underlying dynamics for example? Or about the feasibility of a plan? As mentioned, professionals experienced ambivalences when it came to participating in the FGC. It also became clear that the supportive attitude of professionals is of value in the FGC (see chapter 6 & 8). Professionals can enrich the conference by sharing their expertise; and help actors that are involved to understand the social and mental health problems in the situation of the clients. In chapter 6 it came forward that continuous and reliable professional support is crucial when it comes to forming a partnership between the different actors. Social networks and clients value the contribution of professionals in the process and are glad to 'see a face' that represents the mental health institution.

Forming and strengthening the partnership between clients, social network and professionals

There were situations in which the potential of an FGC was not yet fully utilized by the parties involved; mutual expectations were not fully discussed or there was not enough attention for the ‘struggle’ of the main actor when it came to feeling appreciation or recognition from important others (see, for example, the cases of Henk and Frans in chapter 5). We saw how the main actors in the different cases, discussed in chapter 5, all have issues when it comes to living up to expectations in social fields and struggle, in their own ways, when it comes to recognition or appreciation from (important) others. Underlying expectations between participants, the different relationships, roles, responsibilities and the positions they have in the field could have been discussed more openly (see chapter 5).

The different chapters show how the forming of a partnership is a complex process, wherein actors experience ambivalences and struggle with recognition or appreciation from others. Shameful feelings need to be disclosed; clients often experienced shame and (self) stigma and found it hard to overcome embarrassment about the situation they were in. Ultimately this could have as a consequence in the conference that the situation was not discussed openly and plans were not concrete enough –while we saw that if clients and their social network confronted their vulnerabilities the FGC could break with taboos and prejudices. We saw how so-called ‘courageous conversations’ contributed to forming a partnership; as actors did not avoid to confront each other and discussed the different expectations they had of each other (chapter 6). This made it possible to make plans with a clear division of roles and tasks, meeting the needs of the situation.

Reflections

In this subsection we will reflect separately on the challenges all actors faced in forming a new practice via FGC. Per subheading we will discuss ambivalences and challenges.

Clients & their social network

Pickard (2010) describes two conflicting discourses of the meaning of the ‘good life’ in late modernity. On the one hand, a discourse of individualization in which personal fulfilment is important and where people mainly focus on their own life project (Pickard, 2010, p.471). On the other hand ‘a deontological discourse aiming to delineate ‘correct’ roles and responsibilities within the context of the family and society’ (Pickard, 2010, p. 472). To speak with Pickard (2010) the two discourses with regards to ‘the good life’ are in competition with each other and citizens negotiate about these conflicting discourses in practice. Giving

priority to one's own life project or caring for a loved one with severe problems is not reconciled easily and can lead to contradictory ideas where different moral values come into conflict with each other. Research on informal care in the Netherlands shows that citizens are willing to support others but only on certain conditions; the nature of the relationships is of importance just as the nature of the support and time investment (De Klerk, De Boer, Plaisier, Schyns & Kooiker, 2015).

Tronto (1993, 2013) underlines that 'care has little status in our society, except when its honoured in its emotional and private forms' (1994, p. 122). The organization of care shows positions of power and powerlessness and people's needs for care are met differently, this pattern follows the distribution of power (Tronto, 1993). Giving care is unequal distributed through society; its often left to those with the lowest social status and women (Tronto, 2013). Tronto (1993, 2013) describes the term 'privileged irresponsibility' to explain this, powerful or privileged people in society do not acknowledge their dependency of the caring work of others; the privileged will not recognize that their needs for care are more often met than those of others in society and they can excuse themselves from basis care responsibilities because they have 'more important work to do'. Tronto (2013) argues that the notion 'I made it on my own, you should make it on your own' disguises the aforementioned inequality of distribution of power and privileges; some have more resources and power than others which made it possible 'to make it in society' (see p. 147). In providing or not providing support or care, all sorts of challenges play a role, there are certain ambivalences or negative consequences of giving support and an unfair distribution of caring responsibilities is also problematic.

Professionals

Just as clients and their social network, professionals also experiences ambivalences, although of different nature, when it comes to participating in the process of an FGC. Collaborating with family and important others is still a point of attention in mental health care in the Netherlands. Van Meekeren & Baars (2011) describe that although mental health care organizations often have a family policy the actual active collaboration with and participation of family is regularly missing. In 2016 a manual for family policy in mental health care organizations was published. The authors endorse the important role that family and others may have when it comes to the recovery process of individuals with mental health problems (Landelijk Platform GGZ, 2016). Relatives and others involved need to know that there are professionals to support them and that they are not alone in caring for someone who is in a complex situation. An FGC could be a platform to discuss the foregoing, this requires a change of attitude from professionals; they need to support the primary group (consisting of

the client and family and friends) in dealing with the situation; their expertise contributes to the plans of the group. Schout & de Jong (2018^a) typify this as ‘egoless care’. They mention the work of Gerritsen (2013) who describes a professional who affirms, stimulates and activates others, encourages the group and doses directiveness. This professional does not need to be recognized as a ‘curer’ and is not searching for a relation between his or her actions and the results that are achieved (Schout & de Jong, 2018^a). More visible and accessible mental health professionals, who are there for family and friends in times of trouble, together with the change in attitude described by Schout & de Jong (2018^a), will contribute in forming a partnership between all actors. To handle the experienced ambivalences, change is needed, including an organization and supervising authority that is less focused on control and management. In organizations, space needs to be created, so a dialogue can arise with family and important others in which courageous conversations can take place, and difficult issues are discussed.

Coordinators

The function of the coordinator is seen as one of the strengths of the FGC model, but it also depends on the fulfilment of this role by the coordinator (Skaale Havnen & Christiansen, 2014). As mentioned by Schout & de Jong (2016) coordinators can take advantage of systematically collecting feedback on their functioning as coordinator. This thesis also underlines the necessity of collecting feedback, as we encountered multiple situations that hold learning potential for coordinators. Keeping in mind Bourdieu’s work (chapter 8), it could exploit the potential of an FGC when coordinators point out the value of discussing relationships, underlying expectations and roles and positions of those in the community, to participants of an FGC. With their expertise coordinators facilitate this discussion in different phases; when preparing the conference or in the actual conference. In chapter 6 it came forward that sometimes there could have been more focus on restoring relationships and widening the circle of support when preparing and organizing the conference. Sometimes small family networks do not feel capable to resolve problems and keep giving support; coordinators can expand their repertoire and mention the option of expanding the network with persons who are not directly connected by a shared fate, for example neighbors, volunteers or peers and discuss this with the (small) social network.

In addition, the role of peer support can be of value in the complex processes of organizing FGCs in coercive psychiatry, it may be wise to involve someone who has experienced the same or can be seen as companion in the process. Boumans (2015) shows that working and reflecting together as equal partners- who experienced the same can be a powerful road to

empowerment. Peer support comes down to reciprocal support between people who endure something comparable. It's about discovering that you are not the only one with a problem. This may also be effective in an FGC, and is an option that coordinators could consider when widening the circle of support; whether suggested for clients or family (Boumans, 2015).

Forming and strengthening the partnership between clients, social network and professionals

Forming a partnership between the different actors, with attention for experienced ambivalences, uncertainties and different expectations, seems to be an important element in the process of FGC and contributes to the potential of FGC to function as a catalyst for recovery. In chapter 6 we introduced a partnership framework (Jansen, Baur, De Wit, Wilbrink & Abma, 2015); that consists of four elements: values, relations, actions and conditional factors. The four elements 'were ordered in a causal scheme: conditions facilitate cooperation, consisting of actions and relations, which in turn are necessary to establish or strive for common values' (Jansen, Baur, De Wit, Wilbrink & Abma, 2015, p.71). From the findings mentioned above it is clear that when it comes to forming a partnership in the context of coercive psychiatry it is crucial that actors have attention for issues related to appreciation, recognition, different expectations and positions of actors in the field (concepts in line with Bourdieu, discussed in chapter 8), this also includes recognizing moral damage and apologizing. The foregoing can all be seen as conversation topics in courageous conversations, where a dialogue must be sought in which actors respect each other, open up to each other, put aside their own judgments and listen. This takes courage as relations are often precarious and complex.

Professionals and coordinators have a role and responsibility in facilitating actors in the FGC process to participate in courageous conversations; when facilitated they can establish common values and strive for them in the partnership. In courageous conversations actors are rewarded with a deep understanding of the situation and mutual trust when they experience discomfort and speak the truth (see for example Singleton & Linton, 2006; Singleton & Hays, 2008;). Arao & Clemens (2013), inspired by the work on courageous conversations (Singleton & Linton, 2006; Singleton & Hays, 2008;) mention cultivating brave spaces in their work as student affairs educators; they emphasize the need for courage and not the illusion of safety (Arao & Clemens, 2013). Actors in their practice are supported to better understand- and rise to – challenges of genuine dialogue on social justice issues (Arao & Clemens, 2013). Foucault (2001) speaks about 'fearless speech'; the phenomenon of parrhesia, that he discusses over time in one of his key works. For fearless speech, the courage to speak the truth is required. The one who uses parrhesia, is someone who says everything he thinks: he does not hide

anything, but in his speech he opens his heart and soul to others (Foucault, 2001, p.12). Nevertheless parrhesia is not about saying whatever you want. Out of self-care and care for the other, it is also wise to take into account the conversation partner and be caring, with awareness about how words might come across (Foucault, 2001).

10.2.3 Creating space for involvement of family, friends and others in psychiatry

Ideally speaking professionals have different tasks in the FGC process; they play a role in attending on the option and referring clients to an FGC, provide information during the conference (in consultation with the client) and encourage the group to overcome difficulties and participate in a dialogue. Studies show however that professionals do not always inform their clients about the possibility of FGC and do not always refer them because they see barriers when it comes to their clients and their networks organising an FGC (chapter 4). The FGCs in this project often proceeded with a minimum of professional support. It turned out to be difficult to find sufficient support in the mental health organizations. Different barriers emerged in the context of coercive psychiatry (chapter 4). We discussed earlier how clients and networks experience different kinds of ambivalences, sometimes this also meant that clients or their networks were not open for an FGC and saw no need in organizing a conference (chapter 4).

Furthermore professionals experienced time pressure, in situations of coercion there is acute danger and limited time available. There are circumstances for example, in which the community expects professionals (foremost psychiatrists) to intervene – especially against the background of a culture of control and risk aversion. Furthermore professionals had no experience with FGC and found it difficult to see the merits or could not picture the positive effects in a problematic situation (chapter 3; chapter 4). Professionals had different attitudes about the FGC and its decision-making-process; they sometimes found it hard not to interfere in the situation (in the conference) and to trust the social group to come up with a plan (see chapter 3). Doubts about organising an FGC also arise when it is difficult to communicate with a client; does a client understand what is intended with the FGC? The context of professionalism also rises doubt that clients and/or their social network can adequately join in a dialogue necessary for the process of an FGC. The mentioned barriers show (implicitly) that professionals have to deal with the rules and regulations of their organizations and authorities; promoting the need for control and manageability amongst them, since they are held accountable for their work-load. We saw how the logic of an FGC with an independent coordinator, is at odds with mental health practice, where controlled intervention programs methods are common and where working with protocols is the norm (chapter 3, chapter

4). At the same time, in some cases the FGC rose awareness of the importance of involving the social group in the recovery process of clients (chapter 6 and 8). The lived experience of an FGC, being confronted with the messiness of the process and seeing that clients and the social network actually made plans ensured that professionals in these cases realized how important the social relationships of their clients are and that it contributes to their recovery process. These professionals saw opportunities and recognized the importance of connection with others.

In chapter 3 we discussed the added value of FGC in relation to other strategies where reducing coercive measures, advocacy and/or involving the social network in treatment have a central place. Several interventions were reviewed, like the crisis-card (advocacy tool) and crisis-plan and methods like the admission preventing strategies of Jenner. Or the ‘open dialogue’ approach from Finland where the crisis situation is emphasized and dialogue with clients and their social network is important when it comes to dealing with the situation (Sutherby & Szmukler, 1998; Jenner, 1984; Seikkula, 2008). Besides we discussed forms of ACT – Active Community Treatment, in Netherlands known as FACT (Flexible ACT) and RACT. In the RACT model there is special attention for the involvement of social networks; within this model the social network is educated and trained to form a resource group together with professionals (Nordén et al., 2011).

FGCs can be distinguished from interventions like RACT in multiple ways. The first is the basis of FGC, the decision making model is shaped in such a way that lay people can experience ownership over the problematic situation they are in. In the family driven approach of FGCs the ‘power’ of the social group is used to solves problems and make action plans (Skaale Havnen & Christiansen, 2014). The role of the coordinator herein is only to facilitate this process and not to intervene (Skaale Havnen & Christiansen, 2014). Furthermore the coordinator has an independent position (is not affiliated with a mental health institution) and has a generous amount of time for organizing the conference. A recent study by De Roo, Van der Boom, Vrieling & Jagtenberg (2019, p.14) shows that FGC coordinators spend an average of 30 hours on actually bringing social network together, whereas professionals spend an average of 2.5 hours on this activity. Another difference between RACT and FGC is the private time, without professionals and coordinator, to discuss a plan to deal with the situation and the neutrality it has to offer in terms of location (neutral ground like a community center) and coordination (independent coordinator). The added value of FGC is the ownership it brings, even in situations wherein coercion is inevitable.

Reflections

Both RACT and FGC make an effort to form communities of practice (see Nicolini, 2012). Nicolini (2012) mentions the work of Bourdieu, as this is a more extended theory of practice. Habitus⁸ produces practices, in conjunction with ‘social capital’ and ‘field’ (Nicolini, 2012, p. 59). This means that practice is located and performed within the interplay and interaction between habitus and power dispositions in a specific field⁹ (Nicolini, 2012). Bourdieu speaks of a sense of the game; wherein the habitus articulates the game and gives sense to the next move; opening up a repertoire of moves that fit the context – ‘reactivating the sense of institutions and their norms’ (Nicolini, 2012, p. 61). RACT fits into the field and regime of the mental health care institutions in The Netherlands. The discourses of RACT and mental health care match well, as RACT is professional driven and power dispositions are not questioned – agents in this context act with a sense of feel for the game.

Within the tradition of FGCs, the role of professionals is to support the self-reliance of the group and their learning, responsibility for the problem and the plan is shared by the involved participants. We encountered in this study that the logic of FGC practice and that of mental health care institutions differ and are not easily reconciled. The discourse of FGC is democratic and participatory, while the discourse of mental health care can be typified as bureaucratic, hierarchical and tailored to safety issues (e.g. Ney, Stoltz & Maloney, 2011); and even if professionals have personal interest to be critical against existing protocols or guidelines, the discourse still remains largely political and institutional determined and reinforced (Kunneman, 2009, p.157). Against the background of a neoliberal political context where accountability and risk avoidance are common the two discourses became entangled in a struggle (cf. Ney, Stoltz & Maloney, 2011). Norms, rules and values of professionals are confronted in the FGC process, however, as we have illustrated, professionals are not the only actors facing challenges. Dealing with these challenges requires ‘courageous conversations’; where all actors keep in mind each other’s vulnerabilities and ambivalences. The work of Bourdieu (1990) can help professionals and coordinators in becoming sensitive to the need for recognition in relations and the symbolic value of power and control and encourage actors to participate in ‘brave spaces’. In this way they can support clients and their social network in the challenges they face.

8 Habitus refers to a set of mental dispositions that generates practice, once activated in a field (Nicolini, 2012; Bourdieu, 1990). Also see chapter 8.

9 Field refers to a structured space of social and power positions in which distribution of capital and power is debated (Nicolini, 2012, p. 60). Also see chapter 8.

Participating in courageous conversations and embracing brave spaces requires that actors do not push away complexity but actively seek for ‘places of difficulty’. The participants of the FGC are faced with a challenge here, the place of difficulty brings along what Kunneman describes as ‘messiness’. Following Schon (1983) we make the distinction between between the ‘high hard ground’ where professionals can make effective use of research based theory and technique versus the ‘swampy lowlands’ where situations are confusing and messy. In the swampy lowlands professionals have to acknowledge the limitations of ‘proven’ knowledge and techniques with regard to messy problems (Kunneman, 2017, p.304). When confronted with messy problems professionals need to muster courage to muddle through, undertake small experiments, learn from mistakes and make discoveries in the process (Kunneman, 2017, p. 304). The process of FGC and strengthening the partnership between actors requires a descent into the so-called swamp. While actors are busy making a plan, they are also asked to discuss how this plan could work and what it takes from them as a group to make the plan a success. It requires reflection in action and reflection on action. Kunneman (2017, p. 305) mentions that Schön (1983) has relatively little attention for the bureaucratic circumstances in professional organizations and the power relations between professionals and clients - nudging or sometimes forcing professional to the ‘high ground’ of proven technique. Indeed this is what we saw happening for FGC as well. For FGC to function as a platform to form a partnership there are changes necessary in legislation and policy, changes that ensure time for- and confidence in- the messy process of meaningful involvement of family and the broader social network, giving actors the opportunity to form their partnership, even though it is trial and error. Initiatives such as RACT, even though they differ from FGC, show a psychiatry that recognizes the importance of social embeddedness but also struggles with shaping this within the given frameworks (see, for example, the discussion about WvGGz and its administrative burden). In this project we have made a start with the ‘messy process’ of meaningful involvement of family and broader social network, and shown which learning opportunities there are, and that space needs to be created for the involvement of clients and family and collaborative action-oriented learning in the swampy lowlands.

10.3 Methodological reflections

In this paragraph we will reflect on the overall methodological rigor of our research project, we will discuss how responsive evaluation contributes to changing practice and what the role and responsibilities of the responsive evaluator are in this context. First we will discuss our methodological framework. After that we will reflect on the contribution of responsive

evaluation to changing practice in psychiatry and my own role as evaluator in this process. Then we will reflect on the data collection and analysis in general.

Methodological framework

We have studied FGC in the tradition of practice theory (see Nicolini, 2012). In practice theory social investigation is seen as the ‘patient, evidence based, bottom-up efforts to understand practices and untangling their relationships’ (Nicolini, 2012: 8). Social phenomena are studied and interpreted without losing sight of the heterogeneous nature of everyday life, (per)formed by different activities of those involved. A point of concern when studying FGCs is that these are often treated as interventions with a straightforward approach; and evidence of its effectiveness can only be obtained via Randomized Controlled Trials (RCTs) (see De Jong, Schout, & Abma, 2015). RCTs are seen as the golden standard when it comes to gaining evidence based outcomes in psychological and medical sciences; and are gaining popularity in social sciences as well. Regardless of whether it is possible to study the impact of FGCs with RCTs (see De Jong, Schout, & Abma, 2015), the deployment of FGCs is based on legal or ethical arguments in which people have the right to make a plan before the government intervenes in the situation. Instead of purely focusing on its effectiveness we may study the meaning, such way of working has, for multiple stakeholders in a particular context.

As the ‘Raad voor Volksgezondheid en Samenleving’ (RVS; Dutch Council for Public Health and Society) (2017) mentions, the risk of evidence based practice is that good care is reduced to what has been scientifically proven and measured, as the knowledge is collected via preferable RCTs, and is based on standardized situations. Differences between patients, personal values and the dynamic context in which care or social interventions take place are not properly reflected when using RCTs (RVS, 2017). The foregoing also applies when studying FGCs (in the context of coercive psychiatry), as the situations and their contexts are complex and dynamic. As mentioned by Bonney & Sticklely (2008, p. 150), values like, choice, hope, freedom and autonomy (related to the recovery paradigm) are difficult to measure in institutions with systems that revolve around targets and outcomes. Viewing FGC as a practice opens up perspectives to understand what’s going on and experienced as meaningful in the eyes of those involved (emic / insiders perspective) and integrate action in practice.

The methodological design of responsive evaluation, with quantitative and qualitative elements and a case study strategy, is well placed in the approach of practice theory. Responsive evaluation is characterized by a joint learning process involving the expertise, ideas, and skills of different stakeholders (Abma, Nierse & Widdershoven, 2009; Abma, Leyerzapf & Landeweer, 2016). In this design perspectives are related to each other and the

context plays an important role (Abma, Nierse & Widdershoven, 2009; Abma, Leyerzapf & Landeweer, 2016; Bos, 2016; Woelders, 2020). This is valuable when it comes to evaluating the different FGCs; participants were given the opportunity to share their experiences and reflect on the conference through interviews and member-checks. Furthermore Abma & Stake (2014) describe that case studies are specifically fit to identify the complexity and particularities of demarcated entities (cases) and situations. We used several theoretical points of view, of Muehlebach (2012, see chapter 7), Pahl & Spencer (2004; 2010, see chapter 7) and Bourdieu (1990, see chapter 8) to understand the context and complexity of FGCs in coercive psychiatry. The strategy of Jackson & Mazzei (2013), described, in chapter 8, as ‘thinking with theory’, suited well in the context of theory of practice; its emphasis lies on the interpretation and understanding of findings using relevant theories, recognizing the importance of context and heterogeneity of situations. Concluding, we have worked with the data, in different ways and used both a qualitative case study strategy and quantitative methods to explore the learning process. Quantitative data were not used to prove a causal relations between intervention (the FGC) and outcome (of the plan), but to accelerate and deepen the learning process and create space for the voice of clients and their families. These different approaches complemented each other and made it possible to understand the complex practice of FGC in coercive psychiatry and led to new insights.

Reflection on responsive evaluation in changing practice in psychiatry

The starting point of this responsive evaluation was that people are entitled to their own plan within the context of coercion in psychiatry. We, as researchers, invested time in involving stakeholders (such as psychiatrists, mental health nurses, social workers, family councils and client councils of the organizations and FGC coordinators), so we could learn from each other. All sorts of meetings were organized with different stakeholders in each region; people joined meetings or agreed to make an individual appointment to be informed about the project, validate findings or to explore other perspectives. Nevertheless, the inclusion of clients in the project was difficult. As became clear in the main findings and in chapter 4, there were several barriers when it came to organizing FGCs. Main characters and social networks were not always open to organizing a conference themselves; they experienced ambivalences and did not seem to want to hurt each other (again). The attitude of several professionals with regard to the research project also made it difficult to include clients. In this section I will reflect on my own role as responsive evaluator in the research project, with a focus on the inclusion process as its illustrates the difficulties we encountered when it came to changing practice in psychiatry.

As a young researcher with little work experience in psychiatry I worked together with a very experienced and committed mental health nurse. We brought the research under the attention of professionals in our region and I planned some 'work along' sessions in different mental health care settings. I entered discussions with experienced psychiatrists and mental health nurses about FGC and the different attitude it asked from them. Certainly at the beginning, I took a modest position in these discussions, believing that a bull in a China shop only inflicts damage. Changing a way of thinking and working in an organization is ambitious and tough. I noticed how friction could easily arise without actually having had any substantive discussion with professionals about mentioning the option of an FGC to clients – it was for example hard to make appointments with professionals about the subject as I will illustrate later on. I understood that professionals were hesitant because many jobs at the organization were at stake and the call for 'Eigen Kracht' actually seemed to imply that the professionals were to become superfluous. As mentioned in the introduction of this final chapter of my thesis, the context around concepts like 'Eigen Kracht' was full of paradoxes and unease. It took quite some effort to get across a different message - namely that of partnership and the right of clients to make their own plan. So, I went for a subtle approach, as illustrated below.

In the beginning of the project I had many telephone conversations with different professionals (mental health nurses, social workers, psychiatrists or managers), to introduce myself, the research project and to make an appointment for further collaboration. In these conversations a lot of the professionals were unsure about the research project and indicated that they did not have anything to say about FGC and that meeting each other face to face would not yield an advantage. I made an effort however to meet professionals in person by making individual appointments with them or by joining a meeting of a specific team. After a few conversations it became clear to me that I needed to change my approach. I told professionals about the research project and stressed that I wanted to have a dialogue about FGC. I also mentioned that I wanted to hear from them about the effort they already took when it came to involving social network members of clients in the provided care. In this way the research project became less of a 'threat' and I could speak professionals face to face and make future appointments with them about including clients in the research project. A lot of professionals were still uncertain about the use of FGC and our research project, but did agree to meet with me or invited me to a team meeting.

In a context where jobs were at stake, I tried to reassure professionals and tell a nuanced story about FGC in psychiatry. In this way it became possible to start a dialogue and to make agreements with some professionals. However sometimes another feeling crept up: what if I

approached professionals in a more direct way; where I pointed out that all clients are entitled to make their own plan? Would that have changed the course of action? I want to create mutual understanding, by giving more attention to the marginalized voices of those facing coercive treatment, and the right to make their own plan– but wondered where I should begin. The other researchers encountered similar problems with the inclusion of clients and as a team, we decided to set up a group of designated ambassadors per organization in order to launch an ‘offensive’ about our project. In this way it was possible to involve a representative group of stakeholders and we were able to learn together. Within the research group we often wondered whether we could have predicted in advance that it would be so difficult to include clients. Had we sufficiently realized how difficult it would be for professionals to use a new decision-making model such as an FGC?

In retrospect there were also situations where power, sometimes in an subtle way, hinted through and it became clear how I, as a researcher, was part of a dependency relationship. After all, we needed ‘cases’ within our research project and we were extensively using all recourses possible to make this happen. Confronting professionals, who were of utter importance when it came to including clients in our project, could have as a consequence that they were even more reluctant to collaborate. A striking example in which I let myself be carried away with the mores of the organization and where I conformed to the authority of a professional went as follows.

I was asked to be at a meeting where the possibility of organizing an FGC was discussed with a client. This lady appeared to be unaware of the fact that I would also be at this appointment. I introduced myself to her and said: ‘...and then you are the lady with whom I also have an appointment?’. Which she responded with: ‘no, I am not a lady..I am just a patient’. I was affected by the fact that this lady did not seem to see herself as a lady but as a patient. Nevertheless it happened that she went to the appointment with the elevator, while the professional, who was also there, said to me: ‘come along with me, let’s go to the stairs’ where we then had a conversation, about the situation of the client, in the stairwell, before our appointment took place .

In this example I was quite shocked at first by how this lady saw herself - that affected me and made it clear to me (again) how important our research project was. I had a strange feeling when I went up the stairs with the professional, but I could not explain it at the time. I remember thinking ‘why are we going to this appointment in separate ways – is this normal practice?’” but also remember how happy I was that professionals finally seemed (a bit more) willing to work together in our project. At that moment I ‘just’ followed the person with

authority – not risking anything. In hindsight I regret that I did not go into the elevator with the client and take my role as responsive evaluator by starting a dialogue about what I saw.

The previous examples illustrate the ambivalences of myself in the swampy lowlands of our research project. In this dissertation, this quest can also be seen throughout the various chapters. The chapters increase in complexity, one of the first chapters is about the impact of FGC. When looking back ‘change’ instead of ‘impact’ would have been a better choice of words. Impact seems objective while I was an actor in the process, this also shows the ambivalence I experienced during the research. In the beginning I wanted to be on the high hard ground - away from confusing messes. Ultimately, it was inevitable to immerse myself in the messiness of practice and see and understand the moral and relational complexity of forming a partnership in the context of coercive psychiatry.

A pressing question to ask is whether our responsive evaluation has contributed to changing practice in psychiatry. We mentioned in the various chapters and reflections how difficult it was to change practice and have illustrated how changes occurred at micro level in client situations. As mentioned in chapter 9 we worked together with students in the research project. Students played an important role in generating knowledge from individual cases and together with other stakeholders we formed a community of practice where we experimented, reflected and started a dialogue about FGC in psychiatry. We experienced in member checks how the various actors looked back on the FGC and how it had contributed to their situation. Attention was also paid to making new or improved plans to deal with the situation. The member checks often made clear that the involved actors had become more aware of the complexity of the situation they were in and they also gained more respect and/or awareness for the perspective of others. As researchers, we were also part of this process. Our research approach encouraged actors to take another look at their FGC process and reflect on the situation (catalytic authenticity).

During the research process we collaborated with the ‘Eigen Kracht Centrale’, sharing interim findings with coordinators in order to learn together. For many coordinators, the context of coercive psychiatry was new. Coordinators became increasingly aware of the different perspectives and complexity of situations in the project and gained in experience. If we link the foregoing to the authenticity criteria of Lincoln and Guba (1989), we see that awareness of the complexity of the social environment and of other perspectives happened at the micro level (ontological and educational authenticity). However when looking at the bigger picture than no redistribution of power has arisen among the stakeholders. Furthermore, the organizations involved did not express intentions to experiment further with FGC (tactical authenticity).

Our responsive approach has however ensured that we were able to organize FGC in the swampy lowlands and that we could highlight the complexity of forming a partnership between clients, their social network and professionals and explore learning opportunities useful for changing practice in psychiatry.

Reflection on (qualitative) data collection & analysis

The situations in this study varied strongly when it comes to psychiatric symptomatology and social context; the selection of 20 FGCs per region seemed sufficient in enclosing all relevant perspectives. In total, we conducted 289 interviews with an average length of 60 minutes, and we organized 19 (group) member checks (with 121 participants) to validate our findings. We used a standardized topic list and all interviews were recorded and written verbatim. In every case we asked the main person and other participants of the FGC to reflect on the meaning and impact of the FGC by means of an interview; so we were able to analyse and understand the conference from multiple perspectives and from the inside out.

After every conference we tried to plan the conducting of interviews with the participants between a period of one to three months after the FGC took place. This was, however, not always possible; sometimes the interviews were conducted earlier or later. It was not always easy to motivate participants to engage in an interview. Sometimes the results of the conference were disappointing and participants found it too difficult to respond to the interview request; practical reasons like holidays or busy with work were also named. It was the duty of the researchers to respond with patience and empathy, at times an interview could be conducted after all. Particularly the lack of insights from main characters, who could not be reached or were reserved regarding the interview request, could be seen as a weak point because the ‘thick descriptions’ of the FGCs had the risk to be incomplete. We had to deal with this, it shows the messiness of conditions during the research project.

When the interviews took place shortly after the FGC it was usually easier to reconstruct the FGC and the process around it. It was however more difficult to reflect on the actual impact of the FGC, as little time had passed. The same goes the other way around; when interviews took place a long time after the FGC, it was easy to reflect on impact, however participants had some troubles with remembering the conference and preparation. Our intention was to continue with conducting interviews per case or conference until there was no new information and no new patterns occurred. This is an indication of methodological quality, refers to saturation of information (Guba & Lincoln, 1989; Guest et al., 2006; Small, 2009). In 40 of 41 conferences we were successful in executing this strategy, in one single case it was only possible to reconstruct the process of the FGC and its impact from the perspective

of the FGC coordinator and involved professionals. As the research project progressed we also saw different patterns emerging between the conferences. We have tried to ensure that the diversity of the research population (clients who are at risk of a coercive measure in psychiatry) was included in our research and when regarding the diversity in psychiatric diagnosis and demographic traits (chapter 2) we see a variety of people included in this research project.

Besides, we used triangulation of different methods; interviews, (group) member checks and memos, to increase the reliability. In more detail, triangulation took place by comparing findings between different participants within one case; comparing findings between different cases and regions; comparing findings between the different methods we used and comparing empirical and theoretical findings. Quantitative and qualitative data were combined and complemented each other. The transferability and fairness (authenticity criterium) of the study was increased by presenting thick descriptions of cases. In making sense of the cases, we recognized different levels of context and how they interact (Simons, 2015, p.176). By interweaving these different contexts and the particularities we were keen to highlight the moral and relational dynamics between the different contexts of stakeholders (Simons, 2015, p.176). We aimed at understanding the involvement of family and network members in psychiatry, in a meaningful way - a complex, layered practice where all actors face different challenges related to their specific contexts.

Reflection on quantitative data collection & analysis

Not all participants of the FGCs were able to reflect on the impact by giving scores on the scale questions. This led to missing values, and therefore incomplete data, nevertheless the analysis considering the outcome measures was based on 40 conferences, where the scores have been obtained from 253 respondents. As already mentioned, the data were collected in retro perspective, this could have led to recollection bias. When respondents had trouble remembering the situation before the FGC and giving a reliable score on a scale question, we asked to give arguments so the actual number would be substantiated. The scores that we obtained were not tested to whether they would yield valid and reliable outcomes. The formulating of arguments by respondent was in this light of extra importance, we based the idea for argumentation on insights from the solution- focused approach (see Bannink, 2007).

Despite some weaknesses in our quantitative data collection, the analysis does give an impression of the impact and outcomes of the FGCs, mostly because we have included a variety of perspectives with regards to the impact of a conference. The numbers of respondents that reflected on the scale questions was high (253) this means that on average 6 to 7 respondents shared their vision.

It was not our purpose to prove a causal relationship between the deployment of FGCs and the potential effects or outcomes it might achieve; we do think this part of our study helps to understand the potential of FGC in coercive psychiatry.

10.4 Future directions

Based on the findings in this thesis we provide future directions and give recommendations regarding future research. One could imagine an ideal course of actions and contrast it with the actual process when it comes to the organization of FGCs in coercive psychiatry. The ideal situation shows a client who, despite his (recent) confusion or disruption, wants his primary group to think along in a conference to make a plan. A social network that in turn makes a benevolent contribution to the conference and professionals who value FGC, think along with the group in the conference and accept the plan that the primary group subsequently draws up, as leading. In practice, however, this rarely happened. Clients and their social networks experienced ambivalences when it came to shaping their involvement with others or experienced shame when allowing them back into their lives (again). Professionals and FGC-coordinators experienced struggles when it came to their role in the FGC process. It was difficult for professionals to participate in the FGC because it required a different attitude from them. They are asked to position themselves more modestly and become sensitive to the need for recognition in relations and the symbolic value of power and control and encourage actors to participate in 'brave spaces'. This thesis underlines that making your own plan to prevent coercive measures, as envisaged in the Mental Health Care Act on Compulsory Treatment (Wvggz) is a complex task and requires a strong partnership between clients, their social network and professionals. However, you can also say that a meeting that takes place on neutral ground, facilitated by a fellow citizen who has no interest in the outcome and moreover has much more time, is required more than ever.

There are a number of conditions that contribute to the establishment of FGC practice and they can be linked to local, practical and social conjunctures. The first condition is to establish a legislative framework regarding the deployment of FGCs; wherein FGCs are an option that needs to be considered without having a compulsory character. The possibilities of FGCs cannot be easily overlooked when pointed out in a legislative framework; as all parties¹⁰ involved in coercive treatment have to deal with the framework. A starting point here could be the 'Wet verplichte GGz' (Mental Health Care Act on Compulsory Treatment;

¹⁰ Parties such as: public prosecutors, judges, personnel from mental health institutions and personnel from municipalities (like mayors or policy staff).

Wvggz), which provides room for clients and family to come up with an action plan to prevent coercive treatment (see Tweede Kamer der Staten Generaal, 2017). The ‘Landelijk Platform GGz’ (National Platform Mental Health care) indicated in their position paper about the Wvggz (2017) that it is of importance for clients and their relatives to receive support in making this plan, an FGC could be a platform to discuss the situation and come up with an action plan.

Secondly, at this moment there is no direct financing for the deployment of a ‘family group plan’ or FGCs; municipalities do not reserve money in a structural way. Without structural financing the chances of implementing this decision making model are not very hopeful; see for example the challenging task of integrating the ‘family group plan’ in the Youth Act (Labrujere, 2015). A second condition is therefore to arrange structural financing of FGCs in collaboration with health insurance companies and municipalities. Norway, and the other Nordic countries, are a good example here, because FGC coordinators are paid by the government (Skaale Havnen & Christiansen, 2014).

Despite their importance, the legislative framework and financing of FGCs are not the only conditions that need attention when it comes to deploying FGCs. For mental health professionals, who have an important role in FGCs, conditions need to be created that facilitate them in involving the social network in their daily work. For example professionals in social teams (sociale wijkteams) spend little time involving family and friends into their contacts with clients, or in working together with them, because they experience a shortage in time and space (Redeker, Nanninga & van Steekelenburg, 2017). Furthermore, knowledge, competencies and habitus to involve and work with social networks are sometimes lacking (Redeker, Nanninga & van Steekelenburg, 2017). Space needs to be created for action-oriented learning in the swampy lowlands – this also mean acceptance of ‘not knowing’ and wandering around. Recognizing the complexity requires sincere interest in everyday complexity from directors and managers. Acknowledging the complexity and the questions that arise in the swampy lowlands also requires new governance and accountability opportunities, as it becomes clear to professionals and also to managers that simple rules and targets fall short (See Nap, 2014).

Policymakers from municipalities and their social teams, and mental health institutions need to work together to shape and provide conditions wherein professionals are encouraged to work together with clients and their social network and confront the messy problems in the swampy lowlands. This requires a different mind-set, the social network is not a resource that is used instead of professional support, it is a resource to strengthen the position of citizens who experience problems in their lives (Van der Lans & Hilhorst, 2014). A practice

needs to be built in which new forms of meaningful involvement and collaboration of family and the broader social network emerge and where there is space for recognizing each other's vulnerabilities and participation in courageous conversations.

Recommendations for further research

The usefulness of further research into the forming of a practice based on power sharing via FGCs is questionable in the current situation; there is no institutional and legislative back-up of the practice of FGCs. When the research project finished and did not foresee in the financial and legal conditions to organize FGCs, we saw a decrease of their deployment in the involved mental health institutions. However, given the promising findings of this study, further research into the practice of power sharing and collaborations between clients, family and professionals are fruitful. A suggestion is to conduct a responsive evaluation with a participatory action research design (see Abma et al., 2019). Together with various stakeholders, a joint learning process can be created, in which a new habitus can be developed with horizontal relationships, an eye for tensions and power relations, the moral horizon of 'good care' and a focus on human flourishing and social justice (see Groot et al., 2018). At a regional level pilot projects need to be started, within municipalities, where people who face coercive treatment in psychiatry are offered the possibility of organizing an FGC and where the municipalities guarantee its funding. If possible, these pilot projects should be part of a larger project, aimed at recovery and ownership in restorative cities, in which the possibility of organizing an FGC is prevailed above all forms of coercion exerted by the government. In this way the institutional back-up required for the deployment of FGCs is arranged. Within action research 'practical issues' are of concern, people work together and dialogue and development can blossom (Bradbury, 2015, p. 7). The approach is participatory and democratic; working with participants towards knowledge in action (Bradbury, 2015, p. 7). This facilitates the growth of a practice, wherein co-creation is possible and where professionals learn that their expertise and experience, is especially productive when combined with the expertise of clients and their social networks (See van der Lans, 2017).

The deployment of FGCs requires formation of a new practice. On multiple levels shifts and modifications are necessary to form a restorative practice; the establishment of a legislative and financial framework, a shift in discourses of mental health institutions and public agencies – in short, an 'institutional back up' is required to successfully experiment with FGCs. Furthermore, the role of knowledge institutes (like universities or universities of applied sciences); is of importance, they can be seen as stakeholders. They also play a role in learning staff and students, to promote self-reliance and involve social networks in

their contact with clients. By studying FGCs from an action research framework, conditions necessary to deploy FGCs in Dutch society become visible and the potential of FGC in the context of mental health care can be exploited further.

We have made a start with studying the complexity of organizing FGCs from multiple perspectives. Ongoing research into the power sharing and collaboration between clients, social networks, professionals and FGC coordinators is recommended. New ways of organizing can be introduced such as (community) mental health nurses taking on a more active role in the facilitation of FGCs and reinforce the plans with their expertise; they may strengthen the impact of FGCs even further. Research into the role of the different professionals in the process of FGCs warrants further investigation. Lastly we recommend, that when experimenting with FGCs in the context of mental health care, attention is needed for the success factors of reducing coercive treatment with the use of FGCs, as this is influenced by a complex set of factors.

10.5 General conclusion

Despite the promising findings of studies into FGC, the practice has trouble finding its way in Dutch society. FGC can be seen as a means for regaining ownership over the situation, strengthen and widen the circles of support and restore belongingness – it has potential as a catalyst for recovery. Above all, we saw the complexity of organizing FGCs in the context of coercive psychiatry. FGC requests a change of attitude from professionals, they are asked to position themselves more modestly and discuss hesitations and fears that arise in the FGC process. It requires from FGC coordinators to learn from situations and collect feedback. The work of Bourdieu (1990) can help professionals and coordinators in becoming sensitive to the need for recognition in relations and the symbolic value of power and control and encourage actors to participate in 'brave spaces'. In this way they can support clients and their social network in the challenges they face. Although family and friends experience moral ambivalences- reconciling informal care and the time pressure of today's life's projects – we found that people were willing to participate in FGCs and contributed to the process and plan. The meritocratic and neoliberal circumstances however don't make it easy to support a friend or relative, furthermore experiencing shame and vulnerability make it difficult for clients or their social networks to allow someone (back) into their lives.

All actors face challenges in the FGC practice. This requires 'courageous conversations' with an eye for each other's, needs, vulnerabilities and ambivalences. Partnerships can be formed and strengthened by having these conversations. A collaboration between different

actors and thus the formation of a partnership in an FGC, is characterized by involvement, a shared feeling of urgency, trust in each other, as well as openness with regards to the problematic situation.

It is crucial that FGCs receive an institutional back-up so that the FGC practice can be formed, conditions for this should be considered and investigated with different stakeholders.

It is not a straightforward and uncomplicated task for clients and their social network to make a plan together. Involving the broad network of clients in mental health care however does contribute to recovery processes of clients. In this thesis about FGC, clues can be found for strengthening the partnership between clients, social networks and professionals. Besides FGCs can meet the need for neutrality, in situations where there is coercion. In this way a plan can be made on neutral ground, in a community centre or church hall, facilitated by an independent coordinator. An FGC can offer a platform where people share personal stories, endure troubling times, learn to understand each other, have courageous conversations and share their quest for co-creation. FGC practice creates an opening for clients, their social network and professionals to engage in partnership relations and together the different involved actors construct an open and new actuality.

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Appendix I

Topic list semi-structured interviews

Topic list semi-structured interviews

The topics (topics) are more or less fixed and the interview method is open. First questions will be asked about the process of the FGC and later, with the support of scale questions, about the outcomes of the FGC. By asking open questions, the respondent gets the space and time to tell his / her story.

General information about respondent

Date of the interview: . . - . . - 201 .

The interviewee was a:

0 Male 0 Female

0 Age: year

Relation to the case

0 Main actor/ client

0 Family

0 Friend

0 Neighbor

0 Colleague

0 Professional

0 Other:.....

Process topics:

The respondents are asked to retrospectively reflect on the process and outcomes of the conference.

- The referral: who and what?
- The preparation
- Place of the conference
- How many people where at the conference
- Duration of the conference
- Safety and atmosphere
- Rol van de coördinator

Proceedings of the conference

- Information exchange
- Private family time (division of tasks: taking notes, chairing etcetera)
- Decision making

At the second interview:

- Monitoring. Has (a part of) the social network met to evaluate the plan? Has the plan been adjusted?

Product topics:

Reason for the FGC

- Problematic situation prior to the conference?
- Psychiatric symptomatology
- Nature of the crisis situation: what danger had to be averted?
- How much social support was present prior to the conference?

The FGC

- What does the plan consist of, what agreements have been made?
- Which role and task distribution was agreed upon in the event of a crisis that needed to be averted?

The plan

- To what extent was coercion prevented?
- To what extent has the potential threat or danger (that he/she was for him/herself or others) been averted?
- Are signs of a possible new crisis clear to all concerned? Are risk and protective factors clear to those involved?
- Has mutual trust grown? How does that become clear (for example: are there more people now who have a key of your house)? Do you discuss your problems with more people now? Do other people discuss their problems or difficulties with you? If persons other than the client are interviewed, they will be asked for signs of trust and reciprocity.
- Have the goals from the plan been achieved?
- To what extent was support mobilized?

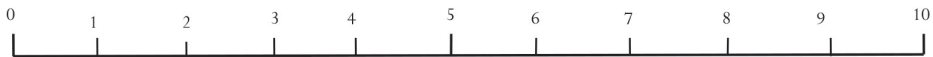
Scale questions

Scale questions are used to evaluate: reduction of coercion, ownership, social support and professional support prior and after the conference. Respondents were asked to give a score to the situation before the conference and a score for after the conference.

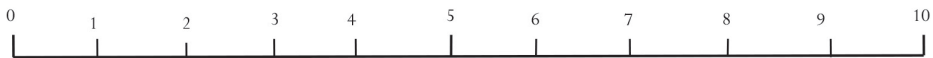
The quality of social support and professional support:

- 0-1: There is no support
- 2-3: There is little support
- 4-5: There is some support
- 6-8: There is quite some support
- 9-10: There is a lot of support

Before the FGC



After the FGC



Discuss given score:

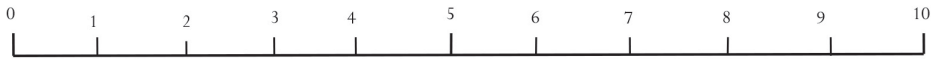
Higher score: how does that show? Can you give examples?

Lower score: what was the cause?

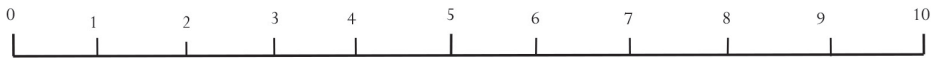
Could the score have been higher, if so how?

To what extent has (the amount of) social support increased?

Social support before the FGC



Social support after the FGC



Discuss given score:

Higher score: how does that show? Can you give examples?

Lower score: what was the cause?

Could the score have been higher, if so how?

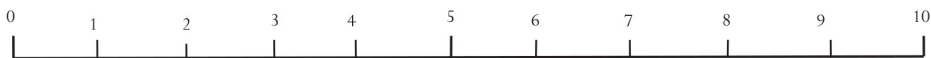
Reduction of coercion (based on Lohuis, Schilperoort & Schout, 200811):

- 9-10: Support is voluntary
- 6-8: Intervention without the clear consent of the person (in Dutch: bemoeizorg)
- 4-5: Informal coercion (can be applied in various forms, a client is put under great pressure to make one particular choice, in Dutch: drang)
- 2-3: Formal coercion in an ambulatory setting (in Dutch: ambulante dwang, bijvoorbeeld een voorwaardelijke machtiging)
- 0-1: Formal coercion in a clinical setting, for example a compulsory admission (in Dutch: dwang in klinische setting, bijvoorbeeld een rechterlijke machtiging of in bewaringstelling)

Before the FGC



After the FGC



Discuss given score:

Higher score: how does that show? Can you give examples?

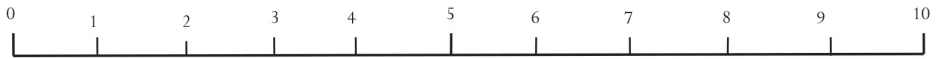
Lower score: what was the cause?

Could the score have been higher, if so how?

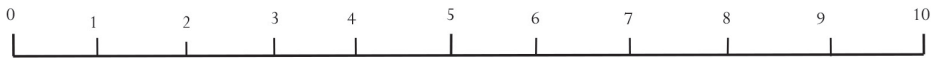
11 See Lohuis, G., Schilperoort, R. & Schout, G. (2008). *Van bemoei-naar groeizorg*. Methodieken voor de OGGZ. Groningen: Wolters Noordhof

To what extent has the feeling of ownership (over the situation) increased?

Before the conference



After the conference



Discuss given score:

Higher score: how does that show? Can you give examples?

Lower score: what was the cause?

Could the score have been higher, if so how?

Has this FGC had other effects?

.....

.....

.....

.....



Summary

Despite policies aimed at reducing compulsory treatment on the one hand, and involving social networks in mental health care on the other, the number of coercive measures in psychiatry in the Netherlands continues to grow. The Ministry of Health, Welfare and Sport expects the new law ‘Mental Health Care Act on Compulsory Treatment’ (Wet verplichte geestelijke gezondheidszorg, Wvggz) to lead to a reduction in the number of coercive measures in psychiatry. The call to reduce coercion in psychiatry takes place in a complex field and time juncture. The past decades an emphasis has been placed on ambulantization and deinstitutionalization in mental health care. Care and support must be offered in society, instead of in psychiatric hospitals, and people with psychiatric vulnerabilities should be enabled to live, work and have meaningful social relationships in society as much as possible. In order to cut public spending the amount of beds in mental health care organizations have been reduced while ambulatory care has become less accessible for people who experience severe mental health problems. A complex spectrum of mutual influencing factors such as marketization, fragmentation of services, consumerism, overtreatment, cherry picking overconsumption and attempts to cut budgets, form the background of the irradiation of integrated care for people with severe and ongoing mental health problems.

In the debate on ‘mentally confused persons’, social problems related to nuisance and safety are linked to mental health care and the occurrence of mental illness. Citizens have high expectations of the police, mental health care and the government to take ‘confused persons’ off the streets and protect society, while at the same time there is a tendency among these authorities to avoid risks. It is often mentioned that society is less tolerant when it comes to deviant behavior and that, for example, concerned neighborhood residents report ‘deviant behavior’ more quickly. The question is whether society is actually becoming less tolerant or whether citizens are not ready to include vulnerable fellow citizens in their midst because they have not been asked to do so in the welfare state for years.

In the Netherlands coercive measures took place under the act Special Admissions in Psychiatric Hospitals (Wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen, BOPZ). The government has decided to replace this law from January 1, 2020, with the Mental Health Care Act on Compulsory Treatment (Wet verplichte geestelijke gezondheidszorg, Wvggz). This law has been extensively discussed and criticized in national newspapers. A guiding principle of this law is that coercion needs to be avoided while strengthening the legal position of people imposed to coercive measures. Those threatened by coercive measures get the option to avert such measures by making a plan with their social network. When this plan brings safety the coercive measures are postponed or cancelled. Furthermore it is possible to impose coercive measures outside the walls of mental health institutions (see Dwang in de zorg, 2018).

It is questionable whether compulsory treatment at home can be seen as an improvement. The law is considered more of a 'safety law' than a law which seeks personalized treatment and improvement of the legal position of clients, as the law is more focused on safety and public order issues. The logic of the Wvz is one of control; of a government that wants to intervene behind the front door and control the behavior of citizens - it shows vertical (hierarchical) power. Looking at guidelines for drawing up an own plan, we see that it is mainly a reflection of practical matters (see for example 'Handreiking Eigen Plan' op www.dwangindezorg.nl), but we also see the reflex to make the plan controllable and manageable. Pathways to invest in horizontal relationships between people are insufficiently explored by this law. Drawing up a plan of one own to avert coercion in the way that is suggested in this new law does not seem to meet the complexity of what is going on in a psychiatric crisis.

Coercive treatment in psychiatry, whether at home or in an institution, is a profound experience for individuals. It violates fundamental human rights and implies a loss of ownership and control over one's own situation. Moreover, when compulsory admitted people are not able to participate in society, it denies citizenship and leads to isolation. This is at odds with the recovery process of people who experience psychiatric problems, as recovery is linked to the social context. Experiencing social support and belonging to a group not only has therapeutic value, it is an existential necessity. The value of social networks and their support can hardly be overestimated, but this does not mean that social networks are systematically involved in the treatment of people with psychiatric vulnerability. Few services actively work on increasing social cohesion and social capital within the communities their clients are part of, in order to improve their clients' mental health.

The aim of this thesis is to contribute to the formation of a new practice based on power sharing among clients, family and professionals through Family Group Conferencing in the context of coercive psychiatry. This exploration is focused on Family Group Conferencing (FGC) as a way to restore ownership, widen and strengthen circles of support. FGC is a decision making model that facilitates families and networks to deal with a problematic situation in a way that is consistent with their own culture and lifestyle.

FGC (in the Netherlands known as 'Eigen Kracht-conferenties') has its roots in the traditions of the Maori, the indigenous people of New Zealand, and is deployed all over the world. It has been developed as a decision-making model that recognizes the collective responsibility of families and nearby communities. Families and friends attending the conference embody the 'life world', while professionals embody the 'system world'. In the system world of professionals, in this case working in mental health care, rules and hierarchy dominate, while the life world of FGC calls for relational and horizontal understanding. The

standards, rules and values of professionals are thus challenged. The deployment of FGC has been studied especially in youth care. Different studies indicate that FGCs can prevent the outplacement of children. Other studies show that FGCs can have a positive role in increasing the relational autonomy of older people; or in strengthening and mobilizing social support from clients' social network (public mental health care). There is, however, a lack of studies on long-term experiences with FGC and research in the field of coercive psychiatry is scarce.

This thesis was part of a larger research project into the impact and process of FGCs in coercive psychiatry in the Netherlands (conducted from 2013-2015). A responsive evaluation, with quantitative and qualitative elements was deployed and carried out parallel to the deployment of FGC. In responsive evaluation, evaluation is aimed at mutual understanding among stakeholders regarding the meaning of their practice as a vehicle for practice improvement. Opposed to a more traditional approach of evaluation, in which the emphasis lays on assessing the effectiveness of interventions. The approach is grounded in social constructionism. In this perspective people give meaning to their social world and social reality is constructed by multiple perspectives. The nature of the study was interpretative and aimed at forming a new practice in psychiatry by exploring the possibilities of FGC in this context. Responsive evaluation suited well in this context, because it aims to derive insight from the insiders perspective; is responsive to the issues, values, experiences and interests of all the different stakeholders and their context. The chosen research methodology of responsive evaluation reflects the underlying values of FGC, both aim to increase personal and mutual understanding through dialogue and to include marginalized voices. They are based on democratic principles in which people are entitled to make their own plan and give meaning to a situation.

A case study strategy was used as part of the responsive evaluation approach to gain an in-depth and contextualized understanding of a demarked entity (the case). Each FGC was considered as a case; the evaluation was based on several case studies (60 cases, 41 conferences). The data were collected by conducting interviews, using a questionnaire containing both open questions and scale questions. The interviews were conducted with 289 of the 466 participants (at 41 conferences) one to six weeks after the conference took place. Besides interviews, participant observations were conducted to unravel the impact of (organizing) FGCs and their meaning for participants. In addition member checks were organized. The latter was done to validate findings from each case and to facilitate a group discussion of the conference that may provide new insights into the process and outcomes of each conference. During the research, data were enriched with theory, whereby theory was not imposed in advance, but was gradually

“plugged in” to enrich findings and deepen insights. In other words, an iterative process of empirical and theoretical exploration.

This thesis is divided in several chapters representing studies that are published as articles in various journals. In the structure of this thesis we reveal an increasing complexity of our study. We start with part one (chapters two & three) in which we discuss the perceived impact and value of FGC. In the second part of this dissertation we discuss forming a new practice based on power sharing among clients, family and professionals through FGC (chapters four, five & six). In the third part of this thesis the moral ambivalences and relational complexity of family and network support in psychiatry are explored (chapters seven, eight & nine). Finally in the last chapter, we reflect on the main findings of this thesis and on the methodological framework. Future directions and suggestions for further research will be explored here.

Chapter two provides an overview of the impact of organizing FGC in coercive psychiatry, this is the quantitative part of the responsive evaluation. The impact of the conferences was examined on the basis of three scale questions during interviews with participants of the conferences (N = 260). There were retrospective reflections on three outcome measures: ownership, social support (belongingness) and experienced coercion. The scores given on the three outcome measures before and after the conference were analyzed by means of paired T-tests and a Multi-level analysis. After the conference, participants indicate that they experience a slight decrease in coercion (not significant) and an increase in ownership and social support.

Chapter three discusses the added value of FGCs in relation to other strategies aimed at reducing coercive measures, promoting advocacy and/or involving the social network in treatment. Different interventions were examined, such as the crisis map and the crisis plan and the open dialogue approach from Finland. We also discussed forms of ACT - Active Community Treatment, known in the Netherlands as FACT (Flexible ACT) and RACT. FGC can be distinguished from the above-mentioned interventions in various ways. To begin, the decision model is designed in such a way that people have ownership over the problematic situation in which they find themselves. This is an important point of the philosophy and is combined with the family-oriented approach where the ‘strength’ of the group is used to solve problems and make action plans. In contrast to FGC, interventions such as RACT and FACT are mainly ‘professional driven’. The professionals in mental health organizations initiate and arrange the process. Ownership of the situation and how to deal with it therefore

remains largely in the hands of professionals. The added value of FGC lies in the neutrality of the coordinator and the place of gathering, but also the specific aim to widen the circle of support.

Chapter four delves into the barriers that occurred when working with FGC in psychiatry. From the start of the study, the inclusion of clients in the project was difficult, professionals did not inform clients about the possibility of organizing an FGC and few referred to it. Barriers were investigated by interviewing psychiatrists and social psychiatric nurses. What were reasons, motives and considerations for professionals not to refer to an FGC? The main barriers emerged as follows: (1) the acute danger in situations of coercion and the limited time available, as well as the fear of liability in a culture of control and risk avoidance (2) the vulnerability of clients and the associated effort to be able to participate in making decisions or communicating about this (3) considering FGCs or collaboration with social networks - and the added value of this - in crisis situations is not yet part of thinking and acting of professionals in mental health care (4) clients and/or the network themselves are not open to organizing a conference. The barriers show that organizing FGC in the context of coercive psychiatry is complex. The discourse of the FGC model (life world) and that of mental health care organizations (system world) do not mix easily. Awareness of possibilities and barriers for FGC help support the quest for least coercive care.

Chapter five examines the possibilities of FGC as a catalyst for the recovery process of people experiencing mental health problems. The philosophy behind FGC is consistent with that of the recovery orientated approach. In both, empowerment, strengthening and broadening the social network are core values. FGC appears to be a promising tool for shifting attention from disorders and inabilities to capacities and the rediscovery of social resources and provide a platform for restoring relationships but also to address the challenges connected to severe and ongoing psychiatric problems. On the one hand, a conference provides a platform for discussing shameful feelings, and on the other, family and friends can express their concerns. The role of professionals in the process of applying FGC should not be overlooked, as most clients are referred to FGC by them; they fulfil a supporting role.

Chapter six focuses on forming and strengthening a partnership between clients, social networks and professionals. FGC offers a platform to shape and strengthen a partnership; in this partnership actors can embrace their vulnerability and engage in so called courageous conversations. Participating in courageous conversations and embracing brave spaces requires

that actors do not push away complexity but actively seek for 'places of difficulty'. All actors are asked to reconsider their attitude in this regard. Especially for professionals this means a profound turn. Encouraging the client and the social network to make assessments, to help the group to analyze what is going on, to support the plan making with their expertise, rather than providing individual care. In addition, they are asked to discuss the hesitations and fears that arise in the FGC process and to encourage actors to participate in 'brave spaces' and not to avoid them.

Chapter seven illustrates with a case study the moral ambivalences that social network members experience when they express their commitment and involvement to others. In our current Western society it is often difficult to find a balance between your own 'life project' and the care for loved ones. Three concepts are used to understand the different relationships people have and the motives for being involved in someone else's life, 'personal communities', communities of choice and communities of fate. Using the case, we identified feelings of self-interest versus solidarity; calculation versus generosity and intimacy versus aloofness. Together these feelings form a complicated whole. Awareness of the moral ambivalences of individuals offers family, friends, and professionals opportunities to consider how they want to shape their commitment and support. The work of Muehlebach (2012) shows that, despite our neoliberal and meritocratic society, people remain relational beings and need each other to shape and express relational autonomy. The case illustrates not only that an FGC can help to determine how you want to relate to a loved one (in need of care/extra attention) but also in restoring relationships and expanding social circles.

Chapter eight aims to understand the relational dynamics between clients and social networks during the FGC process, by applying the theoretical concepts; symbolic capital, recognition, reciprocity and gift-giving of Bourdieu (1990). With the help of the analytical strategy 'thinking with theory', challenges and opportunities were re-examined in three cases, whereby we considered each FGC as a social field. The theoretical concepts of Bourdieu (1990) helped to understand and overcome the difficulties associated with organizing FGC. The process of an FGC can evoke shame, and disbelief that there are people willing to help. Furthermore, a lack of reciprocity in relationships can contribute to the stagnation of the FGC process. Participants of the conference can discuss, decide and negotiate the relational dynamics in their social field. Working with FGCs requires a shift in thinking and acting from professionals: facilitating the primary group (client and network) to start courageous conversations, to explore mutual expectations and to discuss the division of tasks.

Chapter nine demonstrates the commitment and involvement of students as co-researchers within the research project on FGC in psychiatry. Our research project showed that student participation in participatory health research works well on several fronts. First, it provides students with several learning opportunities that can narrow the gap between theory and practice. In addition, it encourages students to put into practice the skills acquired during their studies and to learn from supervisors through demonstration and the transfer of implicit knowledge (tacit knowledge). The addition of co-researchers also brings new perspectives. By involving different actors, and including students in the research process, universities, colleges and services are able to bridge the gap between theory and practice.

In the **discussion chapter (ten)** of this thesis, we outline how the discourse around ‘Eigen Kracht’ and participation has influenced the deployment of FGC in the Netherlands (and in this project). A complicating factor was the Dutch translation of FGC: ‘Eigen Kracht-conferenties’. When freely translated to English it would say self-reliance conferences, suggesting a neoliberal ideal of self-management. As such it was understood and embraced by policymakers, but later also received critique as it was denying the vulnerability and struggles of people with psychiatric disabilities, underestimating the relational complexities in social networks and the collaboration with professionals. Citizens were ought to arrange support in their own network, or with help from volunteers, before they could demand professional support. This order (first arrange support in your own network) disregarded that support of a social network is not always something that can be arranged top-down. Family and network relationships are complex – as we showed in this thesis.

Our project made it possible to look at (coercive) psychiatry in a different way and shows that forming a new practice based on power sharing via FGC is complex and builds on the contribution of all those involved. Multiple contingencies are of influence when it comes to drawing up a plan to deal with the situation at hand; the commitment of the different actors is essential. FCCs contribute to an increase in perceived ownership, restoration of relationships, and an increase in perceived social support. An FGC provides neutrality in two ways, by an independent coordinator and by the fact that these conferences are held on neutral terrain (church hall, community center). In addition, it offers a platform where people share personal stories, learn to understand each other, have ‘courageous conversations’ and where there is room for co-creation.

One could imagine an ideal course of actions and contrast it with the actual process when it comes to the organization of FGCs in coercive psychiatry. The ideal situation shows a client who, despite his (recent) confusion or disruption, wants his primary group to think along in

a conference to make a plan. A social network that in turn makes a benevolent contribution to the conference and professionals who value FGC, think along with the group in the conference and accept the plan that the primary group subsequently draws up, as leading. In practice, however, this rarely happened. Clients and their social networks experienced ambivalences when it came to shaping their involvement with others or experienced shame when allowing them back into their lives (again). Professionals and FGC-coordinators experienced struggles when it came to their role in the FGC process. It was difficult for professionals to participate in the FGC because it required a different attitude from them, they are asked to position themselves more modestly and discuss hesitations and fears that arise in the FGC process. This thesis underlines that making your own plan to prevent coercive measures as envisaged in the Mental Health Care Act on Compulsory Treatment (Wvggz) is a complex task and requires a strong partnership between clients, their social network and professionals. However, you can also say that a meeting that takes place on neutral ground, facilitated by a fellow citizen who has no interest in the outcome and moreover has much more time than a professional on a ward, is required more than ever.

FGC is an ongoing learning process of collaboration and empowerment. The work of Bourdieu (1990) can help professionals and coordinators in becoming sensitive to the need for recognition in relations and the symbolic value of power and control and encourage actors to participate in 'brave spaces'. In this way they can support clients and their social network in the challenges they face. Participating in courageous conversations and embracing brave spaces requires that actors do not deny or push away complexity but actively seek for 'places of difficulty'. The participants of the FGC are faced with a challenge here, as the place of difficulty brings along 'messiness'. Following Kunneman (2017) (who in turn follows Schön, 1983) we make the distinction between the 'high hard ground' where professionals can make effective use of research based theory and technique versus the 'swampy lowlands' where situations are confusing and messy. When confronted with messy problems professionals need to muster courage to muddle through, undertake small experiments, learn from mistakes and make discoveries in the process. The practice of FGC and strengthening the partnership between actors requires a descent into the so-called swamp. While actors are busy making a plan, they are also asked to discuss how this plan could work and what it takes from them as a group to make the plan a success. It requires reflection in action and reflection on action.

In order to make FGCs work in these difficult circumstances changes are necessary in legislation and policy, changes that ensure time for- and confidence in- the messy process of meaningful involvement of family and the broader social network, giving actors the opportunity to form their partnership and to learn from mistakes. Acknowledging the

complexity and the questions that arise in the swampy lowlands requires new governance and accountability opportunities, as it becomes clear to professionals and also to managers that simple rules and targets fall short. Policymakers from municipalities, their social teams and mental health institutions need to work together to shape and provide conditions wherein professionals are encouraged to work together with clients and their social network and confront the messy problems in the swampy lowlands. This requires a different mind-set, the social network is not a resource that is used instead of professional support, it is a resource to strengthen the position of citizens who experience problems in their lives. Initiatives such as RACT, even though they differ from FGC, show a psychiatry that recognizes the importance of social embeddedness, but also struggles with shaping this within the given framework. In this project we explored the involvement of family and broader social networks in these messy circumstances and show which learning opportunities there are and that space needs to be created for action-oriented learning in the swampy lowlands. A practice needs to be built in which new forms of meaningful involvement and collaboration of family and the broader social network emerge and where there is space for recognizing each other's vulnerabilities and participation in courageous conversations. A suggestion is to conduct a responsive evaluation with a participatory action research design (see Abma et al., 2019). Together with various stakeholders, a joint learning process can be created, in which a new habitus can be developed with horizontal relationships, an eye for tensions and power relations, the moral horizon of 'good care' and a focus on human flourishing and social justice. The deployment of FGCs requires formation of a new practice. On multiple levels shifts and modifications are necessary to form a restorative practice; the establishment of a legislative and financial framework, a shift in discourses of mental health institutions and public agencies – in short, an 'institutional back up' is required to successfully experiment with FGCs. Furthermore, the role of knowledge institutes (like universities or universities of applied sciences); is of importance, they can be seen as stakeholders. They also play a role in learning staff and students, to promote self-reliance and involve social networks in their contact with clients. By studying power sharing via FGCs through an action research framework, conditions necessary to deploy FGCs in Dutch society become visible and the potential of FGC in the context of mental health care can be exploited further.



Samenvatting

Ondanks beleid gericht op het verminderen van gedwongen behandelingen enerzijds en het betrekken van sociale netwerken bij de geleverde zorg anderzijds, blijft het aantal dwangmaatregelen in de psychiatrie in Nederland groeien. Het Ministerie van Volksgezondheid, Welzijn en Sport verwacht dat de nieuwe wet ‘Wet verplichte Geestelijke Gezondheidszorg (Wvggz)’ en de aanpak van het eerder opgerichte aanjaagteam verwarde personen zorgen voor een daling van het aantal dwangmaatregelen. De toename van dwang in Nederland is echter complex en speelt zich af in een tijd waarin de participatie van burgers en de-institutionalisering in de Geestelijke Gezondheidszorg (GGz) als belangrijk worden gezien maar ook moeizaam verlopen. Er heeft een beddenreductie plaats gevonden maar de ambulante zorg is tegelijkertijd minder goed toegankelijk geworden voor mensen die ernstige en langdurige psychiatrische problemen hebben. De marktwerking in de GGz, defragmentatie van het aanbod, overbehandeling, overconsumptie, ‘cherry picking’ en de vermindering van budgetten om de explosieve groei van de ggz af te remmen, vormen mede de achtergrond van het onvermogen om geïntegreerde zorg voor mensen met ernstige, chronische psychiatrische problemen vorm te geven. In het debat rondom ‘verwarde personen’ worden sociaalmaatschappelijke problemen op het vlak van overlast en veiligheid gekoppeld aan de GGz en het vóórkomen van psychische aandoeningen. Burgers hebben hooggespannen verwachtingen van politie, GGz en overheid om ‘verwarde personen’ van de straat te halen en de samenleving te beschermen, tegelijkertijd bestaat er een neiging bij deze instanties om risico’s te mijden. Er wordt vaak genoemd dat de samenleving minder tolerant is als het gaat om afwijkend gedrag en dat bijvoorbeeld bezorgde buurtbewoners sneller meldingen doen van ‘afwijkend gedrag’. De vraag is of de samenleving daadwerkelijk minder tolerant wordt of dat burgers er niet klaar voor zijn om zeer kwetsbare medeburgers in hun midden op te nemen omdat dit jarenlang niet van hen is gevraagd in de verzorgingsstaat.

In Nederland vonden gedwongen opnames in GGz instellingen jarenlang plaats onder de wet BOPZ (Wet Bijzondere opnemingen in psychiatrische ziekenhuizen). Door de overheid is besloten deze wet, vanaf 1 januari 2020, te vervangen door de Wvggz om zo beter aan te sluiten bij de belangen van cliënten en de hedendaagse opvattingen over de zorg voor personen met ernstige psychiatrische problemen. De bedoeling van deze wet is om cliënten meer invloed te geven tijdens de periode van verplichte zorg en de rechtspositie van cliënten in de GGz te verbeteren. Zij krijgen bijvoorbeeld de mogelijkheid om gedwongen maatregelen te voorkomen door zelf een plan te maken met hun eigen netwerk. Daarnaast wordt het ook mogelijk om gedwongen maatregelen op te leggen buiten de muren van GGz instellingen om. Het is de vraag of het opleggen van dwang in iemands thuissituatie als een verbetering van de rechtspositie van cliënten gezien kan worden; de laatste ‘veilige plek’ is daarmee ook niet meer veilig, zo is de

kritiek. De logica van deze wet is er één van controle en laat vooral verticale (hiërarchische) macht zien. We zien de reflex in deze wet om eigen gemaakte plannen van cliënten controleerbaar en beheersbaar te maken waarbij het de vraag is of een dergelijk plan dan recht kan doen aan de complexiteit van horizontale relaties in gemeenschappen.

Gedwongen behandeling in de psychiatrie, of die nu thuis plaats vindt of in een instelling, is een ingrijpende gebeurtenis voor cliënten. Het schendt fundamentele menselijke rechten en impliceert een verlies van eigenaarschap en controle over de eigen situatie. Bovendien worden mensen ‘buitenspel’ gezet als zij worden opgenomen; zij kunnen niet mee doen in gemeenschappen. Dit staak haaks op het herstelproces van mensen die ernstig psychiatrische problemen ervaren, herstel is verbonden aan de sociale context waarin iemand ‘thuis’ hoort. Het ervaren van sociale steun van mensen die er toe doen en het horen bij een groep hebben therapeutische waarde. In overheidsbeleid wordt steeds meer nadruk gelegd op actief burgerschap en informele zorg; van burgers wordt verwacht om meer voor zichzelf en naasten te zorgen. Van professionals, in onder andere de GGz, wordt verwacht dat zij cliënten de regie ‘geven’ en hen in staat stellen om eigenaarschap over hun leven terug te krijgen. De retoriek is dat de leefwereld aan zet moet komen, maar in de praktijk stroopt de systeemwereld nog steeds de mouwen op. Hulpverleners vinden het lastig om zich bescheiden op te stellen en zich dienstbaar te maken aan plannen van cliënten. Daarnaast wordt het sociale netwerk vaak nog niet betrokken bij de zorg.

Het doel van deze thesis is om bij te dragen aan het vormen van een nieuwe praktijk, een praktijk waarin gezocht wordt naar het delen van macht door cliënten, familie en professionals gebruikmakend van Eigen Kracht-conferenties (EK-c's) in de context van de gedwongen psychiatrie. Eigen Kracht-conferenties kunnen een rol spelen bij het herstellen van zeggenschap, relaties en het vergroten van sociale netwerken. Het Nederlandse ‘Eigen Kracht-conferentie’ kent zijn oorsprong in Family Group Conferencing. Family Group Conferencing heeft haar wortels liggen bij de tradities van de Maori, de inheemse bevolkingsgroep van Nieuw Zeeland, en wordt over de hele wereld ingezet. Het is ontwikkeld als een besluitvormingsmodel dat de collectieve verantwoordelijkheid van families en nabije gemeenschappen erkent. Families en vrienden die deelnemen aan de conferentie belichamen de leefwereld, terwijl professionals het systeem belichamen. In de systeemwereld van professionals, in dit geval werkzaam in de GGz, domineren regels en hiërarchie, terwijl de leefwereld – en EK-c's- vragen om relationeel en horizontaal begrip. De normen, regels en waarden van professionals worden dus uitgedaagd.

De inzet van Eigen Kracht-conferenties is met name bestudeerd in de jeugdzorg, waar verschillende studies laten zien dat de conferenties een rol kunnen spelen bij het voorkomen

of bekorten van jeugdbeschermingsmaatregelen. Ook binnen de Openbare Geestelijke Gezondheidszorg (OGGz) en ouderenzorg zijn er aanwijzingen dat de conferenties bijdragen aan het ervaren van eigenaarschap en het vergroten van sociale steun. Er zijn twijfels over de lange termijn effecten, en onderzoek naar Eigen Kracht-conferenties in de (gedwongen) psychiatrie is schaars.

Deze thesis was onderdeel van een groter onderzoeksproject naar het proces en de uitkomsten van Eigen Kracht-conferenties in de gedwongen psychiatrie in Nederland (uitgevoerd van 2013-2015). Er werd een responsieve evaluatie uitgevoerd met zowel kwantitatieve als kwalitatieve elementen. Deze methodologie reflecteert de onderliggende principes van Eigen Kracht-conferenties, beide stellen als doel om (wederzijds) begrip door middel van dialoog te vergroten en hechten belang aan het includeren van de stemmen van gemarginaliseerde groepen. Ze zijn gebaseerd op democratische principes waarin mensen het recht hebben op het maken van een eigen plan en betekenis kunnen en mogen geven aan een situatie. De evaluatie vond plaats aan de hand van meerdere casestudies (60). Doel was om de cases te begrijpen vanuit de traditie van ‘verstehen’, waarbij de nadruk niet ligt op feitelijkheden maar bij de door actoren gepercipieerde opbrengsten van het EK-c proces. De data werden verzameld door interviews af te nemen, met behulp van een vragenlijst met daarin zowel open vragen als schaalvragen. De interviews werden afgenomen bij 289 van de 466 participanten (bij 41 voltooide conferenties), na afloop van de conferentie. Daarnaast werden er participerende observaties uitgevoerd en member checks georganiseerd. Dit laatste werd gedaan om bevindingen van elke case te valideren en om een groepsdiscussie over de conferentie te faciliteren die wellicht nieuwe inzichten op kon werpen ten aanzien van het proces en de uitkomsten van een conferentie. Gedurende het onderzoek werd data verrijkt met theorie, waarbij theorie niet op voorhand werd opgelegd maar geleidelijk werd ‘ingeplugd’ op basis van de bevindingen. Met andere woorden, een iteratief proces.

Dit proefschrift is onderverdeeld in verschillende hoofdstukken die als artikelen in verschillende wetenschappelijke tijdschriften zijn gepubliceerd. In de structuur van dit proefschrift laten we een toenemende complexiteit van ons onderzoek zien. We beginnen met deel één (hoofdstukken twee en drie) waarin we de gepercipieerde impact en waarde van EK-c's bespreken. In het tweede deel van dit proefschrift bespreken we het vormgeven van een nieuwe praktijk waarin gezocht wordt naar het delen van macht door cliënten, familie en professionals via EK-c's (hoofdstukken vier, vijf en zes). In het derde deel van dit proefschrift worden de morele ambivalenties en relationele complexiteit van steun gegeven door familie en vrienden beschreven (hoofdstukken zeven, acht en negen). Ten slotte reflecteren we

in het laatste hoofdstuk op de belangrijkste bevindingen van dit proefschrift en op het methodologische kader. Toekomstige richtingen en suggesties voor verder onderzoek zullen hier worden toegelicht.

Hoofdstuk twee laat een overzicht zien van de uitkomsten van het organiseren van Eigen Kracht-conferenties in de gedwongen psychiatrie, ook wel het kwantitatieve deel van de responsieve evaluatie. De impact van de conferenties werd onderzocht aan de hand van drie schaalvragen tijdens interviews met participanten van de EK-c (N=260). Er werd retrospectief gereflecteerd op drie uitkomstmaten: eigenaarschap, sociale steun (belongingness) en mate van ervaren dwang. De gegeven scores op de drie uitkomstmaten voor en na de conferentie werden geanalyseerd door middel van gepaarde T-toetsen en een Multi level analyse. Participanten geven aan na de conferentie een lichte vermindering in dwang te ervaren (niet significant) en een toename van eigenaarschap en sociale steun.

Hoofdstuk drie gaat in op de toegevoegde waarde van EK-c's in relatie tot andere strategieën gericht op het verminderen van dwangmaatregelen, pleitbezorging en/of het betrekken van het sociale netwerk bij een behandeling. Verschillende interventies werden bekeken zoals de crisiskaart en het crisisplan en de 'open dialogue' benadering uit Finland. Daarnaast bespraken we vormen van ACT - Active Community Treatment, in Nederland bekend als FACT (Flexible ACT) en RACT. EK-c's kunnen op verschillende manieren van de bovengenoemde interventies worden onderscheiden. De eerste is de basis van Eigen Kracht, het beslissingsmodel is zodanig vormgegeven dat mensen eigenaar blijven van de problematische situatie waarin ze zich bevinden. Dit is een belangrijk punt van de filosofie en wordt gecombineerd met de gezinsgerichte benadering van EK-c's waar de 'kracht' van de groep wordt gebruikt om problemen op te lossen en actieplannen te maken. In tegenstelling tot EK-c's zijn interventies als RACT en FACT voornamelijk 'professional driven'. De professionals in organisaties voor GGz zijn nog steeds de initiatiefnemers en dragen grotendeels de verantwoordelijkheid voor het proces. Het eigenaarschap over de situatie en hoe daar mee te dealen blijft dan ook grotendeels bij de professionals liggen. De toegevoegde waarde van EK-c's zit in de ervaren toename van eigenaarschap, zelfs in situaties waarin dwang onvermijdelijk lijkt.

Hoofdstuk vier laat zien welke barrières er ervaren werden bij het werken met EK-c's in de psychiatrie. Vanaf de start van het onderzoek verliep de inclusie van cliënten in het project moeizaam, professionals informeerden cliënten niet over de mogelijkheid tot het organiseren

van een EK-c en weinigen verwezen er dan ook naar door. In 17 cases werden barrières onderzocht als het ging om het organiseren van EK-c's door bijvoorbeeld psychiaters en sociaal psychiatrisch verpleegkundigen te interviewen. Hierbij stond centraal welke barrières er in situaties waren waarin niet naar een EK-c werd verwezen en wat redenen, motieven en overwegingen van professionals hierin waren. De volgende barrières kwamen in hoofdlijnen naar voren: (1) het acute gevaar in situaties van dwang en de weinig beschikbare tijd die daarmee samengaat, alsook de angst om aansprakelijk te zijn in een cultuur van controle en risicovermijding (2) de kwetsbaarheid van cliënten en daarmee samenhangend de moeite om deel te kunnen nemen aan het maken van beslissingen of communicatie daarover (3) het overwegen van EK-c's of het samenwerken met sociale netwerken – en de toegevoegde waarde hiervan- in crisissituaties is nog geen onderdeel van het denken en doen van professionals in de GGz (4) cliënten en/of het netwerk staan zelf niet open voor het organiseren van een conferentie. De barrières laten zien dat het organiseren van EK-c's in de context van de gedwongen psychiatrie complex is, het veranderen van de praktijk zou soepeler verlopen als er ook een transitie in de betrokken organisaties plaats vindt. Het discours van het EK-c model (leefwereld) en die van de GGz (systeemwereld) staan op gespannen voet met elkaar.

Hoofdstuk vijf gaat in op de mogelijkheden van EK-c's als katalysator voor het herstel van mensen met aanhoudende psychiatrische problematiek. Het gedachtegoed achter de conferenties komt overeen met dat van de herstelgerichte aanpak. Bij beide zijn empowerment, versterking en verbreding van het sociale netwerk kernwaarden. EK-c's lijken een veelbelovend hulpmiddel om de aandacht te verschuiven van stoornissen en onvermogen naar capaciteiten en de herontdekking van sociale hulpbronnen. Aan de ene kant biedt een conferentie een platform om gevoelens te bespreken en schaamte te doorbreken en aan de andere kant kunnen familie en vrienden hun zorgen uitten. De rol van professionals moet hierin niet over het hoofd worden gezien, aangezien cliënten door hen doorverwezen kunnen worden, zij hebben een ondersteunende rol. Daarnaast is het van belang dat mensen niet worden gereduceerd tot hun problemen of kwetsbaarheden maar aan de andere kant moeten deze problemen niet onderkend worden en onbesproken blijven.

Hoofdstuk zes gaat in op het vormen en versterken van een partnerschap in een EK-c tussen cliënten, sociale netwerken en professionals. Dit wordt bestudeerd aan de hand van verschillende cases uit het onderzoek. De EK-c biedt ruimte om een partnerschap aan te gaan en te versterken; het is een platform waarbij cliënten, sociale netwerken en professionals informatie delen en elkaar kunnen confronteren. In dit partnerschap blijkt het van belang dat de

actoren kwetsbaarheid van henzelf- en anderen – omarmen en met elkaar ‘moedige gesprekken’ (‘courageous conversations’) aangaan. Van professionals wordt hierin een attitudeverandering gevraagd; zij moeten zich dienstbaar opstellen in het ondersteunen van cliënt en netwerk en een bijdrage leveren aan de gemaakte plannen vanuit hun expertise in plaats van individuele zorg leveren. Daarnaast wordt van hen gevraagd om aarzelingen en angsten die zich voordoen in het EK-proces te bespreken en actoren aan te moedigen om deel te nemen aan ‘brave spaces’ en deze niet uit de weg te gaan.

Hoofdstuk zeven illustreert met behulp van een case studie de morele ambivalenties die sociale netwerken ervaren wanneer zij hun steun en betrokkenheid bij een naaste vormgeven. In onze huidige westerse samenleving is het vaak moeilijk om een balans te vinden tussen het eigen ‘levensproject’ en de zorg voor naasten. Het concept ‘personal communities’ is van waarde als het gaat om het begrijpen van de verschillende relaties die mensen hebben en de motieven om betrokken te zijn bij het leven van een ander (keuze vs. lot). Met behulp van de case hebben we gevoelens van eigenbelang versus solidariteit; berekening versus vrijgevigheid en intimiteit versus afstandelijkheid geïdentificeerd. Deze gevoelens vormen samen een gecompliceerd geheel. Bewustwording van de morele ambivalenties van personen die zowel solidaire aspiraties als de wens hebben om hun eigen levensdoelen na te streven, biedt familie, vrienden en professionals kansen om te overwegen hoe zij hun betrokkenheid en steun vorm willen geven. Het werk van Muehlebach (2012) laat zien dat ondanks de neoliberale en meritocratische samenleving mensen relationele wezens blijven en elkaar nodig hebben om relationele autonomie vorm te geven en uit te kunnen drukken. De case laat zien dat EK-c’s nuttig kunnen zijn wanneer mensen steun nodig hebben of gefaciliteerd dienen te worden bij het herstellen van relaties en/of het vergroten van hun sociale kring.

Hoofdstuk acht heeft als doel de relationele dynamiek tussen cliënten en sociale netwerken tijdens het EK-c proces te begrijpen, door theoretische concepten van Bourdieu (1990) over symbolisch kapitaal, erkenning, wederkerigheid en ‘gift-giving’, toe te passen. Met behulp van de analytische strategie ‘thinking with theory’ zijn uitdagingen en kansen in drie cases opnieuw bekeken, waarbij we iedere EK-c zien als een sociaal veld. De theoretische concepten van Bourdieu (1990) zijn behulpzaam in het begrijpen en overwinnen van de moeilijkheden die gepaard gaan met het organiseren van EK-c’s. Het proces van een EK-c kan namelijk schaamte oproepen, evenals ongelof dat er personen zijn die steun willen geven. Verder kan een gebrek aan wederkerigheid in relaties bijdragen aan het stagneren van het EK-c proces. Deelnemers aan de EK-c kunnen de relationele dynamiek in hun sociale

veld bediscussiëren, er over beslissen en onderhandelen. Het werken met EK-c's vraagt van professionals een verschuiving in denken en handelen; zij dienen de primaire groep (cliënt en netwerk) te faciliteren in het bediscussiëren van onderlinge verwachtingen en verdelen van taken.

Hoofdstuk negen demonstreert de inzet en betrokkenheid van studenten als co-onderzoekers binnen het onderzoeksproject naar EK-C's in de psychiatrie. Uit ons onderzoeksproject bleek dat de deelname van studenten aan participatief gezondheidsonderzoek op verschillende fronten goed werkt. Ten eerste biedt het studenten verschillende leermogelijkheden die de kloof tussen theorie en praktijk kunnen verkleinen. Daarnaast moedigt het studenten aan om vaardigheden die zij tijdens hun studie hebben opgedaan uit te voeren in de praktijk en te leren van supervisors door middel van demonstratie en de transfer van impliciete kennis (tacit knowledge). De toevoeging van zoveel co-onderzoekers brengt bovendien nieuwe perspectieven in. Universiteiten en hogescholen krijgen door verschillende actoren, waaronder studenten, in het onderzoeksproces te betrekken de tools om de kloof tussen theorie en praktijk te dichten.

In het **discussiehoofdstuk (tien)** van dit proefschrift schetsen we hoe het discours rondom 'eigen kracht' de inzet van EK-c's in Nederland (en in dit project) heeft beïnvloed. De term 'eigen kracht' lijkt ervan uit te gaan dat mensen zaken eerst zelf moeten regelen voordat zij professionele hulp kunnen of mogen krijgen. Deze volgorde gaat er vanuit dat steun van een netwerk altijd gemakkelijk te regelen is. Deze thesis laat echter zien dat dit niet altijd zo eenvoudig gaat en dat daarnaast het sociale netwerk (ook) steun nodig heeft. Het project maakte het mogelijk om op een andere manier naar de (gedwongen) psychiatrie te kijken.

In de psychiatrie overheerst een bureaucratisch en hiërarchisch discours, terwijl in het discours rondom EK-c's gezocht wordt naar een verhouding waarin de primaire groep - gesteund door de expertise van professionals - zeggenschap verwerft. Deze twee discourses stonden in dit project op gespannen voet met elkaar en dat maakte het lastig om EK-c's van de grond te krijgen in de psychiatrie. Het project maakte het desalniettemin mogelijk om te zien wat er gebeurt als een besluitvormingsmodel zoals de EK-c wordt ingezet bij verplichte GGz. EK-c's dragen bij aan een toename van ervaren eigenaarschap, het herstel van relaties, en het toenemen van de ervaren sociale steun. Een EK-c kan neutraliteit bieden door middel van de onafhankelijke coördinator en neutraal terrein. Daarnaast biedt het een platform waar mensen persoonlijke verhalen delen, elkaar leren begrijpen, 'moedige gesprekken' voeren en waar ruimte is voor co-creatie.

Gebaseerd op onze bevindingen hebben we een aantal praktische implicaties opgesteld. Men zou zich een ideale gang van zaken voor kunnen stellen en deze contrasteren aan de daadwerkelijke gang van zaken als het gaat om het organiseren van EK-c's in de gedwongen psychiatrie. De ideale gang van zaken laat een cliënt zien die, ondanks zijn (recente) verwarring of ontregeling zijn primaire groep wil laten meedenken over een plan, een sociaal netwerk dat op hun beurt welwillend aan de conferentie bijdraagt en hulpverleners die de waarde van EK-c's inzien en dat met kennis van zaken onder aandacht brengt van de groep in kwestie, meedenkt in de bijeenkomst en het plan dat de primaire groep vervolgens maakt als leidend accepteert. In de praktijk ging het echter zelden zo. Cliënten en hun sociale netwerk ervoeren ambivalenties in het vormgeven van hun betrokkenheid bij elkaar of voelden schaamte als het neerkwam op de ander (opnieuw) toe laten in hun leven. Professionals en Eigen Kracht-coördinatoren worstelden met hun rol in het proces van de EK-c, wie was waarvoor verantwoordelijk en moest bepaalde vragen stellen over bijvoorbeeld dynamiek of haalbaarheid van gemaakte plannen. Daarnaast was het voor professionals lastig om mee te doen in de EK-c omdat het van hen een andere houding vroeg, zij dienden zich meer bescheiden op te stellen en aarzelingen en angsten die naar voren kwamen tijdens het proces van de EK-c te bespreken. Deze thesis onderstreept dat het maken van een eigen plan om dwangmaatregelen te verkorten of voorkomen een complexe taak is en een sterk partnerschap tussen cliënten, hun sociale netwerk en professionals vraagt.

De EK-c is een doorgaand leerproces van samenwerking en empowerment. Het werk van Bourdieu (1990) kan professionals en coördinatoren helpen bij het sensitiever worden voor zaken als de behoefte aan erkenning in relaties en de symbolische waarde van macht en zeggenschap. Op deze manier kunnen zij cliënten en hun sociale netwerk ondersteunen in de uitdagingen waar zij voor komen te staan. Participeren in moedige gesprekken (courageous conversations) en het omarmen van 'brave spaces' vraagt van actoren dat zij complexiteit in situaties niet wegdrücken maar op zoek gaan naar de plek der moeite. Dit brengt chaos en rommeligheid (messiness) met zich mee. Schön (1983) maakt het onderscheid tussen de 'hoge harde grond' (high hard ground) waar professionals effectief gebruik kunnen maken van evidence based theory en technieken, en het 'laaggelegen moeras' (swampy lowlands) waar situaties en problemen vooral verwarrend en moeilijk op te lossen zijn. Wanneer mensen geconfronteerd worden met verwarrende (messy) problemen in het moeras, is het van belang dat zij moed verzamelen om aan te modderen, kleinschalig te experimenteren, leren van gemaakte fouten en gaandeweg ontdekkingen doen. De praktijk van EK-c's en daarmee ook het versterken van een partnerschap tussen de actoren vraagt een afdaling in het zogenoemde laaggelegen moeras. Tegelijkertijd met het maken van het plan wordt van de actoren gevraagd

om te kijken naar hoe zij discussiëren over het plan en wat het van hen vraagt als groep om het plan te laten slagen. Dit vraagt reflectie tijdens actie en op actie. Om EK-c's als platform te laten functioneren voor 'moerassige' activiteiten zoals het versterken van het partnerschap tussen de actoren, zijn er veranderingen nodig in wetgeving en beleid. Veranderingen die bijdragen aan tijd voor- en vertrouwen in - de 'messy' praktijk van EK-c's. Op deze manier krijgen de actoren de kans om het partnerschap te vormen en te versterken. Er dient ruimte gecreëerd te worden voor actie georiënteerd leren in het moeras – dit betekent dat tastend en zoekend werken op hun waarde geschat moeten worden. Het erkennen van complexiteit in de praktijk en de vragen die zich ontploegen in het moeras vraagt van bestuurders en managers een oprecht interesse hierin en vraagt ook vernieuwend overheidsbeleid en een andere verantwoordingscultuur. Het gaat hier niet alleen om het creëren van een wettelijk kader maar ook de voorwaarden waaronder de planvorming van primaire groepen kan slagen. Daarnaast dienen ook voorwaarden gecreëerd te worden voor professionals in de GGz - en breder -om hen te faciliteren zich in te zetten voor het aangaan van een partnerschap met cliënten en hun primaire groep. Initiatieven zoals RACT, ook al verschillen ze van EK-c's, tonen een psychiatrie die het belang van verbondenheid en eigenaarschap erkent, maar ook worstelt om dit binnen de gegeven kaders vorm te geven. In dit project zijn we begonnen met de 'messy' praktijk van betrokkenheid van familie en een breder sociaal netwerk, en laten we zien welke leermogelijkheden er zijn en dat er ruimte moet worden gecreëerd voor actiegericht leren in de moerassige laaglanden. Er moet gestreefd worden naar een praktijk waarin nieuwe vormen van betrokkenheid en samenwerking met familie en het bredere sociale netwerk ontstaan en waar ruimte is voor het herkennen van elkaars kwetsbaarheden en deelname aan moedige gesprekken. We hebben een begin gemaakt met het bestuderen van de complexiteit van het organiseren van EK-c's vanuit meerdere perspectieven, maar er blijft een behoefte bestaan om de succesfactoren en de barrières verder te exploreren.

Een suggestie is om een responsieve evaluatie uit te voeren met een participatief actie onderzoeksontwerp (zie Abma et al., 2019). Samen met verschillende stakeholders kan een gezamenlijk leerproces worden aangegaan, waarin een nieuwe habitus kan worden ontwikkeld vanuit horizontale relaties met oog voor spanningen en machtsverhoudingen, de morele horizon van 'goede zorg' en focus op menselijke bloei en sociale rechtvaardigheid. Het organiseren van EK-c's vereist het vormen van een nieuwe praktijk. Op meerdere niveaus zijn verschuivingen en aanpassingen nodig om een herstelgerichte praktijk te vormen; de totstandkoming van een wetgevend en financieel kader, een verschuiving in de discourses van GGz-instellingen en overheidsinstanties - kortom, een 'institutionele back-up' is vereist om met succes te experimenteren met het organiseren van EK-c's. Verder is de rol van

kennisinstellingen (zoals universiteiten of hogescholen) niet onbelangrijk, zij kunnen gezien worden als stakeholders. Ze spelen een rol bij het leerproces van personeel en studenten, om eigenaarschap te bevorderen en sociale netwerken te betrekken in contact met cliënten. Door de praktijk van EK-c's vanuit een actieonderzoekskader te bestuderen, worden de voorwaarden zichtbaar die nodig zijn om de praktijk van EK-c's te vormen in de Nederlandse samenleving en kan het potentieel van EK-c's in de context van de GGz verder worden benut.



Dankwoord

In 2013 begon ik als junior-onderzoeker bij de afdeling Metamedica van het VUmc in het project 'Eigen Kracht-conferenties bij BOPZ-maatregelen' onder leiding van Gert Schout. Gert heb ik leren kennen tijdens mijn afstuderen aan de Master Sociologie bij de Rijksuniversiteit Groningen, waarvoor ik een thesis schreef over de 'acceptatie' van Eigen Kracht-conferenties binnen de Geestelijke Gezondheidszorg. Regie, het delen van 'macht' en het partnerschap tussen client, het sociale netwerk en professionals waren (en zijn) thema's die mij boei(d)en. Het was een mooie kans om mijn carrière met een onderwerp te kunnen beginnen waar ik mij persoonlijk betrokken bij voelde.

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Curriculum Vitae & overige publicaties

Ellen Meijer was born on March 19, 1990, in Pekela, the Netherlands. After her graduation from high school at the Ubbo Emmius college in Stadskanaal in 2007 she started to study 'Applied Psychology' at the Hanze University of Applied Sciences in Groningen. She finished her bachelor in 2011 and then started a master's in Sociology at the University of Groningen. Her master thesis was about the acceptance of Family Group Conferencing in mental health care. In 2013 she obtained her master's degree. After graduating, Ellen started working as a junior researcher at the department of medical humanities of VU university medical centre in Amsterdam. She participated in a research project about the impact and process of Family Group Conferencing in coercive psychiatry in the Netherlands. Her PhD project is linked to this research project. She combined her Phd project with working as a teacher at the bachelor Social Work (Hanze University of Applied Sciences in Groningen). Currently she still works at the Hanze University of Applied Sciences, as a teacher and researcher at both the bachelor and master 'Social Work'. Together with a colleague she is responsible for coordinating the minor 'Mental Health Care' and the graduation profile 'Mental Health agogic worker' (uitstroomprofiel GGz-agoog).

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