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Family group conferencing—its added value in mental health care

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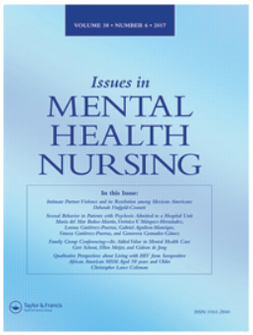

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Family Group Conferencing—Its Added Value in Mental Health Care

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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 article the question, 'what Family Group Conferencing adds to the existing methods that aim to reduce coercion in mental health care and promote inclusion' is addressed.

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', Wvggz). 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 Wvggz as the act aims to provide care under the legislation of a community treatment order at clients' home as a less 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, Molodynski, & Burns, 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 could be seen as a form 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 Wvggz 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

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problems. Between 2011 and 2015 we studied the applicability of Family Group Conferencing (FGC) in mental health care. There is a lot of experience gained with this decision-making model in 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). We have published our research in different journals: both on the outcomes (de Jong, Schout, Meijer, Multer, & Abma, 2016; Meijer, Schout, de Jong, & Abma, 2017) and on the process of implementation and application (De Jong, Schout, & Abma, 2014; De Jong, Schout, Pennell, & Abma, 2015; Schout, Van Dijk, Meijer, Landeweer, & De Jong, 2016). The findings from our study underline the potential of FGC as a strategy to reduce coercion in mental health care. It also highlights the crucial role that nurses can have in informing their clients to the possibilities that FGC might offer and in helping them in the implementation of the plan.

In this discursive paper we address the question 'what FGC adds to the existing strategies to reduce coercive care and promote inclusion'. This article can be viewed as a search for meaning. It aims for an understanding of 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. The conclusions of this paper draw upon an interplay between the empirical findings and a theory driven literature search on approaches that aim to reduce coercion. Let us first explain the origin of FGC and its underlying principles more into detail.

Family group conferencing

FGC 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. The encouraging of self-efficacy and group-efficacy is a central objective of FGC. FGC establishes links between two different worlds: connecting the life world 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?* 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

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

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 axis with a vertical axis, representing the tension between family and professional driven interventions (Figure 1).

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. We attempt to describe the relationships and distinctions between these methods below.

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, (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,). There are just few studies that examined the effects of the crisis-card, however they indicate positive outcomes for clients who make use of 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 et al., 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 developed in an interplay between clients and mental health professionals. It gives an overview of the signals that indicate when the client is not feeling 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 latter 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' 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 et al., 2006; Seikkula, 2008).

Flexible and Resource Group Assertive 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 adaptation on the ACT-model was established 10 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). Although it encourages an intensive cooperation with the social network, RACT remains a model where professionals are in the lead (professional-driven). 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 explores 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 "family-driven" decision-making model and social network strategy that is aligned with the tradition of indirect social engineering (see Figure 1).

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 the organisation responsible for organising FGC on her own initiative, but was compulsorily 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 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 a 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 his 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? We discussed these questions with the different stakeholders of our project. According to the FGC, it has a small chance to generate sustainable outcomes when it is used as a separate, one-time action. And this is especially true when it is organised during the most stressful moment, namely in the event of an impending compulsory measure. In our research we saw that FGC was deployed when other options were already exhausted. This raised the question whether all mental health clients, prior to a compulsory admission, should be informed about the possibility of organising FGC. 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: firstly, 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 this client group is struggling with; thirdly, that some clients only would want to change for their relatives, but not for professionals, and that FGC creates this opportunity; and 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.

Declaration of interest

The authors declare that they have no conflict of interest.

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