British Journal of Social Work (2013) **43**, 1439–1454
doi:10.1093/bjsw/bcs050
Advance Access publication April 18, 2012

Breaking through Marginalisation in Public Mental Health Care with Family Group Conferencing: Shame as Risk and Protective Factor

Gideon de Jong* and Gert Schout

Gideon de Jong has been working for the last three years as a researcher at the University of Groningen and the Hanze University of Applied Sciences. His research focus has been on issues in public mental health care. Currently, he is executing Ph.D. research into the effectiveness of Family Group Conferencing in public mental health care. Gert Schout is Professor at the School of Nursing, Hanze University of Applied Sciences. Over the past decade, he has been involved in the research and development of public mental health care in the Netherlands. He has written books and published in various journals on topics dealing with care for socially vulnerable people. In 2007, he received his Ph.D. at the University of Groningen on a study into the interplay between care avoidance and care paralysis. His recent articles and research focus on the application of Family Group Conferencing in public mental health care.

*Correspondence to Gideon de Jong, School of Nursing, Hanze University of Applied Sciences, Eyssoniusplein 18, 9714 CE Groningen, The Netherlands. E-mail: *gideon.de.jong@gmail.com*; *g.de.jong@pl.hanze.nl*

Abstract

From January 2011 until December 2012, forty Family Group Conferences (FGCs) will be studied in the public mental health care (PMHC) setting in the province of Groningen, the Netherlands. Research should yield an answer to whether FGCs are valuable for clients in PMHC as a means to generate social support, to prevent coercion and to elevate the work of professionals. The present study reports on two case studies in which shame and fear of rejection are designated as main causes for clients to avoid contact with their social network, resulting in isolated and marginalised living circumstances. Shame, on the other hand, is also a powerful engine in preventing clients from relapse into marginalised circumstances for which one needs to feel ashamed again. An FGC offers a forum where clients are able to discuss their shameful feelings with their social network; it generates support and helps breaking through vicious circles of marginalisation and social isolation. Findings of these case studies confirm an assumption from a previous study that a limited or broken social network is not a contraindication, but a reason for organising FGCs.

© *The Author 2012. Published by Oxford University Press on behalf of The British Association of Social Workers. All rights reserved.*

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

Keywords: Family Group Conferencing, marginalisation, public mental health care, reintegrative shaming, social isolation, social support

Accepted: March 2012

Introduction

Worldwide, there is a lack of a comprehensive, integrated and co-ordinated system of community mental health care. This explains the need for a safety net as public mental health care (PMHC) (Schout *et al.*, 2011). The core of PMHC is to provide care for people who are not being helped within regular mental health settings. Clients in PMHC are not sufficiently able to provide their own living conditions (shelter, food, income), have several problems simultaneously (mental and addictions problems, unhygienic living circumstances, homelessness) and normally do not ask for help or are avoiding the care they actually need, so there is unsolicited assistance. Most clients have a limited network (contacts are broken or faded), leaving clients few resources on which to draw (Schout *et al.*, 2010).

During the last decade, there has been an increasing emphasis on involving family in care for people with psychiatric disorders and addiction (see Ewertzon *et al.*, 2008; Jubb and Shanley, 2002; Lakeman, 2008; Mueser *et al.*, 2003; Sherman *et al.*, 2005). In a recent article, Van Meekeren and Baars (2011) argue that psychiatric disorders of clients are influential on the well-being of their social network and vice versa (see also Walton-Moss *et al.*, 2005). As several researchers (Heru, 2006; Mueser *et al.*, 2003; Sherman and Carothers, 2005) note, families are a valuable source in elevating stressful circumstances, but could also unintentionally contribute to the maintenance of problems. Loss of support from the social network holds serious implications for clients, insofar as they risk ending up in a downward spiral of marginalisation and social isolation (Lourens *et al.*, 2002).

Since its introduction in youth care practices of several Western countries, there is growing attention on the application of Family Group Conferences (FGCs) in other areas of intervention (see Gramberg, 2011; Malmberg-Heimonen, 2011), such as education (Hayden, 2009), with minority groups (Chand and Thoburn, 2005; O'Shaughnessy *et al.*, 2010), in situations of preventing recidivism of juvenile crime (Baffour, 2006) and in social services contexts for adults (Malmberg-Heimonen, 2011). However, knowledge on the effectiveness of FGCs in mental health care is scarce (see De Jong and Schout, 2011).

An FGC could be described as a model for decision making (Burford and Hudson, 2000*b*; Merkel-Holguin, 2004). In a conference, all who are involved with the client, and who can contribute, are invited. Not only a client, his or her family and care providers are present, but also friends and neighbours can participate. Central to the model is the private time

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

wherein the client and his or her network have the chance to develop their own plan. Hereby, they are empowered and made responsible for improving their own living conditions. For a more extended description of the origin of FGC and how conferences are prepared and executed, we refer to Burford and Hudson (2000*a*), Hayes and Houston (2007), Levine (2000) and Lupton (1998).

In a recent article, we formulated several reasons to start pilots with FGCs in PMHC practices (De Jong and Schout, 2011). Important to the success of FGCs is the mobilisation of informal support. However, many clients in PMHC have a limited network and are living in isolated conditions (Schout *et al.*, 2011). Relationships are often damaged, resulting in a limited number of people who can contribute to a conference. In our exploratory study, we interviewed both PMHC professionals and representatives of the FGC movement in the Netherlands on whether an FGC for clients in PMHC is indicated (De Jong and Schout, 2011). The case studies we have examined so far imply that a limited network is not a contraindication, but a reason for organising FGCs: with the help of conferences, faded and broken relationships could be restored.

Shame, social isolation and recovery

An important mechanism leading to social isolation is shame. An influential study into the concept of shame and its affection of the human condition was done by the psychiatrist Nathanson. Nathanson (1994) describes that shame can turn in two different directions: driven by shame, an individual chooses to attack other people or him- or herself, as well as withdrawing from or avoiding shameful situations. Much experience of the role of shame in FGCs has been gained in judicial cases with offenders and victims. The purpose of such conferences is to restore the relationship between perpetrator and victim, not on punishing the perpetrator. The underlying philosophy of this type of FGC is the concept of 'reintegrative justice' (Harris, 2006). This concept is inherited from the theory of 'restorative shaming' (Braithwaite, 1989). Important in Braithwaite's theory is the central role of shame. An FGC provides a secure platform to the main characters so that feelings of shame can be shared. In addition, according Braithwaite, relationships can be restored and reintegration will succeed. The role of shame as a powerful engine behind behaviour change is twofold. First, shame acts as a strong corrector, especially when shameful feelings are discussed in between the main actors of the FGC and their social network. On the other hand, shame can act as preventer: the main actors would not relapse into behaviour for which they need to feel ashamed again.

In our study into the application of FGCs in PMHC, we identify that shame is a major underlying foundation of social isolation, as clients

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

revealed to us that, because of shame, they are avoiding contact with their network. This knowledge can help raise awareness of underlying mechanisms of social isolation such as shame.

The study

In January 2011, we started with a two-year investigation of forty FGCs in the PMHC setting in the province of Groningen, the Netherlands (see De Jong and Schout, 2012). On each conference, we will execute a case study (Yin, 2009), using mixed methods (Creswell, 2009). The aim of our research is to provide an answer to the question of whether Family Group Conferencing is an effective tool to generate social support, to prevent coercion and to elevate the work of professionals.

Meanwhile, we analysed eighteen cases in which we executed around 140 in-depth semi-structured interviews. With this article, we want to share our intermediate findings with fellow researchers and professionals in the field of PMHC and social work. The empirical findings of these case studies show a pattern from shame to self-awareness; expropriation to ownership; social isolation to recovery and participation. We will uncover this pattern by highlighting two case studies. In both cases, clients are living in isolated and marginalised conditions and feel embarrassed of their circumstances. Shame and fear of rejection formed the foundation for why clients were avoiding contact with their network. In both cases, FGC proved to be an appropriate tool for the creation of a safety net around clients so that downward spirals of marginalisation and isolation were broken.

This article presents findings from qualitative data derived from two case studies. When all forty conferences in 2012 have been organised and analysed, we will execute quantitative analysis and publish our main findings.

Data collection

As Drisko (1997) states, qualitative research in social work practices should start with a thorough analysis of the specific problem for a given purpose and audience in order to select an epistemological framework and to choose the right method to derive data. To shine light on the success or failure of one particular FGC for a client in PMHC, everyone who attended the conference was interviewed, as well as the care providers involved and the co-ordinator who organised the FGC. In order to reveal the determinants and mechanisms behind the success of FGCs in PMHC, we executed in-depth interviews structured by a topic list, as, within this type of data collection, the researchers have open minds to new clues and insights. Especially in PMHC, clients and their network have a history in which their own expertise is being ignored by professionals (Schout *et al.*, 2010).

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

Therefore, another reason for this type of data collection is that interviewees are treated as experts on the topic and likely would not be reluctant to participate. The topic list contained the main themes we formulated in a recent article on the findings from the first (exploratory) part of our research (De Jong and Schout, 2011). The main questions during the interviews were: (i) How can the living conditions of the client being typified before and after the FGC? (ii) What is the impact of the FGC? (iii) Did the conference yield a plan and did it work? (iv) Did the conference generate self-determination? In the first case, we interviewed the client, three former colleagues (designated as his network—the concept of family in FGC, besides family members, also consists of all 'significant others', such as friends, neighbours and colleagues; see Pranis, 2000, p. 46), the co-ordinator and the care provider ($N = 6$). In the second case, interviews were done with a couple (to be appointed as clients), the mother of the woman, two friends, the co-ordinator and two care providers ($N = 7$). Interviews ranged in length from sixty to ninety minutes, were audio-taped and transcribed verbatim.

Data analysis and validation

Interviews were analysed along Flick's (2009) analytical methods to derive theory from data inductively, resulting in trends, patterns and deviations of patterns. Themes were partly being designed in advance of the data analysis, as they were derived from the topic list. Themes such as 'What happened before, during and after the conference?' and 'How can the role of the co-ordinator be described?' were formed by clusters of codes. Open coding took place inductively. Trends, patterns and deviations from patterns were converted into a theorising text.

In addition to the interviews, we organised two member check meetings to validate our intermediate findings (Guba and Lincoln, 1989). The purpose of these meetings was to gather ideas, find solutions for bottlenecks, validate interpretations and share findings with those being interviewed in order to prevent confirmatory bias (see Drisko, 1997). Both member checks lasted for 1.5 hours, were audio-taped, transcribed and later on analysed.

During the member check of the first case, the client as well as two of his former colleagues and the co-ordinator were present. The couple from the second case and the co-ordinator were present during the second meeting. Besides the participants and two researchers, during both member checks, a representative from the management team of the Dutch FGC organisation ('Eigen Kracht Centrale'; see *http://www.eigen-kracht.nl*) was present as well in order to validate intermediate findings.

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

Ethical considerations

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

Findings

Case I: social isolation and alcohol addiction

The first case is about a sixty-six-year-old man who, after his retirement, got addicted to alcohol and found himself in isolated circumstances. The addiction had led to a worrisome somatic state. A care provider referred the client to an FGC in order to mobilise support from his network. However, the client had been divorced years ago and lost contact with his ex-wife and children. Contacts with other family members were abruptly broken by conflict or had faded.

The client, aware of his deprived living condition, responded enthusiastically to the proposal of the care provider. The main aim of the conference was creating a safety net around the client in order to prevent further deterioration and offer support to get his life back on track. A co-ordinator from the local FGC organisation was appointed to organise the conference. There was a profound discussion between the client and co-ordinator about those who needed to be involved during the conference, finding a balance between supporting the agenda (mobilising enough resources to ensure the creation of a safety net) and respecting the wishes of the client. Only former colleagues were being mentioned by the client. Notable absentees on the list were his children and other family members, including his brother. After several attempts by the co-ordinator to change the client's mind, he still was not inclined to invite his family. It was decided to organise the conference with three former colleagues.

Interviews uncovered a close relationship between the client and his former colleagues. As former employees of the national postal service (in their own words, a real 'family-run business'—fathers from both client and colleagues also had a lifetime career at this company), they always took care of each other. Before the conference, the colleagues therefore did not act aloof, but they often did not know how to deal with the client's circumstances (severe contamination, poor personal hygiene, drunken and intoxicated by alcohol and therefore unresponsive). As one interviewed colleague stated:

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

> For once, when he was on the phone and said: 'I do not know how to get out of this miserable situation', a whole day I helped him to get out of the mess. And really, there was so much rubble. I have a fairly big car, which was totally loaded with empty beer and wine bottles. That I brought to the landfill. I needed to go up and down three times, and still afterwards there were bottles left! There were about thirteen or fifteen garbage bags I could not bring to the landfill, so I left them behind. I said: 'You have to bring these bags yourself.' And for me this was an indicator, because when I asked him later on about the rubble he answered: 'No, they are still here.' And when I visited him again they were still there. And that's what I mean: it becomes somewhat difficult when he needs to act initiatively himself. He was also not physically able to do it himself, I must confess, because he was too much affected by the alcohol.

Informal support is senseless without a feasible plan. It appears that an FGC creates a platform where participants are able to confront each other with their opinions so that awareness can arise. The client reacts as follows on his colleagues' honesty:

> Yes, I am confronted with their opinions. They [his colleagues] uncovered my severe conditions and made me aware of that if I would continue drinking and neglecting myself I would end up in the gutter.

The conference yielded a plan on how to break through social isolation, reduce alcohol consumption and ensure sustainable attention to his household and personal health maintenance.

One month after we collected and analysed our interview data, we organised a member check in which both client, two former colleagues, as well as the co-ordinator were present. We wondered whether enough effort was made by the co-ordinator to involve family members for the FGC. The member check revealed that the co-ordinator had sufficiently questioned the nature of contacts with family members and the pros and cons of inviting them for the conference. One of the colleagues responded as follows:

> I do know some of his family. We have indicated that it would not be a wise decision to invite them for the conference as well. His family is one of the major causes of his deterioration. You can say a hundred times: 'You're responsible as well for these broken relationships', but that is a bit bluntly. Relationships with his family are so complicated that you do not want them to get involved. In general, when you give these people 1 coin they start asking for 10 coins. And B. [client] is already swindled enough by his family, so we considered it not to be a good idea. So during the conference, I and two other colleagues who never led him down during these years of deprivation were present.

As Mueser et al. (2003) appoint, financial abuse within families where members are suffering from addiction is not unusual—a pattern also visible in this case. Co-ordinators who are organising FGCs in such situations constantly need to consider how much effort they need to invest in changing a client's mind when he or she is reluctant to invite certain

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

members from his or her family who can play a role in the conference and provide support.

Two months after the member check, we had another appointment with the client. He invited us to visit him at home. The purpose of this meeting was to discuss the major findings of this case study, as the following empirical memo indicates:

> At seven o'clock at night, the client is awaiting for us outside his house. Instead of walking on two crutches, such as during the member check, he now moves around on one. He acts sharp as well. One of the former colleagues who was present during the FGC joins a short time later. Both client and colleague agree that a lot has changed for the better: abstinence from alcohol, attention to his household, go forth [alone or with friends], good contact with the neighbourhood [now that client is abstinent he does not have conflicts any more with his neighbours]. Colleagues and neighbours keep an eye on to prevent client from deterioration—like during the member check, the colleague expresses jokingly, but with serious undertone, once again:
>
> 'If I see for once again that at two o'clock in the afternoon the curtains are closed, I know what's happening inside and I'll break your legs.'

This quotation shows the sincere support from his colleague and the acceptance thereof by the client. Professionals could never use equivalent words. We continue the memo:

> On the wall there is a picture of his adult daughter. Client responds emotionally when we ask about her. A conversation unfolds indicating that he is avoiding contact with his daughter because he fears rejection [for the past years he had been constantly under the influence of alcohol and therefore did not act as a good (grand)father].

In a follow-up interview one year after the conference (the FGC was organised in February 2011), contact with his daughter appeared to be restored.

Both shame and fear of rejection played a decisive role in why the client prior to the conference found himself in a downward spiral of addiction, self-neglect and isolation: shame for his living conditions, fear of being rejected by others because of his condition. On the other hand, shame also appears as an engine to become and stay abstinent and to take care of his personal hygiene and his household—there is a drive not to relapse into destructive patterns that he will feel ashamed of once again. A similar pattern is also visible in the next case.

Case II: social isolation and unhygienic living conditions

In the second case, we describe the unhygienic living conditions of a middle-aged couple and how their circumstances improved after organising an FGC. Until two years ago, the couple lived in a socially active

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

neighbourhood. After moving to another neighbourhood, problems began to arise. The man had long-lasting working days, while the woman slightly lost contact with her network and felt depressed. Because of negative experiences with previous relationships, she did not dare to talk about her loneliness and depression with her husband. She started obsessively collecting all kinds of gadgets but, simultaneously, also neglected the household, resulting in a messy house and unhygienic conditions.

Due to these hygiene problems, they warded off family and friends: ashamed of the situation they found themselves in. Gradually, they became more isolated from their network, as the woman emphasised:

> At a certain moment nobody came around anymore. But we knew we were responsible for it ourselves. Also a good friend of mine told me she did not feel welcome anymore. I did not want others to see the trash and the dirt we were living in, so I was keeping them out.

Eventually, the neighbourhood detected odour and vermin, such as rats. Residents mentioned this to officials of the municipality and, shortly afterwards, it was decided that a care provider from the local PMHC team needed to undertake involuntary assistance. After several failed attempts by the care provider to establish contact with the couple, she decided that a co-ordinated action needed to be undertaken to clean up the house. A quote from the man uncovered the impact of this action:

> They had thrown everything away. There was a mattress on our bed and besides of that there was nothing else left. . . . We really thought: we can put the whole house on fire, we do not have anything left.

The couple was not present when their house was being swept. It should be no surprise that they acted aggressively and suspiciously to the care provider and officials from the municipality afterwards.

The co-ordinated clean-up, however, did not solve their underlying problems:

> You can see that the house is clean and empty, but the underlying problem [shame and social isolation] was still there. Actually, problems only got worse.

Afterwards, feelings of embarrassment increased, especially when a local newspaper extensively reported on the sweep.

A short time later, another care provider referred to an FGC that might generates solutions for their problems, mainly to break through social isolation and to create conditions for sustainable attention for keeping their house clean. The couple reacted a bit suspiciously but, shortly afterwards, realised that, with the help of an FGC, they and their network would be able to formulate a plan of their own and that the role of the municipality and the PMHC care provider would be rather modest. Actually, it was agreed between the couple and the care provider that, if they would come up with a plan that would convince the care provider that a

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

sustainable solution was being formulated, she would not interfere with them anymore. The woman expressed this as follows:

> We realised that we had to choose: either dealing with the PMHC or accepting an FGC. To us, the choice was very clear: we will choose for the conference, then at least you still control your own life and it is up to you who you will invite for this conference and what information will be shared. And it is not that care providers are constantly looking after you like: did you do this, did you do that? I would say: is it necessary to involve the PMHC? And my answer is: no, it is not necessary. Than the choice is not so difficult.

Four people were willing to participate in the conference: the mother of the woman, a befriended couple and an employee from a local home care institution who frequently had helped the couple to clean their house.

In situations of severe neglect of the household, it is not uncommon that actors are indifferent when it comes to cleaning. This seems also to be a problem in this case:

> At a certain moment the house was one big mess. But we already did not recognised it anymore, it actually slightly became our reality and took part of our lives. He [her husband] sometimes said: 'If we will put this there and throw that away . . . ?' And then you started cleaning and throwing garbage away, but we only moved things from one place to another. Solving one problem actually uncovered another problem. So this was not a sustainable solution. And I was just not able to do it all myself.

The conference provided a platform for the woman to clarify to her family and friends her current situation. Before, she always hid her true feelings and always acted as if there was nothing wrong:

> During the conference I shared my inner thoughts and feelings with others. That I had never done before. I told them everything: how I thought about our current situation, that I wanted to get out of the mess, and which support I and my husband needed. It felt [during the conference] nobody was controlling me, so I totally felt at ease. My mother also revealed: 'F. would never tell us that she is not feeling that well and that her living circumstances are severe.' And really, that shocked me, because since I'm living on my own I have become an expert in pretending that everything goes well, while actually things got worse. I did not expect my family and friends were affected because I did not reveal my true feelings. A friend of mine told me during the conference that I must not need to feel afraid to share my inner feelings with others and just be straight forward with them.

The conference also had a positive effect on the couple themselves, as evidenced by the following quotation from the woman:

> We were [after the conference] back home and he said: 'Why did you never tell what you have on your mind to me before?' But I did not want to bother him before with my own problems, because he worked so hard every day and had so much trouble himself on his mind. While he responded that he actually wants to be the first person I will share my inner feelings with

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

> when I am not feeling well. Now, he knows why I did feel depressed because I was lonely and did not have any contact with my family and friends.

The member check that followed two months after the interviews revealed that, eight months after the FGC, there was sustainable attention paid to keeping their house clean. Both the woman and her husband agreed that the conference created a platform for discussing circumstances that they were ashamed of before. In addition, the vicious circle of unhygienic conditions, shame and social isolation was broken. Another positive side effect of the conference was that the woman now dares to stand up for herself and discuss issues with her husband.

As we have observed in the first case, in this case as well, there were only a few people from the network present during the conference. This critical comment was being discussed during the member check. The co-ordinator responded that, on the basis of his experiences with former conferences, he decided that action needed to be undertaken and that the conference needed to be organised quickly after the referral, otherwise he expected a high risk of relapse into old patterns. Therefore, there was little time left to restore contact with people from the network who could have made a significant contribution in the conference.

Discussion

What does this study add to the existing knowledge on Family Group Conferencing? What are the implications for the practice of organising FGCs in PMHC? What are the limitations of this study?

Clients in PMHC form a group that social workers and other care providers need to deal with. Clients tend to avoid the care they actually need, risking being socially excluded and deprived of benefits of regular institutions (Schout *et al.*, 2010, 2011). The implication for the practice of social work is that, with the help of Family Group Conferencing, downward spirals of social exclusion can be averted. In the case studies that we have examined so far, informal support is being mobilised and the vicious circle of marginalisation and social isolation is broken. In this article, the two highlighted cases reveal that shame on one side acts as an engine for withdrawal and avoiding contact with family and friends but, on the other hand, can also act as a catalyst of breaking through deterioration and isolation. Our empirical data complement the theoretical work of Nathanson (1994). Alcohol abuse can be seen as a form of avoidance—something visible in the first described case: because the man did not want to face the bitter reality (no contact with his daughter, social isolation), he was constantly under the influence of alcohol. Because of her embarrassment of her living conditions, the woman we described in the second case withdrew from her network and found herself back in social isolation. Shame keeps

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

people from being straightforward with each other. A study of the HvA (2008) on using FGCs in situations of eminent eviction indicated that shame is one of the three major reasons why people who are risking eviction did not want to involve their network for support and therefore rejected a conference. It is assumed that, because of shame of involving family, clients turn to professionals for support (Van Rooijen, 2010). An FGC provides space for an open discussion in which feelings of shame can be shared. In addition, restoration of contacts and mobilisation of support will occur. Increased support—especially in PMHC, where clients normally have a limited network—from the social network is an important benefit. As Poortinga (2006, p. 257) states, 'there is robust empirical evidence from the social capital literature that social networks and support are beneficial for people's health'. In the investigated case studies, only a limited number of people from the network participated in the conference. A study carried out by Malmberg-Heimonen (2011) into the applicability of FGCs in a social services setting for adults in Norway revealed that, on average, 4.8 people from the participants network were invited, while 3.9 of them actually participated in the conference. Still, there was evidence of an increase in social support, life satisfaction and mental well-being. A trend that is also prominent in our case studies is that, in both highlighted cases, the main characters that, with the help of the conference, support from their network increased and they are more satisfied with their lives.

Findings from these case studies supplement a conclusion from Mueser *et al.* (2003) that a social network reduces vulnerability and risk of relapse. A social network prevents marginalisation and isolation from occurring again (see Figure 1). Shame therefore cuts both ways: it stimulates self-correction so that correction of others is no longer needed. In PMHC, correction is normally manifested by coercion, such as unsolicited help and

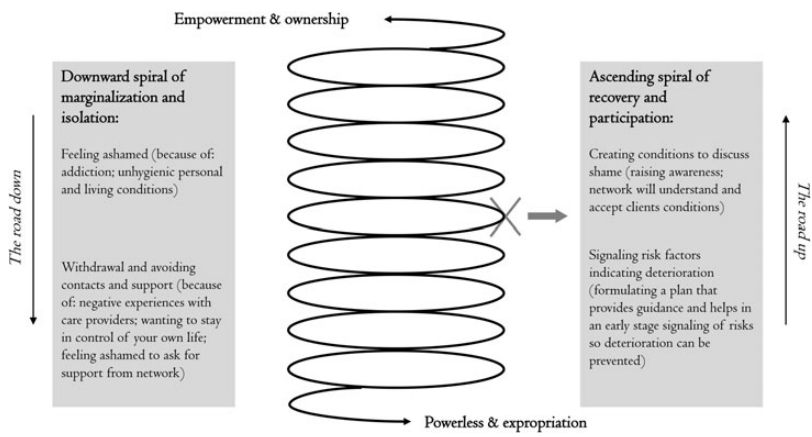

Figure 1 Breaking through downward spirals of marginalisation and social isolation by Family Group Conferencing

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

involuntary admission (Schout *et al.*, 2010). The case studies we have executed so far and the recent study by Schuurman and Mulder (2011) indicates that, with the help of FGCs, coercion can be averted or postponed. It is conceivable that, by averting coercion, clients in PMHC keep trust in care institutions and their representatives.

There are still many unanswered questions. What needs to be done when clients are reluctant to invite crucial members to the conference? Indeed, shame and fear of rejection are strong incentives. Is it the duty of the co-ordinator to insist on overcoming shame and fear of rejection in order to recruit members from the network? Is it the task of the co-ordinator to recover broken and faded contacts or is this the duty of the professional? And, if so, how much time is needed for restoring contacts? In the cases we have studied, the co-ordinator's ability to help select participants for the conference to ensure that those who can really contribute is crucial. A study by Van Beek and Schuurman (2010) into the application of FGCs for people with mild intellectual disabilities designated that the co-ordinator must note the extent to which a social network is capable of taking part in an FGC and to what extent they can influence the outcomes of the plan—a critical issue that a co-ordinator also needs to pay attention to whilst preparing and organising conferences in PMHC practices.

Study limitations

Currently, we have examined eighteen out of forty conferences. The aim of this article is to understand the dynamics that underlie the success of two FGCs in PMHC. We make no claims of universal knowledge; the pretensions of this article are therefore modest. We only wanted to uncover: (i) the influence of shame in the two illustrated cases, both as risk and protective factor, and (ii) the impact that FGCs can generate in mobilising resources for clients with a limited network and breaking with vicious circles of marginalisation and isolation. Nevertheless, we have the impression that the insights can provide inspiration and exemplary value to the implementation and improvement of FGCs in other PMHC settings.

Conclusion

The aim of this article is to reveal how FGCs can help in breaking through downward spirals of marginalisation and social isolation in PMHC. The two cases we have highlighted indicate the impact of shame in both the persistence and reduction of isolation and deterioration. In both cases, shame is a major cause of avoiding contact and support from the informal network. Avoiding situations that one needs to feel ashamed of again seems to be an important drive not to relapse into destructive patterns. The conferences

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

offered a platform where the main characters felt safe enough to address their problems and shameful feelings with their network. The conferences yielded a plan for guidance and support on how to break through their marginalised and isolated circumstances. These case studies therefore confirm an assumption from a previous study that a limited or damaged network is not a contraindication but a reason to organise FGCs.

Acknowledgements

The forty FGCs are funded by the province and municipality of Groningen, the Netherlands. For our research, we received grants from the Dutch Ministry of National Health, Welfare and Sport (Ministerie van Volksgezondheid Welzijn en Sport), the Netherlands Foundation of Mental Health (Fonds Psychische Gezondheid) and NutsOhra.

References

Baffour, T. D. (2006) 'Ethnic and gender differences in offending patterns: Examining Family Group Conferencing interventions among at-risk adolescents', *Child and Adolescent Social Work Journal*, **23**(5/6), pp. 557–78.

Braithwaite, J. (1989) *Crime, Shame and Reintegration*, Cambridge, Cambridge University Press.

Burford, G. and Hudson, J. (eds) (2000*a*) *Family Group Conferencing: New Directions in Community-Centered Child and Family Practice*, New York, Aldine de Gruyter.

Burford, G. and Hudson, J. (2000*b*) 'General introduction: Family Group Conference programming', in G. Burford and J. Hudson (eds), *Family Group Conferencing: New Directions in Community-Centered Child and Family Practice*, New York, Aldine de Gruyter, pp. xix–xxvii.

Chand, A. and Thoburn, J. (2005) 'Research review: Child and family support services with minority ethnic families: What can we learn from research?', *Child and Family Social Work*, **10**(2), pp. 169–78.

Creswell, J. W. (2009) *Research Design: Qualitative, Quantitative, and Mixed Method Approaches*, 3rd edn, Thousand Oaks, SAGE Publications.

De Jong, G. and Schout, G. (2011) 'Family group conferences in public mental health care: An exploration of opportunities', *International Journal of Mental Health Nursing*, **20**(1), pp. 63–74.

De Jong, G. and Schout, G. (2012) 'Researching the applicability of Family Group Conferencing in public mental health care', *British Journal of Social Work* Advance Access published February 17, 2012, 10.1093/bjsw/bcs006.

Drisko, J. W. (1997) 'Strengthening qualitative studies and reports: Standards to promote academic integrity', *Journal of Social Work Education*, **33**(1), pp. 185–97.

Ewertzon, M., Lützen, K., Svensson, E. and Andershed, B. (2008) 'Developing the concept of family involvement and the alienation questionnaire in the context of psychiatric care', *International Journal of Mental Health Nursing*, **17**(6), pp. 439–49.

Flick, U. (2009) *An Introduction to Qualitative Research*, 4th edn, Thousand Oaks, Sage.

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

Gramberg, P. (2011) *Eigen Kracht-Conferenties voor Families en Individuen: Jaarcijfers 2010 [Family Group Conferences for Families and Individuals: Annual Results 2010, The Netherlands]*, Voorhout, WESP.

Guba, E. G. and Lincoln, Y. S. (1989) *Fourth Generation Evaluation*, Newbury Park, Sage.

Harris, N. (2006) 'Reintegrative shaming, shame, and criminal justice', *Journal of Social Issues*, **62**(2), pp. 327–46.

Hayden, C. (2009) 'Family group conferences: Are they an effective and viable way of working with attendance and behaviour problems in schools?', *British Educational Research Journal*, **35**(2), pp. 205–20.

Hayes, D. and Houston, S. (2007) '"Lifeworld", "system" and Family Group Conferences: Habermas's contribution to discourse in child protection', *British Journal of Social Work*, **37**(6), pp. 987–1006.

Heru, A. M. (2006) 'Family psychiatry: From research to practice', *American Journal of Psychiatry*, **163**(6), pp. 962–8.

Hogeschool van Amsterdam (HvA) (2008) *Outreachend Werken bij Dreigende Huisuitzetting: Een RAAK-onderzoek [Outreaching in Situations of Imminent Evictions: A RAAK Study]*, Amsterdam, HvA.

Jubb, M. and Shanley, E. (2002) 'Family involvement: The key to opening locked wards and closed minds', *International Journal of Mental Health Nursing*, **11**(1), pp. 47–53.

Lakeman, R. (2008) 'Practice standards to improve the quality of family and carer participation in adult mental health care: An overview and evaluation', *International Journal of Mental Health Nursing*, **17**(1), pp. 44–56.

Levine, M. (2000) 'The family group conference in the New Zealand Children, Young Persons, and Their Families Act of 1989 (CYP&F): Review and evaluation', *Behavioral Sciences and the Law*, **18**(4), pp. 517–56.

Lourens, J., Scholten, C., Van der Werf, C. and Ziegelaar, A. (2002) *Verkommerden en Verloederden: Een Onderzoek naar de Omvang en Aard van de Groep in Nederland [The Withered and Degenerated: An Investigation into the Size and Nature of the Group in the Netherlands]*, Leiden, Research voor Beleid.

Lupton, C. (1998) 'User empowerment or family self-reliance? The family group conference model', *British Journal of Social Work*, **28**(1), pp. 107–28.

Malmberg-Heimonen, I. (2011) 'The effects of Family Group Conferences on social support and mental health for longer-term social assistance recipients in Norway', *British Journal of Social Work*, **41**(5), pp. 949–67.

Merkel-Holguin, L. (2004) 'Sharing power with the people: Family Group Conferencing as a democratic experiment', *Journal of Sociology and Social Welfare*, **31**(1), pp. 155–73.

Mueser, K. T., Noordsy, D. L., Drake, R. E. and Fox, L. (2003) *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*, New York, The Guilford Press.

Nathanson, D. L. (1994) *Shame and Pride: Affect, Sex, and the Birth of the Self*, New York, W.W. Norton & Company.

O'Shaughnessy, R., Collins, C. and Fatimilehin, I. (2010) 'Building bridges in Liverpool: Exploring the use of Family Group Conferences for black and minority ethnic children and their families', *British Journal of Social Work*, **40**(7), pp. 2034–49.

Poortinga, W. (2006) 'Social relations or social capital? Individual and community health effects of bonding social capital', *Social Science & Medicine*, **63**(1), pp. 255–70.

Pranis, K. (2000) 'Conferencing and the community', in G. Burford and J. Hudson (eds), *Family Group Conferencing: New Directions in Community-Centered Child and Family Practice*, New York, Aldine de Gruyter, pp. 40–8.

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014

Schout, G., De Jong, G. and Zeelen, J. (2010) 'Establishing contact and gaining trust: An exploratory study of care avoidance', *Journal of Advanced Nursing*, **66**(2), pp. 324–33.

Schout, G., De Jong, G. and Zeelen, J. (2011) 'Beyond care avoidance and care paralysis', *Sociology*, **45**(4), pp. 665–81.

Schuurman, M. and Mulder, C. (2011) *Eigen Kracht-Conferenties bij Gezinnen in de Regio Amsterdam: Wat levert het op? [Family Group Conferences for Families in the Region of Amsterdam: What do they yield?]*, Nieuwegein, Kalliope Consult.

Sherman, M. D. and Carothers, R. A. (2005) 'Applying the readiness to change model to implementation of family intervention for serious mental illness', *Community Mental Health Journal*, **41**(2), pp. 115–27.

Sherman, M. D., Faruque, H. D. and Foley, D. D. (2005) 'Family participation in the treatment of persons with serious mental illness', *Psychiatric Services*, **56**(12), pp. 1624–5.

Van Beek, F. and Schuurman, M. (2010) 'Eigen Kracht-conferenties: Kansen en mogelijkheden in de zorg aan mensen met een verstandelijke beperking' ['Family Group Conferences and its opportunities for people with intellectual disabilities'], *NTZ: Nederlands Tijdschrift voor de Zorg aan Mensen met Verstandelijke Beperkingen*, **36**(3), pp. 197–208.

Van Meekeren, E. and Baars, J. (2011) 'Zieke individuen, verstoorde systemen: Over psychiatrische patiënten en hun omgeving' ['Ill individuals, disturbed systems: About psychiatric patients and their network'], *Maandblad Geestelijke volksgezondheid*, **66**(6), pp. 402–15.

Van Rooijen, M. (2010) 'Eigen Kracht Conferenties niet geliefd in psychiatrie' ['Family Group Conferences not popular in psychiatry'], *Psy*, **15**(4), pp. 21–3.

Walton-Moss, B., Gerson, L. and Rose, L. (2005) 'Effects of mental illness on family quality of life', *Issues in Mental Health Nursing*, **26**(6), pp. 627–42.

Yin, R. K. (2009) *Case Study Research: Design and Methods*, 4th edn, Thousand Oaks, SAGE Publications.

Downloaded from http://bjsw.oxfordjournals.org/ at Rijksuniversiteit Groningen on April 22, 2014